DIALOGUE AND DEBATE

Music Therapy in the 21st Century: A Contemporary Force for Change

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Jörg Fachner & David Aldridge (eds.)

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Introduction by Leslie Bunt

It is a great pleasure to be able to write this introduction to the CD-Rom of presentations from the 10th World Congress of Music Therapy held in Oxford in July 2002. A constant preoccupation of attending such occasions is making a choice of what presentation to attend. This is in spite of the conference organisers making life as easy as they can by the careful selection and streaming of presentations into manageable blocks. At such events we are drawn to listening to colleagues within our own area of interest or speciality. A congress also provides opportunities to explore new areas. We may feel obliged to support friends or listen to past students give their first presentation at a major conference. I guess that we can all remember those times when we wonder whether we have made the right choice and whether that close second contender may have in fact be of more interest. So here, thanks to one of the most communicative aspects of modern technology coupled with the professional expertise and work of Dr Jörg Fachner and his colleagues at the Institute for Music Therapy of Witten/Herdecke University, we are able to revisit some of those moments. We have here a record of some of those presentations that you attended and those you did not. You can study the presentations that you missed in lieu of continuing that very interesting discussion in one of the Oxford teashops or bars. You may even be pleased to see how your own presentation has been recorded for others to study.
The Book of Abstracts for the Oxford Congress contained a selection of 250 papers and 42 workshops. Over 40 countries were represented at the Congress. Since the event Jörg has received over 110 articles which they have organised alphabetically. They have also been able to include a few Powerpoint presentations. Powerpoint, alongside video and audio, was very much a feature of the Oxford Congress and we have received much positive feedback for giving access to this technology such a high profile. The availability of these technologies in most of the rooms was a costly investment but as organisers we felt that the results from very satisfied presenters and audiences alike made everything worthwhile. Seeing a room dedicated to technological support in the Examinations Schools of an ancient setting such as Oxford University was on one level rather incongruous - gowns and mortarboards are still common - yet a theme of the Congress was one of a contemporary force for change. Within the last few years regular correspondence by E-mail, for example, has almost become de rigueur in most work and academic settings. One can only but speculate how these technologies will have developed by the time of the Brisbane Congress and beyond.

Dialogue and Debate - this was the main title of the Oxford Congress. From our very first planning discussions we wanted to celebrate these two aspects of hosting this kind of event in a historic academy of learning. The two words are central to what is most human about our most ancient and respected traditions of learning. As organisers we felt that various aspects of these two words filtered through all of our work together during that increasingly glorious week of English weather nearly two years ago. From the outset we also had wanted to focus on three
main areas that appeared to be central to the notion of music therapy at the start of a new century and one embracing aspects of change. For many therapists throughout the world music therapy has its roots in wider musical, cultural and community-based issues. Hence the first area *Music, Culture, Social Action* was introduced with the keynote address from Professor Nigel Osborne. I often find myself quoting the three challenges that Nigel Osborne presented to an audience of over 800 people in the Sheldonian Theatre. Firstly he talked of the practical musical challenges offered by the profession. He highlighted the music therapist's active use of improvisation, incorporating the music of people of all ages in co-created individual and group improvised music-making. Secondly he referred to the intellectual challenges that working as a therapist presents. He compared a group of musicologists exploring some minutiae within late Beethoven to music therapists working towards some theoretical understanding of a music therapy process. Nigel Osborne implied that music therapists had a great deal to offer intellectually to the academic musical community, to the understanding of what music is all about. Thirdly he talked of our 'moral imperative' to go out and work within areas presenting great social and cultural challenge. Here was the emphasis on the social action aspect encapsulated in the title of this area.

I am looking forward to studying the presentations collected together here in relation to these three challenges and am confident that I will:

1. learn a great deal about the practical application of music
2. be challenged intellectually to explore new and different ways of describing the work and
be moved time and time again by the sheer power of music therapy as a means of addressing issues that lie at the core of what it is to be human.

The second area *Music, Meaning, Relationship* moved away from the emphasis on music to examine other frames of meaning within music therapy. In her keynote address the well-known child psychotherapist Dr Anne Alvarez summarised some of the different levels of meaning in psychoanalytic work, making overlaps with aspects of music therapy. I recall her frank honesty in one of her examples when she related her struggle to find the meaning of one of her young autistic children's anger on arriving consistently late to sessions. She told of all her usual analytic interventions that did not ease the situation until the clear simplicity of the reason became apparent, her young patient being troubled by the late arrival of the underground train. She made links in her address to the immediacy and the not only non-verbal but also pre-verbal nature of much of the communications at the root of a music therapy encounter. In these presentations on the CD-R0M you will come across such moments of honesty and insight. You will be able to find out about the many different ways people of all ages use music to communicate with their therapists and how therapists struggle themselves to make sense of what is happening and to reflect critically about the meaning of the therapeutic relationships established within the music.

It was perhaps the third theme *Music, Spirituality, Healing* that was the most controversial to make as a main feature of a world event. Nevertheless we felt that the timing was right for this theme and again the feedback we have received has confirmed this. We were privileged in our
choice of speaker for the keynote address. Many colleagues from around the world have fed back that they regarded the Very Reverend Michael Mayne's address as the most inspiring moment during their time in Oxford. Several people regretted missing this event. Michael Mayne's words appeared to draw together and touch the core of people from all different traditions, systems of belief and philosophy and experiences. His final reminder to consider a person as 'not a problem to be solved but as a mystery to be loved' was a powerful message for us all, coming from a man whose life has been dedicated to ministering to and serving others. Again this collection presented here enables us all to reflect further on the more ineffable aspects of our work, areas that have always been part of the work but perhaps, post-Oxford, have been given a more coherent voice.

I have many treasured memories of the 10th World Congress of Music Therapy. I recall the variety of meetings and discussions with many old and new colleagues and friends from around the world. There was a real lively feeling of Dialogue and Debate, even if Friday evening's programmed debate on the survival of music therapy surprised a few by not being perhaps as formal as expected! If you happened to be present at this rather outrageous event you may recall that, in my rôle as Chair, I chose to conclude by over-ruling the arguments for the survival of music therapy. However as I mentioned in the closing ceremony the quality of the work presented at Oxford and now available in this format bears witness to the fact that there is no fear of music therapy not surviving well into this century.
I would like to thank members of the International Scientific Committee for assisting in the difficult process of making the final selection of the presentations for the Congress and consequently influencing what has been possible to include here. Once again a big 'Thank You' to Jörg Fachner and especially David Aldridge for their dedicated hard work in making the production of this CD Rom possible.

Leslie Bunt
Chair of the International Scientific Committee
10th World Congress of Music Therapy
Oxford, July 2002
Sing & Grow: A New Music Therapy Initiative to Meet Family Needs in Community Settings

Abad, Vicky; Edwards, Jane
Abad, V. Director, Sing & Grow
Playgroup Queensland
Brisbane, Australia

Edwards, J. Course Director & Senior Lecturer
MA in Music Therapy
Irish World Music Centre
University of Limerick
Ireland

Introduction

This paper reports a new initiative in music therapy to meet the needs of families with young children in community settings. The theoretical basis for this project, implementation in the community sector, and outcomes to date will be presented. Case vignettes will be presented that illustrate how music therapy has been used to address identified needs with clients.

Sing & Grow

Sing & Grow is a new music therapy program funded by the Australian Commonwealth Government and presented in partnership with Playgroup Queensland and The University of Queensland for a two-year period. The bid to run the programme was conducted competitively with the music therapy programme at the School of Music, The University of Queensland initiating the bid process in response to a call for new
initiatives to promote family well-being from the Commonwealth Government.

The project provides opportunity for families with Queensland Australia to access a regular series of weekly music therapy sessions over a ten-week period. This opportunity serves as an early intervention strategy to families in communities identified as marginal as a result of socio-economic circumstances including low income, single parenthood, young parenthood, drug and alcohol addiction, living with a disability and being a member of a cultural minority. Families are referred to the program via Playgroup Queensland, Child Health nurses, General Practitioners, social workers and community organisations. Participation is voluntary and free. Over a two-year period, forty programmes will be conducted to a target group of some four hundred families.

Rationale

Children’s development is contingent on a number of factors including the provision of a loving, safe and supportive environment as well as an environment in which the capacity for attachment and close bonding between parent and child is available and realised. Parent-child relationships that are characterised by insecure attachment and a lack of emotional warmth may lead to an increased risk of the child developing major behaviour and emotional problems.

Infant development can be acutely compromised by a number of parental factors including the presence of maternal depression, (O'Connor, Heron, Golding, Beveridge & Glover, 2002), age at the birth of the child and
history of psychiatric disorder (Sidebotham, Golding & The ALSPAC Study team). While child maltreatment knows no economic and social boundaries, parental poverty is a risk factor for physical abuse however is not a risk factor for any greater incidence of emotional abuse than occurs in the general population (Jones & McCurdy, 1992).

Family intervention is a generic term used to define an intervention process that targets family interaction patterns assumed to contribute to the development and maintenance of disturbances in the child’s functioning (Sanders & Markie-Dadds, 1996). Intervention is based on the assumption that many child behaviour problems arise at least in part because of disturbances in parent-child relationships that can be mediated by better support and parenting education.

In the Sing & Grow program parents and children aged 0 – 3 years are provided with opportunities to participate in a 10 week music therapy program aimed at offering musical interaction to assist in the development of the child’s cognitive structures, physical co-ordination and emotional expression. The programme aims to deepen the bonding between parent and child, and increase appropriate interactions between parent and child. Sessions may be conducted within a Playgroup setting or other community centre context.

Research has indicated that music presented to families in a group setting can support them in developing skills that enhance parent-child relationships (Vlismas & Bowes, 1999, Oldfield, 1995, Oldfield, 1999, Oldfield & Bunce, 2001; Shoemark, 1996; Hibben, 1992). Using music to engage a parent and child to help enhance difficult relationships could
therefore be seen as an extension of a phenomenon which is already present in society (Oldfield & Bunce, 2001, p.29).

Music provides a way for families to come together and share an intimate experience within a group setting in a non-threatening environment. Music and movement such as singing of lullabies accompanied by rocking and dancing with infants has traditionally been used by mothers to build a communicative relationship with their infant (1) and is shared across many cultures. The act of singing is one of the earliest and most common forms of musical interaction shared between a parent and child, particularly the singing of lullabies.

Shoemark (1996) conducted a family-centred music therapy program within a playgroup setting with children diagnosed with a condition that was likely to lead to developmental delay. The programme aimed to nurture creative expression in family members and assist enjoyment of each other; and help build mothers confidence in creating any kind of music through offering regular music therapy sessions. The session plan incorporated sitting on floor in circle, using familiar and action songs and quieter material to conclude. Each family was given a tape and booklet with the songs for use at home. Evaluation of the program showed that families were most supportive about the cassette and book; and staff acknowledged the engaging quality of a music program provided by a music therapist that allowed for flexibility.

Oldfield & Bunce (2001) reported on a mother and toddler group that aimed to help families experiencing difficulties with parenting. Many of the mothers had not experienced good parenting themselves and the
programme offered an opportunity for these parents to be shown good modelling care. Families referred to the service had children who experienced extremes of normal behaviour. Music therapy was incorporated into the second half of a 12 week treatment program. Thirty minute sessions were conducted with a flexible structure based around a session plan that included a greeting song, instrumental play, improvisation and action song. Sessions were concluded with quiet relaxing music that encouraged physical closeness between the parent and child, usually rocking to lullabies. This program allows for the parents to interact with their children in positive and spontaneous ways. It helps to recreate a warm, simple interaction between a mother and her child and helps families rediscover the ability to have fun together through music making.

**Implementation and outcomes to date**

This project began in July 2002. Given the unique nature of the project the first 6 months was spent reading related literature and establishing the program. This period of time also saw the development of song material including choosing songs and composing originals, establishing a referral system and developing resources.

The service needed to be promoted within the community sector as a new initiative that people from marginalised communities could access. This included educating the community sector on the benefits of music therapy as well as informing them about the Sing & Grow project.
It became clear early in the project that the success of each program would depend heavily on the relationships that could be established in the community with organisations that supported the families. A total of 30 in-service presentations have been delivered over the past 12 months to approximately 200 people from community organisations that support marginalised families within the identified regions of Brisbane, Logan and Gympie. This included organisations for young parents, young women in crisis, women who have experienced domestic violence, parents and children with disabilities, indigenous families and families from non-English speaking cultures.

During this time a trial program was conducted at a Brisbane Community Centre to evaluate the effectiveness of the songs used, the session plan and techniques used to successfully meet the program goals. Goals and objectives were established based on the outcomes of the project. These are the same for all 40 programs but may be modified if necessary to ensure that the program remains client-centred.

The established goals and objectives of the program address the areas of:

- Parent-child interactions
- parenting skills
- cognitive and physical development
- social skills.

Opportunity to successfully meet these goals is provided each session through various interactive music based activities. The session plan was devised to allow for these opportunities within a structured yet flexible environment. Parents are actively encouraged to sit on the floor in a
circle formation and participate in the program as it is hoped that inclusion will help them learn new skills for playing and interacting with their children that they will be able to transfer into the home environment. Techniques aimed to improve parent-child interactions and child development are modelled by the music therapist each session. To assist in this transfer of new skills from a therapeutic environment to a home environment a free CD and booklet of the songs is supplied to each family.

The community based programs began in January 2002. To date, 22 programs have been implemented in the identified target regions. A total of 213 families have been referred to Sing & Grow programs. Attendance is voluntary so not all of these families have followed through to attendance at all session however, attendance records show that 82% (174) have attended at least one session offered. 220 infants and toddlers have so far participated in the program.

**Service delivery**

- 18 programs have been conducted with families who experience socio-economic difficulties and/or parenting issues:
  - This includes young parent groups (under 25); young women in crisis care; low socioeconomic status; families from Non-English speaking cultures; families with parenting issues such as bonding; and women who have experienced domestic violence and/or abuse.
- 3 with families who experience a disability and 1 with indigenous families:
  - these included 2 programs with Children of Deaf Adults, and 1 group with women who have learning difficulties and/or mild intellectual disabilities and their children.
- 1 group with indigenous families.
Evaluation of the programs completed has shown that parents and children have improved in all of the outlined goal areas. Parental feedback in the form of questionnaires indicates that all families have enjoyed participating, felt the experience was valuable and had learnt new ways to use music at home. Most families reported that the way they use music at home had changed since participation in Sing & Grow, including more live music in the home and an increased repertoire of children’s songs, singing songs from the group together, playing real and imaginary instruments, and using music to help with chores and behaviour management.

**Conclusion**

The use of music therapy to assist parents take on successful and nurturing parental behaviours in interaction with their young children is not new. The Sing & Grow initiative is however unique because it has harnessed the resources of the government to underpin the development of a wider ranging programme that will ultimately be delivered throughout Australia and perhaps more widely in the world. Music therapy offers opportunities for social change, especially in providing input and support people whose social disadvantage has the potential to impact on the current future functioning of their children.

**References**


Adolescence: A time of turmoil: the role of music therapy in assisting the transition from childhood to adulthood in paediatric oncology.

Abad, Vicky

The purpose of this paper is to present case material and related literature that supports the use of music therapy with adolescents diagnosed with cancer. Adolescence is a time of great change, as a child begins the transition into adulthood. A diagnosis of cancer at this time complicates this already challenging phase of development. Music therapy methods helpful in meeting the unique needs of adolescents will be examined and discussed and case examples provided.

The last decade has seen a continuation in advances in research and treatment of childhood cancers resulting in the prolongation of life for many children diagnosed with the illness.

Acute Lymphoblastic Leukaemia (ALL) is the most common form of childhood cancer. Presently, 95% of all children with ALL achieve complete remission, 70% remaining in remission for 5 years or longer (Rostad & Moore, 1997). These increased survival rates reflect the advances in medical technology and treatment, but do not reflect the challenges faced by the patient and their families (Rait, Ostroff, Smith, Cella, Tan & Lesko, 1992). Surviving an initial diagnosis of cancer does not guarantee the end of confronting stresses. As Bauld, Anderson and Arnold (1998) stated “with progress in medical treatments, the imminence of death is replaced by uncertain survival” (p.120). The illness status may change from life-threatening to chronic. Chronic
illness often occurs as the result of aggressive treatment necessary to kill the cancer cells. This includes such regimes as chemotherapy, radiation, surgery and Bone Marrow Transplants or BMT (Rait et al., 1998). This is the process of replacing diseased bone marrow with healthy marrow from a donor (Daveson, 2001).

It is well documented that the treatment of cancer and associated side effects can often cause more distress and pain than the disease itself (Redd, 1994, Hadley, 1996). Studies have reported that several childhood cancer survivors rated the side effects of the treatment as the worst thing about having had the disease (Roberts, Turney & Knowles, 1998; Zelter, 1993). Side effects range from acute nausea and vomiting, hair loss and lethargy to chronic complaints such as infertility, organ damage, cognitive and growth deficits and secondary cancers (Bauld et al., 1998; Rait et al., 1992; Boldt, 1996, Hadley, 1996).

Psychological effects include changes to independence and daily activities, increased risk of reduced self esteem and heightened family stress (Boldt, 1996; Hadley, 1996). Patients who receive a BMT are at further risk of prolonged isolation, increased dependence on adults, reduced levels of activity due to severe lethargy, and increased risk of flattened affect, loneliness and depression (Hadley, 1996; Daveson, 2001; Brodsky, 1989).

This is because the process of a BMT requires that the person be isolated for lengthy periods of time to reduce the risk of infection as their immune system is suppressed. It also results in the child becoming very ill.
A diagnosis of cancer at any age is stressful to all involved. For the adolescent however, the diagnosis comes at a time when they are already experiencing physiological and psychological change and uncertainty.

Adolescence is a period of growth and development characterised by unique changes in cognitive, emotional, social and physical functioning. During this period young people are establishing their independence and identity (Robb, 1996) and creating new roles and boundaries which involve increased levels of responsibility and autonomy (Pendley, Dahlquist & Dreyer, 1997). It is also a time involving social growth in which the adolescent separates from the family and begins dating (Roberts et al., 1998). Peer acceptance, sexuality, body image and emerging independence are issues of paramount importance during adolescence (Kennelly, 1999; Pendley et al., 1997; Roberts et al., 1998).

Cancer treatment imposes increased dependence on parents and sets adolescent cancer patients apart from their peers (Kennelly, 1999; Robb, 1996). Hospitalisation introduces restrictions and stressors that can impact on normal development (Robb, 1996). Adolescents’ usual concerns with body image, emerging sexuality and peer relationships are complicated by the life-threatening nature of cancer and its treatments (Roberts et al., 1998). This, coupled with the normal developmental tasks of adolescence may present many barriers to effective coping (Kennelly, 2001).

Research has indicated that most adolescents who survive cancer show no serious long term emotional complications (Madan-Swain, Brown, Saxson, Baldwin, Pais & Ragab., 1994; Bauld et al., 1998; Redd, 1994;
Roberts et al., 1998). However, it is acknowledged that cancer treatment and pending survival is an extremely difficult experience to endure with noteworthy psychological implications (Kazak, 1993; Bauld et al., 1997; Redd, 1994).

Studies show that adolescent cancer survivors may experience body image disturbances and adjustment difficulties post treatment (Madan-Swain, 1994); employ non-productive avoidance strategies such as denial and have fewer problem-solving skills (Bauld et al., 1998; Bull & Drotar, 1991). They also tend to be more anxious and shy than healthy peers and to participate in significantly fewer peer activities, resulting in higher risks of social isolation (Noll, Bukowski, Davies, Koontz & Kulkami, 1993; Pendley et al., 1997).

While not all young people with cancer experience adjustment problems it could be said that they are at increased risk for developing psychosocial difficulties during adolescence (La Greca, 1990, cited in Pendley et al., 1997), and chronic medical conditions with associated long term social consequences (Rait et al., 1992; Roberts et al., 1998).

It is the role of the health practitioner to therefore ensure that the young person is provided with appropriate opportunities to cope with the multiple stressors that they will face. Adolescents struggling with loss of independence and sense of control, altered body image and potentially reduced feelings of self esteem may require specialised psychosocial support.

Music therapy in a hospital setting aims to facilitate adjustment to hospital for the person and where indicated their family (Edwards, 1999).
According to Edwards (1999) “music therapy is provided to increase opportunities for the use of adaptive psychological means in coping effectively with the disruption and changes associated with admission, treatment and recovery” (p.21).

Music therapy interventions are designed to help paediatric oncology patients to cope with pain and anxiety associated with hospitalisation (Standley & Hanser, 1995; Daveson, 2001; Maranto, 1993; Brodsky, 1989; Hadley, 1996; Bailey, 1983) and psychosocial issues that may arise as a result of separation, loss of independence and locus of control; increased dependency on others, stimulus deprivation and isolation (Daveson, 2001; Edwards, 1999; Kennelly, 1999; Boldt, 1996; Maranto, 1993; Brodsky, 1989; Standley & Hanser, 1995). Feelings of withdrawal, depression and self-helplessness can therefore be addressed (Daveson, 2001; Brodsky, 1989; Maranto, 1993; Hadley, 1996; Kennelly, 1999; Robb, 1996; Bailey, 1984; Dileo, 1999; Turry & Turry, 1999; Standley & Hanser, 1995).

This paper will now discuss specific methods effective in meeting some of the outlined needs of adolescents with cancer, and provide clinical examples that illustrate the effectiveness of music therapy with this population.

**Song writing and performance to provide opportunities for self-expression and improve self-esteem.**

There is growing recognition that children and young people need to communicate their hospital experiences (Brodsky, 1989). It is widely accepted that music plays an important role in the lives of most
adolescents. Using music as a medium to express one’s thoughts and feelings through song writing, including song parody and performance would therefore seem a an appropriate and non-threatening medium for self-expression.

Song writing provides a flexible yet structured musical medium for the expression and communication of thoughts and feelings (Robb, 1996; Kennelly, 1999; Bailey, 1984; Dileo, 1999; Turry & Turry, 1999).

Song writing also allows for experiences of mastery and therefore helps to increase feelings of self esteem and self worth.

In a case study of a teenage boy undergoing treatment for a relapse of ALL, Kennelly (1999, 2001) reported that song writing facilitated the patient to relate his musical experiences to his own feelings. This was despite his refusal to otherwise discuss his illness with staff or family. Hadley (1996) reported that a teenage girl in isolation for BMT participated in song writing and maintained a positive attitude despite her medical decline and physical weakness (p24 –25).

Ledger (2001) reports on a case study in which a 12 year old girl composes a song parody during music therapy sessions that expresses her feelings about her illness and treatment. Ledger felt that the parody exercise had assisted her in adjusting to the cancer, treatment and hospitalisation, as well as providing opportunities for feelings of mastery and control (p.26 & 27). Ledger states that “the idea of parodying songs is highly appealing to adolescents, perhaps because popular music is such a normal and valued part of their lives. Through writing their own lyrics
to a favourite song, adolescents not only express themselves but also gain a unique sense of accomplishment” (p.23).

Song performance allows for the expression of one’s feelings to a broader audience and provides for opportunities to experience success and empowerment. Such experiences in turn help to improve feelings of self esteem. Aasgaard (2000) proposed that song performance brings a new dimension to the song creation. Standley (1996) refers to a case example of a 15 year old boy being treated for terminal cancer who performed a Christmas concert for staff and patients. Of particular interest is the reported excitement of the boy to the reaction of the staff. Ledger (2001) reported that the first time her client sang during music therapy sessions was when she performed her song to family and staff.

Case Example

Jane is a 17 year old girl who was in hospital for an extended stay due to continued respiratory deterioration, malnutrition and arthritic joints. These chronic illnesses resulted after a BMT in July 1999 for treatment of an ALL relapse. Long recurrent stays in the hospital saw music therapy become a regular part of her treatment regime. During this hospitalisation Jane became depressed and reported wanting to “end it all”. She was seen by a psychiatrist but refused to speak to him.

Music therapy focused on providing Jane with opportunities to participate in normalising and positive experiences that would help address self-esteem issues; and opportunities to sing in order to express her feelings and exercise her lungs. Jane had been an accomplished pianist prior to her illness and still enjoyed singing.

Each session Jane would request songs for the music therapist to sing and play on her guitar. Jane would often join in singing, and one day began attempting to harmonise. Together, Jane and the music therapist established harmony lines for her favourite songs. Nurses began visiting her room regularly during mt sessions and telling her how beautifully
she sang. Jane appeared excited and flattered at this new attention she was receiving.

Music therapy sessions continued daily for 2 weeks before the topic of song writing was discussed. This came about during an improvisation by the music therapist aimed at reflecting Jane’s feelings on a particular day. She had thought it amusing. It was agreed that the words of a favourite song could be changed to better reflect how she felt. Hence a song parody exercise began. Jane altered the words to the tune “What’s Up” by the 4 Non-blondes with minimal assistance from the music therapist. She chose this medium to express how she felt about her ongoing chronic illness and the daily battles she faced.

Jane decided that she should “perform” this song for the staff. A concert was hosted in her room where 30 – 40 people attended. Jane’s mother and aunt provided food and drinks adding to the party atmosphere. The concert was a great success. Each song was accompanied by guitar and select percussion. Her song choices included favourites such as Aladdin’s A Whole New World, and songs that were suggestive of her unresolved fears such as Eric Clapton’s Tears in Heaven. Her song parody had references to suicidal ideations. This had been discussed in music therapy and with Jane’s permission a copy of the words had been forwarded to the psychiatrist. He chose to attend the concert and discuss this rather than directly discuss the song words.

Music therapy provided Jane with much needed psychosocial support during her long hospital treatments. Song writing had enabled her to express thoughts and feelings she had been unable to discuss with her family or doctors. Performing allowed her to experience mastery and to have some control over aspects of her life again. Positive feedback from staff and peers boosted her feelings of self esteem, evidenced in increased social interaction, laughing, smiling and a more relaxed state during and after music therapy sessions. Staff reported that Jane would hum all afternoon and be more approachable and more willing to comply with treatments after sessions.

Lansky & associates (1993) viewed adolescent refusal to comply with treatment as their way of asserting their independence and to demonstrate that they are in charge of their own lives. They stated that providing
opportunities to practice control may enhance compliance issues with treatment (p.11). This was the case with Jane.

**Music relaxation and directed imagery to provide opportunities for reduction of anxiety and pain.**

Listening to music combined with relaxation techniques helps to reduce anxiety, increase relaxation and afford for a sense of control over one’s environment.

As well as anxiety reduction (Edwards, 1999; Edwards, 1995; Daveson, 2001) music listening can help reduce the perception of pain and discomfort (Bailey, 1986; Beck, 1991; ) and feelings of nausea (Frank, 1985; Standley, 1992; Boldt, 1996). Music therapy provides opportunities for the exploration and management of these anxiety related feelings with the goal of increasing a sense of control (Edwards, 1999).

Music and directed imagery involves the listening of music in a very relaxed state in order to elicit spontaneous imagery related to therapeutic goals (Maranto, 1993). This may serve as a useful tool to harness the already fertile imagination of most adolescents. A relaxation induction is generally given prior to the music being played and imagery is suggested. The length of music is limited and images are discussed afterwards. No interaction is usually carried out between the client and therapist when the music is playing (Maranto, 1993).

In a study conducted by Plaff, Smith & Gown (1989) paediatric cancer patients who used music assisted relaxation reported a reduction in pain.
Robb (2000) reported that music assisted progressive muscle relaxation produced the greatest reduction in anxiety levels for the subjects. In a 1996 study Boldt reported that all subjects undergoing BMT and music therapy reported positive responses to relaxation and imagery during sessions.

Relaxation techniques taught to the teenager during music therapy sessions provides opportunities for empowerment. This is supported by Ellis (1991) who stated that self-administered techniques give the adolescent a sense of being in control. Gfeller (1992) stated that the music therapist has dual roles in music relaxation and imagery exercises. One is to facilitate relaxation, the other is to coach the client in the relaxation techniques.

*Jonathon is a 13 year old boy who was referred to music therapy for anxiety and pain management after an ALL relapse. He was being treated with chemotherapy, radiation and surgery in preparation for a bone marrow transplant. After initial music therapy sessions, Jonathon chose a program that consisted of learning the guitar and music relaxation and imagery.*

*The program goals were to provide opportunities for Jonathon to experience success and mastery; to reduce feelings of anxiety associated with hospitalisation and to provide strategies for pain management.*

*Sessions would consist of guitar practice and a music relaxation and imagery exercise. Jonathon asked if he could learn the induction so that he could practice the relaxation exercises with his tape when the music therapist was not available. As his treatment progressed, he became too weak to play the guitar. During this phase, sessions concentrated on relaxation and pain management. Due to pain that Jonathon was experiencing a colour induction was used rather than physical muscle tension/relaxation techniques. This involves the client choosing a colour and the therapist guiding the specific relaxation of muscle groups by instructing the client to imagine that the colour is moving around this part of the body. Prior*
to the induction Jonathon would choose a “destination” and share it with the therapist. At the end of the induction the therapist would say “I am going to play the music now. Allow the music to accompany you on your journey”. Music from the CD *Music for Dreaming* would then play for c.7 minutes. No interaction was encouraged during this time. At the end of the music, Jonathon would report feeling sleepy and relaxed, and would discuss “the trip” as he called it.

Jonathon went to many places including the beach, mountains and Antarctica. He never saw other people on his journeys but would see animals and beautiful landscapes that he reported as “calming and gentle”. One day when he experienced a high fever he asked his mother to put on his music so he could go “on a trip”. After the exercise his temperature had dropped significantly. His mother asked “where did you go because wherever it was it worked in bringing down your temperature” to which he replied “I’ve been to Antarctica”. This journey was not facilitated by the music therapist.

Jonathon was able to practice control over his immediate environment by preparing himself in a relaxed state to listen to his tape whenever he felt the need to escape from the confines of his room. This exercise became a special time for family, when they would all sit together, close their eyes and listen to the music.

**Instrument learning to provide opportunities for mastery, empowerment and improved self-esteem.**

Mastery is a technique that helps facilitate an experience of empowerment and increased sense of control over one’s environment by successfully achieving a set task. Daveson (2001) summaries empowerment as a process, or mechanism that results in people, organisations and communities gaining control over their own lives or situations. Empowerment may result in a change in the perception of one’s opportunities for choice and control (Daveson, 2001). and may also result in the acquisition of practical skills (Keiffer,1984 cited in Daveson, 2001).
Learning an instrument provides a motivating and age appropriate way to engage a teenager in music therapy. This may be particularly so with boys who might view guitar playing as cool but singing with the female therapist as not so cool.

In a case study conducted by Lefebvre (1991) music lessons were provided to a 16 year old girl attending a day psychiatric hospital to address self-esteem and loss of control issues. Standley (1996) reported a case study where the guitar was introduced to engage a withdrawn 15 year old boy with terminal cancer. He immediately became interested at the prospect of learning the guitar and participated in lessons over several months. His levels of motivation, cooperation and communication increased. Daveson (2001) suggested that music lessons may be a useful method for meeting the psychosocial needs of children in isolation for a BMT.

Ryan, a 14 year old boy was referred to music therapy because of social withdrawal. Ryan had a long history of illness and was well acquainted with the hospital system and staff. He had first been diagnosed with ALL at the age of 4. He was referred to music therapy during his 3rd relapse and treatment in preparation for a BMT. Ryan did not engage with the music therapist in initial sessions, avoiding eye contact and responding to questions with yes/no answers. After a week of sessions pre-transplant, Ryan’s mother suggested that maybe he could learn the guitar while in isolation to help alleviate the “boredom”. Ryan thought this was a good idea, particularly when his dad added that he would be able to serenade girls when he got better.

“Lessons” began in music therapy with the program goals: to provide opportunities for mastery; empowerment; self-expression and control, and to reduce isolation and increase feelings of self-esteem. Sessions began with identifying songs that Ryan would like to learn, followed by learning and practicing chords and repertoire. Each session would conclude with a performance by the music therapist of songs that Ryan
requested. Despite becoming too ill to play for a time Ryan continued to request music therapy each day and ask the therapist to play for him. As he recovered he continued to play the guitar. His repertoire included Amazing Grace, Tom Dooley (to learn chords) and pop songs such as Savage Garden’s Truly Madly Deeply; Greenday’s Time of Your Life; and Blink 182’s All the Small Things. Staff would come to hear him play and compliment his skill. After treatment finished for transplant, Jonathon experienced many chronic side effects that meant he had to stay in hospital for an unknown length of time. His mother asked if I could try and get him a guitar for Christmas to cheer him up and also to allow him to continue playing after hospital. A local charity donated the money to buy Ryan his own guitar and this was presented 2 days before Christmas.

Music therapy in a children’s hospital provides us, the health practitioners with a useful and age appropriate tool for addressing some of the many challenges faced by young people such as Jane, Jonathon and Ryan.

When working with adolescents we must not forget that they are experiencing a time marked by emotional and social turmoil and great physical and cognitive changes. A diagnosis of cancer at this time inevitably leads to exposure to multiple stressful situations and potential barriers to effective coping. This paper has demonstrated the humanising, flexible and personal ways in which music therapy methods can be adapted to provide for the psychosocial needs of adolescents.

If we choose to rejoice in the medical advances that prolong the life of children with cancer, we must also accept responsibility for the ongoing challenges and upheavals faced by the adolescent during and after treatment.
We can help by providing psychosocial support to assist in the ongoing transition from childhood to adulthood and the ultimate goal of a long and healthy life.

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Novel methodology in psychodynamic group music therapy: treating the patients, training the carers

Anthi Agrotou

Introduction

Though the work presented today grew out of the special situation wherein I found myself, it evolved into a doctorate study that can have wider applications. This special situation concerned the isolation of being the only constant therapist in an isolated institution situated outside the capital of Cyprus.

Therein staff and residents lived estranged lives, with little emotional contact between them. The residents, classified as profoundly learning disabled, had spent their days since early childhood in one room with nothing to do, and the carers, untrained and unsupported, believed in their majority that they were caring for people who felt little and thought even less.

In my desperation to alleviate my own isolation there and that of the institution's population, I decided to create groups with stable resident and carer members. From there a methodology evolved that aimed to create auxiliary therapists out of untrained carers and to facilitate life attachment bonds between the estranged carer and resident members. It also aimed to address the residents' isolating and handicapping symptoms. What actually happened, I shall try to present here today, by focusing, as an example, on one such group.
The carer members were selected at random. The reason was to alleviate the staff's envy and persecutory feelings towards me as being someone who chose some and rejected others. Four carers were thus selected, three as permanent members and the fourth as a substitute, in case of absences.

The selection of the patients followed discussions with the selected carers, the psychologist and the director.

Three women carers were selected, all aged about twenty when we first met in April 1994. They had all spent their entire life in isolation. They had never had speech, nor played or occupied themselves with anything; they had never been attached to anyone in particular in the institution where they had been living since the age of five.

One particular carer was to be allocated to one particular patient for the whole span of the group's life. However, they were to choose the patient to whom they desired to channel more attention than to anyone else. The initial direction was that each carer would give full attention to her allocated patient, while at the same time keeping awareness of the whole group. She would be that patient's special facilitator, her auxiliary hand and mind.

**The members of the group**

I am using pseudonyms and only the first names for the patient-members, so that they can easily be identified. For the carers, I am using their surnames.
Sarah was characterized by a piercing look of screaming intensity, which she gave each passer-by, while she always had a stereotype smile. Indeed when she actually screamed, it was as if the sounds poured out from her eyes.

Her frail body needed to bend and lean on others, in order to make any step, or in order to stand up or sit down. Whenever she sat or walked with someone's support, her body was stooped forward, as if she was on the brink of a big fall.

Any soft toy was the only object for which she expressed an emotional need.

Ms Antouna was Sarah's allocated carer.

During her long days in the institution, Jenny usually sat passively for hours, staring into space; or she moved about aimlessly, sometimes laughing or vocalising, while turning her head from one side to the other. Often, she ground her teeth or abandoned herself to stereotype sounds and movements.

Ms Demetriou was Jenny's allocated carer.

Pamina wore a helmet permanently, when I first met her. According to the staff, this was to protect her from head injuries, in case she suffered an epileptic fit. She spent most of her days in the institution unnoticed by all, in silent anonymity.

Confined to a wheelchair and abandoned in infinite silence or a comatose kind of sleep, she was one of the most isolated persons I have ever encountered.
Sometimes she had an anguished look, her hyperventilation setting her whole body moving, as if suffocated by a hidden anxiety. Her only signs of being alive would come during the moments of moving her wheelchair around the room. It was then that she hyperventilated.

*Ms Kazakaiou* was Pamina's allocated carer.

*Ms Lovari* was the supplementary carer member.

*Mr Loizides* was an assistant physiotherapist and was willing to film the sessions. In this way, he became another constant member of the group.

**The beginning of the group**

Our half-hour weekly sessions began in April 1994. The first months were characterised by silence, isolation, but also deeply-buried expressions of agony in the patients. They manifested that pattern of attachment, classified by attachment theorists as "anxious avoidant attachment", that is, expecting that nobody would be there to receive their signals of attachment needs, they lived as if the comfort of human intimacy did not matter [Bowlby, 1988]. The carers' anxiety was manifested by indifference and frequent absences. Ms Kazakaiou had said during those months: *it is ridiculous to think that people like Pamina have feelings and thoughts.*

**The session of July 15, 1994: awakenings**

To our great surprise, it was Pamina who first led the group towards communicative expression. None of us could have predicted this during the group's initial stages, when Pamina's face underneath her helmet
would appear to have succumbed to life's closing end: still, motionless, comatose.

It is the 15th of July, 1994, three months after our first session. Pamina creates her first sound through her mouth, and this becomes even more important by the slow-moving gesture of creating it over her lifted palm. By pressing and pushing her tongue with force on her hard palate, she communicates her first sound, a sound that the carers had not previously heard in the institution.

Then I respond to the quality, form and rhythm of her sounds by using the temple-blocks. Almost at once Pamina recognises that someone is responding to her and she creates rhythmical themes and variations in her own part.

Here we are watching the beginnings of this first conscious communication. Gradually, Pamina will take part in a dialogue, expecting my responses one second after the end of her own part. She seems to be feeling, however, that all responses originate from her allocated carer, as it is towards her that she keeps turning her head.

*Video excerpt taken from the session of July 15, 1994*

Within two minutes, Jenny reacts: it seems to be hard for her to be present during this first, clear communication initiated by a member of the group, and she heads for the door.

Pamina has just discovered a way of communicating with others - perhaps this is the first time in years that she takes an active part in a human exchange. While trying to keep her interest alive by adding
melodic phrases, I also give direction to Ms Kazakaiou's temple-block phrases, facilitating thus her learning to respond to Pamina on the spot; and Pamina succeeds in maintaining her own part for another ten continuous minutes. Her persistence has an impact on the other two resident-members. What happens then?

Jenny will leave the door and go to the piano for her own first sounds, which, in turn, will bring Sarah to her feet for the first time. In other words, at the eleventh minute of the session, Pamina's sustained initiative brings about the simultaneous awakening of the whole group. At the same time Ms Kazakaiou's faint temple-block phrases follow Pamina's mouth-repertoire as close as possible.

Second excerpt taken from the session of July 15, 1994

Theoretical and methodological issues

Attachment and the first, rhythmical part

There are two issues that I wish to discuss here. The first one is methodological and the second one concerns the patients' process.

In terms of methodology, the work was focused on creating a therapeutic environment that would facilitate the formation of affective bonds between the carers and the patients. According to Bowlby, humans are born with a natural propensity to form affectional bonds to particular others. He regards not only the care-seeking but also the care-giving state of mind as a basic component of human nature, to some degree pre-programmed and elicited automatically under appropriate conditions [Bowlby, 1988].
A number of methods were used in order to elicit a care-seeking state in the patients and a care-giving stance in the carers. Under the limitations of this presentation, I shall be mentioning only a few.

One such method was the implementation of a rhythmical part at the beginning of every session: for approximately five to seven minutes, each carer would focus only on her allocated patient. The main objective was to observe very closely every gesture and expression coming from this patient; and secondly, to respond to her rhythmically, only after the patient had first expressed rhythm through her voice or body language. The carer's rhythmical response had to be based closely and directly on the patient's rhythmical "repertoire".

This sole isolation of the rhythmical element at the beginning of every session had multiple benefits: it gave the patients a space of a special kind of quietness and a certain security at having our undivided, exclusive attention. It was also intended to facilitate the carers to experience closer the patients' world by cultivating a stance of observation and abstinence from impulsive action.

The first excerpt that you have watched was an example of such a rhythmical part; you have also witnessed the consequences of such a setting, whereby the patient experiences all sounds as originating from her allocated carer, to whom she thus expresses her acknowledgment for the response; at the same time the carer learns to respond to her patient on the spot, through a discrete suggestion from my part.
Foundation matrix and dynamic matrix

In terms of the patient group, this work has discovered that it functioned similarly to groups with verbally fluent people as described in the work of group psychoanalyst S.H. Foulkes. Like patients who meet in the context of a group-analytic situation, they create a shared psychic life, a psychic network of communication, "a mother soil (matrix) in which all dynamic processes operate" [Foulkes, 1968: 185]. From the beginning mental aspects of their personalities interact between them instinctively, intuitively and basically unconsciously. This is their fundamental mental matrix, which Foulkes called a "foundation matrix" [Foulkes, 1971].

And what was the foundation maxtrix of this group? One of autistic isolation that was shared between all members, each in her own way.

So, in the initial stages, Pamina's typical comatose state was interconnected to the inner world of the other two women. Her comatose sleep constituted a shell of isolation, but also of protection from an unforeseen and threatening outside world - as well as from a tormenting inner world.

It was a similar shell-like encapsulation that characterised Sarah and Jenny, through their continuous fiddling over their skin or over the soft surfaces of objects. By concentrating excessively on such sensations engendered by their own body, they constructed a protective shelter that allowed neither the externalisation nor the reception and processing of information. Such autistic experiences have been illuminated by the work of Francis Tustin [1986; 1990].
Jenny even seemed to have been using her voice towards a similar end. Her repeated vocalisations - whether emitted softly or forcefully - were a continuing flow that formed a barrier, which distracted her attention not only from everything that existed around her, but also from everything that was inside her. It is for this reason that I have called them autistic sounds. You are now watching an example.

*Video excerpt taken from the session of October 3, 1995*

As with time the relationships of the members become more intimate, Foulkes writes that "they also form a current, ever-moving, ever-developing *dynamic matrix*" [Foulkes, 1971: 228].

The individuals are the foreground, the nodal points in this network, while the group is the background. Yet there is a total psychological network in the group within which psychological processes interact between the members. These are "transpersonal mental processes" [Foulkes, 1971], which permeate each individual's psyche like the X-rays permeate the body. Yet each individual resonates such processes in his own key, "elaborates them and contributes to them and modifies them in his own way" [Foulkes, 1971: 229].

In this context, whatever happens to the individual concerns the group and whatever happens to the group concerns the individual members. They all form part of an intertwined whole.

In this group, the dynamic matrix was set going the moment that Pamina allowed herself to communicate for the first time in that session of July 15, 1994. This dynamic matrix concerned the conflict between
externalising affective states and isolating the self, between the need for relationships of intimacy and the fear of such relationships; the conflict between feelings of trust in our benevolent and reliable presence and mistrust in it.

It is this conflict that characterised the group's life throughout, ever since that first group awakening evoked by Pamina's mouth repertoire, only that it moved into ever deeper layers in parallel to the deepening of trust.

**The session of November 7, 1994: loss and abandonment**

It is November 7, 1994, six months from the formation of the group. Pamina makes continuous circles with her wheelchair keeping Ms Kazakaiou as a focal point. She seems to be acting out a series of endless alterations of appearances and disappearances. Every time she turns her wheelchair towards Ms Kazakaiou, the latter reappears, every time she turns her wheelchair away, Ms Kazakaiou disappears. Pamina herself becomes the active creator of the drama of which she had been the passive recipient in the hands of others: that of repeated abandonment. This actively performed drama can be played, only as long as Pamina has experienced within her some trust in the group and Ms Kazakaiou.

Gradually the circles become differentiated. Her torso becomes all the more stooped, her body curled up and even more handicapped. I feel that a dropped and ailing body and soul drives itself into unending, aimless-appearing circles.

Music is called upon, here, to acknowledge and translate the residents' inner world, the way I experience it at that moment: a painful loss.
Then the group will experience clearly a shared affective intensity. Jenny will place her body on her own chair, so as to assume a similar posture to that of Pamina. Sarah's face will assume an expression of piercing pain, as she keeps turning her glance from Pamina's direction towards me and the other members of the group. It is her murmurs that form the basis of my vocal phrases.

*Video excerpt taken from the session of November 7, 1994.*

It is possible that here the group talked, through Pamina, about the fate of being pushed and dragged day by day, about the agony of being enclaved by despair, about repeated losses and abandonment.

**The session of March 27, 1995: Sarah's beater episodes**

The beaters had acquired a particular significance in the sessions right from the first months of the group's life. Until March 1995, almost a year from the beginning of the group, episodes such as the one we are about to watch, characterised Sarah's presence in the room.

Time and time again she would grasp the beaters from Ms Antouna's hands, so as to throw them onto specific targets: either towards the instruments, thus creating loud sounds, or towards specific persons, like her carer or Jenny, or even intending them to miss the musical instruments and end up on the floor.

Intense cries like laughter, but not real laughter, mouth terrifyingly wide-open, tensed eyes, beaters that were falling - it was as if we were becoming fragmented by the force of that tension.
A brief sample of all this follows, in an excerpt taken from the session of March 27, 95.

*Video excerpt taken from the session of March 27, 1995*

**Further methodological issues: The free-discussion group meetings with the carers**

For the carers, Sarah's laughter and behaviour formed no part of a manic defence; on the contrary, Ms Antouna, Sarah's allocated carer, had said at the time: *her laughter and her joy give me satisfaction; it is the satisfaction of seeing someone who is totally passive in the institution become active here.* It was part of the methodology that such attitudes were not corrected by didactic methods. Instead, the space was given for the carers themselves to search for the meaning in their patients' signals, and for their own true feelings and attitudes. For this reason, a special meeting between the carers and myself took place at the end of every music therapy session. These *free-discussion group meetings*, as I called them, were aimed at allowing the carers' thoughts and feelings to emerge freely and uncritically. I was there only as a facilitator, raising the questions, and trusting the group with my own anxieties, ambivalence and countertransference reactions.

**The session of October 9, 1995: Pamina's limbs move**

But what happens to Sarah, when it is Pamina who throws the beater? Her cries become even more intense, while Jenny emits her loud autistic vocalisations at the end of Pamina's phrases; and Pamina discovers yet another way of forming her repertoire: by combining her tambourine
playing with foot-beatings, in order to create a more complex musical structure: rhythm, volume and tempo. She knows that hers are the initiatives, which determine our responses; and at certain moments she plays tricks on us, indicating the timing of her own foot-beating, yet skilfully delaying this for a split of a second. Would we succeed in following her?

The movement of limbs, that were until that moment considered paralysed by the carers, moved them all to tears in this session. While Ms Lovari's tambourine notes enlarge my responses to Pamina on the piano, I try to unite into one whole Sarah's and Jenny's resonances to Pamina's communications. It is October 9, 1995, one and a half years since the formation of the group.

*Video excerpt taken from the session of October 9, 1995*

**Internal worlds of fear and persecution - the paranoid-schizoid position**

By this time it was becoming all the more clearer in the group that each member's actions, movements and creations, were perceived as threatening by the other members, or were intended to be threatening. Sarah would find it difficult to create a note, as if afraid of what was to befall her from all sides; Jenny would either throw the other patients' beaters to the floor or emit her loud autistic vocalisations in order to destroy another's creations; and Pamina could even use her wheelchair to dislodge another member.

Of course the attack was not in the realm of objective reality, but in that of unconscious phantasy, which loomed very real for these patients.
Having never experienced a benign and emotionally responsive primal care-giver, their inner world was peopled with hostile and aggressive objects. According to Melanie Klein, the absence of the breast is not experienced as an absence, but as a presence of a bad breast [Klein, 1952]. When there is nobody emotionally present to receive your fears, anxieties, hatred and aggression, the impact of these emotions rebounds into the self, with the result that they get magnified and distorted.

In the group, the patients bring a psychic world that is tormented with projections and introjections of persecutory and life-threatening objects. As Sinason writes [1992; 1997], for many learning disabled people, the threat of annihilation and wish that they are dead has a basis in the reality of their life experiences, as well as in their phantasy. This means that persecutory anxiety is exacerbated. All these are characteristics of the paranoid-schizoid position, and this is another aspect of the group matrix. As the patients were forming attachment bonds towards their allocated carers and the group, and as the carers were becoming more sensitive to their signals, the feelings of horror and persecution were even more clearly expressed.

**The session of February 19, 1996: Sarah's belches**

So, from February 1996, it is not the beaters that fall from Sarah's hands, it is something far more internal: endlessly repeated belches and emissions of wind, as if evacuating her whole body, and which she mainly directed towards me, but also towards any other members of the group who were active in some way.
During the moment of her belch, Sarah let her body waver in mid-air, so to speak, as she stooped her torso and stretched out her fingers. Then the facial muscles get all tensed up, the eyes wide-open as if in terror, and immediately afterwards there follows her stereotype smile.

While exposed to Sarah's belches and air-emissions, I had the feeling of not knowing when they started and whether they would ever end. At the beginning I felt sick, like being dropped in dung for a frighteningly indefinite period of time. Then I thought that this was her way of telling me what it felt like to be abusively "dropped" from life into a dirty soil of death.

The sustained chords that I played at the piano were a musical/symbolic way of containing her, though at times they also protected me from her imminent belch. Nor was it easy for me to hold the group from disintegration. This excerpt taken from the session of February 19, 1996 is a characteristic example.

*Video excerpt taken from the session of February 19, 1996*

### The depressive position and the surfacing of new skills

To use an object relations theoretical framework [Klein, 1946; 1952; Ganzarain, 1989], fluctuations between the paranoid-schizoid and the depressive position were another way of describing the group's dynamic matrix. Every regression to the paranoid-schizoid position brought to the surface with more clarity the fragmented, terrifying, part-object world of the patients; and every movement forward revealed with more strength their process towards integration, their greater tolerance for each other,
their sadness, their desire to master and control their actions towards a creative achievement, all being characteristics of the depressive position. In fact every new re-introduction into the depressive position brought to the surface new skills of creative achievement, unprecedented and so far unthinkable in the patients' known life in the institution.

One of the first significant changes was Sarah's ability to walk. Until that time, she had to lean her body on her carer in order to walk. Yet by June 1995, one year and two months from the formation of the group, she was able to walk unaided. This was the most significant transformation in the group, which gave hope and responsibility in the carers and made them feel that it was due to their work that Sarah was able to walk.

**The session of June 17, 1996 and Sarah's piano playing**

The following excerpt taken from the session of June 17, 1996, shows yet another stage of synthesis and integration.

Sarah's tentative touches on the piano keys, her fears for whatever was happening around her, convert into a creative initiative to control her, so far, handicapped fingers. It is she who brings for the first time the rhythmical motif *short long*, which also constitutes the rhythmical motif of Pamina's movements with her wheelchair. In other words, Sarah herself connects her creations with Pamina, and we keep this rhythm as a form and reminder of their own repertoires which are inter-related. This becomes the *rhythmical leitmotif* which binds the music that is formed between Sarah, Ms Antouna, Pamina's pulse and myself. Sarah succeeds in playing the *rhythmical leitmotiv* herself within the tempo of the music.
a number of times. This means that she could retain a focus on a musical thought and control her actions so as to create it.

Her belches and her musical phrases meet one another, until the phrases themselves replace and sublimate the anxiety of her internal evacuations.

*Video excerpt taken from the session of June 17, 1996*

**Theoretical and methodological issues arising from this session: alleviating the handicapping effects of envy**

Sarah had never used her hands for anything in her whole life; yet it is evident in music therapy that she can grasp a beater and that she can press the piano keys; she had never walked without physical support, yet in the music therapy sessions she has found ways to walk unsupported. It is obvious that she experienced reasons that deterred her from revealing her abilities and making use of them.

Sinason [1986; 1992] describes the use of a type of secondary handicap, as the handicapped person's way of dealing with the pain of difference between them and the normal population, which entails an attack on their own abilities. Through such an attack they deny this pain and the feelings of envy for what others have, of which they are deprived. By becoming more handicapped, there can be no comparison.

In terms of methodology, I wish to emphasise here the importance of the carer playing what the patient could have played herself, or could have imagined playing herself - in the excerpt we have just watched, Ms Antouna's clusters were similar to those of Sarah. This brought the patient a step closer to my skills and made it easier for her to receive the
music coming from me. By alleviating in this way the handicapping effects of envy, the patients were freer to make use of their true abilities.

At the same time, the setting facilitated both the formation of attachment bonds between the patients and their allocated carers, as well as the internalisation of the group as one whole good object. The group and my role as a conductor were together both the supportive ambience and the supervising eye, encouraging the evolution of that bond.

**The session of October 21, 1996: Jenny's creative playing**

From the secure base of their growing attachment bonds towards their carers and the group as a whole, the patients' handicapping and isolating symptoms diminished, while their creative moments increased.

A brief example of Jenny's piano playing follows, which keeps her away from her autistic mannerisms. It is October 21, 1996.

*Video excerpt taken from the session of October 21, 1996*

**The session of January 20, 1997: the carers' musical skills**

An example of the carers discovering their own musical ways to engage the group into alertness is shown in this video excerpt taken from the session of January 20, 1997.

*Video excerpt taken from the session of January 20, 1997*

**Changes in the group and the session of May 5, 1997: Sarah's cry**

From February 1996 and after a long preparation the sessions were reduced to once monthly due to my need to study further. Another
important change was that in December 1996, Sarah and Jenny with Ms Antouna and Ms Demetriou were together moved into the first state community home created in Cyprus. The reasons for moving them all there was their acknowledged attachment bond as an outcome of their music therapy participation.

The monthly group sessions, however, continued, but the reduced frequency did not halt the group's process.

It is the 5th of May 1997

*Audio excerpt taken from the session of May 5, 1997*

It was Sarah's voice. She started from the stereotype smile that was not a smile, and from the laughter that was not a laughter, whenever the beaters were being dropped either from her own hands or from those of Pamina. Perhaps Pamina represented, for her, the dropped, handicapped woman, one that became inert through a primary fall; and any drop from Pamina's hands was like throwing Sarah herself into an even bigger fall of her own being.

Then it was endless belches and emissions of wind; and then it was the cry that never was, her first tears. All this constituted a meaningful continuity - or, to put it more clearly, the cries we have just heard was whatever remained hidden behind everything else.

Sarah brings this cry for thirty continuous minutes, until finally she turns her glance towards all of us, as we play music for her. Her murmurs become part of our musical phrases, as she reveals the relief she is experiencing at our collective existence around her. It was the collective,
symbolic and benevolent existence of us inside her, that allowed her to cry. Such tears are poured when a person has internalised a compassionate companion in life.

*Video excerpt taken from the session of May 5, 1997*

**Conclusions and the session of October 6, 1997**

Through this method of group music therapy - some aspects of which were briefly touched upon in this presentation - the patients of this group found attachment figures and trusted companions both in the music therapy sessions and in their everyday lives. Therefore, their relief from life's pain was enormous and their capacity for exploring inner affective states was greatly recovered along with the means of expressing them through sound; buried skills saw the light of day.

It was extraordinary to realise, through second-by-second analysis of hundreds of video-recorded sessions, that, however minimal the repertoire of behaviour available for the individuals, there was no sound, no gesture, or movement, that occurred in such a group that did not form a resonance, an associative link, towards another's way of being.

It is such links that we tried to receive within us and bind together through a live musical creation. One member's movement became the rhythm, another's murmurs became the melody, and yet another's twists and turns, the musical timbre.

The attachment bonds that were formed between the carers and the patients, and the collaboration between us which was strengthened through the *free-discussion group meetings*, enabled the carers to
develop the necessary music therapy skills, so as to function as auxiliary music therapists. While in the session of July 15, 1994, their participation consisted of some soft cymbal touches or brief drum phrases, which served as accompaniments to the conductor-led techniques, in the session of October 6, 1997 - an excerpt of which we are about to watch - their contribution in the creation of music therapy techniques consisted of symmetrical and independent melodic and rhythmical parts.

While Sarah, Jenny, Ms Antouna and Ms Demetriou are now living together in a community home - something that was considered unthinkable by the management some years ago - Ms Kazakaiou is still trying to convince the Social Services that Pamina can also leave the institution's walls.

Pamina never ceased to surprise us, and that is how she entered the music therapy room on October 6, 1997. With this excerpt I am ending this presentation.

*Video excerpt taken from the session of October 6, 1997*

**Brief description of the excerpt for the reader:**

*Pamina has wheeled herself to the synthesiser and placed her body in such a way, so as to be able to strike the keys. She succeeds in playing phrases consisting of clusters, but also of single, clear notes by lifting up her elbow. Indeed, she puts tremendous effort on the task of striking single notes by moving her disabled fingers. The physical effort must have been gigantic for a person with her physical disabilities - to have
kept her elbow lifted and her fingers in such a position as to strike the keys. Her phrases are coherent and consist of a meaningful array of notes. Jenny's and Sarah's softly uttered vocalisations join Pamina's phrases. And the whole music, created by Ms Kazakaiou on the chimes, Ms Demetriou on the xylophone and bongo-drums, Ms Antouna on the metallophone and myself on the piano, contextualises Pamina's phrases alongside Jenny's and Sarah's utterances.

References


1. INTRODUCTION

Music therapy can be hypothesised as a therapeutic process in which the set of interactions between music therapist and one or more individuals that mutually influence one another, creates relationships aimed at developing greater interpersonal connection abilities and obtaining new integration skills by means of participation in musical experiences.

Musical improvisation represents a typical music therapy exercise. We can define musical improvisation as a joint and continuously co-ordinated action between music therapist and one or more individuals, characterised by innovations that extend the musical communication between participants and make it more complex, thus benefiting them.

Therefore, the communication established in the mutual relationship between music therapist and patients assumes a role of fundamental importance as in any other type of interaction and relationship. Unfortunately, at present no research is available that measures the quality of communication and its development during music therapy programmes. This study therefore illustrates the application of a code for reading communicative quality in this specific field and proposes it as a possible method of longitudinal measurement of the relationship between music therapist and patient.
We herein present two case studies that demonstrate the practical application of this coding system to two different case studies. This research project is still in progress and further results will be available in the future. The emphasis of this talk is therefore mainly focussed on this analysis method and its possible applications in music therapy, rather than on the presentation of results, which are still at a preliminary stage.

2. THE THEORETICAL FOUNDATIONS

Communication is often described as an exchange of information between a sender and a receiver. Communication is considered to have taken place if the receiver alters his/her behaviour following the transmission of the signal (SMITH 1977). This model, known as the communication by discrete stages model, originated from studies on cybernetic and electronic systems during the nineteen sixties (von Neumann, 1958).

Some years later, on the basis of video recordings on face-to-face mother-infant communication, Fogel went beyond the communication model based on a series of discreet stages. His theory of dynamic systems is based on a concept of communication that goes further than the individual contribution to inter-personal exchange. Fogel in fact proposes, a “relational” model (1977) where the partners are continuously active and involved in the communication process and in which bidirectionality is not the subsequent “product” of the exchange between partners, but rather is inherent to each action that takes place during interaction. In this model, the individual action is conceptualised
as continuous and relational, connected to both the partner and the context.

This kind of communication is therefore co-regulated in that it is the outcome of simultaneous co-ordinations between the individuals through reciprocal adaptations of posture, expression, movement and any other aspect of communicative actions. During co-regulated communication, the pattern of action within the social system emerges from the limits imposed by the bodies of the participants (shape, size and possibility of perception and action), their psychological processes (emotion, cognition and attention) and the cultural environment (family, society, culture). We can observe the evolution of these dynamic systems in the communicative processes by means of new patterns of co-regulated action. This amplification comes about using positive feedback or rather a process that takes place in periodic interactions when system input is a positive function of output. Through positive feedback the system amplifies specific patterns of an otherwise random or chaotic variability, such as when social play is processed by a series of complementary and creative expansions. For example, a shift towards greater intimacy within a relationship, a sudden insight into a cognitive system and the appearance of strong emotions are a radical change within a system.

3. CO-REGULATION CODING SYSTEM

The co-regulation coding system was designed for application to all forms of interpersonal communication between individuals of any age. The co-regulation coding system is acontentistic and can be used to study both verbal and non-verbal communication, it is based on the theory of
communication as a continuous reciprocal adjustment of actions. Co-regulated communication consists in the active and continuous participation of two or more partners and is characterised by the creative innovation of combined action patterns.

The co-regulation coding system is a measurement of the quality of the communicative process. High quality or co-regulated communication is a continuous and mutual adjustment and is creatively innovative. Reciprocal innovation is produced during communication when the partners are contributing to interaction in such a way that the theme or focus of the interaction is in some way changed during the sequence. Reciprocal innovation can occur in motory, verbal or non-verbal domains.

Decoding is only performed on the concrete evidence of communicative participation and on observed examples of innovation during the communicative process.

The minimum unit of analysis is given by an action followed by an opportunity to participate, but can last much longer. Researchers establish the decisional rules on the forms of communication that they desire to highlight during activity decoding and that can involve both verbal and non-verbal components.

The concept of co-regulation does not imply that the partners share the same beliefs, values, aims, strategies or purposes. Co-regulation is a quality of the communication process and can therefore also be observed in moments of disagreement between the partners. However, in some
cases, conflicts may result in an interruption of communication, which therefore ceases to be co-regulated.

The co-regulation coding system, therefore contains a series of categories that describe forms of communicative processes that are qualitatively different, from the creation of the reciprocal and innovative action to an absence of communication that can be observed between the participants. (FOGEL, 2000) The category is a set of actions grouped according to the characteristics of the communicative process that can be qualitatively identified in a given timeframe. Each category mutually excludes another with different qualitative characteristics.

Another dimension of the decoding system is the identification of frames. Frames consist in the situations that provide the background to the interaction and which, in a given place, time and environment, organise the partners’ co-actions, thus restricting the range and characterising some of its processes. Frames are therefore large segments of co-actions that have a coherent theme and lead to certain particular forms of specific co-orientation between the participants.

4. THE RESEARCH PROJECT IN MUSIC THERAPY

4.1 Premise
The adaptation of the Co-regulation Coding System to music therapy is a clinical research project. It develops on both the qualitative level, in order to suit the needs of clinical work such as unrepeatability and the variability of the phenomena under examination and on a quantitative
level, in order to examine the variables observed through the use of specific statistical tools. The qualitative analysis given by the level of decoding of the various interaction categories is therefore accompanied by the quantitative analysis of the behavioural categories and the analysis of the frames.

The music therapist/patient dyad is observed as a communication system in constant evolution, a system that creates meanings, purposes and emotions. The researcher can therefore formulate commentaries whilst observing the interaction on a video tape and examine them together with the standard coding and the longitudinal statistical analysis of the data. This integrated method offers advantages of accurate and frequent quantitative measurements of the development of dyadic communication and supplies a qualitative clinical interpretation of the history of that particular dyad that permits the evaluation of any recurrences and interdyadic differences in the relational development in music therapy.

We hypothesised that the communication process in music therapy sessions and their gradual longitudinal development takes place during timeframes in which interactions are marked by increasing moments of listening, musical attunements and expressive innovations typical of a high quality communication in musical forms emerging from the music therapist-patient dyad.

4.2 Purpose, phases and objectives
The purpose of this research is to define a system of analysis capable of identifying the series of interactions that occurs in a music therapy process and to evaluate the evolution of the music therapy relationship.
The research project involves two phases:

Phase A started in June 2001 and terminated in July 2002. This period involved:

- the formation of the research team;
- the definition of the research project;
- Co-regulation Coding System training with the group of decoder music therapists;
- the creation of the research setting,
- starting up two cycles of sessions that terminated in June 2002;
- the application of the decoding system to music therapy sessions;

The aim of Phase A was to establish whether the Co-regulation Coding System is applicable to music therapy sessions.

Phase B is scheduled for completion in the first half of 2004. Our aims for this phase are:

- the completion of de-coding the two cycles of sessions performed in phase A;
- to make an initial analysis of longitudinal data;
- to enlarge the group of music therapists/decoders and carry out new training for new decoders;
- to organise six new session cycles;
- to decode the six session cycles;
- to make a statistical analysis of the longitudinal data;
- to perform an inter-dyadic evaluation of relational development in music therapy.

The aim of Phase B is to use communication quality measurements to measure any increase in periods of creativity in the communicative process during the development of the relationship in music therapy.
**4.3 Organisational structure of the research**

The Setting for this research is at the “la Musica Interna” Association, Bologna.

The study is performed in conjunction with the research staff of the University of Bologna and also involves the Chair of Educational Psychology and the Psychology Department of the university.

Project supervision has been assigned to Prof. Maria Luisa Genta, professor at the Chair of Educational Psychology, Faculty of Learning Science and the methodological supervision to Dr. Lucia Berdondini at the Education Research Centre, University of Brighton, UK.

The City of Bologna Local Health Unit, Local Centre for Health in the Formative Years is competent for the referral of cases through involvement of neuro-psychiatrists and local educational referees.

Project planning and co-ordination have been followed by Mrs. Giovanna Artale, music therapist at the “Parco dei Cedri” Therapy and Rehabilitation Centre, Bologna Local Health Unit and FIM (Italian Federation of Music Therapy) trainer, and Mr. Fabio Albano, music therapist, Mental Health Centre, Modena Local Health Unit, CONFIAM (Italian Confederation of Music Therapy Associations) supervisor.

Both the group of six decoders¹ and the eight music therapists involved in the sessions² originate from various different schools of training and

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1. Mrs. Marinella Maggiori, Mr. Cristian Grasselli, Mrs. Luisa Bonfiglioli, Mrs. Mariagrazia Baroni, Mrs. Giovanna Artale, Mr. Fabio Albano.

2. Mrs. Carmen Ferrara and Mrs. Tundra Tommassoni are the music therapists involved in Phase A.
technical consultant\textsuperscript{3} for video recordings also participated in the research.

\textbf{4.4 The operative programme}

Following a number of years in search of a useful analysis tool for the evaluation of quality in music therapy interaction, within the various sector studies, Fabio Albano made a closer examination of the application of the method of relational decoding to music therapy sessions, as the theoretical premises seemed particularly apt to the description of the communication processes that occur during music therapy sessions. His participation in previous music therapy projects permitted him to construct an initial network of contacts and identify Giovanna Artale as the person with whom to define the new research project.

Following these considerations, we contacted the methodologist expert of the research whose book made this methodological approach known to us.

Prof. Genta found the music therapy “object” particularly interesting and indicated Dr. Berdondini as methodological referee for the co-regulation coding system.

Dr. Berdondini is the trainer who allowed us to become familiar with and practice the relational coding method. The training phase included an intensive initial meeting that lasted a few days and subsequent supervision sessions for monitoring the correct acquisition and

\textsuperscript{3} Mr. Mirco Pellizari.
application of the method. The “la Musica Interna” Association welcomed and supported the research project from the outset and acted as a guarantee and permitted the setting to be set up in its main offices.

The music therapy room has a piano and music therapists may choose the other pieces to be introduced in to the setting from a wide assortment of instruments.

The music therapy room is fitted with four colour video cameras, two of which are fixed and have wide-angle lenses and two are mobile with zoom lenses and two microphones. The information recorded by the cameras is sent to a technical room where two controllers handle the material created by the mobile cameras and a view divider permits the recording of the four different signals on DVD-Ram.

Our contacts with the Music therapy schools and with the Department of Psychology allowed us to recruit a number of university and higher education students in Music Therapy, interested in developing the methodology, thus the decoding group was formed.

At the same time we invited various different music therapy schools throughout Italy⁴, to provide us with the names and contact details of experienced music therapists available to conduct the sessions. In order to avoid an overlap of roles, none of the decoder music therapists also conducts sessions.

4. the “Anni Verdi” association: Music Therapy Training School, Rome; the “Music-space Italy” association: three year post-graduate Diploma in Music Therapy, Bologna; CEFIG: two-year course for professional qualification in Music Therapy, Bologna; Training using the Sound Dialogue model, Bologna
Another valuable partner in this research project was the City of Bologna Local Health Unit and, in particular, the Director of the Centre for the Protection of Health in the Formative Years, Dr. Capurso and Dr. Fragorzi, who supported and diffused the project to a number of children’s neuro-psychiatrists in the area of competence.

We then asked the neuro-psychiatrists to propose us a list of school-aged children, between six and eleven, with expressive, communicative and relational disorders with sufficient physical autonomy to allow them to access the setting without difficulty. None of these children had previous experience of music therapy and this choice was dictated by our need to observe the initial stages of a music therapy process.

We believed the choice of using school-aged children appropriate in that the local resource network is particularly active and our professional experiences have permitted us, with time, to build up a solid relationship and a preferential channel with this sector of the public service.

Subsequently, a joint evaluation of the clinical cases was established with a group of children’s neuro-psychiatrists. The two children who constituted the participants in this pilot study have different diagnoses:

1 learning difficulties;
2 overall cognitive slowness, retarded development of speech and of the affective-relational sphere, a chromosome disorder currently being established.

Their families were offered fourteen weekly sessions lasting 30 minutes each, free of charge. In the first case it was possible to perform 13 sessions, in the second nine.
Prior to the start of the cycle of music therapy sessions, we met the families in order to inform them of the research context in which the sessions were to take place. Both families participated in the project with interest and signed consent forms for the video recording and the use of the material obtained for research purposes.

The music therapists involved in the sessions were provided with general indications on the referral meetings with the families and reports to/meetings with the clinical workers, paying careful attention not to interfere with the individual approach of each music therapist. Three meetings were therefore established with the families, one at the beginning of the project, one half way through and the last at the conclusion of the cycle as well as a conclusive summary to the clinicians by means of a direct meeting and/or a report on session patterns. The music therapists also signed a consent form for the use of the recorded material obtained during the sessions for research purposes.

4.5 Analytic procedure

Our working group’s research started with a series of appointments in which we established the concept of co-regulation, the continuous communication process and the category and frame concepts.

As far as the analytic procedure is concerned, the work is organised into two teams of decoders each of which is formed by two music therapists, the two active teams work independently and meet every three weeks to compare notes with one another and share any problems emerging from the decoding work. The enlarged group of decoders is periodically subject to methodological supervision. Moreover, in phase A, the
analytic procedure involved two more music therapists, one for each team, who were responsible for giving a detailed description of the session.

The analysis of the video recordings of each cycle of sessions is performed by a pair of decoders, who fill in the decoding transcript table by watching the video recording in real time and analysing the material together, until arriving at an agreement on the choice of each series of interaction categories. The change of category is noted together with the time of this change, read by a counter on the video recordings that specifies the minutes and seconds, and the frames.

CODIFICA INCONTRI DI MUSICOTERAPIA DIADE C. - G. I

° incontro
data: 02/03/2002 ore: 12.00-12.30

Table 1 Codifica Incontri Di Musicoterapia

<table>
<thead>
<tr>
<th>TIME  (TEMP)</th>
<th>CATEGORY (CATEGORIA)</th>
<th>FRAME</th>
<th>DESCRIPTION (DESCRIZIONE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>00:00</td>
<td></td>
<td></td>
<td>Stanza vuota con strumenti</td>
</tr>
<tr>
<td>00:35</td>
<td>Symmetrical type 2 (Simmetrica 2)</td>
<td>00.46</td>
<td>Mt invita il B a guardare e a scegliere uno strumento da suonare. Il B la guarda attentamente sorridendo e indica il metallofono dicendo “quello”. B e Mt si siedono (uno di fronte all’altro) vicino al metallofono.</td>
</tr>
</tbody>
</table>
**Table 1** Codifica Incontri Di Musicoterapia

<table>
<thead>
<tr>
<th>Time</th>
<th>Symmetrical type 1 (Simmetrica 1)</th>
<th>02.06 Play</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02:06</td>
<td>Symmetrical type 1 (Simmetrica 1)</td>
<td>02.06</td>
<td>B e Mt suonano al metallofono. Mentre suona il bambino rivolge spesso lo sguardo verso il volto della Mt che, a sua volta, mantiene il suo sguardo rivolto al bambino. B propone al metallofono e Mt risponde. Suonano rispettando l’alternanza di proposta e successiva risposta. A 7.55 per la prima volta suonano contemporaneamente. A 8.15 il ritmo della proposte musicali di B e delle risposte di Mt diventa più veloce. Mt risponde a B. imitandolo ed inserendo novità (ad es. utilizza la voce).</td>
</tr>
<tr>
<td>10:55</td>
<td>Symmetrical type 2 (Simmetrica 2)</td>
<td>10.55</td>
<td>Mt, continuando a cantare, sposta delle barre nel metallofono e le sistema diversamente rispetto alla loro posizione originaria. B la guarda attento e sorride. A 11.23 B interviene spostando anch’egli le barre.</td>
</tr>
<tr>
<td>11:23</td>
<td>Symmetrical type 1 (Simmetrica 1)</td>
<td>11:23</td>
<td>B e Mt spostano insieme le barre sonore e provano le sonorità della nuova disposizione delle barre.</td>
</tr>
<tr>
<td>11:50</td>
<td>Symmetrical type 2 (Simmetrica 2)</td>
<td>11:50</td>
<td>Mt sposta nuovamente le barre e ne toglie alcune. Mentre lo fa descrive le azioni cantando. B la guarda attento e con lo sguardo segue le sue azioni.</td>
</tr>
</tbody>
</table>

The decoding work is integrated by another music therapist, who receives the table filled in by the pair and performs a detailed description.
of the behaviour of the two subjects by using a list of kinesic-visual and vocal-audio behavioural indicators.
<table>
<thead>
<tr>
<th>MACRO BEHAVIOURAL INDICATORS</th>
<th>MICRO BEHAVIOURAL INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MACRO OSSERVAZIONI</td>
<td>MICRO OSSERVAZIONI</td>
</tr>
<tr>
<td><strong>Kinesic – visual indicator</strong></td>
<td><strong>Comportamento spaziale:</strong></td>
</tr>
<tr>
<td>Modalità cinesico - visiva</td>
<td>• distanza (vicinanza \ lontananza);</td>
</tr>
<tr>
<td></td>
<td>• orientazione (faccia a faccia, fianco a fianco, ecc.);</td>
</tr>
<tr>
<td></td>
<td>• postura (rilassata \ tesa);</td>
</tr>
<tr>
<td></td>
<td>• uso dello spazio (si muove in tutta la stanza, solo in alcune parti, ecc).</td>
</tr>
<tr>
<td></td>
<td><strong>Comportamento motorio – gestuale:</strong></td>
</tr>
<tr>
<td></td>
<td>• gesti: accomodatori, illustrativi, simbolici, emotivi, regolatori del discorso sonoro.</td>
</tr>
<tr>
<td></td>
<td>• movimenti:</td>
</tr>
<tr>
<td></td>
<td>• rivolti alla persona; rivolti a se stessi; rivolti a un oggetto (ad es: accarezzare, toccare, manipolare, suonare, gesto musicale, ecc.)</td>
</tr>
<tr>
<td></td>
<td><strong>Espressioni del volto – mimica facciale</strong></td>
</tr>
<tr>
<td></td>
<td>• mutamenti della posizione (sorriso, espressione neutra, ecc.).</td>
</tr>
<tr>
<td></td>
<td>• Sottolineature cinesiche: es. come inarca le sopracciglia mentre enfatizza vocalmente o musicalmente le parole e/o i suoni.</td>
</tr>
<tr>
<td></td>
<td><strong>Sguardo:</strong></td>
</tr>
<tr>
<td></td>
<td>• lungo / breve (dimensione temporale);</td>
</tr>
<tr>
<td></td>
<td>• orientamento (verso l’altra persona; verso di sé; verso l’oggetto, verso l’ambiente); occhi chiusi.</td>
</tr>
</tbody>
</table>
### Table 2
**Detailed Description Of Behaviour: list Of Indicator**
**Descrizione Dettagliata: Elenco Indicatori**

<table>
<thead>
<tr>
<th><strong>Vocal – audio indicator</strong></th>
<th><strong>Aspetti non verbali del parlato:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Modalità</strong></td>
<td>• intonazione della parola nella frase;</td>
</tr>
<tr>
<td><strong>Vocale – Uditiva</strong></td>
<td>• qualità della voce - tono;</td>
</tr>
<tr>
<td></td>
<td>• ritmo;</td>
</tr>
<tr>
<td></td>
<td>• vocalizzazioni (sospiri, sbadigli, ecc.).</td>
</tr>
</tbody>
</table>

| **Produzione sonora:**              | timbro; intensità; durata; altezza; ritmo; accentazione;     |
|                                     | tempo; armonia; temi; silenzio; forme musicali; genere;       |
|                                     | pulsazioni; velocità.                                        |

### Table 3
**DESCRIZIONE DETTAGLIATA INCONTRI di musicoterapia diade C. - G. I° Incontro. Data 02/03/2002. Ore 12.00-12.30**

<table>
<thead>
<tr>
<th><strong>Tempo</strong></th>
<th><strong>Descrizione dettagliata</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>00:00</td>
<td>La ripresa inizia con la stanza vuota: si vedono solo gli strumenti musicali.</td>
</tr>
</tbody>
</table>
Dal vetro si vede la mano di Mtp che apre la porta, spalancandola con gesto energico, lasciando entrare per primo B. Con la porta aperta si sente che Mtp ha già iniziato a cantare la frase “Ecco Giacomo! Pronti andiamo! Insieme gli strumenti suoniamo” che ripete due volte. B entra, osserva il pianoforte alla sua sinistra, ha il capo leggermente chino e le braccia distese lungo il corpo, dopo pochi passi, si gira verso Mtp, alza il capo per guardare in alto i suoi movimenti, mantiene il contatto visivo.

Mentre canta, Mtp chiude la porta, si gira di schiena e chiude il piccolo catenaccio in alto sulla porta, si rigira verso B; prima di concludere il canto, lascia in sospeso la seconda parte e, usando il parlato su “insieme gli strumenti… suo…?”, invita B a concludere la parola (“suoniamo”). Mtp usa un canto dolce e sereno che termina con intonazione parlata di tipo interrogativo-sollecito; durante il parlato, china il busto in avanti per ascoltare all’orecchio e unisce le braccia al corpo. B ascolta il canto e al termine risponde all’invito concludendo la parola “suoniamo”. Stacca lo sguardo e china il capo verso il basso, ma subito dopo riaggancia lo sguardo.

Quando B dà cenno di concludere la parola, Mtp allarga le braccia in un ampio gesto, dicendo insieme “niamo” con voce soddisfatta. Riprende subito la proposta dicendo “suonare!” con tono deciso.

Breve silenzio.
Table 3    DESCRIZIONE DETTAGLIATA INCONTRI di musicoterapia diade C. - G. I° Incontro. Data 02/03/2002. Ore 12.00-12.30

00:50 | Mtp ripete il gesto ampio delle braccia, che chiude dietro alla schiena dicendo a bassa voce, ma con fare sicuro “eccoli qua per te”, sorride, fa un passo indietro e accenna con lo sguardo allo spazio circostante, ruotando il capo più volte. B. sorride

00:54 | Mtp si riavvicina e sempre sottovoce chiede: “chi andiamo a vedere?”, “chi andiamo a suonare?” e muove le dita come per suonare il pianoforte.

01:02 | B sorride, si guarda intorno, osserva. Fa cenno di “non sapere”: abbassa il mento a bocca chiusa, alza le spalle e allarga le braccia. Mtp lo anticipa e dà voce a “boh!” e “mah!” ripetendo lo stesso gesto delle braccia. B ripete il “boh!” Mtp “chi lo sa!”

01:16 | Mtp fa due passi indietro avvicinandosi al metallofono, B le si avvicina, abbassa lo sguardo. Contatto visivo.

01:22 | Mtp si allontana di pochi passi mantenendo sempre il contatto visivo e usando un movimento delle gambe “felpato” e morbido, come per mantenere un clima magico di suspance. B la segue con andatura normale, sorride. Silenzio.


The degree of agreement (known as inter-coder agreement) between the music therapist decoders is measured by the overlapping of coding performed on the same material by the various teams and concerns the duration and the type of category. The material, object of the agreement, must be equal to 20% of time of the video recordings performed. Agreement between the coding by the various teams must agree for at least 70%.

4.5.1 The categories
The category is a set of actions grouped according to the characteristics of the communicative process that can be qualitatively identified in a given timeframe. Each category mutually excludes another with different qualitative characteristics.

**Symmetrical category**

The symmetrical category is characterised by periods of co-regulation in which the communication between music therapist and child is continuously co-ordinated and composed of contributions and creative initiatives from both members of the dyad.

In practice, two different kinds of symmetrical category can be observed:

**TYPE 1.** During this timeframe both partners contribute to the innovation of a theme by means of actions that mutually influence one another in a continuously co-ordinated way.

**TYPE 2.** During this timeframe one of the two partners is responsible to a greater degree for the development of a theme whilst the other observes him/her and supports him/her expressively and/or participates as appropriate when dialogue possibilities arise.

**Asymmetrical category**

The asymmetrical category features timeframes in which the attention of the music therapist and the child converge, however only one partner is active in the innovation of the theme whilst the other is merely an observer. The observer has a positive influence on the creativity of the other partner, but is not actively expressive. The observer does not appear to be bothered or bored.
The group initially encountered some problems with this type of co-regulation timeframe as this category was easily confused with that which later emerged as symmetrical type 2.

In fact, the group initially coded the support to the action of the other partner as asymmetrical, thus including the expressive support through brief actions and/or back-up that does not create innovation. However, it was later decided to pay more attention to the specific context and type of interaction in behaviour coding and therefore, in certain cases, a behaviour that may be simple and very slight can indicate active participation that also depends on what the specific type of interaction consents at that particular moment.

**Unilateral category**

The unilateral category features timeframes in which the interaction between the music therapist and child does not show any form of shared co-ordination. One partner only acts according to the other’s activity, in an attempt to participate, but the latter does not take any notice, does not appear to be influenced and proceeds with the development of his activity. Communication where the role of the observer does not appear to influence the activities of the other is also considered unilateral.

**Disruptive category**

In the disruptive category we encounter a degree of disagreement between the partners. One of the two wishes to change the type of reciprocal commitment in participating in the communicative process by means of a variation in the activity in progress or in preparation. The positive action of the first partner ineffectively interrupts the activity of the other, who shows unease, refusal and/or withdrawal.
The attempt to establish a mutual innovation in communication therefore leads to the interruption of the flow of actions of one of the partners.

The method also includes a further non-regulated category, however it has not yet been observed during decoding sessions. This category is coded when there is an absence of communicative commitment: neither of the partners is regulated with the other, even when communication possibilities exist.

4.5.2 The frames

As mentioned previously, the frames are the situations that form the background to interaction and which, in a given place, time and environment, organise the co-actions of the partners thus limiting their range and characterising some of their processes. The frames are therefore large segments of co-action that have a coherent theme and that lead to particular forms of specific co-orientation between participants.

For example, throughout the day, the music therapy session can be described as a frame in which the musical sound universe provides a background in a given place and time, it establishes and characterises the constellations of the participants’ actions and co-orients them to the communication process of the music therapy session.

There are three frames that we recognised as being pertinent to the coded session:

OPENING is the initial phase of the session in which the music therapist and child enter the setting and greet one another using conventional pleasantries.
PLAY is the session’s central phase in which the music therapist and child are involved in activities focused on exploration, expression and relationship.

FINALE is the conclusive phase of the session in which the music therapist and the child prepare to leave and say goodbye to one another using conventional pleasantries.

4.6 Conclusive comments
In this first pilot phase of the research project, we were able to verify the applicability of the method to the music therapy sessions.

The frame and category concepts proved to be applicable and useful in providing a means of interpreting relationships in music therapy. We realise that this first phase has given us partial results that are more pertinent to reading interactions rather than that of relationships. This is due to the current status of decoding, which is yet to be performed on entire session cycles.

The categories have been taken from the studies previously performed by Fogel and applied to the study of relationships in music therapy without undergoing any particular variation.

The application of the frames concept on the other hand, required a more in depth evaluation by the working group. Following the formulation of various applicative hypotheses, our development of this concept lead to the recognition of frames specific to music therapy sessions.

The work system was made possible thanks to the consideration of the type of availability that each partner was able to offer. For example, the
choice of the number of sessions planned is the fruit of negotiations between the requirements of all parties interested in the research process: the commitment required of the music therapists and the families, the time to be dedicated to coding by the teams, the limited availability of the space used for the setting, the expectations of the referring clinicians and the economic commitment required to sustain the research project. We are well aware that the limited meeting cycles influence future research results, but certain considerations guided our actions on this matter. However, we believe that a cycle composed of fourteen meetings can:

1. form the basis of treatment with short term aims;
2. be sufficient for observing the qualitative increases hypothesised;
3. define a historical development of the relationship between music therapist and child.

The exploratory and relational aspects of play, the organisation phases that act as a bridge between one action and another, are still aspects which cause us to reflect on the complexity of the frame concept. This work will be the object of further alterations.

Moreover, during the process, we observed the presence of emotional peaks during the interactions between music therapist and child. Such moments are currently indicated in the detailed description and will become the object of further study, given the attention they caused during analysis.

**BIBLIOGRAPHY**


Music Therapy And Sensory Integration For children With Autistic Spectrum Disorders

Allgood, Nicole
MSEd, MT-BC
Giant Steps Illinois, Inc.

Autism is a developmental disability that profoundly impacts the child’s ability to communicate, socialize and interpret his/her surroundings. Many children with autism demonstrate abnormal responses to sensory information. Through an understanding of sensory integration theory, music therapists can develop a framework from which to assist children with autism to better relate to the world around them.

Autism: Definition and Characteristics

Autism and other pervasive developmental disabilities are neurological disorders that impact brain function and associated behaviors. The estimations of prevalence vary. The Diagnostic and Statistical Manual on Mental Disorders (DSM IV-R) states that the incidence is 2-5 cases per 10,000 individuals (APA, 1994). The Autism Society of America (ASA) states that autism and related disorders occur in as many as 1 out of 500 individuals (ASA, 1999). Current reports indicate that the incidence of autism is on the rise. The Chicago Sun-Times (Beaupre, 2000) reported that the incidence in Illinois rose from 1,353 cases in 1995 to 3,662 cases in 1999 (171% increase). In the United States, the 1995 statistic of 22,664 increased to 53,576 in 1999 (136% increase). Autism is likely to occur more often in boys than in girls (4 to 1), but it is not linked to any specific racial, ethnic, or social group (ASA, 1999).
The primary diagnostic criteria for autism are qualitative impairment in social interaction, qualitative impairment in communication, and restricted, repetitive and stereotyped patterns of behavior, interests and activities (APA, 1994). Research also “confirm(s) the existence of sensory and motor difficulties for many children with autism at some point in their development, although there is much variability in the specific symptoms or patterns expressed” (National Research Council, 2001, 93). Abnormal responses to sensory stimuli can significantly impact a child’s ability to socialize, communicate and negotiate the world around him/her.

While the exact cause of autism remains unknown, there is an increasing body of knowledge about the neurological and biological features associated with autism. In the book, *Autism: Understanding the Disorder* (1997), Mesibov, Adams and Klinger report that “researchers have theorized that autism may be caused by abnormalities in brain development” (p. 51). The use of magnetic resonance imaging (MRI), computerized tomography (CT) scanning and autopsy studies have demonstrated that the cerebellum, the limbic system and the cerebral cortex may be impacted. For example, the cerebellum, which is “connected to systems regulating attention, sensory modulation, and motor and behavior initiation” as well as “emotion-modulation and language-processing systems” (Mesibov, Adams & Klinger, 1997, p.52) shows reduced numbers Purkinje cells and reduced size of vermal lobes. The limbic system, which is associated with emotional regulation, shows some abnormalities including “reduced neuronal cell size and increased cell-packing density” (Mesibov, Adams & Klinger, 1997, p. 53.)
Neurological findings present a foundation for understanding the complexity of autistic spectrum disorders and sensory integration.

**Autism and Sensory Integration**

Both the cerebellum and limbic system directly relate to the child’s ability to respond to sensory information. Children with autistic spectrum disorders may demonstrate hyper or hypo-sensitive reactions to sensory input and may have difficulty regulating physical and emotional responses (Ayers, 1979). The challenge typically lies in the child’s inability to integrate sensory information received from the world and to regulate or modulate the body’s responses to sensory information. Sensory information comes in through the physical senses of seeing, hearing, smelling, tasting and touching as well as other “body-centered sensory systems that provide the sense of oneself in the world” (Kranowitz, 1998, p. 41) including the vestibular sense and the proprioceptive sense. The vestibular sense gives information about movement, gravity and balance. The proprioceptive sense provides information about body position and body parts. Therefore, sensory processing is “the ability to take information in from all our senses and sort it out appropriately so that we can accurately interpret our environment” (Gambrel & Allgood, 2000).

Some children with autistic spectrum disorders experience Sensory Integration Dysfunction which “causes children to process sensation from the environment or from their bodies in an inaccurate way, resulting in *sensory seeking* or *sensory avoiding* patterns or *dyspraxia*, a motor planning problem” (The KID Foundation, 1998). Sensory processing or
integration is typically addressed by occupational therapists in the United States. Treatment focuses on improving “sub-cortical (sensory integrative), somatosensory, and vestibular functions by providing controlled sensory experiences to produce adaptive motor responses” so that “the nervous system better modulates, organizes, and integrates information from the environment, which in turn provides a foundation for further adaptive responses and higher-order learning” (National Research Council, 2001, p. 99). Sensory Integration Dysfunction is typically assessed through formal tools and/ or clinical observations. Clinical observation of what the child naturally seeks out in his/her environment can yield a great deal of information about what the child’s system needs.

When observing a child, the therapist should note responses to sensory stimuli, the child’s overall affect and the child’s ability to move around in space. The following are possible level’s of responsiveness:

(a) normal responsiveness, (b) paradoxical hyporeactivity (the child is overaroused by the stimulus and reacts defensively by withdrawing), (c) straightforward hyporeactivity (the child is underaroused by the stimulus and responds minimally or not at all), (d) paradoxical hyperreactivity (the child overresponds because of lack of sensory input), and (e) straightforward hyperreactivity (the child overresponds to excessive sensory input). (Nelson et al, 1984, p. 105)

An accurate assessment of the child’s level of responsiveness is key to making treatment decisions. For example, “the underaroused child probably needs extra sensory input (e.g. louder music with unsubtle rhythms suggesting movement experiences), whereas the overaroused child probably needs less intense input” (Nelson et al, 1984, p. 106).
Music Therapy and Sensory Integration

Music therapists who work with children with autistic spectrum disorders should be familiar with Sensory Integration Theory (Ayers, 1979) to better serve clients. Knowledge of SI Theory will help music therapists to interface with other professionals and assist with interpretation of the student’s needs and motivations. An understanding of sensory processing will also assist music therapists in the ability to assess client’s strengths and weaknesses (Greenspan & Wieder, 1998).

Music therapists can also take an active role in treating issues of Sensory Integration Dysfunction. Music therapy offers a rich opportunity to address the sensory needs of the child (Nelson, et al, 1984). Musical interaction engages the child on a multi-sensory level. Like occupational therapy, music therapy interventions help “the system encounter and coordinate responses to applied stimuli previously unavailable to that brain, or stimuli that require special focus in order for the sensory system to understand and properly coordinate the information” (Berger, 2002, p. 58). Music therapy treatment interventions can include improvisation, Eurhythmics, instrument-based exercises and sensory-based music exploration.

Elements and Characteristics of Music

A review of the elements and characteristics of music builds the foundation of understanding the role of music therapy in treating Sensory Integration Dysfunction. In her book entitled, Music Therapy, Sensory Integration and the Autistic Child, Berger highlights the connections between the sensory integration treatment and the six basic elements of
music: rhythm, melody, harmony, dynamics, timbre and form (Berger, 2002). Each of the six elements can impact the child’s responses and relationship with music. For example, rhythm “is a physiologic organizer” (Berger, 2002, p. 112). Rhythm provides “a focal point for attention” (Brunk, 1999, p. 16). Form also provides the child with a structural framework that relates to “task creation, task organization, and task completion” (Berger, 2002, p. 127).

Music is effective in addressing sensory integration concerns because of some of the overall characteristics of music: universal, malleable, structured and multi-sensory (Allgood, 2001). Music is universal. It is pervasive throughout our lives. “The therapy that lies in music is…directly connected to the inherent ‘musicality’ or innate responsiveness to music found universally in everyone, whether one is musically educated or not” (Trevarthen, et al., 1998, p. 176). All children, regardless of their ability levels, have been exposed to music in multiple environments. Therefore, music can provide a familiar and safe forum for the child with autism. This familiarity is important for the development of the initial relationship, the ongoing motivation of the child and to encourage the child to take new risks to expand his/her self.

Music is malleable. Music can immediately be transformed to meet the unique needs of any student with autism. Music can at one moment provides nurturing, holding qualities and then be used to reflect a student’s protestation. “Music therapy always begins with where the child is” (Howat, 1995, p. 239) and the music moves with the child. One
piece of musical equipment can provide a student with a multitude of options for self-expression and sensory exploration.

Music is structured. The structure is what defines music as separate from sound. Structure can provide external support to the student with autism or can be revealing of internal dynamics of the student. The external structures of music can assist the student with self-organization and self-regulation (Nelson et al., 1984, Toigo, 1992, Trevarthen et al., 1998).

Music is multi-sensory. The presentation of musical interventions typically involves aural, visual, proprioceptive and vibro-tactile stimulation. By being conscious of the levels of sensory information being presented, the therapist can use multiple pathways to engage and motivate the child.

The characteristics of music significantly impact sensory integration. Music can be used in therapy as a tool to engage the child and develop skill areas. Music can be used as therapy to promote self-regulation and self-expression. In music therapy, the primary goal is to engage the child and assist the child in developing his/ her greatest potential. With the humanistic model as a basis for music therapy work, the focus is on maximizing potentials rather than on simply altering behaviors. “The therapeutic hierarchy begins with the student’s need for self-regulation and basic communication, then the development of relationships, then the development of the student’s role in the community and moving toward the student’s recognition of self” (Allgood, 2001, p. 14). Sensory Integration Dysfunction can significantly impact the child on all levels.
A child with significant dysfunction will have great difficulty forming relationships and interacting with his/her environment.

**Music Therapy Goals**

Music therapy interventions can be designed to meet a wide spectrum of goals related to sensory integration. Goals typically focus on encouraging the child to develop adaptive responses to sensory stimuli in order to better process and respond to input. Sample goals areas might include rhythm internalization, adaptive responses to auditory and visual stimuli, auditory integration and discrimination, perceptual-motor development, auditory-visual integration, attention, limit setting, and self regulation (Berger, 2002, Levin & Levin, 1998).

**Music Therapy Interventions**

Understanding sensory integration can affect music therapy interventions in one of two ways. Sensory integration theory can either provide a framework for making adaptations to current interventions or become the basis of treatment as suggested in the goals listed above.
Table 1 identifies examples of adaptations that may be used in music therapy sessions.

<table>
<thead>
<tr>
<th></th>
<th>Visual</th>
<th>Tactile</th>
<th>Auditory</th>
<th>Vestibular</th>
<th>Proprioceptive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Movement</strong></td>
<td>provide visual boundaries/targets to define space</td>
<td>move over different tactile surfaces; provide an opportunity for tactile at the end of a movement space</td>
<td>Eurhythmics activities; pair movement with specific auditory cues</td>
<td>appropriate opportunities for vestibular input; incorporate large motor equipment (balls, swings)</td>
<td>incorporate gross motor movement with strong movements (i.e. jumping)</td>
</tr>
<tr>
<td><strong>Instrumental</strong></td>
<td>move instrument when presenting to encourage tracking; lazy 8 pattern; visually interesting — ocean drum; clear rain stick</td>
<td>drums; use drums differently; instruments that offer unique tactile feedback—cabasa, vibraslap</td>
<td>use instruments with distinct sound qualities; auditory location, discrimination and comprehension</td>
<td>add movement to instrument play (i.e. with drum, instrument obstacle course)</td>
<td>use instruments that offer input to muscles and joints—cabasa, hand drum and vibraslap</td>
</tr>
</tbody>
</table>
A variety of music therapy interventions can be used to address goals specifically related to sensory integration. Improvisation, Eurhythmics, instrument-based exercises and sensory exploration. Improvisation is an effective technique for addressing sensory integration needs because the music can both express the child’s sensory needs and provide opportunities to meet those needs. Improvisation encourages a response of the whole system. As the experiences “of sympathetic relating and of self-regulation in co-activity progress, autistic children appear to find both security and freedom in the music” (Trevarthen, et al. 1998, p. 175). Techniques of empathy and structuring (Bruscia, 1987) are particularly effective. Children with Sensory Integration Dysfunction may have difficulties developing relationships. Music can provide a safe zone in which to explore a relationship.

Table 4  Adaptations for Music Therapy Interventions  (Gambrel & Allgood, 2000)

<table>
<thead>
<tr>
<th>Vocal</th>
<th>Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>vocalize in from of a mirror; exaggerate mouth movements</td>
<td>be aware of the amount of visual stimulation in the room; visual schedules</td>
</tr>
<tr>
<td>as appropriate encourage child to put his hand on your throat/face as you vocalize</td>
<td>be sensitive to child’s level of arousal; seating; incorporate strategies at transition times</td>
</tr>
<tr>
<td>use unique vocals for attention; explore range and styles</td>
<td>be aware of extra environmental sounds (i.e. lights); recognize and respect child’s response</td>
</tr>
<tr>
<td>use vocals to describe movement</td>
<td>movement breaks; pacing of sessions</td>
</tr>
<tr>
<td>pair vocals with body percussion; encourage child to attend to his own body as he vocalizes</td>
<td>sensory breaks</td>
</tr>
</tbody>
</table>
For many students with sensory integration issues, improvisation can provide a dynamic first step in therapy. Through improvisation, the music therapist can assess how the child responds to different elements of music (rhythms, timbre, melody, etc.) and how the child relates to instruments and people in the environment. For students with complex sensory integration issues, improvisation may provide the just right blend of structure and freedom. The therapist strives to shape the musical encounter to meet the immediate needs of the child to develop a trusting relationship. As the child develops trust with the adult, he/she may be more willing to take risks and explore.

A case example of improvisation as an initial contact for therapy is Matt. When Matt was initially seen for music therapy services he had a difficult time tolerating any contact or being in close proximity with me. He presented with a number of stereotypic movements, challenges with visual-motor activities and overall challenges with motor tasks. Matt protested by crying and/or hitting himself when attempts were made to bring him into structured, therapist-led activities. Through improvisation, Matt was able to slowly increase his tolerance for a variety of activities. During initial sessions, I would sit at the piano and improvise light, non-threatening melodies. Rhythms were used that matched Matt’s body movement. Matt would typically start the session at the furthest corner of the room. Typically he would move to the middle of the room after an introductory period of about 10 minutes. Matt was allowed to control the point of contact with instruments and/or other therapists. The music continued to support him by matching his movements and then encouraging expansion of movements.
Improvisation techniques provided Matt with sensory supports that he needed while developing the therapeutic relationship. Matt is now able to tolerate a variety of types of interventions. Sessions still include improvisation, especially when Matt demonstrates challenges with self-regulation.

Eurhythmics activities are adapted from the model developed by music educator, Emile Jaques-Dalcroze. Dalcroze Eurhythmics was “first developed to improve musicianship” by improving “musical perception, increased awareness, improved attention, and greater control of musical expression” (Schnelby-Black & Moore, 1997, p. 4). Eurhythmics involve whole body movement to explore musical concepts. For example, in order to develop a better understanding of duration and meter, students may “walk, run, or skip four beats, then stop and clap four beats in strict rhythm” (Findlay, 1971, p. 22). In the treatment of sensory integration, Eurhythmics activities are effective in developing auditory processing skills, internalization of rhythm, action/inhibition responses, perceptual-motor skills, and temporal pacing.

A case example of the use of Eurhythmics to address sensory integration is well represented by Corey. Corey typically demonstrates challenges transitioning into the music therapy setting. He giggles, fidgets and he is inattentive to verbal information. Corey is very responsive to completing a Eurhythmic sequence. The sequence typically starts with a set of 4-5 familiar stretches set to music (i.e. stretching up and down with the musical scale) then 1-2 Eurhythmic activities are introduced. Typically activities focus on action/inhibition responses, auditory discrimination,
modulating body movements between 2-4 distinct movement patterns. Music is provided from the piano. With rehearsals, Corey is able to accurately pace his physical movement with the music presented. His attention increases throughout the activities as evidenced by a decline in laughter, improved eye contact and a generally calmer physical state. After completing Eurhythmics activities Corey is typically better able to participate in higher level cognitive activities such as group song writing or music reading.

Instrument-based exercises provides another effective means of addressing sensory integration. The instrument becomes the tool for interpreting musical concepts much like movement as described in the Eurhythmics model. Activities can vary in complexity and are easily modified for individual or group work. Levin & Levin provide many excellent examples of instrument-based interventions in their book Learning Through Music (1998). For example in the “sleeping song” students are asked to wait play a cymbal softly. Modulation of play and grading physical pressure is a challenge for many students with autistic spectrum disorders. Instrument-based exercises can also be paired with movement. Instruction on instruments also provides students with opportunities to develop sequencing, graded physical responses, self-regulation, and visual/motor skills.

A case example of the use of instrument-based interventions is illustrated by Brad. Brad is highly motivated by contact with musical instruments. He presents with strong sequencing skills, but he has difficulty with modulation of his movement and grading his physical responses.
Instrument-based exercises have also been very effective to develop auditory processing skills such as discrimination and memory. Brad engages in activities that pair a motor sequence with a musical cue. The musical structure is provided by the piano. For example, four resonator bells are set up in a row. Brad is asked to listen to the piano then play the resonator bell four times to move through the sequence. Brad typically is very successful with completing the sequence so the activity is expanded to encourage him to play at various tempo and dynamic levels. Brad must tune into the subtlety of the musical cues presented by the piano.

Sensory-based music exploration is another effective strategy for addressing sensory integration needs. Sensory-based exploration involves contact with instruments or sensory/ music equipment to feed the sensory needs of the child. Large percussion equipment is a particularly dynamic tool to address the needs of students who seek high levels of physical input. Large gathering drums or tone bars produce very rich vibrations. Encouraging the child to be in close physical contact with the instrument can offer the child a diet of the input he is seeking in order to calm the system. Small percussion instruments such as the cabasa and vibraslap can be used to provide stimulation to a child who presents with very low physical tone and needs to be aroused.

In addition to contact with instruments, sensory-based interventions can be explored through specifically designed equipment such as the Somatron vibro-acoustic cushions, chairs and bean bags. The Somatron products have specially designed sound systems in the equipment. The items are hooked up to a stereo and any recorded music can be played.
The Somatron products are an example of Vibroacoustic Therapy (Wigram & Dileo, 1997) and can be “used as a relaxation method in and of itself”… or “used as a pre-treatment or preparatory experience for active music therapy” (Persoons & De Backer, 1997, p. 144.)

Paul provides an excellent example of using sensory-based exploration. Paul is a child who is in constant motion. He hums, seeks out tactile media with his hands and feet, and seeks physical contact with people in his environment. Paul was attracted to the large gathering drum. During initial phases of therapy, I led Paul to the large drum and encouraged him to have close physical contact (i.e. laying on top of the drum) while I played strong rhythms for an extended period of time. After a period of sensory input, Paul’s physical activity would slow and his ability to interact with people and objects in his environment improved. Over the course of music therapy treatment, Paul was introduced to the Somatron cushion. Paul will now use pictures to request the Somatron cushion as needed. He often seeks the cushion at the end of sessions for relaxation. He has developed improvement in self-regulation through the use of the sensory-based exploration.

**Summary**

Many children with autistic spectrum disorders face challenges with sensory processing and integration. These challenges dramatically affect the child’s ability to relate to the world around him/her. Music is a dynamic tool to help address sensory integration needs. Music therapists who serve children with autistic spectrum disorders should understand Sensory Integration Theory in order to better serve their clients. Music
therapists can either use the tenants of the theory to adapt the music therapy experience or focus music therapy interventions on sensory integration needs. In order to define treatment goals and interventions for sensory integration, music therapists should research the theories and treatments developed by occupational therapists. On-going consultation with an occupational therapist would also be extremely beneficial. Additionally, music therapists should become familiar with the growing body of knowledge being developed by the music therapy community regarding sensory integration treatment.

References


Acts Of Interpretation: An Investigation Of Music Therapists’ Listening Perspectives And Practices

Arnason, Carolyn L. R.

Preamble

My topic today is how we listen to our clients and the music created within a musical relationship. This presentation derives from an on going qualitative interview study being conducted with experienced music therapists who work in a music centred and improvisational approach. A brief overview of the research process and the main research questions will be discussed as well as research findings that have relevance for how we listen to improvisations. This study investigates both how we listen in sessions and listen back to taped improvisations. However, because of time constraints, the presentation today will focus on listening in individual sessions. Self inquiry is part of this study and, therefore, I will show a videotape excerpt of my work with a 51 year old woman who has severe cerebral palsy and is without speech.

Study Context

The purpose of this study is to investigate the relationship between how music therapists listen in sessions and their process of understanding the music through the analysis of audio or videotaped improvisations. A research aim is to study the listening perspectives of music therapists who work in a music centred psychotherapy approach. Participants are music therapists who look specifically at the music in their clinical work albeit in a variety of ways. Not all participants in this study would
resonate with the term “music centred psychotherapy”. However, the term signifies that when I selected prospective participants, they had to be not only experienced clinical improvisors who work in depth but they also had to reflectively analyze improvisation tapes.

At this time, 13 participants have been recruited from an international pool of music therapists. Countries represented include Australia, Denmark, Canada, England, Finland, Japan, Ireland, and the United States. The representation of countries is guided by who actually agrees to be a participant since the research does require a certain commitment of time and mental energy. Many participants are certified in the Nordoff-Robbins approach to music therapy. However, participants work in a variety of theoretical orientations such as humanistic, psychodynamic and developmental approaches.

Data are collected through email and, when feasible, in person interviews. During in person interviews, participants are asked to share audio or videotape examples of their clinical work. These examples allow music to enter into the verbal arena. When feasible, 2-3 interviews are conducted with each participant in order to strengthen the interpretive analysis of data.

**Research Questions**

A global research question which underscores the study is - “What constitutes the process of musical understanding? More specific research questions are:

- How do music therapists listen to improvisations?
• How do music therapists listen to clients in individual sessions?
• What informs therapists’ musical choices when improvising with a client?
• What connections are there between listening in sessions and listening back to taped improvisations?
• What impact does interpretive analysis of improvisations have on music therapists’ clinical work?

**Research Concepts**

There are two crucial concepts which have emerged from interpretive data analysis. These concepts are (1) *acts of interpretation* and (2) *listening in context*. Regarding *acts of interpretation*, as human beings we constantly interpret our world in order to make sense of it. Due to the complexity of this world, the interpretive process means that we have to make choices about what and how we interpret. In the clinical arena, I understand *acts of interpretation* as being a music therapist’s commitment to, and involvement in, distinct levels of musical listening. Our acts or musical choices as music therapists originate from the deliberate and reflective study of the music and musical relationship co-created with a client. I chose the word “act” because it implies *attention, action, and movement*. The phrase *acts of interpretation* hopefully integrates the classic research triad of description, analysis, and interpretation. I am also attempting, in terms of language, to open up the connotation of the word “interpretation” beyond a potentially restrictive meaning located only in a particular theory such as classic psychoanalytic thought.
The concept of *listening in context* means that context is everything in terms of musical understanding. The title of my presentation refers to perspectives and practices. There are significant external factors or *perspectives* which inform how music therapists listen in the moment of sessions. In sessions, there are multiple levels of listening which a music therapist can *practice* (in the sense of execute or accomplish) in order to guide their musical choices. Although not discussed in this presentation, the *practice* of interpretively analyzing taped improvisations generates clinical and musical *perspectives* which are taken back into subsequent sessions.

**Research Findings**

An important external factor or perspective is a music therapist’s *listening stance*. Metaphorically speaking, our listening stance is the ears we have developed. This stance seems to traverse client groups and different clinical settings. However, it is not totally immutable. Music therapists’ listening stances are informed and developed by other factors such as theoretical frameworks, level of education, experiences as a musician, life history, gender, sexual orientation, multi cultural issues, and, more clinically specific, insights achieved through tape analysis and supervision.

When participants were asked the question - *What catches your ear when improvising with a client?* - their responses revealed that listening in sessions comprises not only the aural experience but all our senses and
more. In sessions, there are multiple levels of listening. I propose that these levels are actually various acts of interpretation. That is, each listening level requires some layer or act of interpretation.

Perhaps the most obvious, although multifaceted level of listening is a musical one, i.e., the client’s music. This level includes specific musical elements and characteristics of a client’s music making, e.g., tones, intervals, and textures. But this level also includes musical listening that require a more sophisticated act of interpretation, e.g., a change in the intensity of a client’s music or recognizing musical shape and patterns.

Another research finding is that we listen to our clients, i.e., their body quality, verbal dialogue, and presence. An example of body quality is the interpretation of a client’s body language (movements/bearing) and facial expression. Listening to a client’s presence refers to intangible aspects of listening which include intuition and our ability to “hear” a client, e.g., when a client does not, or is not able to, give us clear musical cues, physical signs, or verbal direction.

We listen to our own music when improvising with a client. For example, the musical qualities of clarity and openness allow for balance in our playing. Balance is achieved through:

1. Directness (musical structure and form)
2. Freedom (exploration and ambiguity)
3. Movement (clinical direction and therapy process)
Listening to our own music and, I would add, our musical self, also necessitates a balance between the client’s music and our own music making. This balance is the lynchpin of the musical relationship.

**Listening to our feelings** as music therapist is intertwined with listening to our own music in relationship with a client. This level of listening entails being keenly aware of what is being “said” in our music, i.e., what we are communicating both consciously and unconsciously through our playing (musical countertransference). As one participant said - “[I listen to ensure] that my music is communicating directly something about the client’s own needs”. Although this level emphasizes feelings, the self monitoring that occurs at this level seems to actually be a process of drawing not only on feelings but also on thinking, physical sensations, intuition, and imagery.

**Clinical Example**

To musically illustrate the presented research findings, I would like to show you a videotape excerpt of my own clinical work with an individual client. Barb is a 51 year old woman with severe cerebral palsy who cannot speak. She can move her head to indicate “yes/no” to “yes/no” questions and she does not have any discernable cognitive difficulties. She is in a manual wheelchair. We have worked together almost 3 years for a total of 81 one hour sessions. Active instrumental playing and verbal dialogue are not viable means of expression for Barb. Because of her physical disability, I play most of the music since many instruments are not accessible to her. It was with Barb that I really began to reflect on four questions that contributed to my current research topic:
(1) What am I listening for in our sessions?

(2) What factors have a bearing on how I listen? ( 

3) What factors influence the building of our relationship in music?

(4) What aspects of my music and way of being are meaningful or even useful for Barb?

My listening stance with Barb consists of balance and care. I aim for:

• Balance in the timing of my responses, i.e., immediate versus waiting
• Balance in the amount of music played, i.e., simplicity versus complexity
• Taking care to build the relationship in music, i.e., recognition and musical commitment
• Taking care to draw on my experience (musical, clinical, life, education), i.e., accessing professional and personal knowledge

In terms of the improvisation you’re going to hear, there were several external factors or perspectives that influenced my listening. They were:

• Her father’s declining health because of prostate/bone cancer
• My clinical aims, e.g., to give Barb an aesthetic and relational experience in music that would otherwise be denied her because of her disability and living environment.
• Regular interpretive analysis of videotaped sessions
• Impact of this research process and findings on my own clinical work, i.e., conscious and reflective thinking in dialogue with research participants’ ideas in order to articulate how I work with Barb.
• Nature - this improvisation occurred on a day that felt odd because of unusual and sudden humid heat

Levels of listening or acts of interpretation in the session that contributed to this improvisation were:
• Barb’s listening and being in music.
• My own music, e.g., development of 4 note melodic motif, a sense of musical flow, 2 part counterpoint, the placement of tones & intervals on the piano, i.e., touch, dynamics, register, moving bass line versus repeated tonal centre (F sharp).
• An intimate and sustained connection in music
• The space between us & the silence around us, i.e., a sense of spirituality.
• Barb’s presence and body quality, i.e., her intent presence and physical stillness.
• The quality of her gaze
• The emotional quality of her vocal sounds and facial expressions.
• My feelings - In this improvisation, the balance between my feelings while playing and Barb’s presence in music was maintained by a tangible connection between us; a quiet but concentrated intensity.

Of course, the demarcation between factors outside sessions and levels of listening in sessions is artificially imposed. Barb’s physical dependence (she needs total care) impacts her life outside and both our lives inside sessions. Working with Barb for 3 years has created a trusting relationship that influences my way of being with her. The reflective analysis of videotaped improvisations has had a significant impact on how I improvise. Analyzing tapes has allowed me to know what helps Barb to musically engage. For example, you will hear in the video excerpt (1) my use of bass accompaniment on piano which allows Barb’s voice to provide melodic tones or melody, (2) a single bass line which suggests, but does not fill in, harmonic movement, and (3) playing of a repeated tone or interval which I call “holding and signaling”. There are many unknowns with Barb in terms of how she thinks and feels. She is not able to verbalize what it is like to be a 51 year old woman born with
cerebral palsy who has lived in institutions for over 20 years. Getting to know Barb over these 3 years has given me greater confidence to work with someone whose inner life is so shrouded in mystery. I have also learned not to seek those “amazing moments” in music but to have faith that they will happen.

This video excerpt is from Session 73. You will hear the last 8 minutes of our opening music. Sessions usually begin with improvised opening music in order to meet Barb’s apparent mood or feelings, to welcome her back, and to transition into a musical environment. Although this improvisation was based on a 4 note melodic motif from a previous session - c sharp, f sharp, e, d, c sharp - the structure and form of the improvisation as well as its lyrics were originally created in this session. The tonality is F sharp minor and the lyrics are “Welcome to music on this beautiful afternoon”. The improvisation illustrates a contrast between the rich tonality of F sharp minor and the simple improvised lyrics. You will hear Barb play the piano and vocalize. However, being in music and listening are, perhaps most significantly, the ways that she profoundly engages in the music experience.

Authors Address

Dr. Carolyn L. R. Arnason, MTA

Wilfrid Laurier University

Waterloo, Ontario, Canada

carnason@wlu.ca & carboy@golden.net
Becoming a Profession: Pressures of status change for music therapy

Barrington, Alison

_Becoming a profession is a political process which involves...games, strategies and tactics._

So claims the British art therapist Diane Waller. Becoming a profession: how political is the process? What are the games, strategies and tactics that are played?

This paper is going to explore the tensions that exist when any organisation is engaged in the process of professionalisation. It will look at Kenneth Bruscia’s idea of identity - the tension between how music therapists view the profession and how others perceive it.

It will investigate the difficulty of explaining what is music therapy, the tensions between what can and what cannot be defined and, more importantly, the pressure of having to explain what music therapy is - perhaps to employers, to teachers, to the government, to clients and their carers.

This paper will explore the tensions between the political process of professionalisation and the needs of our clients.

Becoming a profession is a political process which involves...games, strategies and tactics in the pursuit of aims which one hopes are altruistic. Why [do]...therapists want to do this when it appears so much at odds with the attitude....to encourage honesty, openness and integrity for self and clients? Why is it necessary? When the...therapist has so often identified with the ‘outsiders’ in our society what is to be achieved and what lost in the process?6

But before investigating all these issues this paper will start by exploring a brief history of music therapy in Britain and the professional developments that have taken place during the past 44 years. It will then go on to look at the idea of professionalisation and to ask the fundamental question - what is a profession? Finally this paper will look at the more recent developments for the profession and offer thoughts for the future.

Although this paper will be focussing on the developments within Britain many of the issues that arise are likely to have some relevance for music therapy in other countries.

The History

In 1958 the Society for Music Therapy and Remedial Music was founded in Britain with a handful of enthusiastic teachers, doctors and musicians who were keen to establish a more formal network for people interested in the therapeutic use of music. Juliette Alvin was undoubtedly the driving force behind these early years and the archives document a growing and enthusiastic Society. During the 1960s the Society focussed on sharing information with both members and nonmembers of the Society but one of its longer term plans was also to train music therapists.

6. Ibid, p246
The first music therapy course began in 1967 at the Guildhall School of Music and Drama, London and the founding of the course was hailed as a new phase in the professionalisation of music therapy. This development encouraged the Society to sharpen its image and change its name. And so the British Society of Music Therapy became its new title in 1967.

The need for a strong image to promote music therapy has been a running theme throughout the last 44 years. As already stated, the initial image was one of an enthusiastic band of people but by the end of the 70s Tony Wigram was keen to promote a more professional image. He says:

We became aware of the situation of needing a career structure, and that our work should be properly paid for. I was on the BSMT committee at that time and I remember one argument I had with Juliette about workshops. I said that a music therapist who did a one-day workshop would have to be paid. She didn’t understand that concept because as far as she was concerned everybody who spoke at her conferences did it for love! The end result was she agreed to it, but she said to me...“Tony, you have the mentality of a trades union official!” and I said to her “Thank you Juliette, that’s fine!” It inspired me, because I thought, yes, maybe that’s what I should be. If this profession’s going to go anywhere we need to take a trades union attitude to it. Not that I was a socialist, but I felt we’d got to start fighting for the profession to be what it is, otherwise we’re going to be everybody’s ‘icing on the cake’ but nobody’s requirement.7

Wigram became the first music therapy advisor for the Department of Health and spent the majority of his time working with art therapists to try to establish a “corporate identity.”8 After enormous struggles to get the government to accept the need for music and art therapy these professions were eventually given a firm pay and grading structure

7. Interview with Tony Wigram (by Helen Loth) in British Journal of Music Therapy, vol. 14, 1 2000, p6
8. Ibid, p7
through the National Health Service. In 1997 music therapy gained State Registration which again furthered the professionalisation process.

Since the 1970s music therapists have been eager to gain government approval and recognition and this is a running theme for many therapists in many different countries. Simply looking through Maranto’s book ‘International Perspectives on Music Therapy’ shows how so many Associations are looking for government approval. For example, Di Franco and Perilli suggested that there was a need to go into “...negotiations with the Italian government for recognition of music therapy as a discipline.”

Although the principal focus of this paper is issues of professionalisation, we have just heard the term ‘discipline’ and it is necessary to look to Kenneth Bruscia for his comments on identity as a discipline in contrast to identity as a profession. He suggests that, as a profession we are obliged to accept the views and opinions of others but as a discipline it is easier to remain more autonomous. He writes:

> When we define our identity in terms of the discipline, we are “field-independent” [and] when we define our identity in terms of the profession, we are “field-dependent.” When we are field-independent, our major task is to educate ourselves; when we are field-dependent our major task is to educate others. Herein lies the developmental struggle. Music therapy is struggling to exert its own identity at a stage of development when perceptions of others are still important. Hence, we are unable to be entirely field-independent or field-dependent. Our identity is being co-developed. The identity we give ourselves influences and is influenced by the identity given to us by others.

What Bruscia highlights here is the tension between what music therapists believe their own identity is and how the profession is perceived by others. He says that music therapy is ‘at a stage in development when perceptions of others are still important’ suggesting that if the profession reaches a higher stage of development it won’t have to depend on other people’s views. Before exploring this idea this it is necessary to ask what is a profession.

**What is a profession?**

Many sociologists in the 1960s identified specific characteristics which define a profession. Millerson listed 23 characteristics but rather than work through all these I quote Terence Johnson who condensed them into 6 crucial points. So a profession has:

- Skills based on theoretical knowledge
- Training and education
- The ability to test the competence of its members
- An organisation
- A code of conduct
- Altruistic service

It might be useful at this stage to put the developments of music therapy that we’ve already seen next to this list to see how music therapy fulfils this definition of a profession. As already noted the music therapy

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profession has established training and education programmes which enables practitioners acquire the necessary skills based on theoretical knowledge. The Association of Professional Music Therapists is the organisation that aims to test the competence of its members and has drawn up a code of conduct for all members to follow. The last point is more difficult to define since it refers to a characteristic rather than a concrete action.

Another sociologist, Eliot Freidson, believes that it is far too simplistic to offer a list of characteristics to define a profession. Each profession has its own history, its own structure and its own unique way of developing. There is a progression from small beginnings towards a more formal, larger structure. So, it is possible to see that a profession develops by:

- Forming an organised group
- Accrediting training courses
- Establishing and maintaining supply and demand
- Monopolisation of professional knowledge
- Working with allied professionals

It has already been noted that Juliette Alvin was one of the founders of the Society and that one of the earliest goals was to establish a training course which happened in 1967.

Pioneers such as Alvin certainly worked hard to establish and maintain music therapy but it is also necessary to explore society’s changing attitudes towards alternative treatment and medicine in order to gain a broader understanding of the development of the profession. Writers

such as Cant, Sharma and Saks suggest that there was growing interest in alternative medicines in the 1960s and 70s.\textsuperscript{13} (Although music therapy is not labelled as an alternative medicine it did also develop in the UK during the 60s and 70s.) During these decades there was general concern that drug trials were not safe and could not be relied upon. (One of the most infamous examples is, of course, the drug thalidomide which was in use during the 1960s.) There was also a growing concern about the perceived ‘authoritarian’ attitude of medics and the public wanted to be able to make their own choices regarding treatment procedures. Saks suggests that alternative medicine and the art therapies managed to establish themselves and to maintain supply and demand due to these changing views.

The ‘monopolisation of professional knowledge’ and ‘working with allied professionals’ are two significant developments for the music therapy profession and this paper will now consider these two ideas starting with the monopolisation of professional knowledge.

**The Monopolisation of Professional Knowledge**

According to Freidson technical knowledge truly distinguishes a profession from other organisations. He states that “[w]hat is generic to the professional is control over his [sic] technique or skill, monopoly over its practice.”\textsuperscript{14} No member of the public can examine or monitor the

\textsuperscript{13}See Sarah Cant and Ursula Sharma (eds) and Mike Saks in *Complementary and Alternative Medicines, Knowledge in Practice*, Britain, 1996.

\textsuperscript{14}Eliot Freidson, [*Profession of Medicine, A Study of the Sociology of Applied Knowledge*], USA, 1970, p42
professional work because they simply cannot understand it. They have not been trained. As Freidson says, a professional possesses a ‘skill so esoteric or complex that non members of the profession cannot perform the work safely or satisfactorily and cannot even evaluate the work properly.’ This gives the professional a powerful position; they feel confident because they believe that their work cannot be judged or assessed. It is clear that power and knowledge are closely linked but a professional can easily abuse their position of authority and as a result the patient may feel both vulnerable and disempowered.

Technical knowledge is only one type of professional knowledge and the sociologist, Abbott, identifies two different types. There is concrete knowledge which is accessible to both trained and untrained individuals. In music therapy it might be the structured information such as therapeutic approaches and musical techniques that are easily understood irrespective of training.

There is also abstract knowledge. By its very nature it is impossible to define to those who are not trained. In terms of music therapy it might include therapeutic insight or the therapist/client relationship. It is the essence of the work and it could be defined as that which cannot be taught. As Freidson states, this is the key element and it helps professions retain some of the unique quality to their discipline. Music therapists are the experts precisely because they have specialist or abstract knowledge which is not so easily accessible to the general public.

15. Ibid, p45

Both concrete and abstract knowledge are required within professional work. The general public needs to have access to the concrete information because it relates to practical and ethical issues which have a direct impact on them. In fact it would be unethical to exclude the public from the discussions regarding this element of the work.

But the public have to be able to trust the professional’s expertise and judgement. They have to be able to trust that the professional is using the abstract, technical knowledge for the good of the patient and of society as a whole. A professional works within and for a community and needs to be working in an altruistic fashion. Altruism can be seen as a most positive trait although it could be argued that most professions will want to be perceived as trustworthy and altruistic in order to be seen in a good light.17

To hold both concrete and abstract knowledge in balance with each other is a challenge. If a profession is perceived to have too much abstract or technical knowledge the general public are concerned about how much power the profession has. However, if the profession is perceived to be based on too much concrete knowledge the general public might judge the work to be ‘no more than a craft.’18

This line of argument links back to Bruscia’s idea that ‘music therapy is struggling to exert its own identity at a stage of development when perceptions of others are still important [and that] our identity is being


18. Ibid, p165, quoting Abbott, ibid, p102
co-developed.’ As already mentioned Bruscia seems to be suggesting that, if the music therapy profession was more mature in its development, it might not need to worry about other people’s perceptions.

So, is an occupation hoping to gain freedom from all these opinions and judgements? Is autonomy the goal of professionalisation? Eliot Freidson believes it is. He says:

**Autonomy is the prize sought by virtually all occupational groups, for it represents freedom from direction from others, freedom to perform one’s work the way one desires.**

Professions and individual professionals attempt to gain autonomy by suggesting that they are trustworthy and do not need supervision. They say that they are conscientious and responsible and that they can regulate their own work since they are the only qualified people to monitor it anyway. Professions are trying their hardest to gain autonomy but we’ve already heard that professions do not exist in a vacuum. But let’s imagine for a moment what would happen if a profession or a professional were to gain complete autonomy.

It has already been noted that the public would be in a vulnerable position. How could the public guarantee that the professional association was disciplining rogue practitioners? Eliot Freidson argues that the general public are within their rights to monitor the ethical and practical issues because all professions work within and for the


20.  Ibid, see p137
community and, as such, have an obligation to demonstrate their ethical practice.

But the profession and the individual professional would also be in a vulnerable situation if they were working in a completely autonomous manner. Isolation can be dangerous. Without liaising with colleagues a professional will not learn about new techniques or changing policies within the professional association. Who will scrutinise the lone practitioner? A profession does need to seek the approval of the general public, not as a kind of ego-boosting experience but as a protective guard against unethical work.

The music therapy profession in Britain is now a member of the Health Professions Council. Certainly music therapy now has a secure pay structure and is recognised by the government but music therapists are now being asked to explain and justify their work in more intricate detail than ever before. New policies have been implemented to do with auditing, accountability, clinical effectiveness and cost efficiency. Emma Bishton wrote about the implications of these changes with regard to music therapy. She stated:

Music therapists need a research and development strategy, and to set up their own clinical guidelines....It was asked whether clinical excellence guidelines can be applied to music therapy.... It is hard to see music therapy in this mould, and the profession must be proactive in putting its views into the debate to get them implemented. We need a strong research base and overview of consequences in order to voice our position.21

21. APMT report of a meeting held prior to the APMT AGM of 17th March 2001 - “The Presentation and Discussion of the Implications of State Registration.”
By joining the NHS the music therapy profession has lost some autonomy. Although this paper has already noted that complete autonomy is not a healthy state of affairs too little autonomy can make a profession feel threatened. Freidson gives the example of the medical profession in the Soviet Union during the 60s which was under such strict rules by the authorities that it was unable to carry out even basic treatment because resources were not made available. It seems that there needs to be some kind of balance between the needs of the profession and the demands of the government.

There are two important questions to ask at this point. What information can music therapists provide about their work? And, to what extent is the profession obliged to produce this information?

Information regarding training, Continuing Professional Development, code of ethics and supervision can be demonstrated to the government. But, would the government authorities be content with this practical, concrete knowledge which is easier to explain or are they demanding information about clinical work? Defining and explaining the technical, esoteric information is not so easy. David Aldridge writes:

> In our attempts to find a common language then it is also important to emphasize 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 from talking about dancing, talking about singing, talking about painting and talking about doing therapy.


Gary Ansdell has also discussed this issue and describes it as “The Music Therapist’s Dilemma.”\textsuperscript{24} The whole point of professional or technical knowledge is that it is impossible to explain to the untrained public.

Pavlicevic wonders why music therapists feel it is necessary to describe or justify their work. Like Ansdell she is concerned that the essence of the music therapy process, i.e. the music, will be compromised if it is described in terms of clinical effectiveness. Furthermore if music therapists attempt to justify and define the process in terms approved by the NHS does this suggest that music therapists are unconvinced by their own work, by the power of music? Pavlicevic suggests that there is a plea for music therapy to ‘be itself’ rather than relying too heavily and exclusively on... ‘approval’ or ‘validation’ of what we do and how.\textsuperscript{25}

Regardless of the difficulties of explaining the processes involved with music therapy, the APMT needs to consider its motivation for producing information which conforms to standards set by external authorities. It needs to ask itself what benefits might be gained from undertaking this task. Of course the music therapy profession is not in a strong position to argue with the NHS. It is one of the smallest component of the Health Professions Council (HPC) which is itself a small section of the National Health Service.

Not only is it one of the smallest components it also tends to work with clients who have chronic health issues, mental health issues, disability

\textsuperscript{24}Gary Ansdell, “Music Therapist’s Dilemma,” in \textit{British Journal of Music Therapy}, vol 15, no. 1, 2001, p2

or may need palliative care. These are known as the “Cinderella services” and do not receive such high profile or impressive resources as services for acute or life-saving interventions.

There is another problem too. The NHS invites any profession to provide evidence about its clinical and cost effectiveness but it does not make it easy to ‘plug into’ their system of providing this information. To begin with professions have to finance their own research. It is the drug companies that are able to fund higher profile research and the NHS are not helping smaller organisations. Also the NHS requires the information in specific formats which may suit drug companies but arts therapies find it difficult to respond. For example the government is asking for information about treatment for schizophrenia. Arts therapies would prefer to respond with qualitative research but the government system makes it clear that quantitative results are more acceptable.

The sociologist Chambers suggests that groups who perceive themselves in more subservient positions can improve their status “through analysis and action.” So what analysis and action can the music therapy profession do to help the situation?

One important development is that the profession has join with a total of twelve other professions allied to health. Many music therapists are in favour of becoming part of this group and Bishton suggests the advantages are as follows:

- Support (both financial and time) from other, larger organisations

• Learning from one another
• Administration can be shared between the organisations
• Having a louder voice when joined with other organisations\(^{28}\)

The last point is crucial. Although on initial glance it seems as if these thirteen professions have little in common with each other they have all been kept in a position of subordination by the more powerful medical profession. By joining together there may be a sense of solidarity and support. Bruscia realises that

...music therapists have had to forge out their identity in a socioeconomic and political climate that is both demanding and changing. Music therapy has had to grow up in a ‘fast-lane’ culture where health professionals are expected to produce results no less spectacular than space travel, and at a time when the values of intimacy and art are easily compromised by the prowess of science.\(^{29}\)

Perhaps 44 years ago music therapists were able to choose their own identity. However, once the Association of Professional Music Therapy moved into accrediting courses and linking into the NHS, the government has been making more and more demands. All these developments have meant that the profession has had to relinquish the ability to define its own identity. As Bruscia states, our identity is being “co-developed. The identity we give ourselves influences and is influenced by the identity given to us by others.”\(^{26,30}\)

How much has the

\(^{27}\) APMT survey carried out in 2000 when 67\% of practitioners were in favour of joining the Allied Health Professions Forum (now Health Professions Forum).

\(^{28}\) APMT minutes from the AGM, 17\(^{th}\) March 2001

\(^{29}\) Kenneth Bruscia, *Defining Music Therapy*, USA, 1998, 2\(^{nd}\) edition, p15

\(^{30}\) Ibid, p26
music therapy profession relinquished its ability to chart its own future, its own destiny?

At the 7th World Congress held in Spain in 1993 Martyn Parker-Eames suggested that music therapy was becoming more ‘professional’ for its own self-preservation. He asked whether “the necessary compromises [were] worth it for the clinicians and for the clients?”

**Becoming a profession is a political process which involves...games, strategies and tactics in the pursuit of aims which one hopes are altruistic. Why is it necessary? When the therapist has so often identified with the ‘outsiders’ in our society what is to be achieved and what lost in the process?**

The music therapy profession needs to remind itself of its primary focus - the clients. But it cannot ignore the fact that it has entered a political arena. Meg Stacey says that “If the profession is unable to [explore accountability and clinical effectiveness] and to articulate a schedule of the goals to be achieved...then others are likely to develop the goals and the schedule for the profession”

I would agree with Bruscia’s idea that the identity of music therapy is being ‘co-developed.’ There are pros and cons to this. There is less freedom, there are more demands for monitoring and accountability but out of this might also grow more security and more trust.

31. M. Parker-Eames, “Professionalisation of Music Therapy,” paper given at the 7th World Congress of Music Therapy, Spain, 1993


33. Margaret Stacey, Regulating British Medicine: The General Medical Council, 1992, p261
I do not pretend that I have solutions to offer to the problems and pressures that the profession is experiencing but I would suggest that we must recognise that there are some important developments occurring at the present time. If the profession can hold on to its integrity, remembering that it aims to be an altruistic service for its clients it might stand a chance of retaining its original, true identity. But it also has to remember that it chose to become part of the NHS and, as a consequence, has lost some of its autonomy. Losing some autonomy is a part of the maturation process for any profession. Somehow the music therapy profession needs to learn how to grow within this new arena. Perhaps we need to learn to speak the language of the NHS without forgetting our roots.
Limitations and Open Spaces: Music Therapy in Neurological Rehabilitation

Baumann, Monika

Music therapy in neurological rehabilitation is a rather new subject in Germany, which has been increasingly gaining in importance since the 1990s. To be more precise, I am referring to music therapy with patients who have suffered a brain injury, patients with acquired brain damage (as opposed to congenital brain damage). My aim is to describe the characteristics of this work to you in the next 45 minutes.

Usually the patient is struck by the illness quite suddenly; be it through a traumatic brain injury, a cerebral-vascular accident, hypoxia (reduced supply of oxygen to the brain), a fast-growing tumour or a necessary operation, it strikes the patient quite out of the blue. It can completely change the life he has led up until now from one moment to the next, and these changes can affect all aspects of being human: his body, his mind and his personality, movement, negotiation, experience, perception, expression, communication with others, orientation, memory and many more aspects, which we healthy people take for granted. What is more, a multitude of so-called higher brain functions contribute to psychological and mental processing, rendering the brain our “central unit” for coming to terms with change. If these functions themselves have been affected by the damage the patient is extremely emotionally vulnerable to the traumatic events.
Following emergency care, which can last from a few days to many months, the patient undergoes a treatment phase, rehabilitation, from which he desires one thing above all else: to be “like before” as far and as soon as possible. This wish is seldom fulfilled; usually losses remain for some time, albeit to a somewhat varied and unpredictable extent. The various therapeutic procedures offer help with working on disturbed functions: the physiotherapists work on the movement functions, the speech language therapists on language, speech and swallowing, the occupational therapists on perception and coping with daily life, neuropsychologists on cognitive abilities. But what does music therapy do? How can it help anyone to regain their former state of health to the greatest extent possible?

Perceptions and expectations of music therapy from the patients’ point of view are highly varied. They span everything from resistance (“I’m hopelessly unmusical”, “what good will that do me at the moment?”) to serious consideration (“I could practise using my fingers on the piano”, “I want to finally play the drums”), to a vague idea of finding something to support your state of mind. (“Music is good for the soul”, “music calms me down”, “music builds me up”) This all becomes clear if the patient can speak; with those who cannot, however, perceptions and expectations remain unclear.

I present music therapy to the patient as an open space in which to search for something that does a person good, that relaxes, excites or liberates, an opportunity to “let go” in the rigid programme of exercising and working, in the daily struggle for motivation and discipline, to enjoy, to
experiment, perhaps to discover something quite new and unfamiliar. The patient has at his disposal a room, various instruments, our voices and cassettes and CDs for listening to music. And of course myself, with whom he can interact. What happens then remains completely open. When I consider courses of music therapy that have been successful (of course one must take into consideration the fact that there have also been failed or discontinued attempts) they all have one thing in common: an encounter takes place. This encounter can be a short moment, it can also, however, develop and intensify gradually over a longer period of time. Its quality can pass through various phases (I will show you an example of this later). The spectrum these successful moments can cover is enormous. I would like to briefly illustrate this to you.

A person lies there, capable neither of speaking nor of understanding his current situation. He looks at me, I hum a melody and move his hand, which I am holding. Suddenly the hand becomes light and takes the lead, it dances, thus changing my melody. Shared music is born of movement and humming.

Once there was a young man who could only communicate by moving his eyes. He directed me with his eyes, he pointed me towards some gongs and tubular bells. His music came to be through my hands.

Then there is the patient who interacts by playing instruments with me, who entices, demands, accompanies me, clings to me, plays only for himself, runs away from me; then there is a search, we approach one another, touch one another and separate again.
Then there is music which is so empty and barren. My patient is sparing with his notes, they come unbelievably slowly in apparently interminable moments. I try to join these sounds together, play into the empty room and then, suddenly, as if from the far distance, there comes a reply. An encounter in space.

And then there are sounds that push to break out, expressive music that carries me away, captures and cries out emotions. An encounter that sends you into turmoil.

What all these situations have in common is an encounter between two entities in a third: sound, melody, rhythm, music, in fact precisely that which is frequently described as THE SPECIALITY OF MUSIC THERAPY. I feel that this quality of encountering in work with brain-damaged patients is particularly impressive as it often just stands for itself, with links to neither words nor deeds nor to everyday reality.

In order to demonstrate the range of the aforementioned spectrum to you more clearly, I would like to present you 2 examples, which can be regarded as extremes of the spectrum.

Firstly a video sequence of therapy with a 64 year-old man, who had suffered brain haemorrhage with various complications. His condition was extremely weak, he could only sit in his wheelchair for a short time and with great effort, only opened his eyes occasionally and for short moments and since the beginning of his illness had only whispered a few words in front of his wife. Whenever he was in a sitting position he seemed to be sleeping. This short extract is from the sixth session of music therapy. As I knew from his wife that he loved rhythmical music
and had very much enjoyed dancing I offered him the large kettledrum. Watch what happens.

What you could see was a quite basic form of communication, an exchange of rhythmic pattern. This made one of my colleagues think of two people communicating by knocking on 2 sides of a wall.

I would like to present you the second example, at the other end of the spectrum, with the help of a cassette recording. The patient, 54 years old, had suffered a stroke, which had left him hemiparetic and with global asphasia (a complete loss of speech) 5 months before starting therapy. As an arts scholar who lived in a world of books he was particularly devastated by this loss. He tried to disguise his despair in his friendly and communicative manner. For many months he played primarily percussion instruments in music therapy, particularly drums. Sometimes he would play wildly and passionately for himself; other times together with me. Seemingly endless energy was released again and again in mutual crescendos and accelerandos. Occasionally he would come to freely use his voice. When his mood very suddenly altered due to his change to day clinic, he appeared exhausted, resigned and very sad (after all, he couldn’t talk about it!) I suggested that we listen to a classical concerto together. While listening (it was a Mozart violin concerto) he cried a great deal. In the session immediately after listening to the concerto he wanted to sing. Listen:

The patient let his emotions run wild. His eyes were partially closed and tears rolled down his cheeks. I felt that here there was a great deal of pain and despair, but also strength and hope. Emotions find expression in
improvisation and can be simultaneously shared with someone. This is an important step for the patient in the process of coming to terms and coping with his condition.

Let us now consider this subject from a more general perspective. I will describe to you the specific methods of music therapy work in neurological rehabilitation, briefly explain the setting and demonstrate indications and objectives. All this has been developed from clinical experiences and constant exchanges with other music therapists who are active in this field. Since 1994 we have had a working group in Germany called “Music therapy in neurological rehabilitation”, which has a current membership of around 40 practising music therapists, and meets three times a year for a working conference. Exchanging experiences is extremely important in such a new subject as ours, which still has to fight for recognition in order to make its mark.

**Methods:**

The individuality and uniqueness of one of those patients, as far as personality and current state of dysfunction are concerned, demands a great variety in method on the part of the therapist. Here is an attempt to systemise these methods:

In the early stages of rehabilitation the emphasis in music therapy is undoubtedly on individual therapy. I intend here to limit myself to this, as in the specific context of my work in the department of early rehabilitation in a general hospital I have been able to gather only limited experience of work in groups.
Singing or humming in time with the patient’s breathing rhythm is based on a method for the treatment of comatose patients developed by Dagmar Gustorff. It is used in a modified form by nearly all music therapists in cases of patients with severe disorders of consciousness (coma and vegetative state): the predominantly vegetative signals from the patient such as breathing rhythm, physical tenseness, small movements, but also facial expression and the atmosphere around him are taken up by the therapist as a starting point for a vocal improvisation. The improvisation is consciously limited to humming phrases and simple melodies. Whilst doing this the therapist establishes physical contact with the patient, usually with the patient’s hands. Modifications come about through vocalising, adding words (random words or song lyrics) or by adding an instrument, and establish themselves in the therapist’s intuition. Through an often quite delicate process of co-ordination (sometimes there are clearer reactions such as hand-squeezing, sighing and turning away…) a dialogue develops.

Playing music to the patient presents the further possibility of communicating with patients who are far from consciousness or those who have been impaired in their ability to operate by disturbed perception or behaviour. With an instrument, often combined with the voice, I present the patient with a space of sounds, which is intended to provide him with a counterbalance to his frightening, painful and isolated condition. I attempt to convey peace and security in order to establish trust. Here he can focus his frequently wandering attention on something meaningful (as opposed to “meaning-less” stimulation), thus experiencing contact with another. During this process I pick up on
signals coming from the patient of course, including those emotions, which I have perceived through countertransference without, however, allowing his breathing rhythm to detract from my plan.

Active music therapy at the patient’s bedside usually develops fluidly from playing music to the patient. The patient is more and more actively involved in the musical process as motor and cognitive skills increase. The most suitable instruments for this are smaller, easily transported instruments such as cantelas (a kind of small harp), calimbas, chimes, tambours, and similar. From one plucked note or a tapped rhythmic motif active participation can develop further into a fully-designed dialogue.

**Active music therapy in a classic setting:**
If the patient can be moved to a wheelchair for a short while and his general condition permitting, music therapy can now take place in a classic setting: in a closed room in which a variety of the easiest instruments to use are available. The patient can choose. The variety has a stimulating effect and presents him with completely new opportunities to communicate and express himself. Improvisation is a central feature, understood as a playful way of dealing with reality, expressing the soul and establishing contact and a relationship with another.

Singing songs is a special form of active music therapy, which reaches back to deeply-anchored personal and cultural experiences and conveys a sense of security and integration. Personal memories and memory work are stimulated. The patient’s active participation reaches from swaying along through mimicry and motoricity through making sounds to producing words, even in a phase where he is not yet able to
communicate through speech. Singing has a particular quality for aphasic patients; that is, patients with central speech language disorders. For neurophysiological reasons they often manage to produce words better when singing than when speaking. Thus they can have positive experiences with their own voices and they experience once again the flow of words completely lost in speech. Furthermore, they experience the bonding element of singing together with others. Even if there is no scientific proof of it, experience has shown that singing has a positive influence in paving the way towards speech.

Receptive music therapy is listening together to specific pieces of music on cassette or CD players. (Of course, the music played by the therapist as previously described is also a receptive offer for the patient.) This can be an opportunity to more closely observe the patient’s experiences, memories and emotions through the listening experience. The wish to do this often comes from the patient himself; he should have a say in the choice of music.

A final method is conveyed by therapeutic instrumental tuition. It frequently but not only occurs with patients who were musically active before they became ill and wish to test out and/or regain these skills. Alongside the musically didactic task the therapist also takes on a therapeutic one. He accompanies the patient, sometimes as support, other times as confrontation, through the process of recognition, the loss of which caused the illness, “which doesn’t work like it did before” and supports him in the search for new opportunities still to be discovered.
What is depicted now by the music symbolises the patient’s entire life situation.

Now a few words about the setting.

The setting, the framework of music therapy treatment is particularly strongly influenced by medical concerns and the situation in the hospital especially during early rehabilitation. As well as the patient’s condition, which is often highly unstable, many other factors can be decisive, such as whether the patient is linked to machines, whether he is isolated in his room due to an infectious condition, whether he is waiting for an examination, or whether there is a carer available to help him into a wheelchair. The place and duration of the therapy must therefore be agreed on individually and within an interdisciplinary context. As you can imagine, this all demands a high level of flexibility on the part of the therapist!

For which indications can music therapy be implemented?

This list has been put together in the context of the aforementioned working group. It is not orientated around the patients’ principal diagnoses, but around physical and psychological conditions to which therapy can be directly applied.

Fear and/or tension

Disorders of consciousness (coma, coma vigil)

Perception disorders
Lack of drive

Restricted expressive abilities

Reduction in emotional dynamic

Restricted facility to communicate

Emotional instability

Lack of motivation for rehabilitation therapies (so-called non-compliance)

Reactive depression

Social withdrawal

And here are the aims of music therapy with brain-damaged patients:

Overcoming fear and building up a relationship of trust

Relaxation

Emotional stability

Improving self-perception and self-experience

Stimulating attentional processes

Facilitating interaction / re-establishing communicative behaviour.

Establishing new means of expression

Increasing the patient’s self-esteem
Improving social competences

Strengthening the patient’s “healthy” sides: vitality and creativity (activating resources)

Working out new qualities of life

Emotional relief

Supporting mourning (letting go of the “old”, beginning something new)

Coping (as a generic term), dealing and coming to terms with the illness.

To conclude this lecture I would like to take you into a therapy process.

The patient is a 58 year-old lady. 3 years before the start of her treatment she suffered severe traumatic brain injury in a car accident. She has lived at home in the meantime and now she has been taken into the clinic for another attempt at rehabilitation. Diagnosis: post-apallic syndrome. Her condition at the start of treatment is as follows: she cannot speak, swallow or carry out any kind of targeted action, such as picking things up etc. She makes eye contact with others and makes noises, mostly yells and shouts. She behaves aggressively towards herself and towards her carers, hitting out and pulling hair, which is to be understood as a behavioural problem which has developed during the 3 years that she spent living with extremely limited opportunities.

I treat the patient for three months with a frequency of 2 to 3 sessions per week, at her bedside or in a wheelchair, depending on her condition. The first sessions take place in the music therapy room, then I stay with her in her own room in order to reduce the impact of unfamiliar factors.
Watch this extract from the second therapy session. The patient cries out in a particular rhythm. I take up her pitch and sing descending melodies. I accompany this with a constant sound frame from the cantela (a kind of little harp, which I have tuned to a pentatonic scale). Presently she seems to stop and to listen for a short while. She lets me lead her hand to the Cantela and makes sounds with independent finger movements, to which I react again by singing.

In the second extract, taken one week later, I am improvising simple melodies again with my voice and with the cantela. Watch what happens. You saw that, when she seemed to be becoming more and more tense, I took a step back from the bed. Then she started to look for me and eventually took the hand I offered her. Now she is visibly calmer and more relaxed, and there is an atmosphere of trust between us. With help she now plays for longer periods herself, and appears calm and concentrated whilst doing so. Another week later you can see the beginnings of a dialogue. She still needs close support at this stage.

The last extract is from the third month of treatment. A stable dialogue has developed. The patient plucks small musical phrases independently, which relate to the rhythm and pitch of my playing, visibly awaiting a reply.

It has become possible to enter actively into a communicative process. She can interact with me and receives a “reply”, which she understands as such. Her cries and hair pulling have completely disappeared during the sessions of therapy. Her behavioural problems have reduced clearly,
even during the everyday routine of the clinic. Now she can be integrated better and a place for her in a nursing home has become available.

I shall end on this positive note. Thank you for listening!
Music Therapy and Narrative: Integrating End of Life Story Telling With Passion For Music

Beggs, Cheryl Leigh

Introduction

People find meaning in life in their own unique ways. When a person discovers due to the disease process, that they have a limited time on this earth, they often seek to find meaning by evaluating their own life experience. This paper will explore the process of finding meaning in life through the dying process. Music therapy and narrative therapy will join together to allow the individual to move from being a patient to becoming an agent (Cochran & Laub, 1994). This paper will examine my work as a music therapist and how I have integrated my work around end of life issues through the people I have engaged with therapeutically within the medical model. Music therapists have a unique way of seeing the world and this account will detail that work and vision through the passionate search for the meaning found within the musical context of moments in time.

Music is an art form, which lends to the beauty of the moment. In times when the world has been troubled by tragic events, music has moved from the back ground to the foreground. It has become important. This could clearly be seen after the September 11, 2001 events in the USA. Nations used music to comfort, heal and express themselves. Music’s healing elements are heightened and clearly utilized by the masses. Music in this context can never be called a luxury. Music is a necessity.
So, is music necessary when people are called upon to deal with life-threatening illnesses that will eventually lead to their death.

Death in Canadian culture is so often masked that most people within our culture struggle to accept that which is not openly seen. Within our health care system, the word “expired” is used to notify people, that someone has “passed away”. To me, parking meters expire, and run out of time; people actually “die”. This is just another example of how we choose not to view death in our health care system. The Hospice Movement has assisted in that fewer people now die alone. Music therapy has made significant contributions to palliative care programs. Music provides a personal and intimate meaning for the individual who receives this service (Monroe, 1978). Palliative care programs provide pain and comfort measures, which reduce suffering. Music therapy is often found as a part of the above programs, to provide comfort, but this is a minimal part of what music therapy can offer.

The basic premise of this unique music therapy work is to integrate end of life issues with music through narrative. The work is about making connections. It is through the integration of music, narrative and end of life issues, that we discover the deeper meaning found in the process of life review. Music therapists have explored life review through music for over twenty years. For many people the milestones in their lives correspond to their memories of music. Music is the ideal stimulus for reminiscence and is one of the strengths of music therapy when a terminal illness is present. As we look back on our life, we can see our achievements and our failures with a new perspective (Bright, 1981).
Life review work is a good starting point for the music therapist before music therapy and narrative are explored together. O’Callaghan (1984) defines musical profiles as a selection of musical works, which has a specific meaning at various stages during his or her life. These musical works are often presented on a tape and may include reminiscence between musical excerpts. This type of work may also be valuable at the end of life.

Music lends itself naturally to connections and these connections can be easily made through the process of authoring one’s life story. The purpose is to assist the individual in finding meaning. For the therapist, it allows insight into what is truly deemed important in the human experience. It is an avenue, which can be presented when active medical treatment is no longer effective. It is a time where the individual is able to make an account of one’s own existence and where units of meaning and experience become the spoken word. It is my belief that all anybody truly desires is to be “heard”. It is not that we as therapists or friends are expected to agree, but that we as individuals are expected to listen, integrate and acknowledge the intent of what has been spoken. By listening, we facilitate the individual to become the author of his or her own life story. This story then allows for the facilitation and integration of emotion and meaning. The musical work allows for dignity and choice.

Music therapy as a profession honors the individual. As a person shares their thoughts and inner lives, music adds to the context of the story. Meaning can be found in the musical content beyond the sounds. The
content of the work is found in the words and chosen vocabulary with the interpretation of the meaning from the person’s point of view. Meaning is defined by that which is intended or found to be significant in that which the individual perceives as the experience. This work calls upon the therapist to become involved as a “witness”. Frankl states that to bear witness to the uniquely human potential at its best is to transform a personal tragedy into a triumph, to turn one’s predicament into a human achievement (1959, Pg. 135). In the case of an incurable disease we are challenged to change ourselves. The role of the witness is to attest to view the document, which in this scenario is the oral history of the person. To bear witness is to hear the story, without judgment.

Cochran and Laub (1994) describe meaning as being the center of a person’s commitment and a sense of purpose. Life becomes meaningful when one sees himself as the author within the context of the story. It has been interesting as a music therapist to share this work with a thoracic surgeon trained also in counseling. I have often asked myself, what have I learned from this collaboration. For me, it has been learning a very different way of seeing what is inside human beings. The surgeon can look inside people in two different ways: in a purely medical manner, and from a counseling/interpersonal perspective. The physician with these skills can offer a person palliative measures at the end of life, as well as the opportunity to so do narrative work around key life issues. This duality allows the physician to care for both the body and the mind. This is the optimal relationship in mind and bodywork. The doctor patient relationship is taken to a higher level: a place where the doctor is placed in a supportive role and the patient moves away from the patient role to
that of becoming an active agent. The role of the physician is to provide the best medical care within any given situation. In narrative work, the physician helps the individual to navigate the medical system, explore options and to give personal care within a system where high technology dominates care. The physician heals, relieves and comforts but never removes hope, for without hope, the soul dies quicker than the physical body. The therapists play a special role in relationship to each other. Both therapists must understand where the other therapist is coming from therapeutically. They must hold a similar basic belief system and a love of music. If the value systems of the therapists are synchronous, then the work will have greater depth and meaning. It is the value system of the therapists that allows the work to be carried out in a way that does not infringe on the belief system of the client. The clinical direction of the work depends on a mutual understanding, respect and a good working relationship.

Individuals are chosen for this type of work based on their acceptance that this work is of personal value to them. My co-therapist Dr. Bill Nelems (Bill) would often meet potential individuals through his work as a thoracic surgeon. As a surgeon, Bill meets patients with lung cancer, or other end stage disease. As a medical practitioner, Bill is able to offer narrative work due to his training in Counseling and his compassionate abilities as a physician. When active medical treatments are no longer an option, palliative measures are introduced. It is at this point, in the medical care that the narrative work can be offered as a viable option. Do you like music is now a standard question at this point in the medical appointment. This process begins to address what happens when the
doctor says to the patient, there is nothing else that can be done medically at this time, but we can consider doing this process together. At this point in time, it is a difficult place for both the physician and patient. There has been much discussion about doctors and their bedside manner, and how to break the bad news to patients. This particular work can open the door and become a means to the beginning of a new process. Rather than closing a door on life itself, it can be an opening to seeing life in a new manner. Life carries on until the last breath, therefore how can we facilitate a transition from hearing the bad news to beginning a new journey together, through till the end of life.

The focus of narrative therapy is people’s expressions of their life experiences. Expressions of experience are seen as units of meanings. These units of meaning speak to the multi-storied concept of life. Narrative is about the telling and re-telling of the stories in people’s lives. It is the telling of these stories that are rich in descriptions that are the foundations for the expression (White, 2001). Narrative therapy involves exploring the moments that shape a person’s life. These include turning points, relationships, and memories. (Sween, 2001). It is these moments that are shaped into chapters, defining the experiences that are seen as key. Narrative work moves through cycles, where the person goes from a position of not knowing, to one, of positioning, positing, and completion. There can be many cycles, which in turn repeat themselves. As life events develop, chapters, like a book, are created and linked to each other. Each chapter can be titled, and integrates emotion and meaning. These chapters help to bring both clarity and closure to a person’s narrative. As individuals move through the process, we have found that
our role as music and narrative therapist often overlapped. Overtime, it was determined, especially in our interview procedures that it didn't really matter. It was the information that was received that mattered, not who put forth the material. As therapists, we could be thought of as information gatherers, seeking to find meaning and direction in the moments presented.

Musically, it is always the individual who leads the way. The individual is encouraged to make connections between musical events and their own life story. These connections allow the person to perform their lives before us (Aldridge, 1999). Whenever possible, it was important to do the work in the home environment. Being in the home setting allows for the intimacy in the conversations. There is a very real window of opportunity for doing this type of work. The individual at the end of life has a time when he has chosen to formulate his story, but more importantly, has the energy to do this musical and narrative work. There is a period of wellness, which allows for the work to be initiated, personally integrated and authored. If this opportunity is missed, it means that the person in most cases is in rapid physical decline and will not be well enough to do any of the work. From personal experience, it is the therapists who feel bad for not moving quickly enough and getting to where they need to be. We have lost patients before we have had the opportunity to begin the work and this is heartbreaking. It is interesting to note that there are times when the individual can integrate the initial work, without further direct intervention from the therapists. This was so in the case of one individual who progressed quicker in the disease process than expected.
Frankl (1959), in his book Search For Meaning, says, “that to choose one’s attitude in any given set of circumstances, is to choose one’s own way” (Pg. 86). This speaks to the journey of the music and narrative and attitude gives the experiences the richness, which it so truly deserves. There is an aesthetic quality found in the music which people deem important enough to sing play and talk about. It is this richness, which is the essence of the human experience found through end of life work. Music is one of life’s basic truths. The experiences are self-defining and life defining. Nordoff and Robbins in their vast music therapy work, talk about “being in music” (Aigen, 1996). Although much of their work was done with children, “being in music” applies especially well to this work with adults. People live in the music. They experience music through sound, silence and words. When end of life is nearing, they live completely in the moments found in the music. “What matters therefore is not meaning in life in general, but rather the specific meaning of a person’s life at a given moment (Frankl, Pg.131).

Many moments can be found in the musical work. If the work has been videotaped, which often it has, the moments can be clearly seen. Music therapy in the context of narrative therapy is about defining moments. I will refer to music therapist Dorit Amir’s work, as she has defined many of the moments, which are relevant in terms of both the musical and narrative work.

All meaningful moments happen spontaneously. The therapist does not plan but facilitates an environment to receive the moment in the present. Amir (1996) describes three moments that occur on an interpersonal
level. I have chosen to use Amir’s headings but have taken the liberty of explaining the moments in my own words, as they relate to the work of music and narrative therapy.

The Three Moments

• Moments of physical closeness between the therapist and the client.
  - Moments of physical closeness between the therapist and client occur as the relationship develops over time. This closeness may be felt through the touch of a hand, a hug or a kiss. These moments are extremely powerful, as there is a sense of holding found within the moment.

• Moments of musical intimacy between the therapist and client.
  - Musical intimacy is shared when the music therapist supports the client through accompaniment. This type of sharing lead to the client being the soloist with a voice to be heard, while the music therapist facilitates and set the stage for the musical interaction to occur.

• Moments of close contact between the client and a significant person in his life.
  - These moments often occurred between family members or life long friends. The music and narrative bring individuals closer together and they found renewed or deeper existing relationships with each other.

The Twelve Moments

Amir also describes twelve moments that occur on an intrapersonal level. Again, I have chosen to use her headings and explain the moments in the context of my own words and work.

• Moments of awareness and insight
  - These are moments in which new insights are gained through the music and narrative. It is usually a sudden realization that has come to consciousness that has never been verbalized in quite a particular way. These experiences tend to reach deep into the awareness of the individual, and often there is an element of surprise experienced.

• Moments of acceptance
• These are moments that a client realizes that things are the way they are, because of something they may have said or done. They gain acceptance within themselves by understanding a part of themselves that they did not recognize before.

• Moments of freedom

  • Moments of freedom are when the person releases tension and find a way of letting go. These moments of freedom may occur through words or through musical experiences, when they live within the music. Moments of freedom imply a level of resolve on the part of the individual.

• Moments of wholeness and integration

  • These are moments in time where the client feels at one with one’s self. They feel a level of both comfort and peace within their words and music making.

• Moments of completion and accomplishment

  • These are moments where the individuals feel they have said what they needed to, or were satisfied with their own music making.

• Moments of beauty and inspiration

  • There are many moments when the therapists may be inspired by the uniqueness and authenticity of the individual. The beauty may be in the creation of the music or found in the way that the person expresses their thoughts and feelings.

• Moments of spirituality

  • These are moments when the individual feels connected to their God or to their way of thinking spiritually about the universe. These moments often inspire awe and lead to a sense of finding peace within the soul. These moments may be expressed musically or through words of meaning. Each person determines his or her own relationship with the spiritual world.

• Moments of intimacy with self

  • These are moments where the individual finds deeper meaning within themselves as people. These moments create an intimacy that leads to self-awareness. This intimacy generally leads to a deeper understanding by the individual.

• Moments of ecstasy and joy

  • These are moments that lead to feelings of happiness and joy. These moments may be heard within the music making or the delight and pleasure may be expressed through the story telling process.

• Moments of anger fear and pain
• These are moments when difficult feelings and emotions are expressed through the music or through words. There is often intensity and angst found in the moment, that the individual struggles to relay to the therapist.

• Moments of surprise
  • Moments, which the client was surprised by something they did or said. Musically, moments of surprise may be found in the act of creativity.

• Moments of inner transformation.
  • These moments occur when the person experiences a change or transformation in the way that they created music or spoke of the experiences. Generally these experiences were very powerful as well as being positive thoughts.

Moments can be found in both the musical and narrative work of the individual. Although it is difficult to find the words to describe what happens within an exact moment, I believe that Amir in her work on Meaningful Moments has captured the essence of the moments within the words and headings she has chosen. Rose Kennedy (1890-1995) also stated “life is not a matter of milestones, but of moments”.

Videotaping is an important part of the process for both the individual and the therapists. The individual soon forgets that the camera is running and begins to author his own story. The video is important from a therapeutic process in that the co-therapists are also living within the moments and may need to view the video in order to realize the extend of what has been said and phrased as well as how something has been expressed. It is about achieving a state of being where both the therapist and client are living as completely as possible in the music. When one is able to live in the music the course of therapy unfolds (Aigen, 1996).

Viewing the videotape afterwards is necessary to see and record the events of what has actually happened. Reviewing the video over different time periods helps with the integration process, and allows the therapist
to see what might have been initially overlooked. Musical themes and story lines are more easily recognized and noted through documenting the videotape. This is clinically important to the documentation process.

The main criteria, for this therapeutic work, is that a love of music must be present. The person must initially be verbal and clear in mind and emotionally ready and willing to talk about their life situation. The work can be effective over as few as two days work, but it is most effective to work with an individual over several sessions in order to allow for the integration and reflection of material. The music at this time acts as a monitoring system and often, it alone tells the story.

Music therapy is not a form of treatment in the medical sense. Aldridge (1999) speaks to music as a form of accompaniment. Music does accompany us as we walk the journey of life through to our last breath. Music provides its own reality, which encompasses our hopes, dreams and desires while finding a place to put our emotions when we are unsure of where they belong. Music becomes the holding tank, a place of safety where whatever we need to express is held securely. There is a quality of transcendence that extends the self beyond the immediate to achieve new perspectives (Aldridge, 1999), a transcendence which takes us beyond what we know to finding a new meaning. Music at the end stage of life whether improvised or pre-composed, allows the individual to find a meaningful form for self-expression. Personal choice in musical selections allows the story line of the narrative to be heightened, by equating musical themes with story line thematic material. Pre-composed material may include hymns or selections of favorite songs of varying
styles. Often people in this work present with their own collections of favorite music already gathered together in a binder. This is a common trait shared by amateur and professional musicians. They like to keep their sheet music and wordbooks close at hand. The piano bench or shelves in the home setting are often the keeper of the music and only need to be asked for by the therapist. Those individuals, who are composers or songwriters, will often have collections of their own original song material. This material becomes a wonderful place to begin talking about the music. You can go through a person’s life, by going through one’s music. This material can then be linked to events in the person’s life and tell a huge part of their life story. Individuals can talk about the music in their collections or they can perform their music. It is important at this point for the music therapist to allow the person to solo, but to feel supported musically if needed. The music therapist is always in a supportive or facilitative role, but rarely in the role of soloist. The musical work is extremely intimate and personal. There is recognition that every song is a piece of the individual’s life. The interesting part of the collaboration is in the building of the musical process over a period of time and how the music speaks to the narrative, and the narrative speaks to the music. This coupling allows life to unfold in the form of oral history.

The music therapist has many opportunities to meet individuals who are suitable for the work. Individuals receiving active treatment for cancer are often in a place where they are beginning to think about what living fully is all about. By offering the work at this time, there is often a longer time frame that the work can be carried out over. Patients receiving
chemotherapy and radiation, as palliative care may also be in a place where they are receptive to the work. As a palliative patient the time frame for the work will obviously be shorter, but this does not diminish the value. Music therapists working on a palliative care unit or within a Hospice setting may have ample opportunities to facilitate the work. No one can say exactly how much time a person has left to live, but as therapists we have found that whatever work we have been able to do, has been valuable.

This work began as collaboration when both therapists realized that they were basically doing the same life work, but through different mediums. One therapist used only words, while the other used words and music. With this realization that our joint work could find a deeper meaning, collaboration was formed to allow the music to heighten the narrative and the narrative to enhance the music. The initial work was funded through a grant received from the Canadian Music Therapy Association, Music Therapy Trust Fund. This grant covered many of the expenses and production costs associated with making a video of the work. This video highlighted the process of narrative and music therapy, showing how individuals author their own life story through words and make connections with music through meaningful moments. After completing the video My Life, My Music, Bill and I decided to continue with the work as opportunities kept presenting to facilitate and talk about the work. Consent forms were always signed before the video work was begun. Individuals were also told that if they did not like what they saw on the tape, that it would be destroyed, and the work would continue without video documentation. This has never happened as of yet and
often people are generally pleased that they look so good, especially if the recordings have been edited. Individuals often consented to the recordings, as they knew that they wanted to leave the recording as a legacy to their families. There was also a general feeling that others could learn from their personal experiences. After the death, sometimes the families are not ready to see the video immediately. Families are told that the tape will be kept, until such a time, that it is requested. The videos are very powerful and often families need time to deal with the immediate death first. In time though, the video becomes the final gift and legacy.

This work generally tends to be quite time consuming. It involves setting aside whatever you are doing, to be available at a moments notice. It involves meetings, music and narrative sessions, travel, overnight stays, trips to the hospital and home visits. It also involves intensive media work, phone calls, documentation and follow-up with families. Debriefing as a therapist is a necessary part of the process. The work holds beauty and is emotionally charged, but can at times weigh a little heavy on the soul. It can also be emotionally exhausting at times. It is wise for the therapist to work with only one person at a time, and wait a while before taking on a new individual.

I have drawn upon the following theoretical foundations in order to support my view of this work: Nordoff-Robbins Music Therapy, Narrative Therapy, Existential Philosophy, Palliative and Hospice Care, plus the work of other renowned music therapists. These foundations have lead to the development of my work.
Facilitation Techniques

I shall try to explain the techniques that are unique to this type of music therapy and narrative work. First and foremost, I believe there is a “setting of the stage” which makes this work happen. The therapists act as facilitators that create an environment for the dialogue to begin. “Dialogue” according to Webster’s New World Dictionary (1999), is a conversation, interchange and discussion of ideas. The dialogue is often very open and very frank and seeks to find a mutual understanding. The opening moves into more of an interview type setting, where the individual is made to feel comfortable and relaxed, so that the process may begin to take its own form, with the music and the storytelling. The music therapist and the individual begin “talking about”, those things that are initiated by the person. This “talking about” is often contained within an intimacy of conversation, which allows for the sharing to begin. The therapists often restate thoughts or bring out key points that have been made. The process may take place chronologically, but it is not necessary that things be initially placed in any specific order. The therapists may ask open-ended questions which allow the person to choose their own words to describe their music or story. Rephrasing of material and reflection of material are also important verbal skills. The therapists play a truly supportive and non-judgmental role. The therapists will often summarize what has been said and may begin to suggest chapters or themes, which emerge. All these techniques assist the person in integrating the experiences they have described. These basic interview techniques allow the person’s life story to emerge as oral history. It is
within the oral history and musical communications that the life meaning is found.

For some people, literally writing their own life story, before the process begins, actually helps the person to gain insight and clarity prior to the actual beginning of the narrative work. One woman took the time to write and type her life story. Her story was seventeen pages long and held a detailed account of her life, from her early childhood to the exact moment in time, which we began to do the musical and narrative work. She authored her own story with detailed accuracy. This written story was later videotaped and read on camera. There is a learning process, which happens through music and narrative therapy. This process involves, wellness, health knowledge, expression and discovering a personal view of the situation they are currently found to be in.

**Wellness at the end of life**

Rarely, do we use the word wellness to describe a person navigating through the process of dying. Yet, I believe that there is an element of wellness, that brings the persons attitude into a place of well-being; a place where all thoughts become focused and realized. A place, where disease has been pushed to the background and where wellness of mind strengthens the thought process. This wellness may be seen in the spiritual, intellectual, emotional and social health of the individual. These elements bring a sense of understanding and acceptance.

Wellness in the terms of complementary medicine is more than the prevention of the disease. It is a focus on engaging the inner resources of
each individual as an active and conscious participant in the maintenance of his or her own health. (Pg.5, Micozzi).

**A learning about what is physically happening**

When individuals are diagnosed with a life threatening disease they will often try to learn as much about the disease process as they possibly can. They will talk to their physicians, search the library and the internet for current information, and read enormous amounts of information on the subject. Many will turn to complementary therapy, and others will totally ignore conventional Western medicine and turn to alternative medicine only. The learning is fast and steady, with new information being integrated quickly in order to try to slow the disease process, and to enhance the quality of time remaining.

**A learning about complementary therapies**

There is a general confusion about what is meant by complementary and alternative therapy. They are not the same thing. Complementary medical systems are characterized by a developed body of intellectual work that underlies the conceptualization of health and its precepts; that has been sustained over many generations by many practitioners in many communities; that represent an orderly, rational, conscious system for the knowledge and thought about health and medicine; that relates more broadly to a say of life (or lifestyle); and has been widely observed to have definable results as practiced. (Pg.7, Micozzi). Alternative therapy as defined by Harvard Medical School refers “to those practices explicitly used for the purpose of medical intervention, health promotion or disease prevention which are not routinely taught at U.S. medical
schools”. (Pg. 5, Micozzi). It is generally accepted that complementary therapy works hand in hand with Western medicine, while alternative therapy is often used in place of Western medicine.

**An expression of their personal view of the world**

The focus of the whole person as a unique individual continues to drive medical system into a new framework. A point of interest is that health care itself, is in crisis, and due to that crisis, it is the individual who is being challenged to look after his or her own health. Health promotion and health prevention are key elements in this process. Mobilizing the resources of each individual to stay healthy and get well will provide a new model of health care, which is driven by rising costs. There is room for both the individual and the physician to work together towards a state of wellness. (Micozzi, 1996). Therapy is a journey taken by both the therapist and the client. It is a journey that delves into the world as perceived and experienced by the client (Corey, 1996). As a therapist, we can help the patient navigate the journey towards the essential aspects of their lives. This is why the journey is ever so precious. It belongs to the person.

**Intimacy**

We cannot talk about making connections with people, without taking about intimacy. Therapeutic relationships are based on trust. Therapeutic relationships are personal and private; yet people share intimate details of their lives through their life stories and songwriting. Intimacy implies an agreement of trust, openness and understanding. Intimacy also implies a sense of vulnerability, in that one opens oneself to another person.
Intimacy within the therapeutic relationship of narrative and music therapy, allows the individual to create a space for issues or experiences that are extremely personal, experiences that may be passed over and remain untold. This is where the value lies.

Conclusion

Why does the music therapist choose to work with the dying?

I believe that it all comes down to being passionate person. Passion by Webster’s dictionary definition involves a strong love or affection. Passion involves an extreme, compelling emotion, and a drive, fondness or excitement. It is about the work. It is about searching for and finding meaning in others people’s experiences. It is about seeking and finding greater meaning and awareness in your own life. You will continue to question everything and search for the answers that define meaning. In the words of Clive Robbins, this work shows a “natural authenticity. It provides a framework for human self –knowing and self-discovery. It connects us to who we are, as we live this personalized biography and it holds and integrates our consciousness”.

References


INTRODUCTION

This is a presentation of a music therapy treatment with a nine-year-old boy (at the beginning of the treatment) focusing the cultural aspects present during some sessions. This study was based on the session reports, recorded tapes, drawings, interviews with the family and team meetings with other therapists and special teachers who assisted the child during a period while the music therapy treatment was going on.

Cultural aspects involving different kinds and uses of music are emphasized in this study even though other aspects such as emotional, cognitive and recreative were present during the whole process as well. This approach has been chosen based on the fact that one of the areas of the child’s difficulties was the search for an identity in a community that still excludes those who are different in spite of the efforts from the family and from the educational authorities to minimize this drawback. The gradual construction of a self and a social narrative through songs, song-writing, sounds, rhythms, characters, tales, drawings and musical games resulted from “the cultural aspects of personal experience”, quoting Ruth Bright. (Bright,1997,p.195).

The whole process lasted from March 1996 to August 1998 and from December 1999 to May 2000 completing altogether two years and ten
months. The first interruption occurred after we had worked during some sessions on a replacement from music therapy to private recorder classes with a teacher who was completing the Bachelor’s Degree in Music Therapy. This change would be an effort to prepare the client, shall we call him Bob, to get into a Music School aiming at his integration to the external world. At this time the therapeutic goals had already been reached and Bob had shown his will to learn music in spite of his learning disabilities. I realized then that the therapeutic process should be followed by a learning process although his mother preferred Bob to return to music therapy. After the second phase of the treatment which lasted about five months, his mother decided to enroll him in a Music School where he is still attending electronic keyboard and singing classes.

**BACKGROUND INFORMATION**

At Bob’s family request, the whole music therapy treatment, which totalized 108 sessions, took place at home. After the initial procedures, it was decided to be once a week, one hour duration. By that time, Bob was attending a special needs preschool, speech therapy, psychotherapy (with his mother), special pedagogic assistance and swimming classes. Busy with so many external activities, a therapy at home gave him comfortable space to express himself without the stress caused by daily strict schedules and heavy traffic. Bob was diagnosed after his birth with a genetic disorder called Prader Willi which, according to the Prader Willi Syndrome Association in the USA, “is a complex genetic disorder that
typically causes low muscle tone, short stature, incomplete sexual development, cognitive disabilities, problem behaviors, and a chronic feeling of hunger that can lead to excessive eating and life-threatening obesity” (Prader-Willi Syndrome Association – USA). The report of Bob’s psychologist, which presented a psychodynamic evaluation including other therapists’ reports, informed that his diet, necessary because he could develop diabetes, gave rise to emotional and behavioral problems. These aspects connected with the cognitive disabilities contributed to difficult relationships with people or institutions.

The nuclear family consisted of Bob, his mother and his grandfather. The first contact was made by the grandfather who saw in music therapy a space to fulfill Bob’s abilities and his deep links with popular music. I could see that the grandfather was quite worried and interested in enabling Bob to reach some kind of autonomy in his life.

During the assessment period I was able to establish the aims of the treatment like help him complete school, achieve goals in outside areas of interest, receive support from people around him and face the serious problem of obesity. The team’s meetings were important for me during this period. But while the sessions were taking place, other important aspects emerged through his attitudes: the search for an identity as mentioned above and the possibility of a better integration in the community where he lived.

The music therapy space has become an inclusive microcosm where the differences were managed while the permanent outside macrocosm did not manage differences so easily. Bob lived in a community with all the
patterns transmitted by the mass media including music, games, clothes, food and behaviors. Outdoors childhood plays have been replaced by cartoons, computers, video-games. These changes resulted from a new social organization where new technologies, small apartments, shopping-centers, day-care-centers and some other circumstances removed children from the streets, squares and parks. Our folkloric traditions through nursery rhymes, songs, dances and tales are becoming less frequent among children although some music educators and artists have been making efforts to maintain this cultural heritage. The music therapy space made the presence of some aspects of this heritage possible in a spontaneous way mingled with the popular music transmitted by the mass media.

CULTURAL APPROACH AND MUSIC AND IDENTITY

Reading the chapter Culture, Mind and Education from Jerome Bruner’s *The Culture of Education* (Bruner, 1996), a series of essays written in the nineties, I got to know the author’s cultural approach derived from the changes of the conceptions about the mind. During the fifties and sixties Bruner dedicated his studies to cognitive aspects creating a new theory of instruction in the U.S.A. In this recent book, Bruner focuses the culturalism which “takes its inspiration from the evolutionary fact that mind could not exist save for culture” (Bruner, 1996, p.3). According to Bruner, psycho-cultural approach presents the “macro” side, which looks at the culture as a system of values, rights, exchanges, obligations, opportunities, power, and the “micro” side which “examines how the demands of a cultural system affects those who must operate within it”
Bruner also mentions the place of emotion and feeling which were neglected in the cognitive psychology and “are represented in the processes of meaning making and in our constructions of reality” (Bruner, 1996, p.12).

While examining Bob’s treatment reports I associated some of Bruner’s ideas to some aspects described and I understood the importance of culture although not being aware of it at that time. During the treatment many musical and verbal situations occurred but instead of describing them as a case study focusing the different stages, I selected some lyrics written in the sessions which illustrate how a boy with special needs, conscious of his limitations, was able to perform an important role in the therapeutic space before the challenge of a coming adolescence.

Another point to mention is the way Bob operated within a cultural system and how the search for an identity was present during the multiple creative experiences in music therapy. A simple narrative concerning these experiences was being constructed, deconstructed and reconstructed together with his efforts to speak better, to learn how to read and to write, to be accepted and so on. Bruner says that “It is through our own narratives that we principally construct a version of ourselves in the world, and it is through its narrative that a culture provide models of identity and agency to its members” (Bruner, 1996, Preface).

Concerning the identity issue, Erik Erikson wrote in his book *Identidade, Juventude e Crise* (Erikson, 1987, p.99) (Identity, Youth and Crisis) that an infant is already dealing in its first encounters with the main aspects of
its culture. From this period on human beings keep struggling for an identity interacting with people along their lives. Erikson also mentions how teachers are important in a child’s life once they are supposed to be someone identifiable by the child (Erikson, 1987, p.125). In my opinion therapists are important too once we are a kind of interpreters of human behaviors, dealing with our clients in the microcosm therapeutic space where their difficulties and also their abilities emerge. Ruth Bright says that “music therapists must be aware of the cultural aspects of both music and human behaviour if they are to provide the maximum benefit to the patient or client through music therapy” (Bright, 1997, p.193).

To describe some of the creative experiences through music during the treatment I based myself in Even Ruud’s music and identity model: music and personal space, music and social space, the space of time and place and transpersonal space (Ruud, 1998, p.33). According to Ruud “music in itself becomes part of the repertoire of ways of responding to the world. Children learn how to select music for listening that matches their moods and emotions” (Ruud, 1998, p.40).

I realized through Ruud’s words that a personal space was taking place and that my role in this space was to make possible Bob express his inner world through music. Ruud also says that “other people are necessary for us to be visible for ourselves. This may lead to an exploration of how our relationships to other people throughout life plays an important part in the construction of our identity” (Ruud, 1998, p.38). Bob’s family had made his interaction possible with the world outside the therapies but that experience did not appear to be spontaneous due to his limitations.
and to the fact that he lived under permanent protection which doubtlessly was necessary.

Cultural aspects had been present since the beginning of the treatment although the first phase was deeply dedicated to Bob’s emotional feelings. In that period I had some meetings with the psychologist, a family therapist, who assisted him and his mother. She listened to some of the songs recorded during the sessions whose lyrics expressed his catarsis. Bob was aware that he was different and that he should be himself in a world full of external demands. In the music therapy sessions the spaces mentioned by Ruud were experienced as I could understand while rereading the reports and listening to the tapes. The social space inside the therapy opened a space to Bob overcome the differences and the possibility of being himself using and transforming the cultural aspects of the external world which were quite accessible to him. Ruud explains that “the recognition of interpersonal aspects of identity leads to a greater awareness of the role of the larger cultural context wherein identity takes form” (Ruud, 1998, p.41).

At that point teachers, therapists and the family were making efforts to improve Bob’s learning disabilities. He had to cope with barriers that as I could see were not exactly clear to him. If on one hand people were so demanding with him with respect to his learning process and behavior, on the other hand he could get everything he wanted. He frequently brought CDs to the sessions performed by his favorite singers or bands. He was given an electronic keyboard similar to mine. In the “social space” the songs, the singers and the lyrics replaced “the others” (in
Ruud’s terminology, as if they were other members of the group. In that space Bob was able to overcome some barriers without so many external demands. Indeed at that period he began to join the syllables through a game we created together on the keys of the keyboard. We stuck tags with the names of the notes: do(C), re(D), mi(E) and so on. While we made sounds and melodies we formed small words using other syllables too.34

Concerning the space of time and place I repeat Ruud’s words that a music experience takes place always in a certain time and in a certain space (Ruud, 1998, p.43). Our identities are linked to our space, where we are born, where we live, the time we live and the events we go through our existences. Our music experiences may construct a “personal calendar” giving through memory the “continuous trajectory with a beginning, a present, and an ending”. (Ruud, 1998, p.44). I see that our “musical autobiographies” are written based on all these experiences including lullabies, nursery rhymes, popular songs, religious or classical music that we hear by chance or we learn and begin to enjoy from birth to death.

Ruud argues that radio and television “punctuate the week into discrete episodes and thus create the impression of time as something that is divided into parts and moves ahead” (Ruud, 1998, p.44). I have realized that the television and its weekly schedule were useful and helpful to Bob’s time perception. During the treatment process the television set occupied an important place and was usually turned on in a low volume.

34. The special pedagogue who assisted the client through private classes gave me support to this exercise which contributed playfully to his learning process.
It sounded like a friend and sometimes a music show or a dramatization for children would inspire us to an improvisation, a composition or a drawing. Bob felt safer with the television together with us as a member of a group and I accepted this circumstance as a therapist. A teacher would probably not accept it unless in special occasions.

Brazilian cultural feasts like Carnival in February or March and St. John’s feast which is cultural and religious in June offer typical songs, dances and stories based on our Indian-African-Portuguese tradition and roots. We absorbed and included these elements in the sessions also punctualizing the year in episodes. Historical, civic and religious festivals celebrations like Easter and Christmas were also present through music. We used different techniques like, to quote Bruscia, “improvising, re-creating, composing and listening to music---each of which may also involve verbal processing, drawing, painting, expressive movement and dance, play, poetry, story-telling, or drama” (Bruscia, 1991, p.5). Bob expressed himself in these situations demonstrating a feeling of belongingness to a nation and its tradition and to a religion. While these episodes went on, the client also created his idols among Brazilian popular music in its different styles experiencing processes of identification while his own identity was being constructed.

Reading some chapters of Abraham Maslow’s El Hombre Autorrealizado – Hacia una Psicología del Ser (Maslow, 2000), (Toward a Psychology of Being), while preparing this paper, I began to understand how the identity concept and the identity experience are important to human beings and also how creativeness contributes to
human development and spontaneity mainly in face of adversity. Ruud includes the transpersonal space (Ruud, 1998, p.45) in his music and identity model as mentioned above. I would say that during Bob’s treatment an humanistic space prevailed over the transpersonal one. I think that a child with special needs is not ready to inner transformation and changes through spiritual experiences. I do not have data enough to make a conclusion on this issue though. Nevertheless I saw during the whole treatment two situations that could be examples of Bob experiencing a transpersonal space. During a period he was attending catechism classes (catholic religious instruction) in a church. At that occasion we used to read together some excerpts of the catechism book and used to sing some religious songs sometimes re-creating the lyrics according to his feelings. While singing we used to accompany ourselves at the electronic keyboard using the organ timbre. Bob wrote a song and enjoyed those moments behaving himself in a respectful attitude. Another situation occurred when an airplane accident killed all the members of his favorite band called “Mamonas Assassinas”. This event convinced him that death is the end and he tried to justify why it had happened imagining some reasons for the accident. A large number of Brazilian children were quite disappointed after this tragedy since these joyful and irreverent artists had an incredible sense of humour and dressed in funny clothes. Their lyrics presented double meaning inducing children to the highest level of amusement and happiness and to a kind of transgression. I consider that at those moments Bob had a space to relieve his anxieties concerning the unknown and the mystery of life and death and also a space to confirm his beliefs in God and His existence.
supporting his own existence. Those spaces could be described as transpersonal ones.

A NARRATIVE THROUGH SOME LYRICS

While rereading the observations of the sessions, listening to the tapes and looking at the drawings in order to organize this paper, I became a researcher of my own study. Applying the qualitative research model, I found in Aigen’s words a support to my understanding of how categories can be changed according to a new approach:

Categories that seemed important earlier in a study can recede in importance or can have their status changed to being a subcategory of a more inclusive category (Aigen, 1995, p. 333).

As I have already mentioned, Bob’s family, special teachers and therapists were all committed to assisting his learning disabilities. Due to his developmental delay, articulation speech disorder and emotional problems, there was a common consent in helping him to achieve a better performance in his daily tasks. I joined the team’s purposes trying to do my best and to make music therapy adequate to Bob’s different needs. Indeed he had to cope with individual and social barriers. His family believed that music could be an important ally in that process once he loved it.

During the treatment, while I was determined to follow those purposes, some important situations emerged and consequently new categories emerged during my recent research. I realized that Bob’s lyrics written together with simple melodies and rhythms and usually accompanied by guitar (as a percussion instrument) or by electronic keyboard (he played
some notes because of the exercises already mentioned) expressed his feelings according to different themes. I selected some of these lyrics and analysed their contents establishing some sources of inspiration and also linking them to cultural aspects and to Ruud’s model of music and identity. Quoting Aigen:

“Categories that initially seemed to be of secondary importance can actually become the focus of a study (Aigen, 1995, p. 333).”

I would say that this research is placed in the segment of interpretive-descriptive research (Aigen, 1995, p. 336) once I am interested in themes, their description and interpretation through the lyrics and through the data analysis. Although I have not delved deeply enough into this study to consider it a hermeneutics qualitative research, I realize that this is the appropriate way to future studies. Bruner says:

“The object of hermeneutic analysis is to provide a convincing and non-contradictory account of what a story means, a reading in keeping with the particular that constitute it. (Bruner, 1996, p. 137)”

Bruner’s ideas on cultural aspects of psychology and education and Ruud’s music and identity model helped me to understand Bob’s cultural context and how he built a personal and a social space concerning his musical envelopment. It was clear that both spaces were safe without the demandings and competitions of the external world.

The family used to take him on weekends to a movie, a theatre or a birthday party but he really enjoyed to see TV at home. It was an accessible entertainment, easy to handle and where reality mingled with fantasy and special effects fulfilled Bob’s expectations and wishes. Some artists became his idols and he would imitate them (inside and outside the
therapy) handling a microphone and performing their gestures and personal styles. 35

Bob’s birthday coincided with one of the first sessions and we celebrated it as a party. During many other sessions he used to sing again the Happy Birthday song or play it in a melodic instrument. I had the impression that while greeting himself his self esteem increased. He also used to sing a popular rhyme among children called “Atirei o Pau no Gato” (“I threw a stick at the cat”) which is a circle-singing play with an easy melody and two beats time. The lyrics describe that the cat doesn’t die but shouts loudly the “meow” at the end when children joyfully sit down shouting together. Bob enjoyed playing the cat and singing some other rhymes and folk-songs very much. He used to alternate that kind of songs (cultural heritage) with popular music transmitted by the mass media. The treatment took place during the second half of the nineties and of course Bob absorbed different styles. He used to bring to the sessions some hits performed by TV stars and we heard them together re-creating in different ways. Those stars led (and still lead) their own live programs for children, usually in the morning, and are champions of record sales like Xuxa, Angelica and Eliana. Bob also enjoyed “duplas sertanejas” (country duet singers); Gabriel, o Pensador (Gabriel, The Thinker, a famous rapper) and some bands (his favorite, Mamonas Assassinas, died in an airplane accident as mentioned above).

With the intention of helping Bob to overcome his learning disabilities, I suggested a praxis of drawing the meanings of the lyrics, which helped

35. There is a T.V. show called “Gente Inocente” (Innocent People) every Sunday in the afternoons when children sing and are judged by a jury for their musical competences.
him improve his knowledge of different subjects according to the songs and styles. Reviewing the drawing copy book I understood the importance of that praxis and the presence of symbols which revealed his search for an identity. Some of his lyrics were written beside the drawings – and both expressed his feelings and ideas facing the world.

It is important to mention that multiple creative experiences like playing instruments, singing, improvising sounds and rhythms, playing musical games and so on were present during the whole treatment contributing to the song-writing. Nothing was planned but some music education exercises were introduced in a spontaneous way.

The lyrics were inspired, according to the interpretional study, from five sources: cultural heritage and environment (rhymes and folk songs); emotional catharsis; ontological themes (from the universe); mass media and religious feelings. Of course there is not a strict boundary concerning these sources once we can find in the same lyric three of these aspects like in The Fish.

The justification for selecting these six lyrics is to present Bob’s feelings concerning his identity and how cultural, social and religious influences contributed to his creativeness. Two lyrics about animals illustrate how a child feels close to love, fear and other feelings present in fables and fairy tales’ animal characters. Bob owned some books on animal themes and we used to read and to make sounds following the situations of the story. Once in a while he would go to the zoo or to a circus. But the fact of living near the beach, where a child see fishes and even fishermen in their boats, must have given Bob the images that he used in The Fish.
This lyric was written in a cathartic period during the beginning of the treatment and was heard by Bob’s psychologist who considered it important and informative about his conflicts.

THE FISH

Part 1

The fish swims in the sea
The fish swims in the sea
At the bottom of the sea
The young man has fished on the shore
The fish died
The fisherman has arrived
There at the fish store
It just stayed there
And I have asked:
“Have you sold the fish?”
“The fish has been sold.”

Part 2

The young lady has gone to the beach with the slipper
And the fish has eaten the young lady’s slipper
And after that she called the lifeguard.
To look for the fish
The lifeguard touched the fish
And could not find her slipper
The young lady kept crying
Got to the beach
And went to the sea
The fish has eaten her slipper.

Brazilian famous folklore researcher Camara Cascudo wrote that most of the folk traditions about fishes include aggression, teeth, fins, fishbones and so on bringing pain and disease. (Camara Cascudo, 1972, p.703). The Fish describes acquisition and loss, life and death, sorrow and relief. This one is not present in the lyric but in a comment by Bob a week later, after we had listened to the tape together: “the lifeguard found a small piece of the slipper”, stressing a “small piece” as I heard recently. It is interesting that Bob found a light in the darkness giving a solution to the situation: a small piece of the slipper was safe. His solution encouraged me to go ahead in the therapy trying to do my best once he showed me that he owned a little of hope.

Bob wrote some other songs on animal themes but I chose “The Monkey’s Rap” which was written half way of the treatment. This choice derived from the fact that he wrote joyfully and hopefully about friendship feelings. In this period Bob brought a CD of Gabriel, the Thinker, to the session and we heard it together. Instead of using the satiric and critical messages of the rapper, Bob used a funny description of a situation:

THE MONKEY’S RAP

Look at the monkey.
Little monkey, big monkey
Goes up and down the branch
Slips and falls on the ground
One monkey, two monkeys
Three monkeys, a bunch
Hairy and roly poly
Jumps so much, jesting
Little monkey, my pal
Little pal, great friend.

In this lyric Bob used lively monkeys in permanent movement describing a friendship in a happy combination of words and rhymes (in Portuguese). Camara Cascudo wrote that Brazilian monkey’s tales have Afrikan origin and they appear in funny stories performing delightful roles (Camara Cascudo, 1972, p. 527).

Nature was a recurrent theme where the environmental images and sounds occupied an important space. There is a song from the Brazilian traditional repertoire which became a kind of a refrain during a long time of the treatment. Its name: “Hurrah for the Sun”.

Hurrah for the sun
The sun of our earth
It rises now
From behind the mountains

We always could see the sun from the window and Bob welcomed and received it in his personal space with happiness. According to Camara
Cascudo a lot of different populations of the world in different periods have been respectful to the sun which is an enemy of evil and brings light to human beings. Its strength, at noon, make the angels sing and the plagues are divinely sentenced if they coincide with “the amen” of the angelical chorus (Camara Cascudo, 1972, p. 828). To include ontological themes concerning the sources of the lyrics I searched in Eliade’s words from his book *Mito do Eterno Retorno* (1992), (The Mith of the Eternal Return), an explanation for Bob’s repetition of that song:

> an object or an action just becomes real when it makes possible the imitation or the repetition an archetype. Thus reality is reached only through imitation or participation.” (Eliade, 1992, p. 37).

Then Bob wrote a song to the moon. Inside his personal space of therapy he sang to the sun and at night, sharing the space with his family, he would maybe sing silently to the moon:

Hurrah for the Moon  
Hurrah for the moon so white  
It shines shines on the height  
Hurrah for the moon so white  
It shines shines on the height.

As mentioned before, Bob’s family gave him everything he wanted but also demanded a good behavior, a permanent diet, homework done and so on. He lived under parental control (family, teachers, therapists) although they all wished to see Bob well. Analysing the lyrics of the moon it looks like a refrain for the family hours, when he looked for the
light in the height. I see in these two lyrics (traditional song and Bob’s composition) a mixture of the past and the present, the old and the new, the day and the night, a space of time and place. That was a hard period because of the demands but he was experiencing a kind of transformation in his life. He was aware that all those efforts, both external and internal, were directed to his development. And these lyrics reflect those moments. As Ruud says:

Musical experience may be regarded as markers of important life events. Some events may be permanently fixed in memory because they mark the transition from one phase of life to another. (Ruud, 1998, p. 44).

Another lyrics selected are:

THE BOY

The boy is intelligent
The boy is intelligent
Sees the mountains, sees the mountains
Sees the mountains, sees the mountains
He goes up the mountain
*He is going up and up and up.*

Here we can see three aspects: the self-esteem increased, the nature and a situation of comfort and improvement. The boy is climbing the mountain and is getting some kind of autonomy on his environment. Maslow wrote that when there is an autonomy and independence facing the environment it means that a kind of independence facing the external adverse circumstances of life are present too (Maslow, 2000, p. 61-62). Bob wants
to be intelligent and wants to be considered as well. It is interesting to mention that he lived between a hill and the beach, and once again a familiar image contributed to his song-writing. Another point to mention is that melodies and rhythms were poor in the sense of absence of more structured composition. Once he wrote a *samba* about an airplane but usually he stressed the lyrics instead of rhythms or melodies. But when playing the electronic keyboard he enjoyed to change the timbres and the rhythms having a lot of fun while doing it.

The last two lyrics selected for this paper are Guitar and Halleluja. The first one is about his favorite musical instrument which he was not able to play correctly only improvising like a percussion instrument. Guitar (acoustic) is a very popular instrument in Brazil and is present in different styles mainly in *choros* and *bossa-nova*. It has been an ideal instrument in urban areas to accompany pop singers but it has been also the favorite instrument for some Brazilian classical composers. 36

GUITAR

Perfumed guitar
Perfumed guitar
That plays and plays, that plays and plays
That plays and plays, that plays and plays
La, la, la, la, la, la, la, la.

36. Heitor Villa Lobos composed beautiful studies and preludes for guitar.
Bob made here an association between perfume and his favorite instrument. He enjoyed perfumes very much so it was a way to praise the guitar. The lyrics are naïve and sincere reflecting that he was in a good humour in that occasion. Similar to other songs, melody and rhythm were simple once Bob expressed more intensively his musicality though words, like a poem. Kenny explains about music and poetry:

Poetry is the music of the language. It sings, it sings, it plays with sound. It ondulates and marches. It punctuates our thoughts more dramatically. It sends arrows through unnecessary semantics. It gives permission to use word in different ways ...(Kenny, 1989, p. 99).

Once Bob wrote a “Story Without Melody” about a tambourine that was crazy because it played by itself. The reason was to chase away a bee that was attacking it so the tambourine had to defend itself. As I read this story from the session observations, I could hear the sounds of the characters and its dynamics according to the situation. Bob touches on the issue of insanity as a reaction to an aggression. Although this story makes more than one interpretation possible, I see a message of indignation concerning his difficulties and limitations and the external demands symbolized by the bee’s attack.

The last song selected is Halleluja.

Halleluja

Lord, thank you
For being
Always by my side
Beside God
Our Father, I shall always be

I have already mentioned that Bob attended classes on catechism (Catholic Church) and used to show me his book and we read it together. When playing the electronic keyboard he enjoyed the organ timbre which inspired him to write this hymn, a song praise to God. When he sang it his face became serious and his attitude respectful. Bob’s religious feelings were pure and sincere and when he thanked the Lord for being beside him and declared that he should always be beside God, he was showing his faith and love. Bob had special needs but one was really special: the need of acceptance and God was accepting him. This belief made him happy and I consider the hymn he wrote and the moments we sang together an experience of transpersonal space as described by Ruud (Ruud, 1998, p.45).

And these were the lyrics that gave me support to build a narrative including emotional, cultural and religious aspects of a child with special needs searching for an identity. Of course this narrative is not complete but I would like to say that Bob is now 13 years old, is still in a special school and is attending singing and electronic keyboard classes. He can read and write and still enjoys imitating at home, with a microphone, his favorite pop singers. So, his own narrative is going on, by himself.

It was a very rich music therapy experience. We both learnt with each other. Bob found in music itself an ally and told us through some lyrics his life story during the period of the treatment. He wrote about animals,
about the moon and about a guitar. He also wrote about himself and about God. He mentioned loss but added later a feeling of hope. He wrote about friendship and intelligence, about music and faith. The guitar had a perfume and if a bee came to attack there was a tambourine ready to react. Concerning the faith, The Lord was beside him giving support and he was grateful. So, conscious of his limitations, Bob was able to perform and important role during the music therapy treatment before the challenges of a coming adolescence in the social and cultural environment where he lived.

REFERENCES:


**PRESENTER**

Vera Bloch Wrobel, MT, MA. Bachelor’s degree in Music Therapy and Piano and Master’s Degree in Music Education at Conservatório Brasileiro de Música do Rio de Janeiro, Brasil.
Abstract:

Successful termination, in which the client is empowered to move into the future and the therapist feels satisfied about the ending of therapy, is an appropriate aim in music therapy, as it is in other allied health professions. Several factors influence the outcome, and the future well-being of clients (and, possibly, of therapists also) may depend on achievements during therapy, the circumstances of the termination, and on previous personal experiences of success or failure, acceptance or abandonment.

Responses to a research questionnaire on termination in music therapy disclosed both positive features of the process (such as helpful methods currently in use), and negative features, (including major difficulties when decisions on termination are made without reference to the music therapist.) Ideas for further research may evolve from this project.

Introduction

Many music therapists write about establishing relationships with clients, setting goals, working with different populations and evaluating progress, but there only a few articles discussing the ending of therapy. [McGuire & Smeltekop (1994), (1) & (2)]

Definitions: We talk about 'closure' 'separation', 'termination", but all these have the same implication - that we have been in a therapeutic
relationship with someone, as client or as therapist, but will be so no longer.

In the literature, 'forced termination' usually refers to closure by trainees at the end of placements, [Zuckerman 1999] but - as this paper demonstrates - the term is more aptly used for situations in which, without any preliminary discussion with the RMT as to the appropriateness of the decision, music therapy is abruptly terminated for one reason or another.

How termination occurs and proceeds

Ideally termination includes various components:

- Achievement of identified goals (Therapist's view)
- Achievement of identified goals (Client's view)
- Adequate time to prepare for separation
- A satisfying 'termination event

If this all happens, both client and therapist feel satisfied, and the client moves confidently into the future, benefiting from the changes that were achieved during therapy.

But this doesn't always happen!

Difficulties occur when:

- Funds end before work is complete - often without consultation with the therapist
- Clients are unwilling or unable to continue
- Therapist's employment ends

Result: Client and/or Therapist feel frustrated, disappointed, unhappy, angry, ...
In 2001, some Sydney clinicians discussed termination and realised how little is known about it; it seemed that some research was needed. A questionnaire was devised by the author to cover those areas which were amenable to investigation; after approval by AMTA's Ethics committee, this was posted to all Registered Music Therapists in Australia; (Australians working overseas were omitted because their work in termination may be influenced by their current work situation).

In deciding how to formulate the questionnaire, four important aspects of termination were considered:

1. The circumstances in which it arises
2. How the process is carried out
3. How the client feels about closure
4. How the therapist feels about closure

1. **Circumstances:** Termination may be planned or unexpected; it occurs because a trainee's placement or the therapist's employment ends, because the client has reached nominated goals, because death or intercurrent illness has intervened, because money has run out, because the client decides to leave, because someone decides that the client should leave the unit, and so on.

This was clearly important to include this area in the document, with queries as to how decisions are made on termination and whether or not the music therapist's views are sought.

37. Throughout this paper, AMTA = Australian Music Therapy Association, founded 1975
2. **The process:** The termination event depends on several factors:

- whether or not we are able to prepare for termination and who made the decision
- the quality of the relationship which has existed
- the goals and 'agenda' of the therapy
- the therapeutic orientation and approach of the therapist.

It was clear that the termination process is so complex a matter that complete research would demand resources unavailable to the writer! The questionnaire did, however, include questions as to whether the therapist's therapeutic orientation affected the termination event, and what features were included in that event.

3. **The client's feelings** are also problematical: we observe what happens when termination is suggested or a decision pronounced, and deal with whatever arises. Verbal and musical responses may tell us that the client:

- feels that the right time has arrived for termination
- feels that the closure is premature perhaps feels rejected and abandoned - especially so if he has already experienced rejection and abandonment in life. This may present as anger, a threat of suicide, pleas for continuation [Brodaty 1983]

But what happens for the client afterwards is largely unknown; few people responding to the Questionnaire knew anything about subsequent effects of termination.

4. **The therapist's feelings about termination** are, however, more amenable to investigation!

We may feel satisfied that goals were reached, or frustrated, disappointed or even guilty that closure occurred before therapeutic plans reached fruition.
The project

To make the project achievable, the main questionnaire asked only about work with individual adults, but an introductory section was included which all RMTs were invited to complete. Some questions required quantitative and others required qualitative responses, but free comments were invited throughout.

This paper describes first the responses to that introductory section of the questionnaire and then discusses question specific to individual work with adults.

Introductory section of questionnaire

A total of 54 completed questionnaires were received by 31/3/02, a response rate of approximately 37.5% of the total professional membership.

Of these, 40 responses were from RMTs who work on an individual basis with adults; it is not known what proportion this represents of the therapists who work in this way. But, because many Australian therapists work only with groups, and many work exclusively with children, responses may genuinely reflect Australian work with individual adults.

Respondents' length of work experience covered a wide range:[O/H 4.]
Respondents' work experience:

Mean length of 6.9 years
respondents' 1:1
work with adults.
Length of Under 1 year to 42
experience with all years
populations, range:

Respondents to the first section of the questionnaire were asked about training on termination.

- 81% of respondents had received help re termination
- 90% of those were enabled to deal adequately with closure at the end of placements.
- All 29 student-supervisors required advance preparation for termination, generally 2 - 3 weeks.

No supervisor suggested preparing students for unplanned, premature closure. [Youngren, 2000]

Death of client.
48 Respondents had experienced death of a client.

Coping strategies included:

- Supervision, counselling and de-briefing (usually with non-RMT.)
- Conversation with friends, family & colleagues
- Attending funeral and/or memorial service
- improvisation, journalling,
Burnout:

- 31 Respondents believed that difficulties re termination contributed to burn-out.
- 14 thought it unlikely
- 9 had no opinion.
- But no apparent correlation was seen between this view and length of work experience.

Various comments reflecting diverse opinions supplemented the quantitative answer:

"Absolutely!"

"Depends on a variety of factors, especially the experience of the therapist"

"....indicates poor communication in the workplace"

"....only if the boundaries between client and therapist have been crossed"

".I find termination positive, the client has achieved progress or I have moved on..... of course there are feelings of loss but burnout is more likely from other circumstances."

What the research on work with individual adults revealed

1. Professional isolation in the workplace

Few Australian facilities employ more than one music therapist and this commonly causes professional isolation. Although non-RMT colleagues learn of the role and achievements of music therapy, the RMT benefits by
discussing clients' progress with fellow RMTs; clinicians meetings of the Association are therefore important. De-briefing and supervision after a crisis are, however, usually provided by colleagues in the workplace, who are generally not RMTs.

2. Referrals

RMTs accept referrals from various sources, including - for some - self-referral; most referrals come from non-RMTs, colleagues who recognise the value of professional music therapy.

Reasons for referring clients for music therapy are diverse and are not mutually exclusive:

Referrals were listed as received for:

- emotional and 48
  behavioural issues
- management of 20
  psychiatric disorders,
  dementia and confusion
- pain and terminal 7
  illness
- rehabilitation for: 11
  adult autism, substance
  abuse and other
  unspecified disorders

But the wording of a referral does not necessarily indicate the expectation of the referring person: depression and failure of communication may be aspects of dementia or part of adult developmental disability; 'grief and
'loss' may be a separate entity or may overlap with mental illness and/or substance abuse.

What is expected from and what is provided by music therapy often needs to be discussed when we receive a referral, lest our aims and objectives are misunderstood. **Serious difficulties can arise if the referring person expects one type of intervention and we provide something different.** *(Author's comment.)*

### 3. The impact of part-time work

At the date of the questionnaire, most respondents worked part-time:

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>Average Hours per Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Practice</td>
<td>Approx. 13.7 hrs/wk</td>
</tr>
<tr>
<td>Hospital/Clinic</td>
<td>Approx. 20.4 hrs/wk</td>
</tr>
<tr>
<td>Combined Private/Clinic</td>
<td>Approx. 25.1 hrs/wk</td>
</tr>
</tbody>
</table>

Responses to all questions indicated the significance of therapists' working conditions; especially of significance of part-time work and the consequent professional isolation.

**Hazards of part-time work**
• Other staff may not recognise professional nature and value of music therapy
• When management changes, this ignorance adversely affects employment stability.
• If RMT is not at Case Conferences, RMT's opinions may not be recognised/valued, especially if non-integrated progress notes are used.
• Part-time therapist rarely informed of death or discharge of client.
• Termination decision-making varies in various units

But there are positive aspects of part-time work

There is interest and challenge in part-time positions with a variety of populations

New therapists learn about different aspects of music therapy, and

• establish skills and preference, also
• learn of employment prospects
• part-time work may suit the therapist's personal life. (Sharing a position between two RMTs is the ideal for this.)

**General comments on closure**

When do you think about closure? A range of possible answers were listed, but respondents were also free to write their own ideas, and the query evoked a variety of replies. The printed list was thus:

* at the first session

* when the client achieves goals

* when I feel stuck

* when the client reaches a plateau
* when preparing for vacation,

* when changing employment

Comments from therapists were interesting, e.g. 'when I'm stuck - Off to supervision!"

**Does progress in music therapy influence team decisions on discharge?**

No single answer emerged on this query, partly because several respondents work in different places which have different methods when discharging someone or transferring him/her to a different unit.

But what was clear is that it is **rare** for the RMT's opinion to be critical in decisions on discharge from a *multi-disciplinary unit*.

In *private work*, however, evaluation of progress is a key factor in decisions about termination.

**Causes of termination**

Several reasons which lead to termination were listed in the questionnaire:

* goals achieved

* client stuck

* client is discharged, leaves therapy

* therapist stuck

* illness of client

* patient died

* funds cut
How many sessions? Responses varied, minimum from 1 to 50, maximum from 5 to 200 or 'until death', these may be correlated with the workplace. In acute psychiatry, admissions are brief but in nursing homes sessions may continue for years. Funding too limits length of intervention, and RMT's therapeutic orientation will also influence the number of sessions: e.g. a longer series may be sought by a psychoanalytically-orientated RMT than by someone strongly committed to Cognitive-Behavioural Therapy or Solution-Focused approaches. Responses reflected these factors.

How many sessions to prepare for termination?

AMTA guidelines give 3 (weekly) sessions as ideal preparation for termination. Opinions varied as to whether or not this is realistic, 21 saying it was, and 19 saying it was not! But reasons for opinions varied: Some said it was realistic in certain circumstances, some said it was impossible if admissions are short, some simply said it was unrealistic and a few said it was not long enough! Opinions are influenced by one's workplace and population, and the management structure.

We cannot always predict what will happen: in palliative care death may still be unexpected, and in private practice, when length of interventions may seem predictable, clients' funds can end unexpectedly!
Respondents were asked about their **clinical orientation** and whether this influenced their approach in termination. The therapeutic orientation of respondents was varied;

26 out of 40 RMTs described multiple clinical orientations.

These figures are important as indicating that, in Australian music therapy, a flexible multi-faceted approach is generally preferred rather than a single therapeutic orientation.

A question on possible correlation between the RMTs therapeutic **creed(s)** and the methods used in termination, elicited several comments:

"Each client is an individual with individual needs, and [requires] individual means of closure." (A therapist of 1 year's experience, with a strongly eclectic approach.)

"Gestalt and TA help me in both the MT process and in termination, in giving both my client and myself understanding of ways in which a person makes changes, and consolidates these changes. Psychodynamics assists me in dealing with transference and countertransference [i.e. in termination]." (A therapist of 7 years experience)

A therapist of 20 years experience, listing Jungian psychodynamic, humanist and eclectic orientations as informing his or her work, described these approaches and their influence on termination thus:
Features of the termination session which were listed included:

- Open acknowledgement of finality
- Improvisation;
- Other music: client's personal theme + items from sessions;
- Song-writing and poetry;
- Review of achievements in therapy;
- Plans for the future, e.g. inclusion of achievements;
- Client & Therapist expressions of thanks;

(These are similar to suggestions for therapists in USA. [McGuire and Smeltekop, 1994(2)])

Responded believed that, in ideal termination,

- the timing was planned, termination discussed;
- goals were met for client and therapist,
- the client moves on without feeling rejected or abandoned and without dependency, having dealt with transference issues
- yet taking the gains made in sessions to be used in everyday life and relationships.
* the therapist says 'farewell' without pain.

But ideals are not always realised, and most RMTs have experienced premature, unplanned closure.

The impact of unplanned closure of music therapy

Respondents were asked how they responded when music therapy ended (for whatever reason) when the RMT believed that work was incomplete.

5 different philosophical or active responses were listed, contrasted with 49 different negative emotions.

Categories of words used re responses to termination when work is considered incomplete:

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness and disappointment continuum</td>
<td>20</td>
</tr>
<tr>
<td>Anger and frustration continuum</td>
<td>15</td>
</tr>
<tr>
<td>Personal inadequacy continuum</td>
<td>7</td>
</tr>
<tr>
<td>Unfinished continuum</td>
<td>7</td>
</tr>
<tr>
<td>Hope, positive/active strategy continuum</td>
<td>5</td>
</tr>
</tbody>
</table>

The responses indicate both that a realistic scenario was posed by the question and that premature or unplanned termination causes various emotional difficulties for therapists.
For some, negative responses included doubts on their own competence, the value of music therapy *per se* and its recognition by other professionals and funding authorities.

**Because we know that feelings of reduced personal accomplishment contribute to burn-out, [Maslach & Jackson 1981, Farber 1983]** the answers to this question constitute a danger signal.

**Implications**

This was a pilot study and results were drawn only from Australian music therapy practice. From discussions with therapists elsewhere, however, it seems possible that the findings have wider relevance. The study may well have implications for termination in group work with adults, and in both individual and group work with children. We also need to look at implications for music therapy world-wide, e.g. in music therapy practice under 'Managed Care', whether in private practice or when working in a hospital or other formal facility.

We can however say confidently from this research that:

Premature closure in 1:1 work with adults is risky for therapist and for client, so we must:

* enhance recognition of professional music therapy, and meanwhile......

* support both therapists and clients in coping with premature closure and

* train students so that they can if necessary cope with unplanned and/or premature termination
But despite all the potential for harm in forced termination, it is clear that Australian RMTs are flexible in their therapeutic approach, and work towards ideal termination, in which:

# the client sees termination as transition, and

# the therapist relinquishes the care of the client with ease

**SUMMARY**

This paper has described an Australian research project by questionnaire, investigating termination in one-to-one adult music therapy. Results have been informative and may or may not be applicable elsewhere. Although to some extent discouraging, results have delineated difficulties which may not otherwise be fully recognised, providing our profession with information on issues which need to be addressed.

The research also demonstrated that most Australian RMTs adopt very positive attitudes in their work, and use an eclectic rather than a single orientation, adapting their approach to the client's needs and the progress which is observed in achieving change.

**REFERENCES, BIBLIOGRAPHY and RECOMMENDED READING**

_Termination in Music Therapy:

Music Therapy Perspectives 12(1) 20-27

Music Therapy Perspectives 12(1) 28-34

Forced termination.

Training students to cope with premature closure:
Youngren, J.N. (2000) "Is managed care really just another unethical Model T?" The Counselling Psychologist 28(2) 253-262

Responses to termination at the end of student placements;

Discussion re decisions as to whether or not to extend psychotherapy:

Imperfect termination as contributing to 'burnout' in therapists:
The video you have just seen is an excerpt from a longer film, and edited for this presentation. I am going to touch briefly on the rationale behind music therapy in childbirth and give you a quick outline of the prenatal work in choosing and using the music. I do want to leave time for questions, and you may want to discuss areas of the work I haven’t covered.

**Music Therapy and Labour Support**

There are as many stories about music in birthing as there are women who have used it. The women whose comments and birth stories you heard in this video chose music therapy-assisted childbirth for many different reasons, but all agreed their experiences were positive.

Women who choose music therapy for birthing are not all musicians. A few have some formal training, but most have none. The one thing they have in common is that they all love music, and they feel it will be beneficial for them and for their infants.

Recently, research and improved technology have shown that the sensitive, knowledgeable use of music can positively affect not only one’s mental and emotional state, but one’s physical state of health as
well. For instance, studies in the use of music in medicine conducted by Dr. Ralph Spintge at the Hellersen Sportclinic in Ludenscheid West Germany illustrate for us that music chosen by the listener can reduce the secretion of stress hormones and increase the manufacture of important chemicals in the immune system.

So, women who listen to their own choices of music for pregnancy and labour may experience reduced stress and improved functioning of their immune systems, both worthwhile goals. They have control over how the music is used. In childbirth, the aspect of control is particularly important.

When mothers feel more in control of their labour and their environment, they are less likely to give in to the fear-tension-pain syndrome, a term coined by Dr. Grantly Dick-Reid, a pioneer in natural childbirth. This is a particularly nasty cycle. When women in labour are fearful, tension in the muscles decreases the supply of oxygen to mom and baby, increased stress produces excessive amounts of stress hormones which decrease the efficiency of contractions and can prolong labour and pain.

Pregnant women often think about their labours, and consciously or subconsciously worry about their physical and emotional ability to birth their babies. The main fear women express is that they will be unable to cope with the pain of labour. They want to be able to protect their infants from excessive medication, but they are worried that at some point, they will give in and ask for and/or receive pain medication.
The Mind-Body Connection

The common thread in studies of music therapy-assisted childbirth has been the emphasis on the connection of body and mind in dealing with pain and anxiety. Researchers have shown that psychological and physiological factors interact in the pain experience. Controlling any or all of these factors will affect the duration, intensity, and quality of the experience. Studies also show that emotions play a very large part in the physical and emotional health of both mother and baby. In fact, a mother’s emotions, both positive and negative can affect her unborn child.

As Dr. Esther Sternberg points out in her book “The Balance Within”, researchers in disciplines relating to various organs of the body, such as endocrinologists, neuroanatomists and immunologists are now communicating with each other and with psychiatrists and psychologists who study the mind and its emotions. They are all coming to the same conclusion. The mind and the body are inter-connected.

In childbirth pain and anxiety are intensified, maybe because a new life hangs in the balance. Women are concerned not only for their own well-being, but also their unborn child’s. The emotional state of pregnant and/or labouring women affects positively or negatively their health and that of their babies. We all know that music affects our emotions, and ongoing research such as that of Dr. Spintge shows that music can affect physical health. It seems reasonable to assume then, that the right type of music chosen by an expectant mother, and used with guidance prenatally, during labour, and postnatally would have a positive effect on the
connection of body and mind in dealing with the pain and anxiety of childbirth.

As you just heard, music therapy can be very effective prenatally to encourage relaxation, positive imagery, and communication with the unborn child. During labour and childbirth, music therapy has been used by mothers as a coping strategy to provide a focus for relaxation, a sense of control, and a distraction from the pain of labour. Familiar music chosen by the mother tends to “normalize” the environment. It is a non-medical, non-invasive method, which has been shown to be very effective in enhancing the birth experience for mothers, babies, and their families. Postnatally, mothers have found the same music very comforting, and they have used it to settle their infants when nursing or putting them to sleep. Mothers will use it for their own benefit as well, finding the music soothing for their own meditation or naptime.

**Labour Support, What Is It?**

As mentioned in the film, I am also a certified doula. Although the term “doula” is well known in some areas, there are still many people who have never heard of these dedicated women who are trained in labour support and help women to discover and draw on their own strengths. To quote DONA, the organization most recognized in the training of doulas in North America, a doula is “a woman experienced in childbirth who provides continuous physical, emotional, and informational support to the mother before, during, and just after childbirth.” Doulas of North America (DONA) have a website offering information for those interested in knowing more about labour support.
Doulas work from the waist up. That’s the best description I have ever heard. We are not medical caregivers, although there are nurses and doctors and midwives who are trained as doulas because they believe fervently in the advantages of labour support for mothers. Penny Simkin, a founding member of DONA, says that a woman remembers her birth experiences her entire life. It is in society’s best interests to see that her memories are good ones.

Women’s bodies are designed to have babies. They have been birthing since the beginning of human existence. Some women are better at it than others, but all women who give birth have the right to a positive experience. In our Western culture, our “civilization” has in the past denied women the comfort of another woman to be with her throughout her labour, to touch her, hold her, mother her. Now, studies are showing that continuous social support throughout labour significantly reduces medical interventions, complications in newborns, and maternal fever.

**Combining Music Therapy and Labour Support**

As a doula and a music therapist, I combine my two passions, labour support and music, when I work with mothers. I think the combination of labour support and music is unbeatable. There is always a time in labour when mothers sort of go into themselves; when talking is not as effective. Music, because it is non-verbal, provides the comfort they need without being invasive.
Mother Knows Best

The music used in childbirth must be that chosen by the mother. I can’t stress that too strongly. Research in the use of music for pain relief indicates that preferred music, music chosen by the client is most effective.

For their births, women choose music ranging from Bach and Beethoven to Garth Brooks and Rod Stewart. I have never found anyone whose choices of music were identical to anyone else’s. Not one! Many of the same pieces of music appealed to many of the women, but I have learned from experience not to become complacent. The moment I begin to think I might have at least one tape that everyone will like, along comes someone who will say, “Well, I like every piece except these two, and there is one piece on the other side I really wonder about as well”.

I was once told a story by a nurse about a woman who arrived at the hospital in labour. Her husband followed after parking the truck, with some CDs in hand. He thought they might provide some listening pleasure for his wife. They were Heavy Metal. They might have offered some support to the husband, but, as the nurse tactfully suggested, they would not be very comforting to the poor woman in labour. We must keep in mind whose music is preferred.

Another potentially dangerous situation can occur when mothers have not chosen the music. Women who have been physically or sexually abused are subject to flashbacks. These may be triggered by seemingly innocent words, events, and by music heard at or around the time the abuse occurred. This can be devastating. The wrong music played to an
unsuspecting woman in labour can add enormous stress to an already potentially stressful situation. It is very important to these women that they are kept informed every step of the way. Music can be a great comfort, but it should not come as a surprise.

When I work with women prenatally, we spend at least two sessions of two hours or more choosing music. They choose every piece of music they will have for the birth. It is crucial that they can listen to the same music many times without growing tired of it. Always, mothers are encouraged to tell me if any of the music is not appropriate. I will change it, substitute different music, and redo the tape.

**Choosing the Music**

Choosing the music with the mother allows us to spend time together getting to know each other. We will be in an intense relationship during her labour, and we both need to feel comfortable. Her husband or partner may be involved in the choices of music as well, and I find that is a good way to include him in the process.

I never download music from the Internet, nor do I use music purchased by anyone other than me or my client. The music is taped specifically for one woman for her personal use only, and I ask my clients to sign an acceptance of responsibility to that effect. The tapes are part of my service; they are not sold, and I do not make generic tapes. In any case, I don’t believe they would work as well because the music would not be the mother’s choice.
Types of Music

There are essentially two types of music taped for each woman: relaxation music and what Diane Allison calls “rocking” music. The majority of the music is geared toward relaxation. I make three relaxation tapes, two more upbeat, rhythmic tapes, and one tape consisting of her favourite music on one side, and music for the baby on the other side. So that is six tapes in all. I usually use 90 minute tapes, so each mother has about nine hours of taped music to choose from in labour.

I am with each mother throughout labour and delivery, providing a mixture of labour support and music therapy. The type of music used during labour depends on her response. I need to be attuned to her – sometimes her cues are very subtle. I need to watch carefully as she goes through each contraction.

Relaxation Music

I base the choices of relaxing music on some research completed by Dr. Ralph Spintge. He found that a certain type of music reduced blood pressure, heart rate, and breathing rate of most people. These people preferred this type of music when relaxing. Dr. Spintge called this kind of music anxiolytic. By this he meant it produced the desired physical effect of reducing anxiety. I have adapted his definition of anxiolytic music to the preferences of my clients, but essentially, I stick to the following basic format.

- Music should be selected that has no extremes in dynamics and tempo
• Instrumental music lends itself to relaxation. I have used music with lyrics, but most moms find instrumental music best for complete relaxation.

• The recordings should be of high quality, and easy to use

• Keep looking for new selections. I find that the mothers themselves are my best sources for new ideas.

• Taking these suggestions into account, the mother should make the final selections.

**Rocking Music**

As I mentioned, I do record music that is more upbeat and rhythmic. For this idea, I am indebted to Diane Allison, whose work in *Case Studies in Music Therapy* inspired my research. There is always a time during labour when a woman will lose focus and tire, and need stronger support. I have found that a change in the type of music at this point can be very helpful. Stronger rhythms, and selections with lyrics to which the mother can sing along, really encourage her to focus on the music. The intensity of the music acts as a distraction from the intensity of the contractions.

Some women will hum under their breath; others will simply mouth the words. I will often sing with them or cue them to sing by beginning myself. If the singing is done regularly pre-labour, it will become a natural thing to do.

For rocking music, almost anything goes as long as it has a definite melody, lyrics that are positive, and rhythm that is noticeable, but not too obtrusive. Of course, it’s up to the mother, but I have advised against music with a really fast beat or extremely pounding rhythm. The music should be uplifting, but not frenzied.
I also encourage mothers to listen to the lyrics carefully. The last thing women need to hear when they are uncomfortable, is a song about heartbreak or abandonment.

The **favourites tape** contains the music I like to play during the second stage of labour when the cervix is fully dilated and the birth is imminent. It seems to uplift spirits, and give a labouring woman renewed energy and incentive when she hears the music she loves most. It is such a re-affirmation of her as a person. It’s her music, her support, her birth, and her baby.

The “favourites” also seem to be helpful if mothers get to a point in their labour when they feel they can’t go on. They can focus on the music, and use it as a distraction by swaying, pelvic rocking, singing or humming along. I find that this is a time for me to be more directive, so I sing with them, and encourage movement of the hips with my hands or direct them to sway in their partner’s arms to the music. This seems to be helpful in focusing their attention more on the music.

**Using the Music Prenatally**

**Music For Relaxation**

I always spend some time with a client showing her some techniques for relaxation. I like to use progressive muscle relaxation because it gives her a sense of the difference between muscle tension and relaxation. It’s very important for her to know when and where she is holding tension, so she can work with me to release it. Each time she practises the technique with the relaxation music, she encourages her body to produce a
conditioned response to the music. In other words, she associates the relaxation response with the music she is hearing.

**Music For Movement**
Regular exercise is important during pregnancy. However, I always advise my clients to check with their medical caregivers before they embark on an exercise regimen. The rocking music is very motivating as an accompaniment to any activity, whether it’s a daily walk, light aerobics or simply household chores. Exercise instructors use upbeat, rhythmic music in their classes. It tends to invigorate and motivate people to move. Rocking music, used prenatally, and at points in labour, often has the same effect.

**Music For Singing**
I encourage mothers to begin to sing along with their music. Singing involves the whole breathing apparatus. The breathing must be rhythmic, and they must use the muscles of the abdomen and back to support the breath. These same muscles need to be strong for birthing.

They don’t even need to sing words; just use “la”, or nonsense syllables, or hum. They find they focus more on the music, and that’s what they will want to do in labour. Mothers who have sung during their labour have told me how effective it was in focusing their attention on the music and distracting them from the pressure of the contractions.

**Birth Songs**
The women with whom I work are encouraged to write birth songs to welcome their newborns into the world. The music usually comes from
one of the lullabies on the baby tape because the melodies are short and easily remembered. The lyrics sometimes come from a letter written to the unborn child or simply words or phrases that have meaning to the family.

I write out the melody line for them and we work together to fit the lyrics to the music. When the parents are satisfied, the birth song is sung prenatally to their child, and as you heard, it is sung shortly after the birth. This song is special to each child, and I think it is a wonderful way to promote family-infant bonding.

The women with whom I have worked have put a tremendous amount of faith and trust in music therapy-assisted childbirth. It is an awesome responsibility and I am so grateful for the opportunities they have given me to share in such an intimate life-changing event. My research continues as I learn from every new birth.

Music therapy-assisted childbirth is a relatively new aspect of our profession. I believe that it is particularly rewarding. We know that music therapy is very helpful for those leaving this world; it is just as helpful for those entering it.
The presentation began with the showing of slides of two original works by Barbara Hepworth, a sculpture and a poem. *Curved Form (Delphi)* was sculpted in 1955 as part of a series of excavated wooden forms inspired by a visit to Greece. Hepworth exhibited one of these forms at an exhibition at the Institute of Contemporary Arts in 1957 alongside a poem reflecting on form, time, landscape and a contemplation of our roots entitled *You are I and I am the landscape*. The audience in Oxford was asked to think of what, if anything, the sculpture and poem communicated?

**INTRODUCTION**

Images such as these by Hepworth, shown at the beginning of our presentation, have become important in our recent work together providing space for reflection and helping us to observe how such 'contemplation of our roots' is translated into artistic form. We have found our responses to sculpture, poetry, literature and music helpful in uncovering metaphors for connections between the therapeutic and artistic processes and as illustrations of a therapist's practice and development. For example we have been inspired by the balance of space and mass (and musical allusion) within Hepworth's forms and invited the artist Jonathan Barnes to respond to Hepworth in creating the image for
the front cover of our recent text *The Handbook of Music Therapy* launched at this congress.

(A slide of Jonathan Barnes’ front cover illustration responding to Hepworth’s sculpture was shown here.)

The main theme of our presentation emerges from some of our discussions and work in preparing this text. As trainers we are increasingly aware that the foundation for effective music therapy practice is the development and subtle interweaving of a complete set of skills, qualities and attributes. While these varied areas of learning are initiated and nourished during our professional training courses, they also form pathways for continued understanding and enrichment throughout our professional lives. In our discussions together we identified some key features of learning that bridged art and therapy (what mechanisms are needed in both) and how each discipline - for us music- complement and help the other. What emerged from our thinking are four key processes in building and sustaining the professional music therapist. Integrating and balancing these four areas is a continuous task in our professional work but emerges as a crucial step in reaching the point of qualification.

We propose to you that: imagination, intuition and intellect are three of these key processes for effective practice. Improvisation is also central to much current music therapy practice in this country, hence the four I's of our title. We aim to present a rationale for why developing a balance and integration of these four I words provides a strong and enduring foundation to a music therapist's training and practice.
We were rather delighted to discover in a recent lecture to the Royal Society of Arts about educating children to manage in real life - that is a complex world of uncertainty - some parallels with our connections. In discussing the learning process Professor Guy Claxton pointed out that:

There are four main compartments of the learning tool-kit - learning through immersion, through imagination, intuition and through intellect - and the accomplished real-life earner needs them all.

(Claxton 2001: 3)

‘Improvisation’ instead of ‘immersion’ was the only point of divergence! Claxton connects these components to a lifelong approach to learning. We need strategies to approach the new situations we meet, to bridge and adapt from our existing bodies of knowledge or to assimilate and accommodate as described in Piaget's developmental model (Piaget 1936: 17-18). Such integration is as relevant to the primary school classroom as it is to the training of mature music therapy students. This process is assisted by teachers continuing to explore and be open to learning themselves. Claxton argues a strong case for the teacher admitting or indeed relishing when things are not known - as nice a link as you might find for therapeutic learning being a model of all kinds of learning. This also links to Casement's advice for the therapist to explore the creative tension between a state of knowing and not knowing (Casement 1985: 5).

We feel that our first musical example encapsulates something of this integrated balance. It comes from the end of the second act of Handel's Theodora. This late oratorio is here given a very intuitive and
imaginative interpretation by the American director Peter Sellars, translating the formal constraints of an oratorio chorus into the full-blown and vibrant gestures of an operatic moment. Notice the use of movement and gesture in the chorus, which both harks back to an early baroque tradition of linking stylised movement and singing and also suggests something of the African idea of ‘Ngoma’ where the flow of song, dance and storytelling are all part of the same concept. This extract shows a critical moment for the guard Didymus. His feelings of concern and love for Theodora are conflicting with his duties as a professional (and a member of the opposition, in the original conception a Roman officer). Here the chorus of Christians reflect on his feelings and urge him to rescue his beloved Theodora.

(A video extract from the end of the second act of the Glyndebourne Festival Opera's production of *Theodora* was played here.)

We shall spend some time on each of imagination, intuition and improvisation. Each section will end with reference to the framing boundary of the intellect and the very nature of clinical thinking that underpins all constructive therapeutic work.

**ON IMAGINATION**

Michael Mayne (the keynote speaker on the last day of the Oxford Congress) has published a series of letters to his grandchildren entitled *This Sunrise of Wonder*. Near the start of the letter entitled *The Meaning of Wonder* he refers to W.H. Auden's inaugural professorial lecture here in Oxford in 1956 (a year later than our opening Hepworth image) when
Auden made the distinction between Primary and Secondary Imagination. Michael Mayne continues:

By Primary Imagination he meant that within us which has contact with the sacred in the widest possible sense of the word, and which creates in us the sense of awe and a need to respond. But a need to respond to what? At this stage there is simply the unspecific and intuitive awareness of what might be called the sublime. The function of what Auden calls our Secondary Imagination is to give form to this awareness, to incarnate it, to give it flesh and intelligible form in words and images, in music, shape or colour. (Mayne 1995: 83)

There is a significant bridge between creating art and practising therapy. While different modes and forms apply in these two disciplines, both artists and therapists are crucially concerned with the personal feeling experience, how we translate and communicate the 'truth' of heart and mind into the concrete world shared by others.

Let us consider one example from art and one from therapy where the expression of aggression is a focus. In Ian McEwan's recent novel 'Atonement' there is a vivid passage describing a twelve-year old girl whipping nettles in a rage (McEwan 2001). McEwan shows how her feeling is transformed from a state of fury to a sense of control and authority through composing a story for herself, a daydream if you like. He describes the regular rhythmic quality, the concentration and the singular purpose in slashing. He writes that Bryony is 'grimly content, even though she appeared to the world like a girl in the grip of a terrible mood.' The satisfaction comes through both the energy of the discharge of feeling but also that she makes herself powerful in the story (no longer being the victim of others' cruelty).

(A passage from Atonement was read here)
The following is a clinical example that we use in The Handbook of Music Therapy (Bunt and Hoskyns 2002: 28).

A six-year-old boy called Sergio with dyspraxia and severe difficulties with verbal communication spends the first five weeks of his music therapy avoiding any encounter with the instruments or the therapist. He packs the instruments away in the corner of the music therapy room, and crouches in guard of them. His first expressive gesture towards the therapist after five sessions is an aggressive one: he begins to throw drums sticks at her. This is a notable change in energy and the therapist catches the sticks in an upturned drum. Like Bryony in the description above, the therapist begins to make a shape or pattern in responding to Sergio’s throwing. A musical catching game is created, where Sergio is ‘firing arrows’ at the therapist (to be caught in the drum). The song the therapist sings is quite aggressive in quality, characterised by sharply accented rhythms and semitones in the melody. The song makes Sergio laugh initially but then he becomes absorbed in the feeling of the game. Over several weeks, various activities with sticks occur, but eventually one stick becomes a microphone and Sergio sings with great and loud delight as a kind of pop star, with the therapist accompanying on guitar or acting as an enthusiastic audience.

Again like McEwan’s character, Sergio takes energy and power for himself, through a joint imaginative process between himself and the therapist. The process of invention makes him feel differently about himself. But note that unlike Bryony Sergio's feelings and imaginative play have all been contained and framed within a therapeutic relationship.

For trainees, this process of harnessing the imagination both for themselves and for the purposes of the client’s growth and change is fascinating and confusing. Trainees need to recognise their own instincts and capacities for creative play (awareness of Auden’s 'Primary Imagination') but then to adapt to the client’s imaginative potential and to work towards putting ideas into musical form (Auden's ‘Secondary
Imagination’). As in the case of ‘Sergio’, we need to be comfortable with the pacing of this integrative process, learning both when to intervene imaginatively and when to hold back.

To recap then, it seems that the artist and therapist have a joint passion for finding expression for deeply-felt personal experience, for communication and connection between conscious and unconscious processes, for discovering a form for expression that suits the evoked feeling. Students of arts therapies need to be aware of a fundamental responsibility to provide opportunities for patients to use their imagination, to play with different identities, to gain more sense of personal authority and empowerment. Imagination enables a child or adult to become inspired, fortified and to move and change.

It is interesting that the process of music therapy training can often have profound effects on the way that musicians view their own music. Many professional players who have trained later as music therapists have reported on a re-awakening of a more feeling response, more playful spontaneity, risk and energy in their playing. The re-working of their music in this way has often brought about truer involvement of the personal self. Perhaps we give something back to our parent art form by the concentration given to feeling expression in our training courses.

Imagination, like therapy, needs limits and boundaries. Unbridled imagination carries the risk of madness or even death, if not held within a rational frame or perspective. Selection, refinement, form, limits, deadlines – these are thinking processes, which are needed to accompany
the imaginative drive. Such a frame of thought gives meaning, focus and safety to the creative process.

**ON INTUITION**

Women's intuition has been neither magic nor genius but the result of close attention to minute signs and an interest in unspoken emotions: it is as rational, and elusive, as medical diagnosis, using past experience in the face of uncertainty; but it is never easy to learn from experience, because two experiences are seldom exactly alike; an imaginative jump is needed to spot the similarities. Zeldin (1995:442)

Musicians are aware of the need for hours of practice before playing can become natural and spontaneous. But it is often difficult to explain to new trainees how what may appear as a very intuitive and spontaneous moment in a piece of observed therapy is grounded in previous knowledge - 'using past experience in the face of uncertainty.' A practising therapist would have knowledge of the individual or group involved. There would be the natural unfolding of the session itself and memory of any previous sessions, in addition to a general familiarity with the clinical features of the particular client group. The therapist will also have practised vocal and instrumental exercises in personal improvisation, both in training and as a practitioner. As can be seen much will depend on the therapist's level of experience.

Intuitive knowledge….proceeds from everything we know and everything we are. It converges on the moment from a rich plurality of directions and sources - hence the feeling of absolute certainty that is traditionally associated with intuitive knowledge. (Nachmanovitch 1990: 40)
Intuition is therefore not only a sensing but also a mental event. It links
creatively with the rational, the Latin root of intuition meaning to look
upon, consider or contemplate.

Intellect has, first, the valuable and necessary function of interpreting, i.e.,
of translating, verbalizing in acceptable mental terms, the results of
intuition. (Assagioli 1965: 223)

Intuition… is the ability to let your mind go soft and quiet, and to allow
things to 'come to you.' Reverie is the nursery of creativity. (Claxton
2001: 3)

A student's experience on a one-off placement visit highlights the risk-
taking embedded in experience and knowledge that is part of every
intuitive moment in a therapeutic process. The example also highlights
the need to be still and quiet in order to be open to intuitions.

The student was observing a group of very anxious people. In the
opening improvisations the therapist had been gently encouraging the
group members to take small steps with expression of their feelings. The
start of the session was difficult and the lack of confidence and anxiety
almost palpable in the room. The therapist has previous knowledge of
this client group and is aware of what is at stake for the individual
members. He feels physically a sense of loss, feelings of being stuck and
a lack of direction and flow within the music and the dynamics within the
group. But the visiting student provides a new opportunity and challenge
for everyone, the therapist included. The music pauses, the stuck feeling
continues and during a moment of stillness the therapist has an intuitive
feeling that the student could offer something. This is a risk. Some
passing gestures and a whispered enquiry bring the idea from the student
that she should sing a rather poignant song - an Eastern European folk
melody about autumn and the decay of the natural world. The risk pays
off because a new connection is made. The group is taken away from the
immediate preoccupation of their own painful experiences to a more
universal perspective, while still maintaining the link with individual
feelings. The group members are very curious about the meaning of the
song and talk in an animated way about their reactions. This sense of
liveliness is a real change in energy and dynamic. Out of this intuitive
moment has come a shift in the obstacles within the group therapy
process. The individual has been linked to the collective. The student is amazed by the potential power of her contribution - a beautifully crafted song presented with an innocent directness, as if telling a story.

In this session an honest risk was involved in inviting the student to sing but the request was also framed by the intellect in the way it emerged from the natural unfolding of the session. What appeared as spontaneous was embedded in the frame of previous knowledge: of the session; of this kind of group and the therapist's level of expertise.

(We were most grateful to Tiffany Hughes for performing live during the presentation the song called ‘Jesenska’.)

After the session Tiffany discussed the experience with her college tutor. She was very affected by how a direct expression at a crucial moment in a session had made such a powerful impact on the group and what occurred after. She was able to frame the experience within a developing clinical perspective and awareness of both group and therapeutic process. In this situation, both the student and the practising therapist were able to (according to Claxton) ‘let their minds go soft and quiet’ and in this state, something helpful and productive for the patients was created.

ON IMPROVISATION

Improvisation is at the core of much music therapy practice and is the action-product of our musical imagination and intuition, or ‘intuition in action’ as described by Nachmanovitch (1990: 41). Definitions of improvisation often involve ideas of a simultaneous combination of reflection and action. The Australian composer, Richard Vella describes learning to improvise in this way:
By exploring and reflecting, the user can develop a sense of musical thinking based on doing. The ‘doing’ informs the ‘thinking’ and the ‘thinking’ informs the ‘doing’. (Vella 2000: 99)

The *New Grove Dictionary of Music and Musicians* defines improvisation as ‘the creation of a musical work, or the final form of a musical work, as it is being performed’ discussing its significant existence in ‘virtually all musical cultures’ of the world (Nettl 2001: 94).

Music therapists also have to think of both musical and clinical requirements while playing ‘in the moment’. Such thinking links to our theme of connections between the imaginative, spontaneous process and the need for active thought as a boundary or shape.

Although the first British texts on music therapy seemed to make some categorical distinctions between playing therapeutic pieces and creative free improvisation, twenty-first century music therapists would probably have a more fluid idea of their work. Sometimes the music of sessions might start from established repertoire, for example with the song a patient brings to a group, but this can easily become played with and loosened. There might be changes in pace, style and expression, words altered by the patient’s current feelings, the group’s adaptations, harmony dramatically changed, rhythm adapted to match flagging or rising energy. Likewise, work which begins wordlessly with the exchange of expressive sounds might travel in any direction, perhaps ending with recall of some particular instrumental music or song. There is more the sense of a continuum of improvisation used in clinical practice with free playing at one end working through improvising in
various styles, extemporising on themes or pieces back to working loosely with (or even performing) a written piece.

We suspect that cultural influences and late twentieth-century shifts in music practice and education have all had their impact on the use of improvisation in therapy. The edges between traditional and popular forms from diverse cultures begin to be blurred by the improvisatory experiments of celebrated classical and pop artists. Nachmanovitch explores the weight and significance of improvisation in an inspirational way in his book of unusual ‘lightness’ *Free Play*, already referred to. Many ideas leap out for consideration, but here are some that emphasise why improvisation is the central force in music therapy. Firstly, the emphasis on the unfolding process rather than the end moment of public performance is a prevailing theme in the book. 'Not only is practice necessary to art, it *is* art' (Nachmanovitch 1990: 68). For the therapist the private work with patients exploring and experimenting with sounds and music has something in common with the musician’s world of personal practice. Both are part of ‘real music’ and by this analogy a necessary process in exploring our real selves.

Secondly, Nachmanovitch argues that improvisation, in its concentration on ‘the moment’ involves what he calls ‘continuous surrender’ - giving up control and allowing the surprising to happen. 'Improvisation is acceptance, in a single breath, of both transience and eternity. We know what might happen in the next day or minute, but we cannot know what will happen' (ibid: 21). 'The therapist's openness to the unknown in the patient leaves more room for the patient to contribute to any subsequent
knowing; and what is thus jointly discovered has a freshness which belongs to both (Casement 1985: 26-27).

A third idea is the ‘inside-out’ relationship between free play and limits, between spontaneity and security. Nachmanovitch describes all kinds of limits - such as the length of time, the shape and size of our hands, the size of the playing space and suggests that any of these frames or structures can ‘ignite spontaneity’. He quotes Stravinsky’s reflection that ‘The more constraints one imposes, the more one frees one’s self of the chains that shackle the spirit’ (ibid. 84), the paradox of structure offering liberation. Therapists might interpret these ‘constraints’ as strong clear boundaries. Again the notion of bringing an intellectual frame to shape the imaginative, intuitive free musical play comes to the fore.

**A FINAL NOTE ON INTELLECT**

In each of the three sections above - imagination, intuition and improvisation - were included comments that focused on the containing and framing aspects of the intellect. As proposed excessive imagination unregulated by the rational world can lead to chaos and disintegration; we need to translate and make sense of the intuitive moment through the intellect. Improvisations are held in musical pattern and form, the composer Alfred Nieman noting on many occasions during his teaching of music therapy classes that even the freest of improvisations contained within it an inherent logic and formal cohesion.

This rational underpinning or over-arching (depending on one's perspective) is a fundamental feature of effective music therapy practice.
The ‘thinking’ of the clinician based on observation, clinical knowledge and experience is what distinguishes music therapy from music making, education or the pure art. In training and clinical practice, therapists build a body of knowledge about features of illness, human development, theoretical constructs and musical forms and gradually accumulate a framework for shaping differentiated approaches to treatment, based on the needs of different client groups. The therapist needs to interact sensitively with clients, but at the same time to be able to watch the interaction, to note key points and changes, and to relate to mental constructs that underpin the work. The intellectual side of the work will also involve reading; relating work to knowledge of the client group; developing aims and strategies; planning for breaks and endings; discussing ideas in clinical teams; exploring appropriate theory and devising research. In this way, the intellect complements and supports the artistic areas characterised in the other three ‘I’s.

CONCLUSION

Why are these processes important in training? As Claxton asserts in relation to lifelong learning, we consider that the four I’s are important foundations for a career-long approach to music therapy. They instil in us good habits of learning, to carry through apprenticeship into the world of work. Learning to improvise, which is the basis of the musical part of UK trainings, is of central significance to therapeutic learning, in that it opens us to exploration and reflection simultaneously. The combined use of our intellect, imagination and intuition, as we have described, allow us to approach new problems with openness and concentration. We propose
a balance of: using models from our memory and experience, being receptive to the unknown in our use of the intuitive and being willing to take a creative risk in our embracing of the imagination. We consider that these processes contribute to the training of a well-integrated potential member of the music therapy profession.

(The paper then concluded with two extracts of video: one of a session of music therapy and the other, a trainee reflecting on the impact of the training process.)

The first example was a brief video clip of Christopher improvising with his therapist Sarah Chater. We chose this clip firstly because it links in some ways to the sensitive use of gesture in the earlier Handel example. As in the illustration from *Theodora*, here is this balance of imaginative processes framed in musical form and flow that appears almost spontaneous. As Wittgenstein is attributed to have said: 'It is obvious that an imagined world, however different it may be form the real one, must have *something* - a form - in common with it.'

Our second reason for the choice is to point up the differences. The music therapist demonstrates in her sensitive pacing, development of musical ideas and use of silence her intuitive understanding of the musical moment. It is also clear that such intuition is grounded in her knowledge of Christopher and their relationship unfolding over time. Critical reflection frames the intuitive and creative moment.

The second video extract of Adrian a current student in training at Bristol concluded the paper. Adrian describes eloquently the considerable change in his music and thinking that has been created by his music
therapy training, and demonstrates a powerful example of ‘lifelong learning’. The audience were left with his observations.

REFERENCES


Flexible Tempo Performance as Indicator for Expressiveness?

Busch, Veronika 1,2, Thomas K. Hillecke1, H. Volker Bolay1, Wolfgang Auhagen2

1 Deutsches Zentrum für Musiktherapieforschung (Viktor Dulger Institut) DZM e.V. (German Centre for Music Therapy Research)
2 Musikwissenschaftliches Seminar, Humboldt-Universität Berlin (Department of Musicology, Humboldt-University Berlin)
Contact: veronika@busch.net

Abstract

The empirical study presented aims at finding out how expressive behaviour and musical tempo performance are correlated and what effect this could have for music therapeutic treatment of patients suffering from chronic pain disease. In an experimental setting - with pain patients performing on an electronic drum while listening to a standard track of conga-improvisation with varying tempo - flexibility in tempo performance is tested pre, interim, and post music therapy treatment of 20 sessions. According to the „Heidelberg Model“ (Hillecke & Bolay 2000) music therapeutic treatment for patients with chronic pain disease focuses on emotional flexibilisation through musical flexibilisation. It is assumed that this treatment helps pain patients to become aware of their physical and emotional needs, and revives their sensitive awareness and emotional expressiveness. In addition to the musical experiment psychological questionnaires are used to measure treatment outcome and expressive behaviour. Preliminary results are presented.
1. Introduction

Although music psychology and music therapy research are both interested in how we perceive music and how music affects us, it is astonishing how little co-operation exists between these two disciplines. There is also not much research done so far concerning the causative factors which are specific for music therapy: that is the use of music.

The study presented tries to bridge the gap between music psychology and music therapy research. In examining tempo as one musical parameter the study tries to find out whether this parameter has any effect on the outcome of music therapy treatment.

This study is tightly connected to a project at the German Centre for Music Therapy Research in Heidelberg, which examines the effectiveness of music therapy in the treatment of chronic pain patients (Hillecke 2002).

About 7 million people in Germany suffer from severe chronic pain, like headache or back pain, for which no medical explanation can be found. The patients often have a long history of frustrating medical treatment without any relief. Therefore psychological factors are assumed to play an enormous role in developing chronic pain disease.

For the psychological treatment of patients with chronic pain disease a variety of concepts exists, two of them form the basis for the presented research. Traue (1998) introduced the concept of “inhibited expressiveness” that describes a psycho-physiological state of pain patients. The concept of “inhibited expressiveness” is based on the fact
that pain patients often show a very high muscle tonus without being able to realize it. They seem to be insensitive to their physical and emotional needs and Traue observed a discrepancy between physiological reactions, verbal expressions, and mimic-gestural behaviour of pain patients. The high muscle tonus might serve those patients to suppress emotional involvement (Traue et al. 2000). There is also empirical evidence that the chronification of pain is accompanied by an increase of introversion (Phillips & Gatchel 2000). The patients can hardly remember moments of well-being anymore and often develop depressions (Weisberg & Keefe 1997). The expressive abilities of chronic pain patients are very limited and also their emotional perceptions seemed to be reduced to only a few emotional qualities like aggressive-depressive. After many years of severe suffering pain is often the only sensation they allow themselves to feel.

This is meant by “emotional inflexibility”, a second concept in the treatment of chronic pain disease using music therapy (Bolay et al. 1998). Research has shown that music therapy reduces the perceived intensity of pain and the affective suffering (Hillecke 2002) and it is assumed that music therapy revives the sensitive awareness and emotional expressiveness of pain patients. Enhancing expressiveness through increasing musical flexibility and expressiveness is one important aspect of the “Heidelberg Model” for the music therapeutic treatment of patients with chronic pain disease (Hillecke & Bolay 2000).

Music therapists who treat chronic pain patients according to the “Heidelberg Model” explained that it is often very difficult to musically...
improvise with pain patients because their musical performance is very inflexible. They play within a very small ambitus, often choose the same instrument, and hardly exploit different levels of dynamic. But especially tempo variations seem to be very difficult for the patients. They are either unable to perceive accelerandi and ritardandi in music or they are not able to perform them. For the music therapists it was obvious that the pain patients’ emotional inflexibility and inhibited expressiveness is mirrored in their musical performance.

From a music psychological point of view it also seems plausible that especially tempo and timing parameters in musical performance would be affected by inhibited expressiveness. For tempo and timing play an important role in communicating emotions through music. During the last years a large variety of research has been conducted to analyse musical performance with a special focus on musical motion and gestures. Music as an art that unfolds as time goes by relies heavily on the general tempo of the sequence of musical tones as well as on the exact timing of musical onsets. Analyses of concrete timing structures of accelerandi and ritardandi have shown that these timing structures resemble timing structures of physical motions, like slowing down from running, and that listeners prefer those musical performances which imitate the timing structure of physical motions (Kronman & Sundberg 1987; Feldman et al. 1992; Repp 1992). Epstein (1995) suggests a parallelism between the mental control of musical gestures and the motor control of limb movements and Kopiez (1997) assigns an “iconic function” to final ritardandi in music because musical comprehension is built upon listeners’ knowledge of physical retardation in everyday life.
For Todd (1992) musical motion does not only lead to associations with physical motions but induces a sense of self-motion because of the physiology of the inner ear. There is also some evidence that listeners do not perceive music as a sequence of distinct events but combined as a gesture (Auhagen & Busch 1998). Clarke proposes that:

“…the sense of motion and gesture in music is a truly perceptual phenomenon, and that the perceptual information that specifies motion is broadly speaking the same as the perception of motion in everyday circumstances.” (Clarke 2001, p. 228)

So if we speak of musical motions and gestures we are not using a metaphorical expression but referring to perceptual reality.

For patients with chronic pain disease who are suffering from very high muscle tonus without realising it, who are often not aware of their physical and emotional needs or who are not able to express their emotions adequately through gestural, mimic, and verbal communication, it seems likely that their reduced expressiveness will be reflected in their musical performance, especially concerning tempo and timing aspects.

2. Question and Hypothesis

The aim of the study is to test whether inhibited expressiveness is a psychological characteristic of patients suffering from chronic pain and to develop an experimental setting for testing flexibility in musical tempo performance. The questions are whether pain patients actually perceive themselves as less expressive and whether they show lower musical
ability to react flexibly to changes in musical tempo than a healthy control group.

The hypothesis is that expressiveness and tempo flexibility are positively correlated: the higher the expressiveness, the better the flexible tempo performance.

3. Groups of Subjects

3.1 Experimental Group
The experimental group consists of patients with chronic pain disease who are medically treated at the Pain Centre of the University Hospital of Heidelberg and who receive additional music therapeutic treatment at the Music Therapy Outpatient Department of the University of Applied Sciences Heidelberg. Different diagnoses of chronic pain disease are included as long as the pain is not caused by cancer. The music therapy treatment they receive follows the “Heidelberg Model” which focuses on emotional flexibilisation through musical flexibilisation (Hillecke & Bolay 2000). The patients are treated in an individual setting with a total of 20 sessions, 50 minutes weekly. So far 14 pain patients have finished their treatment (sex: 11 female; age: 53.1 +/-10.5). This experimental group is tested 3 times on the psychological measures and the tempo flexibility test: pre, interim, and post the 20 sessions of music therapy.

3.2 Control Groups
As a first control group serve 21 pain patients who only received medical treatment at the Pain Centre of the University Hospital of Heidelberg
(sex: 14 female; age: 53.3 +/-8.9). This group is tested once on the psychological measures and performs twice the tempo flexibility test.

A second control group is formed by 30 subjects without any medical conditions and therefore without neither medical nor music therapeutic treatment (sex: 25 female; age: 50.7 +/-18.1). This healthy control group is also tested once on the psychological measures and performs twice the tempo flexibility test.

The third control group consists of 21 healthy students of music therapy who volunteered in a pilot study to test the experimental setting (sex: 13 female; age: 24.2 +/-3.7). The students are only tested once on the psychological questionnaires as well as once on the tempo flexibility test.

4. Method of Assessment

4.1 Psychological Measures
During the music therapy treatment a variety of psychological measures are used. The German version of the “Outcome Questionnaire” (OQ-45.2; Lambert et al. 2000) serves to measure co-morbid psychological symptoms (general therapy outcome). Pain intensity is measured by a visual analogue scale from 0 to 10 (VAS), and the affective dimension of pain are assessed by the “Pain Perception Scale” (“Schmerz-Empfindungsskala”, SES; Geissner 1996).

For the measurement of expressive behaviour the German versions of two psychological questionnaires are used: the “Inventory of Interpersonal Problems” (IIP, “Inventar zur Erfassung Interpersonaler Probleme”, Horowitz et al. 2000) and the “Affective Communication
Test” (FEX, “Fragebogen zum Expressiven Verhalten”, German translation by Traue 1998; Friedman et al. 1985).

The “Inventory of Interpersonal Problems” summarizes on 8 dimensions problems one can have in contact with other people. Subjects judge their interpersonal problems on a 5 point scale. The focus at this questionnaire lies on the dimensions being “too introvert” and being “too expressive”. The “Affective Communication Test” consists of 13 questions concerning the expressive style of a person. On a 9 point scale subjects rate their expressive behaviour.

Although the method of self-assessment in the field of expressiveness does not correspond very well with behavioural observations (Traue 1998), this method had to be used due to lack of financial and human resources which are needed to conduct large-scale observation of expressive behaviour.

The experimental group of pain patients with music therapy receives all the above mentioned questionnaires. The control group of pain patients without music therapy is measured on the “Outcome Questionnaire”, the Pain Intensity Scale, and the “Affective Communication Test”, as well as on a reduced version of the “Inventory of Interpersonal Problems”. The control groups of healthy subjects is only tested on the “Affective Communication Test” and on the reduced version of the “Inventory of Interpersonal Problems”.

4.2 Tempo Flexibility Test

To examine the hypothesis that pain patients show a less flexible tempo performance than healthy controls one needs standardized conditions to compare different music performances. Therefore the analysis of the music pain patients perform during their music therapeutic sessions was no option and an experimental setting for testing tempo flexibility outside the therapy session had to be designed.

This tempo flexibility test consists of a musical stimulus that was presented to the subjects via headphones. The subjects were asked to listen very carefully to the stimulus, to imagine that their therapist or someone else would be playing for them, and to drum along with the music on the MIDI-pads of an electronic hand percussion instrument\textsuperscript{38} using both hands. The musical performance of the subjects was also reproduced via headphones and it was recorded as Standard MIDI-File. The musical stimulus was realized as vibraphone sound and the subjects drumming performance as conga sound.

The standardized musical stimulus has a total duration of 220 seconds during which 35 different tempo sections are performed. One tempo section lasts for either 3, 5, or 10 seconds. The different tempi circle around a mean tempo of 100 beats per minute (bpm). In addition to quarter notes (the beats) eighth notes are realized. Whereas the metronome tempi are between 50 and 200 bpm, the onsets per minute (opm) tempi (the so called “inner tempi”, Christensen 1960) reach values between 60 and 252 and reflect the rhythmic activity of the musical performance.

\textsuperscript{38} We would like to thank Roland Elektronische Musikinstrumente GmbH, Norderstedt for their support of our research by providing us with a Handsonic HPD-15, an electronic hand percussion instrument.
stimulus (quarter and eighth notes). The metre is stressed by standardized velocity values for the beats.

5. Method of Analysis

5.1 Psychological Measures
The analysis of the different measures is conducted using the statistic software SPSS. The distribution of scores of the subject groups are described using error bars which show the mean and the 95% confidence interval of the distribution. Significant differences between the means are calculated by t-test. The correlation between different measures are tested using correlation analysis by Pearson.

5.2 Musical Measures
To analyse the musical performance of the subjects different measures were developed. These measures can be categorized either whether they are based on the general frequency of onsets per tempo section or whether they take the exact onset time into account. The present state of analysis neglects the velocity values of the onsets and only considers how many onsets are performed and at what time.

5.2.1 Measures based on onset frequency
The first measure “General Fit” describes how strongly the onset frequency of a subject correlates with the beat and the onset frequency of the stimulus, respectively. One receives two scores for every subject: the “General Fit” for onsets per minute and the “General Fit” for beats per minute. “General Fit” provides an estimation about the willingness of the subjects to follow the tempo changes of the stimulus. One can also
conclude from this measure whether the subjects orient their musical performance on the metronome tempo or rather on the rhythmic structure (the inner tempo) of the stimulus.

The second measure “Range” shows within which tempo span (maximum tempo / minimum tempo) the subjects realize their performances.

The third measure “Tempo Fit” calculates how many of the subjects’ tempi fall within +/-10% of the metronome tempi and the inner tempi of the stimulus, respectively. This means that, like in “General Fit”, two scores result for every subject: “Tempo Fit” for onsets per minute and “Tempo Fit” for beats per minute. This measure takes into account that tempo changes of more than 10 % are very obvious and easily perceived (Drake et al. 2000; Reed 2002). Therefore this measure has less strict criteria than “General Fit”, but corresponds to perceptual reality.

5.2.2 Measures based on onset time

For a more detailed analysis of the music performance measures based on the exact onset time of the musical activity are currently developed.

The first measure “Synchronisation” uses cross-correlation analysis to quantify how well the subjects synchronize with the stimulus and whether they perform systematic anticipations or delays in comparison to the stimulus.
The second measure “Inner Structure” uses auto-correlation analysis to measure whether the subjects’ performance show internal structure which might even be different from the stimulus structure.

The development of these measures is not yet finalized, therefore results can not be presented yet.

6. Results

One question to focus on at this early stage of data analysis is how psychological measures of the experimental group change during the course of music therapy treatment. Differences between subject groups concerning expressiveness scores will also be presented. For the musical measures it can only be referred to the control group of healthy subjects because the musical data of the other groups is not yet analysed.

6.1 Psychological Measures

6.1.1 Experimental Group

According to the “Heidelberg Model” successful music therapy for patients with chronic pain disease is indicated by improvements on three psychological measures concerning therapy outcome, pain intensity, and affective pain perception (Hillecke 2002). The following diagrams show the distribution of scores (error bars) for the 14 patients with chronic pain disease who are tested three times during their 20 sessions of music therapy.
The Outcome Questionnaire for general therapy outcome does not show any significant changes (pre-post: $t=0.936$, $p=.366$).

A somewhat different picture is drawn by the scales concerning pain.

At the perceived pain intensity one can discover a small reduction from the pre- to the post-therapy test, although pain intensity remains within a medium range and the difference is not of statistical relevance (pre-post: $t=1.157$, $p=.268$).
But statistically significant improvements can be found at affective pain perception.

**Figure 3  Affective Pain Perception (3 tests of experimental group)**

After 20 sessions of music therapy the pain patients are less affectively suffering from their pain. This means that the patients describe their pain as less “cruel”, “killing”, or “unbearable” than they did before music therapy (pre-post: $t=2.979$, $p=.011$).

For the measurement of expressiveness results of the Affective Communication Test (German: FEX) and the subscale being “too expressive” of the Inventory of Interpersonal Problems (IIP) will be presented.
Figure 4  Expressiveness (3 tests of experimental group)

The FEX-scores do not show any significant improvements (pre-post: \( t=0.475, \ p=0.643 \)). Therefore, one can not conclude that pain patients perceive themselves as more expressive at the end of their treatment. But recent calculations suggest that one has to divide the group of patients into 2 subgroups: one subgroup scores very high on the FEX, they describe themselves as extremely expressive, and another subgroup scores very low at the self-assessed expressiveness. But for now, the patients will be looked at as one group.

Figure 5  Interpersonal Problem of being “too expressive” (3 tests of experimental group)
On the IIP-subscale being “too expressive” in interpersonal relations one can see a tendency towards higher scores at the end of music therapy treatment (pre-post: t=-1.789, p=.097).

6.1.2 Group Differences
For the analysis of group differences the two groups of patients with chronic pain disease (the experimental group and the first control group) are combined to one group of pain patients (N=14+21).

Figure 6 Expressiveness (comparison of groups)

The comparison of the different subject groups reveals that pain patients tend to reach lower scores on the expressiveness questionnaire FEX than healthy subjects, although this difference is not statistically relevant (t=-1.428, p=.158). But the patients perceive themselves as significantly less expressive than the students of music therapy (t=-4.617, p=.000).

There are also interesting trends at the IIP-subcales being “too introvert” and being “too expressive”.
While the healthy subjects on both scales more or less meet the norm, the pain patients seem to encounter more problems in contact with other people because of introversion and less problems because of expressiveness. For the students of music therapy the scores are exactly the other way round: they tend to have less problems being too introvert and more problems being too expressive. But these group differences have only eye-evidence and are not strong enough to show statistical significance.

### 6.2 Musical Measures

Up to now, only the music performance of the second control group of healthy subjects is already analysed using the three developed musical measures based on onset frequency.

The next figure shows the two scores of the musical measure “General Fit” at the two points of measurement.
Figure 8  Musical Measure General Fit (2 tests of healthy control group)

One can see that both scores – the beats-per-minute (bpm)- and the onsets-per-minute (opm)-score – improve at the second test (bpm: t=-2.408, p=.023; opm: t=-2.33, p=.029).

Figure 9  Musical Measure Range (2 tests of healthy control group)

The musical measure “Range” shows a very strange effect: a reduction at the second trial, which might be caused by a few extreme musical performances (t=2.006, p=.054).
Figure 10 Musical Measure Tempo Fit (2 tests of healthy control group)

The musical measure “Tempo Fit” again has two scores which display an interesting trend: while the subjects show an improvement on the bpm-score, their second performance seemed to be slightly weaker on the opm-score. This might indicate that at the second trial the subjects synchronize their performances more closely with the metronome tempo of the stimulus on costs of synchronising with the rhythmical structure (the inner tempo) of the stimulus. But the differences show only a statistical tendency at the bpm-score ($t=-1.731$, $p=.094$).

6.3 Correlation between psychological and musical measures
For now the final step of analysis is to correlate the psychological scores for expressiveness (FEX) with the musical scores of the healthy control group. The calculations reveal positive correlation coefficients of statistical relevance between the FEX-scores and the musical measures General Fit (bpm) ($r=0.377$, $p=.040$), General Fit (opm) ($r=0.344$, $p=.063$), and Range ($r=0.403$, $p=.027$).
7. Summary

The study has shown that patients with chronic pain disease tend to perceive themselves as less expressive than healthy subjects. Therefore the results support the concept of “inhibited expressiveness” which forms the basis for the “Heidelberg Model” for music therapeutic treatment of patients with chronic pain disease.

Whether expressiveness and emotional flexibility is mirrored by musical performance was the guiding question in developing the musical tempo flexibility test. The analysis of the musical performances of the healthy control group showed that there is an habituation effect. Only by performing the musical test for a second time significant improvements were found. Therefore when it comes to the analysis of the music performances of the experimental group one has to be very cautious. Possible improvements in music performances can not simply be interpreted as effects of music therapy, because habituation to the test situation must be taken into account.

Very interesting is that there exist significant correlations between the psychological and the musical measures: the more expressive the subjects judge their behaviour, the better they perform at the tempo flexibility test. This result encourages that flexibility in tempo performance might function as an indicator for expressiveness, and that a musical test might be as helpful for music therapists as psychological questionnaires are.
8. References


Music Therapy Intervention For The Visually Handicapped At The Rittmeyer Institute For The Blind Of Trieste (Italy)

Busolini, Rosanna

My experience of working with blind children developed over a number of years at the Rittmeyer Institute for the Blind of Trieste where the Centre of Music Therapy is active.

Music Therapy was first introduced to the Institute thanks to the work of Luigi Mauro. He introduced to Italy both the pedagogic principles of Carl Orff and the later reconstruction of his work in terms of Music Therapy developed by Gertrud Orff.

This is active Music Therapy, which stimulates creative activity in children with sound, rhythm, movements and words. This enables each individual to reach their highest level in cognitive, expressive and communicative terms.

The main points of the technique are sound and rhythm expression of the body and the use of “Orff instruments” considered in three aspects: touch, sight and sound.

The instruments are used producing a melody in the pre-melody style, where there is no recognisable melody and/or in pre-rhythmic style, without a precise rhythm.

The technique is particularly interesting precisely because a non-verbal channel of communication is activated. This is the essence of Music Therapy.
In the Music Therapy session the elaboration, the interpretation and the recognition of non-verbal communication are fundamental aspects, which originated from the intrauterine communication between mother and foetus.

The range of instruments should be used sparingly: the instruments to be used should be chosen carefully according to the established aims. This is to avoid overloading the child with excessive stimulations, which could lead to a lack of attention and interest and impede spontaneous and above all creative behaviour.

During the session, music, language and movement need to be adequately integrated.

Even though the sessions are conducted in a flexible way, the therapist must work according to a structured plan, following pre-established strategies.

This is particularly important for individual sessions.

Specific exercises are structured according to each individual handicap.

These handicaps include: sensorial deprivation, affecting sight, hearing and language, movement disturbance, mental disorder, personal disturbances and autism.

As elaborated by Gertrud Orff, the work carried out is aimed at simultaneously stimulating the senses and the organism of the child with a variety of impulses, with the assumption that one or several stimulants together will have an effect.
Sometimes when a channel of communication is interrupted, because it is physically damaged and unable to process messages received from the external environment, other channels can take on a vicarious role.

This working technique is also based on the results of physiological research, which demonstrates an interdependence of the body’s biological regulation systems.

Another interesting aspect of the original pedagogic method is the wide use of the pentatonic scale linked to Orff’s theory of the use of “elementary music”. Due to the absence of semitones, this scale allows a free exploration of melody without the problems of the choice of notes and almost always provides satisfactory results from a musical point of view.

According to many experts, this scale is a sort of “originating scale” which can be found in a great number of musical cultures and is always present in children’s chants.

The scale is developed from the ideal interval of minor third descending which forms the basis in many countries for “conte”, nursery rhymes and lullabies that children all over world sing during play.

I am very fond of recalling how Luigi Mauro described: “[…] the minor third descending interval, which is present in all lullabies, rounds, “conte” and in nursery rhymes, in the cry of the pedlar, in the chant of the huge crowd urging their team on at the stadium […]” and in my opinion that represents the first cell of universal sound.
In group work, wide use of “ostinato” and of “bordoni” is made, creating a many layered sound during the musical performance. This creates a kind of polirithymic stratification.

The group work doesn’t require highly developed skills, but it manages to involve the entire group of children, even the less attentive.

During the course of a number of years of research, study and application of music therapy at the laboratory of the institute, I have been able to experiment various musical activities in the context of prevention and education, organised and aimed at children and adolescents attending the centre. As a consequence the above describe method has been enriched and integrated with new principles developed in music therapy in recent years with special attention being placed on the specific problems of visually handicapped children.

I personally believe in a broad vision of theoretical aspects which can be integrated and enable the construction of a comprehensible and applicable methodological model.

The theoretical principles that have enabled me to carried out a music therapy project which in my experience enrich, reinterpret and adapt this method are the following:

• The ISO principles – as described by Benenzon. It is the combinations of sound, acoustic and movement energy which belong to each person and make them an individual. This flow of internal energy is made up of sound inheritance, the sounds perceived by the foetus and the sound experience from birth to adulthood which comprises respectively: Universal ISO, gestalt ISO, cultural ISO and group ISO (Benenzon, 1999). Universal ISO contains in the subconscious the fundamental sound energy inherited over thousand of years. These belong to mankind and in Western man they are the following: the binary
rhythms of the heart beat, the sound of respiration, the pentatonic scale with second and third intervals, the tonic and dominant, the perfect chord, the obstinate, the canon, a silence.

- The intermediary objects consider an element, which enables the flow of communicative energy from one individual to another.

- The integrating object considers a body-sound-musical instrument which enables the flow of the communicative energy among more than two people and which therefore facilitates more than two channels of communication at the same time.

- The “transitional phenomena” of Winnicott: there is the series of activities such as vocalisation, lallations and the first nursery rhymes which the child uses to keep himself company, and which help him to recover the original unity by means of the recovery of an original sound and rhythm which although they speak of this world, they also speak of another world (Fornari, 1984). According to Winnicott transitional objects and phenomena belong to an area of human life which is found neither within the individual nor outside the world of the shared reality. In this area, the child uses his imagination to recreate his physically absent mother substituting her with a mental image which takes on her role, and this is at the origin of the creation of musical figure. In music therapy the recovery of the world of sound of the early infant stage helps to achieve what Winnicott himself defines “holding”. This takes place thanks to the specific propriety of music with its physical, acoustic, sensorial and motor aspects, as well as other characteristic elements which are typical of sound sequence such as rhythm and rest.

- The use of PLAY as described by Winnicott “[…] play is universal and belongs to good health; play leads to group relations, facilitates growth and therefore good health […]”. Giving children and adolescents (in this case suffering from visual impairments or other disorders) the chance to express themselves through sound, rhythm, movement and play, doesn’t only mean participating in a creative experience but also, as Gaddini states: “[…].the aim of creativity consists in allowing the subject to take shape and face all situations but the aim is also to direct ones own attention to prevention”.

- The theory of harmonisation of the handicap: this is a strategy which utilises sound/musical parameters to enable the enhancement of the development of the syntonisation of the affective nature. According to the theory of D. Stern this constitutes the basis of any type of non-
verbal communication. To summarise, the syntonisations are the technique which aims at a better integration of the personality. They can be:

- syntonisation of the synesthetic variety, that is the transmodal translation which enables the affective quality of behaviour;
- exact syntonisation, that is, identical imitation of behaviour (sound reflection, imitation, repetition);
- inexact syntonisation, that is, a slight variation of the presented stimulation (theme with variation).

The concepts outlined so far have been put into practice, in individual and group musictherapy sessions using special sound and musical techniques.

Before describing this aspects a number of psychological and organisational features need to be kept in mind which are essential for a successful session.

There are a large number of fundamental elements for the planning and implementation of the intervention.

These include: the regularity of the session, the organisation of the music room and the instruments, a careful compilation of the information necessary for compiling a sound and musical case history, the register which records the activity carried out during each session, the evaluation meetings with the team responsible for the re-educational intervention.

The activity which should be centred on the healthy part of the body, particularly in the early stages, can be non-completely guiding according to the abilities and the difficulties of each individual or group.

During the session, the music therapist makes their musical presence felt in the relationship which is being created.
Particular attention is made to not condition or limit expressiveness. Instead, where necessary the proposals (of the individual or the group) are taken up in a sort of “dialogue” which takes in consideration the exclusive sound dimension and therefore non-verbal.

The sound dialogue (and I refer to the Orff method which, as we have seen, uses musical sequences based on question and answer, as for example the various formal models: echo, rondò, ostinato, variations…) can take place through a gradual process distributed in a numbers of stages which naturally are modified according to the level or severity of the handicap.

Generally, the course of activities evolves from a passive to a stereotypic attitude, eventually arriving, if there has been positive communication, at an imitation phase, which follows the question and answer pattern typical of dialogue.

The music therapist using this type of intervention must not only identify with the patient and therefore try to understand their musicality, but also emphasise and harmonise their inner world.

A good way of beginning the session is to propose a kind of greeting, a repetitive “rite” which offers the individual and the participants of the group a feeling of welcoming, constancy, the security of a recognised place and time. In this case, the exchange of the greeting followed by the child’s name, sung or played in the interval of minor third descending can be a joyful and gratifying experience.
The time dedicated to improvisation is without doubt the most important for intensity and duration. It allows the individual to express their own feelings without the difficulties of using the spoken word.

It can be a creative-communicative moment for listening to each other and there experience in the here and now. According to the type of programme and to the way the music therapist verbally communicates (using simple, clear and understandable sentences) various instruments placed in the centre of the room will be used. Other instruments may be added to these during the course of the following sessions.

The instruments used belong to the traditional group of Orff instruments: xylophones, metallophones, glockenspiels, bass bars, timpani of various sizes, big drum, bongos, cymbals, bells, maracas, sticks, integrated with folk instruments, ocean drum, guitar, celtic harp and the piano always present in the room.

My experience of a number of years of work with blind or severely visually impaired children has made me realise that the immediate introduction of improvisation in the early session tends not to be effective and fails to involve the participants.

Each individual requires their own time to become familiar with the instruments and above all with the surrounding environment.

How is the music therapy room set up? How big is it? Where are the windows? Where is the piano? All these are questions that most of the patients (those who are able to move and walk by themselves) can ask themselves during the first exploration session.
For those confined to a wheelchair, getting to know the space will take place in their own good time. To assist them in this, they will be able to hear the sound of the instruments of various sizes, timbre and material placed at various distances from each other around the edge of the room. This creates a kind of sound route which will remain fixed in the following session. These instruments should be kept in the same position at the beginning of each session, although they can be moved by the patients if they wish.

So for I have spoken about the layout of the room. I will now proceed to explain a part of, and then if possible, the entire range of instruments.

Each instrument, whether small or large, will be explored handled and played in both a conventional and non-conventional manner.

During group session, one instrument is passed around the group; each participant plays their own musical production. This will last a fixed period and will allow the music therapist the possibility of getting to know the sound expression characterising each patient.

In this way the sound parameters of the instrumental sequence can be analysed in turn: pitch, intensity, timbre, duration, together with the rhyme, the creativity and the imagination of the individual or the group.

All or some these activities will be experimented according to the level of cognitive ability and will be for the music therapist important elements for structuring and planning the next music therapy course and evaluating, where possible (after a limited number of sessions), a greater
understanding of the handicap (and whether spatial integration should be the first or simply one of the objectives to be reached).

The music therapy intervention structured in this way aims to facilitate an integrated project of personal identity which as described by Grinberg and Grinberg (1975) constitutes the first step towards an awareness of the existence of both an internal and external world.

With regard to spatial awareness the above-mentioned distinction between self and non-self enables the confrontation with external objects and the ability to perceive differences and leads to the acquisition of a primitive body scheme and knowledge of one's own position in the surrounding space.

These technical aspects confirm the importance of the technique of “exploration” of the sound/musical material and the collocation in the music therapy setting.

Furthermore, it should be noted that the exploration phase can influence the emotional/affective state of the patient, transmitting a sense of security, a starting point for experimenting differential situations, such as the more complex and profound situations of musical improvisation.

Once this initial phase has been completed (which as I have already underlined will have a specific duration, according to the needs of the individual or the group), the technique of musical improvisation can be proposed, which will occupy a large part of the session.

This is manifested as a spontaneous production of sounds of a variety of types, including vocal, and go from a hum of various intensities and
sounds produced by lightly touching the stretched skin of a drum with the hand, to loud and very loud sounds given off by large instruments (bass drum, bass xylophone) struck with mallets of various sizes. These low notes can evoke the rhythm of the heart, of footsteps or of particular experiences, such as expressed by one of the children of the Centre, who recalled the rhythmic sound of horses hooves. As the improvisation progresses, my job is to pick up on the formal qualities of the group (sound) production, to echo them and transform them into recognisable sounds, which enable the exchange, the alternation and the possible creation of a “unified music”. Playing together in a group produces in the child the joy of playing a game, and allows the release of anxiety and aggression and other defensive behaviour (which often hide other problems) brought into the music therapy room. In some cases, it can be useful to provide a more organised structure to the improvisation. In such circumstances the pentatonic scale (achieved by removing the F and B bars from the C major scale) and/or some modal scales are especially recommended.

The length of the improvisation varies according to the age and the disabilities of the children. Either it comes to a spontaneous end, or it concludes following my request (this can be a simple verbal invitation or a light pressure of my hand on the children’s shoulder). Of course, this will depend on a careful analysis and evaluation of the particular situation. The sounds produced can be toned down or transformed, adding to them new and different proposals, or repeating activities experimented in previous sessions, such as singing and playing together a song, or a nursery rhyme, or a game involving sound, music and
movement. Repetition in this case takes on a particular meaning: it helps the members of the group to recognise each other and to have fixed points of reference. Sound games in which each member of the group takes it in turn to play one or more instruments allow each child to express their own state of being, to increase their attention span, to learn “to wait their turn”, to tolerate the wait and to listen to their classmates.

In the practical organisation of this activity, which is not always easy to carry out, the aim is to gradually reach a shared harmonic and rhythmic course and a conscious ability of control.

The task of the music therapist is a difficult one which often cannot be adequately expressed in words capable of rendering the intensity of the relationship, the minor and imperceptible progress, the moments of standstill and the difficulties in comprehension.

The correct application of a methodology, a patient and willing attitude and often a long period of time will enable the established aims to be achieved. It is hoped that the results obtained will not only be taken outside of the music therapy room, but also be long lasting.

According to current clinical studies, visual impairment goes beyond the confines of simple sensorial deprivation, being amongst the risk factors in disturbances of mental development.

In the more severe cases, being deprived of an understanding of the surrounding environment, such as the perception of the shape of everyday objects, of depth and of colours limits the child’s complete understanding and memory of the object itself. This can compromise the
development of personality to the point that, according to some authors like Moretti and Canaan (1988), the child assumes a number of characteristics such as reduced planning abilities, operational confusion, dependence, resignation, extensive passivity, insecurity and a tendency to withdrawal and isolation.

Another aspect which needs to be kept in mind regards the different influence that the visual impairment has with respect to a variety of variables, such as the age of onset and the degree of residual sight.

Children affected by congenital visual impairment are at risk of damage of a different origin which involves the progressive loss the stimulation and information necessary for the development of intellectual potential and which can also negatively influence negatively affect the sphere of interpersonal relations. Consider the enormous loss for the child of visual contact with the mother, which can lead to difficulties in communication. In this case, maternal “sounds” (of the body and the voice perceived also in the foetal period) take on a significant importance, because they offer the newborn child the possibility of tuning in to the verbal messages of the mother. For unimpaired children those messages, together with motor and sensorial messages, make up the first stages in the development of personal identity. That is why it is important to intervene as early as possible, so as not to deprive the child of that stimulation, of those feelings, of those experiences aimed at supporting a course towards independence.

An appropriate use of hearing can present considerable difficulties, given that the child perceives a chaotic and undifferentiated array of sounds
that do not allow him to effectively link the sound or noise with the object that makes it (as the case may be with a musical instrument). There can be a certain amount of confusion, or the child may think that the object is the sound itself. It is therefore of fundamental importance to help the child to establish a correlation between the sound and the object, by demonstrating the object’s shape, position, surface, temperature and method of use.

With regard to the sense of touch, special attention needs to be placed in stimulating the hands, which should be “curious” and not blind. To effectively develop a good sense of touch it is important to undertake the planned activities in a relaxed and affectionate climate characterised by a sense of playfulness (consider for example the explorative handling of the various musical instruments suitable for the purpose), together with a coherent vocal/verbal message which is as pleasant as possible with regard to rhythm, tone and intensity.

The complementary nature of these two senses, hearing and touch, together with information provided by smell, temperature differences and the work of the muscles used in movement, can offer the visually impaired person the possibility of strengthening and enriching their perceptions, improving their knowledge in doing so.

In contrast with the world of sound, silence is the real darkness for the blind. Silence here is intended not only as an environment absent of all manner of stimulation, but also as the silence of the interlocutor, of the person nearby. This sensation of silence in the wrong doses creates unease, because it is incomprehensible and badly interpreted. At the same
time, darkness can also be represented by an excess of noise or chaotic sounds, which leaves the visually impaired individual with a negative experience, a sense of loss, such that he may even lose the very same representation of himself (Mazzeo, 1997).

These aspects are to be kept sharply in mind during the various music therapy activities, distributing and graduating the instrumental and vocal sounds which can be experimented during the session.

Unfortunately, however, the visual impairment in many cases is the most evident problem in an entire series of more or less severe disturbances, such as psychosis, autism, behavioural and learning disorders, mental retardation, Down syndrome and numerous others, to which are added an entire series of problems linked to familial and extra-familial relations.

Almost all of the children who attend the centre at the Rittmeyer Institute, as well as being visually impaired to varying degrees, are affected by an entire series of physical and mental disabilities, such that we speak of visual impairment in the presence of multiple disabilities (or additional disabilities).

The therapy they receive is organised and planned by a team of professionals from various fields and includes a series of integrated activities such as visual stimulation, psychomotor activities, hydrotherapy and music therapy, to which is added a scholastic support programme.

Music therapy finds a rightful and useful place amongst these activities. It offers the child the possibility of entering and rediscovering the world
of sounds already familiar to him (the prenatal sound experience). It increases not only his self-confidence, but also his musical and non-musical communication, and above all positively influences his emotional growth with the aim of achieving the highest level of harmonious re-composition possible.

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The elderly Jewish woman living with Dementia could be heard all the way down the hall yelling “Mama, Mama”, in her room. I closed off the group I was doing in the dining room. Priorities had shifted. As I knocked on the door and began to open it, she pushed the door closed, and sang “They’re opening the door.” (M.E. #1) I let go of the door and began to sing “oy mama” (M.E. #2) in a soft, minor, lullaby-like, Yiddish-style melody. She slowly began to open the door and let me in. As I closed the door she hugged me and said, “G-d bless you for coming. Thank G-d you’re here.” She was physically shaking. I resumed singing the same melody and she started to sing as well. We walked to the bed and sat beside each other, my hand on her shoulder. We rocked side to side. She hummed and I hummed. She sang and I sang. She sounded mournful. I noticed she was shivering in the thin nightgown she was wearing, so I put slippers on her feet, a blanket on her legs, and a blanket on her shoulders. She stopped shaking and became visibly relaxed. She began to look tired. I helped her to climb into her bed, covered her and sat with her until she fell soundly to sleep.
Introduction

This presentation describes a way of working in voice-centered improvisational music therapy with residents living with Dementia, their families and caregivers. I describe a setting and the processes that seemed to develop organically out of music therapy sessions in the special care unit environment of Louis Brier Home and Hospital,
Vancouver, British Columbia Canada's Jewish Home for the Aged. I describe my style within this framework and my own sense of how to communicate and map the processes. This is a work in progress. Though I leave the setting to begin graduate studies at Temple University this fall, I hope to further focus on this material at another time. In my early days of presenting and indeed through part of my preparation for this congress, I framed it as a developing model of practice. I am no longer completely sure if that is an accurate way to describe it. I feel it has the potential to develop into a model but prefer not to call it that at this time.

The congress participant will find this paper organized into the following categories:

1. Background Information,
2. Contexts and Frameworks,
3. Salient Concepts - Therapeutic Process and

**Background Information**

Louis Brier Home and Hospital services the needs of Jewish and non-Jewish residents in a multi-care-level, long term care setting. A majority of residents in the facility are Jewish but a more heterogeneous population exists in Special Care. I began working there when the special care unit was only two months old. Music therapy was introduced, in part, to help mediate some of the stresses that staff, residents and families were experiencing.
From the beginning I found staff extremely supportive and helpful. They immediately referred high-need residents and understood the importance of quality-directed care. I was given the space to experiment so that I could truly learn to meet the needs of the unit in a most effective and appropriate manner. Many different thoughts and practices came out of that experimentation. I would like to share some of them with you today.

**Contexts and Frameworks**

My early experiences on the unit taught me the importance of being flexible and ‘in the moment’ so that I could meet priority needs as they developed. Out of this I learned to visualize the whole shift as a session with individual sessions in it, some with distinct boundaries and some without. I made scheduling decisions and grouped people together directly in response to observation, process and environmental cues and I worked in a free flow style that could incorporate both emergencies and pleasant surprises. I still work that way. I begin each shift by observing the environment and asking staff who they feel needs extra attention. I engage with residents and I speak to family. I meet overt priority needs or begin where it naturally feels right to begin.

I visualize a 'group' that includes all individuals in the special care unit environment. I believe resident-centered care requires sensitivity and attendance to the needs of family and staff. As I support a resident within a resident-centered model, I also respect the impact on families and staff and the secondary impact their stress can have on a resident, so I use purposeful interventions to ease their negative experiences and promote positive ones. In a way, I incorporate components of a palliative care
framework. A palliative care framework respects the wisdom of residents and family members and it recognizes the toll care giving can have on staff in a challenging environment. Supported individuals are better able to support others. And residents, families and staff deal with issues of death and dying in Special Care. The CPCA Standards Committee definition of Palliative Care (1995) reads as follows.

_Palliative Care, as a philosophy of care, is the combination of active and compassionate therapies intended to comfort and support individuals and families who are living with a life-threatening illness. During periods of illness and bereavement, palliative care strives to meet physical, psychological, social and spiritual expectations and needs, while remaining sensitive to personal, cultural and religious values, beliefs and practices… Palliative care is planned and delivered through the collaborative efforts of an interdisciplinary team including the individual, family, caregivers and service providers. Integral to effective palliative care is the provision of opportunity and support for the caregivers and service providers to work through their own emotions and grief related to the care they are providing (cited in Pelman, 1999, section 1, introduction)_

Carolyn Bereznak Kenny writes:

_The clearest point for me is the idea of the importance of loving and creating. The value of a loving and supportive field which has its goal the creation of beauty seems to me a simple human ideas which is clear and unequivocal for any type of development, therapeutic or otherwise (Kenny, 1989, p.7)._

A warm, loving environment is essential to resident and non-resident quality of life. We all value a warm and close environment in our Special Care Unit and everyone contributes to it, as they are able. Diagram #1a, seen in appendix #2, shows my vision of resident, family and staff co-empowerment within a framework where the music therapist is providing the supportive container. Though I may lead and facilitate, it reflects a commitment to leave room for and support the leadership and healing/
teaching abilities of others as they may naturally arise. The intertwining
lines on the outside represent all three groups as an integrated whole, the
part of community that is the sum and bigger of all its parts.

I try to provide a ‘psychic container’ for individuals in the unit every time
I enter it. I communicate warmth, caring and acceptance of residents,
families and staff in all their full spectrum of emotions and experiences.
At times, I find residents calming each other or engaging with each other
in languages none of the staff can understand. More than once I have
counted on a resident to help translate and assist in my de-escalation of
another resident's agitation. I feel we all have the potential to be healers.

I infuse the environment with humor, creativity and fun. I do this to
counteract some of the coldness individuals can feel in a clinical
environment. I use almost any opportunity to sing. I can be found rolling
down the hall on my favorite chair, singing to a resident, staff or family
member. I dance, do impromptu ballet steps. Some times I break into a
'cowboy accent'. I do whatever feels right in the moment to connect with
and add to the 'joie de vivre' of individuals on the unit and I find residents
sharing both subtle and overt humor through their creative musical
improvisations and their verbal and non-verbal interactions. We do a lot
of laughing in Special Care.

With a mixed population set within a primarily Jewish environment I
sometimes find myself using music without lyrics to bridge gaps between
cultures. Myself, residents, families and staff improvise around cultural
and religious preferences of each different resident. Music, especially
song, features prominently in the religious practice and secular
experience of Jews of all ethnic backgrounds and affiliations. We share a common biblical language, common texts and common holidays. We express all aspects of life, of struggle and overcoming, of joy and sadness through music. We express our commonalties and differences through cultural and ethnic treatments of optional religious melodies and folk music (Shiloah, 1992). The Hassidim, an orthodox branch of Jewry, sing Niggunim, prayers without words, to “express feelings before G-d that are too delicate or intimate for conventional, verbal language” (Rykov, 2001, p. 71). I work with residents who have lost the ability to use purposeful language. In some cases I observe some of them sing Jewish sacred and secular melodies in ways that suggest a similar emotional and spiritual outpouring.

Rykov (2001) describes characteristics of Jewish music. The emphasis on vocal music, especially a cappella singing, the high value given to music and the importance given to ornamentation and improvisation all clearly resonate with what I have experienced develop in our setting. As a Jewish music therapist and singer working in a Jewish facility, I would be surprised if I was drawn to working in a way that conflicted with these characteristics, but I find it interesting that a naturally developing style so clearly fits with an established list of characteristics. What it tells me, perhaps, is that, if I am really listening, if we are really listening in our environments, we can come to a place of reflecting them organically through music.

It is important to recognize the many issues specific to a Jewish environment including those presented by a Holocaust history. Survivors
sometimes respond to institutional triggers in ways that seem out of context because they are re-living their memories. (David, date unknown) A shower might remind a resident of the gas chambers. A locked unit might trigger memories of a concentration camp (Bernick et. al, 2001). Families might respond with heightened feelings of loss. I remember framing one family member’s reactions by recognizing that she had lost everything in the Holocaust. Her husband’s Dementia was taking away everything she felt she had rebuilt.

**Salient Concepts – Therapeutic Process**

*Music Therapy involves the process of therapy shared between a trained Music Therapist and client with elements of Music, Person, Relationship and Environment serving as raw therapeutic material. Through the primary, improvisational use of music, the Music Therapist and client co-create a dynamic and creative medium for positive change and maintenance of abilities in areas of the client’s physical, emotional, mental, social, communication, spiritual and musical states.*

Elements, as raw therapeutic material, interact with each other through musical and non-musical improvisation. Improvisation is clinically imperative within a dementia context. It facilitates a flexible, in the moment, process-directed and priority-directed response. The therapeutic/musical use of improvisation involves the application of music in terms of its elements. Elements are altered in the moment to invite, respond to and engage with therapeutic process. The process applies equally to both through-composed and familiar music contexts.
and to non-musical processes such as scheduling, group and session makeup.

Improvisation patterns and draws out the most flexible aspects of self and environment. It introduces an experience of musical conversation in a context where residents may have lost other avenues to meaningful interaction. We assume a flexible cadence where sound and silence can naturally interact at a speed allowing the resident to recognize, engage and respond. We remain open to creative opportunity and a larger awareness of self. (Kenny, 1989). Improvisation aligns itself with the non-linear, intuitive aspects of experience (Ralston Saul, 2001). I feel like it resonates with the permeable, shifting nature of consciousness and experience observed in the person living with Dementia. As an equal partner with clinical expertise, intuition draws on those aspects of the therapist’s wisdom less describable; those aspects felt on an emotional/somatic level (Raulston Saul, 2001) A music therapist working in an intuitive improvisational style must learn to trust his or her inner wisdom.

**Musical Media and Their Application in Therapy**

I use voice as a primary instrument because it works. Voice is the most powerful of instruments. There is nothing that separates it from self. There is no intermediary object and no separate physicality. It is a direct expression of self. Voice and person are one; each the other’s instrument; each the other’s vessel. Voice is a vibration of fundamental human energy. There are those who view disease as blocked energy. If we accept that premise, as I do, we can say that the potential exists for a person to
knowingly or unknowingly, metaphorically or practically break down blocks from within.

In the words of Leonard (1978): “We now know that every particle in the physical universe takes its characteristics from the pitch and pattern and overtones of its particular frequencies, its singing.” (Cited in Kenny, 1989, p.7)

Voice is not dependent on language or cognitive understanding. It is elemental. Sound itself is the language. Every response and every sound can be understood and/or experienced; gain significance and find equal merit within a therapeutically and musically integrated fabric of both communicated and reflected process. Through sound a person’s existence can be voiced and validated. “It is through you that I know I exist; you help me define my reality” (Pavlicevic, 1997, p.15). The Music Therapist and client have the potential to co-create a basic dynamic interrelationship that is separate from the sensory effect of other more intermediary sources.

I use Voice and other musical media in terms of their elements to help me invite, reach, engage with, match and expand the vocal, verbal and non-verbal responses of residents. I energize, focus and excite residents through dramatic shifts in dynamics and percussive use of Voice. I use body movement, body percussion and an assortment of percussion instruments to highlight and expand the effect. I slow and concentrate vocal sound to allow time for music to ‘land’. I watch for eye contact and signs of attention and track to extend that attention. Sometimes I use Voice as a container. I hang on to every vowel and every word. I image
my voice, its sound and energy like ‘taffy’: to reach, stretch around and encompass, contain and help to ground the energy of residents and others in the environment. Diagram #1b in appendix #2 shows my sense of the flow and process involved in reaching and engaging with a resident. I show the potential directions and interactions and the interplay between engagement and silence. In diagram #1c, appendix #2, I highlight the importance of 'celebration' in therapeutic process, especially in terms of its effect on motivation and activation. Of course, implicit, is the value of celebration for celebration's sake, the value of acknowledging, celebrating and helping a resident to celebrate his or her beauty and ability and musical self.

Residents can open and transcend superimposed, perceived or actual limitations. I am reminded of one particular man with Alzheimer's disease and Aphasia. His family was very upset and conflicted in his first week of admission. They hadn't wanted to move him in. When I met him he seemed withdrawn and minimally responsive. He had a flat affect as he sat silently with his frustrated wife trying unsuccessfully to feed him medication in a banana. I asked that we bring him to his room and as he sat quietly, I got an intuition.

"HELLO!" I sang it at the top of my lungs. It was a spontaneous hello, my intuition transformed into action. I had never initiated a session with anyone quite like that before. He came alive, eyes shining, a look of surprise and engagement. “ARAARH!” He sang at the top of his voice… sudden, strong and beautiful. I matched his sounds. He matched mine…a dramatic transformation.

We discovered a unique way of working together partly inspired by that first meeting. Video excerpts of our interactions show a level of intensity that developed organically out of process. I alternate subtle non-verbal/
verbal interventions with loud, dramatic use of voice. I move right into his space at times in order to reach him. I watch his non-verbal and verbal behavior, his motivation and his initiations and responses very carefully and I shift in response to them. I see his engagement and motivation increase and I see him express himself with intentional eye contact and a big smile on a face that normally reflects minimal emotion. He shows his engagement through that smile and through the eye contact and tracking. He follows my every move. I shift my position all over the room, often singing an improvisation based on the words "I'm over here." In response, he surprises me with sudden movement and a playful manner. We interact back and forth non-verbally. He communicates through laughter, sudden sounds, coughs and the rare "yes!" He initiates connection. He moves his head or his hands. He reaches out to take a maraca. He hits my maraca with his. He extends his normally stiff arms. We "box". His wife says he used to be a boxer.

Residents engage in beautiful vocal improvisations; the sparse percussive kinds like those featured in the video excerpts and lush harmonic and melodic ones. They engage in improvisations reflecting a variety of themes, emotions and cultural/religious orientations. Improvisations show residents demonstrating independence and leadership, reaching out, connecting and expressing their beauty, humor, creativity, flexibility and health.

**Summary**

Like many others, I witness the power of music therapy to reach and engage the most flexible and healthy part of a person. I also experience
how individuals sometimes disregard a person's potential through assumptions or lack of understanding. Music Therapy delivered within an intuitive, improvisational model can speak to the potential in every person. I have learned many things from residents, families and staff in seven years of professional practice. They have taught me to believe in possibilities and they have taught me to work the way I do. I salute them with song.

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Appendix to Nadine Cedesky

Figure 12 Musical Example 1
Figure 13 Musical Example 2
Figure 14 Musical Example 3
Figure 15 Musical Example 4

Appendix #1

MUSIC EXCERPT #1

MUSIC EXCERPT #2

In this paper I am going to present the ways in which a MT group can be used to assist in the diagnoses of children attending a psychiatric assessment unit. The paper is based on an article that Amelia Oldfield and I wrote on the subject in the recently published “Music Therapy and Group Work.” The article originated from our observation that there is surprisingly little written about music therapy group work, especially work that is specifically to aid diagnosis, and so we felt that it would be useful, and hopefully insightful, to detail our approach to group work.

Firstly, I will briefly refer to some of the relevant literature on the subject. Then I will describe the setting where I work, my working practice and how a music therapy group can be used as a diagnostic tool and can contribute in answering some of the questions posed in the assessment procedure. I will also explore my particular role within the multidisciplinary team and then look at the group from the perspective of my co-worker.

The work I am doing at the moment is very much still evolving and, as yet, I do not follow a formal procedure. However, over the last two years I have begun to develop certain approaches that are specific to this type of work. One of the most important factors has been to keep an open mind about my role. I have had to rethink my definition of how a music therapy group can work and what it can achieve. In many ways this way
of working goes against the traditional way of running a group, in the sense that it is short-term, highly structured and has a specific purpose – diagnostic. It has been important to find a balance between developing a therapeutic relationship and evolving certain ideas and activities that can enable me to answer specific questions relating to diagnosis.

As part of the research for our article, we found that although a number of music therapists have written about music therapy groups with children, such as Hibben (1991) Oldfield (2001) and Tyler (2001) none of the literature focuses on group work with a diagnostic aim. Music therapy used as a diagnostic process for individual children has been looked at and developed by Tony Wigram through his work at Harper House. In a 1995 publication he describes how he examines the way children respond to music by focusing on five areas, including general interaction and response, physical activity and transference of behaviours or features of pathology into musical behaviour interaction. In more recent writings he describes his model of diagnostic assessment sessions (Wigram 1999, 2000) and explains how he uses his Improvisation Assessment Profiles (IAP), adapted from Bruscia’s IAPs (Bruscia 1987). Wigram defines his focus as “concerned with analysing musical material as the essential “raw data’ of our work, and using musical events as the starting point to explain psychological, pathological and emotional behaviour.” Molyneux (2001) describes her approach to music therapy diagnostic assessment in her work at a child and family psychiatric unit. She focuses on three cases where she was able to contribute to the team’s evaluations of children’s diagnoses. This brief look at the literature shows that as far as we have been able to determine, there has been
nothing published on the subject of music therapy diagnostic group work, with the exception our recently published article.

I will now briefly describe the setting in which I work. The Croft Children’s Unit is an assessment and diagnostic centre for children up to the age of 12. The service focuses on children with severe psychiatric disorders and those with psychological and behavioural difficulties associated with medical problems or with parenting difficulties. Over the last few years, the most common diagnoses given include ADHD, autistic spectrum disorders (including Asperger Syndrome) Tourette’s Syndrome, Obsessive Compulsive Disorder, language and learning difficulties, attachment disorders and conduct disorders. The unit is also asked to carry out assessments and provide opinions in cases of emotional, physical or sexual abuse. Furthermore it also can admit parents with young children or babies for parenting assessments.

Children are admitted to the unit for a period of between 4 and 6 weeks, although in some cases the admission may be extended. During this time they will be assessed using a variety of different methods. Some children attend the unit as day patients and others are admitted residentially with their families. There are usually no more than eight children attending the unit at any one time.

During the day children attend a unit classroom in the morning and various groups in the afternoon, including a social skills group, art, recreation and a music therapy group. The multi-disciplinary team includes psychiatrists, specialists nurses, clinical psychologists, and, at present, two music therapists.
My work on the unit involves carrying out individual music therapy assessments, diagnostic assessments, on-going individual treatment for some children, short-term work with families and running the weekly group. At this point it is important to distinguish between music therapy assessments, which are to determine whether music therapy might be a useful intervention and diagnostic assessments, which look at whether, within the music therapy process, evidence can be found to support a diagnostic hypothesis. It is of course possible to achieve both these aims within the same session. Although the principal aim of the group is diagnostic, within this framework it is also possible to assess whether a child would benefit from some individual music therapy.

There are a number of issues concerning the running of this group that I have had to take into account. Firstly, the population of the group is continually changing. Each group therefore exists as a separate entity with some children at the beginning of their admission process and some at the end. Some children may be unable to tolerate the whole length of the hour-long group and may be gradually introduced. Due to the types of cases assessed on the unit (for example, cases of abuse or bullying) the atmosphere may be highly emotionally charged with children displaying unpredictable or difficult behaviour. As a response to the fact that there are very few constants in this situation, the group can offer some constancy and containment by being highly structured and therapist-led. This is similar to the initial stage described by Towse and Flower in their article “Levels of interaction in group improvisation” (Towse and Flower 1993). They pinpoint the initial stage of their group as consisting of the first five sessions. As the average length of admission on our unit is 4 – 6
weeks, our work could be described as always being at this initial stage. However, unlike in their group, consideration must be given not only to the therapeutic needs of the children but also to how to provide a forum in which to assess the strengths and difficulties of children. As the role of the unit is to assess and diagnose children, the music therapy group must play its own part in this process.

I will now describe different sections of the group and then explain how each activity helps us to assess the children’s strengths and difficulties.

After a verbal introduction and a discussion about the rules of the music group, I introduce a hello song. The group is encouraged to clap along with my rhythm on the tambourine and sing if they can. I then choose someone to pass the tambourine to by singing his or her name. We all then follow the new rhythm. The song is sung until every member has had a turn. From this simple way of introducing each other it is possible to observe whether a child can make choices, whether the structure of the song engages them and holds their attention and whether they are able to wait, listen and take turns. Sometimes children are reluctant to say their own names and will just beat or hold the tambourine; others may refuse to have a turn at all. This could clearly be indicative that a child lacks self-confidence, especially in new situations and I will then observe how they develop within this activity over the next few groups. Some children will be reluctant to follow their peers’ beat and may feel a constant need to be in control. It is always interesting to observe whom children choose to pass the instrument on to. Some children, for example, always choose
adults while others might choose the “leader” or seemingly most confident member of the group in the hope of gaining approval.

After the hello song I might suggest that the tambourine be passed around the circle in different ways, for example, pretending it is very hot, sticky, heavy or asleep. I will then ask children for their ideas. This activity often draws in the children who did not participate in the hello song as the focus is now away from the individual and onto the imaginary situation. During this game it is possible to observe whether and how the imagination is used, what interests children who were previously disinterested and whether children can accept each other’s ideas.

The tambourine will then be put away and preparations made for the next activity. During these few minutes we can see how individuals cope with transitional periods, what happens when the time is suddenly unstructured and how children cope with change if we introduce a new element to the group.

This way of starting the group remains the same each week and what follows changes according to the general feel and mood of the group. A flexible approach is therefore the key here and one has to be constantly aware and observant of mood and behaviour changes.

In the next stage I will often introduce a group playing activity with the aim of involving and engaging all the children. I may choose one child to choose instruments for the rest of the group while others are encouraged to close their eyes and wait. We can observe how children respond to the passive role of having instruments chosen for them. Is excitement, apprehension or lack of interest expressed? Are they able to tolerate it if
they have been given something they do not like? For the child who is choosing the instruments, we can see how the responsibility is used and whether they are able to risk making their own decisions. It is also interesting to observe the choice of instruments as it may shed some light on how the child perceives himself and others within the group and perhaps how he would like to be perceived. During the activity children are invited to offer their ideas for how the group should play, for example, a particular song, style or mood, such as quiet and calm or loud and energetic. This provides the opportunity for the children to be involved in the activities and for us to observe how and which choices are made. Sometimes a child will choose an age-inappropriate song, showing no embarrassment, others may need to choose one of a given selection as they find making choices very difficult. Sometimes I may introduce a competitive element into the activity by stating that the first person to put their instrument down and their arms up will be the “winner.” Often children seem the least tolerant of losing during their first few group experiences but as they become more familiar with the structure of the group and understand what is expected of them, they appear to settle and allow themselves to accept encouragement, and move on.

This group activity provides an opportunity to assess how engaged and motivated the children are in playing with others. We can look at how they are playing, whether they interact with others or would rather play in an isolated way, unaware of what others are doing. Sometimes children will lack the confidence to play on their own but can play as part of a group. Often children are drawn into the structured songs but disengage
when the improvisation starts and the music becomes more chaotic or unpredictable.

The music I play in the group activity is predominantly structured or pre-composed songs. For many children, familiar songs often hold their attention and interest. With so much unpredictable behaviour in evidence, it is important to create an opening to the group which includes an element of familiarity and predictability. However, I strongly feel that the success of this group as a whole, and what prevents it from being a series of activities, is the fact that it does contain a mixture of structured and improvised activities. One such activity I have devised using this combination is called “Pass the beater.” I introduce this only when I feel that the children can tolerate being within close proximity of one another. Group members sit around a standing drum and a beater is passed around whilst the “passing music” is played on the piano. It is explained that whoever has the beater in their possession when the music stops has the opportunity to play a solo, whilst others listen. The passing music has a distinctive rhythm and melody and children soon recognise it and may sing along or move to the rhythm. The music to accompany each solo is improvised. As well as listening and responding to the individuals’ drum playing, we can also observe how the time and space is used. Some children appear very engaged and involved in their playing, seeming aware of the therapist but also able to express themselves within the music. Other children may need more encouragement and may only want to play for a short while. It is also interesting to note how endings are made and whether children can organise themselves to bring the music to a close or whether they need verbal as well as musical prompts to do so.
In some cases, children who present as quite chaotic in terms of their behaviour and thinking are able to respond to specific musical prompts, such as the slowing down of tempo or cadence points. As with many of the group activities we are trying to ascertain what children can understand and achieve musically, despite their difficulties. This may then provide some insight into the abilities and disabilities of children. Sometimes we find that children who usually find it very difficult to conform to rules and wait their turn are motivated to manage this by their enthusiasm and eagerness to play. It is these types of observations that are some of the most useful and informative to feed back to the rest of the team.

Often children listen to and encourage the one who is playing. One of the values of this group is the fact that opportunities to observe positive interactions between children are provided. On a unit like ours, it is easy to focus on all the difficult behaviours. In order to gain the whole picture of a child, we also must try and find out what kinds of interactions produce positive behaviours.

One way of observing how children lead and direct each other is to suggest to the group that we each play the part of a conductor and direct each other’s playing. Sometimes this may involve taking it in turns to lead on a large drum, with others encouraged to follow the tempo, dynamic and rhythm of the leader. At other times I may suggest that children actually stand up in front of the group, equipped with “conducting gloves and baton” and direct using gestures, facial expressions and the baton to indicate who is to play and how. This way of
leading can obviously be modified depending on the children’s level and abilities. Thus we can look at how children respond to being in the leading or the following role. For the child conducting we can observe how ideas and intentions are communicated in a non-verbal way and whether they find this easier or more difficult than using words. We can observe if and how eye-contact and facial expressions are made, how long the concentration span is, how the children respond to the position of control and whether enjoyment or anxiety is expressed. Sometimes the “orchestra” does not respond in the way the conductor has intended them to and so we can observe how the unexpected is dealt with. For some children, to stand in front of and direct a group can be a daunting and difficult task and it make take time for self-confidence to be developed, if at all. We can look at whether the child can acknowledge success and how they respond to praise and encouragement. For the children in the following role we can see how they cope with another being in control, perhaps finding it easier to accept direction from another child rather than from an adult. In addition, it will be possible to determine whether children with specific language or learning difficulties are able to pick up non-verbal cues and signals.

There are many more activities and ideas that I bring to the group. Sometimes I introduce an imagination activity. This involves children being encouraged to relax, to close their eyes if possible, and to try to find a relaxing and peaceful place in their imaginations. We look at whether children can relax and whether they are able to access their imagination. If so, where do they allow their minds to travel? Are children interested in each other’s ideas? Some children who usually
speak very little throughout the group can become very animated during this activity.

“Catch my eye” is an enjoyable activity for children but also a very effective way of observing whether children can pick up non-verbal cues. Players “invite” each another to play by catching their eye. Children are often quick to understand the concept. However some children, who are quite concrete in their thinking, become confused and may struggle to participate or they may say the name or point to the person whom they want to play. These kinds of observations on how children process verbal and non-verbal information are clearly useful to feed back to the team.

On other occasions I will suggest that we have a guitar conversation. Two people sit back to back, one with a big guitar who asks questions, the other with a smaller guitar who answers them. Children are asked to think of what they would like to find out about their partner. Questions are sung. The fact that the guitars are the focus attention can make it easier for some children to participate. We can observe whether appropriate questions can be formulated and whether singing them makes it easier or more difficult. For the child answering the questions we can observe if they can wait and listen to the question without playing and whether they can offer appropriate answers.

At the end of the group children are offered a “free choice.” Each child can choose an instrument and perform it to the rest of the group, who must listen. The “performer” therefore has the opportunity to play freely and to be briefly in control of the group. Issues of self-confidence can be observed during this activity. How do they use their special time? Do
they become distressed if others interrupt their playing? How do they respond to praise? And for the “listeners?” - can they sit and listen? Can they cope with others being in the limelight or do they need to always be in control?

After each group I review the session with my co-worker. We discuss each child in turn, reflecting on our observations and organising exactly what we think is important to feed back to the team. The fact that this member of staff works with the children in other groups and situations on the unit means that her observations play a vital role in determining what behaviours are being brought out specifically in the music group. She can also see whether the musical activities engage children more or less than other interventions on the unit. The combination of her skills and experience as a nurse and mine as a music therapist means that together we can really focus on what is being revealed during these groups.

In weekly management meetings, headed by the unit’s consultant, all professionals working with the children are given the opportunity to discuss their observations and thoughts. This allows us to gain an overall picture of how children are managing. It is also the time when decisions are made about what further interventions should be offered to the child, both during and after the admission. Sometimes I will just need to confirm that I observed the same behaviours in the group that have been generally observed. However, on some occasions I will be able to add further insight. The kinds of observations I might bring to the team’s attention could include:
• An observation that a child who has attention difficulties and is being assessed for ADHD can concentrate for up to, say, five minutes when he is engaged in a particular musical activity. I will then explain what I thought it was about the activity that seemed to enable him to concentrate. Perhaps it was a particular musical structure or the type of music played. As part of the unit’s work involves providing information and strategies to people concerned with caring for the child, any thoughts like these which may provide ideas are invaluable.

• Insight into what particularly motivates a child. Sometimes children express very little enthusiasm for anything on the unit but can show an interest in music making. It may be because the group involves non-verbal ways of communicating which some children find easier to tolerate. If so, we can look at why this might be the case.

• The ways in which a child interacts with peers and adults through music. Staff may have observed that a child struggles to make contact with others. I may confirm this by what I have seen during the non-musical parts of the group (for example, group discussions or transitional periods) but can add that he is able to use music as a way to interact. I can also note whether a child prefers to play alone and what happens when others join him. Perhaps he is only able to play when he is in control.

• Whether a child is sensitive to loud noise. Sometimes I am told that a child may express intense fear of sudden, loud noise. In some cases it is clear that a child has a genuine sensitivity. However, in other cases, this fear will only present itself when others are making the loud noise and the issue may be more about control.

• Sometimes children may be assessed for possible physical difficulties, in addition to other difficulties. I can provide information on their physical presentations in music, such as observations on hand-eye coordination, the presence of clumsiness, how instruments are played (one or two hands at the piano?)

• In the case of Tourette’s Syndrome, I can look at certain behaviours, such as tics and see if they occur or cease during a particular activity. For example, do they increase in intensity when the child is put in the spotlight or when they are part of group playing?

• Sometimes children with a learning difficulty, who usually find verbal instructions difficult to follow, pick up activities quickly through visual clues. Some children demonstrate a good aural and visual memory by copying musical motifs perfectly. Psychologists and
teachers are often interested in the different learning skills and strategies that are brought out in some of the musical activities. Part of my role is therefore to look at behaviours within the context of musical activities in order to try and determine any particular ones that may assist in the finding of a diagnosis. In order to do this my observation skills, as well as my musical ones, have developed to work in this very specific way.

I will now look at some guidelines of certain disorders that explain what aspects of a child’s behaviour should be looked for. Many of these questions can be answered through careful observations of how children present themselves within different musical activities in the group.

**Aspects of behaviour to look for in a child who might have an autistic spectrum disorder**

- **Look at use of eye contact**
  - with peers normal, over-intense, lack of
  - with adults Does s/he communicate with his/her eyes?
  Activities such as conducting or “catch my eye” which focus on using eye-contact to communicate can look at this.

- **Do they use a normal range of facial expressions e.g. anger, upset, surprise, pleasure?**

- **How good is the child at reading other people’s facial expression/**
  - Sometimes I introduce an activity where a child is asked to choose an expression to make without verbally explaining what it is. The rest of the group must try and “describe” or reflect the expression though the music they play.

- **Is the voice modulated appropriately for social context?**
  - Sometimes I notice a difference between the “speaking” and the “singing” voice of a child, the former being unvaried and monotonous and the latter
being more varied. In the “guitar conversation” some children are able to
sing questions to a peer but are reluctant to speak them.

• When s/he’s enjoying an activity – does s/he spontaneously share the
pleasure for e.g. by pointing out or looking in others’ direction?

During both group playing and individual times we can look at how a
cchild expresses their enjoyment by listening to their music and looking at
how they are playing. What kinds of facial expressions are used if any?
After a solo we can see how praise is accepted and whether and how
others offer it. Does the child enjoy interacting musically with others or
does he prefer to play alone?

Repetitive/Stereotyped patterns of behaviour

Special interests

• Does s/he appear pre-occupied by a particular or restricted interest e.g.
always returning to the same conversation the their specific interest?
Does the interest have a social interest or is it largely a solitary pursuit?

  • Sometimes children who are pre-occupied with a particular theme or word
can focus on music making, although they may continue to refer back to
the theme. I can look at which activities in particular engage these children
and see what happens just before a switch in concentration occurs.

Routines/Rituals

• Does s/he have particular non-functional routines that s/he has to
adhere to? Does a particular routine have to be carried out?

  • In the group I can look at whether children play in a certain way, for
example, repeating rhythmic or melodic patterns. Can music distract or
engage the child and if so, what kind of music? Is the same instrument
always chosen? How does the child respond if an activity is changed?
Does the child become less intent on following routines as s/he becomes
more settled into the group?
What to look for in a child who may have ADHD

Inattention

- How long does the child sustain attention on a range of activities? (Note e.g. for how long is focus sustained on an enjoyable/play activity? Compare with attention on a school-like activity)
  - Music often interests and engages children. This can often be observed in the group, which is why it can be a very good place to elicit this kind of information. I can look at how long attention can be held and provide ideas as to what aspect of the activity seemed to interest the child.

- How organised does the child’s play and behaviour seem to be? Does it seem to have an order or an aim?
  - We can look at how a child plays. Is it very chaotic with little sense of phrasing? What happens when structured music is introduced? How do they bring their playing to a close?

- Is the child easily distracted by things going on around him? - sounds? visual stimuli?
  - This is a question that can easily be answered by looking at a child’s behaviour in the group. We can look at what happens when there are lots of different instruments being played at the same time and compare this to when children play a solo. We can also look at whether there is any change in behaviour when spoken or singing voices are used.

Hyperactivity

- Is the child able to pace himself at various activities? Does s/he tend to rush things?
  - During the “free choice” activity children are given a specific amount of time to play. After about a minute they are asked to make an ending. Some children will make an ending soon after the request while others will need several reminders.

- How often does the child fidget, fiddle, move hands or feet, especially when s/he is meant to be sitting still?
  - We can look at when and how many verbal prompts must be made to encourage the child to focus on his/her task. We can also look at the effects of activities involving movement or those that involve a combination of playing, moving and singing and compare them to activities that require just one person to play at a time. Thus we are trying to find out if there are any specific triggers to hyperactive behaviour.
Impulsiveness

- Does s/he find it difficult to wait his/her turn?
  - Turn taking forms an integral part of the activities and observations can be made as to how children manage.

- Does the child constantly interrupt or tend to blurt out answers before question has been completed?
  - In an activity such as the “guitar conversation” are children able to listen and wait for the question to be asked before they answer? Can they listen to other people playing music without having to play or interrupt?

As part of the research for this paper I asked my co-worker to comment on what she thought it was about the group that enabled us to observe particular behaviours in children. What kinds of questions can we answer that other groups or assessment processes cannot? She felt that the music therapy group is unique in the way that it can bring out a child’s creative side. At times she has been surprised by a child’s musicality and imagination as these qualities has not been observed in other settings. The group provides a “useful form of expression [and an opportunity to respond to] a different language, a natural, instinctive language. To be listened to and interacted with in this way can give children a confidence to communicate. It is through this language that observations can be made.”

She felt that the group was particularly useful for observing how children express enjoyment, for looking at differences between musical interactions and other kinds of interactions, to see how children take in information and whether they can share their achievements with others. Looking at issues of control was also something she highlighted. Does a child feel the need to remain in control throughout the group or are there
some types of interactions in which he can let others do so? Also observations can be made as to how a child responds to change and transitional periods. She felt that activities such as the relaxing/imagination one helped us “gain insight into [the child’s] world by encouraging them to daydream, go on a journey or to a special place.” At the end of her comments she wrote, “Due to the type of children that we encounter and their often severe difficulties, I personally feel that some of the joys of working in this group are to see a child gain in self-confidence and their self-worth grow. Also it is good to see children react positively and enthusiastically with peers within a boundaried and hopefully non-threatening environment, even though initially they may have found it very difficult to even enter the room. The group provides a consistent space for the children to use and it can be the only opportunity on the unit to observe the creative, imaginative and musical sides of a child.”

At the start of this paper I referred to the fact that there is very little written about music therapy work that specifically aims to aid diagnosis. I have described how different musical structures can enable us to observe strengths and weaknesses in children. I have also explored my role within the unit team and looked at what unique observations I can provide which will help gain a global assessment of a child. Finally I looked at how some questions asked as part of the assessment process can be answered by looking at how children present in various activities. Thus I hope I have shown how a music therapy group has an important part to play in aiding diagnosis of children with a wide range of behavioural and emotional difficulties.
References


Authors Affiliations

Emma Carter read music at St. Hilda’s College, Oxford before training as a music therapist at Anglia Polytechnic University, Cambridge in 2000. She currently works at a child and family psychiatric unit and a child development centre both in Cambridge.
Musicians And Anxiety - A Music Therapy Perspective - A musical psychological approach to musicians’ tension, anxiety and stress

Cartocci, Alessandra
Pianist, dip. Mt, Laurea cum laude in Lettere

Introduction

The profession of music carries with it a number of troubles. Tension, stress, competition, stage fright, sense of judgement, the concept of performance itself, are all elements that put a terrible pressure on the artist and may even drive musicians away from music.

The number of artists, especially musicians, suffering from more or less serious forms of neurosis is increasing at a worrying level.

Coping with this situation often requires a huge amount of energy. In some situations there is so much pressure that some musicians are forced to stop performing for a period of time. Even in less extreme situations, maintaining a good level of well-being in making music as a profession isn’t always an easy task.

In my experience as concert pianist, piano teacher and music therapist, I’ve had the chance to experiment with the problem from different perspectives. I’ve experienced the problem myself while performing. I’ve seen other colleagues suffering terribly from stress and stage fright. I’ve seen young students already suffering because of a performance instead of enjoying it.
Finally, as music therapist, I’ve had the chance to find and experience a possible way out of the tunnel and a possibility for young musicians and professionals to overcome troubles and regain their enjoyment of their feelings about music.

With this paper I wish to share some of my thoughts on the possibility of directing some music therapists’ work towards troubled musicians, and on the possibility of inserting some elements of music therapy into the training of young artists as a way to cope with and perhaps overcome anxiety and prevent the creation of tension or stress.

**How it has all begun**

How did I come upon this idea of addressing music therapy to troubled musicians?

During the early years of my career as a pianist I happened to gradually develop a kind of awkwardness. I was basically feeling that what I was doing with practising, rehearsing, performing, travelling and doing the same things all over again, wasn’t constructive. Travelling from one place to another, performing, practising, and rehearsing were all things involved with the music business I was part of. I was proud to have the possibility of doing it while many others struggle a long time and don’t manage to “get through”. Still, I wasn’t feeling comfortable with it.

I felt that something was missing. This way of making music did not feel right to me. In a way, I was feeling that it was all quite useless. I was somehow trapped in the circuit of playing music, worrying about perfection, thinking about how it would be judged, worrying about the
audience, and I was almost on the verge of leaving music and no longer playing.

I studied several approaches and found different ways of being involved in the art/business which became important for me. One of these was certainly Music/Theatre.

But it was only when I discovered music therapy that I became very excited. The idea of music with a therapeutic value had a great appeal to me and I thought that this particular approach to music would fulfill my need for a goal, for feeling useful in doing music.

I then decided to train as a music therapist. This added a new dimension to my whole musical life. Surprisingly enough, at the end of the training, not only did I receive my Diploma in music therapy, but I also realised that my piano playing was quite different. It was freer, much more relaxed and I actually enjoyed being back at my instrument.

In fact, I was playing again and I could regard my newly found piano career from a totally different perspective.

Music making had a real meaning now that it was a ‘giving experience’, helping others through music, and I realized that a new way of intending music was indeed possible.

**Anthony Rooley’s suggestions. Ideas from the past**

In developing these ideas, I found great inspiration in the book of A. Rooley called *Performance, revealing the Orpheus within*.³⁹

³⁹ A. Rooley (1990), *Performance, revealing the Orpheus within*, Longmead, Shaftesbury, Dorset, Element books.
Rooley reminds us that ideas such as these are absolutely not new. In the Renaissance, for example, platonic philosophers discussed the importance of music in reaching a higher level of conscience, and as something absolutely vital to fulfilling our need to “unseat the soul trapped in the ‘muddy vesture of decay’” because otherwise the soul becomes locked in, and “forgets its true home (partaking of divine essence, rather than gross substance).” In this view, Rooley points out that “the true task of the performer is that of ‘soul-tickling’ - drawing the soul, via the means of aural sense, out of the body, through the aperture of the ears.”

Rooley goes on even further and extracts three principles out of the famous renaissance text *Il Cortegiano*, form Baldassarre Da Castiglione and uses these principles as a metaphor of music elements. These are called in Italian:

*Decoro*, *Sprezzatura*, and *Grazia*.

**Decoro** – represents the appearance of things, what can be learned, practised, developed, controlled. In simple terms: all the technical matters. It is also concerned with rules and tradition. Of course, it is a fundamental quality, but it is easy to imagine that “An overuse of decoro leads inevitably to rigidity, to dullness, lacking any inner spirit or strength.” Unfortunately, the majority of our training system is entirely based on this single principle.

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40. A. Rooley (1990), *Performance*.

41. A. Rooley (1990), *Performance*, pag. 11.
Sprezzatura – is the balancing principle of Decoro. It is the energy. It has to do with communication, passion, “delighting in the moment, a love of improvisation, a kind of calculated carelessness, a ‘noble negligence’”. As opposed to Decoro, it is a quality that cannot be learned or practised “yet experience” as Rooley says, “the greatest teacher, may help us to learn to deal with this fiery concept.”

Grazia – is a quality that is difficult to describe, but its presence, according to Rooley, is immediately perceptible. It has to do with a sort of illumination of the experience one is living. Rooley says that “it is a gift, belonging to no one but it’s sure of emanation. Marsilio Ficino regarded it as ‘sublime tranquillity’”. I like to think of this concept as the expression of the intention, of a creatively inspired energy for which the artist is in fact a catalyst.

What is very interesting about this perspective, is that it reminds us that music can be a major element of help for the holistic growth of human beings. In order to reach this point, all three principles are fundamental: Decoro because correct form and technique are vital for the message to be correctly manifested. Sprezzatura, because it carries the energy that allows the ‘message’ to actually reach the listener. Grazia, finally, because I think that its presence can represent the message itself and the capacity of the artist to be a real catalyst and facilitator.

42. A. Rooley (1990), Performance, pp. 11 - 12.

43. A. Rooley, (1990), Performance, pp. 11 – 12.
External and inner worlds

As I said, usually today our actions as musicians are directed uniquely by Decoro.\textsuperscript{44} It happens so dramatically often that we assist to performances, which are technically excellent, even perfect, but absolutely cold, and not emotionally involving. Many consider “good” a performance or “good” an artist, when his performance is perfect; technically, musically, stylistically perfect.

Unfortunately, we very seldom hear about a musical event as something that opens our emotional side or as something that touches us and that, in some way, lifts us up.

Today, a musician, from the early formative years, is trained to achieve an extreme perfection of technique, of style, of historical knowledge. He is not at all sensitized to the other aspects of making music, which we can call Sprezzatura and Grazia. It doesn’t matter if these are the main aspects that have brought him to music itself.

In a way it is like learning a language with a perfect knowledge of its pronunciation but nothing else, and an extreme specialization in that language without ever trying to understand the meaning of what one is saying, nor why one is saying it. The language loses its sense and its very fundamental characteristic, which is that of communication. In many cases artists simply go on with this situation, but in many other situations, by leaving the artistic soul too far from the inner source of

\textsuperscript{44} On the other hand, if we had performances ruled only by Sprezzatura, we could easily shift to a lack of discipline and it would still be impossible to have a correct perception of the ‘goal’ of the performance. The real communication only begins when Decoro and Sprezzatura are both present and balance each other. We will then have the gift of a performance difficult to forget.
creativity, very often, troubles begin. I’m talking about a sort of inner conflict among the musician’s self, his inner world connected to music, on the one hand, and the professional world he is part of, on the other.

There is a recurring element in many artists’ performances. Although the following description is a very subjective one, it seems to be shared by many artists who have reflected upon it. I can describe it with the help of an image: the image of a canal in which silt has accumulated. It is a sort of illness that strikes the communicating canal of creativity. The silt seem to be determined by layers of conditioning and restrictions to the free flow of creativity due to the contrast between the inner self and the technical training, which, for their part, bring inhibitions, anxieties and fears to the artist. Subsequently, we have performances in which moments of strong creative vibration when we feel a flow of energy, alternate with moments where creativity emerges with difficulty and we feel something “awkward.” The singer’s voice doesn’t come out fluently, the player’s fingers move without ease, muscles become tense, etc. Generally these things are hardly perceptible to the audience, but they are easily felt in the quality of the musical action itself and, most importantly, they literally wear out the artist. We then have the feeling of an artist being trapped in a construction that stops him from freely expressing his creativity, a real prison.

In these cases, the artist has lost the feelings of what he is doing and why he is doing it. He is only in contact with Decoro; he has difficulties finding Sprezzatura beside him; and he is completely closed to Grazia.
We normally think that a musician is the centre of the performance. We think of him or her as the prime mover of the mechanism - the first and only one responsible for either a great success or a terrible failure. With such great responsibility, the artist is exposed to tension, frustration, and anxiety. Sometimes these pressures are so heavy that serious troubles ensue.

Among the many other important aspects of music investigated by Rooley, I want to underline the simple statement that this situation of music making doesn’t represent a “definitive sentence”. We can fortunately change perspective. We can shift, from a viewpoint that puts the artist at the middle of the performance circuit and leaves everything else simply around him, to one which puts music and its creativity and communicative potential in the middle of the circuit. The musician, then, assumes the function of facilitator who puts creativity in the circle to the benefit of everybody (artist and audience as well).

If the artist chooses to participate in the artistic experience in this way, he finds that he is not the centre or creator of the musical activity. He acts in answer and transmission of a creatively inspired energy that does not originate with him, but for which he is, in fact, a catalyst.

The main implication of this new perspective is that the true objective of performance is to contact elements already existing on a different level such as energy or inspiration and to bring them to the light, literally, “to the form”. It is in this way that the artist becomes a facilitator. The goal is to bring music back to its proper place, at the heart of a circuit where the musician finds his identity in being a true messenger of creativity. He is
the one who helps music to reach people and people to enjoy and understand music. Through his skills, his training, and his creativity he has the capacity to “fish” unformed ideas from a subtle sphere and help them to become manifest in our world of tangible forms. This helps to create a performance where energy flows intensely. In such a performance a musician is literally refreshed by the task rather than exhausted by it. And so is the audience. The concept of being judged loses its role.

**Humanistic music therapy and psychosynthesis**

Why do I think that music therapy can be a proper answer to artists’ problems?

Let’s go for a moment to the meaning of the word *Performance*. The root of the word is Latin (*per formare*) and it is usually translated in “to shape,” but it could also be referred as “to bring out.” The two words together have a complex meaning that gives sense to this translation. “*Per*” literally means through and “*formare*” has several possible translations: to give a shape, a form, to organize, to educate, to create.

To bring out some non-formed material and give it a shape.

We then find common elements between performance and music therapy. If performance means to shape, to bring out what is inside and help it become manifest offering a holding environment (the form), this is exactly what happens during a therapeutic process.
The special thing about music therapy is that the person does this process through music.

I think that music therapy can be a very powerful answer to such troubles because at the very core of the therapy stands music itself and this makes it extremely useful for those people whose problems are specifically connected to music.

Through a music therapy process, music, from being the cause of discomfort, can be brought back to its original place as a source of joy and well being and this can be achieved through a process (indeed, the therapy) in which music, again, stands as the main carrier of healing.

The reason why I chose a psychosynthesis perspective is that this psychological approach is based on a holistic view of the human being. Assagioli, the founder of psychosynthesis, said that the state of balance and health can be reached only by starting from the whole of the human being. This means establishing or re-establishing a harmonic balance through the reconciliation of opposite elements within the whole of the person. This statement, in the perspective discussed earlier, means that Decoro, Sprezzatura and Grazia can be all balanced together within the person and the artist.\textsuperscript{45}

The goal is to reach a good level of synthesis within every function of the person and a good harmonization among the various functions without disproportion. Music therapy, helping to reach the many aspects of the person and the many aspects of the performance, can act as a matching

\textsuperscript{45} R. Assagioli (1973), \textit{Principi e metodi della psicosintesi terapeutica}, Roma, Astrolabio Ubaldini, pp. 207-208. The translation is mine.
element. It can help the artist to find a balance and help him bring performance at its proper place within the self.

How does this happen when practically applied to music therapy?

**Music therapy for musicians**

Nancy, a professional singer with a major interest in art history, came for some music therapy sessions. Her problem was that she had sudden lapses of memory during performances and wanted to address this problem through music therapy. I chose to work directly through pieces of the Lieder repertoire. The objective was to try to understand how she reacted to a piece of music, how problems begin, which are her strategies of defense and of control and how they manifest.

We started with Mozart’s *Abendempfindung*, a piece that she didn’t know. I chose that piece for the quality of the music, for the quietness and profundity of the text, for the vocal range and particularly for the quality of the interaction between piano and voice: the instrument acts as an amplifier of the feelings expressed by the text and represents the emotions in a very immediate way.

She had first to ‘sight-sing’ the Lied so that the approach to the music was totally spontaneous and if there were any problems they could come out clearly.

I also asked her not to practise the piece at home so that every time she would sing it she would have a fresh and spontaneous approach to it. We realized that every session her approach to the piece was different, and I saw this as a sort of mirror of her feelings. I invited her to see it as a rich
resource of her making music when not concerned with a mental approach (Decoro oriented).

We immediately realised that she had a sort of blockage with a passage towards the end of the piece. For some reason she could not sing it correctly. We soon realized that this was not due to any technical difficulty. There was no rational explanation.

During the music therapy it became clear that this problem was affecting the whole of her singing.

From the very beginning of the Lied, she was already thinking about the “problem passage”. She couldn’t enjoy singing nor being involved with the interpretation of the piece. The quality of her voice changed and she didn’t seem to care much about the piano accompaniment. There was no Sprezzatura. This problem in the Decoro part of the performance was literally sucking out all the energies and ruining her participation in the performance. I called it a “black hole.”

We worked on shifting the emphasis from the technical qualities of the piece (Decoro) towards the text and the musical quality (Sprezzatura). In order to shift the emphasis to a different perception, from that of technical worry to that of inner participation and imagination, we went through a stage where she carefully listened to the sole piano part imagining her singing simply by perceiving the feeling of it.

We used various music therapy techniques. Since she has a great interest in art, I thought that we could use the visual element as a privileged canal of experience and communication also in music. We then worked with
creative imagery, (colours, shapes, lights and shadows), movements and improvisation. She finally found a way of using the visual canal (obviously very important to her) as a personal resource and also as a way of memorizing music.

The next step was then to play and sing it together and she could feel that the quality of the music was changing a lot. The quality of the feeling was changing and even the quality of my playing was quite different when it was vibrating together with her singing. She then felt how important her intense participation in the performance was, she felt, to be part of a circuit in which the important elements are not just technical perfection, but also and more importantly a real participation, a vibration, expression, the presence of *Sprezzatura*. Listening to the two different parts (vocal and instrumental) and working on them in a way that emphasized the relationship between the two, helped her to realize the importance of cooperation, of working together toward one goal.

After this process, she not only sorted out the problem of the “black hole,” but her singing reached another level. Her voice was much more resonant, powerful, feelings were strongly perceptible. There were no more mistakes in the end.

She is now performing happily and she has no more problems with memory. And if mistakes occur, she doesn’t worry anymore and they don’t affect her whole performance.
Processes in music therapy relationship

During a music therapy process, the artist can be helped and supported in the realization that it is possible to discover one’s personal music and not be judged for it or criticised. The musician can experience the fact that composed music is a most perfect moment of creativity, but that, at the same time, he is able to play something absolutely personal through improvisation which need not be “good” or “artistic”, but simply authentic. Going back to the linguistic metaphor, we can say that it is very difficult to “speak” through someone else’s words, even the most perfect and beautiful ones, as we normally do when performing any composer’s piece if we haven’t learned “to speak with our own words”.

The artist can learn that “good” need not be “perfect”. He can learn to cope with frustrations. What matters is its power of communication, whether it is creative and moving. Technical or stylistic aspects can be studied and learned. The only thing that has to be ‘good’ is the feeling that brings us to another plan in our mind, body and soul.

During music therapy the therapist and the client experience the feeling that every musical gesture is extremely meaningful, not just from a purely musical point of view, but also as a sign of personal assertion.

“I am something, I am saying something to you, and I do this through my music. I feel that my music (me) is accepted and understood without judgement. Not only this, but I realize that my music can be influenced by yours and vice versa”. This is communication and relationship.
The quality of the musical relationship that develops during music therapy allows the artist to become aware of the great importance of the human aspect in performance.

The musician can learn that the audience is equally **involved in the process**. Normally, during a performance, the audience does not play music in response to the artist, but nevertheless the audience does participate actively in the performance. Music Therapy helps people become aware of this and not be afraid of it anymore.

A Music Therapy process can help reach this point because it helps contact the human element without implications of judgment and because it shows, in a safe setting, what happens during the circuit of performance.

All this helps the growth of one’s self-esteem. This happens because of the discovery of an intimate relationship with music and its communicative potential, giving more sense to the performance itself and not depending entirely on its success.

Music Therapy can also help rediscover the expressive richness typical of a non pre-formed musical language.

It can help a musician to discover his own spontaneous and personal music. The competitive element is put in its proper place and can become less stressful, while leaving enough space for other aspects.

Last, but definitely not least, due to its nature of synthesizing music and psyche, freedom and consciousness, I think that music therapy has a great potential in the training of young musicians. Some elements of music
therapy should be included in the every music course in order to prevent the many and stressful problems afflicting so many performers.

**Group of music students**

I’m going to show you a video of a situation I have experienced recently. I was invited to a Conference on music therapy where I had to present to senior students at a Music High School a session on what is music therapy and to illustrate the new approach I am developing using elements of music therapy for musicians.

At the conference there were about 60 students. During the conference, two things became immediately clear:

1. the students were extremely interested in music therapy as an approach to musicians’ problems and
2. many of the problems that generally affect professionals and adults were already unfortunately present.

Some of them (talented indeed) were already thinking of ending their musical studies.

The students asked the director to organize some music therapy sessions with me.

By that time, it was quite late in the year and close to the final exams. I agreed on some meeting with the students in their last year.

The goal was to help the students face the exam with a more relaxed attitude and find a new perspective on music.

We only had time for 3 meetings of 2 hours each. The sessions took place in a room of their school were there was a Grand Piano.
At the first meeting, they immediately showed the desire to get rid of their instruments. I invited them to bring the instruments with them anyway, so that the instrument would be present and could at least ‘witness’ the process in which their owners were involved. We worked on ethnic instruments, mostly percussions. I had to consider the little time available. We worked on these instruments during the session, and, by the end of it, I felt that they were ready for a first step towards classical western instruments. Strangely enough, none of the students was a pianist. I then suggested an improvisation that, from the drum, would lead us to the piano (the step was less traumatic then going directly to their own instruments).

The idea was simple: we improvised all together on one single big drum trying to create the feeling of a ‘group’, the idea of sharing one common thing - music as a joy, not only as a problem - and to find a common vibration. I then moved to the piano and started accompanying them from there. Slowly, one by one, they joined me at the piano and we ended up with an improvised piano piece for 12 hands. Everybody was happy and felt relaxed.

At our second meeting, we worked on many different aspects and problems with music. We worked on the group, we worked on addressing difficult situations through the help of music via improvisation.

Towards the end of the session one of the students felt ready to join the group using his own instrument (guitar). We improvised with him. The others were still using ethnic instruments. They were all admired and very inspired.
At the third and last meeting, I felt that they were ready for a first step towards their own instruments. I played a piece on the stereo which is quite important and symbolic: old music with a modern instrument improvising on top. I invited them to draw whatever the piece had suggested to them. They chose to do the drawing together. I then suggested they take the drawing and use it as our personal ‘score’ and we improvised on it. All of them, then, felt free to use their own instrument and we had our final improvisation in which everybody tried to freely express the feelings that the experience had brought out.

The music therapy process was a success both for the students and the Institution.

The few sessions we had helped to restore a situation of serenity and freedom from tension.

I received spontaneous feedback from the students about what they had felt and on how the experience had been useful for them. All of them told me that they have been using our experience as a way of relaxing before exams and concerts. All of them, later on, told me that they have been using memories of the music therapy experience as a guiding light in moments of troubles.

None of them has quit musical studies.

**Conclusions**

I hope I have shown that music therapy can be useful for professional musicians who are affected by their stressful careers and can help them ease the tensions of the profession. I believe that the new approach that
I’ve just underlined can be useful for audiences as well, who may possibly be able to enjoy a performance on a higher level of communication and involvement.

Now, to conclude. What I’ve just expressed here is the result of some recent years of considerations and it’s just an outline of possible future studies. I think that the potential for work in this field is very high. I’ve spent the last few years working in this direction. I’ve been working both with professionals and with students, in groups or individual sessions and there have already been very interesting results. I think that there is a great need for trained music therapists with high musical skills who can support the development of this different approach to musicians’ difficulties.

I hope I have shown that music therapy can be useful for professional musicians who are affected by their stressful career and can help them ease the tensions of the profession. I believe that the new approach that I’ve just underlined can be useful for audiences as well who will possibly be able to enjoy a performance on a higher level of communication and involvement.

I think that the greatest potential is to use this different approach to music and some music therapy skills to help music students to prevent those same difficulties while training for a professional career as performers or teachers and contribute to a different approach in which, to use A. Rooley’s words
The Orpheus within can be nursed and nurtured so that our very own song can begin to be sung, so that our brief play may become more tuneful, and delight in its own re-sounding.46

Caruso, Carlos

"We lay more of the account, Also the truth invents"

Antonio Machado.

Presentation of the clinical case in point. At present state and antecedents.

The subject is an unmarried 41-year-old man. At the moment of the first interview he had a stable partner since three years and half, he lived alone and worked as advertising producer.

His parents got divorced when he was 14 years old. 11 years later his father had a cardiac syncope (stoke?) and died unexpectedly (after a discussion with a neighbour he shouted: “shit!” and fell death instantly). He has a brother 2 years younger and other three stepbrothers and stepsisters from the second father's marriage.

He was referred to me by a college who was his mother's psychotherapist and knew about the symptom's variety my patient had, about my specialization in this psychopathological area, my own working style (non-stuck to any orthodox orientation) and that I considered art and music firstly as main therapeutic resources.

During the first interview as a presentation the patient said:

"I have a long history of therapies. The first time I was with a psychologist I was 4 years old. I have had bad experiences with
therapies. My mother was in treatment for seven years. I come from a crazy family. I did group therapy from 1988 to 1990. I was absolutely crazy. I shaved my head. I was scared to go out. I couldn’t move. I was lying in bed. I couldn’t cook anything to eat."

I asked him how and when he had arrived at that condition, he answered:

"I had a friend who had lung cancer, and was unemployed; I took him to my place to live with me. Soon he suffered brain metastasis and he was carrying a gun. He didn’t let me go into my house. I had to convince him to let me in. Finally he had to be hospitalized and he died. A crazy mess! After his death I was really bad. I was 3 days without sleeping. I lived in the 11th floor. I had tried to gather force to jump from the balcony many times. Dr X got me out of that state. In January 93 I started to work"

Nearly a year before consulting me the patient worked at a radio’s advertising department in a stressful work environment. He refers:

"The General Manager was absolutely crazy. He tortured us everyday saying: “Do this!” And the following day: “don’t do this!” There were dismissals all the time"

When he began the treatment and during almost a year the patient was ill frequently: tonsillitis, bronchitis, and the flu. He received antibiotics, X rays and he passed the weekends in bed, sick or at the Emergency room in some Hospital.

He used to say about his somatic symptoms that:

“ I’m always having some health problem: bronchitis, headache, allergy. I start swimming and ...I get sinusitis. Every week something different
happens! My GP told me: “you are becoming a hypochondriac”. When I went on holidays I was very stressed. I thought that if I worked one more day I would die”

When I asked what did he mean when he talked about stress, he told me:

“it is not having limits to work. During the promotion I got to work 20 hours a day. I did a whole month’s work in a week and half. I fainted twice.”

The subject's compulsive behavior's object may vary but the compulsive behavior has been invariable during a long time. In this way, when he won a TV in a raffle he spent 14 hours watching TV.

"I was starving and sleeping and I couldn’t stop and get up"

He also went to “Anonymous Gamblers” for a year (six months before the first meeting with me) because he was gambling compulsively. He gambled and lost U$S 6000 which were saved by his partner. He had taken the money in a deceptive form and at last he had to give it back.

Masturbation also takes part in his compulsive behavior. Occasionally he used to masturbate two or three times a day without knowing the reason why, without being sexually aroused, without desire. Other times he did it immediately after sexual intercourse.

At the beginning of the treatment, many upper maxillary teeth were missing. He explained that he had lost them because of caries, for chewing too much bubble gum (lots of cases daily) for six years at the same time he stopped smoking. He made a decision when he was smoking 80 cigarettes a day.
He was also worried about another symptom: sleeping difficulty. He told me:

"Sometimes it is 2 or 3 am and I can’t fall asleep. Other times I sleep for 10 hours and I still feel like sleeping. When I’m in an euphoric good mood I can’t sleep. I can’t sleep anyway, neither when I feel bad either when I feel good."

On the other hand, although he didn’t show it as a reason for consultation, his exaggerated sweating related to the room temperature was a very obvious sign of their clinical manifestations. During summertime, he gets to soak his jackets. When I asked him about it, he refers that:

"it was always like that "... since my adolescence my hands started sweating too much. I was very shy ".

Besides all that he told me he was worried about his social phobia to crowds:

" I worked 2 months, without free days, in a shopping moll. 14 to 16 hours non-stop! You don’t have any idea how I suffered "

He defined himself with a phrase that synthesizes his oscillation from one end to the other:

" I believe I'm superb and simultaneously I believe I 'm a foolish! . I must always be Gardel in everything I do, and I am so insecure " (* It is important to remember this, it will appear again)

His corporal attitude attracted attention too, he was "on the watch out", in a permanent state of muscular voltage. He couldn't remain quiet and
relaxed at any moment. His face statement was of alert, worry and fear, nearly all the time with his frown contracted. When he entered, moved or went away, he did it furtively as if he would have not wanted to produce any noise or disturbance, or as if his presence was not detected.

When treatment began, he always arrived at least fifteen to twenty minutes delayed. In other occasions he arrived thirty or forty minutes late. This behavior was slowly modified when he was pointed to it and we focused attention on its possible reasons.

Occasionally, when he remembered some life situations he was always surprised by how the grotesque and the extreme, disturbed facts. He was conscious of this and so he recognized it. In some opportunities, his friends requested him to tell what it had happened in such-and-such occasion, to laugh themselves together.

An illustrative example of this could be the time that, in the middle of a fury attack, he kicked the wall and his toe was broken, reason by which he had to be plastered. Some days later, plastered and leaning in a cane, while he slowly and with difficulty lowered the underground stairs accompanied by a friend, he was run over by someone from the crowd that lowered fast towards the train. Just, in the middle of the stairs, he began to give blows with the cane right and left. His friend could not help him because he was almost made kneel split one's sides with laughter.

Another opportunity his right hand finger bone was broken when he punched the table during a discussion with his brother. In the fights he had at school, he often got blinded and ended up hitting the walls. He
showed me the knuckles of his hands full of scars as a consequence of the wounds received in the skin that covered them.

Nevertheless, behind disturbed and apparently comic facade, there is a history of pain and abandonment (isolation). Their mother's treatment for 8 years, mentioned previously, was because of deep depression. The patient said that his mother remained in bed nearly for the whole day, without caring off the tasks of the house neither the children. There was always a house keeper who replaced her.

He said:

"My mother overprotected me in a way and over demanded me in another".

He does not remember affectionate demonstrations, smiles, caresses or embraces.

The house was always in state of abandonment and lacked of preservation tasks. A shady climate, without happiness.

When the treatment started he told me:

"A month passed since I have gone to my mother's house. I haven't got the time to get there".

"My father's family side was full of madness. My grandmother was a 'medium'. Later she came in the black magic. She became crazy. She did some "jobs" against my dad and me. We have had moments of comradeship with my father. He wasn't a gambler, but he was a compulsive shopper. In two years he squandered a fortune".
His father was absent all day long, since he had to work. The economic consequences of his management were not successful. There was a family company with non-clear handling where he did not get any rent.

"He bought a house and he registered it with grandma's name. We never had a house. His mother and his sister became rich. They cheated him. He was dominated ".

In spite of his father's efforts, attempts for business setting had an unfavorable result.

This meant for the patient several address changes, which supposed change of schools, friends, socio-economic context and also living in an urban zone moving to a rural one, with the consequent uprooting feeling.

He also helped his father doing different tasks, which took time out for peer relationships and playful activities. Apart from that he assumed the roll of caretaker and looked after his smaller brother, who was hyperactive, prone to bone fractures and to hurt himself accidentally.

His grandmother (father's side) baptized by the patient as "the nameless", was a dictatorial, hard and detached person.

"When I was a child I couldn't call her grandma because she didn't like it. She said it made her older".

Without any doubt, this was one of the things that contributed to a great degree to develop the awful image that women happened to have for him. One of the consequences of this explosive mixture between "careless woman and punishing woman" was that he had his first sexual
intercourse after he was 31 years old and his first stable partner when he was 36.

**Music in the therapeutic process**

While the patient was interviewed for his clinical record, he told me that sometimes when he was relaxed it was possible to be slept listening to music. I requested him for more details, and he added: "I have always liked Music. Any kind of music ".

When I asked him why he didn't play any music he answered:

"*Perhaps because can't tolerate going through things. I want to play right now! I began studying guitar twice and I couldn't stand exercising*."

Then he asked me:

"*How are we going to work Dr *."

I replied: "*Don't do the same as you did with the guitar! We didn't finish with the interview yet and you are already asking how are we going to work*."

Later referring to treatment I suggested that we could use all the thoughts, images or sensations that happened to him, his dreams, what he wanted, poems, books and newspaper articles. I was also going to teach him some exercises that were good for relaxing and to become aware with his body. We could listen or play music as well.

After that I proposed the patient that if he wanted he could bring a tape with the music he most like or seemed significant for him for any reason. Thus he did it.
The first track on side A he recorded was David Lebón's "How long will it take?" (An Argentine Author).

Listening to the song, allowed us to speak about his anxiety, hoping immediate results, without being able to look forward to. How that feature of his personality had conspired in such way that he never could persist as much as it was necessary in a task, study or business to arrive at some goal.

We began working on the idea that on between "a foolish person" and "Gardel" (Who was considered as the greatest tango singer in the world) there are many possibilities of singing. If he proposes himself and studies and improves little by little, he would reach to sing good or very good although he did not sing like Gardel. Finally, between white and black there are many grey tones.

I proposed him to begin studying percussion, because he had told me he liked it since he was a boy. It will be an activity that would help in his processing. The first musical instrument he had played was a "basic battery" that he himself built with tins, pans and covers of pots. If he liked, why do not do it?

**Composing a song, composing a life**

Ten months later, he brought to the session a poem that he had written. He explained me that he had been watching the Reporter on the TV and saw some images of how the police repressed without any risk the students in the Faculty of Social Sciences, after an "Escrache" (to
denounce somebody in the whole society, so they go to the house and stick posters against tortures and murders on the walls) that the group HIJOS (CHILDREN of argentine missing people) did to the torturer M. Etchecolatz.

He told me that he felt a very strong rage and that it made him remember the time of the last military dictatorship, to his jailed, tortured and even disappeared friends and to " all the fury he had to swallow ".

As he did not know what to do, he took a seat and began writing the first it came in his mind. The poem that him " left as a pull " and he entitled: "It does not stop, it does not pass, it does not close ".

What I said him first it was better and less harmful to express the rough writing a poem than kicking a wall breaking a finger. In addition, the poems keep on (the time - lasted more than) more than a blow and also could be found out by a lot of people. The type of cadence of verses, was almost naturally right to the musical genre (o rhythm) of milonga. I proposed him to arrange it into music. What did you seem about a milonga? No, he preferred a candombe.

We have worked and of a very difficult and non continuos way. Ever since he brought the poem until we gave him the final form passed a year and half.

As it commonly happens, what happened in the therapy sessions was just like in his life: it was always something interposed and avoid to go on with the task, it was interrupted or delayed. I decided not to force the work or to start. What I did do was to point to the difficulties that were
demonstrated throughout our work which prevented us to carry it out. It was not easy at all (it was not far from easy,) but then we were solving little by little and specially his "great difficulty", the one to take ahead he proposed himself persisting until finishing it.

This made me suspect and after asking he about it I could verify, that he had serious difficulties to arrive at orgasm (which is designed in the common language as "finish").

The work began when the patient sang poetry with a simple melodic line [is recording]. As it sounded monotone because of the extension of the verses, I suggested him to develop a little, enriching it harmonically. Each modification, by minim that was, was consulted and agreed. I limited myself only to introduce possibilities and to write what finally the patient decided. In the rhythmical part I did not take part in anything.

In the last part, he wanted to add to the candombe a guajira rhythm and thus was done.

During the time we worked, the patient continued learning and advancing slowly in his dominion of the percussion, still with disadvantages, absences to some classes or arriving late at others, specially at the beginning (repeating the same behaviour he had had in his psychotherapy).

Our work was carried out in the middle of a transference relationship where I occupied the place of a father comprehensive and respectful of his person and possibilities. I accompanied him to put order in his life slowly, but not without competition links. The delay in carrying out the
task and the uncountable troubles that interfered with it. Partly were the
method in which resistance in the processing was pronounced and his
envies against whom appeared always calm and with the possibility of
being able to write the music that sounded (since he did not know it). The
distrust was not missing: and if I "stole" his idea?

The patient knew I was a musician. He read an announcement of a
concert in the newspaper, he remarked and later he attended to a concert I
performed. I appeared like whom already had been able to do what he
still sought, as it happens to a boy with his father.

In regard to the selection of instrument, I understand the drums represent
the woman-mother, in the anthropological and historical meaning of the
musical instruments. I already mentioned the almost manifest hostility
that the patient felt by his mother and in this one case also it is fulfilled
that always it is socially more acceptable to unload the rage beating the
drums than to the own mother.

But it is very important to point that the relationship with his mother was
manifestly improving for the reasons that: in the first place he was
understanding "the abandonment" he suffered was the consequence of
the depression state she suffered. The mother has been a very ill person
who only did what she could. Secondly, the mother was also doing
important changes in her personality, since she was carrying out
psychotherapy. Perhaps the most representative to demonstrate her
changes is to relate that for the first time, were the manifestations of
affection among them, as much corporal, as hugs, kisses and caresses,
like verbalised, being able to say that they loved themselves and they recognised what each one had done and did by the other.

Another thing that was showy modified was its health, since it stop getting sick continuously. His friends and worker mates commented too that they saw him much more calm and that he did not became ill like before.

Once finalised the joint work, I accompanied him to SADAYC to register his first musical subject. Therefore reality became an old dream of him.

To have been able to manage the project, persisting until its conclusion, demonstrated to him that he was able of accomplishments, giving him more security in himself and greater self-esteem.

From that moment he composed several musical themes, some of which he performed publicly and with his companions of the percussion workshop. I was invited to attend to of those shows twice and I did do.

**Diagnosis by poetic images**

Four months after the session of the poem, as a result of the digestive annoyances that he came suffering half year ago, he did clinical studies (gastric duodenal progression x-ray and endoscopy) and he was diagnosed with gastric ulcer.

I said that the diagnosis had done it he himself, four months before, when he wrote: " What it does not close is the hole ". And this is neither miraculous nor magic; it is only an illustration that the patient, through his owns perception sensitivity had the knowledge in unconscious form
of what it happened in his stomach. But that could be expressed in a non-rational or non-logical way, but only metaphoric, through the poetry.

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Extend me on the bonds between the gastric ulcer and the autonomic nervous system, endocrine and immune systems, the brain right hemisphere, intuition and artistic manifestations, exceeds the limits of this article. (Whom who is interested in deepening in the subject could consult my book "Whistling in the dark. Music and Psychosomatic").

**Bibliography:**


**Biography**

- Prof. Dr. Carlos E. Caruso. He was born in Buenos Aires, Argentina, 1942
- Psychiatrist, Specialist in Psychosomatic Disorders.
- Manager of Music Therapy in the Art Therapy Center. British Hospital, Buenos Aires.
- Teacher at the University of Buenos Aires, Argentina, in the Music Therapy School at the Psychology Faculty.
- Member of the Managing Committee of ASAM (The Argentine Association of Music Therapy).
• President of "Art and Psychiatry" Section of APSA (The Argentine Psychiatric Association).

• Publications: he has published numerous articles about his specialty in different Psychology and Psychiatric Journals.

• Published Book: "Whistling in the darkness. Music and Psychosomatic".

• Musician (Pianist and composer)

• CD recorded: "Tangos by Caruso. Concert Piano Solos".

**Address**

Medrano 1394 (CP1179)

Buenos Aires

Argentina

e-mail: ecaruso@psi.uba.ar ; www.carlos@tangosbycaruso.com
Music Therapy In The Environment - Sound/musical integration in the community for mental disabled

Cominardi, Claudio

AIM OF THE RESEARCH

The sound/musical dimension is a basic element of relation among us and the environment we live in, as it establishes an environmental context’s identity and it defines its own quality.

In the residential communities for mentally disabled (mental retardation) with psychopathologic and neurological disorders, the quality of life is strictly connected with the quality of the environment they are offered and which they live, so that the sound/musical dimension becomes an important channel of analogical interrelation, especially where the spoken and digital communication among the patients is altered, or completely absent.

The aim of this research has been to

• create a sound/environmental integration among personalities,
• as an improvement of the community life’s quality.

THE SOUND ENVIRONMENTAL RELATION

The environments which surround our life, transmit us some messages, codes and relationships, in a continuous evolution of physical, sensorial and affective spaces which flow and change in time.
At the same time we communicate with them too, through our real presence and our own codes, our relationships and experiences, in a determining report of exchange for the life’s walk of each person, and each community.

If we add to that the relationship channel, we obtain a comparison between our experience and that of other men who share the same environment, producing a common denominator that gives it an own qualitative identity, so that it becomes a cultural and communicative channel who shares it in.

The identity’s relation, that is created between us and the environment, can be described as

- **a feedback among an external context, a man’s internal dimension and a relational dimension among men.**

Even sounds, noises, words, music belong to this feedback too, and everything that can be defined as an object or a sound fact (sound/environmental triad).

So it is clear

- **a direct relation between life’s quality and sound environment’s quality**

where the first one’s well-being or uneasiness influence the second one’s and vice versa.
THE ENVIRONMENTAL ISO

Every man who lives in a community context gets a correspondence between its own ISO’s complex and the environment’s one, which surrounds it.

The environmental sonority formed by the dynamics’ unity occurred at its inside, represents the personalities’ group identity who live the context, in a perpetual remand between the group and the environment.

So, every man can represent his own identity through a communicative complex connected with the environment, which receives and sends back his messages, where he expresses his own personality as a project of interaction balanced on the context.

That is explained by affectivity, conflicts, preferences, defences, selections, expulsions and everything that is part of the relations of an institutionalised group.

The Environmental ISO is formed on the whole of these dynamics as the identity of a community environment.

THE INTEGRATION AIM

All the idea of this enquiry’s intervention on the Environmental ISO refers to a main goal:

THE INTEGRATION.

THE INTEGRATION of a community which can communicate according to an original environmental and cultural identity, where the
spoken language is often altered, not homogenous, but induced as prevailing - probably the only one communication model, and the sound sources like TV, radio etc, are the cause of the levelling, fragmentation and isolation in the group.

THE INTEGRATION starting from the people mostly compromised, less autonomous and more abandoned on the relational plane to be transmitted to those luckiest according to an opening way, knowledge and awareness of themselves and the others in its own context.

This aim’s development includes the following therapeutic indicators:

1 IMPROVEMENT OF ECOLOGY AND SOUND/ENVIRONMENTAL QUALITY, ACCORDING TO A FORMED AND PERSONALIZED IDENTITY SHARED BY THE GROUP.

2 RESOLUTION OF BEHAVIOURS-PROBLEMS AND CONFLICTS WHICH REVEAL THROUGH SOUND AND PHONOLOGIC ELEMENTS.

3 IMPROVEMENT AND OPENING OF INTERPERSONAL RELATIONSHIPS IN THE GROUP, ACCORDING TO SOME COMMUNICATIVE ANALOGICAL AND NOT VERBAL CHANNELS.

4 ACQUISITION OF A BEST PERSONAL AUTONOMY AND SKILL OF INTERACTION, INTENDED AS A NEUROMOTORY ACTIVATION SPECIFICALLY DESIGNED TO THE ACHIEVEMENT OF AN AIM.

THE INTERVENTION STRATEGY

Before acting by the intervention it is necessary to carry on a special diagnosis of the community environment through a specific way of tests, enquiries and examinations created for the survey of all the relational dynamics that bring back to the sound/environmental dimension.
Once you have discovered the problems and the therapeutic aims, the main strategy of this intervention lies in introducing a proposal inside the community that can

- **modify the relational environment according to some communicative analogical channels shared in the group,** through a setting of instruments and sound/musical objects studied onto relational dynamics expressed by the patients.

By this proposal the community is stimulated keeping unchanged all her environmental identity, being able to represent herself in a symbolic and modified situation, but it gives the opportunity to rebuild and express analogically her own affectivities, pulsations and daily interactions.

Now it is possible to give the intervention a therapeutic value by introducing and developing the semantic and relational variables during the way’s evolution according to our own aims’ expectations.

By this different analysis of pulsations and communicative ways, we can correct and harmonize the relational quality inside the group, by reorganizing consequently the environmental identity of the community, in her integration’s aim.

**Authors Address**

Claudio Cominardi
music therapist - researcher - University of Verona - Italy
For further information, write to:

Via Conche 38
25057 Sale Marasino –Bs- Italy

E-mail: c.cominardi@tiscalinet.it
A Case Study: demonstrating how the principles of dynamic psychotherapy can be used in Music Therapy

Compton Dickinson, Stella
KCL
Guys and St. Thomas’s Hospitals
M.Sc. Mental Health Studies.

ABSTRACT

The aim of this paper is to consider within the context of clinical practice how the process of psychodynamic music therapy may be informed and understood with reference to several theoretical perspectives. The emphasis is on the process rather than on aims and objectives. The latter were required for reports and were formulated and reviewed in response to clinical presentation and change.
The paper will explore psychodynamic and phenomenological aspects and the role of musical improvisation. It will also consider some aspects of the named nurse and therapist’s working relationship. The patient’s name has been changed to protect confidentiality.

Introduction

I have chosen to demonstrate the principles of dynamic psychotherapy, and their application in psychodynamic music therapy in the form of a single case study. As such the theories are considered following clinical presentation. In this way they provide a framework of understanding and a means of comprehension. The duration of treatment was one year.

A CASE OF WORK, REST AND PLAY- Music therapy in early onset psychosis PART 1

Description

Reason for referral: Jacob was referred at the age of eighteen to the residential assessment and treatment unit where I then worked. This
small unit specialises in the treatment of patients who have learning
disabilities, mental health problems and who present with challenging
behaviour.

Jacob was diagnosed with Aspergers syndrome at the age of thirteen, he
was described as having complex needs and psychotic illness. His
admittance followed a violent attack on his mother. His behaviour was
described as unpredictably aggressive and he was verbally abusive.

Educational History: At the age of seven, Jacob received a statement of
special educational needs. Nevertheless, he attended mainstream
secondary school for four years, supported by the special needs
department. He suffered a serious deterioration in his mental health at the
age of fifteen, also becoming physically aggressive to another boy. Jacob
then received home tuition but assaulted the tutor. He was admitted to an
adolescent unit. After several months he was transferred to a specialist
residential school for patients with aspberger’s syndrome. He did not
settle. Jacob became anxious, disturbed, disruptive, disinterested and
isolated. He spent long periods listening to music in his own room having
reportedly frightened other pupils.

Developmental history: The pregnancy and birth were normal and no
major physical illnesses are reported. From the age of three when starting
nursery, Jacob displayed unusual mannerisms: hand wringing and
clutching his knees. He showed repeated interest in flushing the lavatory
and in water rather than social interest with his peers. Jacob seldom
smiled, he found it difficult to share toys or ask for help and he rarely
engaged in pretent play.
Jacob’s early verbal development was normal but he did not develop verbal social skills until the age of thirteen, instead he used repeated questioning.

The psychology report indicates that Jacob’s IQ has been assessed as within the mild to borderline range (69) Nevertheless, he succeeded in passing a GCE in English. He has knowledge of social rules but can be rigid and repetitive as well as openly outrageous, personal and bizarre.

Family History: Jacob’s parents are both teachers. His father is a headmaster, his mother teaches French, English and special needs education. Jacob has an older brother who is at university and reportedly suffered one psychotic episode requiring a six week hospital admission. One report stated that Jacob’s mother suffered post natal depression following the birth of her first son.

Psychiatric History: Jacob has a history of psychotic episodes which began at the age of fifteen and a half. These resulted in hospital admissions and outpatient support. He received a diagnosis of acute schizophrenia type psychosis and was assessed as having a very high Hamilton Depression Rating Scale Score. Auditory hallucinations are first reported at the age of sixteen. The psychiatric report questions some sort of delusional ideation from Jacob’s remark “hold my hand, squeeze it so I can take your power to make me better”.

**PART 2 - DIAGNOSES:**

Firstly I will present these from a psychiatric perspective. I will then discuss presenting phenomenology as the case unfolds.
Asperger’s Syndrome: This diagnosis comes within the autistic spectrum of pervasive developmental disorders. The underlying triads of impairments are in verbal and non-verbal communication, two-way social interaction (relationships) and impairment of imaginative skills and limited interests. As the child gets older some milestones may be late or missed, odd interests develop and there may be a strange lack of interest in others. Asperger’s syndrome usually refers to individuals who have normal or above normal intelligence, though in this case it may be viewed as a controversial point. Reciprocal social interactions are impaired leading to isolation, language problems and reported difficulties in non-verbal communication.

Learning Disability: is not defined by intellectual functioning alone, but also adaptive behaviour. It manifests before the age of eighteen in sub average intellectual functioning in two or more of the following areas: social skills, communication, self care, community use, home living, self direction, health and safety, leisure, work, self direction and functional academics. AAMR 1992 definition (from the Psychology report).

Idiopathic aetiology may result from hidden deprivation in non-deprived family backgrounds or there may be a physical cause of unknown aetiology.

The lack of a stimulating and nurturing environment can lead to delay in all areas of development: cognitive skills, communication, social skills, emotional maturity, personality formation etc. (Winterhalder 1998)
Paranoid schizophrenia: The consultant psychiatrist confirmed this halfway through the treatment, supported by evidence from the multidisciplinary team.

A sense of perplexity is common in the prodromal phase, prior to the onset of florid symptoms. This period is also characterised by a loss of interest in social activities, generalised anxiety, mild depression and preoccupation.

There are no pathognomonic symptoms to this disorder: It is diagnosed by the presence of specific symptoms and signs. Clear consciousness and intellectual capacity are maintained. A diagnosis of organic brain disease must be eliminated. The disturbance involves a loss of sense of self in the feeling of individuality, uniqueness and self direction. Intimate thoughts, feelings and acts are felt to be known and this can lead to the development of explanatory delusions.

Hallucinations, particularly auditory ones are common, characteristically they are in the form of a running commentary in the third person. Their content is often derogatory.

Delusions are culturally inappropriate or completely impossible, they may be delusions of control, influence or passivity. The latter carry a high risk to the individual and to others. Thought echo, thought insertion, thought withdrawal and thought broadcasting also have special importance to diagnosis.

Thought disorder in the form of interruptions to speech, in the train of thought i.e. derailment or word salad, are common in acute stages, affect
may be incongruent and mood disturbances include irritability, sudden anger, fearfulness and suspicion. Symptoms must persist for a month or more to apply the diagnosis. (ICD10 1992)

Depression is a frequent secondary feature and must be differentiated as such, i.e. schizophrenic symptoms should antedate affective disturbance. (ICD 10 1992).

PART 3 - THE PROCESS OF THERAPY:

Chapter 1. Beginning:
I first met Jacob when he was brought along to a music therapy group, which was open to residents of the unit. He talked about his brother having been psychotic and his own fear of psychosis. I perceived a vague sense of fear and perplexity at Jacob’s identification with, yet the invisibility of his brother. I wondered how he was experienced in Jacob’s phantasy.

Jacob dominated the second session and played with loud, grim determination. I considered this as reminiscent of his school report, which said he had frightened others with his loud voice. Jacob was challenging, facetious and he emanated a sense of superiority over the other clients. We finished with a game of free association in which each person played in turn and then voiced the first word that came into their head. Jacob’s word was “Dove”. We considered this, he said he liked Dove soap and I responded that the Dove is also a symbol of Peace.

I have considered Adler’s(1927) views on the striving for superiority. I understand his concept of the life goal and “social feeling” as
distinguishing between maximum personal growth and fulfilment in the shared happiness of the self and others or in retreating from these aspirations for fear of failure into a lesser goal of superiority over others. Adler saw this latter goal as the cause of all neurosis, psychosis and crime. (Macdiarmid 1997). Jacob had understandable reason to question his ability to achieve a life goal. His education had already been severely disrupted due to social and mental health problems. In comparison, his older brother had already flown the parental nest and I wondered if this raised sibling feelings of envy or inferiority.

I was also interested in the acceptance of my interpretation of the Dove as a symbol of peace and whether Jacob was unconsciously expressing a desire to purge himself of badness. In retrospect I considered this disturbed young man in the light of Fairbairn’s (1952) theories in which he viewed the delinquent children that he analysed as only able to internalise bad objects. To enlarge further: It became apparent to me as the work with Jacob evolved, that despite threats and conflict with his parents, Jacob could not admit externally that they were bad but he appeared to have internalised them as being so. In reality his parents would not be judged as being bad they were quite the contrary in very difficult circumstances. We are however exploring here the unresolved phantasies of the new born infant’s primitive relating to a possibly depressed mother and a stressed father.

Fairbairn’s (1952) model of the mind conceptualises the intrapsychic world of the infant as object seeking, with investment of libido through the central ego, rather than as Freud viewed it as primarily pleasure
seeking. The child strives only for acceptance by the mother as loving him in his own right as a person. Instead however, the split off libidinal ego may seek the exciting mother (part object) or the internal saboteur may prevent success by identifying with the rejecting mother (part object). Thus the good mother is not introjected. The infant thus makes himself bad internally and externally in order to preserve the parents externally as good. By taking on the badness he creates for himself a safe and good environment. I could now understand this sense of the invalidation of the self in favour of the object, which is so desperately needed. It is at this stage that the guilt, (and thus possibly the need for the dove soap), may be understood in terms of Fairbairn’s moral defence or Freud’s (1923) superego.

Jacob’s behaviour was contemptuous and threatening, this alternated with despondency. In retrospect I can understand this in Ryle’s (2002) concept of the narcissistic personality in which alternating self state’s flip from grand, controlling, contemptuous with seeking of admiration and ideal love to feeling rejected, viciously controlling and contemptible. This was first demonstrated when Jacob isolated himself in his room from which, whilst lying despondently on his bed, he grandly informed me, as I stood outside the threshold, that he would like to play Richard Strauss, Debussy…or did I know Fat Boy Slim? He then threatened me, saying: “Do you think it would hurt if I kicked you on the ankle?” It was summer time and I suspect he had seen the red scar on my ankle where I had fractured it some years earlier. I flinched inwardly as almost nowhere else would hurt as much. I responded to Jacob’s threat. “I am wondering if you have been hurt on the inside?” This interpretation really engaged
him and perhaps also gave us a point of identification with the unsaid acknowledgement that I knew something about being hurt.

Winnicott (1947) emphasises the value of an accurate interpretation as the only solution-particularly in a crisis. This was apparently truly valued by the delinquent boy that Winnicott described.

I have since wondered if I denied my own hatred of Jacob at that time. Winnicott (1947) considered a truly objective counter transference as being based on the analyst’s love and hate in reaction to objective observation of the patient’s actual behaviour and personality. Jacob was responding with threats of a vicious attack and with rejecting behaviour. Perhaps I was a little frightened, but more importantly I perceived a damaged, vulnerable individual in need of recognition as yet perhaps never experienced. It may be understood within Ryle’s (1991) concept of the reciprocal roles: in this case those of rejecting and rejected. The parental and child derived patterns of behaviour may have led him to expect rejection when he behaved rejectingly or to feel rejected in response to a primary carer.

Subsequently I invited Jacob for an individual session, this enabled us to have access to the Piano. To my knowledge Jacob had no formal musical training. I reassured him that this was not necessary in order to benefit from music therapy and for him to explore the expression of his feelings through music. Jacob came in with an attitude that I perceived as sullen, sulky and disrespectful. He picked up a recorder, dismantled it and threw it in pieces to the floor. This indicated to me a gesture of contempt: the instrument may have reactivated memories of school. We left it in pieces
on the floor and nothing was said. Jacob then sat at the Piano next to me. He began to play with loud, brittle sounds. I experienced his mood as taut, aggressive and murderously rhythmic with hard, dissonant stabs of sound. I felt I was being mocked. Jacob would suddenly stop as if to try to catch me out, yet our music together sustained. I felt as if I was grimly hanging on, but of course this may have been mutual, and therefore a counter transference: particularly in consideration of the emotional impact on Jacob of having recently been admitted. It gradually became possible to attune to Jacob as if a non-verbal form of cathartic abreaction was taking place. By this I mean that something is being said non-verbally, responded to and simultaneously experienced with affect.

Jacob had as yet made no eye contact, but then our music synchronised, a moment described by Woodcock as a “critical moment” in his paper “Communication through music: what is communicated”. I understand this as being based on the concept of Daniel Stern’s (1985) affect attunement. Stern considered that the inner state of the child or patient has to be read through his overt behaviour, imitation is not sufficient, it is only through the similarity of the inner experience that attunement is achieved. I considered what I was feeling: Tested, trying to survive and then utterly surprised by the sudden connectedness. Jacob stopped. He gazed directly at me with searching, deep intensity. I noted the darkness of his large brown eyes and long lashes. I experienced a sense of a profoundly deep split between open hostility and a sense of being in love. This felt quite shocking. I experienced an unlocated and ambivalent feeling of reluctance and longing. This felt very significant. It took considerable retrospective thought to redeem my equilibrium, and to
understand the experience as a counter transference of Jacob’s inner state. The music became gentle but then fluctuating as Jacob verbalised his contemplation of smashing the piano lid onto my hands. Had he acted on his two aggressive urges so far, I would by then have been immobilised from the feet and the hands.

Jacob’s presentation may be further understood through Fairbairn’s (1952) theory of aggression as the frustration of libidinal needs. I suggest that this unintegrated state may manifest as an adolescent issue ambivalence and dependency: The development of the object-relationship and subsequent healthy separation comes about when infantile dependency is gradually replaced by a mature dependence based on the sense of being two separate, different people. I concluded that our music with its murderous stabs and moments of profound togetherness led to Jacob’s apparent surprise in feeling connected. The interaction apparently highlighted the unfamiliarity of this feeling for Jacob.: an inner conflict between desire and reluctance or inability to abandon this position for independence. Clinically this was represented in the sense of longing and love, and the desire to renounce it through hostility and aggression. The fact that Jacob was able to verbalise his aggressive thoughts as well as to express them in the stabbing music, thus abreacting the affect, may have relieved the necessity for him to act on the impulse. Instead Jacob picked up the wire cymbal brush and ruefully stroked the back of his hand. He remained seated at the piano and then violently hit the cymbal that was situated at his side. The strength of impact made it slowly descend upon its stand. Whilst it may have been perceived as a disappointing cymbal, it may also be considered visually as a symbolic
representation of the full and rounded breast. Jacob fiddled restlessly with the centre screw as if it was a nipple. The therapeutic alliance had tentatively begun.

Chapter 2. The prodromal phase.
The therapy lasted in all for one year. It was characterised by several significant breaks, some of which were not planned due to sickness both on my part and Jacob’s. I will discuss these as they arise.

At this stage Jacob presented with a fixed smile, incongruent to his agitated, irritated and angry moods. He would mention his brother saying that he “was quite like him, but now more different.” There was a sense of ambivalence as though he was trying to reassure himself. He asked bizarre questions such as “Do you think in fifty or a hundred years time you might end up more like me or me more like me? I wondered on a more profound level about the desire of the infant to merge and whether Jacob had fully experienced this as a baby. It appeared to conflict directly in adolescence with his desire for independence.

I will digress for a moment in consideration that the learning disability in itself as well as autistic traits, intra psychic and external factors all contribute to the delay in adolescent psychic development. Thus from this point of view Jacob’s chronological age may be seen not to correlate with his stage of psychic development.

There was a pervading sense of sadness as further fragmentation of Jacob’s sense of self occurred. I am limited by space to provide all the
details so I will focus on aspects that I considered to be particularly relevant in therapy.

Jacob warned me that he would feel “uncomfortable” were I were to dress in a “more modern way”. I considered this remark in relation to Fairbairn’s model of the mind. Perhaps there was a potential that I may become the exciting object to his libidinal ego, split off from the central ego. I examined the possibility of whether I was being experienced as seductive. I certainly did not feel that way.

Alternatively, Jacob’s remark might indicate suggestions of the Oedipus complex manifesting in the mother transference. (Freud 1909) Freud’s discovery is frequently considered to be controversial, it nevertheless may have important implications for treatment. I view the oedipus complex from Freud’s autobiographical perspective: his mother was very young, about the same age as Sigmund’s half brother. She was his father’s second wife. Freud had a vivid childhood memory of having watched his mother undressing, thus activating the instinctual sex drive. The horrific story of Oedipus, who killed his father and unknowingly married his mother, has undoubtedly stood the test of time having originated as myth and as used in ancient Greece in a play by Sophocles.

I consider that the vast majority of adolescents would find the conscious thought of sex with their mother as utterly repugnant. It thus becomes taboo and as a defence is repressed into the unconscious. The situation is normally resolved when the youngster has separated and found a partner outside the family. This would be a difficult task for Jacob bearing in mind his impairment of social function alone.
Due to the level of risk at this time, a nurse attended the session. Jacob liked this man, clearly viewing him as a positive male role model. The effect of this harmonious team working was intended to promote a perception in Jacob that it may serve his best interests to receive the additional, albeit passive attention. It was also necessary to meet the risk requirements. In my mind I was making the best of the necessity of a potentially triangular situation within the therapy room. The situation was thus thought of as working towards the amelioration of the unconscious sense of conflict that can be activated within the oedipal triad. I would suggest that in clinical practice, harmonious team working is a simple practical solution to the clinical phenomenon known as the Oedipus complex. A subject that is otherwise frequently viewed with suspicion by some clinicians. This oedipal pattern fitted with the family history and Jacob’s reported inappropriate sexualised behaviours towards his mother and anger towards his father. This was further supported when Jacob later referred to his father as being like a nuclear bomb, a force too powerful to overcome.

There was then a three week break, during which Jacob became more and more disturbed. The next week the staff felt he was too unwell to attend. He came the following week and I experienced a longing to give out love. I considered whether this was my own sense of guilt for not being there for him or a counter transference linked to the previous hypothesis: i.e. that in the absence of anyone else, as in the unresolved Oedipus complex, whether I filled Jacob’s verbalised need to be with “girls”. Perhaps it felt too horrid for me to contemplate. Whilst the Freudian
concept was valuable in understanding the process I considered what else I might usefully represent to Jacob.

I considered that the Jungian view of the archetypal mother as protective and nourishing rather than incestuous may prove to be more fruitful from a universal perspective. Considering that she can also be devouring it would be important to maintain a balanced perspective. I will now attempt to validate this change of approach. Jung’s ideas about incest coincided with my view that there may not be a conscious oedipal desire. Jung viewed it as symbolic and associated with death and rebirth. Myth and religion were not only important to him but he also witnesses these themes with his schizophrenic patients at the Bergholtzi,(1961) The primordial images or archetypes originate as universal symbols both in myth and in psychotic delusions.

Jung (1961) worked with patients with schizophrenia prior to the introduction of neuroleptic medication. Not dissimilarly, Jacob was resistant to medication which had not at this stage been stabilised.

In retrospect I am interested to note that Jung (1954) maintained that regression was necessary if the individual lost sight of his inner psychic reality. This was ultimately to occur, though I had no indication or thought of it at this stage. Jung viewed the self as the central archetype. This is a concept to which I will return. Meanwhile it was becoming apparent that Jacob’s sense of self was fragmented and undernourished.

Jacob was considered to be too challenging and aggressive to attend the next session. It was nearly Christmas time and the following session, which preceded the Christmas break, was full of anxiety. Jacob played
the Congas (two large free standing hand drums). He excluded me despite my best non-verbal, musical efforts to communicate a sense of being there. He then settled as I played the bass chime with its calming low vibration. Then he suddenly shouted “Stella, that’s enough!” I obeyed. It felt difficult to know if it was the connected moments or the disconnected ones that were so anxiety provoking. I was aware that Jacob desperately needed to find a way of gaining some control. The subsequent stillness enabled Jacob to take the initiative. He became more explorative, playing over the full range of the piano. I maintained a passive stance, and was able then to just be there, attentively watching. I am reminded of Kohut’s (1971) theory that primary narcissism requires acknowledgement, the damage having been done initially through empathic failure. Kohut maintains that the separate psychobiological existence of mother and child evolves from the union of the two. This seems fairly obvious so far. Object relations do not exclude narcissism, though narcissism in this respect relates to objects that are negative in the service of the self, thus the risk is that the narcissistic experience is of objects as part of the self. I considered that were I to become too closely identified to Jacob through the musical interaction this may serve the opposite to the desired effect and reduce his sense of self identity.

Whilst Freud’s (1932) model of the mind as ego, super ego and id are according to Kohut (1978): ‘States, abstractions’ and ‘experience distant’ concepts, our psychic apparatus. i.e. personality and identity seek harmony with the observation of social behaviour and a description of the self in interaction with others. Thus the self may be viewed as an ‘experience near’ concept, being a structure within the mind rather than
an agent of it. In health it is imbued with energy and has continuity of
time. The adult personality is impoverished if the patient remains fixated
in the grandiose, archaic, non integrated self. Realistic activities are
impaired by the more infantile manner of relating. Kohut maintains that
the result amounts to the same as the instinctual repression of incestuous
object relating as seen in transference neuroses.

Freud’s concept from which I see Kohut’s (1978) as developing,
maintained that anxious situations render the ego helpless in its efforts to
explicitly acknowledge, express and gratify the instinctual desires and
still sustain its own organisation, particularly if the situation reactivates
unconscious earlier infantile situations when the ego was still immature
and rendered helpless (DeKoning 1982). This also involves not only the
interaction of mind and body as a whole person but interaction with the
outside world.

All this indicated to me an interpersonal approach, the intrapsychic
aspects remaining indispensable for understanding and informing my
therapeutic technique.

Coltart in “The self: what is it?” considered that through the process of
free association the patient begins to share in a process of learning about
their ‘self’ experience. Through the analyst’s receptivity he may reflect
on his thoughts, feelings and underlying aspects and thus deepen his self
awareness. Bion called it a state of reverie. The object relations theorists,
Guntrip, Fairbairn, Balint and Winnicott take this a stage further from the
one person psychology of Freud. They view the development of self
occurring through a relationship. Winnicott’s (1971) most well known
saying is probably “There is no such thing as a baby”. This indicates the necessity for the facilitating environment in which sustenance is gained from the primary carers and individuality is developed through creativity and play. This continues to be acknowledged in Ryle’s (1991) cognitive analytic approach in the development of the procedural sequence object relations model incorporating Vygotsky’s activity theory (Ryle 2002). In psychodynamic music therapy the learning process may be less structured than the cognitive analytic approach but I suggest that learning still occurs through the same process of sign mediation. i.e.from a more experienced other who provides just enough scaffolding in the form of musical structures that have meaning. This does not exclude the potential for free association.

Chapter 3. “The world works in twos.”

Jacob was agitated, leaving the room twice and returning. He then played the metallophone (tuned percussion) and then the Congas. I played the piano aiming to reflect and empathise with his disturbed mood. Jacob said he found the piano “frightening” though I suspect it was the reflection of his inner state in my music that frightened him. He paced the large room restlessly and in an intimidating manner, he was self absorbed with no insight into the intimidating nature of his behaviour. Suddenly he stopped and stared at the wall, looking at two orange electrical cables that entered a wall socket. He was transfixed, he asked me to look at them and then quickly said “Stella, hold my hand” but then continued to pace the room. Jacob said with agitation that the cables made him think about death. He then went to the Congas referring
to them as twins. I suggested that we tried to play some music together. Jacob played in a challenging manner, loud and fast. It felt as if we were trying to exorcise fear. I then experienced a sense of bonding in something that felt more reciprocal. The two of us were in this thing together. Firstly Jacob imitated me, then subtly this shifted so that he led and I followed. This was our first sustained improvisation that proceeded with sustained turn taking interaction. This aspect may have helped to differentiate between our separate identities. The ability to take turns, as a precursor to dialogue which Jacob’s verbal interactions did not generally include, felt significant and an important step in our communication. Jacob then stopped and asked me to copy him. Finally I missed one of his beats and it felt as if I had been caught out. He shouted “That’s it! Game’s over!” He marched off across the room. Was this his idea of a Game? of play? It felt macabre.

I hadn’t been perfect, I felt that he had sought control in pursuit of an ideal good object, and it was apparently to be that or nothing.

Jacob’s presentation supports Tustin’s (1981) description of the desire in an autistic child that everything should be perfect. She viewed their difficulty in taking in of shared realities as presenting as psychotic.

I reflected after the session that it felt significant that there was a desire from Jacob that we should be exactly the same in our playing but then I was overwhelmed by a terrible state of nothingness, it was desolate. I wanted to hand Jacob over to my supervisor for further sessions. He and I talked about this and I was contained.
I can explain the experience as a narcissistic counter transference of annihilation. This would appear to be supported by Jacob’s talk of death. The experience of musical interaction and the resulting counter transference had reinforced my understanding of Jacob’s inner state of disintegration. He finished the session in a calmer state and I wondered if the interactive process and my absorption of his feelings had relieved some of his distress, just as his idea about holding hands might give him the strength he needed.

I also considered my own narcissistic tendencies and wondered what I was doing and why I was there.

I have considered that the schizophrenic patient is alone and alienated from us when in a delusional state. It is only real to him and thus it is potentially non empathisable.

The orange cables presented to Jacob a terrible fear that I was unable to see or understand. His psychotic perceptions could exist alongside and among but yet isolated from mine. All I could do was try to lead him back to our world.

Vera Strasser (DeKoning 1982 ) pointed out as early as 1921 that even if there is a disturbed exchange of affectivity, the patient may respond very sensitively to the departure of a doctor or presumably a therapist. The patient is both separated from us, alone in his hallucinations and delusions yet capable, prepared and needing to belong and to be the same as us. This was demonstrated in our music and in the therapeutic relationship.
Jacob continued to present with psychotic symptoms. I would agree with De Koning (1982) in his assertion that some clinicians have a feel for when a patient is hallucinating. It is very difficult to substantiate such a claim, but De Koning notes that a quick negation from the patient suggests that the patient knows what the interviewer means. The patient perceives and he hallucinates and others aren’t asked to listen. Thus we both see an object, such as the orange cable, but the patient attributes special meaning to it. The delusion in thinking or the hallucination, usually in the auditory modality, occurs amid what we can all see and hear. As such, Jacob and I were both alone and together in the subsequent sessions, with the added dimension of psychotic intrusions. Jacob muttered to himself and sometimes shouted “Shut up”. This was quite clearly not addressed to myself but as he quickly looked over his shoulder as if in response to an invisible external voice, I thought about the whispering voices on the tape in the film “the sixth sense”. I wondered if I really was the impervious, unseeing, unhearing protector of a patient who was vulnerable to attack from an abstract, alien force that could subtly access the more fragmented self of the schizophrenic mind.

Nevertheless Jacob’s new found ability in turn taking gradually led to more sustained interaction. The fixed smile had become a broad but sometimes grim smile that often followed our musical interactions. I considered whether Jacob hated me and whether I was in denial of this, I didn’t experience a negative transference of hate and Jacob’s level of engagement appeared to indicate that I was needed. He nevertheless remained threatening and agitated and I attributed this to his responses to the psychotic experiences that he was suffering. He would pace the
room. I made the mistake of suggesting that perhaps the Congas which he had called twins were in fact brothers as they didn’t look quite the same. Jacob shrieked, ”Don’t even mention twins!” It would appear that the world working in twos was a very ambivalent and dangerous place. But in other ways it sustained him and the truth of this idea may be considered in that none of us would be here if the world did not work in twos! : Jacob would request “angry” music and “peaceful” music, he could copy and he could accept praise, he made more varied use of the instruments and he began to share his frustrations with me, as well as his desire to go home.

He would finish calmly and his arousal levels could be moderated within the musical improvisation. His music therapy at that time was the only ray of hope at a time of desperation, when he harmed and traumatised nursing staff. He wasn’t to go home he was about to be locked up.

**Chapter 4 The Secure unit.**

Jacob was transferred to the new intensive therapies medium secure unit that opened on the same site. We both had to get to know a new Team. There was a three week break which began with Jacob being unwell. I then had to take a one week break. When we met again it was in the new music therapy room. Jacob took a macho and defiant stance, making a point of demonstrating his superior strength on the Djembe drum and temple blocks and then with chord clusters at the piano. I had a member of staff, Jacob’s new Named Nurse in the room with me. Without a staff presence I could not have felt safe. I perceived Jacob’s need for recognition as in any needy child, initially like an infant too distressed to
accept comfort, gradually Jacob catharted this violent rage. He picked up a heavy Cabasha (hand held instrument) and swung it threateningly. I was aware that I was in danger but as I watched Jacob I played the treble recorder, following the beat of Jacob’s swings. The aim was to create a nourishing, low and gentle effect but there was a melancholic sadness too, symbolic of hurt. Jacob played his Cabasha and becoming calmer he asked if I was his friend and whether I cared. During this session he left twice but returned firstly in response to my piano playing and secondly as I vocalised gently “where’s Jacob?” I wondered if he needed to allow himself to become a child again.

The music held him though I considered that he may have tried to finish me off. After all, I was the woman who had disappeared and abandoned him when he had been too ill to attend. Fairbairn’s (1952) theory held up: The infant’s perception that the mother failed to love him in his own right, and in his entirety was fundamental to the situation. It seems simple enough but nevertheless, I am undecided whether this is instincstcal or too intellectual for a tiny child to conceive. It certainly was not beyond Jacob to express his sense of abandonment when he most needed someone during the move to unfamiliar confined surroundings. In later sessions he was able to reflect that during that period he thought I had died, as indeed within him I must have done.

The session supports Klein’s (1956) view that if a baby is able to accept love and food, albeit in this case metaphorically, this means that he can overcome resentment about frustration fairly quickly. When gratification is again provided he regains feelings of love. Whilst we are considering a
young man of eighteen years we are also considering an unintegrated and now also a disintegrated state of mind. Klein viewed these internal factors as generally under rated.

I began the work with Jacob with a supposition that something went wrong in the early weeks of his life through no one person’s intentional fault. Balint (1968) considers the notion of the schizophrenogenic mother who cannot be in harmony with her child but loves it both excessively and conditionally, thus she is unable to experience what is happening internally for the child. This theory appears to be sound from a variety of different psychodynamic frameworks however I consider that it may be construed as judgemental towards the biological mother. I consider her state of health as well as biological, social, genetic and environmental factors as contributory factors.

Klein held that innate aggression is bound to be increased by unfavourable external circumstances. She considered that the ego was influenced by instinctual impulses that were kept under control by repression. She maintained that the ego exists from birth to defend from anxiety. It initiates the process of introjection, initially of part objects and the external world, which become part of the individual’s inner life. It also initiates the process of projection. This pertains to the infant’s capacity to attribute to others the feelings of love and hate, these are directed primarily onto mother who thus becomes good or dangerous. Considering that these processes are part of the infant’s phantasies the external world is changed when it is introjected. If the mother is introjected as dependable the ego is strengthened. Identification with the
good object according to Klein is displayed externally with the child’s copying of mother’s actions and attitudes. This is a less pessimistic picture than Fairbairn’s and the chances of Jacob internalising something good via myself as the transferential mother had already been displayed in his copying, though I currently definitely felt like a bad mother.

Klein stresses the importance of good relations between parents so that aggressiveness and hate do not remain operative and expressed in oedipal rivalry with the father. As discussed earlier this continued to be simulated with a close working relationship between Jacob’s new named nurse and myself. He took an encouraging and helpful interest in the process and our independent approaches were compatible and supportive of each other.

In the next session Jacob asked “Its going to be alright, isn’t it?” this appeared to be directed half to himself and half to me. He was distressed and said that he wasn’t sure who he was, he asked “Am I Jake or Jacob?” he continued by saying that he wanted to be in the real world. He expressed a desire for comfort, “homely things like muffins” and he asked if he could hug me but then realised that he couldn’t. With a view to meeting the need for soft comfort I decided to acquire a furry bean bag for the next session. But firstly perhaps the most important thing happened. I took a risk but I intend to validate it. I stretched out my hands towards him in a gesture of comfort that still maintained some distance. Freud (1955) having abandoned the technique of hypnosis, developed the technique of putting his hand on the patient’s forehead to encourage free
association. Balint (1959) emphasises the importance of some form of appropriate contact at a significant moment.

Jacob took my hands. I noted how cold his hands were. It was a very powerful moment, a positive maternal counter transference that I experienced as ‘poor cold baby’. It was apparently comforting but then suddenly frightening for Jacob. We considered in my supervision whether there really was some delusional ideation in Jacob’s idea that he could gain strength from holding someone’s hand. Is it not part of natural maturation? Just as a child might go through a stage of avoiding the cracks in the pavement whilst playing with the fantasy that they might die if they step on one of them. I suggest that morbid play may be inherent in the fantasy games of childhood.

Jacob finished his session after thirty minutes.

Over the next five weeks Jacob had two thirty minute sessions a week. This served the purpose of reinforcing continuity but also I validate this move in reference to Klein. She explains that destructive urges can lead to greed and envy. Jacob’s sessions were absolutely exhausting and I felt drained. I didn’t want to give him more actual time, but his limited attention span could sustain over the two half hours more easily than over an hour.

During this time Jacob was more able to accept nourishment with boundaries and with less separation anxiety. Klein considered that greed was increased by anxiety and deprivation; of being robbed and not being good enough to be loved i.e. that the phantasy of the deliberate withholding of love and food result in envy and the urge to spoil. Envy
when strong leads to a sense of no goodness, this provides no sense of
gratitude, the latter being linked to enjoyment. So, this I conclude
accounted for a lack of the ability to play.

Jacob may therefore have felt that he received more of me whereas in fact
he was aware that the same total time applied. He remained psychotic,
reporting derogatory voices in the third person and he said “Stella, you
know all about me don’t you.” This was delivered as a statement rather
than a question. It gave me cause for concern as I considered whether I
had made a too clever interpretation that was fearful to him. The
psychiatric view would suggest that this was delusional thinking of
thought withdrawal. Interpretations during this phase were becoming less
frequent and I would suggest may be viewed as inappropriate in view of
Jacob’s degree of paranoid ideation and thought disorder. The latter
presented in his pressure of speech and a loosening of associations in the
form of derailment.

Klein’s theories explain Jacob’s mental state as the paranoid schizoid
position, she viewed this as the fixation point for schizophrenia i.e. this
disorder’s psychodynamic, aetiological root. The paranoid schizoid
position is characterised by persecutory anxiety. At this point I must
digress again for a moment to reinforce the accepted viewpoint of the
scientifically researched multiple aetiologies of schizophrenia, with
biological, genetic, social, family and environmental aspects all playing
significant roles. Thus indicating a multi disciplinary approach.

This period was the pinnacle of psychotic disturbance, there appeared to
be a greater need for catharsis through the musical instruments than at any
other time. I was concerned that this was becoming destructive and enormous containment of the situation was required. Jacob interrupted the session in an attempt to engage the attending nurse saying to him, “You know all about me don’t you”. Jacob became more challenging in response to a fearful, defensive arm gesture from the nurse, who then called for assistance. Another nurse took his place. I informed Jacob that unless he could play the instruments without trying to destroy then, we would have to curtail the session, He subsequently asked me “Am I good or bad?”. This question demanded a response. I said that perhaps there may be both good and bad in all of us. This concept was apparently new to Jacob. He stopped and thought then said “ Right…. , OK” . Jacob agreed to my request to play the Djembe drum with his hands rather than with beaters, thus feeling it if it hurt. I accompanied with a slow blues. Jacob expressed his satisfaction and then said with an air of relief “I AM Jacob B! I experienced this as though he was orientating and finding himself. But then he asked “Am I a boy or a girl? The sense of disturbance was palpable, he shouted at his voices to “shut up”. Jacob engaged in musical improvisation in a way that I experienced as an attempt to escape his distress. My feeling was not of personal threat but fortunately I recognised Jacob’s fear in the counter transference. It felt utterly paralysing in its strength, my fingers were suddenly frozen into stiffness, yet I had to play. My heart beat was fast. Without the understanding of countertransference I would not have been able to go on. In contrast Jacob’s musical input became surprisingly gentle, this pleased him and he expressed his desire to play with me at the piano, but the voices intruded again. He shouted at them “Oh just shut up about it
and let me play at the piano!” His music was chaotic, but we sat together and made up an extraordinary discordant blues that seemed to reflect his inner state. The new nurse offered some initial words of encouragement, he listened intently to Jacob and interspersed some gentle laughter in a way that felt harmonious and non intrusive. His presence had made it possible for me to continue the session. Jacob’s destructiveness had been acknowledged without admonishment. The young man who came into the session talking to himself, shouting and threatening to destroy animate and inanimate objects alike, left calmly but curious to know who I would be seeing next. Once again he had witnessed two adults working together in harmony.

Balint (1968) refers to research by Stanton and Schwarz (1954) which emphasises the necessity of harmonious team working during the treatment of patients with schizophrenia, disharmony inevitably leading to a deterioration in their condition.

Klein’s (1956) explanation of persecutory anxiety involves the keeping of the loved object from the dangerous one, thus love and hate become split. This is characteristic of the paranoid schizoid position. This manifested not only in Jacob’s perception of himself but also in a split between the good therapy room and the perceived bad and frightening unit. The aim of therapy was to consider if Jacob could tolerate frustrations sufficiently to accept a good enough whole environment which would enable him to reach the more integrated state of the Kleinian depressive position. The link between the two positions according to Klein, with all the changes to the ego which are implied, is
the outcome of the struggle between life and death. Klein believed that internalisation of the good object was vital for change to occur in the ego and for life to continue. Jacob had displayed how paranoid anxiety is focused on the preservation of the ego: The orange cable had represented death. The depressive position however is involved with the preservation of the good object as the focus of depressive anxieties. Klein sees the depressive position as the process by which the good and bad part objects become synthesised leading to some disillusionment. She refers to Segal’s (1956) work on how the patient with schizophrenia deals with depression. This emphasises the need to diminish splitting and projection in order for the depressive position to be experienced. Jacob’s clear expressions of despair, confusion and being in bits supports Klein’s theory that we may expect this situation would lead to guilt and depression about being dominated by destructive urges and about having almost destroyed himself and the good object.

The next stage differed in many ways not least in Jacob’s concern to frequently check my continued existence saying “alright Stella?”

Chapter 5 Regression

This period lasted for four months. It began forty six days (6.5 weeks) after Jacob changed to Clozaril medication and the fourth week after the session previously described. The diagnosis of schizophrenia had been applied. Clozaril is generally only administered to patient’s who are formally diagnosed with Schizophrenia, a reduction in psychotic symptoms is generally seen after two weeks. Clozaril stabilised Jacob’s
condition, though it transpires that it took considerably longer than expected.

Jacob’s attention span had extended and he started to push the boundaries on his half hour sessions, we therefore agreed to resume a one hour session per week. Jacob began to take an interest in the Bean Bag and would flop down onto it. His psychotic symptoms had subsided. When either myself or Phil, his named nurse were away Jacob was able to express his upset feelings verbally and musically in a more containable way, perhaps realising that it was recognised, understood and also felt by us. Jacob had become less anxious and despite some breaks in the therapy he acknowledged his trust in us both. These breaks were difficult for Jacob and initially for myself but they served also to create the necessary distance to enable the work to continue.

The breaks that occurred during the forthcoming period served to create a space during which Jacob reflected and began to develop an ability to tolerate the frustration of my absence, knowing that I would return. Balint (1968) emphasised the importance of remaining “in tune” with the whole of the schizophrenic patient’s life and to work in harmony with him. He warns that this involves much more from the analyst than standard technique. Balint noted that the change of atmosphere that occurs during regression requires a particularly mindful approach on the therapist’s part in order to maintain objectivity, thus the breaks provided me with space in which to renew my energies and to maintain an objective approach.
It was no longer necessary to have a member of staff in the therapy room. Jacob would sustain his musical interaction with me. Whilst stopping on some of the critical moments of connectedness, he would re-engage without apparent discomfort and with far greater toleration of interaction. This may be seen in terms of effective affect attunement (Stern 1985) as required for healthy childhood development.

Suddenly, during such an interaction he stopped and looked at me and said “Stella, you’ve done well to stick with me through all this.” I was very surprised and quietly amused at this apparent non-egocentric display of understanding. I wondered whether I had unconsciously been seeking praise. Perhaps I was heaving an inner sigh of relief at the calmer change of atmosphere and without conscious thought I may have subtly displayed a more relaxed body language. I wondered about attributing Jacob’s response to the narcissistic reciprocal role relating of admiring and admired. (Ryle 1991) but it didn’t fit with the low key non verbal interaction that had been taking place.

Jacob was apparently displaying some insight into the difficulties that we had both been through together, as such displaying a more sophisticated form of object relating. It felt appropriate to reflect on his progress. Jacob was able to accept some praise for his work in the sessions, this I viewed as significant because Jacob was able to take it in as inner goodness. We considered that he had recently had his nineteenth birthday and I wondered if this might be symbolic in leading us towards a ‘new beginning’. Balint (1968) used this term in referring to how a patient may
progress from the regressed state. As the weeks progressed Jacob reflected on “the dreadful time” he had been through.

Returning to the moment: we took stock that Jacob could more freely explore the instruments. Jacob finished the session by choosing the Cabasha but no longer as a potential weapon. He used it to create a rhythmic dialogue leaving silences in which he waited and watched for me to respond. I return to Klein (1960) for further understanding: She explains how the ego is strengthened through a developing ability in the patient to experience the split off goodness of both himself and the object, demonstrated here in a healthy musical interaction. This further supports Klein’s view that with this process, fragmentation is diminished thus enabling access to the lost parts of the self. This was displayed in Jacob’s ability to show concern for others.

Over the forthcoming weeks Jacob went straight for the bean bag. On one occasion he curled up in foetal position and asked if he could just have a rest. He snuffled and rubbed against the bean bag’s furry texture. Balint viewed the foetal stage as the schizophrenic point of regression. He stated that in regression the patient seeks something better than the original object returning to the state of the harmonious mix up. I played the metallophone as Jacob appeared to doze off or daydream. Jacob occasionally twitched his leg or rubbed his ankle. After eighteen minutes I stopped playing and we remained there in silence together until I raised him, without physical contact to finish the session. Giving him a two minute count down he reluctantly got up and left, calmly and sensibly after a final squeeze of my hand.
The next week after a brief play at the Piano, Jacob said that he didn’t want to play. He just wanted to have a rest and “be”, because he felt safe. We reflected on the feeling of rest as opposed to restlessness. The session remained quiet and calm with long silences but Jacob shared his fear of night time and of the main unit. I decided that some sort of bridge between the therapy room and the unit was required. So I decided to join the nurse in escorting Jacob back to the unit. I left him in the lounge and entered the adjoining nursing office. Jacob remained outside and became agitated when he was asked by a nurse to go for his tea. He said he couldn’t go through to the dining room. Firmly I asked Jacob if he would like me to take him. He took my hand as if unconscious that he was doing so. It simply felt as though we were about to cross a busy and dangerous road.

The other patients in the lounge were all considerably older and they silently looked on with some bemusement. Off we went across the lounge with Jacob squeezing my hand rhythmically like a small child. I was reminded of Margaret Little’s (1985) moving account of her analysis by Winnicott. She described the lengths that he went to in order that she should be safe. When he went on holiday and she was psychotic and unstable he arranged for her to be admitted to hospital. He took her himself and she remembered clutching at his coat tail as they approached the time of separation. It remains questionable whether I colluded with a delusion. The reader may however consider it in term’s of Balint’s concept of ocnophilic clinging. Balint used this Greek term to describe a pathological state in which the infant clings to comfort, with a need to preserve and control it. This may actually interfere with his real need,
which is to be held. Balint believed that ocnophilic tendencies that may surface in regression can be counteracted by the encouragement of philobatic tendencies. These represent the thrill of leaving and returning to mother, not dissimilar to the risks of the acrobat.

I have thought about this issue and gained some reassurance in consideration of the trust that Jacob was displaying and the reduction in his controlling behaviours. I took Jacob to an area of the unit where I don’t usually go, therefore my work is not strictly analytical. I consider that it demonstrated on a deeper level a sense of exploration with a perceived safe person, that may ultimately be achievable by the patient on his own and not dissimilar to scaffolded learning. (Ryle2002) I also aimed to heal the split in Jacob’s mind by taking him into a perceived bad area where he discovered that he was able to receive nourishment. Nevertheless I realised that I would have to be mindful to ensure that regression would meet Balint’s specification of being benign for recognition rather than malignant for gratification.

Balint (1968) used the term of The Basic Fault to describe the point of regression that may be achieved. This represents the time in an infant’s life when there was an apparent lack of fit between his biopsychological needs and the provision of care by the primary carer within the environment. It is where something went wrong as a result. It is upon reaching the basic fault in regression that primary love or the primary harmonious mix up may be experienced. Balint emphasises that the therapist must consider that this represents a time before the infant’s separate identity is experienced. The therapist must therefore become
totally part of the patient’s world in the same way as the primary object-the mother. Interpretations are no longer well received at this stage which is pre verbal in quality. It is a one person condition that Balint sums up with the Japanese word “Ameura” this means to wish or to expect to be loved, in the sense of primary love. The Japanese vocabulary expresses the various attitudes and moods that develop if Amuera is frustrated or repressed (Balint1968).

Balint experienced regressed patients, particularly those with schizophrenia as highly sensitive to the therapist’s moods. This was supported by Jacob’s ability as previously described, to engage mutually in the musical enactment of affect attunement. It was prevalent in his ability to apparently pre-empt verbally some of my thoughts and actions such as the anticipation of the next planned break. Balint states that this is a characteristic presentation when working in the area of the Basic Fault, but it turns around Jacob’s remark ‘You know all about me don’t you’ thus requiring discreet but firm boundaries.

In the next session Jacob expressed how much he missed his parents and his home. He said that “some people say that being in prison is worse than being homeless” I asked him if he felt homeless and he said “yes, its horrible”. I didn’t explore the use of the word prison but it may have represented Jacob’s inner desire to start to seek more freedom, as in Winnicott’s (1971) facilitating environment. Jacob asked me if he could have music therapy after he left. I responded that it sounded like a good idea but if so it would probably be with someone else. I also said that when he left we would have to say goodbye. Jacob finished the session
by saying he was frightened, we played a mournful dirge. I experienced it qualitatively as brooding, repetitive, dark and thoughtful. It may have been necessary to consider our separation in order to offset any ocnophilic clinging thus embracing the idea of Jacob eventually going off on his own adventure.

The following session Jacob thought about a forthcoming break, which was due to team training. He continued his rest on the bean bags. At the end he did not require my hand, saying “off”. I wondered how he would manage. In subsequent weeks Jacob fluctuated between the paranoid schizoid position, making the unit bad but still working with the toleration of feelings of frustration and ambivalence that when he left we would say goodbye. He made himself a cot by placing the pentatonic chime bars along the side of the bean bag, he chose the glockenspiel and played in desultory turn taking as I played the metallophone. These are two similar looking instruments, the glockenspiel is smaller than the metallophone. Visually they might be seen to symbolise the mother and baby: similar and related but different. As Jacob got off the bean bag at the end of this session he played with my fingers as I raised him. This was such a small gesture but I experienced it as very beautiful and tender. Jacob was less needy and he went back to the back to the unit without my accompanying him. He could finish with a natural, grown up hand shake. The following week he appeared to be resurfacing. He came in and sat on a chair instead of the bean bag. He reflected that his experience in the room was unlike any other, subsequently he proceeded with rest and then moved into play, though all the time checking the time, perhaps as a way of feeling in control.
In the next session once again Jacob anticipated the announcement of a break, my holiday. It was also the anniversary of his admittance. This appeared to trigger some of the old verbal responses: Jacob fired some questions at me about “doing it the good way without being abusive”. We reflected on how he copes with absences and how it felt when I went away. Jacob was thoughtful. My musical improvisation seemed to reflect abstract spaciousness. I said that I had seen Jacob being angry in here after I had been away. This appeared to relax Jacob. We had worked and now he chose to rest. He lay on the bean bag and I sat on the floor and quietly played the metallophone for a few minutes, we then went into silence. Then I became aware of the sound of a mechanical digger outside and not very far away. A sound that one might consider as not particularly peaceful. Nevertheless I was transported back to my own childhood and remembered an idyllic time and the low, slow drone of an aircraft flying high on a hot summers day. It seemed that even a potentially intrusive digger was incorporated into this blissful experience which I couldn’t help thinking must be what Balint(1968) meant by” the harmonious mix up.” He describes this as representing a time before a sense of separate identities are established. Symbolic of the womb and linked according to Balint to the elements of earth, water, air and fire. There was a sense of resolution and sufficiency. Jacob broke the long silence asking “Is this a secure unit?” I wondered with mild amusement if he meant the room or the building and asked “How does it feel in here?” Jacob responded “safe”. I asked if it felt like a place to run away from. Jacob replied “No”. We thought about where the safe feeling came from and about the meaning of the words. I introduced the word “lovely” in
response to a strong counter transference feeling of being in love which was so very different to the initial deeply split sense of love and hostility of one year ago. Perhaps for the first time Jacob experienced a positive sense of integration in the word “secure”. He chose to leave one minute early, I wondered if this symbolised an acceptable form of asserting control or of independence. He walked back to the main unit without me.

The next session started with Jacob asking me if I could fight, it transpired that this may have been triggered by some disturbance on the Ward. Jacob introduced me to his little boy language and asked me if I could speak German. This felt to me like a mildly mischievous game. He was particularly pleased that I could understand and translate it - it bore little resemblance to German. In retrospect I can see that this stage was necessary in moving gradually on from the non verbal stage of the harmonious mix up. Jacob then went off into a deep sleep. I improvised on the treble recorder and was somewhat curious that my music was reminiscent of the theme by Ennio Moroconi: “The good, the bad and the ugly”. This wasn’t a conscious choice but presumably my unconscious had integrated these qualities in response to the situation. Whilst Jacob was not ugly, together we had been to some metaphorically ugly places.

The role of sleep and day dreaming was significant throughout the regression. The dream that Freud (1900) had following his father’s death was of great significance in his development of dream analysis. He was told ”One has to shut the eyes” the experience enabled him to recognise his own hostile feelings, ambivalence and guilt towards his father.
Freud viewed day dreaming as a form of regression and a secondary defence against inattentiveness in which daytime content may be linked to childhood memory. This theory was supported in the session by my own experience of the sound of the mechanical digger. Freud maintained that free association could thus subsequently lead to insight. Hence Jacob’s question about whether this was a Secure unit.

Balint (1968) felt that if a patient closed their eyes it is only after a lot of work within the therapeutic process that they can open them and view the world as a less hostile place. (Macdiarmid 1996). In later sessions Jacob would lie comfortably with his eyes open but stretching and rolling in apparent blissful comfort.

Jacob continued to ask curious questions that were mildly mischievous in quality rather than challenging. He asked me my age. I responded by asking him how old he thought I was. Firstly he said twenty two. We considered that if I was twenty two years old then I would be almost the same age as him. Jacob then said “Eighty” It was unusual to have an experience with him which we both found funny. I asked him if he knew his mother’s age and responded that that might be nearer the right age for me. Perhaps this interchange promoted the resolution of any oedipul phantasies.

Jacob started to think about his future and wondered if he could join the army, as any aspirations would begin after discharge we were able to think about this. Subsequently he said that the ending of his therapy made him feel like “a dead soldier” but agreed that he would just have to soldier on.
Chapter 5 The ending.

I learnt that I had been offered a new job.

It was the following week that I had to inform Jacob that I would probably be leaving before him. Whilst Jacob had already explored issues around separation there was a significant difference between my leaving him than he leaving me. He was surprised, sat up suddenly and looked at me with enormous wide eyes saying he was “upset”. He then lay back on his beanbag and I wondered if this news would lead to a sense of impingement of the facilitating environment (Winnicott 1971). The ending worked through over the following four weeks. The penultimate session occurred very soon after the attack on the World Trade Centre. Jacob had witnessed this on T.V. and it had frightened him. He reflected that at least our experience together could not be destroyed in such a terrible manner because it would remain inside him. Much anger was worked through- with many exits from the room to go the toilet. Perhaps this was a representation of leaving all the bad stuff with me. Staff support was valuable in providing additional encouragement so that Jacob did not act out. There was acceptance of sadness and of feelings of loveliness in a universal sense. The final session was spent reviewing our work. Jacob lay on the bean bag and said he didn’t want to play any music. He listened as I played some of his old motifs, thus creating a review of our musical journey. It felt as if all that needed to have been played out was done. I said “I don’t think I got it right all the time” Jacob replied philosophically “No, you didn’t”.
Jacob expressed a wide range of emotion at the end of the session, he asked if on this occasion he could hug me and he held back his tears with some emotional snorting. He was able to express gratitude and acceptance. Jacob had displayed signs of coming through the paranoid schizoid position, overcoming his fear of disintegration by introjection of a good enough object that made mistakes.

Postscript:
Jacob remains well a year after music therapy ended and he is preparing for discharge to independent accommodation.

PART 4 - Conclusions
I suggest this Case supports Winnicott’s (1988) view in which he maintained that dependent and deeply regressed patients tell us more about infancy than mother/child observation, he viewed it like a notebook that fills in the gaps in the history.

Balint (1968) points out that high intensity experiences can’t usually be explained satisfactorily in words. This was displayed in the musical interactions and in the significance of the hand contact. The hug that Jacob requested may be seen as too regressive a need to meet, however the hand contact provided an acceptable step towards integration. The vibration that is created through music and interaction may be seen to bridge the gap between the regressive state and speech. Jacob became able to successfully move to and from this state to an age appropriate, independent mode of being which indicates development in ego functioning.
When regression occurred, the nurse’s presence was no longer needed. Music therapy reached Jacob on a pre-verbal level which led to qualitative developmental changes.

Levin, Knight and Alpert (1984) researched vocal expression with patients in schizophrenia and concluded that this could not be reliably identified in a positive or negative direction. Musical communication would suggest may provide a more reliable indicator of affect.

Alpert and Anderson (1977) suggest that the signs of schizophrenia implicate a defect in language processing which manifests in thought disorder. This may take varied forms such as a loosening of associations, word salad and thought derailment. It is also valuable to consider that hallucinations are usually verbal in content. They evaluated experiments with white noise: i.e. unmodulated frequencies of sound that do not carry any information. These showed that hallucinating patients with schizophrenia hallucinated more as the white noise increased. They suggest that the hallucinogenic mechanism might overlap with disturbance in arousal.

From this experiment I suggest that if white noise exacerbates symptoms, then structured musical sounds that are designed to communicate with meaning and attuned affect may reduce symptoms, particularly as this need not utilise the linguistic functions of the brain.

Andreason (1979b) highlight that it is the communication that is disturbed, through which the schizophrenic patient is initially unable to appreciate the task of the listener though he can listen to himself.
Kohut (1978) states that creative potential is diminished if intense ambitions remain tied to grandiose, unmodified fantasies. These are common in paranoid schizophrenia and may become part of a delusional system. They can also be frightening to the subject who remains weak, separated from his desired actions and unable to play. The importance of a musical medium that does not collude with unrealistic aspirations is therefore valuable in providing the patient with a medium for meaningful self expression and an outlet for creativity.

I consider that the combination of the musical medium and the therapeutic relationship can contribute towards self development. The object relations approach can be aimed towards intra psychic resolution of narcissistic aspects of the nuclear self (Kohut1987) which is both primitive and complex. Also integration of the fragmented self, over stimulated self or over burdened self. (Kohut 1978). There are thus also implications for treatment of personality disordered patients.

In the development of interpersonal aspects of relating, Horney (1950) considered that a lack of genuine warmth gives rise to anxiety. She looked towards spontaneity rather than compulsively driven action. i.e. “want” rather than “must”. Psychodynamic music therapy provides an arena for the development of choice without compulsion.

These factors support the provision of community and hospital based music therapy to promote the quality of life and potential for change in patients who live with the disorder of schizophrenia.

Until studying the chronology of events in detail I thought that the main changes had occurred after the stabilisation of medication. This proves
not to have taken place as chronologically expected. i.e. two weeks after the change of medication. It thus gives me reason to have some conviction in the independent containing and changing processes that occurred. The process was nevertheless deepened and promoted as psychotic symptoms and signs were reduced. It raises the question of what part music therapy plays in the overall treatment of the patient:

This included drug therapy, in-patient management, social skills and occupational therapy.

One year is a comparatively short period of psychodynamic therapy. As such this case demonstrates that meaningful change can occur and that the prospect of ending can become an integral and effective part of the therapeutic work. It does not demonstrate whether continued therapy would consolidate the process of internalisation. The question may however be raised whether this patient would require life long continuation of the maximum dose if music therapy was provided. This ongoing developmental process may enable some flexibility in medication levels. By this I suggest that internal, intrapsychic changes in the mind may affect changes in sensitivity to medication and thus also the optimum required levels of medication.

Whilst not suggesting the withdrawal of medication or an anti psychiatry model, any reduction may reduce the impact of side effects. Klein, Gittelmann et.al (1980) in considering general side effects of antipsychotic drugs, state that the following acute extrapyramidal effects can manifest from five to forty days after initial administration. Dystonia, (unco-ordinated, spasmodic movements of the body)
dyskenesia, akathisia (motor restlessness) and parkinsons syndrome. The latter may include hypersalivation and drooling as well as muscular rigidity, alterations of posture, tremor and autonomic symptoms. These side effects are often distressing to the patient and necessitate the prophylactic prescription of anti Parkinson medication. The chronic, irreversible disorder of tardive dyskenesia can also develop. This is a neurological syndrome consisting of abnormal, involuntary, stereotyped and rhythmic motor movements of the face.

A randomised controlled study may demonstrate whether a more subtle interaction is possible between moderated medication levels and the provision of consistent therapeutic input. This obviously requires sensitive monitoring with regard to the impact of planned and unplanned breaks in therapy, levels of developing insight and the individual’s psychic and cognitive ability to internalise the experience. Patient’s are frequently both knowledgeable and interested in their medication. This approach may alleviate distress and thus encourage compliancy to medication. More individual case studies are required to establish whether these findings can be replicated.

Stella Compton Dickinson. July 2002

“The whole of manifestation has its origin in vibration, in sound; and this sound was the first manifestation of the universe. Consequently the human body was made of tone and rhythm. The most important thing in the physical body is breath, and the breath is audible; it is most audible in the form of the voice. This shows that the principal signs of life in the physical body are tone and rhythm, which together make music. Rhythm appeals to man because there is a rhythm going on in the body. The beating of the pulse and the movement of the heart both indicate this rhythm. The rhythm of the mind has an effect on the
rhythm which is going on continually in the body, and in accordance with its influence it affects the physical body. The notes appeal to a person because of the breath; breath is sound and its vibrations reach every part of the body keeping it alive. Therefore in having an effect on vibrations and the atoms of the body, sound gives us sensation.”

Hazrat Inayat Khan.(1964)

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Introduction

This paper is based on the research and writing I have done for work on my forthcoming book, Music and Soulmaking: Toward a New Theory of Music Healing. I began work on this theory and philosophy of music therapy nearly ten years ago. The impetus for this research was my frustration with the current scientific model and, especially, with the reductionistic paradigm for research. Often as a practicing music therapist, I would see the effect of a music therapy intervention on a client. It was clear that the music therapy made a positive, beneficial difference to the client and client functioning. Then in an effort to "prove" that music therapy "worked" I would embark on a research project. As required by scientific method, I would set a hypothesis and design the research protocols controlling all variables except the music or aspect of the music I thought was "causing" the positive therapeutic change. And yet time and again, I would get no significant results. The research "proved" that what I had observed, had known deeply and absolutely through my experience of the effects of my music therapy intervention were wrong. There were no significant results. But how could my observations of client change be so wrong? Was I that self-deluded to believe in the efficacy of my work when, in fact, it had no
value? What about the confused, agitated client with Alzheimer's disease who talked and smiled during a rhythm-based music therapy activity? What about the severely, multiply-disabled child who made her first purposeful, goal-directed movement only during music therapy? How could these results and countless others not really exist?

It became clear to me that what was wrong was the tool for researching a complex, intricate process like a music therapy intervention. Dennis Fry's (1971) observations of the study of music in general highlight the problem. "In the case of music there is also continuous interaction between the physical character of the musical stimulus and its physiological and psychological effects so that a more thorough study of music would demand at least the combining of a physical, physiological and psychological approach. Modern science has relatively little information about the links between physical, physiology and psychology and is certainly not in a position to specify how the effects are related in music, but most scientists would recognize here a gap and would not want to deny the facto of a connection" (quoted in Aldridge, 1996, p.23). There are clearly gaps and deficiencies in the approach taken by "modern science" that prevented these methods from substantiating the impact of music therapy interventions.

Modern scientific method, like all paradigms, is based on a series of assumptions - an idea or belief we take for granted as "the way things are". The assumptions of scientific method are well known to us. They include determinism, potential for control, objectivism, positivism, reductionism,
linear development, and the context-free nature of phenomenon. I will briefly examine each of these assumptions.

Determinism is the belief that absolute truth about the nature of the world already exists and is waiting to be discovered. Scientific determinism assumes we can determine how a process works (like alleviating depression with music) and then prove that the discovery is true. This leads to another assumption, replicability. If you have "proven" something works, you can safely assume, under the same circumstances, you can repeat the process. Determinism also leads to the assumption of control. If the laws of nature can be determined, then humans can manipulate these laws to control it.

Objectivism is another assumption of the scientific method. This is based on the belief that the world is an objective place. An observer can, with care, look at a phenomenon from a distance and study it separately from herself. Human contaminants, like bias and emotion, are eliminated. This belief relates to several other assumptions of modern science - positivism and materialism. Positivism and materialism are the assumptions that the real world is what is physically measurable. A process or phenomenon is not "real" unless it is physical and measurable. This leads to the belief in mechanism - the world, including human functioning, is a machine. These assumptions emphasize structure and discount on-going process.

Reductionism, the next assumption of modern science, is the process of understanding a phenomenon by studying the behavior of its elemental parts, which leads us to an understanding of the whole. A process in its wholeness apart from an examination of its component parts is never
considered. In scientific method, this reductionism leads to the "proof" so highly valued. Reductionism also leads to the next assumption, linear development. Linear development assumes that complicated processes are made up of identifiable parts and progress from simple to complex and inferior to superior. It also assumes that big effects are created by big inputs and that small changes can not significantly influence a phenomenon and can be ignored.

Finally, modern science assumes that phenomena are context-free. Context is made up of identifiable elements that are systematically related. It is the environment within which the phenomenon occurs. Context is routinely ignored or assumed to be controlled in scientific method.

Though scientific method has brought us much - technology, material gains - it clearly has limitations, as evidenced by its inability to either explain or prove the efficacy of music therapy interventions. As I began to explore music therapy theory, I felt the need to find a scientific paradigm that better fit the processes I observed in music therapy. I feel I found that paradigm in the new science of complexity.

**Complexity Science**

Complexity science, also referred to as chaos theory, is a newly developed scientific paradigm related to systems theory. It is the science of the global nature of *dynamical systems* - systems in motion. According to Williams (1997), complexity is a "...type of *dynamical* behavior in which many independent agents continually interact in novel ways,
spontaneously organizing and reorganizing themselves into larger and more complicated patterns over time" (p. 449). Complexity science recognizes basic underlying inter-relatedness and interdependency of the various parts of a whole system (deQuincey, 2002). It focuses on hidden patterns, nuance, and the sensitivity of real things. And complexity science establishes the "rules" or constants for how the seemingly unpredictable leads to the new (Briggs & Peat, 1999). Complexity science is the science of the real, practical, messy world. Nature, then, is recognized as a highly complex, interlocking network of nested, dynamical systems. "Relationships between 'parts' are dynamic, ever-changing, because they involve complex networks of feedback and feedforward loops. It becomes difficult, if not meaningless, to identify or isolate individual causes...Such nonlinear evolution means it is impossible to accurately predict the behavior of complex systems..." (deQuincy, 2002, p. 30-31). Dynamical systems are simultaneously stable and ever-changing. They are in a constant state of renewal. Complexity science also asserts that everything in nature is complex - from weather systems, to economic trends, to population growth, to the formation of mountain and rivers, to the functioning of the human body, to health and disease. This complexity also includes the functioning of the human mind and its products like consciousness and music. I will now briefly summarize the principles inherent in complexity science to contrast its assumptions to the current scientific paradigm.
Deterministic Chaos

Chaos theory explains how new patterns of order emerge from the movement patterns of dynamical systems. Unlike entropic chaos, which is a state of disorder characterized by a total lack of organization or structure, the deterministic chaos seen in complex systems in motion is the sustained and seemingly random, unpredictable evolution of a system. But over the long run, it is this chaotic movement that gives rise to new order, new patterns in the system. In fact, a highly complex system is highly unstable - it is the source of creativity. Such a system is aid to be at the edge of chaos, a place of optimum vigor and potential. In this way chaos is extremely complex information - not the absence of order - out of which new and more adaptive patterns emerge.

Order and Form

Complexity science addresses deterministic chaos because it is out of the highly complex information of the chaotic movement that new order and form (known as a bifurcation) occurs. A moving system reaches a state of chaotic movement through iterative feedback - when output returns to serve as input over and over again (much like compound interest). As Briggs & Peat (1999) point out, a moving system breaks into chaotic movement when this physical movement as feedback enters resonance. "Resonance happens when systems vibrate or swing in sympathy with each other so that the tiniest connection between them progressively magnifies their mutual interaction" (p. 155).
I will use the example of a smoke trail off an extinguished candle to illustrate the process of bifurcation. When the candle is blown out a single smoke trail occurs. As this moving system increases its complexity through iterative feedback (the smoke trail begins to move in air currents and adds into the continuing stream from the wick), a doubling phenomenon occurs - the single smoke stream breaks into two. With more complexity (movement) through additional movement (feedback), doubling occurs again and the two streams become four. These new branches or bifurcations in the movement flow continue to double until, at the furthest distance from the candlewick, the smoke breaks into a seemingly chaotic pattern of movement. I say seemingly chaotic patterns because complexity science, through mapping the points of the movement, has found an underlying order and form to the chaos over time.

This order comes from the action of *attractors* in the system. An attractor exerts a magnetic appeal for the system acting as a set of stable conditions. They underlie and govern the dynamic behavior of the complex system. A good example of the attractor action is the Cymatic research of Hans Jenny (1974). Most of us have seen the videotapes of sound of various frequency and amplitude creating specific shapes in various materials (sand, iron filings, liquid). If you watch the video carefully, as the tone begins, you first see chaotic movement of the sand particles in no particular pattern or shape. Then a particular form emerges and is stable. But if you look closely, you will notice that the sand particles are still moving. The frequency at a particular amplitude acts as an attractor revealing the underlying order implicit in the chaotic
movement. This is deterministic chaos - the complex movement and the presence of one or more attractors (in this case a periodic vibration that is the tone) determines the order and form that will emerge.

There are a number of possible attractors in a dynamical system. A fixed point attractor is a place of no momentum and no displacement, like a swinging pendulum vibrating back and forth around a point of rest until the movement stops. A limit cycle attractor is a regular, periodic vibration. As the Cymatics example illustrates, the frequency of a tone, because it is periodic, is a limit cycle attractor. A torus attractor occurs when there is coupled motion of an oscillating pair. A perfect interval in music likely creates a torus attractor. As a dynamical system increases its complexity, it jumps from fixed point, to limit cycle, to torus attractors. But when the system breaks into chaotic movement, a new attractor, the strange attractor, emerges. The strange attractor is the implicit order underlying chaotic movement. It is the activity of a collective chaotic system composed of interacting feedback loops among its many scales of organization (Briggs & Peat, 1999). All attractors working within a complex system create form through the branching or bifurcations they create. There is a constant, 4.4492016090, that predicts when bifurcations occur. This constant is universal - different complex systems behave exactly the same way. The patterns of chaos reveal a universal order inherent in the nature of any dynamical system - water turbulence, population growth, healthy human heart beat, and the resonance characteristics of musical instruments. The bifurcations create shapes or patterns. The characteristic patterns that emerge in dynamical systems are known as fractals. A fractal is a map of the movement patterns in the
system. Fractal organization and functioning is the same at all levels of scale - from the largest to the smallest. It is a form that has self-similarity. A visual fractal, the Mandelbrot set, is a good example of this principle. The entire fractal has a characteristic shape. When a small portion of that shape is magnified, it looks the same as the entire form. This is self-similarity - as above, so below.

Though there is an underlying order in chaotic systems that gives rise to form, the process is so intricate our ability to observe these systems and predict their behavior is extremely limited. In fact, unpredictability is the overriding principle of complexity science. Even at the most basic level of complex behavior, systems go in unpredictable directions. They lose their initial conditions and cannot be reversed or recovered. This certainly is opposite of what the current scientific model says. There are several characteristics of complex systems that give rise to this unpredictability.

**Nonlinearity**

Complex, dynamical systems are nonlinear in nature, meaning that the relationships between factors in the system are not proportional. The whole does not equal the sum of the parts. Nonlinearity involves the influence of the amplified "small". Nonlinear systems are profoundly influenced by the subtle. Because of this exquisite sensitivity, nonlinear systems cannot be broken apart and added together. If you do, you get different results because the many small differences will be different each time you re-construct the whole. This sensitivity to initial conditions, or the so-called Butterfly Effect, describes the dramatic effect
that small factors can have on large systems because of the underlying web of relationships and iterative feedback in dynamical systems. Complex systems are sensitive to even the smallest change or input. It becomes impossible to know, let alone predict, what factor has made the important impact. This idea is again in sharp contrast to the current scientific paradigm that assumes linear development where only "big" things can have big effects.

**Wholeness**

Unpredictability, nonlinearity, and sensitivity to initial conditions require complex systems to be considered in their wholeness. Complexity science tells us that a natural event in motion - human neural firing, a hurricane, or a musical concert - must be seen as an unfolding, whole process. Studying an isolated portion of that event can not tell us much about what is really occurring. Different from the reductionistic, deterministic assumptions of current science, cutting up and examining the parts of dynamical system cannot tell us its true nature. Because the whole is always in a state of flux or transformational change (a dynamical system is always in motion), the phenomenon must be studied in its whole aspect.

**Emergent Properties**

The order and form that emerges from the complex movement patterns of a dynamical system are greater than and different from the sum of its constituent parts. These different properties are known as emergent properties of a dynamical system. For example, when hydrogen and
oxygen combine in a ratio of 2:1, water results. Water is an emergent property of this combination of hydrogen and oxygen because water has unique properties different from either hydrogen or oxygen.

Having described the principles of complexity science, it is now time to relate this new scientific paradigm to music therapy practice and research. To do this, it is necessary to look at both music and human functioning from the perspective of complexity science.

**Complexity Science and Music**

Many researchers and theorists, myself included, believe that the phenomena of music meets the criteria for a dynamical system (Wallin, 1991). First, music, as a physical event, is immensely complex. A single, complex (note the terminology) tone with its overtone series is by itself a complex physical vibration. And vibration is movement. When you combine the tones, timbre, and multiple parts of a musical event, an incomprehensible amount of complex movement is generated. Music has a nonlinear quality where the whole is greater than the sum of its parts. This gives rise to emergent properties of this dynamical system. Our experience of a musical event like a symphony concert is an example. The combined efforts of all the musicians playing the various musical parts and the conductor coordinating the effort is greater than and different from the individuals parts. As a life-long second violinist, I can certainly attest to this phenomenon. Alone each part is rather unremarkable but put together, the musical event is far greater than the sum of its parts. And all these various elements fuse together into a single experience.
Like all dynamical systems, music must be considered in its wholeness. Music, to be music must be considered as a whole. When we listen to music, we do not hear each distinct part or recognize chord progressions. Even professional musicians, who are trained to hear and recognize a chord sequence or rhythmic device, does not hear these parts as separate entities. The music is heard and enjoyed as a whole thing. As a violinist, I hear the symphony as a unit, I do not just hear the violin parts.

Another characteristic of dynamical systems, sensitivity to initial conditions, greatly impacts a musical experience. Slight change sin tempo, room acoustics, and even the mental state of the performers can make huge changes in the experience people have of the music. When devising her Guided Imagery in Music technique, Helen Bonny (1973) recognized this when creating her listening programs. She specified not only particular pieces of music but also particular performances of those pieces. It was her great genius to recognize that a seemingly small difference - the individuals performing the music - could make a noticeable difference in client response. Musical instrument construction is another example of sensitivity to small variable in music. Instrument makers know that even a slight change in construction can completely alter the instrument's sound.

Music production, like other dynamical systems, requires iterative feedback, both auditory and muscular. Violin playing is a good example. The skilled motor behavior of performance requires immediate and instantaneous adjustments of the muscle spindles to control and time the movement needed for playing the instrument. Feedback from the
auditory and muscular senses build on themselves as they are enfolded again and again to accurately execute the motor sequence needed. The intonation aspects of playing also require iterative feedback. When playing the violin, the placement of the finger on the string only approximates the desired note. The true note is achieved by input from the ear that is processed continually to maintain the proper intonation. All musical performance is dependent on the continual refolding of feedback into the on-going motor behavior.

Finally, the action of attractors is seen throughout the musical experience. Tones of the harmonic cadence act as a fixed point attractor, pulling the tones of the melody to it (Wallin, 1991). I already discussed tones with their periodic movement as limit cycle attractors, which can pull materials into specific shapes. With the coupling of tones in intervals, it is also likely that music contains multiple torus attractors.

Because of the immense complexity of movement indicative of complex sound and the combinations of complex sounds in music, it seems likely that music is itself a strange attractor. A strange attractor system has geometrical (fractal shapes like the Mandelbrot set) and, in particular, time fractal features. The most common of the fractal time patterns found in nature is the 1/f spectrum - an intermittent bursting of behavior or "noise". It is found in earthquakes, rates of cricket chirping, river flow, in animal neural firing rates, and in musical melodies. Music, in fact, is a collection of fractals in time. "All musical melodies mimic 1/f processes in time and mapping 1/f noise to sound generates a reasonable 'fractal forgery' of music because the correlations inherent in the sound mimic
the meaning found in natural sounds and music" (Voss & Clark, 1975, p. 317). Music is imitating the characteristic way our world functions and changes over time. Both music and natural 1/f spectrum changes are intermediate states between randomness and predictability (Voss, 1989). And because music is a dynamical system that is intermediate between randomness and predictability, it exists at the edge of chaos, the place in our natural world of optimum vigor, information, and potential.

**Complexity and Human Functioning**

Dynamical systems like the human body are examples of a self-organizing system - one whose form is relatively stable yet constantly self-renewing. We know that every cell in our body is replaced every seven year, yet the general form it takes remains the same. But to function optimally a self-organizing system must stay open to a constant flow of energy and information. They are dissipative structures, capable of maintaining their identity only by remaining continually open to the influx of information from the environment. For example, our brain's gross structure remains essentially unchanged throughout our life. Yet it self-organizes by constantly changing its subtle connectivity with every act of perception in order to maintain a creative and healthy response to an ever-changing environment. Brain structure remains the same yet is ever and always changing. To stop this constant change is to die. The human body and all its systems, including the brain, is a special kind of self-organizing system. It is autopoietic or self-creating. In nature, there are many self-organizing systems but anything that creates and constantly re-recreates itself is a living entity. In fact, an autopoietic
nature is now the new definition of life. Autopoietic processes are emergent properties of biological systems. We now know that life is not a thing, it is a process.

Human functioning on all levels of organization is a dynamical system. It shows nonlinearity, fractal patterns, emergent properties, and edge of chaos dynamics from the smallest to the largest organizational systems. Nonlinear dynamics are seen in neural firing patterns, respiration rates, hormone fluctuations, and, especially, in the rhythm of a healthy beating heart (Gleick, 1987). A beating heart is a mass of complex, coordinated movement following fractal laws. It shimmers in this complex rhythmical dance. In fact, if the heart loses this highly complex, edge of chaos beating pattern and approaches a simple beat pattern, heart failure occurs (Goldberger, et. al,1985 ). Our body structure is also fundamentally nonlinear and fractal in nature. For example, the branching of the veins and arteries of the circulatory system is based on fractal branching patterns (Briggs & Peat, 1989).

**Complexity Science and Music Therapy**

How does the science of complexity relate to music therapy practice and research? Clearly both music and human functioning are complex dynamical systems. It seems to me that the purposeful interaction of music directed by the music therapist and human functioning is itself an immensely complex dynamical system, where the therapeutic benefits are emergent properties of that complex interaction. In music therapy, and all therapeutic intervention, we strive for our client's "health." Health is not the mere absence of problems or symptoms. From the perspective
of complexity science, health implies a balanced and harmonious relationship between and within all aspects of human functioning - body, mind, emotion, and spirit (Quinn, 1989). In a state of health, this "right" or balanced relationship is a coherent state where a natural and logical connection exists as a result of being part of the whole. Coherence is not a static state, however. This right relationship of coherence is an ever-evolving, ever-changing process. Health is also a dynamical system in motion. It is constant, nonlinear movement keeping all aspects of human functioning in right relationship. This constant movement can be thought of as a dance at the edge of chaos. The edge of chaos is the place of optimum vitality and optimum creative potential. It is a place of transition, a boundary which, when crossed, creates a sudden change of state. Too much chaotic movement and all form is lost, too little and the form becomes rigid and non-adaptive. Our complex heartbeat is again a good example. Too much complex movement and the heart goes into defibrillation. Too little complex movement patterns and heart failure follows. Optimum heart health is the maintenance of the edge of chaos place of maximum vitality. When such a state is maintained, health becomes an emergent property of the human system pushed to the edge of chaos by increased complexity but stabilized by the right relationship of the four components.

Music engages all aspects of human functioning It is a fundamental, all-encompassing human event involving the complete range of experiences. Music is a sensory, physical, and perceptual experience. It engages a large portion of our brain influencing behavior, consciousness, and memory. Music, especially when it is performed, requires fine motor
skill, muscle coordination and timing, and the sense of hearing, touch, kinesthesia, and proprioception. It is an event of deep emotion - joy, pleasure, grief, sadness, and numinous transcendence. Music is the human experience of spirit, the sense of belonging, community, and life flow. The music itself and the intention and consciousness of the music therapist provide highly complex information to all areas of human functioning. I believe that this complex dynamical system - music and the music therapist using music with intention - brings individuals to health by supplying vast amounts of information, complexity, that keeps individuals in the edge of chaos dynamics and allows the creation of the emergent property of health. "Systems that self-organize out of chaos survive only by staying open to a constant flow-through of energy and material" (Briggs & Peat, 1999, p. 16). Music provides that constant flow-through of energy and information.

**Implications for Music Therapy Practice and Research**

If we approach music therapy practice and research from the perspective of complexity science, a number of things become immediately apparent. First, music therapy process must be addressed in its wholeness. A science of wholeness sees the world, not as a machine, but as a living, open-ended system. Therapy becomes an on-going process not an end product. Wholeness implies extensive levels of interrelated connectedness and the futility of identifying which causal factor creates a certain effect.

Secondly, complexity science tells us that small factors can have huge effects through amplified or iterative feedback. Because of this we can
never prove what factor in the music therapy process does or does not impact the process. Nor can we predict or control the outcome of our music therapy interventions. Is the effect from a rhythm pattern, tone combinations, the musical form, or the thought of the music therapist? There is always missing information in a complex system. "Chaos, it turns out, is as much about what we can't know as it is about certainty and fact. It's about letting go, accepting limits, and celebrating magic and mystery" (Briggs & Peat, 1999, p. 7). Our current scientific model is based on proof and replicability. As music therapists we routinely assert that to be accepted, music therapy must prove that our interventions impact people in the same ways over time. As Dale Taylor (1997) wrote in response to a speech I gave in 1991, "...a way can, and indeed must be found to define music therapy in terms that objectively explain a basic domain, a common factor, or a single therapeutic focus that is applicable to all areas of music therapy practice" (p. 5). Complexity science tells us this is impossible and, in fact, not desirable. We can never completely know how and why music therapy works because complexity science implies there will always be missing information that, through feedback, may be profoundly affecting the outcome. And each time we do music therapy, even with the same client, that unidentifiable factor will likely be different. or the feedback patterns will magnify a factor in a different way. Based on the principles of complexity science, it is impossible to find any therapeutic intervention, including music therapy, which will affect every client in the same way consistently. This does not mean music therapy is not effective, beneficial, or efficacious. It only means
that our standards of "proof" are impossible and unrealistic based on the real, complex nature of the world.

Music therapy practice based on the principles of complexity science will be less concerned with predicting results of the therapy and be more involved with the process as it occurs. Music therapists will recognize that the three-way interaction of the music, music therapist, and client has its own unique emergent property. The music therapist will respond to the subtleties inherent in the situation since small factors can have huge impact. The music therapist will respond to the on-going process creatively and aesthetically using a sense of what fits, what is in harmony, and what will grow and what will die. We will rely more on intuition - the immediate knowing or learning gained without evident input from the sense or rational thought (Borczon, 1997). Through intuition, the music therapist will perceive all aspects of therapy as possibilities. Intuition gives a holistic awareness of the unfolding process of therapy. The therapy session will be guided by this deep inner sense of what is happening and how to proceed as the session unfolds. The music therapy will then become a true creative process, a dance of interaction between therapist, client, and the music.

Music therapy research will also change. It will seek understanding rather than causes. It will aim to illuminate rather than predict and control (Harmon, 1994). Heuristic research methods that seek to discover, clarify, and understand will be employed. However, complexity science is an inclusive theory. Traditional reductionistic research has a place in giving us reasons why an effect occurs. The new music therapy research
will demonstrate relationships between factors without being required to prove that one factor caused the other. It will emphasize practical rather than theoretical understanding. Emphasis will be placed on effectiveness research, which acknowledges the importance of context - the environment, client mood and emotion, intention of the therapist, musical elements, etc. Music therapy research in complexity science will require us to ask new and different research questions. More "what" questions will be asked than "why". What happens to the client during music therapy rather than why it happens.

Complexity science offers music therapy a scientific model that brings greater understanding to the immensely intricate process that occurs in our therapeutic discipline. It can help us demonstrate the efficacy of our discipline and lead us into new and more appropriate research approaches. But most importantly, complexity science will help us to be more effective therapists acknowledging the importance of both the experience of music and the overt and subtle efforts of the music therapist to positively impact our clients and their lives.


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Fertility rates have been on the decrease world-wide since the 1970s, mainly due to women entering the labour market and the growing use of contraceptive methods. However, teenage pregnancies have been increasing steadily. “In 1970, fertility rates were around 5.8 children for each women in reproductive age. This dropped to 4.3 in 1980 and 3.5 in 1984. The 1991 census in Brazil attested that this falling trend continued in the second half of the 1980s, with fertility rates dropping to 2.5 and as low as 1.8 in large urban centres. Conversely, in the under-19 age bracket, there was a rise from 11.8% in 1976 to 14.08 in 1985 and 15.78% in 1989” (MONTEIRO et al., 1998, p. 153). Among developed nations, the USA exhibits one of the highest teenage pregnancy rates (8.9%), while in some areas of Latin America, pregnancies happen in 30 to 40% of teenagers. The overall figure for Brazil is 18%, with poor areas displaying rates of 25% (PEREIRA, 1998, p. 05).

Young girls do not usually worry about using medical birth control methods until 6 to 12 months after their first intercourse, as shown by ZABIN et al. apud MONTEIRO et al. (1998, p. 182). For this reason, half of all teenage pregnancies happen within the first six months of sexual activity and 20% within the first month.

The effects of teenage pregnancies are evident in biological, psychological, social and economical aspects.
Among these, CUNHA believes (1998, p. 33) that the biological element is the one that might be subject to the lesser impact, at least among the 16+ age bracket, because at this age, the body of a teenager is no different from the one of an adult woman - and this includes the result of gestation.

The psychological aspect, on the other hand, is far more complex, since the young girl has not yet completed her psychological development and is still full of doubts, anxieties and fears in relation to life in general and particularly in relation to pregnancy.

The social aspect implies two issues: dropping out from school and the limitations that will affect the young girl's professional training. In addition, the recurrence of pregnancies in 30% of teenage mothers further aggravates the problem. “The gestation of new members of our society is turned into an autophagic action: ... a share of our society... does not produce new resources and at the same time, uses existing ones” (CUNHA, 1998, p. 34). Resource allocation is shifted forward from 20 years old to 12 years old, with an average of 4 years, and this is a burden on the healthcare system.

In the pregnant teenager, the process of psychological development is hampered because all her activities are now centred around the reproductive function. To the specific conflicts of adolescence are added the intrinsic anxieties of gestation. The young girl has to deal with the prejudice on the part of her family and of society, with her own ignorance of gestation processes and with her own feelings of guilt.

Anxiety hampers the development of maternal availability to the baby.
In pregnant teenagers, anxiety is often increased because of the omission of the baby's father. This often takes great importance and negatively affects the mother's care for her baby. In fact, a large share of the her thoughts become focussed on the family conflict and on her partner.

Even in the womb, babies are extremely sensitive to their mothers' emotional balance, which will influence the relationships he/she will establish in the future.

Unfavourable psychosocial conditions interfere in a deeply detrimental way in the obstetric development of adolescents, but the offer of proper care during pregnancy and delivery can result in positive outcomes for the mother in the perinatal period, in some cases offsetting the intrinsic disadvantages of motherhood at a young age.

ARAÚJO et al. (1998, p. 101) state that the adolescent's performance during pregnancy is similar to that of an adult woman. However, it requires special attention because of the former's psychological makeup. In this way, delivery will not be seen as a punishment but as the beginning of a time of commitment. Pregnancy is a consequence of an immature act that imposes adulthood upon the young girl.

VIÇOSA et al. (1997) point out the key role played by groups of pregnant women groups in supporting young mothers. In these groups, they can talk about their problems and reflect upon them.

Clinical observations show these pregnant adolescents experience great relief of their anxieties as they become aware of the phenomena involved
in gestation, start participating actively and become emotionally involved.

The group "functions as an adequate mother that placates anxieties and allows the integration of psyche and body" (VIÇOSA et al, 1997).

“The combination of saying, reflecting upon and receiving scientific information contributes to reducing their fears of the unknown and thus, to relieving anxiety”, believes VIÇOSA et al. (1997).

THE PROGRAM OF FULL-TIME ASSISTANCE TO TEENAGE MOTHERS (PAIGA) of the MOTHER AND CHILD HOSPITAL PRESIDENTE VARGAS in PORTO ALEGRE (RS, Brazil) – HPV - was created to assist young mothers (19 years old and under), their families, partners and children through the services of a multidisciplinary team. This assistance encompasses the gestation, delivery and post-natal periods, including their babies' first year of life.

PAIGA originated in a project started in 1983 after the observation of two facts, according to VIÇOSA et al (1992):

20% of all women that came to the maternity ward were under 20 y.o. the children who came to the pediatrics ward because of physical abuse had very young parents.

The program is carried out by a multidisciplinary team made up by obstetricians, pediatricians, psychiatrists, nurses, dentists, social workers, a nutritionist, a physical therapist and a music therapist.

This mode of care was chosen because of the teenagers' tendency to be gregarious and form groups. All groups are 'open', which means there are
always new patients joining in at the same time some are leaving because they have reached their aims. If we consider that pregnancies last for a specified period, this mode is ideal as the work developed in enriched by the presence of pregnant women at different stages of their gestation.

In order to reduce ANXIETY among the patients, according to VIÇOSA et al. (1992), the team approaches three aspects which are shared by most of them:

• emotional helplessness
• lack of knowledge about their own bodies, changes during pregnancy, birth and the postnatal period.
• Lack of knowledge concerning the psychological and sexual development of their babies and the role that mothers, fathers, siblings and grandparents play in this context.

The PAIGA team shows great interest in helping these young pregnant women to make contact with new forms of expression and communication, new languages that allow them to exercise and expand their creativity in order to help them better know themselves, increase their own sensitivity and raise their self-awareness. By creating a space of their own, for the understanding of the pregnancy process, they will be better equipped to make up some room for the child their are now carrying inside - to understand, care for and love him or her.

VIÇOSA ET ALII (1992) investigated the results obtained with 2,000 patients who participated in the program. After several studies with the pregnant teenagers, their families and partners, it was found that:

• Adolescents' ages ranged from 11 to 19 y.o.; average age was 17 y.o. and 16% were 16 y.o. or under;
• 31% were single, 28% married and 39% lived with a partner;
• 83% had finished primary school; 89% were not studying during pregnancy but 71% intended to go back to school after the baby was born;
• 66.5% did not not have a job;
• their partners' average age was 22 y.o.;
• 59% used contraceptives (55% took the Pill). However, only 31.5% of pregnancies had been planned;
• 54% of the adolescents had divorced parents;
• 38.8% of their parents drank regularly;
• 43.5% of their mothers became pregnant as adolescents and 82% had 3 children or more.
• 55% had at least six pre-natal consultations, which the authors believe had a positive effect on:
  • normal delivery rate– 81%
  • premature birth rate– 12%
  • breastfeeding– most patients breastfed their babies and 50% did so for over 6 months.

The authors concluded that “systematic care combined with the clarification of doubts and misconceptions and guidance during difficult times will reduce the obstetric and emotional risk of these patients. At the same time, this will facilitate parent-child interaction and increase father/mother availability to the child. Only by doing this will we have mothers who feel strengthened in their new role, mothers who feel respected and integrated in their societies”.

The Music Therapy project at PAIGA started in February 1999.

Music Therapy sessions happen in the same room used for the meetings of the PREGANT WOMEN GROUP. The room is full of light, with large windows and curtains, and has several power points where we can connect our stereos. There is some noise in excess coming from the
street, the dentistry department and some adjacent rooms. There are many chairs in the room (about 18), which makes moving during sessions a bit difficult. There is also a washbasin with a tap, several lockers, a blackboard and seven large mats about 8cm thick that are used in the music therapy sessions. Before the beginning of each session, the music therapist takes several chairs out to clear up some room for the young girls to move.

The music therapy sessions use recorded tapes with music, some of which are brought by the pregnant girls themselves and then copied during the session. There are also several musical instruments and we also use objects in the room to produce sounds.

During pregnancy, music therapy will have very important psychological and prophylactic effects by acting in an evolutionary stage that will be extremely important throughout a person's life. This is possible due to the close communication that exists between the mother and the baby during pregnancy.

Dr GERALDINA VIÇOSA, says that music deals with both the psychological and bodily aspects, which cannot be dissociated (...) and it is a very important language in any age. She believes it is the language of excellence for adolescents, specially because of the changes their bodies undergo [...] and the great vulnerability of their egos caused by the changes they are experiencing in their bodies.

“Music therapy ...studies the sound-human beings-sound complex to use movement, sound and music to open communication channels in human
beings in order to produce therapeutic, prophylactic and rehabilitation effects in them and in society.” (BENENZON, 1988, p.11)

The foetus is capable of hearing after 21 weeks, and can perceive touch. For the embryo, the skin can be understood as an extension of the ear.

The foetus perceives the sounds and rhythm in his/her mother's surroundings. The feel of the walls of the womb, the flow of blood in the vessels, the sounds of the bowels, the mother's voice, heartbeats and breathing are some examples of sounds that surround the foetus. The experiences of sound vibration and movement are the main stimuli and communication means for the foetus and complement all the interconnected experiences of pregnancy.

Music can be used as a means of communication with the foetus as he/she is sensitive to sounds and vibrations. It is believed that communicative stimulation in this period can be beneficial, and its positive effects will have lasting results affecting a person's life forever.

The strengthening of the communication bonds between a mother and her child can contribute to the emotional health of both, and affects also the emotional health of other involved parts– the father, other children and closer relatives.

“Another important aspect in Music Therapy is [that] the work you are developing during pregnancy is providing these girls with a tool they will be able to use themselves, a language they can use with their babies. (...) Another form of communication, which is most beautiful and strikes us deep inside. In addition to strengthening the bond between mother and
child through music, the baby also becomes calmer. I really think this is great for one's mental health [and great for] for the organisation, to open a potential space for creativity. Anything that is offered with a view to achieving this is welcome in our project. We always like to try new things”, says Dr. GERALDINA VIÇOSA.

Aims of the Music Therapy project:

• Open new communication channels between mother and child by means of music therapy activities;
• Explore the relevance of music therapy experiences to the mother/child relationship;
• Provide the pregnant adolescent with a realm where she can think about herself and her pregnancy
• Reduce anxiety
• Provide relaxation
• Develop maternal instincts in the pregnant adolescent.

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The case of “L” – Music-Therapy treatment for a patient in coma

D’Ulisse, E.; C. Ferrara, F. Polcaro, C. Picconi

Foreword

This paper work deals with our experience of music-therapy treatment carried out on a patient in a state of coma caused by head trauma.

The patient in question was part of a pilot project for music-therapy treatment, set up by the music-therapy service run by the “Anni Verdi” Association in Rome, in collaboration with the Institute for Anaesthesiology and Reanimation at the “Università Cattolica del Sacro Cuore” in Rome (“Policlinico A. Gemelli”).

The project took place from June to August 2001 at the hospital. The basic premise was to observe, measure and check whether the application of music-therapy, in all its forms (body-sound-music), could be of help to traditional therapy for patients, aged between 20 and 40, in a state of coma due to head trauma. The theory and methodology was based on that developed by Prof. Benenzon.

The pilot project

The project was divided into three phases:

a) observation of the ward and surroundings;

b) gathering information on the patient’s clinical background;

c) administering the treatment sessions.
a) Observation phase
This preliminary observation phase, prior to actually dealing with the patient, enabled us to study and observe closely the life of the ward and its surroundings, especially the types of background sound present there. In addition, an important task during this preliminary phase was to put together the team of doctors and nurses who would work together with the two music-therapists. Our careful study and observation of the ward enabled us not only to work out how to organise the programme of treatment but also to decide which of the patients, in the category described above, would benefit most from music-therapy treatment. Only one patient had these requirements.

b) Gathering information on the patient’s clinical background
L. is an Italian man aged 33. He lives with his family which is made up of: father, mother, and a younger brother and a sister. All the members of the family, including L., work in the pub which they own. Generally speaking, the background music in the pub is recorded (hip-hop, jazz) and live (blues and Celtic).

During the first meeting with the family, we discovered that L. had studied music and played the saxophone in a local band for many years. In addition, he had taken modern dance lessons and had worked as a disk jockey in various places.

Working with a patient with such a rich and varied musical background was a challenging opportunity for the team of therapists.
When L. arrived at the hospital after a motorbike accident, the diagnosis was as follows:

- emergency condition endangering life functions;
- X-ray and CAT scans showed severe sub-arachnidan haemorrhage in the rear parietal area and in the front bilateral area, more pronounced on the left side;
- no traumatic lesions to the spine;
- multiple fractures;
- low reactions to stimuli (GCS = 5)

Before starting the music-therapy sessions, we agreed on a therapy contract with the family after explaining the aims, the timescale and the method we would be using. The family was extremely helpful and provided all the sound material required. After filling in the music-therapy info sheet, they recorded an audiocassette lasting about ten minutes with their voices.

Basically we were working with the patient and with the family in an interactive triangle. A shared space was screened off in the ward to enable the family to be with the patient as much as possible.

c) Administering the treatment sessions

The music-therapy treatment was split up into ten sessions of about thirty minutes each, taking place every day. The sessions were always held in the late morning – a time when the patient was relatively tranquil. Late morning is a time when patients can relax to some extent, once the daily chores of hospital routine are over.

The sessions were videotaped and were carried out by two music-therapists – one with an active role, the other as an observer with the job
of recording any changes in the patient’s life functions by checking the monitoring equipment and by direct observation of the patient’s reactions to the various sound stimuli.

So as not to overlook any variable, we decided it was essential to make a note of every type of change in the patient’s condition before each session, including the number of other patients in the ward (which changed from day to day, though was never greater than three).

Each session was structured as follows:

- initial greeting (about 5 minutes): the music-therapist would sing the patient’s name to the tune of children’s songs which the family had told us about in the sound history;
- improvisation phase (about 10 minutes): the music-therapist would sing various tunes, with or without words and in different keys, again drawn from the patient’s sound and musical history.
- phase of administering the pre-recorded sound stimuli (10 minutes) consisting of the voices of family members;
- repetition of any sound fragments (2 minutes) which had produced any sort of reaction from the patient during the session;
- farewell and exit (about 3 minutes): the music-therapists say goodbye to the patient.

No musical instruments were used during the sessions. In designing the therapy programme, the aim was to reduce the number of sound stimuli to the minimum, giving priority to voice and song as the intermediary activity in the relationship with the patient. The music-therapist improvised several tunes, with or without words, based on the patient’s sound and music history, and played the recorded voices of family members on a cassette player placed on a shelf beside the bed.
On this subject, we should point out that we chose to administer the same types of stimuli throughout the sessions, to make sure the data were unambiguous as far as possible. In each case, we carefully took note of any relationship between the stimulus (sound event) and response (presence or absence of any reaction by the patient) in order to determine whether such responses were random or linked in some way.

**Protocol forms**

We used specially designed protocol forms to collect data and to have a quick-reference description of the events. These forms were prepared by the music-therapists for this particular type of session and therapeutic treatment. The Observation Protocols were filled in at the end of each session.

The first protocol dealt with the description of the surroundings, the patient’s clinical condition before each session, and a description of the session itself, by carefully recording the following elements: time (in minutes), sound stimulus, patient’s physical response (tension, distension, sweating, tension in body hair follicles, movement of limbs, of the head, facial movements, opening and closing eyes, uttering sounds of any sort) as well as any change in the patient’s life functions.

The second protocol recorded the subjective data gathered by the music-therapist, correlated with whatever went before, during and after the session, mainly from the relational point of view.

The information put together on the protocol forms show that some events were closely related to a gradual improvement in the patient’s
clinical condition which progressed from a state of deep coma to one of semi-coma.

The following changes were noted, with respect to the parameters under consideration:

- motor response: as the patient gradually regained motor functions, initially on the left side of the body followed by the right, he became more communicative. Several times during the sessions, he squeezed the therapist’s hand, especially during the improvisation phase and when his eyes were open;

- eye movements: the type of eye contact changed as the treatment progressed. During the first five sessions, there were frequent involuntary eye movements while he was still unconscious or sleeping deeply, apparently in response to the audiocassette or during the first singing of children’s songs. As he gradually regained consciousness, his initial vacant gaze changed to a more focused one, taking in the pair of therapists; from the seventh session onwards, his gaze was accompanied by slight movements of the head. These events took place during the first singing of children’s songs, the improvisation phase, and the farewell at the end of the session;

- muscular tension: except in the sessions when the patient had his eyes closed, we noticed a certain muscular tension which was more evident in the early stages of the sessions (during the first singing of children’s songs), as well as a tendency to muscular relaxation when listening to the recorded voice of his family on the audiocassette; on occasions, this relaxation enabled him to close his eyes and go to sleep;

- sweating: the patient sweated profusely on the face and upper body, and this sweating increased throughout the sessions;

- breathing: in the first session, there was a slight increase in breathing rate during the second singing of children’s songs, and this became more pronounced as the session progressed. In subsequent sessions, his breathing was more regular and deeper, coming from the diaphragm, without any significant variations.

As for other body functions, such as coughing and yawning, no significant correlation was noticed with the sound-music stimuli.
At this point, we feel it is important to point out that the patient’s condition was critical at the beginning of the treatment. The situation was extremely serious since the accident had caused external and internal injuries of such a harmful nature that the doctors felt that it was almost useless to attempt our treatment with a patient in such a state, with “little hope of survival”.

Instead, beyond all expectations, the patient gradually became conscious again during the course of the treatment. However, by saying this, we have absolutely no intention of claiming that music-therapy was responsible for this improvement (the data is insufficient to draw such a conclusion, since the treatment only lasted for a short time and concerned only one patient), but nevertheless there’s no doubt that the improvement came about parallel to the treatment.

This brief experience was insufficient to provide a scientific response to the question of the validity or otherwise of applying music-therapy to patients in a state of post-traumatic coma, nor was there enough data to establish whether there exists any relationship between cause (the sound stimulus) and effect (the patient’s response to the stimulus), and whether such responses were random or linked in some way.

The goal we set ourselves was to document the music-therapy event in the most objective way possible, using the recorded data to design a protocol which might help, in the future, to “measure” the effects and the music-therapy events, in an attempt to find out whether there is any link between them.
From the technical point of view, it was interesting to note, while for conventional treatment the music-therapy room represents the “container” within which the relationship develops, in this case the role of “container” was played by the pair of therapists, who in their different ways, around the patient’s bed, contributed to setting up and maintaining the relationship.

The priority given to voice and song made it possible to accompany any sign of life from the patient, ranging from almost complete immobility to certain clear movements, and this was the main feature of the treatment.

In terms of empathy, it was extremely difficult to work every day with a patient in such a serious condition, and to deal with the frustration of receiving only the bare minimum feedback. For all these reasons, we feel it is essential for the therapists to work in pairs.

In conclusion, we could define the sound-music element as a sort of energy that may be recorded or not at the conscious level of the person involved in the musical experience. It influences the human perceptive system with varying degrees of direction and intensity. In isolated cases, as in the situation described here, music from outside can have different effects, ranging from “enveloping” the patient to becoming part of the patient’s interior world.

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Music-therapy treatment for chronic adult patients living in institutions

D’Ulisse47, E.; Maria Emerenziana; Carmen Ferrara48, Raffaele Burchi49, Federica Polcaro50

The Anni Verdi Association

The Anni Verdi Association was founded in 1964 under the name of the Anni Verdi Special School in Rome, and began operating in the socio-didactic field for handicapped infants and school-age children.

In the 1970s, the Special School became an Association, focusing its activities mainly on rehabilitation, social assistance and health.

In 1983, the “Anni Verdi” Association was officially recognised by the Italian government as an Ente Morale (community service provider).

Today, the Association concentrates its efforts on providing assistance for physically and mentally handicapped people; in particular, for the latter, research into autism is being carried out in the Association’s experimental centre set up for this task.

47. Psicologa, psicoterapeuta, musicoterapista, responsabile del Servizio di Music-therapy dell’Associazione Anni Verdi, Coordinatrice Responsabile e docente della Scuola di Music-therapy “Glass Harmonica”

48. Musicista, musicoterapista, Responsabile Area Didattica e docente della Scuola di Music-therapy “Glass Harmonica”

49. Dottore in musicologia, musicoterapista, Responsabile per il Tirocinio e docente della Scuola di Music-therapy “Glass Harmonica”

50. Musicista, dottore in lettere, musicoterapista.
The Association provides a range of training courses for physiotherapists and specialised physiatrists, working with the respective departments at Rome’s University of Tor Vergata.

The Association also collaborates with several universities in Italy and abroad, in Europe (France, United Kingdom, Belgium, Sweden), and in North and South America (Argentina), in order to improve knowledge and awareness of the most advanced scientific and applied methods for dealing with mental backwardness and psycho-social rehabilitation, with particular interest in the sectors of genetics and of neurosciences.

**The music-therapy service (origin, development, present organisation)**

The music-therapy service furnished by the “Anni Verdi” Association was first set up in 1986 (AA.VV., 1994), through the efforts of Dr. Maria Emerenziana D’Ulisse who currently heads the department.

The initiative arose from the need to try out the effectiveness and the range of a type of treatment which had not previously been used by the Association.

The service is made up of a team of specialised operators in two centres run by the Association, coordinated by Dr. D’Ulisse; all activities are supervised directly, on a periodic basis, by Prof. Benenzon, and indirectly by the team who meet regularly as an in-house supervision group.

In both of the centres run by the Association, music-therapy reaches a group of users ranging from children to adults, most of whom are
The Glass Harmonica music-therapy school

As a natural consequence of the development of music-therapy activities, in terms of experimentation and deeper knowledge of the discipline, in 1995 the “Anni Verdi” Association set up the Glass Harmonica music-therapy school; the school is directed by Prof. Benenzon, who is also the creator of the Benenzon Music Therapy, the didactic approach which the school follows.

The school organises three-year training courses aimed at creating a specific professional qualification in the music-therapy field. Attendance is compulsory, and involves study periods in the areas of medicine, psychology, music-therapy, as well as practical training in various workshop sessions.

Every student is expected to carry out a practical internship lasting 250 hours, of which a part takes place in the two centres run by the Association where music-therapy is carried out. In this way, students can immediately work alongside expert therapists, and are included in a programme of individual and group activities.

Through the school’s training courses, music-therapy within the Association is going through a period of development and expansion, with the start-up of external collaboration with hospital psychiatric services (Saraceni, Bertolotti, Ferrara, Diana, 1996), (D’Ulisse, Ferrara, Boggio Gilot, Di Massimo, P_, Ordine, 1998), and mental health centres,
family homes, psychiatric communities (Abrescia, Funari, Gagliardo, Gargano, Rinaldi, 2002), local didactic groups, where the school is seen as a multi-discipline approach to children, in which the principles and methods of music-therapy can be extremely useful.

**Music-therapy (theoretical considerations)**

**Benenzon Music Therapy**

According to Benenzon, music-therapy can be defined in terms of its *scientific* aspect, and its *therapeutic* aspect.

From the scientific point of view, music-therapy is “a scientific discipline dealing with research and study into the complex relationship between sound and human beings (music and other sounds) with the aim of researching diagnostic elements and therapeutic methods” (Benenzon, 1998: 13).

From the therapeutic point of view, music-therapy is “a paramedical discipline that uses sound, music and movement to provoke regressive effects and open up channels of communication, with the aim of activating, through them, the process of socialisation and social acceptance” (Benenzon, idem).

From the methodological and technical points of view, the principles of ISO and the “intermediary object” are important.

Benenzon takes the concept of ISO from research by Altshuler (1943), defining it as “the notion of the existence of a sound, or a pattern of sounds or of internal sound phenomena, which characterises us and makes us individually distinct. This is an internal sound or movement
phenomenon which sums up our sound archetypes, the sounds we experienced in the intra-uterine phase, at birth, in childhood, up to our actual age” (Benenzon, 1998: 46). This definition leads directly to the concept of sound identity, which is split up into various levels: *gestalt* or *individual*, *complementary*, *group*, *cultural*, *universal* (for more details, see the relevant publications).

In sessions of active music-therapy with patients, either as individuals or in groups, it is important to take into account the sound identity of the patients in its various aspects, ranging from the most original and personal to those that form part of the wider relational context within the therapy group, as well as those within a socio-cultural context, which patients may well express through sound in one way or another. On the part of the music-therapist, it is equally important to be aware of the various levels of one’s own sound identity, in order to be able to use them appropriately during the settings, first and foremost to avoid the risk of projecting and imposing one’s own ISO onto the patients, through the medium of sound, without achieving any creative or generative effect.

In music-therapy sessions, the use of sound-producing instruments is regulated in specific ways for the music-therapist, which make the object suitable to the therapy context. Benenzon describes the characteristics of the *intermediary object* in these terms: “An intermediary object is an instrument of communication able to act therapeutically on the patient within a relationship, without giving rise to intense states of alarm” (Benenzon, 1998: 56). To meet these requisites, the intermediary object must have the following characteristics: “real and tangible existence;
must be innocuous – not giving rise to reactions of alarm; malleability – can be freely used in various roles; it is a ‘transmitter’ – enabling communication to take place, replacing the link and maintaining the distance; adaptability – adapts to the needs of the subject; easily assimilated – it leads to an intimate relationship since the patient can identify with it; it is an instrument – and can be used as an extension of the subject; easily identifiable – it can be recognised immediately” (Benenzon, 1998: 58).

**Music-therapy in the Total Language Experience**

“Total Language Experience” is a dynamic approach to people in every aspect of their being, not just sound and music. It concerns relationships between fields of many types which may be psycho-motorial, psycho-organic, sensorial-perceptive, emotive/affective, communicative/relational, and can be used in the following types of treatment: educative and re-educative, preventive, rehabilitative and therapeutic.

The methodology is based on considering the “body” and the interaction and relation of bodily functions as the main source of experience: “touch” is considered the primary sense of communication (deep memories are brought to the surface by stimulating this sense); “rhythm” (the first experience in the mother’s womb) is a basic element of synchronous communication with the outside world – repetitiveness, sensorial patterns in the search for equilibrium and safety (…). Extension and contraction (tension towards… and returning inward) as an emotive chiaroscuro expressing itself through muscular and verbal languages: harmony of movement and the musicality of language; development of
representative intelligence through sensorial intelligence and movement; perceived information takes shape by being transformed into a mental picture” (Guerra Lisi, 1987: 12).

In music-therapy, used with this approach, music is considered as “sound which is experienced aesthetically, where ‘sound’ is any type of sound event; and ‘aesthetic’ (aisthetikos) means, etymologically, ‘sensorial’, and implies immediate pleasure, or better, gratification” (Guerra Lisi, Stefani, Parrini, Burchi, Balzan, 1997: 22). Viewed in this light, musicality becomes “aesthetic sensibility to sound, or ‘ability to experience sound aesthetically’. This is an instinctive reaction in human beings, who are therefore all musical, each person in their own way, but no-one – by definition – with more or less ability than another person. Because Nature gives everyone the human potential for the ‘art of living’ which includes sounds, so it can be described as the ‘art of sounds’” (Guerra Lisi, Stefani, Parrini, Burchi, Balzan, idem).

Many of the patients treated in our centres have serious multiple-handicaps, and their lives are marked by an apparent absence of communication with their surroundings, although they do produce sound and gesture stereotypes ad infinitum. Using the approach described above, many of these behavioural patterns can be interpreted as the recreation of a sound “cocoon”, an area in which they transfer the main characteristics of their regressive world, through sounds and gestures (by processes of synthesis and analogy), as the last refuge of a being who never ceases to be a player and performer, drawing on the well-defined patterns of prenatal expressive tendencies (Guerra Lisi, Stefani, Parrini,
Burchi, Balzan, idem). Our task is to interpret and understand these sounds and gestures in the attempt to find out what sort of relationship can possibly be set up with such patients; so, stereotyped behavioural patterns have to be interpreted in order to find out what messages they contain, what physical or mental state the patient is trying to communicate. This approach enables us “to make sense of apparently meaningless behaviour” (Guerra Lisi, 1987), opening up new possibilities of working with patients who are apparently unreachable with other types of treatment.

**Pragmatic Approach to Human Communication**

A “pragmatic approach to human communication”, as a systematic study of communicative relations, starts from an assumption that is directly linked to what has been stated above: *it is impossible not to communicate* – all behaviour is communication, and everything a human being does constitutes behaviour (Watzlawick, Beavin, Jackson, 1971). Therefore, communication always involves a *commitment*, since it always transmits information; at the same time, it involves behaviour, and in this sense defines the relation between the communicating people. Watzlawick accordingly distinguishes a level of *content* and a level of *relation* and, distinguishing between a ‘healthy’ relation and an ‘unhealthy’ relation, he affirms that the latter is characterised by “a constant struggle to define the nature of the relation, while the actual content of the communication becomes less and less important” (Watzlawick Beavin, Jackson, 1971: 45).
Furthermore, human beings communicate both in digital (spoken) mode (words, phrases, etc.), and in analogical form (posture, intensity of gesture, look, tone of voice, etc.). Even if we don’t understand a foreign language, by listening to someone speaking it, we can always understand the “movement of intent”, that is, all those non-verbal elements (analogical) which accompany communication. So the actual meaning of the words may escape us (and may indeed not be decisive), while the feelings and intentions accompanying the communication will certainly be comprehensible.

This aspect becomes particularly important for us, as it provides a key to interpreting many of the verbal stereotypes which our patients use to express themselves.

In our wide experience of music-therapy with patients, we have seen that the more our communication revolves around the most primitive elements of sound, the more we are able to open up a dynamic type of communication leading to acceptance; vice versa, the more music-therapist wants to give such a message to the patient, the more the message must correspond to these levels of sound communication.

This happens mainly with more seriously handicapped patients – those in deep regression who are only receptive to the most basic forms of communication… and only to those.

**Nordoff-Robbins: the spirit of creative improvisation**

In active music-therapy, sound and music can be used in a structured or an improvised manner; improvisation can sometimes take on more
structured characteristics which the patient recognises, and which act as a guide. An open space of freedom within a basic structure can serve as a stable reference point, and a point of contact for the continuum with the operator/therapist. Without going into further details, we’d like to round off the outline of our principles by quoting a passage from Nordoff and Robbins: “Basically, the way people ‘feel’ is more important, for their lives and development, than the way they ‘think’ (…). By experiencing the feeling of music, discerning the elements of the structure of which it is composed, and by expressing freely their reactions to the rhythm, (children) go through an important experience; all aspects of their personality are strongly stimulated and become harmoniously involved.” (Nordoff-Robbins, 1993: 55).

In this creative process, the patient displays what Nordoff and Robbins call the “rhythmical-musical image of self” (Nordoff-Robbins, 1993: 58), onto which are grafted the sound dialogues with the music-therapist. This is why it is important to consider also the form that the sound exchange takes on in the music-therapy relationship: in the same way in which “doing is describing oneself” (Guerra Lisi, 1987), human beings exchange and share, by means of sound, images, sensations, representations of self, restructuring the contents each time according to their own mechanisms of recognition process, in the sense described above.

**Application of music-therapy and incidence of treatment**

Patients are directed towards the music-therapy service by the doctor-psychologist team in each centre, after which they are evaluated during a
variable number of music-therapy sessions, at the end of which a
decision is taken, together with the team, on whether to include them or
not in the treatment programme.

The evaluation follows an established pattern: the patient is seen during a
number of sessions varying from two to five, in a setting comprising
various instruments, so as to give the patient the chance to explore the
possibilities of sound production in their own way, according to the basic
types of sound – percussion, wind instruments, and string instruments.
The patient is left free to explore the surroundings and to structure any
sound interactions that might develop, together with the therapist; from
these observations, note is taken of problem areas that the patient might
have shown in relation to the objects, the therapist, the setting in general,
their relationship with the world of sound, after which a plan of treatment
is drawn up.

No time limit is fixed for the treatment, which can be considered finished
once the goals have been reached, or to be continued according to new
objectives, or according to a maintenance programme which might be
required.

Sessions can be video-recorded, and lead to documentation which may
include specific protocols (see Benenzon, 1997); finally, the music-
therapy service periodically updates the data in the patient’s medical
record regarding actions taken.

In each of the two centres, music-therapy is carried out in specific ways:
In the *via Colautti Centre*, the service is conducted by an operator, and currently involves 38 internal patients out of a total of about 80 at the Centre; the number of patients treated in 1986 was 75, while all the patients were evaluated. At present, therapy therefore covers about 50% of the patients, while overall, since 1986, the music-therapy service has covered 87.5% of all the patients at the Centre; the entire patients population was evaluated. The sessions take place once a week, either individually or in groups, lasting for 30 minutes; a further 30 minutes are given over to updating the relative documentation and protocols. In addition, for about two years now, the Centre has been running a music-therapy workshop, which also deals with 13 external patients, mostly children. Since the workshop opened in 1999, a total of 30 patients has been treated. Activities take place in specific settings, fitted with video equipment for recording and monitoring the sessions from outside the room. The music-therapy methodology is the active type as defined by Prof. Benenzon (BMT).

In the *via Dionisio Centre*, the service is conducted by an operator, and currently reaches 23 patients out of a total of 150; the number of patients treated since 1995 is 53, while 13 other patients have been evaluated and are waiting for treatment. Therapy at present covers 15.3% of the patients, while overall, since 1995, the service has covered 35.3% of the patients. The sessions take place twice a week, with individuals and in groups, lasting 40 minutes for individuals, and 60 minutes per group; the documentation protocols are written up in an hour at the end of each day’s work. Activities take place in specific settings, fitted with video-recording equipment and a one-way mirror so that the sessions can be
followed from outside the room. The music-therapy methodology consists of an integrated approach based on active music-therapy BMT (regarding the use of multi-level ISO), the total language experience (for work on body history, the overall approach to human expression and work on the sound archetypes in relation to the universal ISO), the pragmatic approach to human communication (focusing on verbal and pre-verbal relationships), and creative improvisation according to Nordoff-Robbins (mainly used in the active music-therapy sessions for groups). The sessions are organised on a cyclic pattern (annual and for several years) of activities and of rest, according to the seriousness of the situation being treated; at present, plans are being made to organise activities according to fields of objectives, such as self-esteem, autonomy in the relationship, harmonious development of the personality, socialisation, integration, the ability to listen, powers of concentration, sound discrimination, specific physical and neuro-sensorial disabilities (in this last case, activity is aimed at promoting a relationship that integrates the unhealthy part with an overall approach, the discovery of other expressive modes and communicative styles which enable the person to use a wider expressive range, together with and beyond their own disability).

**Data relating to music-therapy treatment**

In the two Centres, most of the patients are suffering from serious mental handicaps; the fields of action regard communicative abilities, socialisation, improving the image of self (also by finding specific ways of expression, through sound activities, to support physical disabilities).
On average, a course of treatment can last from one to five years, according to the seriousness of the disability.

To collate all the data obtained from the survey, taking into account the number of patients treated and the history of their treatment, the following aspects were examined: degree of mental backwardness, problem areas and treatment time.

Considering the overall number of patients in the two Centres, the percentage of those who underwent music-therapy, with respect to the level of mental backwardness, is as follows:

- Serious mental handicap 27%
- Medium-serious mental handicap 20%
- Physical-mental handicap 15%
- Medium mental handicap 13%
- Slight-medium mental handicap 10%
- Very serious mental handicap 9%
- Slight mental handicap 6%

The outcome is that the highest figure of 27% refers to serious mental handicap, while the lowest figure of 6% refers to slight mental handicap.
The problem areas examined in the treatment plans refer to: communication, social relations, powers of concentration, physical disability and image of self. The data obtained from the survey show that communication and social relations have a percentage of 35%, powers of concentration 12%, physical disability 10% and image of self 8%.
Figure 17 Patients treated with MT based on problematic area

The treatment times for the patients varied from less than one year to seven years. The highest figure is 23% regarding treatments lasting between one and three years, followed by 18% for two-year treatment, 13% for treatment lasting less than a year, 8% for treatment of between four and six years, 5% for five years, and 2% for treatment lasting over seven years.
Conclusions

In both the Centres, going beyond specific problem areas and treatment guidelines, from time to time the various operators and members of the doctor-psychologist team have noticed positive effects on the daily lives of the patients treated. Broadly speaking, these signs include increased social participation in the life of the Centre and in relationships with other patients and operators, a general improvement in the patients’ mood and behaviour and therefore a condition of improved well-being; in addition, some patients showed they were able to regulate their personal timetables according to the frequency of the music-therapy sessions.

For the Centre, these positive effects on patients undergoing music-therapy are an advantage, when compared to the behavioural problems of other patients.
**Bibliography**


A music-therapy daycentre

D’Ulisse, M.E.; F. Polcaro & C. Ferrara

The music-therapy daycentre run by the “Anni Verdi” Association in Rome (via Colautti), is a private service set up in 1998, open to anyone who wants to undergo music-therapy treatment. The sessions take place in the afternoons so as not to interfere with the patients’ normal activities (school, work, other types of treatment). The methodology used involves the application of active music-therapy, as developed by Prof. R.O. Benenzon.

This method is based on setting up a relationship between the music-therapist and the patient using non-verbal communication channels and the concept of body-sound-music interaction. The goals are to enable patients to build up new ways of communicating which will help them to improve their quality of life. Such new skills include developing basic abilities, raising and reinforcing awareness of “self”, knowledge of their own deep emotional structure, increasing self-confidence, the pursuit of happiness and pleasure through self-expression, improving communication and relational abilities.

The most important aspect of music-therapy work is the relationship itself; and the therapist makes use of musical instruments, sound production, singing and movement to build up that relationship. The patient should see the therapist as someone who is able to help them recover their image of “self” by highlighting and reinforcing their
normal, healthy abilities. To achieve this, the non-verbal context is fundamental, made up of a combination of a vast array of communication codes, including music, gesture, body language (with its proximal, axial and distal movements), as well as verbal and mime codes.

The Benenzon proposition is based on:

• the ISO principle,
• the intermediary object,
• and the non-verbal context.

ISO, meaning equal, “is the sum of infinite energies relating to sound, acoustics and movement which an individual possesses and which characterises that person” (Benenzon, 1997, page 77). It sums up the sound archetypes – the intrauterine sound experience and that of birth, childhood and adult life – for very human being. To set up a communicative channel between therapist and patient, a situation has to be created in which the patient’s biological and psychological mechanism can synchronise with the therapist’s sound-music activity. The communication channel is truly open when it is possible to discover the patient’s ISO through empathy with the therapist. There are three basic types of ISO – the Universal ISO, encompassing the sound energies that the human race is heir to; the Gestalt ISO, including the unconscious, the sound energies which each individual perceives from birth; and the Cultural ISO, the flow of sound-music energies which exists from birth onwards, through which each individual receives sound stimuli from the surroundings.
The intermediary object is a communication instrument which is able to act therapeutically on the patient within the relational framework. Its characteristics are as follows: it has a real and tangible existence, it can be used as a "transmitter" making communication possible by replacing the link and maintaining distance, it can be adapted to the needs of the patient, it leads to an intimate relationship since patients can identify it as an external object outside themselves, immediately recognisable as such. Musical instruments and sound can be considered intermediary instruments, since they possess all the characteristics listed above.

The non-verbal context, “is provided by the dynamic interaction of infinite elements making up codes, languages and messages which influence and stimulate the perceptive system enabling patients to recognise the world around them, their surroundings, their environment and the other human beings with whom they want to communicate” (Benenzon, 1997, page 53). The non-verbal context is therefore the paradigm of music-therapy, and a fundamental part of the music-therapist’s job is to recognise it and utilise it. The concept of interaction shows that the non-verbal context cannot be made up of only one of these elements, since that would not be sufficient.

The two technical aspects that characterise a music-therapy session are: the setting and the IOG (Instrumental Operating Group).

The setting plays a very important role within the therapeutic process, since it provides the space in which the patient feels contained. It can be the actual music-therapy room, or an open space such as a field, a wood or water space. For all these reasons, it should have the following well-
defined characteristics: it should be sufficiently isolated from external noises, so as to enable communication in the non-verbal context to proceed aseptically, and it should be large enough to encourage movement, without leading to dispersion. Within the space, there should be as few items as possible to distract attention (the minimum furnishings required, few pictures on the walls, etc.).

Since body movement is encouraged during the session, and since body vibrations are transmitted, the setting should have a wooden floor, or better still a raised wooden platform which will help the sound to carry. As far as the group of instruments is concerned, any item able to produce an audible sound or a movement as a means of communication can be included in a music-therapy Instrumental Operating Group. It is important to bear in mind that an instrument can be used not only conventionally, but also in any way that makes it a vehicle for communication and expression.

The musical instruments must be of different shapes and sizes so that patients have the chance to project their personal fantasies onto them. The body-sound-music instruments used in music-therapy must have distinct characteristics: they must be made of natural materials (leather, wood, materials of animal origin, water, etc.); they must be easy to use, not requiring particular abilities (motor, sensorial or physical) to produce forms of sound; they must emit different types of sounds similar to those made by animals or human beings; they must enable unhindered movement, using only one part of the body. In addition, they must
encourage ways of relating with other instruments, and must stimulate communication.

Getting back to the music-therapy daycentre, the sessions are held in a fairly large room, equipped with a wooden platform which transmits vibrations well, and patients must be able to sit or lie on it so that they feel more at ease.

The walls are covered with a layer of material forming an air gap which both insulates the room acoustically and helps to transmit the sound; patients often use the platform and the walls as percussion instruments. The room has four large windows and is fitted with a closed circuit video system which makes it possible to videotape the sessions. The room has no furnishings of any kind, such as pictures, cupboards, lamps, etc. but only the instruments needed for the session.

The IOG used by the "Anni Verdi" Centre is made up of both traditional and non-traditional instruments (percussion, stringed and wind); the latter are built by the patients themselves (or with help) and are then brought into the music-therapy setting. The instruments are chosen according to the needs of individual patients or a group of patients. For instance, when working with adults, we try not to use IOG instruments that are too infantile; similarly, with small children we avoid instruments that are too large.

Since most of the patients up until now have been children, the organisation works as follows: after initial contact by phone with one of the parents, usually motivated either by curiosity to try out a new therapy for their child or by suggestions from specialists, psychologists or
rehabilitation centres, we provide all the information necessary on the therapy itself and on the practical organisation of the sessions. Then the treatment is divided into a number of stages: the music-therapist first of all meets the patient three or four times (in the typical setting for the actual sessions), after which an evaluation report is produced in order to analyse the data which has emerged from the visits and to decide whether music-therapy would be suitable, and with what specific goals.

At the same time, a psychologist arranges a number of interviews with the parents as a couple, in order to put together the patient’s and the family’s clinical history with the aim of investigating the family’s background in terms of music and sound experiences since the child’s birth. These parallel encounters with the child and the parents are important in order to examine the two sub-systems within the family from different, but related points of view, providing as much information as possible about the child.

It should be noted that the interviews with the parents as a couple do not concern the question of providing them with psychotherapy, but rather deal with the practical importance this would have, especially in the early phase of the child’s treatment.

Once the music-therapist has completed the observation stage, aspects of the child’s behaviour in the setting are examined. The main parameters are the child’s ability to set up a therapeutic relationship and the way the child uses instruments, voice, movement and the surrounding space. It is not always easy to establish a therapeutic relationship. Some children, for example, immediately trust the music-therapist, and allow themselves to
be taken into the setting, happily staying there for as long as required. Others have difficulty in accepting the therapist and are reluctant to go into the room. Once they have been persuaded to do so, they often try to get out of the room and have to be persuaded to stay. This sometimes sets up a refusal mechanism which can last for a long time.

Then there are all the aspects regarding the quality and quantity of the child’s powers of expression (including attention span), in other words, the way they react to the surroundings: the use or otherwise of the instruments, the way they move within the setting, the non-verbal ways they use their bodies and their voices, or the way they express themselves using sound (singing, shouting, crying, etc.).

With the parents’ permission, all the sessions are videotaped so that the whole therapeutic process can be kept constantly under control and under supervision.

The session videos are then checked at regular intervals by the whole team, to pick up useful information and to see whether any changes have come about during the therapeutic process. During the cycle of music-therapy sessions, the parents are contacted every five or six sessions, to keep them informed on how the treatment is progressing, and to find out whether any changes in their child’s behaviour have taken place outside the music-therapy context. If the child attends a rehabilitation centre or a school, it can be very useful to meet the operators involved (doctors, psychologists, support teachers, therapists, etc.). In this way, music-therapy is more effectively included in the overall treatment programme.
Bibliography

Watch out for her Powerpoint Presentation in the “Oxford Powerpoints” folder on this CD

The presentation today will focus on the influencing determinants of song preference in girls with Rett syndrome, which came out of the results of my PhD research, which I recently concluded. I will begin with a short overview of Rett syndrome and a very brief description of my methodology.

**Rett**

*Syndrome is a neurological disorder due to an X-linked dominant mutation effecting mainly females.* It causes neurological and developmental arrest and is *found in a variety of racial and ethnic groups worldwide.*

The prevalence rate is believed to be 1 out of 10,000 live female births and is accounted for the most common cause of multiple disabilities among females.

One of the main features of females with Rett syndrome is the impairment of receptive and expressive communication.
Previous research about their communicative skills have shown Rett Syndrome to be pre-intentional, severely limited in communication and to be having delayed reaction.

Music therapy is extremely liked by females with Rett syndrome and has shown to promote and motivate their desire to interact and communicate with their surroundings.

The following hypothesis was formed for my research:

- Can songs in music therapy enhance communication in girls with Rett Syndrome?

There were several sub-questions, which I will not go into, as I will focus on song determinants in this presentation.

There were two parts to this research. One part was finding out whether girls with RS can choose intentionally. The second part to the research was how they respond to live musical experiences.

I will now describe the research design:

The design I used for this study was a multiple baseline/multiple probe design. This research design is a form of a single subject/case design. In this time series design, each individual is viewed as a single case unit in which the comparison is within and between the individual cases.

Seven girls with Rett syndrome ranging in age from 4-10 participated in the study. They received individual music therapy sessions about 2-3 times per week for five months.

These were followed by another three months of follow up sessions.
There were a total of **18 pre-composed children’s songs** in the study. These were divided into **three sets** of songs, a total of six songs in each set (four familiar and two unfamiliar songs in a set).

I had to establish a steady baseline (with no music) before the intervention was applied and its purpose was to determine whether they could choose or not (a sort of assessment).

The girl chose between groups of two or four picture symbols or through orthographies (written words) symbols. This was determined according to each girl's ability as established in a pilot test prior to the research.

Once the preferred song was chosen, I randomly changed the order of the symbols and asked the girl to show me her choice one more time. The purpose of this was to verify the intention of her choice. Immediately following her confirmation, the song was sung to her.

Let's watch two *video samples* of how this worked.

**Results** of the research revealed that girls with Rett syndrome have **intentional choice** making, their **response time decreases** with time, have **learning abilities** and maintain acquired learning.

They have a definite **songs preference**.

We will now look at the **song preference** and what elements these may contain, analyze these, and look at the **emotional and communicative** response the girls reveal in certain songs.
**Song preference:**

Here are all 18 songs. The songs go from the overall most preferred to the least preferred songs. The numbers above each song show the average percentage of choice making by all girls throughout the research. For example: The nut song was chosen 76% of the total times it was presented, the monkey 72% of the times it was presented, etc.

**Figure 19 Song preference girls**
**Figure 20 RS Song Preference**

Song preference in each individual girl was determined according to the percentage. The graphs indicate that despite individual preferences between the girls, there is a resemblance of preferred and non-preferred songs. Graph in the middle indicates the overall order of total preferred and non preferred songs.

Lets look at a video sample of contrasting response between songs that are least and most preferred.

{Video of Aviv in most and least preferred songs}. 
The 18 songs used in this research were structurally analyzed according to the following features: familiarity, tempo, meter, key signature, tempo variability such as: fermatas, pauses, accelerando, ritardando, upbeat, syncopation. Other features such as rhythmical patterns, melodic motifs, harmony, dynamics and vocal play were analyzed.

**FAMILIARITY:**

The participants were familiar with twelve out of the eighteen songs. These were randomly categorized into sets of four familiar and two unfamiliar songs, a total of three sets. They chose out of these sets and had many opportunities in making choices between familiar and unfamiliar songs.

Four out of the five most preferred songs were familiar while only one was unfamiliar.

Findings by researchers and clinicians support the present one that girls with Rett syndrome who selected familiar songs became more animated and generated greater communication and responsiveness when songs are heard (Braithwaite & Sigafoos, 1998; Elefant and Lotan, 1998; Hadsell and Coleman, 1988; Holdsworth, 1999; Woodyatt & Ozanne, 1992, 1994).

A diminished responsiveness was detected in another study when unfamiliar music was heard (Holdsworth, 1999) in similar to the present study.

Familiarity is very likely to be a contributory and a vital factor to song preference.
Two explanations can be regarded: The first explanation could be due to the novelty of the songs. The participants seemed to prefer songs with which they were familiar.

The second explanation could be that the least preferred songs (including the unfamiliar songs) were musically un-satisfying. This will be discussed further on. Although all of the participants chose unfamiliar songs during the study, they only returned to the ones they seemed to like, and never returned back to the other unfamiliar songs.

**MUSICAL FEATURES**

Due to the limited time I will only talk about musical elements that seemed to have an influence on song preference.

**Tempo**

There was a dramatic difference in tempo between the five most and the five least preferred songs.

The mean tempi of the five most preferred songs were 144.8 beats per minute, while the mean tempi of the five least preferred songs were 83.6 beats per minute.

The tempo seems to have a big effect on whether or not the participants preferred the songs, as they were typically drawn to music with faster tempi. This reinforces other findings that girls with Rett syndrome appear to prefer energetic music (Holdsworth, 1999).
One suggestion for this is that the fast tempo as the external stimuli (the songs) may be in synchrony with these girls’ internal level of arousal, which is observed and reported to be at a constantly high level due to over activation of the sympathetic nervous system (Julu, 2000).

Another suggestion for explaining the preference of faster tempi may be that since girls with Rett syndrome are limited in their initiation of purposeful activity, they may respond enthusiastically when being activated ‘emotionally’.

Fast tempi in music bring vitality and energy into their lives while slower tempi may provoke their potential passivity.

Better yet, a very simple explanation for fast tempi preference by girls with Rett syndrome is due to their “normal” attitudes towards music. Their song preference has been supported by similar song preference of professional musicians/music therapists and it is also supported by research, which has shown that children in the same age group (as this research population) prefer music with a fast rather than a slow tempo.

**TEMPO AND RYTHMIC VARIABILITY**

Ritardando (slowing down), Accelerando (moving forwards), Fermata (holding note) and Pauses, Upbeat introductions and Syncopation

All of the favorite songs had these tempo and rhythmic variability’s, while only one out of the least preferred song.
These variability’s may promote emotional reaction to the music and cause for emotional arousal (Meyer, 1956; Sloboda, 1991), give new energy to the tempo, build up tension, elicits excitement in the music, invite response, provoke playfulness and humoristic teasing, adds vitality and excitement.

The results suggest that tempo and rhythmic variability is important feature when determining preference or when composing songs for this population.

**Rhythmic grouping**
The rhythmical patterns in the most preferred songs have interesting rhythms with rhythmic energy, rhythmic surprises and tension.

The least preferred songs have rhythmical patterns that remain rather static and have almost no rhythmical development. There are almost no rhythmical surprises and barely any changes in the rhythmical pattern to break the monotony.

All least preferred songs are built on quarter or eighth note patterns that repeat themselves from the beginning to the end and may cause boredom and tiredness in the listener.

Listen to Elephant song in comparison to the Nut song.

**MELODIC MOTIF**
“Melody is an important aspect of musical expression, and is related to inner experiences and memory."
Melodic contour is an important feature in melody perception from early infancy and therefore it seems only natural that melodic motifs will have an important impact on the girls when preference is determined.

Melody is an important form of expression and girls with Rett syndrome need to express their emotions. As they don’t have any verbal means to express these emotions they can do so by actively listen to the melodies in the songs.

In the most preferred songs the melodic developments are more interesting and with more variability with interesting intervals when compared to the least preferred songs.

The girls in the study seem to be sensitive and tend to melodic developments.

DYNAMIC VARIABILITY
All favorite songs have dynamic variability.

The limited amount of variability in dynamics in the least preferred song can contribute to the monotonous feelings of these songs.

The dynamic variability evokes energy, power, control and commitment (Amir, 1999) and all these are expressed in the most preferred songs.

VOCAL PLAY
All preferred songs have different types of vocal play and only two of the least preferred songs and these appeared at the end of the song
They may be similar to real life imitation of objects, gibberish vocalization, and changes in pitch and give meaning to the music.

An example is the Train song, which has sounds ‘puff puff’ and ‘toot toot’, reminding the listener of the sound of the train.

The ‘toot’ sound is heard on a high octave which may provokes tension and at the same time excitement.

This type of vocal play gives freshness to the repetitive verses. The vocal play elicits emotional and communicative responses and seem to provoke happy response and add to the fun when listening to the songs.

Let’s look at a video clip with three girls listening to the Bee song which contains real life vocal sounds of a bee and the sound of the reaction when being stung by one: “bzzzz” & “oops”

**SONG PERFORMANCE**

Some comments can be made in reference to the style of performance. The songs were sung by myself. Although the songs were meant as a stimuli used in the intervention for intentional choice making, once they chose, it was up to me to sing their choice.

I attempted to be very true to the music and its form, putting the song in the center and at the same time I was very tuned to the emotions and communicative responses the girls might have revealed in response to the song. These responses were reflected in the style in which the presentation was performed.
Meaning was incorporated into the emotional expression of the singing, almost as if a new story was told each time the song was sung. I never experienced boredom singing the same songs even though the girls chose some of them endlessly.

The fact that the girls responded differently each time encouraged me to sing accordingly.

During songs when the girls did not respond as positively and sometimes made frown faces, I attempted to ignore their response and focused mainly on the song’s musical ideas. However, on some unconscious levels I was influenced by their response, which could be viewed on the videos. The above description is similar to the mother modifying her behavior to fit the expression formed by her baby.

It is what Malloch (1999) refers to as ‘communicative musicality’, a narrative of combination of pulse and quality of pitch, which allows “…two persons to share a sense of passing time” (p.29).

This type of communication is vital to the mother/baby or therapist/client interaction for the emotional and cognitive growth of the child. I was attuned to the girls and attempted in expressing musical ideas through the songs, in order to provoke some type of emotional or communicative responses.

**Emotional, Communicative and Pathological Behaviors**

The girls’ behavioral responses in this study were divided into three categories:
Emotional behaviors: smile, laugh, cry, etc.

Communicative behaviors: eye contact, body movement, etc.

Pathological behaviors: stereotyped hand movements, hyperventilation, etc.

This division of categorization was made to organize their responses and to give it a meaning.

I’ll summarize some of the findings.

During baseline negative responses such as: serious face/frown, cry, shout, turning head away, leave seat, walk towards the exit door, push picture symbols away, etc. were evident.

Their facial expressions reflected either distress or irritation. These behaviors seemed to enhance with time, became more frequent and stronger.

These responses suggest that the girls did not accept a situation where they received no song, and reacted in a way that can be perceived by a trained clinician as a communicative act. While closing the eyes and looking away are behaviors that might be interpreted as somewhat negative and their meaning can be debated by different viewers, there seems to be no doubt that getting up from the chair and standing at the exit door or pushing the symbols away are obviously signs of revolt and rejection.
Least Preferred songs:
The girls demonstrated positive response when the music began.

Their emotional reactions were ambiguous and limited when non-preferred songs were sung. These were: eye contact, smiles (on/off), frown, moan, and rocking movements, stereotypic hand movements and hyperventilation.

Emotional response (on/off smiles) may indicate uncertainty while hearing the songs or a mixture of emotions created by the fact that a song the girl chose was being sung to her, while disappointment from the actual song itself as a musical entity.

Most preferred songs:
Very positive responses were observed during the preferred songs. These were: smile, wide smile, laughter, vocalization, eye contact, body movement and more.

The most prominent fact was the abundance of responses displayed by the participants when preferred songs were played.

Vocalization:
All girls vocalized somewhat during the preferred songs, but nearly not as much as I had anticipated.

Vocalization increased in quantity and intensity after the song had been sung, and mostly at the end of the sessions.

Stern et al. (1975) discuss two modes of communication: ‘co-action’ (mother and infant vocalize together) and ‘alternation’ (mother and
infant alternate vocalization). The mode of alternation was how the girls in this study responded. They concentrated on the therapist while the song was sung to them, as a young child may be when listening to his mother talking ‘motherese’ or singing to him.

**Conclusion:**

Specific individual song preferences were found in this study. Establishing each child’s **individual preference** is an important first step when trying to achieve active participation by the child.

When determining what type of songs to use during music therapy intervention it will be more effective if they **encompass** some of the **musical elements found in this research** (always remembering each child’s personal preference and musical background can and will differ).

The **presentation** (singing) of the songs should address the **expressive** part of the music and at the same time needs to be presented as **true** as possible to the **musical structure and its style**.

Being tuned to the child’s emotions and reflecting these emotions musically does result in a meaningful form of interaction between therapist and the child. This type of musical/emotional interaction establishes an important dynamic foundation for growth and learning in the child with developmental disability in general and with Rett syndrome in particular.

In this study the girls vocalized more in between the songs and at the end of the sessions. In **order to enhance vocalization** it is recommended to
give ample space and time for the girl to respond either in pre-composed songs or in improvised activities.

It is important to identify emotional reactions and different behaviors that can be interpreted as communicative attempts by a familiar figure of the client, such as a caregiver or a family member.

Recognition of these behaviors and understanding their intended meaning will increase shared understanding.

If these emotional and communicative attempts go unrecognized and unanswered, it may lead to the decay and demise of forms of behavior that, when recognized and interpreted, satisfy the needs of both client and caregiver.

I would like to end with a video showing Aviv emotional response in different events in the music, followed by a decline. It is like an exciting stimulus, which becomes familiar and then the response fades away.

It becomes habituated.

You will see 5 out of 14 presentations the same song at different times. It shows a very consistent progression of her response.

Pay attention to the rich palette of emotional and communicative responses the girl reveals as well as to the changes in my singing accordingly.

{Video that illustrates this with Aviv "Train song".}
Integrating Special Needs and Typical Children through Group Music Therapy

Elefant, Cochavit & Agami, Anat
Watch out for their Powerpoint Presentation in the “Oxford Powerpoints” folder on this CD

INTRODUCTION

Integration of special needs children in the community through music therapy is a common interest for both Anat and myself. We were involved in integrating special needs children in the USA before returning to Israel and continued there in pursuing our interest, which wasn’t an easy task. No regular school in the community was really interested taking part in a project, which involved disabled children. I finally “found” one school (seven years ago), a religious school that saw this project as a “good deed” to the community. It took Anat another three years before she found a school. I work in Beit Issie Shapiro in Israel for developmentally disabled children, and Anat in a school with children with autism.

We both wanted to see these children take their place in the community.

Video 1 – overview of the special needs children

Our motto in integration

Integration though music is:

• Powerful in establishing relationships.
• In tracing channels of communications.
• Serves as a bridge between the two populations living within the same community.

**Starting points in integration through music**

1. **Music encourages communication** – Being nonverbal music is suitable for people suffering from severe disabilities such as difficulties in establishing communication, lack of language, motor problems, cognitive disabilities, emotional problems, etc.

2. **Music as a means for expressing emotions** - Music is a direct means which enable almost everyone to express his/her feelings, independently of his individual abilities and disabilities. Almost all the children are capable of reading emotional codes, such as joy, sadness, frustration, anger, excitement, shyness, etc. In our daily work, as well as in our integration programs, we rely heavily on nonverbal codes.

3. **Music narrows gaps** - The advantage of integration through music lies in the fact that through this medium the gaps between the disabled and the typical children are considerably lower. In joint activities involving music we find that the disabled children display a lot more abilities than in activities, which demand cognitive or motor skills.

4. **Music enable social interaction** - Although the disabled children have difficulties in acquiring social skills and in understanding social rules, we shouldn’t jump to the conclusion that they are not interested or not enjoying being in social interactions.

They frequently show interest and make contact with others, but the difficulties they have in establishing contacts through conventional means makes it hard for the onlooker or for the child with whom the
contact is made, to understand what they want. In fact, integration with autistic as well as with developmentally disabled children is complicated because of the difficulties they have in establishing interpersonal interaction.

**Video 2**

Let’s watch video showing attempts to establish contact not based on conventional rules.

Before starting the project of integration we prepare the typical children towards the integration. Cochavit even prepares the parents of the two groups of children as well as the staff of both schools.

**Preparing the typical children**

The preparation comprises two stages.

1. Stage one - The meetings are focused on the self, the similarity and the differences between my classmates and myself.

We believe that before facing and learning to cope with the disabled child, the typical child has to learn to recognize and face his own difficulties. How does he see himself among his peers and does he feel different from the others in some fields and if so, how does he cope with this fact.

After listening to a story or a song dealing with these issues, e. g. (for example) “A song about the smallest boy in the class” children express their feelings.

Another example, a boy wearing glasses told about the unpleasant feeling being laughed at by his classmates.
A short girl experienced unpleasantness when people thought she was in kindergarten while in fact she was in the second grade. She emphasized that now being in the third grade, she got used to it and it didn’t bother her as much.

We play a game in which sentences displaying various difficulties have to be completed, e.g. “I hate mathematics lessons…. because I have difficulties solving mathematical problems. During this game each child encounters the difficulties he might have.

At these meetings various important topics are brought up by the children, which leads to dialogues between the children in the class. The classroom teacher may further develop these topics. We usually provide them with appropriate reading material.

2. Stage 2 - Getting to know the disabled person in the community. We ask the children what exceptional people they know.

Through games the children experience how it feels to be frustrated caused by the inability to succeed in various fields.

Example: To illustrate fine motor problems the children are given the assignment to thread beads while wearing gloves.

In order to illustrate excessive auditory sensitivity we make them listen to very loud and unpleasant noises, e.g. we approach the children with a recorder or a drum and play harsh and dissonant tones till they cover their ears with their hands.

Another example: A child fills his mouth with water and his classmates ask him simple questions, which he has to answer. In order to do so he
will use alternative communication: gestures with his hands, pointing to pictures on the wall or showing letters to illustrate words.

Afterwards we link these experiences to the disabled children and show them a video of the children.

The class teacher and the counselor of the class choose the children who will attend the integration program. We recommend that they choose not only the good and successful children for this program, but also children who have difficulties. 2-4 preparatory meetings are held.

The special needs children are told that they are going to meet a group of children and we show them pictures connected to this meeting.

**PREPARING THE PARENTS AND STAFF**

- Preparing the parents of the typical children.
- Preparing the parents of the disabled child

Due to our limited time we are unable to discuss this part although will show a short video segment with initial attitudes of the people taking part in the project.

**Video 3**

**Preparing the staff of the typical children**

At the beginning of the year we meet with the staff of the typical children and we tell them about the disabled children and enable them to ask questions. They usually ask pertinent questions without relating to their fears and feelings.
In the course of the years of this program the staff has undergone a process enabling them to be more and more open.

The second meeting with them takes place in the special school, where they meet with the disabled children. This encounter raises their apprehensions and we encourage them to speak openly about these feelings during all subsequent meetings.

**Preparing the staff of the disabled children**

At the beginning of this project the staff at Beth Issie Shapiro expressed their opposition to the idea of the integration. Their strong feelings were mixed with excessive protectiveness. They believed that this experiment would cause the children mental and physical harm. They wanted the typical children to come to Beit Issi Shapirpo and were very concerned with the well-being of the disabled children.

At the beginning of the program their fears increased, as they found it very difficult to watch the disabled children being rejected.

Meetings are held with the staff every week.

**The therapist / Leader**

- The task of the therapist is similar to the function of the conventional leader in the group. In addition we have to be the voice of the disabled child.

- The task of the therapist is to guide the staff of the two educational frame-works and to be in contact with the parents.

The disabled children know us from beforehand and have an emotional contact with us. This creates a special dynamics.
When working only with the group of the disabled children the therapist establishes individual contact with every child, however in the integration group these children become part of the group, which causes us new dilemmas.

We have to cope with the interaction between the children and the staff from the two frame works.

**The group**

The group consists of disabled children who know one another. The regular child is chosen from his class to participate in this new group.

**THE MODEL OF INTEGRATION AND THE DEVELOPMENTAL PROCESS WITHIN THE GROUP**

During the whole process of integration we use musical activities, as well as hold conversations with the children. We will give more details later and watch video segments.

We will refer to the developmental model of the group according to Fuchs, Garland and Hibben.

Due to the fact that this is not a regular homogenous group, we will deal with only the significant stages.

**I. First Stage – Pre interaction**

- At this stage there is no interaction yet between the children.
- The musical activities enables keeping a distance without requiring cooperation. The therapists’ are aimed in creating interaction between the children.
At this stage the main factors in the group are anxiety, avoidance and confusion. Especially in this group the anxiety is greater than in a homogenous group because of lack of knowledge and previous contact with the disabled child. The natural urge of both groups is to fight off their anxiety through binding together with their own sub-group while denying the differences. The children stick to their “original” group. The differences within their own group are less conspicuous in comparison with those between the two groups.

During the first discussion the typical children sometimes say “We thought that they were much more frightening and different, in fact they are not much different from us”. In this kind of group it is important to give clear and structured guidance from the beginning. At this stage the children sit where they choose to. They usually will sit in groups known to them. During this stage each child plays his own instrument and we are using accessories as parachutes, elastic band as communicative objects.

Video 4: We will watch two video segments showing various examples of these activities:

1) Each child plays a different instrument. There is an attempt by the disabled child to make contact but there is no real interaction yet.

2) Non-direct contact with the aid of accessories- elastic band.

II. Second Stage - Separation

At this stage the group test its right to be different and the “resisting” members test their place in the group and challenge the therapist.

At this stage we can distinguish different behavior patterns among the children. This is due to the fact that some of the children are still in stage one characterized by anxiety, avoidance and confusion. While other children will test the limits and try to stand out.
Typical activities at this stage include imitation of movements, leading and following the leader, playing together on the same instrument which serves as a connecting object.

**Video 5**

*Now we will watch a video showing activity involving imitation of movements. The imitation may seem obvious, but for the autistic child imitation means relating to the other and this is very meaningful.*

**III. Third Stage- "Intimacy"**

During this stage the level of trust each child has in himself and in the group has enhanced. The group is ready to take risks and is able to contain individual anxiety. There is anxiety, but also containment.

During this stage we present the group with musical activities that have flexibility in choosing between intimacy and/or distance.

The leadership becomes more flexible and free. By now some physical closeness is revealed such as: holding hands during dance or other activities with partners. During parachute activities the children will typically gather underneath or on the parachute mixing and mingling and being quite close to one another.

The children with autism have high anxiety levels. During this "intimacy" stage it is evident that familiarity, consistency and repetitiveness in the activities creates and contributes to their feeling of security.
Their method of expressing intimacy is quite different than one might expect from the norm. For example: the autistic child can express intimacy by suddenly getting close to a typical child touch him and/or directly gaze at him, then withdraw abruptly.

The cognitively impaired child could express intimacy by giving a "slap" (hit), by giving especially wet kiss or by a very strong hug.

* **Video 6: We will now watch two video segments.**

The first segment is an example of a group dance, which shows closeness and intimacy. The second segment reveals intimacy, which occurred spontaneously by a special needs child towards a typical child.

**IV. Fourth Stage "Renewal or Attachment & Differentiation"**

During this stage the children enhance their emotional involvement in the group activities. The conversations and activities are more on a personal level and focus on the "me" and my relation to the group with the support of the group leader.

This stage has two sub-phases:

1) **Disintegration** - of individual member of the group and by the whole group. A feeling of chaos overwhelming or disorganization is evident, "I am viewed differently than what I thought of myself". During this phase there are some typical children who requested to leave the group. One example is the boy you just saw on the video who felt that it was "just too much" for him to continue to be a member in the group. Most children pass this phase and move on to the next one.
2) **Reintegration** - which is reconstruction and reorganization. The participant forms a new picture of himself, sees parts of himself he/she never realized existed. These children who build the relationship through a slow process may feel more secure and comfortable in the relationship.

During this stage new group activities are added such as: birthday parties for the children in the group, trips in community such as going to eat pizza, celebrations of holydays and shared camps during school and summer vacations.

Only during this stage real integration occurs, after a process of individual emotional growth in the group.

**V. Fifth Stage "Ending"**

During this stage the group has a past and a present and is now occupied with the fact that there is no future. There is a preparation for ending/closure of the group.

The emotional experience in the group has deepened and there is an awakening of apprehension in what would become of each member of the group in the future. More evident is the worry that the typical children exhibit towards the future of the special needs children. "What will become of them next year? Are they going to develop?" The children share their hopes that the special needs children will grow up and be just like them and that a medical cure will be invented so that they can begin to quickly walk and talk.

We, structure the closure stage by summarizing all the activities the children were involved in and enable them to choose the once they want.
The typical children remind themselves about the fear they initially exhibited and about their families who sometimes rejected the integration. They speak of how they view the special needs child now and how they see them differently than they initially did. They experience the child's strengths and not his weaknesses.

**CONVERSATIONS WITH THE CHILDREN**

During every session we undertake conversations with the typical children. The purpose is for the children to express their experiences, feelings, and difficulties and to relate their emotions to the group process during that session. We attempt to give legitimacy to ALL emotions that may arise and encourage the child to talk about it and mutual attempt by all children to give a solution to the specific problem that takes place. This process of solving a problem is especially rewarding and powerful as it provides the children control over their environment.

The typical children see sights never seen before such as a child biting himself, a child constantly shouting or a child when excited jumps up and down or hits.

Every such interaction or difficulty becomes a pivot point which we and with the assistance of the children try to think of ways to solve or to reduce these difficulties.

They attempt to understand the special needs child’s responses and emotions they exhibit. They look at why they may laugh or cry and they also try to put meaning to their gestures and movements. They come to
the conclusion that we all have feelings only our manners in expressing these are different.

SUMMARY

There is no doubt the program contributes to the enhancement and enrichment in both populations. The program contributes in accepting “myself” & “others”.

Advantages of Integration for the Special Needs Child

- **Distributes models for imitation** (The child learns to imitate normative behaviors).
- **Improvement in social skills**
- **Enables different experiences** (repetitive activities: reinforce security, enable independence, create higher self esteem), as a result attitude towards them changes by the surrounding.
- **Provides stimulation and motivation** (The child is more active when compared to his passivity during classroom activities).
- **Enables a feeling of belonging** (By being part of the group).
- **Emphasizes strengths and not weaknesses**

Advantages of Integration for the Typical Child

- **Opportunity to interact with special needs children** (This children belong in the community - a fact that can not be erased).
- **Develops patience, pluralism and mutual help**
- **Changes attitude towards the exceptional child** and decreases the negative stigma towards him.
- **Increases security and self-image** by self-fulfillment of aiding others.
- **Conveys the message to** the general community – they become society’s messenger.
- **Focuses on the person rather than on the disability**.
The staff and parents

• The staff becomes better career, as they believe in the children’s abilities.

• Other staff members and parents value and show interest in becoming part of the program.
  • For us as therapists leading the integration groups is complex, interesting and immensely satisfying. It demands facilitating different groups with different needs (children, staff and parents). It is up to us to find different ways for meaningful experiences.

Our goal is to enable the client to leave the therapy room and to find his place in the community.

Video 7

We will end with a short video, which summarized the process of integration through the eyes of the typical children.
Jazz, improvisation and a social pharmacology of music

Fachner, Jörg

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 20\textsuperscript{th} and 30\textsuperscript{th} 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, & McKeeganey, 1997), with 1,523 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 prejudices 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.

**Music, Model-psychosis and psychotherapy research**

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,
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 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 neurophysiological exploration of fantasy systems using results from
psychedelic research (Emrich, 1990; Leweke, Giuffrida, Wurster, Emrich, & Piomelli, 1999). In recent animal studies a new brain system - the cannabinoid 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 Disease, 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 therapy clients and drug-induced music experiences
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, Mendelson, & Benedikt, 1995; Wise & Bozarth,
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 ‘khif’, 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 widespread, 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, characterised 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 kairological 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-individual 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 understand ways of perceiving and processing music in different states of consciousness.

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The Whole is greater than the sum of its parts: Experiences of co-working as music therapists

Fearn, Mary-Clare and O’Connor, Rebecca

Abstract

This paper will illustrate the experiences of two music therapists who have been working together for ten years and the benefits of this partnership. It will show how working practices and therapeutic processes have evolved over a decade. It will demonstrate that working as a team over this length of time has resulted in significant improvements to the therapy given to children with special needs and support offered to their parents. Various topics will be explored and illustrated including the development of a co-therapy assessment procedure, group psychodynamic music therapy for children with autistic spectrum disorder, sessions for children and their parents and the significance of counter transference.

Introduction

In our profession, we all know what it is like to work in isolation; we feel fortunate to have been working together for the past 10 years. Although our situation may be unusual for music therapists working in this country, we hope that what we have discovered together will be useful for other music therapists.

We are going to explain and illustrate how our working practices and therapeutic processes have developed over the past decade.

This paper will be focusing on how the following have developed:

• Co-Therapy Assessment Procedures
• Sessions for Children and Parents
• The Need for Parent Support
• The roles of Therapists within Psychodynamic Music Therapy Groups for Children with ASD and Communication and Developmental Delay

Co-Therapy Assessment Procedures

Our assessment procedure is not set in stone, we are constantly redefining and re evaluating it as new challenges arise.

When we started 10 years ago, following a referral, an appointment was made for an assessment with one therapist, and the child would attend without their parent present. Following the assessment, a brief report was written for the referrer and parents. Our primary aim was to ascertain if a course of music therapy would be appropriate.

However, it became apparent that this was not the most effective method to assess children for music therapy. We discovered that:

• Often children were distressed upon being separated from their parents.
• Sometimes the parents themselves felt excluded and suspicious despite reassurances and explanations.
• It was unnatural for a parent to leave their child with an unknown adult in an unfamiliar environment.
• Feedback following the session was not adequate, the brief verbal and written reports were not sufficient. Parents needed more information.

An alternative assessment model was developed over the subsequent ten years and we have found the model we currently use to be very effective.
The Assessment Process

Following a referral, a lengthy discussion takes place with the parents. At this time we explain exactly what music therapy is, what we will be looking for in the assessment, their role and the structure of the session.

- We emphasise the therapy aspect of music therapy and that during the assessment we will be looking at the non musical use of the space as well as the musical.

- We stress that there are no musical rights and wrongs, that their child does not have to play if they do not want to and that it is not about passing or failing a test.

- We explain that we will not only be assessing the child’s ability to use music for interactive and expressive purposes, but also their emotional needs and difficulties.

- We describe the proposed format of the session, that there will be a welcome song, an instrumental section, a concluding song and an opportunity for discussion at the end.

Sometimes at this stage, parents say, “Oh this is not what I thought music therapy was. I don’t think it is what I want for my child.” Sometimes, what parents are really looking for are music sessions and we are able to suggest more appropriate musical input.

In the assessments we found that it was more effective if we split our roles. One of us acts as “the lead therapist” taking a more proactive role, leading the session both verbally and musically. The other therapist remains at the piano throughout and takes a musical and observational role. This allows the leading therapist to be subjective so that the person at the piano can be more objective.
Following the assessment the lead therapist takes the parent and child to a separate room for a feedback meeting whilst the other therapist does a written brainstorm of the session using the following format.

**MUSIC THERAPY POST-ASSESSMENT BRAINSTORM**

**CHILD’S NAME:**

**AGE:**

**DATE OF ASSESSMENT:**

**DIAGNOSIS:**

**PHYSICAL DESCRIPTION:**

**INTERACTION WITH MUSIC THERAPIST:**

**DEPENDENCE ON PARENTS:**

**PARENT’S UNDERSTANDING:**

**GENERALLY HOW IT FELT BEING WITH THE CHILD:**

**BEHAVIOUR:**

**ORDER OF SESSION:**

**MUSICAL USE OF SPACE:**

(instruments used)

**NON MUSICAL USE OF SPACE:**

(including any verbal input)

**URGENCY OF NEED FOR MUSIC THERAPY:**
The therapist-parent feedback starts with the therapist asking the parent(s) what they thought of the session and how they felt their child reacted. This had proved to be a useful technique as the parents’ response is often surprising. This meeting is invaluable as it puts the assessment into the context of the child’s wider life.

“Is your child different in other situations, or was this typical behaviour for him?” is a question we always ask. Often the answer to this is that their child reacted very differently in the music therapy situation. This vital information is something we missed out on when we were using the initial assessment model. We would not have realised that the child’s behaviour was unusual or have been aware of the significance of their responses. These feedback sessions also give us insight into the parent’s understanding of music therapy.

Some parents say they have never seen their child so responsive and they are amazed at what he is able to do. At times, parents find it quite an emotional experience and often say they have never seen their child focus for such long periods of time or interact so easily. Other parents find it hard to hear about the difficult emotions and tend to focus purely on the musical aspects of the session and say “they obviously enjoyed themselves” or “he really loved the music”.

The advantages of having two therapists have proved to be of great benefit. We are able to bounce ideas off each other, discuss how each of us felt in our different roles and it is fascinating to observe how often we both agree. Following sessions, we often discuss the transference and
counter-transference that existed in the session. This enables us to write reports from a more subjective point of view.

Sometimes a one session assessment is not enough to assess the needs of the child. For example, one child came to the room, sat on the mat and did not move or make a single sound for the whole session. Clearly we were unable to obtain a full picture of this child in such a short meeting. He needed a longer assessment period which gave him the opportunity to reveal a totally different side of his personality. It was not until session six that he began to interact and use the music purposefully. In cases such as this, we offer blocks of four or ten weekly assessment treatment sessions. These take place with just one therapist; often the reason a child is unable to respond seems to be linked with the overwhelming experience of having two adults focussing so directly upon them.

Following the session, the lead therapist writes the report, whilst the second therapist also has input. Both sign the report and it is sent to parents, the referrer and all professionals involved with the child. The parents are invited to contact us if they wish to discuss the report.

**Sessions for Children and Parents**

Following assessments, it sometimes became apparent that for some children, and indeed their mothers/fathers, it would be of more benefit if they attended sessions together. This could happen for a number of reasons:

- High level of separation anxiety possibly due to autism
- A very young child
• A child with a recent diagnosis
• A child that had never been separated from their mother before
• Where there were high levels of anxiety surrounding the child
• Where mothers were finding it very hard to interact with their child

Also, groups for children under 5 and their mothers or fathers developed when parents were in obvious need of support from others in a similar situation. And, where the children did not have exposure to social situations due to the nature of their disability.

Four clinical examples

1 Sean was a child with autism and severe behavioural problems. His mother spent a great deal of time saying no to him. During sessions, she was constantly interjecting with the word no. It was suggested that in future sessions the therapist could be the person who dealt with any difficult behaviour therefore enabling his mother to comment on the positive things that her son could do. Initially, she found this very difficult, but in time was able to praise her son and experience a different way of being with him, which hopefully was beneficial for them both.

2 Terry was a 4yr old boy on the autistic spectrum who had never spent any time apart from his mother. We questioned whether he was aware that he was a separate person to his mother. He was totally unable to interact with anybody except her. Sessions focussed on encouraging them both to experience interacting with each other and the therapist through improvised music. The overall aim was to facilitate, and support his mother, encouraging her to begin to let go of him and enable Terry to interact with the therapist. By the end of a year’s therapy he was able to interact independently and attend sessions by himself.

3 Charlie was a 3 yr old boy who had a rare chromosomal abnormality. His mother was finding it difficult coping with his emotional needs, as she had been finding it hard enough coming to terms with his physical needs. She was a very supportive mother and was keen to attend sessions with her little boy. The most valuable and significant outcome of music therapy for her was being able to focus on what Charlie could NOT do and for her not to try and over-compensate or to
“rescue” him from situations that resulted in him becoming upset. For example, not being able to walk on his own very easily or get onto a chair without a struggle. She wanted support in helping him to confront his difficulties, but everyone, particularly her family, concentrated on what a lovely/gorgeous boy Charlie was. He was a loveable little boy, but clearly everyone was colluding with ignoring the awfulness of his disability, as it was too unbearable to think about. We thought about this in long-term individual therapy and both parents attended sessions (at separate times). They were very supportive and the outcomes were immense. They both just needed a little encouragement to trust their instincts and were able to continue helping Charlie to acknowledge and work through the painful emotional aspects of his physical and learning difficulty.

4 We have been running groups for parents and children under the age of five for six years. These groups give the adults the opportunity to be in an environment where their children’s emotions and behaviour is accepted and thought about. The parents are able to experience interacting with their children in a non-verbal way. They are often amazed by the power of music and how their child responds with the other group members. They have also commented on how supportive they find the groups for each other.

The more time we spent with parents, the more apparent it became that there was very little support for families out in the community. We regularly discussed this dilemma together and concluded that support for parents needed to be formalised.

**Parent Support**

We also ran psychodynamic music therapy groups for children. During these sessions the parents waited together in a separate room and over time, they often formed supportive friendships. Although this was helpful for them, we felt it was not enough. We realised that this group presented us with the ideal opportunity to create a parent support group with professional input.
We undertook a research project to assess the demands and evaluate the usefulness of such a group. This project ran for six months and took place in conjunction with a music therapy group for children with autism. A specialist health visitor who is a member of our multi-professional team facilitated the parents’ group. Three questionnaires were used to assess the effectiveness of the project. The results were outlined in a paper\textsuperscript{51} and proved that parent support groups are an invaluable resource. They are both needed and in demand. The research also discovered what parents wanted from such groups and what they gained from attending one.

- All parents commented that they had gained a great deal of support and help from attending the group.
- It was of value to be able to listen to and share problems and difficulties through facilitated discussion.
- All group members commented that having a space to talk about their own needs helped them in their relationship with their child.

Sadly, we were unable to develop this further and to have regular parent support running in conjunction with music therapy sessions due to funding limitations. However, we still see parent support as an essential part of the service we offer. We believe that without support for parents the progress in their child’s music therapy is often curtailed. In order for children to change and grow emotionally, it is vital that their parents are open to hearing about this change and are able to support it.

One of the changes to our treatment programme that we have implemented as a result of this research has been to have a parent

meeting prior to therapy commencing. This involves an hour and a half’s meeting with the parent(s) and therapist without the child present. At this point we

• Bring ourselves up to date with their child’s current situation
• We take a detailed history, particularly concentrating on the early development
• We find out what support is in place for the parents, if any

Often parents become quite tearful at this point and say “you are the first person that has ever asked me about my needs”

We have put together a data base of support networks for families within the local community. This is made available to parents at the end of the parent meeting or as and when they require it.

Our Roles As Therapists Within Music Therapy Groups

Preparation For Groups
The groups run for 20 weekly sessions and have a maximum of five children. During the parent meeting prior to commencing therapy, the structure and aims of the group are discussed.

The Music/Structure of Sessions
Groups begin with a greeting song and conclude with a goodbye song. The rest of the session uses improvisation.

Five minutes prior to the goodbye song, we encourage the children to help move the instruments to the corner of the room, in doing so they create space for everyone to sit around a large tambour for the song. We have found that this focus promotes a calm period allowing space for
thought and verbal input from the therapists and the children about what has happened during the sessions.

**The Boundaries**

Obvious boundaries of safety are stressed from the start. We feel that having two of us has helped us be very firm and clear about what is acceptable and what is not.

Some of our more specific boundaries are:

1. Starting and ending the session on time, regardless if only one child has arrived
2. That parents do not come into the room
3. Generally, children do not leave the room until the end of the session unless it is impossible to enforce the boundaries of safety.

**The Therapist’s Roles**

We each have clearly defined and consistent roles within the group. We do not work as therapist and co-therapist, rather as two therapists with different roles to play. One person is predominantly static at the piano whilst the other is more fluid, uses the flute and is on the floor with the children. We both use our voices and both interject with verbal input where appropriate.

The pianist aims to provide the musical glue, holding, reflecting and containing the groups’ emotions with her music. On the whole, she aims to remain at the piano providing a central focus for the group.

The flautist is essentially involved in managing the group both verbally and physically. She deals with the practical issues, welcoming the group, discussing endings and breaks and helps to facilitate access to the
instruments. For example, there was a child in one group that we ran who could not bear it when the group became cohesive and musical interactions were taking place. He did everything he could to destroy and disrupt the session including turning the light switch on and off and throwing instruments. One therapist was able to focus on managing his destructive behaviour, acknowledging it, supporting it and maintaining the safety boundaries whilst the other maintained the musical line. It was important that the groups’ music was not allowed to be completely broken as we felt this would be damaging for both the child and the group.

These roles create a predictable structure that help the children to eventually feel safe and secure in their therapy. They are not interchangeable and we feel it is vital that these boundaries do not become blurred. Despite the fact that we both play the piano and flute, we stay with our allocated roles for the duration of the group. This splitting of our roles provides a strong structure for the group.

The flautist has a more subjective role which allows the pianist to be more objective. This is particularly useful when the group presents with chaos, anxiety or challenging behaviour. On the whole the therapist on the floor becomes involved with individuals and the pianist is able to have a more global view of the group.

Throughout the sessions we are aware of the projections that are happening within the group. We examine the transference and counter transference. One of the benefits of having two therapists is that we are both open to projections from different children within the group. The
time spent discussing and analysing the group is essential for moving forwards within the therapeutic process.

For example, in one session, the flautist began to prepare the group for the ending by saying, “We have 10 minutes left”. A little later, she said “We have 5 minutes left”. Then she said, “It is nearly time to finish”. And finally, “It’s time to sing goodbye now”. The pianist was getting very irritated and wondered why the other therapist was so obsessed with the ending, as she herself did not want the group to end at all. Afterwards, when we discussed this, we realised that we were both identifying with the different feelings being projected by the group members about the ending. Two children had been very anxious and wanted to leave the room, whilst the other two had been fully absorbed in their improvisations.

Occasionally one of us feels that the other is playing too much and that their music is mis-attuning. (Stern, 1985). The therapist who is observing objectively feels that the other is desperately trying to connect with the child who in fact has withdrawn from the interaction. Between ourselves, we have termed this pouncing and as a result, following the session one of us may say, ‘you were pouncing today, I wonder why?’ We believe that honesty within any therapy partnership is essential in order to maximise the therapeutic potential.

**Supervision**

We both attend different supervision groups. This has brought useful insights to our group work. Because we have worked together for so long, we read each other well and have become able to anticipate the next
move. For example, in group sessions, more often than not we sense what the other is going to do next. Many times, one of us has lifted a hand up for the flute just as the other had already started to pass it to her. This was thought about in supervision. One supervisor suggested that the group members might feel that we were communicating with each other almost by magic and we needed to be aware of how we are seen to interact with each other in sessions.

Feedback to and from Parents
Some groups have been more successful than others, a large part of this success is due to the support and input we have had from parents.

Following each group, when we return the children, we give a brief overview of the session, concentrating on the group dynamics as much as possible, rather than focusing on individuals. Once again, we have found it particularly helpful having two of us. In a recent group that we ran together, there was a parent who found it difficult to accept the enormity of her child’s disability and as a consequence, constantly de-valued our therapeutic input. She did this by talking about irrelevant and distracting issues whilst we were feeding back to the parents at the end of a session, bringing her child late to sessions and cancelling sessions without warning, (on one occasion telling us that she had needed to paint the bedroom instead). However, by combining our confidence and belief in the value of what her child was achieving in therapy, we were able to be firm and not allow her to sabotage our feedback or monopolise the conversation. Gradually she became less obstructive because we were not allowing her to destroy the goodness of what the group was
achieving. As a result, she was able to listen more and became supportive – she went to a great deal of trouble to arrange babysitters so that she could attend the final feedback meeting.

At the Conclusion of therapy, we meet with all of the parents, without their children present, and sum up the therapy progress with audio and video excerpts.

Patterns emerge repeatedly with this particular client group and this specific way of working. For example, after the first three sessions, we often question what we are doing and what we are trying to achieve. However, by ‘trusting the group’, (Cox, 1990) we usually find that by approximately session seven the group feels established and there is a strong sense of cohesiveness.

Conclusion

The working practices and procedures discussed in this paper have been developed over the past ten years. They have evolved as a result of constantly reviewing the way we work, both together and in supervision. It has been an essential part of the department’s growth that we have been open to change. Our mutual enthusiasm and the honesty between us have been vital for the success of our working partnership.

Authors

Mary-Clare Fearn and Rebecca O’Connor share a Head IV Music Therapy post at the Cheyne Child Development Service, Chelsea and Westminster Hospital, London. They have both been instrumental in
setting up music therapy departments and have extensive experience working with adults and children who have *special needs/physical & learning difficulties*. Rebecca also teaches on the Introduction to Music Therapy Course at Trinity College of Music, London.

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Fetal Responses to a Musical stimulation. Music Therapy and Pregnancy.

Federico, Gabriel F.

In this lecture I am going to develop my clinical practice in Music Therapy and its specific application during pregnancy. I will also speak about the fetal ability to hear and, of course, about the results that I have obtained in relationship with the moment of birth and in the subsequent development of the newborn who has undergone a Music Therapy treatment.

When I began developing this lecture, I reflected about the area that comprises my work. I came to the conclusion that it is included in the "Prevention" field.

This word has always been under discussion. This is so because science is always looking for proofs supported by scientific grounds and I believe that the work I carry out, in which the primary goal is related to humankind, society, specifically speaking about bonding among human beings, cannot be measured by the required scientific parameters.

This lecture is not based upon scientific grounds; it is supported by the proofs and results I have obtained during eight years of clinical practice.

The environment has always directly or indirectly influenced the psychophysical development of the man. For example, if we consider two babies, one born in Brazil and the other one in Alaska, we will find out that the one from Brazil will be in contact with the sand and the one from Alaska, with the snow. Their clothing will be totally different and so their motor development will be. And we cannot believe that, owing to
the fact of wearing heavier clothes, the Alaskan baby will suffer from motor retardation. His development will just have its own rhythm.

Therefore, if we consider that the environment has a molding effect on people, we shall then think that during our own gestation, we live inside an atmosphere that is very vulnerable to changes.

There will always exist external factors that will influence us and provide different parameters so, as I said before, it turns to be very difficult to outline a comparative description.

External conditioning can be grouped into three fields:

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<th>Obstetrical (strictly referring to gestation)</th>
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The man is the only animal that is born immature, as far as the development of the functions is concerned. Many professionals believe that gestation would last, at least, 18 months, because only nine months after birth, the human baby can be compared to a newborn horse, dog or cat. These animals stand up, try to walk and move from one place to another as soon as they are born. On the contrary, human babies achieve the ability to move on their own around nine months after birth, period in
which, under normal development conditions, they start crawling, something impossible to achieve at the moment of birth.

That is the point that sets a great difference with the other beings. Human babies need their mothers to survive, through food, care and affection, which are the essential elements.

After birth, the newborn baby is not able to understand in what way the maternal womb could protect him and, for this reason, he needs the warm support of his mother’s arms.

Many things of the new world impact directly on the newborn. Gravity is one of them and it strongly affects the baby; for example, what he could do a few days before birth, now turns to be impossible. He will have to wait for some time till his body matures and it gets the tonicity to turn his head or rotate his body again, as he was used to doing while in utero.

What happened? This is a process through which we, human beings, start to adapt to life and this process has to be undergone by two parts simultaneously: mother and son. We would be totally different if, after birth, we left our mother’s side and stay on our own.

All the things received inside the utero remain engraved or registered as a memory track; the growth of the newborn is at stake. Everything will be vitally important, from the mother tongue to what has been practiced through the senses. I am going to develop my work on this field.

Prenatal stimulation through varied music, chosen by the mother will help to stimulate the cerebrum of an independent being. On the contrary, cerebral prenatal stimulation developed by a company that
commercializes this product, applying the same music for all the babies, will result in the creation of a regiment of clones, because it derives from something that is purely mechanical.

That music will only be a mental pacifier. Contrarily, in the other option, it will be part of a whole process and will take the child to enjoy creativity. Besides, through this process, the woman involved will become a mother.

Tomatis says “All human beings have come across the same itinerary and stayed in utero”.

But, the path of this journey will be different for everybody, because environmental factor will influence it. During gestation, these environmental factors emerge from the emotional patterns of the mothers, which will be transmitted taking her life experience. Ambient sounds will also participate. They will get to the fetus’s ears and it will not be even aware where they are coming from, but they will present in everything surrounding its mother.

**Effects of music on people**

We can start by saying that music has a special effect on people, that it accompanies all the moments of our lives and that it can unconsciously take us back to the past just in seconds. Through the history of music, we are able to see that it has always produced effects on the different levels of a human being’s life: biologically, sociologically, spiritually, intellectually and psychologically. We are immersed in a sound universe, where tempo, rhythm, melody and harmony govern us; all the
elements that are comprised in music itself. Music has the ability to relax, give pleasure, irritate and deafen us, stimulate, excite, make us feel happier or sadder, it can remind us of things. It can make us associate different situations, take us on a trip to the past and to different places just by closing our eyes and listening to it.

Some of the physiological effects that we can find in relaxing or stimulating music are stated below:

- Changes in blood pressure. This varies according to the person’s musical history and not according to the kind of music.
- Changes in the heart rhythm.
- Changes in breathing.
- Galvanic responses of the skin.
- Increase in muscular activity and achievement, through training, of an increased level of pain resistance.
- Relaxing effects that can be felt by the body and be detected by the cerebrum.

**Music Therapy and Obstetrics**

I would like to refer to Music Therapy in Obstetrics and not in Pregnancy, because the former includes much more than a nine-month period of gestation.

During pregnancy, mothers-to-be experience hormonal changes that generate an increase in the sensitivity of all their senses: all their feelings are exposed. The emotional side is extremely sensitive and they can usually pass from tears to irritability very easily. This makes us understand why some women can reject certain odors more than others do or why they suffer from food aversion. Pregnant women are more
alert. When they are walking in the street, they are paying attention to where they are stepping; they develop a different sense of responsibility. They are also more alert to their environment, which greatly influences them, not only through what they hear but also through what they can see.

This increase in sensitivity is consistent with the gestational period they are undergoing. If we make a relationship between sensitivity and hearing, we will note that the latter is more acute, in many different ways. I frequently meet mothers who tell me that they are able to hear babies crying at more than a block away and it never happened to them before becoming pregnant. When I make them listen to music and I ask what they can hear, they speak about the singer’s voice, the beautiful words the song has or the nice melody of the piano. In any other moment of their lives, they would have just answered “I liked it”, “It is nice”, or simply “I didn’t like it”.

Prenatal stimulation through music allows expectant mothers to connect with their unborn babies in a very different way. The bond is strengthened using the effects that music has on them together with therapeutic activities within a context of group support. This kind of application of music therapy improves quality during pregnancy, labor and delivery, helping to lower the mother’s anxiety level and neonatal stress, too.

It favors pain control of the mother during the contractions that take place at labor and delivery.
As far as the therapeutic context is concerned, the mother-to-be shall be more focused in the four main fields of pregnancy: physical, psychical, spiritual and emotional aspects. On the other hand, the fetus will be developing a relationship with melodies that it will recognize inside the utero and that will stimulate its neurological system.

The baby’s active movements of limbs provoked by the music will allow him to have greater oxygen intake, thanks to the increase in the fluid exchange, also allowing the mother to connect more deeply with her baby’s physical sensations while she is relaxed.

Music operates as inter-active neurotransmitter, acting directly on the cellular and glandular systems, leaving a memory track, a footprint. It is in this way that the different sensations the baby has lived inside its mother’s womb will be engraved in its body and mind, which will then remind him of the pleasant experiences he lived while in utero.

We can define music therapy as the work that is applied to pregnant women as a psycho-prophylactic activity. This term includes two important and specific fields on which we are always working: the relaxation and therapeutic one.

It is very important to outline the difference between both of them, as the activities inherent to them as well as the aims that shall be pursued in the treatments, are going to be different.

It is not the same thing to assist an expectant mother who suffers from panic attacks whenever she enters an operating theater and is scheduled to undergo a cesarean operation than assisting a woman who is a first
time mother and who has not had any obstetric complication. Same thing happens if we consider a mother who is going to give birth to a premature or high birth-weight baby due to obesity or hypertension problems.

Therefore, we group pregnant women according to their characteristic symptoms and we divide them into three different categories: normal, high-risk and special pregnancies.

**Normal Pregnancies**

Within this group, we will find those mothers who have not had any obstetric complication, where she and her baby are in excellent health conditions, who do not require more than the minimum basic care for the normal development of a pregnancy.

**High-risk Pregnancies**

In this case, we will consider women who do need special care and assistance because they have experienced a threatened abortion, unusual vaginal spotting, were told to lie in bed or were prescribed special medication so that their pregnancies could be alleviated of risks. In these cases, our assistance is carried out at the mother’s address or at the hospital due to her impossibility to move.

**Special Pregnancies**

Within this group, we can find those mothers who have special problems, such as obesity, blindness, deafness, multiple gestations or those
pregnancies that have been achieved through assisted fertilization or artificial insemination. We can also include pregnant women under 15 or beyond 40 years old or those mothers who will have to undergo a scheduled cesarean operation. Finally, those pregnancies in which situations from the outside directly influence them are also included; for instance, those cases in which there exists a previous handicapped child, those couples who have undergone a special situation, involving the death of a close familiar or friend. Also, those who have experienced the birth of a non-living child.

The characteristics of the pregnancies mentioned before shall outline the approach and activities to be carried out which shall be totally different in each of the groups.

**Fetal Auditory System**

The unborn baby’s auditory system is fully developed approximately after four months and a half of gestation. Only after this period of time he begins to hear sounds, first inner and then outer ones.

Through sound, the fetus receives the richest and most varied information. The body of the expectant mother is not silent. In the amnion, the inner part of the utero, there exists a sound atmosphere. There we can find the sounds of the mother’s cardiovascular system, blood circulation, the baby’s own heartbeat and its movements, outer sounds, even when they are attenuated by the amniotic fluid in higher frequencies. Finally, its mother’s voice, with all the vibrations of her
larynx. All these sounds are audible 24 hours a day and their loudness level go from 30 to 96 db. The utero is quite a sonorous place, if we compare it with what we could experience within our environment with sound ranges that go from 50 to 60 db.

There are some musical instruments the frequencies of which are below the ones that can be found within that sound atmosphere and, despite this situation, the baby can hear them. Those frequencies generate a vibration provoking a physical sensation in the fetus. Even in this case, it is possible that they are not registered by its auditory system. On the other hand, there are other frequencies that can be heard by him but cannot be felt by its body because the vibration is not strong enough.

I have specifically selected different types of music for the sessions I carry out. They are specially chosen because, not only can the baby hear them but its body, due to their vibratory frequency, can also feel them. On the other hand, we must point out the effect of music on the mother while enjoying a relaxing exercise has also determined our selection. The fetus is then a direct receptor of the emotional sensation that music has over its mother.

Therefore, by repeating the same music with different exercises that allow the mother to be relaxed and connected with her baby, this music will begin to have a special meaning for the fetus.

We have to bear in mind that the auditory system is the only one that establishes a connection between the fetus and the outer world, and consequently, it is the one that we can stimulate the most. It is possible to find babies that, even when they are very little, are able to make mental
relationships and associations before what is usually expected. For instance, they can associate melodies with intrauterine states, fix their attention before other babies do or recognize voices.

During the last years, we have been undertaking an investigation regarding fetal responses to music. All women involved in this research had participated in at least eight sessions of prenatal stimulation through music before being tested. We could prove through ultrasound that the fetuses reacted to these musical stimuli in very different ways. We directly applied different types of music on the mother’s belly through two small speakers, placed according the baby’s position. The volume we used was always very low. This was so for two reasons: first, to prevent the baby for being disturbed by this high volume and second, in order to measure real responses to the auditory and not to the osseous system.

The first conclusion we arrived at is that in all the cases there existed an increase of more than 10% in the fetal heart frequency that took place at the very beginning of the stimulus. It remained like that for approximately twenty minutes more, if compared to the sound stimulus usually applied during the standard fetal monitoring proceeding.

We could also observe that when the music was recognized by the fetus, it was evidenced by its sucking, intrauterine breathing movements, and the opening and closing of its eyelids, following the emitting source of the sound with movements of its head and with soft movements of its limbs. In those cases where unknown music was applied, we could only observe heart frequency increase. All these signs show us a good fetal
vitality and they help us to discover whether the unborn baby has any auditory problems or not, as early as on the seventh month of gestation.

We have tried this experiment even on expectant mothers who had not eaten any sweet thing (glucose increases fetal movements) before the test and we could observe very active fetal responses through movements towards certain types of music. Besides, once music began, it could be seen that the time elapsed between the beginning of the stimulus and the beginning of the movements was very short. Once the stimulus was over, fetal movements stopped. But we are not speaking about abrupt movements but about those telling us that they were paying attention to the melodies. We could also see that when the babies heard their own heartbeats through the ultrasound doppler, they were so excited that we had to wait for a couple of minutes till the normal rhythm was restored, in order to apply music.

The unborn baby’s environment has a number of sounds that are more familiar to it: its mother’s, father’s and siblings’ voices, its own heartbeat, just to name a few.

Thanks to this experience, we could note that when fetuses are exposed to the stimulus of a music that is already known by them, they remain still as if they were enjoying these melodies. And the interesting part is that if the music is not known to them, they do not react in any way, but only in the physiological one that is expected before any sound stimulus. When I speak about music that is not known by them, I am referring to those melodies that the baby’s mother did not listen to when she was pregnant.
In the case where we used the father’s voice, recorded speaking or singing, we could see that the babies began to move because they could recognize it. In their movements, we could observe how they closed and opened their eyes and moved their little hands. What most surprised us was the fact that if we moved the sound source from one place to another, they began to move trying to find the location of the emitting source till they finally did. And, there they stayed, as if they could appreciate the value of the message that was been generated by the speakers on their mother’s belly. I placed a little speaker with music on one side of the womb, then I turned it off and put it on the other side where I turned it on again and the fetuses moved around looking for those melodies known by them. (It should be pointed out that this part of the experience was made with babies of not more than seven months and a half of gestation). The same thing happened when we used the voice of their fathers that had to be recorded due to the fact that many of them were not able to attend these sessions.

- When analyzing fetuses near their due date, those in the 40th week of gestation, we could see that these babies react faster than others because the auditory system is much more developed at this time and because the filters generated by the abdominal walls are thinner and more vulnerable. Another very important point about the fetal ability to hear is to take into account the position in which the baby is situated. If he is situated in breech position (buttocks first) his head will be nearer to the sounds of the maternal heartbeat and he shall then hear higher sounds more easily. And, if he is in vertex position (head first) an acoustic law called vibration by sympathy will be manifested. This law establishes that any major vibratory force takes a minor one to the same frequency of the former and, as sound is vibration, this reverberates in the maternal hip cavity amplifying it and causing a reaction in the little ossicles chain of the fetal auditory system. This is why they will hear lower frequency sounds more intensively.
If we try to outline what the main goal of the music therapy work with future mothers is, we could state that, through these techniques, they will be able to achieve the following:

**Music Therapy work goals in pregnancy**

- Enjoy a deeper connection with the unborn baby.
- Reduce anxiety level.
- Stimulate the fetus and be able to transmit a pleasant state feeling to it.
- Discover intrauterine bond earlier so that it can be enjoyed.
- Prepare women for labor and delivery with different psycho-musical techniques.
- Achieve a more relaxed labor.
- Achieve self-control of pain.
- Be conscious about physical sensations.
- Contribute to reduce peri-natal stress, giving the newborn the possibility of being connected, through his auditory system, with a sound atmosphere that he already knows.

All these things will help mothers to be better prepared for labor and delivery and this is essential in order to give birth. Their attitude towards it will be different.

In the videotape we are about to see, we will observe how the unborn baby responds to musical stimuli in different ways. We will also see part of the work carried out with pregnant women and a birth.

In conclusion, we can say that Music Therapy is beginning to build its grounds within the prevention area of prenatal psychology.

The unborn baby absorbs and engrave the information its mother is transmitting to its surrounding environment and if it does not only
receive information, but also human affection, we will then be nurturing
the baby as well as the future humankind.

And, as John Lennon said, “Can’t buy me love”, we would thus be
speaking about prevention.

Gabriel F. Federico MT

info@mamisounds.com.ar

www.mamisounds.com.ar

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Biography

Gabriel F. Federico has developed a method called Mamisounds, which includes prenatal stimulation through music, appropriate musical stimulation for the newborn, precocious stimulation for premature babies, early musical stimulation for babies of special needs and pediatric neurologic rehabilitation.


He has lectured in Canada, USA, Brazil, Peru, Chile, Uruguay and Argentina, among other countries.

He is a teacher of the Music Therapy programs at several universities.

info@mamisounds.com.ar

www.mamisounds.com.ar
Aesthetic Music Therapy with a Young Child with Asperger Syndrome

Fischer, Rosemary G.
Ed.D, MT-BC, MTA
Wilfrid Laurier University

The core principle of Dr. Colin Lee’s The Architecture of Aesthetic Music Therapy (2002) is musical dialogue through improvisation. This principle has become central to my own work and has profoundly influenced my work with a young boy whose diagnosis is Asperger Syndrome whom I will refer to as J. Our therapeutic relationship as well as our relationship as human beings became imbedded in our musical relationship, a relationship that allowed us to interact musically at a level which we could not possibly have done verbally. It is my sincere belief that through his improvising J. was able to access the part of his personality that is not autistic.

Improvising antithetical to the condition of autism

The key to perceiving the enigma posed by this study is within the improvisations themselves. My presentation for the World Congress was focused on listening. Here we are limited to description. For example, let us consider an excerpt from a six minute piano improvisation J. and I did together on the day before his 9th birthday. This improvisation is representative of the level of musical maturity he had attained by the third year of our work together. In his earlier efforts and most always in his vocal improvising the phrases were usually in the standard eight-bar classical “question and answer” format. In this improvisation in f minor,
a favorite key, the phrases are long and melismatic with many twist, turns and subtle avoidance of cadences. It is as if the melodic line is spinning out from a central source. The dynamic range is wide, from the softest pianissimos to fortes reached by dramatic and artistically paced crescendos, by J. and followed by myself. The style is clearly romantic with a nice touch of chromaticism and with the addition of thirds for dramatic emphasis. Other stylistic attributes are his use of appoggiaturas and trills punctuated by rhythmic “scottish snaps”. As is typical of Nordoff-Robbins’ sessions, the client is at the upper register of the piano.

In addition to its intrinsic beauty, there are several characteristics of this improvisation that are antithetical to the condition of autism. This music is creative. It is spontaneous. It is reciprocal. It is deeply expressive of human feeling and it is performed with innate musicality. (Figure 21).

If we consider music as the agent of change, what then are the potential implications of this kind of work for this child? Could it even give him the option of functioning ‘in or out’ of his autistic disorder? My work with this child has raised far more questions than answers and it remains one of the most intriguing experiences I have ever had with a client.
The best way to trace the progression of this work is by studying and listening to J’s improvisations. In the absence of an opportunity to listen, descriptions will have to suffice.

The improvisations contain music regressions, musical resistance, musical perseverance, musical countertransference as well as explosive musical breakthroughs. At the conclusion of this paper we will explore the question: “What does this all mean”?

**Initial assessment**

To understand the implications of this rather complex story, it is best to start from the very beginning, the day when J. as a six year old was brought to me for music therapy. As is typical of Asperger Syndrome, J.
had two obsessive interests, music and computers. His knowledge about—and ear for—music, at the age of 6, would be the envy of most music students. His skills included perfect pitch, a prodigious memory with enormous storage capacity, and immediate recall. He could recognize, name and play all intervals, major and minor scales, triads, and seventh chords. To him it was all a game and a golden opportunity to show off what he himself referred to as “J’s Magical Brain”. In his initial session, in the course of running around the room entertaining me with his “Brain” J. came across a xylophone and began to play “Twinkle, Twinkle, Little Star” beginning on “C”. Immediately noticing that the xylophone had an “F#,” bar instead of an “F” (he didn’t know the bars were removable), he quickly grabbed an untuned guitar, found an F, handed me the guitar, placed my finger on the correct spot on the string, returned to playing the piece on the xylophone, and with grandiose gestures directed me when it was time for me to play the “F” on my guitar.

Besides “Twinkle” J. had an enormous repertoire of memorized musical material: pop, religious, country, show tunes, etc., all of which he could of course play in any key. But with all of these obvious gifts, a key element was lacking: musicality. His playing was mechanical, almost robotic, and he sang in a “fake” sing-song voice trying to emulate whomever he had heard perform the piece. It was the same with the simple piano pieces he had learned. In spite of his remarkable gifts he appeared to be one of the most unmusical children I had ever encountered. More significantly, J’s relationship with music was
symptomatic of his condition. Although he clearly deserved to be given musical instruction, there was little probability of a “Music Child” here.

Changing my approach

Fortuitously, the arrival of J. coincided with my decision to revise my clinical approach by studying with Dr. Colin Lee, who had the year before become my successor as Director of the Music Therapy Program at Wilfrid Laurier University in Waterloo, Ontario. Although I had had many years of clinical experience and extensive work with autistic persons, including the TEACCH Program out of the University of North Carolina, most of this was either strictly behavioral or geared more to special education.

My sessions with Colin were as terrifying as they were challenging. Looking back, it seems as if it was more that just serendipity that placed the three of us together in that time and place and under those circumstances.

Search for the music child

It was hard going for both J. and myself and, I strongly suspect, for Colin as well. I wanted to use clinical improvisation with J. so I invited Colin to an early session. He too was challenged. My work with J. became the laboratory for my new training which consisted of analysis of audiotaped sessions. We were searching for J’s “Music Child”, if indeed there was one to be found. However, while I valiantly tried to improve my skills to facilitate this goal, J’s goal was very different. He simply wanted to entertain himself by entertaining me, his audience, with his
“Magical Brain”. My role was to be the audience, the “entertainee” and to provide new technical and theoretical information only when it would enhance this activity. J. was too young to be aware of any social deficits in his behavior and was happily reaping the rewards of his autistic persona. It would, however, be difficult to overstate the charm and appeal of this persona.

It became clear from the beginning that J. was totally in control of the sessions. This had to change if ever we were to have any kind of a relationship—musical, therapeutic, human or otherwise. Before we could begin to establish an equal working relationship I had to take control, and I did. I became quite directive, but never confrontational. Although the sessions became easier to manage, his relationship with the music remained the same. I knew that the key to our therapeutic relationship would only evolve from a working alliance, grounded in a musical relationship, which would allow us to work together as equals. (Figure 22) We were a long way from this. The following diagram illustrates my concept of an ideal relationship with this child.
Figure 23 illustrates the early stages of our relationship, with either J. or myself in control of the sessions. J. was operating within a large space of his own making, which he clearly enjoyed and which was difficult to penetrate. Neither one of us seemed able to permeate the boundary. We were clearly “stuck”.

Figure 22
Exposure of the music child

Eight months later, it happened, out of the blue, a miracle. Within the “Magical Brain” there really was a “Music Child”. In the middle of a
fairly typical session, (he had already interrupted twelve times), J. did three vocal improvisations. It was the first time he had ever done anything original and I think he was as shocked as I was with our five minutes of sustained musical interaction. Each improvisation followed the format of a vocal duet with overlapping lines. The piano served as a third voice with continuo. His voice became more natural and child-like as he sang. He was already showing a sense of phrasing. The third improvisation is notated in Figure 24. Notice his use of sequence and the suspension near the end. In between each example he said, “let’s do it again”, and at the very end he actually shivered (and so did I).
If only for those brief moments we had experienced a musical “meeting”,
an experience intimate, immediate and profound. At the end of the
session J. sang, “I tried hard and I liked my singing”. We had clearly
begun phase three of our relationship. (Figure 25)
Figure 25

PHASE THREE

J = R

MUSICAL RELATIONSHIP

MEANINGFUL WORK

INTENTIONALITY

SPONTANEITY

CREATIVITY

FREEDOM

MUSICALITY
Vocal and drumming work

I would like to say that from then on, our relationship continued in a positive direction, but nothing could be further from the truth. This wonderful creative breakthrough was followed by resistance and regression. For several weeks he refused to sing at all.

Adding to the complexity was my process of reconfiguration as a music therapy clinician. Changing my approach wasn’t easy, and it certainly wasn’t comfortable. It was much more comfortable, almost seductive, to allow myself to be entertained by J’s autistic persona. I had to consciously resist the urge to do so, particularly since he enjoyed it and--I like to make children happy.

But then, I had Colin to contend with and so that option was not open to me. And so, on we went. Whenever we tried to improvise at the piano, he always used familiar material or materials that sounded like theory exercises and he still played in his familiar mechanical style. However, his interest in drumming increased as did his attention span. J’s unrestrained expression of excitement at the conclusion of one 12 minute drumming session which to me was indicative of a new level of freedom.

A further breakthrough was J’s first solo vocal improvisation. This was also the day we ceased to used his “Hello” song, which was the only non improvised music we did. At this point in his therapy J. was focusing completely on his improvisations. J. liked to play the bell-tree as a “time out” or a “recess” from the mental exertion required for our work. I accepted this as a normal reaction and I never discouraged it. As you
can see from Figure 26 at the very end of this improvisation he gravitated to the bell-tree.

**Figure 26**

1st Solo Vocal Improv.

\[\text{moves to "bell-tree"}\]
In the spring of his second year, when he was 7, J. sang a beautiful improvisation on the word “Alleluia”. The following spring at age eight he improvised another “Alleluia”, this time as a solo, and again in one of his favorite keys, E Flat. In the second solo improvisation there is an increased level of confidence and maturity. Also, in the second example he bursts forth into improvised song scripture. There is a seemingly effortless elegance to J’s singing.

**Piano breakthrough**

Transferring the concept of real improvisation to the piano was the last thing to come. J. seemed unable to stop playing music he already knew or, alternatively, just using his remarkable theory skills to perform unmusical magical tricks. When his creativity was unleashed, however, it was astonishing. J’s gift for melody sometimes left me breathless.

In *The Architecture of Aesthetic Music Therapy*, Colin Lee quotes Stephen Begbie who mentions our unfortunate “customary picture of improvisation as a discrete and relatively frivolous activity on the fringes of music-making”. There was nothing frivolous about J’s creative improvising. Far from being on the “fringes of music-making” J’s improvising was at the very core of his music-making. He had now attained a new level, a level that by its very nature was both intellectual and reflective of human feeling. As stated by Pressing (1998), this level of improvising requires focused and prolonged attention, memory storage and recall, decision making, prediction, error correction, movement control and interpretation.
Once J. realized what he could do at the piano, we had a fresh explosion of creativity, complete with new terminology. For example, he applied the word “seed” to short motives which I showed him to introduce counterpoint, enabling him to present new ideas for improvisation. I also introduced him to all the church modes. He thought these were so much fun, he invented a few of his own. One, which he labeled the “mixolorian mode”, he wrote out and frequently used it in his piano improvisations. Another favorite term coined by J. was “mixed-up keys” which was his way of telling me that he wanted us to improvise without a tonal center.

Figure 27 is an harmonic ostinato, which J. had invented and called bflat minor and D# Major, and he suggested we improvise on this progression.

Figure 27

B-flat Minor - D-sharp Major Ostinato

![Musical notation image]
This was a long improvisation. For a while I played a melody as J. improvised on the harmonic pattern at the upper register of the piano. But when I suddenly said, “Now you play the melody” he spontaneously and with great musicality created an elaborate melody. His melody had to fit within the framework of the given harmonic pattern. I could not have done it that well.

**Musical resistance**

When a child experiences intrinsically healthy musical events through improvisation, a breakthrough in the therapeutic relationship can occur. This is surely the case for J. However, these creative breakthroughs would most often be followed by resistance and a regressive shift in our musical, and consequently in our therapeutic, relationship. The resistance was often obvious; openly banging on the piano, silly talk, interruptions, dropping or fiddling with drumsticks.

Besides inventing new scales and modes of his own, sometimes J. rediscovered scales that already existed. This is the case with the whole-tone scale. After I showed it to him, beginning on “C”, he came back the next week and told me that you could do a different one if you started on “C#”. He had taken a familiar tune, *Do-Re-Mi*, from *The Sound of Music*, which broke our cardinal rule of no familiar music. However, he played it in the whole-tone scale.

(Figure 28) What is far more interesting here however, is his perseverance. J. seemed resistive during most of this session with lots of interruptions and “twiddling”. We had begun to improvise together
using the whole-tone scale, something we had both agreed upon, when suddenly he shifted into Do-Re-Mi. Once he began, he would not stop playing it no matter what I did. I tried every musical “trick” I could think of to take him out of it but to absolutely no avail. This is also a good example of musical countertransference. I clearly remember feeling very annoyed with him (‘how could you do this when we have worked so hard?’) After this session I also remember feeling annoyed with myself.
Whole Tone Scale

"Do Re Mi" in Whole Tone Scale
In another session J. made it clear that he did not want to invest in the music but he was briefly “pulled in” in spite of himself. Does this mean that his creative and musical self might be stronger than his autistic self? The audiotape of this session sounds as if, in spite of himself, he couldn’t resist becoming engaged in the music although he was exerting tremendous will to keep himself from doing so. I chose to provide him with an ostinato based on 4ths (Figure 29) which served as a container. At first, he sabotaged all my efforts by percussively playing tones which did not fit the ostinato pattern and with loud tone clusters. You could not call it open “banging” because he was too subtle for this. However, the message was clear. Then he “entered” the music with a beautiful melodic line–resisted again, etc. This went on for 7 minutes.

Figure 29

A Major Ostinato

etc.

Conclusion

The six minute f minor improvisation described at the beginning of this paper should be considered as representative of J’s most mature efforts.
Having traced the progression of our work together and of our musical relationship, we are left with the enigma I posed at the beginning of this paper. What does this all mean?

The following questions remain:

1. **HOW IS IT POSSIBLE TO SPONTANEOUSLY CREATE MUSIC OF SUCH AESTHETIC VALUE AND SO EXPRESSIVE OF HUMAN FEELING, WITH ANOTHER PERSON, PERFORMED WITH SUCH SENSITIVITY AND STILL HAVE A DISORDER ASSOCIATED WITH AUTISM?**

2. **IF WE CONSIDER MUSIC AS THE AGENT OF CHANGE, WHAT ARE THE POTENTIAL IMPLICATIONS OF THIS KIND OF WORK FOR A CHILD LIKE THIS?**

3. **IF THIS APPROACH WERE UNDERTAKEN WITH THE SAME FREQUENCY AND INTENSITY AS OTHER PROGRAMS ALREADY DESIGNED FOR PERSONS WITH AUTISTIC DISORDERS COULD IT POSSIBLY AFFECT DEEP AND PERMANENT PERSONALITY CHANGE?**

Admittedly, J. is exceptionally gifted. However, as a result of my sessions with J., I have come to realize that this kind of work might very well offer similar children a choice as to whether to live ‘behind’ or ‘without’ the mask of an autistic disorder. This suggests a significant focus for further research, in particular the efficacy of early intervention, frequency and intensity.
In conclusion, there is only one thing of which I am certain and that can best be said in an excerpt from a poem by Dr. Heidi Ahonen-Eerikainen, a colleague at Wilfrid Laurier University.

I LISTEN,
I MEET YOU,
WE SHARE,
WE ARE TOGETHER,
WE ARE ALONE,
WE ARE EQUAL

Rosemary G. Fischer,

Waterloo, Ontario, July 2002

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“Help me find my voice again”: Music therapy in bereavement care.

Forrest, Lucy

Introduction

Each of us, during our lifetime, will experience bereavement. The death of our loved ones can be both distressing and stressful, impacting on our lives in often complex and profound ways. Our experience of and response to bereavement, and our conceptualization and cognisant understanding of death is shaped by a range of factors with the experience of bereavement potentially varying greatly from one individual to the next.

Music can play an integral role in bereavement. Songs and significant music may comfort and support, facilitate remembrance, reminiscence and sharing between family members and friends of the deceased, and allow emotional expression and release. Engagement in musical processes such as improvisation and performance may also allow the bereaved to explore and experience their reality creatively and aesthetically. This paper examines the experience of bereavement and the application of music therapy in bereavement care through three case studies. The role of group improvisation, song choice and performance, and musically-facilitated life review in assisting the bereaved to address their losses is described.
The Bereavement Experience

The experience of bereavement may vary greatly between individuals, and family, social and cultural groups. The potential or real losses of the bereaved, the intensity of their grief experience, and the way in which the issues of loss and grief are addressed may be affected by a variety of factors including the following.

Cultural beliefs and background

Bright (1996) discusses the role that cultural and religious beliefs play in shaping our response to death and bereavement. Importantly, Bright highlights the fact that cultural beliefs and practices may vary on both a macro- and a micro-level between families who share the same ethnic background, and cultural and religious beliefs. Cultural beliefs may impact on all aspects of the bereavement process, from funeral rites to gender and age differences in culturally-shaped bereavement responses and grief processes (Reimers, 2001). For example, I worked with a young Moslem Australian mother of Middle-Eastern descent, whose baby had died, and noticed that her experience of bereavement was greatly different from that of an Australian Catholic woman of Irish descent whose young son had died.

Case vignette will be presented

These case vignettes illustrate how cultural differences can impact on and shape religious practices, and also our own response to, and experience of bereavement.
The age of the bereaved
Bright (1996), Germain (1991) and Peterson (1989) discuss how age can play a significant role in shaping an individual’s response to the death of significant loved ones. For example, the experience of bereavement for an elderly person on the death of their life partner may differ greatly from that of a younger couple. Although each situation involves the loss of a partner, the experience of loss and bereavement for each couple is likely to be very different, just as the expectations and hopes of each in their different life stages may also vary greatly. The age of the bereaved can also impact on their understanding of death, particularly with regard to children. For example, young children, unlike adults, may find it difficult to accept the permanence and universality of death, instead believing that people can escape death via special or magical means. Young children may also believe that the death of a sibling, parent or friend is due to something bad or wrong that they have done (Peterson, 1989).

The relationship of the bereaved to the deceased
Colvin (1995) and Rando (1991) suggest that the relationship of the bereaved to the deceased can impact significantly on the grief process. For example, the death of a parent, favourite grand-parent, sibling or friend can have an enormous impact on children, potentially shattering their sense of security and control, and resulting in separation anxiety or regressive and out-of-character behaviours as they attempt to come to terms with the seemingly chaotic and unpredicatable experience of bereavement (Colvin, 1995). For the bereaved adolescent, Mearns
(2000) states that death can “generate apprehensions about attaining the goal of adulthood”, and suggests that adolescents may “suppress or deny their emotions of grief” as these feelings can seem overwhelming and uncontrollable (pp.13-14). The feelings that a parent experiences upon the death of a child will be very different in their make-up from those of the child, but not dissimilar to those of the adolescent, and may be experienced both by the parent whose infant child dies, and the parent whose adult child dies. The losses that parents experience can be complex and diverse, and may include loss of parental identity, changes to the family group, and loss of hopes and dreams for the future. The diversity of their losses may result in bereaved parents experiencing a wide range of feelings including helplessness, failure or guilt in their inability to protect and nurture their offspring (Rando, 1991).

**The manner in which the deceased dies**

The grief response of the bereaved can be impacted upon by the way in which a person dies, especially as the bereaved try to find meaning or sense in the death of their loved one (Bright, 1996). Importantly, the family experiencing a sudden, unexpected or traumatic death may respond very differently from the family who has accompanied a terminally ill patient on their journey from diagnosis to death. Unlike the family who experiences a sudden or unexpected death, the bereavement of the family caring for a terminally ill patient may begin days, weeks, even months before the death of the patient, and be shaped both by the progression and impact of the illness, and ultimately the death of the patient. However, even knowing that someone is to die does not
necessarily allow us the time to prepare adequately or to resolve issues surrounding the impending death of our loved one. This can be particularly pertinent when a patient with a terminal illness deteriorates rapidly following diagnosis (Beresford, 1995).

**Involvement in the care and palliation of the deceased**

Colvin (1995) suggests that the extent to which family members, and particularly children and adolescents are informed of the dying process, and involved in the care of the dying person can have a strong impact on their adjustment to subsequent bereavement. Knowledge of and involvement in patient care can empower families to make important decisions together and potentially encourages open communication and expression between family members. Conversely, lack of knowledge about the impending death of a family member and/or exclusion from patient care can potentially leave family members feeling disempowered and distanced from one another and the patient, and may result in feelings of helplessness and hopelessness, with each family member feeling that they have to cope alone and unsupported in their bereavement. Whilst involvement in the care of the deceased is not always possible, such as in the instance of a sudden or unexpected death, it is still important for family members to be given opportunity to contribute to bereavement rituals, such as the funeral and memorial services, and acts such as the scattering of ashes or the choice of a gravestone or memorial plaque.
Support networks and coping mechanisms
Germain (1991) suggests that the presence or absence of both formal and informal support networks can impact on an individual’s adjustment to bereavement. Formal support networks offer professional and/or specialised support and advice, and may include schools, hospitals, government, community and social departments; whilst informal support networks may include relatives, friends and neighbours. Formal and informal support networks, and the sub-networks within each, can support the bereaved in different ways, fulfilling different needs and roles. For example, neighbours may be able to assist with tasks such as childcare and housework, whilst professionals assist with funeral preparation, legal and financial matters. Of particular consideration are those individuals who do not have adequate networks to support them emotionally or practically in their bereavement. Conversely, some of the bereaved’s support networks may fail to recognise or understand the bereaved’s unique and individual experience and offer support which they feel is appropriate, but which is neither helpful nor supportive to the bereaved.

Perhaps the most important consideration for community and health programs providing family-based bereavement support is to acknowledge that whilst we will all undoubtedly experience bereavement, loss and grief during our lifetimes, each of us will experience our grief and bereavement in unique and individual ways, and accordingly, respond to it in our own way and in our own time (Germain, 1991).
Responses to Grief and Bereavement:

The responses of the bereaved, and the experience, intensity and duration of grief may vary greatly from person to person, and culture to culture. Reimers (2001) describes grief as a social phenomenon in which the individual’s experience of grief, and their responses to bereavement are not only felt, but performed within their social context. This context shapes both the responses of the bereaved, and the responses of society towards the bereaved, so that each works in counterpoint with the other, employing time-honoured traditions and rituals, behaviours and responses that are deemed to be appropriate and acceptable within a particular context.

Shaped by cultural and social conceptualisations of death and bereavement, individuals may experience widely ranging emotional responses to bereavement, including numbness, anger, sadness, guilt, loneliness, and relief. Grief may also be experienced physically as pain (such as headaches), appetite and sleep disturbances, exhaustion, loss of concentration and memory, and confusion. As time passes, the bereaved begin to return to normal routines and functioning, making necessary decisions and changes in their lives and loosening emotional ties with the deceased so that eventually new attachments can be formed (Bowlby, 1980; Parkes, 1986). Whilst there is no set pattern to the experience of grief, Kübler-Ross (1975) found that the process of accepting death - either for the dying or the bereaved - could be divided into the five stages of denial, anger, bargaining, depression and acceptance. Similarly, Bowlby (1980) and Parkes (1986) divided the experience of bereavement into three phases consisting of shock; working through the pain; and
reorganization and resolution. Importantly, all three authors highlight the fact that these stages and phases are not necessarily sequential, but rather more flexible, ebbing and flowing through time, so that an individual may move back and forth from one phase or stage to another throughout the grief process, with significant events such as anniversaries and birthdays impacting on the individual’s journey through grief (Beresford, 1995).

Music and Bereavement
The power of music to evoke, move and affect make it a potent tool to use in grief work, allowing the bereaved to engage in a process of remembrance, resolution and release. Bright (1995) emphasises how difficult and confronting it can be for the grief-stricken to explore and describe their experience through verbal conversation, and suggests that music offers the listener time, space and opportunity to process their thoughts, ideas and feelings. Music, through its combination of sound and silence allows both active exploration and participation, or time to stop, listen and reflect. Engagement in active music making and creative music activities, for example, through improvisation or performance, potentially allow the performer to experience both a physical and an emotional catharsis; a space in which to explore and share their experiences and feelings. Conversely, music can provide a retreat for the listener, allowing time for listening, reminiscing, reflecting and healing, whether independently or communally. The use of significant and meaningful music in funeral and memorial services can offer comfort and support to those who are grieving, allowing remembrance and personal
reflection within an experience of group bereavement. Religious or spiritual songs and rituals can be uplifting, offering messages of hope, support, and acceptance, whilst through their familiarity they can also provide a sense of continuity and structure during a period that is typically experienced by the bereaved as chaotic and disordered. The following case studies highlight the efficacy of three music therapy methods in addressing the needs of the bereaved.

**Case Study 1 - Song Choice & Performance for a bereaved family**

The intimacy and range of feeling and experience that can be communicated through the human voice is well-reflected in the form of song, a media that is flexible in structure, style and content, and able to directly and indirectly access and affect our feelings and innermost emotional states. The musical and lyrical aspects of songs make them a potent tool to use in therapy, particularly in fields such as palliative care, in which the use of songs is well-documented. Bailey (1984) suggests that patients and families choose to hear those songs which express what they want to hear, whilst Hogan (1999) describes songs as being able to provide a safe, creative and alternate means of communication and emotional expression through which one can experience and express those thoughts and feelings that may be too confronting, painful or poignant to voice directly. Martin (1991) and Whittall (1991) describe the positive impact that the sharing of familiar and meaningful songs can have on patients and their families. Special songs, chosen and performed by one family member for another can create an intimate, personal and lasting gift, providing opportunity for positive and meaningful
interaction between people. Through the act of performing selected songs, the singer can also perform their existence and experience through music and potentially recreate their identity within the context of this experience (Aldridge, 1996; Stokes, 1994).

Case material will be presented

**Case Study 2 - Musically-facilitated Life Review for a bereaved woman**

Martin (1991) suggests that the power of music “to give voice to the ineffable...to express beauty and pain simultaneously, and...to transport us to another time and place” makes it effective in helping “dying patients and their families cope with the difficulties they face” (p. 619). In the midst of a stressful and distressing situation, music can be enjoyable, familiar and relaxing, reducing the tension and stress of the situation, encouraging interaction between the patient, their family and friends, and allowing the sharing of memories, thoughts and feelings. Familiar and meaningful music may “evoke and organise collective memories” of other times and places, reminding the listener or performer of times shared with the dying or deceased (Stokes, 1994;p.3). Similarly, the process of musical life review allows a “natural pairing of music and verbal discussion in exploring important life events”. Through “singing, playing and listening to music...and talking about...associations and memories that were triggered by the music”, the performer or listener is able to remember significant people and important life events, and evoke
and explore the feelings associated with these memories (Beggs, 1991; p. 613-614).

*Case material will be presented*

**Case Study 3 - Musical Improvisation for bereaved children**

Turry and Turry (1999) suggest that the creative and spontaneous act of musical improvisation has the potential to “act as a catalyst in illuminating painful feelings...helping to externalize these intensified feelings and provide a nonintrusive way of offering direction through emotions such as confusion, despair and turmoil” (p. 172). They further describe music as being able to “simultaneously contain and express the ambiguities and subtleties of the human experience as the musical elements are combined to create different textures and colours” which reflect the individual’s unique and evolving experience (p. 167). Similarly, Hilliard (2001), McFerran-Skewes and Erdonmez-Grocke (2000), and Skewes (2000) suggest that music techniques such as improvisation can be helpful in, amongst other things, developing self-awareness, allowing self-expression and enhancing coping and self-healing skills for bereaved children and adolescents. McFerran-Skewes (2000) describes improvisation as allowing the bereaved adolescent to experience both freedom and control, whilst Aldridge (1999 and 1996) suggests that engagement in creative processes such as improvisation allow us to musically define ourselves, playing who we are and what we are experiencing: creating and recreating the improvisation of our life according to the changing circumstances within it.

Case material will be presented
Reflections and Conclusion

Whilst each of us will experience bereavement during the course of our lives, we will each respond to our bereavement in differing ways according to a range of factors including our cultural beliefs, our relationship with the deceased and our individual circumstances and experiences. Music can potentially play an important role in addressing the issues of loss and grief that bereaved children and adults may face. Through music we can remember those we love, express and communicate our innermost thoughts and feelings, and creatively explore and define ourselves within the context of our bereavement. The structure and ritualistic use of music in funeral and memorial services can also help to comfort and support those who are grieving. Through creative music processes such as improvisation, life review, song choice and performance, we can experience our bereavement in unique and creative ways.

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Using Music Therapy in the Symptom Management of Patients with Motor Neurone Disease

Forrest, Lucy

Introduction

Motor neurone disease (MND) has been recognised and described by medical practitioners for more than a century. However, now, as then, the aetiology of the disease is not fully understood, there is no cure for the disease, and the prognosis for patients diagnosed with MND is terminal. The progressive symptomatology of MND is insidious and pervasive, primarily affecting motor and bulbar function but leaving intellect and memory largely intact throughout the disease process. Although no curative treatment is currently available for patients with MND, there are therapeutic interventions that can assist in symptom management and maintaining quality of life. A coordinated, multi-disciplinary approach to the care of patients who have MND can help to alleviate distressing physical symptoms whilst also providing support to both patients and their carers. In cooperation with more traditional and accepted interventions such as physiotherapy, music therapy is being found to be effective in addressing both the physical symptoms and the associated psycho-social and emotional needs of patients who have MND. This paper will discuss the role of music therapy in the symptom management and care of patients who have Motor Neurone Disease.
Motor Neurone Disease

Motor neurone disease (MND) is a progressive, degenerative disorder of the motor neurones that primarily affects voluntary motor and bulbar function, and ultimately results in death (Beresford, 1995; Oliver, 1994; Rowland, 1983; Walton, 1981).

The number of people affected by MND has in recent times been reported to range from 1 in 12,000 people (Oliver, 1994) to 1 in 50,000 people (Beresford, 1995), with a slightly higher number of males than females being diagnosed with MND (MNDAA, 1997). The average age of onset is approximately 50 years, although patients may be considerably younger or older at the time of diagnosis. The prognosis from time of diagnosis to death is generally between one and five years, although some patients have lived much longer than this. (MNDAA, 1997, Beresford, 1995). The patient’s prognosis is determined largely by the extent of bulbar involvement in the disease process, and hence the extent to which respiration is affected (Sedal, 1987).

MND is characterised by the degeneration of motor neurones in the corticospinal pathways, the anterior horn cells and the cranial motor nuclei of the brainstem. Depending upon the location of the lesion(s), patients with MND may present with a range of upper and lower motor neurone features, and varying symptoms. The disease may be categorised into three main types according to the presence of specific features, although it is not unusual for patients to present with features of more than one type. The three main types of MND are:

- Amyotrophic Lateral Sclerosis (ALS)
• Progressive Muscular Atrophy (PMA)
• Progressive Bulbar Palsy (PBP)
(Beresford, 1995; MNDA, 1997; Oliver, 1994)

Whilst MND causes significant motor impairment, it generally does not impair memory or intellect, although 5-10% of individuals may experience fronto-temporal cognitive changes such as emotional lability, pathological laughing, adynamia or disinhibited behaviour. The autonomic nervous system and sensory nerves also remain unaffected by MND, as do the voluntary pelvic sphincter muscles controlling continence and the motor nuclei which control eye movements (Beresford, 1995; MNDA, 1997; Oliver, 1994; Sedal, 1987; Swash and Schwartz, 1995).

The rate at which the disease progresses is largely unpredictable and may vary considerably between patients. Hence patients may experience a gradual but continuous deterioration over a period or time, or a rapid deterioration in function followed by a period during which they remain relatively stable (Beresford, 1995; Oliver, 1994; Walton). Similarly, the presence, extent and severity of symptoms is both unpredictable and likely to change significantly throughout the disease process (Oliver, 1994; Sedal, 1987).

**Progressive Symptomatology of MND**

Patients with MND may present with a range of symptoms, and needs. For the sake of clarity, I have separated physical symptoms from psychosocial, emotional and spiritual needs, however, it is important to
remember that each symptom or area of need is likely to impact on, and in turn be impacted upon by the others.

**Physical symptoms**
Patients may experience a range of physical symptoms including the following:

- Muscle weakness and wasting, fasciculations and fatigue
- Reduced mobility and reduced fine and/or gross motor coordination
- Pain and/or physical discomfort
- Respiratory distress, dyspnoea and breathlessness
- Dysarthria, dysphonia and dysphagia
- Insomnia

(Borasio and Voltz, 1997; Langton Hewer, 1995; Oliver, 1994; Swash and Schwartz, 1995)

**Psycho-Social, Emotional and Spiritual Needs**
Beresford (1995) and Oliver (1994) suggest that patients and their families may also experience various psycho-social, emotional and spiritual needs during the course of the patient’s illness, including the following:

- Social isolation and loneliness
- Communication impairment
- Anxiety and fear
- Issues of loss and grief
- Feelings of sadness and depression
- Spiritual and existential issues

(Langton Hewer, 1995; MNDA, 1997; Oliver, 1994)
A Multi-disciplinary Approach to the care of the patient with MND

Patients may experience a diverse range of disabilities and special needs over the course of the disease process. These may require the intervention and support of a large number of specialist health professionals and health care services. Hence the primary health care team may include both hospital and community-based services, and incorporate a large number of specialist staff including medical, nursing, allied health and pastoral services and supports. The inclusion of specific health care professionals in the primary health care team will be determined largely by the presence and severity of symptoms and the rate at which these change and the patient’s health deteriorates.

The literature highlights the importance of developing a coordinated, multi-disciplinary approach to the care of patients with MND, and suggests that interventions should focus on caring and quality of life. As the needs of the patient change throughout the disease process, so too should the healthcare plan so that it remains effective, and appropriate to the needs of the patient. In developing a healthcare plan for the patient with MND, it is important to consider not only those skills and functions affected by the disease process, but also those that remain intact and unaffected. (Beresford, 1995; Langton Hewer, 1995; MNDA, 1997; Oliver, 1994; Oxtoby and Eikaas, 1993; Sedal, 1987).

Music Therapy and Motor Neurone Disease

There has been little written about the use of music therapy in the care of patients who are terminally ill with MND (Forrest, 2001; Petering and
McLean, 2001). Whilst there is a growing body of literature regarding the use of music therapy in palliative care, the majority of this literature refers to the care of patients who have terminal cancer and HIV-AIDS.

Similarly, the body of literature pertaining to the use of music therapy with adult patients who have neurological disorders primarily discusses the role of music therapy in the care of patients who have stroke-related disorders and conditions such as multiple sclerosis and Huntington’s Disease.

Using the general palliative care literature to guide and inform my practice, I have found music therapy to be an effective and appropriate intervention to incorporate into an holistic and multi-disciplinary approach to the care of patients who have advanced or terminal MND (Forrest, 2001). In coordination with more traditional interventions such as physiotherapy, music therapy can play a significant role in managing distressing physical symptoms such as insomnia, dyspnoea and pain, whilst also addressing the associated psycho-social and emotional needs of the patient such as anxiety, loneliness and depression. As Aldridge (1999a) states, music therapy can play a central role in “integrating the physical, psychological, social and spiritual dimensions of...being” (p.9).


Music that is significant and meaningful to patients can help in maintaining or improving their quality of life, providing a familiar, comforting and calming environment in which they have the opportunity to creatively explore, express and define themselves within the context of their illness (Aldridge, 1999a, 1996). Fagen (1982) addresses this point quite succinctly in discussing her work with terminally ill children, stating that “while accepting the tragedy of the patient’s condition one must affirm the child’s (or in this case the adult’s) continuing right to be engaged in a creative act” (p. 21).

For the purposes of this paper, the role of music therapy in managing breathlessness, anxiety and pain; and loneliness, insomnia and depression for the patient with MND will be discussed.

**Breathlessness, Anxiety and Pain**

Dyspnoea and breathlessness can be frightening and distressing, disrupting normal sleeping patterns and everyday routines and activities. Aldridge (1996) and Hogan (1999) report that through manipulation of the musical elements of tempo, rhythm, melody, harmony and instrumentation, music can positively alter human physiological responses such as respiration, heartbeat and pulse rate. Familiar and comforting music can also help to reduce patient anxiety by:

- providing a calm and relaxing environment for the patient
- triggering a physiological response in the listener or performer, to potentially facilitate physical relaxation, reduce physical tension and induce a state of calm.
- providing opportunity for direct or indirect exploration and expression of fears, anxieties and other feelings (Fagen, 1982).
Reducing a patient’s anxiety and stress can, in turn, have a significant and positive effect on a patient’s tolerance to pain, reducing muscle hyperreactivity and physical tension (Selm, 1991). The literature also highlights the impact that emotional experience and interpersonal relationships can have on a person’s experience of pain (Bailey, 1986; Godley, 1987; Wallis, 1984).

Wall and Melzack’s (1965) Gate Control Theory has played a significant role in guiding pain management programs, particularly in relation to sensory-based treatment modalities such as music therapy. Wall and Melzack postulate that the nervous system is able to act like a ‘gate’, to open or close and hence increase or decrease the amount of sensory information that is received from sensory receptors at any given time. Both pain and music are experienced sensorily, and the Gate Control Theory suggests that the transmission of negative sensory information, such as pain, can potentially be blocked or overridden by positive sensory information such as music, hence reducing a patient’s perceived level of pain.

Positive environmental stimuli such as familiar music can potentially modify a person’s pain experience, increasing tolerance to pain, reducing the perceived level of pain and associated physical and emotional distress, and facilitating relaxation and positive changes in feeling states (Bailey, 1986; Bonny, 1983; Brown, Chen and Dworkin, 1989; Curtis, 1986; Godley, 1987; Taylor, 1997). Music can engage our attention, evoke positive moods and feelings, and arouse pleasant thoughts and memories that facilitate catharsis and release of tension (Brown, Chen
and Dworkin, 1989). However, it is worth noting too, that some music may potentially exacerbate a patient’s perceived pain or anxiety levels, through negative or poignant association and memory. Importantly, Bailey (1986), Godley (1987) and Gross and Swartz (1982) suggest that active participation in the music - such as engaging in reminiscence or visual imagery, or involvement in music-making - can help to significantly reduce distressing symptoms such as pain, not only by engaging the patient’s attention and diverting them from their pain experience, but by also encouraging them to become actively engaged in the management of their pain. Brown, Chen and Dworkin (1989) suggest that the elements of music - such as the tempo and rhythm - are able to reinforce relaxation exercises and offer the listener cues to carry out these exercises. However, in using music for relaxation or to address issues of pain and anxiety, the literature highlights the importance of selecting music that is familiar and meaningful to the patient as this will encourage active participation and greater awareness of self and surroundings (Davis and Thaut, 1989; Godley, 1987; Gross and Swartz, 1982). Davis and Thaut (1989) also highlight the importance of considering each individual’s unique “physiological and psychological reactivity systems” when selecting music to induce changes in physiological response or to facilitate relaxation (p. 172).

Case Material to be presented

**Loneliness, Insomnia and Depression**

Social isolation, loneliness and insomnia can have a significant and detrimental effect on a patient’s sense of well-being and self-esteem,
affecting their ability to cope with the changes they are experiencing. Sanna and Bruera (2002) describe insomnia as being one of the most distressing and frequently experienced symptoms of terminally ill patients that may be caused by, or be a contributing factor to the development of symptoms such as extreme sadness, depression and anxiety. Patients may also experience increasing social isolation and loneliness as their disease progresses and they become increasingly disabled and unwell. Reduced social and physical contact with friends, family and loved ones can also be a potential contributing factor to the development of depression.

Thompson, Arnold and Murray (1990) point to the importance of maintaining a familiar environment for patients and maximising their independence and autonomy through choice and control in order to reduce the risk of their developing extreme sadness or depression. Within the strange and sometimes frightening surrounds of a hospital or hospice, music can be familiar, calming and reassuring for the patient, anchoring them in an unfamiliar environment. Music can also facilitate musical interaction, potentially recreating connections between people and encouraging collective and shared experiences (Pavlicevic, 1985). The use of the human voice in song can create an immediate and intimate connection between the singer and the listener, providing opportunity for expression and communication, and potentially reducing the isolation and loneliness of patients. Through inflection and tone, pitch and word, the voice can caress and nurture, reassure, communicate and express, allowing the patient to “auditorily touch and be touched” (Bailey, 1984; p.7). Creative music activities such as improvisation, song choice and
song writing may also provide opportunity for individual choice and expression, allowing the patient to choose the means and medium through which they express themselves and communicate their experience of their illness to others, if indeed, they choose to do so at all.

When patients no longer wish or are unable to actively participate in creative music activities, music can be used to encourage rest and relaxation, and to address sleeping difficulties. Songs such as lullabies can help the listener shift from a state of alertness or wakefulness to a state of rest or sleep, with the sedative effects of these songs lying in “the elements of repetitiveness, softness, simplicity, slow tempo and...‘soothing quality” (Shoemark, 1999, p.36).

Case material to be presented

Conclusion:

In conclusion, MND is a terminal illness that presents its own unique and complex challenges to the palliative care clinician. Whilst there is only limited literature pertaining to the use of music therapy with patients who have MND, music can be an effective tool to use in both symptom management and in addressing the psycho-social, emotional and spiritual needs of terminally ill MND patients. Familiar and meaningful music can help reduce distressing physical symptoms such as dyspnoea and pain, and associated feelings of loneliness, anxiety and sadness. Music can also encourage relaxation, whilst allowing the expression and communication of thoughts and feelings. Importantly, music therapy can offer patients with motor neurone disease a creative means of experience
through which they can potentially address a range of distressing symptoms and needs, and ultimately improve their quality of life.

References:


A question of theory and practice: applying ethnomusicological theory to music therapy practice.

Forrest, Lucy

Introduction:

The latter half of the twentieth century has seen the profession of music therapy develop formally and globally, to be practised in many countries and cultures. As a profession whose foundations have been grounded predominantly in western philosophies, theories, and music systems, there has, in recent times, been an increasing awareness of the richly diverse cultural experiences and traditions that both music therapy clinicians and recipients of music therapy services bring to the therapy process. The cultural diversity of clinician and client alike will potentially have a significant effect on the future development of music therapy. The philosophies of practice, the methodologies and techniques employed by clinicians and the content and structure of music therapy services may vary greatly from one continent to the next, from country to country, even between and within regions, dependent upon the historical, cultural and philosophical context in which a clinician works. Likewise, recipients of music therapy services and the clinicians providing these services may represent many different backgrounds, a factor likely to have a significant impact on the development and provision of music therapy services (Aigen, 1996; Bright, 1996; Munro, 1984).

Concurrent with the global development of music therapy, the latter half of the twentieth century has also seen increasing world-wide movement
of migrants and refugees (Reyes Schramm, 1990), which has “resulted in many...societies becoming increasingly ethnically and culturally diverse” (Forrest, 2000, p.29). The implications of developing culturally appropriate music therapy services for migrants and refugees are profound and complex. Recipients of music therapy services may be living in a country and culture far-removed from that in which they were born and/or raised, potentially triggering issues of identity, and loss and grief.

As music therapy extends across a diversity of cultures, and the populations of many countries become increasingly ethnically diverse, it can be expected that the populations accessing and providing music therapy services will likewise become increasingly ethnically and culturally diverse in their make-up (Forrest, 2000). In ensuring the provision of effective and culturally appropriate music therapy practices, it is necessary for clinicians to have an understanding not only of the musical aspects of a specific culture or sub-culture, but also to have an awareness of the social, cultural and historical context(s) surrounding their clients and their clients’ music. The beliefs, values and traditions upheld by different cultural and social groups, and the role and function ascribed to music by these groups may have a significant effect on the provision and content of music therapy services (Bright, 1996). Similarly, the music systems utilised by a group, including their means of notation, use of instrumentation and teaching methods may influence not only the provision and content of music therapy services, but also the interpretation of musical behaviour and musical events that occur during therapy. Importantly, clinicians should be aware of how their cultural
heritage and experience differs from that of their clients, and the impact that this may potentially have on the perspective that they bring to the therapeutic process (Aigen, 1996).

The following discussions offer an introduction to ethnomusicology, exploring how ethnomusicological theory and research may potentially inform and guide music therapy practice. It is not my intention to give an overview of all ethnomusicological theory, but rather to offer you a sample of theories and ideas that have been addressed by ethnomusicologists over the past 50 years, and which I have found to be useful both in the application and evaluation of music therapy methods, techniques and practices. I hope that the following discussions will provide some food for thought for you, to benefit you in examining and exploring the cultural dimensions of your music therapy practice and in turn, help shape your ideas regarding the development and provision of culturally appropriate music therapy services.

**Ethnomusicology - an introduction**

From its emergence as comparative musicology in the late nineteenth century, the field of ethnomusicology has studied music and musical sound. Ethnomusicologists have explored the way in which music reflects, expresses and creates social and cultural context, examining how it is understood and utilised by people, and the effects that it has on people (Blacking, 1971; Merriam, 1977). Hood (1957;2) describes ethnomusicology as “the investigation of...music as a physical, psychological, aesthetic and cultural phenomenon”, whilst Reyes Schramm (1990;3) suggests that the focus of ethnomusicological
research lies in “the study of music...to include social, cultural and historical context - wherever and by whomever it is made”.

**Music versus Non-Music**

Let us now look at how ethnomusicological theories may guide and inform music therapy practice. Perhaps the first step towards being able to interpret or understand music is to determine what we define as music: how do different cultures and social groups differentiate between music and non-music (Blacking, 1973)? Whilst music appears to be a universal phenomenon, Merriam (1964) suggests that it is not a universal language, but rather “shaped in terms of the culture of which it is a part” (p. 223). Hence, music versus non-music might be defined primarily in terms of its meaning within a particular cultural and social context (Blacking, 1973), with music resulting from “human behavioural processes that are shaped by the values, attitudes, and beliefs of the people who comprise a particular culture” (Merriam, 1964; p.6). If a person’s understanding of musical sound versus non-musical sound is culturally bound, it may therefore be assumed that individuals who share the same background will have a similar understanding and interpretation of the symbolic and expressive qualities of musical events, and importantly, ascribe similar meaning and function to sound and music within specific and particular contexts. However, different cultural groups may ascribe different meaning to particular sounds. For example, cultures may differentiate between accompanied and unaccompanied song, or instrumental and vocal music, including or excluding particular categories from their cultural definition of music.
To determine what is music as opposed to non-music in music therapy is perhaps a little more difficult. My clients and I do not share the same social, cultural and historical background, and hence it is likely that we have differing understandings of what is or is not music. Similarly, our interpretations of, and the meaning or function that we ascribe to a particular sound within a particular context may be very different. However, by developing an understanding of the contextual, symbolic and functional aspects of music as used and understood by the client, the clinician can potentially bridge the gap between their own and the client’s understanding and interpretation of music and musical events that occur within the music therapy context.

In 1955, Waterman wrote the following in the journal *Music Therapy*:

“Music in every human culture has many functions of importance both to society and to the individuals who compose it, and an understanding of these functions in a general way would seem prerequisite to the wise use of music in specific instances as a means of introducing changes in social or individual behaviour” (Waterman, 1955).

Whilst Waterman’s statement was written in reference to the use of music in indigenous australian culture, it may also be applied to music therapy practice. Through music therapy, we aim to facilitate individual growth or change within our clients. However, to do this, we ultimately require an understanding of the context surrounding our clients so that both the methods we use to facilitate change and growth, and the goals we ultimately work towards are appropriate within that context. Importantly, Merriam (1964;112) states that “people’s of different cultures respond physiologically in different ways to the same music or sound, depending on its cultural significance”. This suggests that for a
therapist to interpret a client’s responses, it would be necessary for the therapist to have an understanding not only of the social, cultural and historical background of the client, but also of the psychological and cognitive processes peculiar to that particular client population(s). Furthermore, the therapist would need to have an understanding of the ways in which these processes might affect how music is conceptualised, understood, and used by the client, and how this in turn impacts on the role and function ascribed to music within a given context.

Examining the Role and Function of Music in Culture

In looking at the role and function of music within a society, culture or music therapy program, it is important to consider the broader context of which the music forms a part. Merriam (1964) suggests that we do not want to know “only what a thing is, but...what it does for people and how it does it” (p.209). This would be as true for music therapy practice as for ethnomusicological study. When a client vocalises, we want to know not only what notes they are singing, but how they are singing in relation to the entire musical context, what this music represents or expresses, and what changes have been induced in the client through the musical experience: in short, we want to understand the functions of music in the therapeutic process.

Whilst in the nineteenth century Dr John Byrney described music as a luxury, in more recent times, the idea that music is essential to life and society has gained prominence. Merriam (1964) describes music as being “used as accompaniment to or part of almost every human activity” (p.215-16) and suggests that there is “probably no other human cultural
activity which is so all-pervasive and which reaches into, shapes, and often controls so much of human behaviour” (p.218) In describing the range of human activities in which music plays either a central or tangential role, Herskovits (1948) divided musical activity into five categories as follows:

1 Technology and economics
2 Social institutions
3 Man and the universe
4 Aesthetics
5 Language

Herskovits (1948).

In seeking to understand not only the role, but also the function of music in society, Merriam (1964) divided human musical behaviour into 10 distinct functions which can, in a general way, be applied cross-culturally. Merriam’s (1964) functions of music are as follows:

1 Emotional expression
2 Aesthetic enjoyment
3 Entertainment
4 Communication
5 Symbolic representation
6 Physical response
7 Enforcing conformity to social norms
8 Validation of social institutions and religious rituals
9 Contribution to the continuity and stability of culture
10 Contribution to the integration of society
Are Herskovit’s (1948) and Merriam’s (1964) models of musical behaviour relevant to the practice of music therapy? Yes and no. Whilst originally written in relation to society at large, some of the roles and functions ascribed to music may also be applied to music therapy practice, and can be quite useful in describing the goals of therapy, which in themselves are likely to be developed within a specific set of parameters bound by social and cultural context. They can also be helpful in describing a client’s music and the musical process, allowing us to reflect on our work within the cognisant framework of social behaviour and experience at large. Furthermore, whilst Merriam’s and Herskovit’s models are fixed and concrete with regard to the categories, there is essentially no limitation placed on how music might be used to fulfil these roles and functions within differing contexts, making them an interesting and flexible tool to use in cross-cultural analyses.

However, by compartmentalizing human and musical behaviour into separate and discrete roles and functions is to ignore the often multi-functional, complex and sometimes conflicting nature of the relationship between the biological and social processes inherent in human and musical behaviour. Musical behaviour may be fulfilling a number of roles and functions simultaneously, and each is not necessarily mutually exclusive of the others. Moreover, each role and function of music is likely to impact upon, and in turn be impacted upon by some or all of the others. Importantly, where music may be fulfilling a specific role or function for one individual, it may be fulfilling a different role or functions for another individual, even though both may be experiencing the music in a shared time and space.
Interpreting Musical Events and Processes - Instrumentation, Notation and Transcription

Just as the functions of music may be interpreted in varying ways so too may the musical elements and the instrumental arrangements employed within the music. This can be particularly problematic when the client and therapist approach the performance and analysis of music from very different musical perspectives. The interpretations we place on a musical improvisation or performance are shaped not only by our understanding of the cultural and extra-musical associations of the musical event, but also our knowledge of the music system underpinning the musical event. Our understanding of the roles and uses ascribed to musical instruments, the melodic and harmonic features used in the music, and the means of notation we use to transcribe music can impact on our analysis of musical events.

First, to the issue of instrumentation. Over the years, musical instruments have been used in many different ways, representing different things to different people and being afforded various meanings and functions. The materials from which an instrument is created, the way in which it is played and its use as a solo or ensemble instrument may be significant, determining which members of society may play each instrument and within what context. The use and significance of musical instruments in society may be complex and diverse, and tell us much about the cultural values of different groups. Some considerations when using musical instruments in our clinical practice include the following:
• Instruments as symbols of identity
• Instruments as symbols of social and cultural history
• Instruments as works of art and complex technicality
• Instruments and gender associations
• Instruments as extensions of the body

Nettl (1964) and Sachs (1962).

Understanding the role that instruments play within the social and cultural context of our clients is particularly important if we wish to attempt an understanding or interpretation of our clients’ music. It may also go some way towards explaining why certain instruments are chosen or rejected by clients, or played in particular contexts. The choice of instruments, musical genres and forms of expression may be shaped by social convention and cultural tradition, preventing participation in some musical activities or shaping the manner in which participants may participate.

Now let us look at the issue of notation and transcription. Hopkins (1966) suggests that we transcribe music to provide “a comparison of that which is unfamiliar to that which is familiar” (p.312). In the course of analysing and trying to understand the music of my clients, I have often undertaken the exercise of notating their music from an audio-recording. A seemingly easy enough task at first glance. However, one of the difficulties I have frequently encountered in attempting to transcribe both Western and non-Western music is in determining pitch, intervalic structures and pitch deviation from the standard 12-tone Western scale, and then trying to accurately notate these using a Western stave. Whilst my ear is quite sensitive to pitch changes, I doubt I have either the
capacity or an appropriate notation system to accurately transcribe music that employs micro-tonal intervals.

When transcribing unfamiliar intervals, Hood (1960) suggests that the listener tends to ‘correct’ these intervals, often unconsciously, so that they will fit within a known and familiar musical system. He suggests that it is necessary for us to understand the imperfections of the pitch system employed in the Western music tradition when it is being used to determine micro-tonal intervals employed in non-Western music. Hood (1971) describes this as the challenge of ‘bimusicality’, stating that “every aspect of Western notation represents a corresponding chronic problem in cross-cultural transcription” caused by “the disparity between a culturally determined system of notation and the musical sounds of some other culture it was never intended to represent” (p. 89-91).

Similarly, cultural and social differences in musical events may affect how the event is perceived, and hence transcribed and notated. How do we transcribe musical movement patterns that produce rhythmic beats or musical notes where the movements associated with the production of sound are integral to the overall musical event, and the sound itself is only one part of a bigger movement, body action or dance (Blacking, 1971)? In Western notation, we focus on writing the notes, their pitch, rhythm, attack and duration. The musical notes are often complete within themselves, and hence we don’t tend to transcribe the actions that may be associated with the production of these notes. But what if the actions and movements between the sounding of each note are essential both to the timing and production of each sound and to the overall
meaning and symbolism of the musical event? How do we transcribe these actions and movements in conjunction with the sounding of the instrument?

In discussing various approaches to transcription, Nettl (1964) describes the not uncommon scenario of the transcriber “faced by musical phenomena too detailed to be notated”, and by other phenomena that does not fit easily into a given notation system (p.103). Reid (1977) and Abraham and Hornbostel (1994) suggest a number of basic criteria which a system of manual transcription should meet in order to provide accurate transcriptions of music. They also offer various solutions to overcoming the difficulties that may be faced in notating non-Western music using Western notation although it is beyond the scope of this paper to examine these in detail.

Musical Enculturation

Working within a diverse and culturally rich community highlights the fact that cultures not only have their own unique musical traditions, but also quite individualised methods of learning and perpetuating cultural practices and traditions. The process of enculturation, or learning about one’s culture may happen through a variety of media, including music, and may vary significantly between cultural groups.

Musical enculturation may occur both formally and informally, with the role and function of musical events shaping the way in which enculturation occurs within a particular context. Formal enculturative processes may include the provision of specialist training by professional
musicians, whilst informal enculturative processes may include the acts of observing, imitating and participating in social and cultural activities. Enculturative processes may be affected by factors such as age, gender, social role, and the amateur of professional status of the musician (Doubleday and Baily, ). For example, Waterman (1955) in discussing the enculturative processes of music in traditional Yirkalla society, describes music as teaching the aboriginal about his natural world and his familial and cultural history, whilst also shaping his world view and developing his individual identity within the community. Musical enculturation occurs at a number of different levels, so that learning is defined by the age, gender, position, status and role of the individual within the group. As the individual moves through different life stages, he is engaged in different enculturative processes that act both to inform and guide him, and to reinforce and uphold the social parameters of the group.

The social and musical enculturation of individuals may impact on the way in which they use and respond to music, and is an important consideration when using music as a therapeutic medium. Along with factors such as age and gender, the musical background and training of the individual, and the social roles and cultural meaning attached to musical events may impact in varying ways on the therapeutic process and individuals’ musical and other responses within a music therapy session.

An individual’s background may dictate their level of participation in various music activities, whilst also determining the appropriateness of
using particular music therapy methods and techniques. There may be a social stigma attached to the playing of particular types of music or musical instruments which may represent a social group or status to which an individual may not belong. In some circumstances, it may be more culturally appropriate for individuals to be engaged in receptive music therapy methods such as music listening, rather than active music therapy methods such as instrumental playing, singing, improvisation or music and movement. The role of leader or follower adopted by the individual in their musical or verbal interaction with the therapist or other group members may also be indicative of broader “patterns of relationship”, social structures and cultural processes (Dokter, 1998, p.17).

Musical behaviour and responses to music may also be shaped by cultural convention. For example, Baily (1995) suggests that for Afghans, the act of listening to music is “an inner experience and one should not betray overt signs of keeping time, such as tapping one’s foot or beating with the hand” (p.25). In some circumstances, it may also be inappropriate for individuals to discuss the emotional and spiritual impact of music, as this too may be regarded as an inner process, to be experienced personally rather than shared communally.

Similarly, the use of terms such as ‘relaxation’ and ‘pain’ may be quite loose in their definition when applied cross-culturally and potentially somewhat problematic when used to describe processes or goals of music therapy within a multi-cultural framework. An individual’s cognisant understanding of the concepts of pain and relaxation are likely to be
culturally-bound, with some concepts perhaps not even fitting within a particular cultural or cognitive framework. The way in which interventions are introduced, offered and applied can determine whether an intervention will be accepted or rejected by an individual. It is essential that clinicians offer interventions that are both appropriate to the needs of the individual and respectful of the individual’s beliefs and customs.

The gender of the clinician is also an important consideration. Some cultures do not condone women engaging in healing rites or public music performance, in which categories music therapy can sometimes be included. Gender may also impact on the therapist-client relationship, with it sometimes being inappropriate for a female therapist to be working with a male client, or vice-versa. Similarly, it may be more appropriate to work with a client within a group setting rather than individually, in order to maintain appropriate patterns of relationship and social form (Dokter, 1998).

Enculturation can impact on many aspects of behaviour and response within the context of music therapy practice. However, perhaps the most important consideration in using music as a means of therapy with individuals is to examine the way in which individuals use music in healing and therapeutic practices within their own cultural framework. The concept of therapy, like those of pain and relaxation, is potentially somewhat ambiguous when examined from a cross-cultural perspective. The issues that we seek to address through a Western-based model of practice may be addressed very differently within non-Western cultures,
so that the seeking of professional support to address personal needs may seem strange and intrusive, perhaps even laughable to some. Importantly, the role of music as an enculturative mechanism may at times make it inappropriate for clinicians to apply it as a therapeutic tool.

**Music, Migration and Musical Change**

Let us now take a look at the issue of music, migration and musical change. Voluntary and forced migration has had a profound effect on the ethnic and cultural make-up of many countries. Alongside the development of air and sea transport, war, civil conflict, religious, political and economic factors, and natural disasters have resulted in the world-wide movement of people. If we look at Australia, we can see that the cultural and ethnic diversity of the population has changed significantly over the past fifty years due to migration. In 1947, only 10% of the population had been born overseas, with 81% of these migrants being born in the main english-speaking countries of Britain, Ireland, New Zealand, South Africa, Canada and the United States of America. In contrast to this, 24% of the australian population was born overseas in 2000, with a further 27% of the population having at least one parent born overseas. Importantly, there has been a marked diversification in the country of birth of Australian immigrants in recent years, with immigrants hailing from more than 200 different countries. In 2000, only 39% of all immigrants were born in the main english speaking countries, whilst there has been a marked increase in the number of migrants of south-east, north-east and southern Asian descent,
and Indian, African and European descent coming to Australia (ABS, 2000).

As has been emphasised throughout the preceding discussions, there appears to be a strong link between musical systems and the social and cultural structures in which they are embedded. What happens, then, when two separate social groups come into contact with one another, as in the case of migration, forced or voluntary? Which social and/or cultural elements change, stay the same or are exchanged in response to this contact? Under what circumstances may musical traditions and structures change or become acculturated?

Contact between cultures may result in social, political, religious and/or artistic exchange, with each culture mutually impacting on and influencing the other. The extent of exchange, assimilation, eradication, combining or maintenance of any cultural elements may depend on several factors. These include the relative strengths of each culture and the intention of the peoples involved in the meeting of cultures (Blacking, 1977; Nettl, 1978).

With regard to music, Merriam (1990) and Nettl (1978) suggest that the degree of similarity between two types of music, and the number of features common to both play an important role in determining the extent to which ideas are exchanged between the two: musics that are highly similar and share a number of common features being more likely to become acculturated than musics that are highly dissimilar and share few common features. Musical acculturation may include exchange of musical systems, including scales, modes, rhythms and harmonies,
introduction of new technology and different instrumentation, and
introduction of new social rituals, roles and functions ascribed to music,
musical events and musicians (Nettl, 1978). Let us take a look at some of
the different aspects of musical acculturation:

• Syncretism
• Compartmentalization
• Westernization
• Modernization

Nettl (1978).

Migration can play a significant role in the process of acculturation,
invoking social change and impacting on the maintenance or loss of
cultural practices. Whilst Baily (1999) suggests that upholding cultural
practices and traditions can be beneficial to maintaining the identity of
the migrant, traditional music and customs may also be perceived as a
barrier by migrants wanting to assimilate into the community to which
they have moved. This may be particularly pertinent for the children of
new migrants, who can feel torn between wanting to identify with their
traditional cultural group and their contemporary Australian peers. How
then do cultural groups maintain their musical identity and traditions,
whilst also adapting to the demands of a new, and potentially hostile
environment? What role, if any, does acculturation play in shaping
enculturative and traditional practices?

Stokes (1994) suggests that music is able to not only reflect and maintain
social and cultural identity, but also provide a means through which the
boundaries of society and culture can be negotiated and potentially
altered, as individuals seek to create and define their identity within a new and changing set of social and cultural parameters. Hence acculturation may potentially play a very important role in assisting migrants to develop their identity within a new country and cultural framework, whilst also allowing them to maintain their traditional practices and customs in either their original or a modified form.

The emergence and development of technology over the past 50 years has also had a significant impact on cultural contact and change, allowing indirect contact between musical cultures that may never come into direct contact with one another. The introduction of wirelesses, radios, television, the internet and recording facilities has allowed music to be globally transported and shared. The effect of this global technology has resulted in some interesting musical changes. For example, the presence of the radio in the city of Herat in Afghanistan in the 1940’s and 1950’s allowed the broadcasting of a new popular music containing elements of Hindustani, Pushtan and Indian film music which utilised musical instruments not previously found in Afghan music. Popular radio music ultimately had a significant impact on the dutar, a lute-like instrument used in the playing of traditional Afghan music. Originally a two-stringed instrument, the influence of new and unfamiliar modes and scales resulted in the dutar evolving into a three-stringed, and then a 14-stringed instrument, with changes accordingly made to the design of the instrument. The musical changes associated with the development of the dutar were reflected by important social changes. These included the evolution of the dutar from a rural instrument to an urban popular instrument, the changing status of musicians from amateur to

So how might the issues of migration and musical acculturation impact on music therapy practice? Music can be used as a means of creating, maintaining or changing group or individual identity, allowing individuals to identify with particular social or cultural groups (Stokes, 1994). For migrants, the issue of identity may be complex. Migrants may have multiple cultural identities, shaped by factors such as war, trauma, and the various communities of which they have been a part. Migrants may feel dislocated and lost, their identity torn between different countries and cultures. This sense of loss and dislocation may be compounded when migrants have few or no living relatives. The creation of a new musical identity that blends elements of both the familiar and the non-familiar does not necessarily guarantee a sense of identity and belonging for the migrant, and may even exacerbate an individual’s feeling of isolation and segregation from both the culture they have left, and that which they have entered. However, whilst some individuals may feel unable to establish their identity within their changing circumstances, others may deny their ethnic and cultural roots, perhaps in an attempt to forget a traumatic past and forge a new future. In the context of music therapy practice, this can be highly significant, as music of a person’s ethnic or cultural heritage may, in these circumstances, trigger both traumatic and poignant associations and memories, raising issues that may not have been discussed or even acknowledged for a very long time. Furthermore, the migrant’s descendents may not previously have been aware of these issues, or of
the circumstances surrounding the individual’s migration, which in turn can raise further issues of identity and grief (Bright, 1996; Forrest, 2000). Music therapy can potentially play an important role in addressing the needs of migrants, providing opportunity for individuals to grieve and mourn their losses and then develop or recreate their identity through music, integrating their past and present experiences through creative expression.

Importantly, we should not assume that the cultural background of an individual necessarily determines their musical preferences and choices, and hence the type of music that we use during a program. It is essential, no matter the background of the individual, that we establish and continue to confirm and clarify events, responses and behaviours with our clients. An understanding of the circumstances surrounding the development and use of musical styles and genres is also important, as the meaning and significance attributed to music may vary greatly from one person to the next, and be shaped by different circumstances.

**Conclusion**

The challenges of working within a multi-cultural framework will play an important role in shaping music therapy practice in the 21st century. As the cultures of many countries become increasingly diverse, and music therapy continues to spread globally, clinicians are becoming increasingly aware of the need to be culturally empathic in their work (Brown, 2002). As a profession, we face the daunting and yet exciting challenge of examining our theoretical and practical models to ensure that we provide culturally respectful and appropriate interventions that
address the needs of an increasingly culturally diverse clientele. Ethnomusicological theory and research can offer much to the field of music therapy, informing and guiding our practice whilst offering practical information about specific cultural and musical practices. Furthermore, the study of ethnomusicology allows us to examine our clinical work from a different perspective, to explore and develop the theoretical and philosophical models in which our clinical practice is grounded.

References


Gaertner, May

Sésame Autisme France and the National Federation Sésame Autisme, have existed since the 1970’s. Their head-offices are in Paris. France Telecom has been the sponsor of both associations for a very long time. As communication is its aim, France Telecom was motivated to be the sponsor of autistic people, who, amongst other things, suffer from a lack of inter-personal communication. The sponsorship is carried out by 2 channels:

1. FTF : France Telecom Foundation which contributes financially to various associations, and

2. AVA : Association of Volunteers for Autism, whose members are either employees or retired employees of France Telecom.

“Sésame Autisme Hérault was created in 1990 by Sophie Lamour.

The aim of this association, is to help families who are touched by autism, to go beyond the limited support of established institutions. Sophie Lamour saw the need for a place, “our own place” for the autistic population of the Department de l’Hérault : a place where they could visit, celebrate birthdays, take part in various activities, have meetings, lectures, etc.

There are about 200 autistic people in the Department de l’Hérault with no “pris en charge” or state aid, so this place and its activities would be of great importance to them and to their families.
This dream was made possible by France Telecom, in April 1995, when it gave “Sésame Autisme Hérault” the free use of a 5-roomed villa in Montpellier, for its activities.

Since that date, the volunteers of AVA have invited the autistic members and their families to Villa Clématites, Rue Clématites, Montpellier, every Saturday afternoon from 2.30 pm to 5 pm. Various activities are offered, e.g. pottery, patisserie (baking), expression corporelle, dancing, and ending off the afternoon with a tea party.

During this time, the parents may either remain at the Villa to chat to other parents and volunteers, or take advantage of this free time to do the weekend shopping or whatever they need to do. Some volunteers also offer to babysit at home, giving the parents a chance to go out with peaceful minds.

Many university students and college students have offered to help. Some activities have spread to Wednesday afternoons (when all nursery and primary schools in France are closed) and even to some school holidays. Villa Clématites is the meeting place before outings e.g. to the seaside, the zoo, the countryside. There is emotional, psychological and practical support for parents and siblings. There is a sympathetic ear, a comforting smile and a helping hand.

In 1990, when “Sésame Autisme Hérault” was being created, I returned to Montpellier from South Africa. I happened to meet an old acquaintance, and we exchanged our news. I had studied remedial teaching at the University of Cape Town, and had worked in a remedial school, and also in a school clinic, and was enthusiastic about helping
anyone and everyone with learning disabilities. He was an educator, working in schools and centres with autistic children and adolescents.

“Ah!” said I, “they need music!” Whilst in Cape Town, I had visited the Vera School for Autistic Children, and had heard singing wherever I went. A lively discussion took place, which ended with: “Let me come and try! Free of charge!” He replied, “You are too far ahead for France! Some time in the future. I’ll let you know. You see, we have a project in mind”… He was referring to “Sésame Autisme Hérault”.

In 1995, just before the opening of Villa Clématites, I was held to my promise. The educator took me to the Villa. I entered a new world, the autistic world of Sésame Autisme. I met the President and his wife. We had a lengthy discussion about autism and music. They were willing to let me try, as a voluntary worker. So, music became an activity offered at the newly created centre of Sésame Autisme at Villa Clématites. I called it “music” because I was a remedial teacher. However, I had already enrolled as a student of music therapy at the University of Montpellier. I was the grandmother of the class, but my enthusiasm and work easily matched the enthusiasm and work of the youngsters in my class. As time and studies went on, the musical activity became known as music therapy.

I was shown around during my first visit. The entrance of the Villa Clématites is up some steps to the front door of the upper storey. There is a large, bright room with a long table and chairs down the centre of it. It is a very useful room for meetings and lectures, but especially as a place for gathering together for friendly chats, luncheons, goûter (afternoon
tea) birthday parties, drawing pictures, playing games, playing cards, etc. There are two other rooms for interviews, administrative work, TV etc. There is a kitchen and a bathroom. Another door revealed stairs leading down to the ground floor. There is a front door to the ground floor, but it is usually kept locked.

I was shown an empty room, which I could use for music. There were built-in cupboards containing some toys, books and games. A couple of small tables and some chairs were rapidly brought in. As the project was in the early stages, there was no musical equipment at all. I’d have to bring whatever I required for my music sessions.

There was another room. It had a comfortable couch and an empty cupboard. The large garage had been converted into an art room, but could also be cleared and used for dancing, expression corporelle, and the kitchen would be used for baking and pottery classes.

For the first music session, I took a portable tape-recorder, cassettes, a ukulele and a collection of little percussion instruments which I’d built up over the years. This collection consisted of bells, triangles, castagnets, cymbals, wood-blocks, tambourines, tapping sticks and African drums.

I prepared the room by airing it, arranging the furniture, setting out some instruments, playing a cassette of cheerful French nursery rhymes, and putting all other equipment on a high shelf in a cupboard, out of sight.

Sounds outside and upstairs, heralded the arrival of the first families. The silent house was filled with voices calling out greetings, crying, laughing. Chairs were dragged, tables were banged on. Next came the tramping of
feet, as some children came downstairs to explore their new world. I called out greetings, chatted briefly to the parents, and then began tapping a tambourine in time to the music. There were six children aged 3 to 8 years. They picked up the instruments. They banged them, sucked them, licked them and threw them down or across the room. They threw objects out the window. Some-one was always fiddling with the tape recorder, so I eventually placed it upon a shelf in the cupboard. I sang. Two volunteers sang with me. “Frère Jacques” and “Sur le pont” were popular. We sang and played. I played the ukulele. Parents and volunteers came crowding into the room. With happy smiles, they joined in, tapping drums or sticks, jingling bells or tambourines, beating triangles or woodblocks, and singing. This sounds like one big, happy event. Yes, it was, but not as orderly as the words describe it. There were cries, there were screams, there were howls. There was always some-one leaving, some-one coming back. There was banging on the table, opening and closing of cupboard doors, something being picked up, something being dropped, something being thrown out of the window. But there was also something else: something warm, loving, positive. It drew the children, time and time again, back to the group.

Shakespeare would have said, “Yes, music is the food of love, so let’s play on”!

The first musical encounter was unlike anything I’d ever imagined. Nothing in my years of teaching experience had prepared me for this session. I had so much to learn. The parents and voluntary workers were most enthusiastic. They brought down different age groups. Again, we
played the little percussion instruments in time to recorded music. Again, we sang and played. Some danced up and down, some jigged around. As with the little ones, I played the ukulele to accompany the singing. Sometimes it was grabbed from me and a tug-of-war followed; sometimes, it was gently strummed for short moments.

The following Saturdays produced much the same type of sessions. There were little changes, as I attempted to structure them. The sessions were “open”. I never knew how many people I’d have, and how long they’d stay. There was a constant flow in and out. I persuaded some of the music therapy students to help me. We were able to use the other room as well, so that there were two groups of music at the same time. We posted a volunteer outside the door to stop interruptions. Gradually, we built up a collection of instruments for Villa Clématites. I was relieved to eventually leave mine at home. They were in a sorry state.

I’d like to mention Jean, a 44 year old autistic man. This mother wheeled him in to the sessions, using the front door which was usually locked, to avoid the stairs. He was known to be very violent, and everyone was wary of him. Soon after his first session began, he grabbed an 18 cm tubular, metal shaker and shook it enthusiastically. Next second, he threw it at my head with terrific force. I ducked and it only just missed me. I was very shocked but managed to smile bleakly when his mother exclaimed joyfully, “He is trying to show you how happy he is!” The instrument was broken. The strength of his right hand had squeezed it in half.
The following Saturday whilst preparing for the afternoon’s musical sessions, I was startled to hear a noise. I believed I was alone downstairs. I had been playing the ukulele, so I took it with me when I went to investigate. Lying on the couch in the next room, was an enraged Jean. I had disturbed his siesta and he was livid. He roared at me, pushing himself up. I was absolutely terrified! In sheer fright and in self-defense, I imitated his roars.

R. Benenzon\textsuperscript{55} wrote that “to be able to establish a contact with another being, or to open some channel of communication, it would appear necessary to imitate the other, to do something similar.”

Jean and I roared at each other. A look of surprise crossed his face, and with it a little of the fury left him.

I imitated every noise he made, somehow changing it ever so slightly in volume and intensity. I began to strum my ukulele, and eventually our roaring, shouting and yelling changed to singing out, then to singing gently and finally to sighing with satisfaction. His anger was spent, and so was I. He was smiling happily when I went to call his mother.

When I did my practical training in my final year, with advanced Alzheimer patients, a music therapist friend, Colette Rivemale\textsuperscript{56} lent me her “\textit{roue musicale}”, the musical wheel. She created it with her husband’s help when she studied music therapy a few years before me. The musical wheel is a percussion instrument made of metal, wood and skin. It is round and was created with group games in mind. As soon as it


is set up, like a table with 5-6 people around it, one hears the tinkling of the chimes which are arranged around the drum centre, or the beating of sticks on the drum centre.

As soon as I’d set it up one Saturday afternoon, the musical wheel drew people to it and the air was filled with sounds. The autistic members, their parents and the volunteers gathered around, everyone wanting a turn. We played the imitation game. Everyone, together, copied the rhythm played by someone. All afternoon we conversed and communicated, dialogued and debated, nonverbally. There was much laughter, and encouraging calls. By the time tea was served, everyone was adamant: Sésame Autisme had to buy a musical wheel!

The musical wheel has pride of place at Villa Clématites. It is in constant use. A photograph of a session with les autistes and their parents has been published in one of the national magazines of Sésame Autisme.

I also used the Soundbeam. I first heard of it in 1996 in France, at the Pre-World Conference Seminar of the International Society for Music Education (ISME). Listening to two presenters, Tim Swingler of the Soundbeam Project in England and Dr Phil Ellis of the Institute of Education at the University of Warwick, and watching their videos, convinced me of the great potential of the Soundbeam. I could immediately imagine ways of using it in practically every sphere of my work.

Tim Swingler lent me a Soundbeam for my practical training with Alzheimer patients. I took it along to Villa Clématites. “Les Autistes”, their parents and the volunteers were fascinated. Some of them, in their
most unreachable moods, were lured out of themselves by the Soundbeam. When the invisible beam as interrupted somewhere along its signal, it sent out a message to a MIDI module, which had been programmed to play musical sounds of varying pitch and intensity according to the depth of the interruption. Little by little, they began to understand that they had something to do with the sounds they could hear. When they kept still, silence prevailed. When they moved, they heard sounds. Some of them realised that they had power to produce sounds, to create and to control something. The wonder and joy of this realisation, filled them with a radiance, and peace.

There were some very interesting and rewarding sessions, when a parent and an autistic child communicated with the Soundbeam. With improvised movement, they improvised music, which spoke to them and thus they were able to speak to each other non-verbally. It was a very moving experience for all. Again everyone was adamant: Sésame Autisme had to acquire a Soundbeam. Unfortunately, after the Musical Wheel and other expenses, the budget couldn’t rise to the occasion, so Soundbeam remains a dream. But maybe one day…

Two months ago, the mother of a 28 year old autistic lady came in and closed the door. She spoke of her terrible anguish: of how she drives off alone in the car and screams and cries, when things become too much for her. She said that twice she had slapped her daughter, and that the look of shock and pain on her daughter’s face would live with her always. She asked me to help.
Villa Clématites is closed for the long summer holidays, but I was able to have a couple of sessions with mother and daughter. The daughter Maria moved constantly, picking up as many instruments as possible. There were four occasions when she kept still, made eye-contact with me and uttered some sounds, as if she were talking to me. The mother, Zoé, was overjoyed, and kept prolonging the session, in the hope of witnessing it again.

To work alone with the mother, we had to push furniture against the door to discourage Maria from entering. Her sister tried to keep her occupied upstairs but she kept coming down and banging on the door. In spite of this, Zoë was able to relax whilst listening to music, and was able to communicate her feelings and memories afterwards.

Anne-Laure is Swiss, and comes from Geneva. She is studying music therapy at the University of Montpellier. She is doing her practical training at Sésame Autisme, Hérault. Every Wednesday and Saturday afternoon for a year, she has come to Villa Clématites to do music therapy. She has done excellent work and the parents speak highly of her. The autistic members have progressed in their own various ways. They are completely at ease with her. I have peeped in at one of her sessions, and was truly amazed and delighted at the high standard of her work. She was reluctant to be filmed during a music therapy session: I understood and respected her decision – regretfully.

Music Therapy at Sésame Autisme has proved to be a great success, as have the other activities. If Villa Clématites is like a flowering oasis in an autistic desert, music therapy is like a gentle breeze bringing relief.
Address

May GAERTNER
91 Rue Jacques Tati,
34070 Montpellier.
France.

Tel/Fax: 33 (0) 467 690 769
Email: qprint@qp.com.fr
Music Therapy and Temporality

Gaggero, Giacomo
MusicSpace Italy, Genova – Via Chiodo 23

Temporality and “lived time”

By music therapy I mean an activity whose purpose is the care of human health and whose main work instrument is the relationship between the patient and the therapist as it configures through the musical expression of intentionality. Therefore it is a clinical relationship with a prevailing musical nature.

As Kant showed, space and time are the basic dimensions of human experience and are, therefore, present in every form of this experience. However, this does not prevent us from seeing that some particular art forms, such as the more figurative painting and sculpture, have as their basic theme the relationship between form (that is intentionality) and space, while other arts, such as music, deal with the relationship between form (a musical form in this case) and time.

Michael Imberty, using an effective metaphor, speaks of music as the “writing of time”; but what aspects of music does time “write” about? Of course not about exact time, which is dealt with by science and technology, but about those expressions of sound which testify to the quality of what Minkowski, in perfect harmony with both Bergson’s and

phenomenological philosophy’s teachings, called “lived time”\textsuperscript{59}. As it flows, “lived time” involves simultaneously all those emotional, affective and cognitive aspects that together concur to connote the person’s \textit{mood}, or, to use a phenomenological term, his \textit{Stimmung}.

My work, both as a therapist and as a teacher, shows me that is particularly important that the music therapist is able to understand the quality of his patient’s life, in order to modulate his clinical treatment more consciously and effectively. In fact the way the patient “lives” his time dimension qualifies his Being-in-the-world (his \textit{Lebenswelt}), and, referring to a concept introduced by Minkowski, his \textbf{vital contact} with reality \textsuperscript{60}.

But which are the main indicators that can help a therapist interpret the \textit{sense} structures characterising the patient’s existential experience? I think that the main indicator is \textbf{style}. A music therapist should always pay special attention to all the stylistic elements that mark out his patient’s presence and behaviour, first of all his \textit{musical style}, but he should pay serious attention also to other aspects, such as posture, gestures (there is no sound without a movement), quality of eye contact and breathing.

My reflection on the clinical experience carried out in recent years (also with the team of MusicSpace in Bologna) has also led me to grasp

\textsuperscript{59} E. Minkowsky, (1933) \textit{Le temps vécu}, Paris; (1971); \textit{Il tempo vissuto}, Torino, Einaudi

\textsuperscript{60} E. Minkowsky, (1927) \textit{La schizophrénie}, Paris, Payot et Rivages; (1998) \textit{La schizofrenia}, Torino, Einaudi
another significant indicator of the quality of the patient’s “life experience” \((Erleben)\) in the relationship between his \textit{style} and \textit{silence}.

What I have said so far has therefore brought me to connect the experience of “\textit{lived time}” with the affective-emotional connotation \((\textit{Stimmung})\) that features everyone’s existential experience \((\textit{Lebenswelt})\); this also permits to identify in the expressive \textit{style} \((\textit{and then also in the musical one})\), the main indicator of the connotations of sense which qualify the individual existential experience.

But what do I mean by \textit{style}? How does this connect with the basic emotional, affective and cognitive intuitions that characterise everyone’s life experience?

\textbf{Style, Narration, Poetics, Temporality}

There is a common saying according to which ”\textit{style is everything}”

There is something very important for us in this sentence. What it really means is that through his \textit{style} the person gives us synthetic information about his identity, which is sufficient for us to recognise it. If we listen to a few notes of a composition by Mozart, or of an improvisation by Keith Jarrett, we are immediately able to recognise them. But \textit{style} can reveal people’s identity also through humbler and more mundane ways. Sometimes we have certainly recognised someone only by the sound and rhythm of his steps, or we have immediately decided whether we are interested or not in a TV programme by watching it for just a few seconds. In many cases, by merely listening to the recording of a \textit{musical}
dialogue in a session of music therapy, we are often able to recognise the participants’ identity.

We can define the flowing in time of a story (musical or not) as narration. This is therefore the diachronic articulation of sense. We call style the structural component of the story that, moment by moment, synchronically, reveals to us the how of narration.

Since the how is basically made up by ourselves, with our specific features and differences, we could say that style ensures unity of sense to the narration. In fact, style continuously brings back narration to a specific how, to a specific interpretative perspective and to a specific who.

Style testifies, in the here and now, to the how of narration, to the specific interpretative view in which it takes shape: in other words, it reveals the interpreter’s poetics.

Poetics is made up by that set of conscious and unconscious psychological indicators which, as a whole, give shape to our emotional, affective and cognitive evidences. Style, on the other hand, is the concrete testimony, in every moment of the narrative flow, of the interpreter’s poetics.

Heidegger writes:” What is time? Time is the ‘how’. If one insists on asking what is time, one mustn’t hastily cling to an answer (time is this or that), which always says a ‘what’. Let’s not look at the answer, but let’s repeat the question. What’s happened to the question? It has changed.
'What is time?' has become: 'Who is time?'. And, more precisely: 'Are we ourselves time?' Or, even more precisely: 'Am I my time?' 61.

The way we live our time thus appears, as the deep core of our identity. Our style proves to be the form in which we express this core; it, at the same time, represents the element of communication beginning from which it is possible to go back to this core. As Imberty says, “style, as an organiser of time, is a sense-bearer” and its modulations “outline the web of an unconscious symbolic structure“.

Silence as a metaphor of Sense

We can consider silence both as a physical and a psychological phenomenon.

As a phenomenon studied by acoustics, silence doesn’t really exist; one will rather speak of sound waves of such a width and intensity as to be perceived or not by the human ear.

As a psychological phenomenon, silence is only partially connected with the acoustic dimension. In fact it is possible that someone, even though he is in a place that could be rightfully be described as “acoustically silent”, perceives his “mental space” as inhabited (sometimes “invaded”) by buzzes or by speaking, quarrelling, appearing and disappearing “voices”. He is living anything but a silent inner experience. In fact, beginning from such a psychological situation, in which the person, according to the psychoanalytical meaning, is “driven ” by his own inner

voices, it is quite difficult to attain that silence which is the basic condition for any true **listening**.

As Heidegger says, “to be able to listen is not a consequence deriving from speaking together, but it is, rather, its condition”\textsuperscript{62}. The psychological attitude of listening, in a way, “roots” the internal and external interlocutor’s existence in its radical **alterity** (by this concept I intend the “otherness” of someone). But to really recognise the Other’s profile (inside and outside us), it is necessary to create a space, a distance, a wait and silence.

Silence, as a metaphor of death, reveals to us that we can meet the Other only when we will be able to let him go. As long as we are not able to let him go, we will not meet the Other in his own identity and difference, but only the shapes our desire for Him take.

The creation of any authentic **dialogue** necessarily requires the painful passage through the mysterious “zone” indicated by silence\textsuperscript{63}. Only if we begin from such a dimension is it possible to start a real process of **sense** construction. However, the extent to which this dimension is felt as painful and destabilising is shown by the thousand and one ways in which, in the present age, silence is exorcised.

So, we have come to the well-founded correlation between silence, **listening**, **dialogue** and construction of **sense**. We also believe that these elements are fundamental aspects of musical experience. "Music


\textsuperscript{63} A “zone” perfectly evoked by the director Andrej Tarkowskij in his movie *Stalker*, URSS, 1979.
recovers energy from the sources of silence” (Jankélévitch) 64; “Silence is the potential music can arise from. Music is the significant activity that only silence can produce” (Jarrett) 65; “Only if you drink from the river of silence, will you be really able to sing” (Gibran) 66; these are only some of the many influential authors that could be quoted to underline the close link which connects the psychological dimension of silence with the perception of sense that the musical experience, in its most genuine form, seems to be able to promote.

On the basis of the remarks made so far, an area of research emerges, which aims at investigating the connections linking the different existential kinds of “inhabiting” time, the corresponding styles of expression (with particular reference to their musical aspects), with the different forms of soul-suffering, or psycho-pathology.

**Kinds of temporality**

The theme of time is one of the basic subjects around which philosophical discussion has developed. In particular Bergson, Husserl, Heidegger, Jaspers and Sartre, have provided the conceptual framework for the psychological interpretations of temporality. Phenomenological psychiatry, thanks to the brilliant insights given by masters such as Binswanger and Minkowsky, starting from such philosophical references


and reflecting on the meaning of psychical suffering, has been able to identify some basic features of the subjective experience of time.

For instance, when conscience loses contact with its past and its future, it is no longer able to give a psychological setting even to its present. In fact the disappearance of the two poles in relation to which the “intentional bow” is structured, the past and the future, causes a form of decontextualization in the individual’s conscience, with the related alterations in self-perception.

In this perspective it is possible to understand that the construction of sense and the subjective experience of lived time are intimately connected and therefore that, by a study of temporality, the connections between this, the phenomenology of desire and the related forms of psychical sufference can emerge.

As Eugenio Borgna says, “to know how time (time experience) develops in a moment of sadness, or of schizophrenic metamorphosis of the world, provides a better and deeper understanding of the meaning, and of the hidden dimensions, of psychopathological experiences; this is not a merely theoretical speech: it involves immediate practical (clinical) implications”67.

In melancholic and depressive states 68, when desire is no more supported by hope, the future vanishes on the horizon of conscience and the present sinks into the past. Every kind of “planning” seems to be


68. For a more detailed survey of the typical features of the melancholic and maniacal existential experience (Lebenswelt), see E. Borgna (1992) Malinconia, Milano, Feltrinelli
senseless and our eyes continuously turn back to the past, being seized by a sense of longing nourished by constantly renewed experiences of loss. The falling of hope and an overwhelming sense of guilt cause a pain that can become unbearable and favour the emergence of suicidal intentions.

“Slowness” and “heaviness” evidence therefore seem to characterise the melancholic and depressive existential experience (*Lebenswelt*), even though at different levels of intensity.

In the maniacal *Lebenswelt*, often marked out by false, and therefore hypertrophic, cheerfulness and optimism, time gets very fast and gives rise to “light” (rootless) and fickle life experiences; these features are reflected by a convulsive and “greedy” inhabitance of space. In such a dimension “the past and the future seem to fade away: only the instant (the here and now) time survives, aimless and floating; (... ) time slips out of the patient’s fingers and vanishes.”

In anxiety, instead, a devouring sense of guilt makes the past and the future “fall” and “sink” into a convulsive, frenetic, again hopeless present. The constant anticipation of the future prevents from living it as probable or possible; on the contrary, it is felt as if it had already happened; such an anticipation breaks into the present, destabilising its interpretative links with the past. This, therefore, no longer makes sense, cannot passes and thus assumes “driven” forms of presence such as, for example, “acting out” or psychosomatic symptomatology, and with the

69. The melancholic *Lebenswelt* seems to be well represented by the image of slow and long waves.


future (which can no longer be perceived in its constitutive dimension of possibility).

Breathing, often short, quick and superficial, suggests the idea of escaping, the unrestrainable tension towards a fundamentally unreachable elsewhere.

Speed, weightlessness (in the sense of “semantic gravity”), combined with a pervading and destabilising feeling of anguish, seem to characterise the anxious person’s “lived time”.

In the schizophrenic Lebenswelt, in which a chilling anguish cancels both the past and the future, the present, that stops in tedium, “crystallises” and survives in arid isolation.

In catatonic states, stillness and silence express the smashing and the loss of personal identity.

In obsessional neurosis the defence mechanisms against anguish take the shape of hyperprecision and perfectionism: time must always be “planned”, any new event, since it portends anguish, must be exorcised by the predictability ensured by repetitiveness and rituality. In the obsessional subject’s Lebenswelt hierarchies fall, that is to say “everything is important”, and the past doesn’t spread through nostalgia, but because it can never be felt as “concluded”. Repetitiveness puts on a kind of false movement in which the same movement, that in a way animates repetition, actually proves to be an apparent one, a kind of time-marking in which action, in its appearance, loses its true sense that

consists in *remaining* always at the same place (the same dimension of alienated temporality).

**To summarise:**
The categories through which we propose to interpret life experiences are **style** and **narration**.

*Style* (a “vertical” structure) is the specific way in which an individual reveals, by expressing himself, his **poetics** and the intuition of his horizon of **sense**.

Such an intuition takes place within those attitudes of conscience that Husserl called “protentio” (projection towards the future), “retentio” (“retention” of the past, memory), “praesentatio” (the “present” of conscience, in which all the intentional connotations appear).

*Style*, by connoting the quality of **intentionality** (Husserl) or **care** (Heidegger), reveals the particular existential configuration of any individual, testifies to the quality of everyone’s relationship with **sense**73 (16), the distinctive character of any identity.

*Narration* (a “horizontal” structure) is the gradual unfolding in time of the individual’s intentional activity, who, through his stylistic modulations, becomes a creator of “history”, changing “facts” or ”events” into meanings, thanks to the interpretative work, which sets them in a narrative context.

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73. On this subject it seems useful to remember the distinction between the ontological and the ontic level. From an ontological point of view the survey aims at discovering the categorial structures of “being”(Heidegger); from an ontic point of view the research tries to find out the connotations of the single “presence”s psychological features. The phenomenological research in its philosophical implications develops on an ontological level, whilst in its clinical connections it favours an ontic point of view.
In this perspective it becomes clear that for the music therapist it is mainly important to understand how every patient lives, perceives and expresses his time dimension, his lived time.

In fact lived time and the alterations in the way we perceive duration are strictly connected with the inner perception of sense and with the stylistic quality that feature everyone’s way of listening and expressing himself.

Reflecting on our clinical experience, we have formulated a theoretical hypothesis, according to which we can identify the following kinds of temporality:

- Healthy ritual temporality
- Healthy daily temporality
- Alienated (or unhealthy) ritual temporality
- Alienated (or unhealthy) daily temporality

**Healthy ritual temporality**

In this dimension style, which, through its integrity, ensures experience of its unity of sense, intends to testify to the intuition of its horizon of sense. This attitude of conscience creates an effect of suspension in the perception of the time flow; in it we reach a kind of “listening of listening”, an encounter with ourselves, with the original opening to sense that we ourselves are, and with that set of emotional, intentional and cognitive qualities that characterise our style, that is our identity.

The assumption of such an attitude of conscience is made easier by the processes of artistic creation, by playing experiences and by the moments of contact with the “natural” sublime, of falling in love, by all those
experiences, such as prayer, where the object of narration proves to be or reflects a “totality” which the narrator can identify himself with. We could speak, referring to the different forms of “inhabiting” this time dimension and in accordance with Jung’s meaning of the term, of “Self-narrations”. In this time dimension the individual takes care of his conscious-intentional structure, of his own way of opening to the world, that is to say of his style of opening to sense. Inside ritual temporality, the prevailing attitude of conscience is “praesentatio”.

**Healthy daily temporality**

In this case style, which, through its integrity, ensures experience its unity of sense, proposes to narrate contents, events, facts and relations; these, when invested with (or enlightened by) the “epiphany of sense” testified to by the style itself, reveal themselves in their “significance”.

For example, the events of a literary narration, or of the story of a community’s vicissitudes, reveal, when described with unity and style coherence, their web of sense, their becoming “history”. In healthy daily temporality the individual experiences his being “memory” or “project”, and the related attitudes of conscience: “retentio” and “protentio”.

In the first kind of temporality we have described, the lived experience shows an ecstatic character, while the second one reveals a good level of vital contact with reality 74.

One could say that, within a non psychopathological condition, the ritual temporality situations enter into the flowing of daily time nearly almost

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as “filling stations” of that so precious existential “fuel” which is sense. A concert, a religious ceremony, a deep emotional involvement with one’s family, are all examples of moments of healthy ritual temporality which contribute to root our existence in sense.

Even more so, who is in in a condition of suffering may feel the need of such “filling up”.

A session of music therapy (just like one of psychotherapy) takes place according to particular “rituals”, in a space-time context (a setting) having the same qualities of what Jung calls “Temenos” (sacred precinct).

The therapist, in some cases, will employ such qualities to evoke or grasp time dimensions of a ritual kind (for instance, in order to emphasise those moments of intense and deep contact (empathy) which sometimes seem to “enlighten” the session with sense). In other situations, he will choose time dimensions of a daily kind; it happens, for example, when the session assumes connotations more strictly connected with “playing”, which provide a very useful opportunity to “fluidify” style, to improve the swing of the relationship both from the intrapersonal and from the interpersonal point of view).

Alienated (or unhealthy) ritual temporality

As Borgna writes, “in the autistic condition…one can (also) observe the metamorphosis of time experience, which “stagnates” and stops, in a watery and still present, opened to the past but close to the future”⁷⁵. In this case a style which, because of its disintegration, cannot ensure the
unity of *sense*, encounters, as an object of narration, the insight of its horizon of *sense*. Also this experience produces a kind of suspension in the perception of time flow. For example, in the case of psychosis, as Jung points out, patients “are often lost in the labyrinths of a garden…where the same unchangeable story continuously repeats in a timeless present…the hand of the world clock has stopped, for them there is no more time, no more becoming, for them it doesn’t make any difference if two days or thirty years pass over their dreams”.

This time dimension is not marked out by the “listening of listening” we have spoken about, with reference to healthy ritual temporality; in this dimension the person assumes the *role* of a listener, but he really doesn’t listen. The crushing of the unity of *sense* (no longer guaranteed by stylistic integrity and by the ability to listen in a true, not confusing way involved by the latter) causes the individual to meet, after projecting them out of himself, some of his parts, aspects and contents, in the different kinds of alterity he experiences, but he is unable to recognise them as his own any more.

When what the person projects is not a particular psychological content, but the confused insight of its general disintegration, what occurs is actually a moment of alienated ritual temporality.

In the most serious cases the subject raves. Loosening or losing the identifying connection with his personal style and “wearing” the style, or


“mask”, of one of the specific kinds of soul-pains (psycho-pathies) which are apparently so “impersonal” that they can be inserted in neutral classifications such as the DSM or the ICD. Being partly or totally unable to organize his narration in a *kosmos*, he becomes “theatre”, performance of the irruption of *kaos*, in which Everything, now nothing more than an uncontrolled flow of experiences, consists. In the cases of schizophrenia and autism one is often faced with what really seem to be *frozen acts* \(^78\). The *vital contact with reality* loosens, till it leads to a condition of *ontological insecurity* \(^79\) whose sign seems to be the loss of natural evidence.

All this happens not without that fascination, that “numinosity” which derives from the “total” character, involving the whole person, which is typical of the kind of experience we are describing; a numinous fascination that the psychotic experience often expresses by a style of

\(77\) Hitler’s oratory is a very good example of “alienated ritual temporality”; in fact, the orator, far from authentically listening to himself and to the others (in their constitutive alterity and difference), lets himself be “driven” by his inner “demons” (also present in the collective unconscious) and “performs” them in front of his audience.

The audience can fall under the spell created by the veracity of the performance and, at the same time, it can accept the legitimation, operated by the leader through his charisma, of a process in which everyone can confusedly identify himself with his unconscious projections. In this way, with numinous and satisfying immediacy, people remove the effort of choosing a “critical” point of view, and, even more, of adopting an attitude of both authentic and responsible listening of himself. What is communicated in this kind of oratory is not “this” or “that” particular argument, but, more generally, the legitimation of a “driven” (and aggressive) performance of one’s anxiety and anguish; these feelings, instead of being investigated and recognised, are exorcised by a reassuring process of objectification. In this way the distressing ghosts of the collective unconscious take the concrete shapes of a real enemy, who, unlike a ghost, can be seen, faced and fought against.

\(78\) E. Minkowsky, *op. cit.*, pp. 93-108.

communication marked out by authenticity, lack of mystification, independence from every fashion or convention 80

**Alienated (or unhealthy)daily temporality**

This kind of temporality is characterised by a *style* which, with its relative disintegration and loss of contact with *sense*, chooses from time to time, as the objects of its narration, specific contents, events, facts, relations.

Insofar as a residual organisation of *style* persists and since these contents, because of their “partial” character, don’t possess the cognitive-emotional impact of the experience of intuition of the whole, the same contents can be recognised as *meanings*. However, insofar as such contents are not integrated in a sense-rooted narration, they turn out to be *alienated meanings*.

Typical examples of alienated daily temporality are provided by the existential narrations described as neurotic.

Where *presence* lives neurotic experiences, temporality is not felt (as in the “ritual” temporality experiences) as suspended; on the contrary, it assumes from time to time the wavering dynamis of Anxiety, the slow and melancholic one of Depression, the excited rhythm of Mania, where time flows in an everyday life whose degree of existential alienation is directly proportional to the degree of mystification and to the lack of recognition of the single meanings that the subject puts into action within and against the narrative context..

80. E. Borgna, *op. cit.*
Temporality and the Senex/Puer archetype

In outlining the main features of the Senex/Puer archetype we shall refer to the description of it given by James Hillman.  

Senex and Puer are a couple of polar and complementar principles through which our desire for sense reaches out to its objects.

These figures, such as all the archetypal ones, are ambiguous, since in each of them it is possible to find both positive and negative aspects.

In Hillman’s opinion, Saturn represents the Senex’s character quite well: in fact he used to be invoked as a very powerful god, whose words were sure and sincere: he was Wise (since he possessed Memory), Sensible, (for the enormous depth of his judgement), able to keep order (Kosmos). But at the same time he was described as Cold, Sterile, Mournful, Impenetrable, an old, weak and tired god: Chronus-Saturn who devoured his children, a frustrated and frustrating ogre. So, Senex’s ambiguity indicates on one side the ability to build sense through the practice of a Logos able to create a Kosmos, on the other side he represents a rancorous, deadly frailty, generated by the energetic sclerosis and by an exaggerated emotional distance (consequent on a kind of Logos hypertrophy) from the objects of his desire.

Senex’s time therefore can be slow (it is not in a hurry), heavy (it is fraught with sense), serene (it is rich in wisdom) and protective, since it testifies to a reassuring Logos and Kosmos. However, it can be marked out by grim and destructive slowness, by lightness not deriving from

levity, but from his being a contracted and shrunken desire, unable to accept difference and change, which shows in his attitudes of narrow-mindedness and intolerance. Repetitiveness and monotony are then (also from a musical point of view) the distinctive marks of the negative Senex’s temporality.

Puer, who is represented in mythology by gods such as Eros and Hermes-Mercury, possesses the positive features of an eternal youth rich in energy and vitality, of imagination, intuition, speed, love, but, at the same time, the negative characters of impulsiveness, unreliability, adolescent irresponsibility and inconclusiveness, generated by his whirling getting nowhere, and of the unconscious cruelty so typical of children.

So, Puer’s time can tend to represent qualities such as immediacy, freshness, vital heat, joy and the perception of Sense in its most communicative aspects (the winged Mercury is the gods’ messenger, an entity able to connect the Earth with the Sky). On the other hand, Puer’s time can be characterised by superficiality, inability to listen (deriving from his inability to concentrate), lack of empathy and a propensity to escape from the time of history (which is necessarily connected with memory and responsibility) to fall off into the dimension of “acting out”.

A condition of mental and spiritual sanity involves a harmonious combination of the positive aspects of both principles.

Existential suffering and problems essentially show themselves through those kinds of temporality we have called “alienated”, and at the same
time, to a certain extent, they are characterised by the negative aspects of Senex/Puer.

According to his own clinical experience, everyone will be able to correlate the distinguishing marks of the Senex/Puer archetype with the kinds of temporality described just above, and, most of all, to reflect on the musical implications of what we have said. In fact “music (...) is always a stylisation of time”82.

Conclusions

The ability to recognise the different qualities of temporality revealed, through their style, by patients (as well as by the musical pieces proposed in clinical work) combined with the ability to tune in and to consciously modulate his practice accordingly should be, in our opinion, an integral part of the music therapist’s bag of knowledge.

Thus an understanding of the elements described in this paper reveals useful for interpreting the patients’ needs and also, therefore, for choosing which therapies to adopt.

It will be usually possible to employ this knowledge successfully, both “in session” and during the “reading” phases, for a therapist who works in the field of non verbal therapies (especially in the area of arts therapies


We think it is useful to point out that Jankélévitch always refers, in his analysis, to a “noble”, “authentic” and therefore “total” musical experience, which is to be included in those kinds of temporality we have called “ritual”. For our purpose however those kinds of musical communication that, according to the philosopher, should be considered unauthentic or “decorative” music, are equally important and dignified. In fact they show indicate possible ways of “inhabiting” time and so, of course, are integral part of our survey.
and music therapy) and is therefore constantly involved in that relationship between style and narration which has emerged from our exposition.

The specific musical training of a musician-therapist, according to Ficino’s notion of musicus, so appropriately mentioned in his works by Prof. Bunt, involves his ability to recognise, also by intuition, the connotations of sense of the Other’s music and will help him understand, his own way of inhabiting time that, after all, features his Being–in-the-world.

The “musician-therapist” should direct such understanding towards a care and therapy plan which, as well as achieving specific clinical aims, should, at the same time, per se help to create a horizon of sense, that, as Wendy Magee appropriately reminded us in a recent meeting, can only be connoted by hope.

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**Biographic notes**

Giacomo Gaggero, pedagogist and psychotherapist, studied philosophy with Prof. Carlo Arata (University of Genoa).

He trained in Music therapy with Prof. Leslie Bunt in 1995 (Post Graduate Diploma in Music Therapy- University of Bristol).

He has a background as jazz musician.

He collaborates as teacher and supervisor with different institutions (Course Post Graduate Diploma in Music Therapy University of Bristol, Bologna- Centro Ricerche di Psicologia Analitica, Genova).

He works as musictherapist in private and public institutions with handicapped people and autistic people.

He also works as trainer with groups of personal development.
He has published articles of philosophic and musictherapic arguments.

In 2001 he presented with Leslie Bunt and Barbara Zanchi at the 5th European Music Therapy Congress in Naples a work titled “Musical interpretation and therapeutic relationship”.

He is Vice President of MusicSpace Italy and, for the same institution, Director of the Center of Genoa.

**Address:**

Giacomo Gaggero  
Via D. Chiodo 23  
I - 16136 Genova  
phone +39.0102517322 - +39.0102722582  
[giacomo.gaggero@libero.it](mailto:giacomo.gaggero@libero.it)
Gallicchio, Maria Elena S. S.

Abstract

This work has been developed at São Lucas Hospital of the Catholic University of Rio Grande do Sul in Porto Alegre, south of Brazil. It started in 1996, as an internship in Music Therapy. Afterwards it resulted in the Academic Paper with the title “Peter and the Wolf – Music Therapy with Children in Chemotherapy”. Nowadays, Music Therapy has been applied to children with cancer (tumors, lymphomas and leukemia) under chemotherapy treatment. During all these years of work with this clientele, we have come across to the following thought and ideas. One of them is the fact that these children face the process of death, what led us to reconsider the therapeutic goals including the preparation for the “end of life” (in reference to the work of E. Klüber-Ross).

- Music Therapy techniques used: musical re-creation (K. Bruscia), free and oriented improvisations, listening, composition, creation of singing stories, rhythmic and sound games.
- Activities used: singing, playing instruments, free dancing and body movement, CD’s listening, relaxation exercises, graphic representations of music therapy experiences.
- The sessions usually take place either in the Music Therapy room, the nursing room, the isolation room or in the ITC.
- To evaluate the emotional state, I use the tool known as the “PAS Ruler” (Pain Assessment Scale) an instrument for the psychological self-evaluation identified by self-portraits.

Introduction

In 1996, at São Lucas Hospital which belongs to the Catholic University of Rio Grande do Sul, in Porto Alegre, south of Brazil, I started an internship on “Music Therapy with Children under Chemotherapy and Extended Hospitalization.” At that time, it was a pioneer work in our
state with the support of Dr. Délio José Kipper, the chief of the Pediatrics Department.

Afterwards, I continued to work with children in chemotherapy, what resulted in the academic paper with the title “Peter and the Wolf – Music Therapy with Children under Chemotherapy” which I presented at the 9th World Congress of Music Therapy in Washington in 1999.

At present, I still give continuity to this work having as main clientele children with cancer (solid tumors, lymphomas and leukemia).

To the Hospital Board, I placed as the main objective of the music therapeutic attendance, to diminish the suffering of the child who, having cancer, a disease that requires chemotherapy and radiotherapy, suffers from the disease both in view of the treatment and of staying away from home and from the family environment.

We know that the treatment with chemotherapy is really efficient against the sickness, but the reactions that it causes are extremely aggressive for the human being. An adult can have an idea of what is occurring to his organism in this situation, but the treatment and the consequences are too menacing for the children, who cannot understand what is going on in their bodies. Such conclusion led us to consider authors who believe in the brain capacity to alter the chemistry of the body, by producing substances to eliminate or to attenuate the pain, like encephalon and endorphin that are present in a healthy human being. So it is understood that the brain has the ability to intensify chemical alterations when the desire to live exists (1,2,3,4). That is why music therapy is becoming more and more useful in Oncology-Pediatric Care Centers, where the
therapeutic effects are seen as transformers of the patients physical and emotional state, giving them the opportunity to express their needs, desires, fears and solitude (5,6,7).

I believe that music therapy sees the human being as a whole, where body and mind, psyche and soma, matter and spirit, constitute an indivisible being (8).

Music has been used with the objective of producing therapeutic effects since the beginning of the civilization, applied among all peoples and civilizations all over the centuries. Initially there seemed to be a magic character it it, but nowadays it is recognized as a valuable instrument in the somatic medical area (9).

The music therapy sessions are an interpersonal process, in which the MT uses music and all its facets – physical, mental, emotional, social, esthetical and spiritual – to help the patients to feel better, to recover or to support the health (10). The music therapy effects can be better than other therapeutic effects, even better than games, because it stimulates children to a better verbalization of their needs and fears. There is specially the music applicability as a therapy to children with cancer, because it is a creative process, generating creative energy, improving their quality of life, awakening the imagination and providing children with the opportunity of expressing their reality (5,6,7).
OBJECTIVES:

The prime objective is:
Improving the mood – happiness in opposition to sadness - of children with cancer resulting in better acceptance of the treatment.

The specific objectives are:
• Giving the children the opportunity to feel and express their emotions with music;
• Helping the children to face the troubles caused by chemotherapy and radiotherapy;
• Providing the children with relaxing moments and to set them free of tensions;
• Giving them the opportunity to share friendly contacts in delightful moments;
• Using music as an element to make the hospitalization less threatening.

Target Population: newborn to 15-year old children admitted in the Hospital S. Lucas of the Catholic University of RGS, Brazil.

These children are attended either at the nursing room under Public Health Care Services or at other nursing rooms under private health care services.

The covered areas are: the states of Rio Grande do Sul and Santa Catarina, Brazil.

MATERIAL AND METHODS
On Tuesday mornings, I have a meeting with the medical staff of the Pediatrics Department and with the staff of the Children and Adolescents Human Rights Committee of which I am a member. Then, I get
information regarding newly admitted patients and of those who are hospitalized and already addressed to the music therapy attendance. An evaluation is made of these patients’ state, of the difficulties they have faced during the past week and which medical and hospital procedures are foreseen for that day and for the coming week. I am also given a feedback about how the patients are reacting in face of the music therapy attendance.

The first part of the music therapy process is carried out in a visit to the child and relatives. In this occasion, I tell them what MT is and which its objectives are. Both the child and the relatives have to mutually agree upon the music therapy program. The bases of such agreement are the following:

- Respecting the child’s desire to participate or not of the MT sessions;
- Respecting the child’s need to interrupt or leave the session;
- Respecting the child’s rest;
- Assuring medical secrecy on confidential data about the child;
- Assuring the MT treatment free of any charges
- Setting when and how the sessions will occur.

Then, I fill in a music therapy form.

I make an evaluation of the child’s emotional state regarding himself/herself and then I evaluate how the parents or relatives see the child’s emotional state, using the Pain Assessment Scale (11,12).

This psychological self-evaluation scale is represented by faces, which the child associates to what he/she is feeling:

- From A to D – positive disposition state
E – neutral disposition state
From F to I – negative disposition state

I use the scale showing it to the child and ask:

- “Look at yourself, show me how you are feeling! Which face looks like yours?”

To the relatives I show the scale and ask:

- “Show me which face represents how your child is feeling.”

These evaluations are repeated before and after the sessions.

The musical testing, a kind of an investigation to know aspects of the child’s sound identity, discloses reactions to rhythmic/sound stimulus or preference for an instrument performed at the Music Therapy room or in the room where the child is.

The duration of the session is planned according to the age of the child.

There are sessions twice a week.

**The musical instruments used are:**
- Percussion instruments,
- Metalophones;
- Xylophones;
- K-7 player;
- CD player;
- Flutes;
- Recorders.

**The material needed is:**
- Gym mats;
• Medical items;
• Camera;
• K-7s for the recording;
• Colored pens;
• Paper.

**The main Music Therapy Techniques are:**
• Musical re-creation (Kenneth Bruscia Technique);
• Free and directed musical improvisation;
• Musical listening;
• Composition;
• Sung stories creation;
• Rhythmic and sound games.

**Activities involved:**
• Singing;
• Instrument and body performance;
• Free dance and body movements;
• CDs/ K-7s/ musical instruments listening;
• Relaxing exercises;
• Graphic representation of the musical creations.

The sessions take place individually or in groups at the MT room, when the child is able to go there even though he/she has to be carried on a wheelchair.

If that is not possible, the sessions take place either in the Infirmary, isolation room or in the ICU even if the child is sedated or just sleeping. And the child knows it. This procedure gives tranquility to the child and helps her to cope fear later on.
In the MT room, as well as in the Infirmary, the musical instruments are disposed in such a way that the child can reach them easily.

When the sessions are in the ICU, I select the adequate instruments for that place and respecting the other patients. The child is asked to say what he/she wanted to listen or to attend. If there are no conditions, I use musical listening only.

The sessions generally start by handling the musical instruments. Even when the child does not know the instruments, he/she uses to play them, trying to make music.

**DEVELOPMENT**

The music therapeutic attendance starts right after the child has been hospitalized, even before the final diagnosis confirmation. At this stage, independent of his/her age and ability to understand what is going on, the child already feels that something bad is happening with him/her.

During all these years working close to children with cancer, I have observed that many of them face death inevitably. At first I did not include in the music therapeutic goals the child’s preparation for such passage. However, when I began to come across such cases, I became aware of the need for such preparation, what led me to widen the scope of my work.

According to Dr. Elisabeth Klüber Ross (13,14), the emotional reaction of people in front of death possibility goes through five distinct phases:
Denying, Anger, Negotiation, Depression and Acceptance.

People do not necessarily wait for the final stage to express their emotions. Likewise not all of them go through such phases in the same way and following such sequence. But I have observed that both child and parents in general experience them.

Initially, the shocking diagnosis of the disease affects the parents and even if they want to postpone telling or not about it to the child, even being very young, she perceives that something severe is happening and feels the need to know what it is. The younger the child is, the more he/she perceives the realities as a whole, not being able to distinguish himself/herself from the world that involves him/her when sick. The older child perceives progressively the menaces around him/her (15). He/she perceives how afflicted his/her parents are and in one way or another he/she becomes aware of what is happening with his/her body.

In general, at this stage, I have already had contact with the child and already told him/her about Music Therapy, its objectives and how the sessions work. If the child accepted to make Music Therapy, I inform the parents or relatives how this attendance works and ask them for the necessary permission.

The child usually feels music as “an anchor”, a reality that he/she knows and likes. It is quite different from all the other hospital procedures that are unknown to the child and that he/she is forced to undergo even being frightened and feeling pain. I have already explained to the child what the PAS Ruler for Pain Assessment Scale is and how it works.
Then I prepare the child’s history through interviews with him or her and
the relatives. The job starts with the mother, who is asked to tell how her
pregnancy was, what is recorded in a tape. After that, I make an
investigation on the musical preferences of the child.

**Denying**

In the first sessions, I have very often observed that both child and
parents are still in the denying stage of the disease. The songs they
mention, sing or perform in the instruments reflect such emotional state.
They classify these songs as the happy ones. Generally, these are songs
from popular TV programs and divulged by the media, with simple
melodies and rhythms that suggest dancing. Generally, both child and
parents participate of the Music Therapy session with certain easiness as
if they were just visiting the hospital.

Example: “Funi funicula…” Roberta LM, 2\textsuperscript{nd} session, in a group
together with mother before starting chemotherapy.

**Anger**

The other phases, mentioned by Dr. Ross, also appear clearly in the
worked songs, as well as in the posture of the child.

Anger does not appear only before the perspective of death but also in
face of the disease, the diagnosis, the treatment, the medical staff and
sometimes also in face of the Music Therapist.

An example of this phase is G’s anger.

G, 5 years old, from an inland town, with diagnosis of lymphoma,
reserved prognosis that represents a very bad prognosis, it means, the
child will hardly survive. In the meeting of the Pediatrics Department, I was told that G. used to express to the mother that she was giving up: “I am not going to overcome it.” To the father, she said: “Take care of mother, I am giving up.” She repelled the medical staff with cries. She started with Music Therapy after leaving the ITC where she had been hospitalized urgently.

She had already undergone four painful hospitalizations, even in other cities.

In a few days, G accepted promptly to attend Music Therapy. But in others she expressed her anger with cries, shouting me out of the room. She did not want anybody with her except her mother. However, when the session was performed with other children in the Infirmary, little by little G. surrendered to the power of music. In the beginning of the session, she would sit with her back to the group, sometimes covering her head with the linen. I told her that the Music Therapy was about to begin with the other children and that she did not need to participate of it. During the session, however, G. slowly uncovered her head, turned to the group and started playing the musical instruments, placed strategically on her bed. In spite of her debility, many times she played them aggressively producing fast and strong sounds that did not follow what the group played and sang, but exclusively concentrated on her anger. She held the wooden hammers using all of her strength, with tight closed hands. However, she would slowly apply herself to music, changing her posture, participating by playing and singing, making music, integrated in the present moment. I believe, that after having experienced anger, she
passed to the acceptance phase, acceptance of her sickness and of her present state, many times manifesting happiness, but rarely smiling.

**Negotiation**
I have observed the negotiation phase, for example, when the child changes from strong and aggressive sounds to soft sounds, although this is not a definite indicator. Other signs must identify this stage. They are however so subtle that one must be very attentive to perceive them. They rise in between the musical lines of the sounds that are transformed through the musical dynamics. I also consider indicators of this phase, the quick looks she gives around the room, while she plays and changes the intensity, as if she was testing the effect that it is causing, as if proposing “I am going to be good, I am not going to break anything and then I will be allowed to go out of here.” Or when she gives a religious feature to her songs when she sings: “I am not going to fight anymore and Jesus is going to cure me.” It seems to me that she puts here the expectancy of a possibility to be rewarded for good behavior and therefore to make the situation better.

**Depression**
Children with cancer are constantly depressed. At each hospitalization, the child suffers because she has to leave his/her home, relatives, activities, hometown, toys, it means, his/her world. When the child is hospitalized and readmitted in the hospital, he/she generally undergoes the depression phase. And, many times, upon the re-admittance, the child returns to the hospital in worse conditions than in the previous hospitalization. Therefore, he/she suffers more deeply in this new phase.
In these moments, Music Therapy is essential. With music, the child expresses his/her emotions, elaborates non-verbalized contents and changes his/her mood. So it was with F., 15 years old. He had cancer in the knee and had his leg amputated. After the surgery, F. was extremely depressed. When I talked to him to make the usual session with live music, he refused it. Then, I offered a session of music listening. I started with a selection of songs classified as the “sad ones” by the children. When he listened to “Meditation of Thais” by Massenet, F. cried compulsively for a long time. After that, I put on his bed a “Pin Set” of four sounds, tuned in C major. I started playing it slowly, using two sounds, then three and four in ascending movements. I offered F. a wooden hammer. He followed me in the melodic game. We passed to a faster speed, making in the top of the melodious line a dotted eighth note. F. began to demonstrate that he was less depressed, dried his eyes, sat better in the bed and even smiled while we played.

At the end, we agreed upon that in the next session we would play flute, the instrument that he learned to play at school but he never wanted to play in the hospital.

The fact of accepting to bring his flute to the Infirmary, being the flute the musical instrument that he used to play when he was healthy, represents in my point of view the acceptance of his new physical condition. I also believe that listening to songs classified as “sad songs” and crying led this boy to externalize his depression and mourning for the loss of his leg. In the continuation of the session, without saying anything, he could start to elaborate this great suffering.
I notice that in general the children finish the Music Therapy session less depressed than they were when they started it.

I would like to mention here the data elaborated in “Peter and the Wolf” through the PAS Ruler (16). Before the Music Therapy session the children presented a rate of:

- Before, sixty-nine percent of positive mood;
- Afterwards, ninety-three per cent of this same mood.
- Parents or relatives, regarding the children:
  - Before, sixty per cent of positive mood.
  - Afterwards, eighty-three per cent of this same mood.
We can see this transformation in the photos.

**Acceptance**

The Acceptance Phase, according to Dr. Elisabeth Klüber-Ross:

A patient of Dr. Klüber-Ross wrote:

> “I can already leave! My brothers should say farewell to me!

Regards to all of you; I start my depart.

Here I give the keys of the door back and give up my rights in the house.

Goodness words are what I ask of you, lastly.

We were together for so long, but I have perceived more than I could give.

The day has cleared up and the lamp that lightened up my dark room has turned off.

The order has come and I am ready to my travel.”

I think that both child and most adults feel when the end is close, when there are no conditions anymore for his/her body to fight.
I have noticed that, in general, before entering this phase, the child goes through a period of time when he/she feels much fear. Fear from being alone, fear from the night, fear from sleeping. It also seems to me that in order to pass to the acceptance phase, in spite of being very weak, the child needs to put in order emotional issues not solved yet. As in the example of C., 10 years old with Wiskot Aldrich Syndrome (degeneration of the lungs) for more than 6 years going through long hospital stays. His genetic disease was transmitted by the mother and attacks the male children only. During these years, C. spent many days alone in the hospital and did not demonstrate to be missing his mother. When his case became very severe, he asked for her desperately. In his last improvisations, he gave them the following titles: “I love my mother” and “Homage to my mother”. I made a copy of the tape recording and C. gave it to his mother. Later on, I used this recording when he was in the ITC and had to be intubated and sedated. In this occasion, I noticed in C., through his facial expression and less accelerated cardiac beats, certain tranquility. I believe that with his music, even without verbalizing anything, this boy succeeded to elaborate and to rescue in relation to his mother, feelings that made him suffer for a long time.

I have also noticed that when the child is really in the acceptance phase, he/she generally uses for the improvisations sounds that he/she previously had classified as “of tranquility” or “of a boy without fear”.

It is clear that this is the occasion when music acquires a deep meaning, more important than the present moment. The child generally
demonstrates with his/her sounds, titles of the improvisations, re-
creations and created stories, an attitude of turning to himself/herself
with tranquility often difficult to be understood by the people who
surround him/her.

In some cases, like that of A.P., 12 years old, with leukemia, I observed
the acceptance of the depart mixed with the hope of a transformation
when she created in the xylophone the non-sung music for the

“The History of the Plaster Doll”
Doll that was born in a flower,
Was bewitched by a bad witch
That keeps her in an icy house.
She falls in love with a prince
That saves her
When he cries on her.
She departs to far away, flying with the prince.”

In some re-creations, the child does not search for his/her songs a theme
from outside the hospital environment, but yes in what is very close to
him/her. As in the case of “My Little House” of G., 5 years old, with
cancer. This child passed away before the next session.

“My Little House” - G., 5 years old, cancer.
My little house, of wood,
It has on the roof, a chimney
It has a rattle
It has a smile
It has a wish
And a yawning.”

Serenity

I would like to finish this presentation talking about Serenity.

Music Therapy, as a creative process and energy-generating activity, generally arises Serenity in the child with cancer, independent of the stage of the disease. It is a feeling that is revealed, even when the child is in his/her terminal state, independent of having gone or not through all the phases mentioned by Klüber-Ross. It is a peaceful manifestation. I notice it in the way how the child sings and plays, in the posture of his/her body, in the glow of his/her eyes, in the smile of his/her lips and in the way how he/she even plays during the Music Therapy session.

This happened for example with K., 5 years old, with cancer (neuroblastoma), 1 year and 5 months of disease. When K. heard from the isolation room the group of children singing in the hospital corridors, he asked his physician to call me to make Music Therapy. In the terminal phase, K. could not sit by himself, his voice was just a low whisper, but even so we played together his favorite song in the keyboard. His sounds and his smile demonstrated the serenity of making music in that moment.

I also observed such serenity to arise and fill N., 6 years old, suffering from leukemia as I listened to her when she sang and played during a session performed in the ITC.

I noticed identical serenity in the last improvised session of G. when she gave to her song the title “A Swimming-Pool” played in the metallophone. The same serenity could be noticed in D. at the ITC, 24
hours before his death, when in between the repetitions of his favorite song, he toasted with me a “Viva” with the rattles or glissando in the xylophone.

Klüber-Ross tells us of the Hope that her patients kept until their last moment. I would add to that the feeling of Serenity. Serenity mixed with Hope is renewed at each sound rhythmic play, at each sung song, at each improvisation, at each instrument performance, at each composition. I believe that whenever there is a musical creation, a music performance, a life renewal is present in that moment, creating a music cycle that renews Serenity and Hope and the Hope and Serenity that renews life, independent of how long it might last.

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Biographical Data

Name: MARIA ELENA S. S. GALLICCHIO

Address: R. São Manoel, 1558 – apto. 202
90.620–110 Porto Alegre - Rio Grande do Sul
Brasil

E-mail : mgallicchio@cpovo.net

Author’s Title: Specialist in Music Therapy

Certified by The Brazilian Music Conservatory of Rio de Janeiro, Brazil.

Field of Activity: Clinical, in the Pediatrics Department of Hospital São Lucas of Pontifícia Universidade Católica do Rio Grande do Sul - PUCRS, Porto Alegre, Brazil

Maria Elena S.S. Gallicchio, specialist in Music Therapy by the

- Brazilian Conservatory of Music of Rio de Janeiro, Brazil.
- Member of the World Music Therapy Federation
- Founding member and first secretary of AGAMUSI, Gaucho Association of Music Therapy.
- Founder of Pedro e o Lobo – Musicoterapia Limitada, an enterprise that renders services of Music Therapy for Pontifícia Universidade Católica do Rio Grande do Sul.
- Founder of Vida em Harmonia Centro Musicoterápico, Life in Harmony, a Music Therapy attendance center.
- Active music therapist in Hospital São Lucas of Pontifícia Universidade Católica do Rio Grande do Sul since 1996.
Does Size Matter?? Why effect sizes are important in music therapy research

Gold, Christian
Aalborg University

Only as Powerpoint Presentation in the “Oxford Powerpoints” folder on this CD
Grusovin, Antonella

I would like to begin by telling you about the factors which led me to my interest in vocal improvisations and the reasons why I am dedicated to this field.

Although singing and the voice in general had caught my attention even before I became involved in music therapy, during my training and the first years of practical work in music therapy I discovered that in groups of instrumental improvisation the voice was always introduced after a number of sessions. In general, when a female voice was introduced, the instrumental group remained “enchanted” and responded to the voice with a fall in the intensity of their production. From that moment on the group had completely modified the dynamics of their production, continuing to follow the voice, maintaining a kind of unexpected and “magic” moment. It seemed like a dream, one of those beautiful dreams you wish would never end; and so it was for the instrumental group which participated in such a special event.

These experiences led me to wonder what would come out of a session comprised of vocal improvisations alone. How would the voice be used with respect to the use of a musical instrument? What differences would there be between instrumental groups and vocal groups?

Another question also led me to compare instrumental and vocal improvisations. On the one hand, during instrumental improvisation, there is a certain distance between the musical instrument and the body of
the player, which enables the feelings and emotions to find a greater “breathing space”. On the other, the voice is a part of the body and it brings each person directly “into play”. I therefore wondered what the impact would be in a session where the participants were invited to improvise only using their voice. Professor Benenzon himself states that “of all the sonoric phenomena, voice and song are the most profound: voice and song are the most regressive and resonant elements...”

The information I am about to present to you regards the sessions of vocal improvisation for groups of individuals affected by common neuroses. The theoretical references relate to the theory of professor Benenzon with regard to ISO, the theory of professor Bion with regard to group dynamics, and the theory of professor Winnicott with regard to the role of games in the course of the sessions.

To provide parameters for the comparison between vocal and instrumental groups, I have adopted the method of professor E. Lecourt, to whom I referred for the instrumental improvisations, adding some passages as I deemed opportune and which we will see shortly.

During my speech you will hear the terms *improvisation* and *dialogue*. With *improvisation* I intend the moment in which the group is invited to improvise with the voice during the session, whereas with *dialogue* I intend the group of improvisational events in their entirety which take place during each session.

The sessions take place once a week and last approximately 90 minutes. The groups are made up on average of five people: a prior individual meeting is held to evaluate the insertion of each person into the group.
The experiences which I am about to relate, refer, on average, to a period of a year. Some groups, however, have requested longer periods.

In general, the reasons which lead these individuals to participate in the sessions are the following: the desire to improve their relationship with their own voice; inhibitions related to singing which trace back to childhood; the desire to free their voice. Exactly what freeing one’s voice means is a question which would require a lot of thought! On some occasions the reason suggested was purely musical, that is to say the desire to learn to sing. On these occasions the individual has not confused the sessions with the lessons of a music school, but rather is expressing a real request for help which often hides situations of extremely deep suffering. The individuals who participate in these sessions, often complain of pain at the throat, chest and stomach, and of irritation and blockage of the cervix, that is to say, all vital regions.

The first dialogues are characterised by a variety of experiences of vocal production and listening to one’s own voice and the voice of others. This preliminary phase, carried out in the form of a game, allows the participants to concentrate on the vocal sound without creating excessive anxiety or alarm. Furthermore, in these early sessions, the participants already begin to perceive a change in their own voice and in the voices of others. It is worth noting that the passage from the verbal to the non verbal, turns out to be so soft that individuals can express themselves and make themselves known using both channels.

The next stage of the improvisations sees the participants being invited to communicate with the voice, without, where possible, the use of words.
At this point I avoid adding the optional activity of closing their eyes, preferring to introduce this in later sessions.

The first improvisations last for ten minutes. A first verbalisation comments upon the vocal experience, which is followed by the listening to the recording of the improvisation itself. A second verbalisation follows, commenting upon the recording listened to. In the last part of the session the participants are invited to vocally represent an object.

In the terms proposed by professor Bion, Beta-type elements arise from the sensations and perceptions stimulated by the voice during the course of the improvisation. Such elements, are then developed and included in the course of the verbalisation through the words which transform the sensations and perceptions, bringing them to maturation (Alpha elements). The representation of an object completes the cycle of this alternation between Alpha and Beta elements, placing thought (Alpha element) and representation (Beta element) against each other.

The following outline provides a summary of the shift between Beta and Alpha elements during the session:

- **Voice** Beta
- **Verbalisation** Beta / Alpha
- **Listening** Alpha / Beta
Verbalisation Alpha

Object Alpha + Beta

Let us now listen to three brief extracts of improvisation taken from groups in the early stages of the experience.

Each group which I have worked with over the years, has been characterised by its own expressive and dynamic aspects, even though there are features common to all of them. As you will have heard, the first vocal improvisations are characterised by an explorative/imitative phase in which regressive sounds are present such as sucking, animal calls, lullabies sung quietly, the reproduction of noises and voices with modified timbre. The group is distinguished by sharp contrasts, emotive tensions and embarrassment. In this phase imitation plays an important part amongst the group. The expression of the participants seems to say: “Look at what my voice is doing – I would never have thought it possible!” A proprioceptive exploration of the sound is in progress and the visible element is preponderant. The inability “to see” one’s own voice leads each participant to closely observe the group and their facial expressions, intensifying the imitative element. The posture assumed by the participants is closed and some of them rock backwards and forwards. I have noted that in the groups where musicians were present
there was an alternation between moments with expressions such as those described up to now and rhythmic moments aimed at regaining a more general and recognisable musicality from the group. Take for example the participant who in the first session reproduced the jingle of a nappy advertisement. In this case the expression of a gestaltic/universal/cultural ISO transmitted by the individual enables the sharing at a cultural level of the group, which in turn involves the gestaltic/universal ISO of each individual participant.

Of course the “voice/song”, that is the profound vocal expression of the individual, is at this stage absent, given that the participants are exploring their own voice and those of the others. In addition, a word or a phrase sporadically appears, commenting on a particular sound or situation. For some individuals it is extremely difficult to cast off their lifeline to the spoken word, even during the improvisation.

The first verbalisations are brief and barely express whether the participants enjoyed the improvisation or were irritated by it. The comments are limited and no imagery is present.

These first sessions are followed by a self-evaluation phase in which the participants comment on the pleasant and surprising sensations they have experienced since the beginning of the first phase. In other cases the participants make statements such as “I don’t like my own voice; I can’t bear listening to my own voice; my voice sounded different.” (In some cases the group did not wish to hear the entire recording of the improvisation.) The first images or expressions of colour emerge at this
stage. The participants perceive their own voice on the background of the group voice which has not yet formed in relational terms. In this phase the sound content is characterised by questions and answers. During the course of the verbalisations, such sound content leads to a questioning of the importance of the group and of a need for adaptation, which opposes the narcissistic tensions expressed by the individual. The discussion involves harmony, feelings of well-being, but also isolation; the attention expressed by the individual regarding the group production is, nonetheless, strong. Only during a later stage do the participants discover their ability to metaphorically distance themselves from the group in order to be able to bring much more content to the group itself. Still in this context the sounds begin to lengthen and the first melodic units emerge together with voices in unison. The type of listening changes and the voice/song comes to the fore and, like glue, tends to produce aggregations, as in the following example:

Here you will have noted that among the many voices one voice in particular comes to the fore, and then is followed by a part of the group; this brings about an immediate change in the group dynamics.

A little at a time the voice of the individual begins to be a part of the whole, therefore beginning to be a “PART of the group” rather than simply “PARTICIPATING in the group” and becomes in turn the means of expression of the first manifestation of group creativity (Bion).

Once unity has been found, the participants can finally allow themselves to play, in the true sense of the word. Indeed, professor Winicott states:
“Playing means doing”. “It is playing and only during play that the individual, child or adult, is capable of being creative and capable of using his entire personality... Playing leads to cultural experience in a natural way and in truey forms its foundation.” In this third phase (group play phase) ancient sounds such as the animal calls which we will hear later are rediscovered. New sounds are also experimented, to which increasingly rich and detailed images and verbalisations are associated. In the improvisations there is the simultaneous presence of long and short sounds as well as sounds of differing intensities, whereas the timbres become increasingly clearer. Another important factor is silence, which also becomes a feature of interest during the verbalisations. Silence is no longer perceived as “the bogey man” within the group, but rather as a necessity.

An important point to keep in mind is that the participants now find it a pleasure to close their eyes. We can say that at this point the group is now able to participate in the improvisation with different eyes and different ears. Vocally the group makes a number of precise choices, no longer being lost in the confusion of “contingent sounds” as occurred during the early improvisations. The group ISO has come to the fore.

Let us now listen to playful improvisation performed by three voices: this group is normally composed of four people, but one was missing that day.

The improvisation begins with a rhythmic motif which will become the leitmotif of the entire improvisation and which is structured in the form of a round (as you can see from the overhead transparency).
RHYTHMIC VARIATIONS ON THE THEME

VARIATIONS AND NEW ADDITIONS

LOW SOUND IN UNISON WITH RISING INTENSITY

INCREASINGLY LOUD SHARP RISING SOUNDS

LONG SOUNDS IN UNISON INCREASINGLY LOUD AND VIGOROUS RISING SOUNDS

LOW SOUNDS TENDING TO HIGH IN CRESCEPDO

MID-RANGE / HIGH SOUNDS TENDING TO LOW of medium-high intensity

VARIOUS LOUD SOUND IN CRESCEndo AND DIMINUENDO

VERY INTENSE RISING SOUNDS
MODULATED “DUCK” SOUNDS

LEITMOTIF

VARIATIONS ON THE THEMERISING SOUND IN DIMINUENDO

LEITMOTIF AND VARIATIONS

VARIATIONS + LEITMOTIV + VARIATIONSCALLS

AEROPLANES INTENSE MODULATED CIRCULAR SOUNDS THE

VARIATION CONTINUES WITH MODULATIONS OF VARIOUS KINDS

LEITMOTIF

CIRCULAR SOUNDS UNISON VOICES OF INCREASING INTENSITY THEN IN DIMINUENDO

In the verses the participants experiment new sounds and intensities which had not been used before until that moment, ranging from soft light sounds to very loud sounds bordering on a scream. The return to the leitmotif allows each of the participants to express themselves and to vary the leitmotif itself during the course of the different “verses”. At the same time a number of old formulas reappear, particularly melodic formulas, which are taken up again varied and elaborated.

During the verbalisation, as well as dwelling on the overall aspect of the improvisation and the chorality, the participants presented some very precise images. The improvisation was described as a “silent film with sound” and the leitmotif was compared to “a safety anchor which, in a stormy sea arrives and save the three of them, who fearlessly went on despite the adversities, and therefore could continue to play.” In this
improvisation one of the participants felt “the Voice”. That means that he was able to express a large part of his emotions.

Physically the participants feel a “pushing in their abdomen” or perceive a sound in their abdomen (one could talk of a vocal birth), while the disturbances initially felt in the throat, the cervix, the chest and the stomach no longer appear. I feel that the appearance of the abdomen is important, in that it indicates centrality, balance, energy!

After these improvisations, where the group feels united, very poor dialogues follows and the group no longer finds the “wonderful game”. In this phase, which we could call the post-play depression or post-partum depression phase, despite the fact that in some cases the improvisations are rich in sounds, a significant elaboration of the past sound experience occurs within the group, and there is the feeling, in some cases, of a return to the early sessions. The group expresses itself in negative and depressive terms, and the participants have the impression of continually repeating the same thing and fear that they have lost that sense of balance which they had felt earlier. A strong sense of frustration and an absence of creativity are characteristic. In this context the memory of the good times is strong, of when the group was creative. These moments are mentioned as if they could never come back again and as if the group had succeeded in magically transforming itself and creating. There are many contradictions in the verbal debate, that is the participants tend to deny the group, but at the same time they ask if they can hear the most inspiring improvisations again. Verbal attacks against the therapist are not uncommon.
This phase is necessary for bringing into the discussion all of the expressions of the group itself, which finds itself fighting between the recovery and elaboration of the content expressed up till now and the destruction and/or the denial of it. The verbalisations become necessary, and often turn into real verbal battles.

Once this moment has been overcome, the group discovers the possibility of communicating and “playing” at a much more profound level (group self-awareness phase). These dialogues are often characterised by long and very intense silences. During the improvisations the vocalisations are very long and intense, and there is the sense that they materialise. During the verbalisation expressions are used such as “the taste of days gone by”, or “the flavour of a wonderful memory,” and the image of the totem pole is at times present. At the same time memories and very concrete present situations are brought together, situations which refer to very strong feelings of presence and reality. The participants feel a part of the group and at the same time they are strengthened by the experience.

Let us now draw some conclusions. I would like to address the main question of this speech: what distinguishes groups of instrumental improvisation from groups of vocal improvisation?

From the dynamic point of view I have found no substantial differences in the developmental process of the two situations: instrumental groups and vocal groups go through very similar stages. The same phases of vocal improvisations which I outlined earlier

- explorative
• self-evaluating
• group
• depressive
• group self-awareness

can also be found in instrumental improvisations. The voice, like an instrument, becomes a real experimental Object, a cathartic Object, a defensive Object, an incorporated Object, an intermediary Object and an integrating Object.

As occurs in instrumental improvisations, vocal improvisations are characterised by the appearance of a leading voice and the voice/song which leads the group to a primordial maternal world.

The key question is whether the voice aides or hinders group dialogue.

Vocal expression has a distinct expressive and communicative mode, and in contrast to instruments it vibrates within the body towards the outside and causes the body itself and the entire feelings, emotions and affection present in each person to vibrate with it. Over the years I have observed that the voice in improvisation groups is initially used as a new instrument and only in later stages is it recognised as one’s own. This first distancing from oneself enable the partial and temporary exclusion of states of anxiety which could block vocal expression. As I noted earlier, the voice is perceived as a foreign element or a novelty which arouses curiosity, amazement and a great deal of bewilderment.
The following expression of the participants during the dialogues outlines this point: “Seeing that I can’t look by myself, look at what my voice is doing, yet I never would have thought it possible!”.

The verbal instruction “to communicate with the voice” also produces three important changes:

- the gradual abandonment of the verbal environment
- the immediate contact with a new instrument which cannot be seen – exclusion of the visual element – which at the same time can be heard through the body
- the discovery of a “new voice” which enables an overlapping of others, but which does not yet represent a song and even less a choral dimension

What springs from this is an entirely new intermediary sound space which is neither word nor song. In its journey the voice will find the road towards its own song and therefore towards an emotive and effective dimension which will lead the individual to nurture an experience of internal change in a continual exchange with the song of the group – therefore, from the interior towards the exterior and vice versa.

What I have described until now regarding vocal improvisation groups can be compared to the stages of birth and separation between mother and child. As a matter of fact the image of an upside-down child appeared during the verbalisation, as well as the scene of a child being born. Often the voice was defined as “life”! Indeed, reviewing the various phases it is clear that the first perceptions are internal, within each individual and within the group itself, just like during gestation. It is a “love song” that is about to be born which contains primordial and violent expressions as we shall hear in the last recording.
Vocal improvisations, however, require greater involvement on the part of the participants with respect to instrumental improvisation, given that using an instrument of the body is a direct expression of the emotions and feelings present in that body. For this reason, to relieve the tension and the emotive stress, I have purposefully included some instrumental improvisation in some groups. The use of instruments allows a temporary easing of the group’s emotive load. At a later stage the group returns to the vocal sessions without further requiring the use of instruments; The use of instruments is, nonetheless, not seen as an interruption but rather as integrated in the entire process.

And now I would like to conclude, leaving space to the artistic and creative experience of the voice which supports the development of these dialogues. Let us listen to an improvisation where the energy of the group is evident and which brings up very strong and intense primordial situations.

I think that comments are unnecessary, and I only wish to add that this moment was followed by a very deeply-felt period. After long and animated vocalisations, when at last the individuals had rediscovered themselves within the group itself, the participants bid each other farewell with an improvisation characterised simply by long silences and very light and intense expiration and whistling. The group silence allowed space for each individual to feel the almost tangible reality of the experience; it also left the participants with the memory, “the art of memory”, as Hermann Hesse put it, “the first of all the arts.”
I hope that the memory of this meeting will remain with all of those present as an enjoyable and enriching experience, as it is for me in this moment.

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Address

Antonella Grusovin
Musician – Music Therapist
Via della Guardia, 13
34137 TRIESTE – ITALY
Tel . 0039.040.775330
e-mail antonellagrusovin@virgilio.it
Experience Of Music Therapy For Selected Alcohol Addicted Clients

Hairo, Ulla
Sibelius-Academy, Finland
uhairo@siba.fi
phone: +358-40-526 8912

Abstract

The purpose of the study “Therapy clients´ experiences of the music therapy process for the addicted” is to find out more information on the use of music therapy in the treatment of alcoholics. The meanings that 15 clients gave to the music therapy process and the meanings they gave to the process in their life context were examined. Clients´ views about significant moments in the therapy and also about their physical and psychological conditions were included. Moreover, the statements of five group leading music therapists were used as research data. The method was a thematic interview and a qualitative analysing process was made by using grounded method (Glaser & Strauss 1967; Strauss & Corbin 1990; Lincoln & Cuba 1985). Music therapy techniques that will be addressed include different group music therapy technics and a physioacoustic method.

The significant moments the clients were able to recall afterwards were especially important for the effectiveness of the music therapy. Those moments were connected, on one hand, to intensive, interpersonal moments in the group and on the other hand, to the moments of active self-processing. Various kinds of physical feelings, powerful experience of emotions, moments of learning, creativity and success and, on the other hand, moments of calming and well-being were moments of significance. A common factor for these moments was a strong feeling of presence and deep experiencing.

Music therapy is capable of facing the client`s personhood comprehensively and at the same time it takes into account the personal life context. The significant moments made the music therapy meaningful and fully experienced and these factors contributed to the client`s life in general. For most clients the experiences in therapy added acceptable stimuli and resources and thus lessened the meaning of alcohol in their lives. In the best cases therapy helped the client to attach to a more temperate lifestyle.
The study took place within five centres for rehabilitation in the area of Helsinki and Espoo, Finland.

Outline of the study

Purpose of the study
The purpose of this study, “Experience of music therapy for selected alcohol addicted clients”, is to examine the clients’ perspectives of the therapy process. I sought to determine: What this form of rehabilitation offered to addicted clients; (a) Which factors of music therapy were especially meaningful for participants; and (b) How the therapy related to participants’ life context in general. The study is still in progress.

Setting
Five different centres for rehabilitation in the area of Espoo and Helsinki, Finland took part in the study. The study included 69 clients who were divided into 13 groups. Group meetings took place first twice a week for two months and then once a week for the rest of the process. The music therapy process for each group lasted about a half a year. Being in the therapy groups was voluntary.

Research methods
In studying the experience of the music therapy process for selected clients, the so-called “significant moments” of that process were given focal attention. These are events and moments that, being phenomenal and meaningful, have impressed the minds of clients. Such moments are clearly influential in the success of therapy and, thus, in the improvement of a client’s well-being (Elliot & Shapiro, 1992).
Clients’ were interviewed shortly after the conclusion of therapy, focusing the interview on the therapy sessions, different treatment methods used and on some facts about the clients’ personal life and background. A thematic interview method was used. In addition to these interviews, other qualitative data involved notes from the therapists’ research diaries, their statements about the clients given after the period of music therapy, and the researcher’s notes from monthly meetings. The main data, then, comes from the feedback received from the clients and the therapists in their interviews. In addition, clients filled out a form at the beginning of the therapy period concerning their drinking history, employment situation, and background. This information was verified during the interview with each client. The working methods and the philosophical-theoretical frame of reference influencing the therapist’s work were also noted.

**Research questions**

The purpose of the study is to find out:

- What kind of meanings clients gave to the music therapy process in terms of their life context?
- Which factors were significant for clients in the music therapy process? In particular:
  - Which were experienced as helpful to the music therapy and rehabilitation process?
  - Which were experienced as hindering the music therapy and rehabilitation process?

This study originally also used various physical and psychological tests. These data were not included in the final study because of the great amount of valuable qualitative research material and because, in this
case, the qualitative approach was found the only possible way to examine individual cases and experiences. However, a third research question was added:

- Has the client experienced any change at the end of the treatment process, compared to the starting point
  - in consumption of alcohol?
  - in physical health?
  - in psychic health?
  - in social relations?

**Research process**

As mentioned above, interviews formed the central data of the study. Analysis of the interviews was qualitative and used a grounded method. According to Strauss and Corbin (1990) the grounded theory approach is “a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon…One does not begin with a theory, then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge” (Strauss & Corbin 1990, 23-24). The grounded method helped outline a large amount of material, revealing sometimes unexpected, new meanings and opening up ways of understanding the data. The naturalistic paradigm on which the study is based, uses the grounded approach as a method of analysis. However, according to the naturalistic paradigm, the aim is not to create new theory. Instead, the naturalistic approach is limited to data processing aspects (Strauss & Corbin 1990, 340). Data take the form of “the constructions offered by or in the sources; data analysis leads to a reconstructions of those
constructions” (Strauss & Corbin 1990, 332). Inductive data analysis is one of the 14 characteristics of naturalistic approach. Other characteristics, typical of this kind of study also include, for example, natural setting, utilization of tacit (intuitive, felt) knowledge, case study reporting mode and idiographic interpretation (Strauss & Corbin 1990, 39-43).

Of the 45 interviews, 15 were chosen for the analysis. Interviews were selected for inclusion on the basis of theoretical richness. This meant including clients from all five therapists, both women and men, and a clients’ ability to express her/himself fluently instead of in one word-answers. Particularly important to selection was the richness of factors mentioned by clients that involved significant moments of helping or hindering treatment during the therapy sessions.

The process of coding interviews started as intuitive and tentative as is common in grounded theory approach. During the first phase of “open coding”, ideas found in 15 interviews were put into different figurative “baskets” using one phrase as an analysing unit. Differences and similarities were determined by asking questions such as: What is this? What does it represent? In the coding process categories were first given a concrete label and, after more analysis, more abstract names. After this conceptual sorting a second phase of “axial coding” was begun. This focused on defining and specifying the categories and testing the relations between them. Corrections in categorization were made as
needed. Along with coding, an “index tree” was constructed. There, the main themes formed main boughs divided into several smaller branches linked with the main themes.

Because of a large amount of data, there sometimes was a sense of “drowning” in the research material. In order to be able to both build an index tree with main categories and their hundreds of subcategories and simultaneously to stay “in touch” with individual cases, notes, main ideas and general observations were written down during the coding process.

The coding continued as “selective coding”. It involved explicating a story line, which according to grounded theory, means “the conceptualisation of a descriptive story about central phenomenon of the study” (Strauss & Corbin 1990, 119). Finally, the aim was to form a core category, meaning “the central phenomenon around which all the other categories are integrated” (Strauss & Corbin 1990, 116). Ten case stories were also written. This was found essential. Otherwise, an individual would “vanish” into the index tree. Moreover, it made it possible to pay attention to each client’s personal history and life context.

Before returning to the final analysis, it is helpful to describe what actually happened in groups and to present Sirpa, whose case is presented here as an example of a typical music therapy client in this research.

**Working approaches and methods**

**Approaches**

Five therapists conducted the therapy groups. Each group was conducted according to the therapist’s own philosophy, education and experience.
Each designed a therapy program bearing in mind the needs of the group and the individuals in it. However, the therapists shared the following common factors in their work.

The therapy given can be described mainly as supportive and solution-centred. Some psychotherapeutic techniques and exercises that analysed the subjects’ past, were also used in some sessions (i.e. depth psychiatry). Some cognitive therapy techniques and short-term therapy exercises were also sometimes used; for example neurolinguistic programming (NLP) exercises. One of the therapist’s clients were members of a residential home for alcoholics and thus the Alcoholics Anonymous principles on which their program was partly based were used. Clients of that specific group thus went through different themes such as emotional life, social relations, responsibility, controlling stress, developing concentration and relaxation ability.

Each therapist used also other art forms in therapy in addition to music. However, the emphasis was on musical and verbal communication (therapeutic discussion) and on interaction with the therapist and between group members. According to Bruscia (1998), this kind of music therapy can be defined as either music-centered psychotherapy or as music in psychotherapy.

83. “The therapeutic issue is assessed, worked through, and resolved through creating or listening to music; verbal discourse is used to guide, interpret, or enhance the music experience and its relevance to the client and therapeutic process” (Bruscia 1988, 2-3).

84. “The therapeutic issue is accessed, worked through and resolved through both musical and verbal experiences, occurring either alternately or simultaneously. Music is used for its specific and unique qualities and is germane to the therapeutic issue and its treatment; words are used to identify and consolidate insights gained during the process.” (Bruscia 1998, 3).
Working methods

Improvisation and other creative music-making was carried-out in group situations. The group members improvised, for example, with Orff- or band instruments or by singing or using the voice in different ways. They improvised using rhythmic or melodic components and played solo improvisations using a certain scale or on certain tones. They also made music or created sounds spontaneously using body parts, their voice or an instrument to express mood and emotion; or they associated sound with some object, a poem, picture or event as a way of stimulating imagination or story telling etc.

In stimulating vocal activities timbre, dynamics and vocal sounds were explored. Sounds could be nonverbal or verbal. The singing of familiar songs (for example associated with some event or feast) was also used. Exploring their own voice or hearing it through microphone was a new experience for many clients. Because one’s voice is such an essential part of ones personality, the aim of vocal activities was to enable each person to add self-knowledge and find new abilities.

During group listening experiences the clients listened and responded to the musical experience silently, verbally or by another modality such as movement or drawing. The main clinical goals were to promote receptivity, to stimulate or relax a person, to evoke affective states and experiences, to explore the client’s own and other group members’ ideas and thoughts, to facilitate memory, reminiscence and regression, and to evoke imagery and fantasies (compare Bruscia 1998, 120-121).
In projective listening clients created, for example, a story, either orally, in writing or via drawing while listening to the music. The group members very often discussed such drawings and analysed them with the therapist and other group members. At the end of the music therapy process the drawings/paintings were collected and analysed by the clients as a reflection of the whole process. Literal works produced in groups were poems, “stream of thoughts/mental images/imagination” or other writing about themes under consideration. Literal works were also used for group discussion or as material for musical improvisation.

Some therapists used movement activities mostly as warm-up or “tuning” for the session. Music often helped to motivate movement, provide structure for movement or to stimulate changes in movement. Movement was also used as the basis for making expressive sound. The aim was to allow an individual to move through self-discovery and to become more familiar with the physical body that was so destructively used for the satisfaction of addiction.

In addition to movement, a physioacoustic chair was also used to add even more consciousness of the body. The chair uses low frequency sinusoidal sound combined with specially selected music to involve not just the ears but the rest of the body with sound vibrations, as well. The chair was used for the reduction of stress, emotional tension and, subjective feelings of pain and, most of all, for inducing a relaxed state. In many groups the session would begin with a twenty-minute physioacoustic treatment. It would help clients to relax and concentrate on the day’s subject. In many groups it was used together with music
listening to enliven imagination. For many clients the physioacoustic chair represented something concrete in comparison to the mental work and music-making that quickly vanished into the air. One could touch the chair, sit back and not necessarily do anything active. These are among the reasons why “the electric chair”, as the clients themselves called it, became so popular among group members.

Relaxation techniques were also used without the physioacoustic chair. Learning to relax without alcohol was important to many clients. The aim was to learn to use relaxation techniques independently when needed.

The basis of the activity in groups was not only articulation and communication through music, but also therapeutic verbal conversation with the therapist and the group members. Verbal activity is important because an individual often conceptualises and becomes more aware after verbalizing. It is also central because peer group members could share their experiences collectively in a safe and consistent place and give their support to others who are also working through their problems. Group meetings were very often based on, or at least started and ended with discussion. The purpose of these moments was to work and resolve, articulate, clarify and assess therapeutic issues or personal and unique musical/artistic experiences verbally whenever possible.

**Findings of the study**

After coding and categorising with the data, a “story line” was summarized as a collage of the index tree and its categories:
**Story line**

The meaning of music therapy in a client’s life was determined by the client’s phase of life and personal values. The place of music therapy as a method of rehabilitation was for some clients of no significant value. For those clients it was considered rather as a form of hobby. To other clients it was of central value and for some clients its value was seen as supporting other forms of treatment, or other forms of treatment were seen as supporting music therapy. Each client had a personal relationship with arts and music in general. Important determinants in the clients’ relations to alcohol – as both helpful and hindering factors - were social environment and, especially, close relationships. Other important elements were commitment to the therapy, attitude and outlook on the satisfactory life.

Helpful impacts for the therapy in the long run were a confidential, enthusiastic, innovative and unconstrained therapeutic climate in therapy group, and an honest and understanding relationship between the client and the therapist. The significant moments that the client was able to recall afterwards were especially important for the effectiveness of the process. Those moments seemed to be connected, on one hand, to intensive, interpersonal moments in the group or with the therapist; and, on the other hand, to the moments of active self-processing. Various kinds of physical feelings, powerful experience of emotions, moments of learning, creativity, success and, on the other hand, moments of calming and well-being were characteristic of moments of significance. A common factor for these moments was a strong feeling of presence and of deep experiencing. The factors that made these moments possible
were music, vibration of sound and the reciprocal action and interpersonal communication between the client and therapist and the group members.

Hindering impacts mentioned by the clients were few. By the time of the interview, some of them took the form of clients’ views, wishes and suggestions. They were very often mentioned in terms of the opposites of helpful impacts. Hindering impacts had to do with heterogeneousness of the group members. With many people in a group there were too many differences of goals, taking part in groups and in some cases playing skills. Some hinderances dealt with rigidity between group members, usually in the early stage of the group process; or with clients’ lack of ability to concentrate or relax in the group. Malfunctioning of technical device or shortcomings of therapy room were also mentioned. Some critique of the therapist was also presented: Clients’ experiences of unevenly attention given to group members, of the therapist hiding behind his/her role, bad timing or wrong focusing in certain situations and, in general, giving too little response to the clients were found to hinder treatment.

Out of 15 clients, no one’s drinking had increased during the music therapy period. Two reported using less alcohol. One client finished the therapy before the end of the process and another had an unusually long sober period during the therapy process. The greatest changes in clients’ life in terms of mental health were better self-esteem, higher spirits, more open mind and more positive hopes for the future. Their ability to show emotions had become more spontaneous. Physically, relief in the state of
tension was reported by many clients, and new means to improve and maintain their physical condition were found. Social relationships with close people had improved and contacts with drinking friends lessened in many cases. Self-control, initiative and freedom from prejudice had strengthened.

The commitment to music therapy added interesting, attractive activity to an otherwise irregular weekly program. In many cases this reduced drinking in preceding days. The significant moments made the music therapy meaningful and fully experienced, and these factors contributed to the client’s life in general. For most clients the experiences in therapy added acceptable stimuli and resources and lessened the meaning of alcohol in their lives. In the best cases therapy helped the client to attach to a more temperate lifestyle. The central contribution of music therapy was the enrichment of life.

As the core category mentioned above, I chose the meaning (content) of life. All the categories mentioned earlier seemed somehow reduce to or amount to the quality of life the client reported experiencing: a person was lacking, searching, finding or enjoying a meaningful life; a life full of enrichment.

**Case of Sirpa**

Sirpa was a woman in her fifties, jobless and without a family. She had a history of a violent common-law marriage. Sirpa often mentioned her sister who also had suffered from an addiction problem and who had died a year previously. According to the therapist, Sirpa often discussed her yearning for an intimate relationship. The most important goal for Sirpa
in therapy was to release tension; alcohol had previously been her “cure” for that problem. Her interview often stressed the negative. She said she felt like “seeking her own self”. However, she worked toward the goal of getting her life settled and had an intuition how to get there.

In the interview Sirpa quite often used the word “oppressive” in connection with moments that created tension in her life.

In certain situations I feel like not making it or that I’m going to be disappointed with myself or that someone else will be disappointed in me…or I won’t be accepted. That’s about how I feel inside…and then I get paralysed…

Sirpa recognized traits of an introspective, sensitive and easily responding person in herself. Her self-doubt could be seen in dependence on other people. She was easily persuaded by the model and influence of others. Many times these situations had to do with drinking.

Sirpa’s consumption of alcohol during the music therapy process varied. She tried without success to moderate her use of alcohol. As a result of one-month of heavy drinking during the music therapy period, Sirpa spent three months in a rehabilitation center. After those weeks in rehabilitation, then, she was able to retain a temperate lifestyle for the rest of the music therapy.

Music and arts in general provided a vital role in Sirpa’s life. She also played guitar and took an interest in singing. She saw herself creative, artistic and musical. She viewed these factors as important in her life. In her opinion, music was an important factor in abstaining from alcohol and for enlivening her occasionally dull life.
For so many years I have been hiding in my apartment. I didn’t even have any music there because the neighbours once complained. I suffered a lot because of it..because I wasn’t able to take up music, until now. Since I finished with drinking I had to replace it by music..

Sirpa believed that rehabilitation should take multiple forms. According to her, music therapy alone felt too one-dimensional. Something else was also needed. The experience of treatment in a rehabilitation centre made her certain of this. At that time she was isolated from her own “circles” of acquaintances. The alcohol-free and stress free environment supported her strongly. Sirpa considered music therapy a hobby-like activity. However, her own interpretation and the therapist’s statement supported the conclusion that the music therapy treatment had in many ways been a significant period in her life. Music therapy was an artistic and interactive experience for her. Her significant moments in therapy were connected to moments of creativity inspired by music, deep interactive moments in the group and moments when Sirpa herself felt her thoughts elicited a respectful response from the group.

Sirpa felt that as a result of relaxation in music therapy she was able to release muscular tension, but hitting the skids during the month of heavy drinking added to her pain again. However, a long, sober period reopened the gate to her creativity. Recognizing and treating emotions via therapy was successful. Sirpa was able to meet and deal with such difficult matters as falling in love with a group member and his disinclination for dating, with her solitude and desire for finding a life companion, and with her sister’s death. In Sirpa’s opinion, the previously mentioned “oppressiveness” of her mind declined, her mind “opened” and her courage, initiative and freedom from prejudice increased. Moreover,
Sirpa felt that her ability to express and put “soul” and her “self” more fully into, for example, music had increased and developed.

Sirpa’s plans for the future included involvement in music and arts and going back to work again. In her opinion, the period of music therapy could have been longer. After the music therapy process she continued taking part in AA-groups and she used less alcohol than before. Relations with her non-drinking friends had strengthened.

**Conclusions**

Each addict is not only an individual as person but the nature of the addiction is always individual, as well. This has to be considered when assessing the effectiveness of music therapy. Another factor to consider is that many of the clients in this study received alternative kinds of care in addition to music therapy. Concerning a follow-up-study, Mäkelä (1998) suggests that no personal data can predict the progress of the addiction. A specific treatment of care usually gives only short-term results; but in the long run the personal circumstances of the individual are more decisive (Mäkelä 1998, 160-161). Thus, no follow-up-study was taken; nor were one-sided conclusions drawn, for example about whether greater or lesser amount of alcohol were used before and after treatment. Instead, the best indicators of the possible effectiveness of music therapy were seen to be the changes in the quality of life and the diversity of factors that contributed to a client’s ability to lead a “normal life”.
The study shows that music therapy with alcoholics profits from being combined with other forms of rehabilitation, if necessary. For example an additional treatment that concentrates more directly on the ways of controlling drinking may also be needed for some clients. An appropriate set of treatment conditions varies with each individual and points to the value of developing and offering new forms of individualized rehabilitation. For many subjects in this study, music therapy offered one important ingredient of a total treatment plan.

Alcoholics who stop drinking can feel like they are living in a vacuum with an oppressive sense of emptiness, as though they are breathing but not actually living. Instead of “alcohol” suddenly there is just “no alcohol”, yet all the other factors in life remain (Toiviainen 1996, 416). Only after experiencing significant moments without alcohol can life become meaningful and colourful again. The strength of music therapy as a form of treatment is in its potential for controlling, supporting and strengthening the relevant aspects of a client’s “normal” life and the quality of the client’s life in general. By eliciting cognitive and emotional processes in the person’s mind, music may open up new possibilities, may discourage cyclic, addictive behaviour, and may help experience emotions and deal with personal problems constructively. Music is an area where one can try new things without the sense of failure or shame so familiar to addicts. Music works supportively in strengthening the harmonious parts of the self (Nummelin 1989).

For many clients, music therapy groups, such as those in this study, have been the only positive social contact with non-drinking people and with
others who are attempting to stop drinking. Such contacts may form a basis of building a “new” life. Many of the clients were unemployed, felt useless from time to time and suffered from a lack of initiative. Music helped them to become more aware of their own physical body and its constructive (not destructive) possibilities. Through successful occasions of significant moments in sessions they could also find new mental resources and developmental potential.

Music therapy is capable of engaging and involving the addictive client’s personhood comprehensively. At the same time, it can take into account variables of the personal life context that are crucial in treating alcoholism. With the influence of music therapy, life without alcohol can also be found to be rich and meaningful.

References


Observation and treatment criteria in music therapy for forensic patients

Hakvoort, Laurien
MA, RMTh

Abstract

This paper presentation describes three major aspects of forensic treatment to which music therapy can contribute: Offence-related behavior, coping-mechanisms and ways of behaving and conducting oneself. These aspects are further discussed with regard to observation and assessment of forensic patients. A music therapy method to assess offence-related behavior is presented. At the moment no such methods are available in the literature (e.g. Gregory, 2000). Hoskyns (1995) made a first attempt to analyze offender’s behavior during music therapy. For this paper the three aspects (offence-related behavior, coping mechanisms and ways of behaving and conducting oneself) as observed in music therapy were scored using the “Forensic Profiling List” (Brand & Van Emmerik, 2001). Some examples are presented.

Introduction

I started my job at the Dr. F.S. Meijers clinic, a forensic psychiatric hospital in the Netherlands back in 1995, as the first music therapist in that clinic. The clinic was specialized in observation, diagnostics, and defining indication criteria for treatment. In a period of three year I saw about 200 individual forensic offenders in music therapy observation. After their assessments patients were assigned to treatment-clinics or had

85. Laurien Hakvoort (MA, RMTh) received her BA-degree in music therapy (1993) in the Netherlands and her MA-degree (1994) from University of the Pacific, Stockton, California. Since 1995 she is working as a music therapist in forensic psychiatry (Dr.F.S.Meijerskliniek) and teaches methodology of music therapy at the Conservatory of Music at Enschede. She was member of the board of the Dutch Association for Music Therapy. Currently, she is secretary of the Dutch Registration and Certification Board for Music Therapy. Work address: Dr. F.S. Meijerskliniek, Gansstraat 164, 3582 EP Utrecht, The Netherlands. Tel.: +31-(0) 30-2569311. E-mail: L_Hakvoort@mi.dji.minjus.nl
to wait for further treatment in one of the prisons. From 1997 onwards more and more treatment was added to the program.\textsuperscript{86}

The aim of this paper is to demonstrate the suitability of a music therapy program for the assessment of offence-related behavior, coping mechanisms and conduct of forensic patients. I will share with you a part of our music therapy observation program. This program is designed for forensic patients, but I expect that it is applicable to all clients who suffer from outbursts of extreme behavior. Music therapy can contribute to different aspects of forensic treatment (compare Hakvoort 2002). Here, I will discuss these aspects with regard to observation and assessment of forensic patients with music therapy.

I have patients coming in, who speak with a very loud and commanding voice; up to seven feet (over two meters) large, weighing more than 300 pound (around 140 kilos). They hit the congas with just four fingers and it sounds like fortissimo! They tell me how strange it is that people are not honest with them or seems to run away. I let them exercise with their voice from very soft to very loud. I let them experiment with tone and warmth and confront them with their way of speaking, e.g. by imitating them or making audio records.

To narrow down my argument I first provide you with some definitions of key-concepts in this paper. My first key concept is ‘behavior’. Behavior is for me all the acts, actions, activities, responses, reactions, movements, and processes that can be observed in a person’s body.

\textsuperscript{86} Since 2000 the clinic has become a treatment-clinic with just a few observation patients a year (about 20).
positioning, action, improvisation, facial expression, and movement (compare Reber 1985). In other words, I focus on the overt, expressed behavior.

My second key concept is observation and assessment. Observation I use to describe the whole process of the patient in music therapy during the first weeks after admission. Assessment is used for all those specific assignments and activities during music therapy that I use to gather valid information about a patient’s pathology and personal strengths.

The third key concepts are the patient’s three ways of functioning: (1) offence-related behavior, (2) coping mechanisms, and (3) ways of conduct.

1 Offence-related behavior is those responses during the therapy that show similar or analogue patterns with the assumed behavior leading up to the crime.

2 Coping mechanisms are those patterns in acting and mental representation that help a patient deal with difficulties, solving problems or handle inconvenient events.

3 Ways of conduct is the only description that best resembles the Dutch word “handelingsvaardigheden”. These are the skills patients use while relating and interacting with other people or with situations.

Forensic assessment at the Dr. F.S. Meijers Clinic

Because of the history of the dr. F.S. Meijersclinic as a selection clinic, observation and assessment is its most important expertise. A major caseload of observed patients was collected through many years of experience in our clinic. Patients are observed and treated by a multi-disciplinary treatment team consisting of a head of treatment (senior psychologist), unit psychologist, art therapist, music therapist,
psychomotor therapist, psychiatrist, social worker, vocational counselor and group-workers. Each member of the multidisciplinary treatment team offers a specific contribution to ‘Forensic Psychiatric Profiles,’ i.e. a bio-psycho-social-emotional and risk assessment profile, which we make for all of our forensic patients. The close deliberation within the multi-disciplinary team and a carefully articulated assessment strategy from the head of treatment, obtained by means of thorough dossier analyses, is a prerequisite to investigate the ways of functioning of patients.

Psychologists in the multidisciplinary team reflect on the cognitive behavior of patients and try to influence their cognition and emotion. Psychiatrists test the mental, hormonal, chemical reactions in a patient’s body and try to establish behavioral change by the prescription of medical drugs. Music therapists (together with art and psychomotor therapists) make a major contribution to the observation and assessment. Music therapy offers additional information about a patient’s overt and emotional behavior; more specifically, the offence-related behavior, coping-mechanisms, and ways of conduct.

Participation in the observation and treatment program is not mandatory. During the seven and a half years that I have been working in the dr. F.S. Meijers clinic I observed over 300 forensic offenders. About 30 of them refused to participate in music therapy assessment immediately at invitation or after the first session. I terminated some observations after

87. This assessment profile (FP40) was developed by a research team from our clinic and is now further validated in forensics in The Netherlands. The profiles are tailored to the problems, risks and characteristics of the forensic psychiatric population. By now about 40 scales are created to measure the different characteristics of the forensic population (Brand & Van Emmerik, 2001).
two or three sessions, because music therapy had a negative influence on the patient’s well being (e.g. suicidal thoughts, psychotic decomposition).88

**Essentials for forensic assessment with music therapy**

In this section I describe the main assumptions that underlie the music therapy assessment program. My experience with forensic patients in the program has shown three important essentials for an assessment within music therapy: (1) the importance of overt and active behavior; (2) provoking habitual versus situational behavior; (3) a methodology stressing replication in time and the application of multiple criteria.

**The importance of overt and active behavior**

In the first place, overt, expressed behavior is very important for this population. The major contribution of music therapy to the overall assessment and observation of a forensic patient should be to investigate missing competencies and explore existing capabilities: cognitive, behavioral and emotional. Forensic assessment has to be focused on the active, overt behavior that might have contributed to or preceded the offence of the patient. The offence has been active, overt behavior. Hardly any victims occur after a *verbal* offence, but they almost always

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88. An example is patient F, a man suffering from schizophrenia. He arrived in the music therapy room whimsical, but at ease. He was doing pretty well at the unit. Each music therapy session he became somber and even suicidal within half an hour. It did not matter whether we listened to music or played an instrument (and without any difference for the style or kind of music). Music confronted him too strongly with his loss of freedom and (mental, physical and emotional) capabilities. In close dialogue with the treatment coordinator I decided to terminate the music therapy observation after three sessions, because no single intervention of me (whether it was musical, verbal, structural, et cetera) seemed to aid mister F. This client should be put back to prison after seven weeks and I did not want him to be suicidal than, without the assistance of any mental professional.
incur by active behavior. Forensic patients are convicted because of their active, overt behavior.  

Why is music therapy so appropriate for the assessment of this type of behavior? The key idea is that people express themselves, among others, in their active behavior; in their handling of material, instruments, relations, emotions, situations, et cetera. In this stage of treatment we assess overt behavior and expressions, no psychological or symbolic interpretations of musical performance. Forensic patients are well equipped to maintain a manipulation with and within symbols for a short period of time. For example, when a forensic patient does not want to show anger, he is inclined to play a soft sound. His movements, however, could be very tensed. In order to prevent this kind of manipulation, I do not ask patients to express emotions musically (everyone can act according to my opinion), nor what emotions they feel when listening to certain pieces of music. I observe what is visible and audible in their improvisations. I watch for tempo changes when agitated, because of a difficult assignment. I listen to pulse structures when a patient has to continue his own beat when I am trying to disturb it. I observe reactions when a patient is left with only ten keys of the piano and see what his reaction is in the next improvisation: is it revenge? Does he cling to rigid structures? Is it fear, suspicion, wariness, alertness, fun, or sadness?

89. Of course this does not mean that talking about the offense is not important (in fact it is essential for the patient to have some cognitive grasp on what has happened), but the assessment and treatment of his active behavior has the important function described here.
Example: Assessment of overt behavior during therapy

Patient A. comes to music therapy for the first time. He walks in and sees the drum set. He chooses to play the set, but when he sits behind this massive instrument, it turns out to be too difficult for him to play. What will he do now? Does he try to play it anyhow? Does he immediately give up? Does he become angry, or irritated? Does he verbally blame himself for failing; does he blame the instrument, or me? Does he ask for an example? Does he stay behind the instrument or walk away? For the same reason, I never start with symbolic themes or cognition, and never ask patients to express their emotions musically. For example, I would never ask: “How would you play sad?” While making music or improvising I watch what kind of emotion shows up in a patient’s posture, facial expression, muscle tension, and the like. Therein I observe tension, relaxation, pleasure, joy, boredom, uncertainty, anxiety, somberness, sadness, irritation, anger or aggression. Additionally, I look for a congruency between the patient’s encounter of the situation, the music and my observations of his body language.

In this respect, the added value of music therapy is the fact that it can examine minutely the missing competencies, the existing capabilities, and coping-mechanisms of a forensic patient. From the process of making music, music therapists are able to observe the patient’s capacities, skills and deficits. If you read psychological reports it describes what a patient tells and what impression he makes on the psychologist or psychiatrist. Group-workers describe the patient’s group-behavior. Active music therapy (together with art, drama, dance and psychomotor therapists) is powerful in uncovering the behavior, which a

90. By assessing and checking such strategies I clearly observe a persons coping mechanisms.
patient expresses when he is *in action*. For their treatment it is essential that forensic patients learn new behavioral strategies or learn to handle their actions differently.

**Habitual versus situational behavior**

Overt and active behavior can be determined by habits and by situation. People react to or confront new (unfamiliar) situations with their habitual behavior; the basic behavior they are most familiar with (compare Piaget). This behavior is reinforced by the situation at hand. Some situations are so specific, that they provoke *situational* behavior. If this behavior occurs under different circumstances, it is defined as *habitual*.

**Example: situational behavior**

Patient B. comes to music therapy for the first time. He cannot decide with what instrument he would like start. I offer him the possibility to play the piano. We both sit at our own piano. I give him an assignment, varying between a free improvisation, to adding more and more structure, for example an action-reaction game or a simple melody (which I adjust, depending on his expected mental strength). I observe his actions and reaction. What does he do? Imitate? Play variations? Improvise? Connect? Seclude one self? How intensely is he involved in the activity? How independently can he function, does he show any initiative, has he any reflective possibilities? This assignment gives me information about the ways of conduct and the coping mechanisms of a patient.

For me behavior is habitual if it occurs in at least three analogue but different situations. Situational behavior can hardly be influenced, in contrast to habitual behavior. However, habitual behavior cannot be assessed easily (otherwise a test of 30 minutes would do instead of the four to six one-hour sessions I need now).
Example: habitual behavior

Patient C. plays the lyre. There is no musical contrast audible (no sudden high or low notes, no dynamic changes, and no rhythmic syncope). I could jump to the conclusion that C. avoids vehemence or violence, is rigid or does not dare to show any outbursts or emotions. But a lyre sounds very soft by nature. It is more important to examine this behavior with other assignments. What happens with the absence of contrast in his music when he plays the guitar with a similar assignment as I gave when he played the lyre? How does he handle moments that I bring dynamic, tonal, rhythmic, contrast in my accompaniment? Does he follow, withdraw, and exaggerate?

Some remarks about methodology

The latter example shows how important it is to use different assignments to assess specific behavior. This avoids jumping to premature conclusions. In research methodology this issue is known by ‘data triangulation’: measuring the same concept with different indicators. Additional to the use of multiple assignments, I repeat the same assignments over time, in order to establish a reliable assessment. Moreover, I create some variation in situations because only when a certain overt behavior appears in analogue situations, or after multiple repeating, one can speak about the habitual, basic behavior I am interested in.

4. Three fields of assessment

In section one I distinguished between three ways of functioning: (1) offence-related behavior, (2) coping mechanisms, and (3) ways of conduct. I try to distinguish between the habitual aspects of these ways of functioning and the situational aspects in order to make a thorough assessment of the aims for future treatment.
The three ways of functioning become apparent three fields of assessment of the forensic patient in a music therapy observation program:

A: Common behavior;

B: Musical behavior;

C: Social-emotional behavior.

The combination of those three assessment fields with the ways of functioning of a forensic patient establishes the fields of forensic assessment in music therapy. Table 1 provides an overview.

<table>
<thead>
<tr>
<th>Overt behavior → Habitual aspects</th>
<th>Fields of assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common behavior</td>
<td>Musical behavior</td>
</tr>
<tr>
<td>Social-emotional behavior</td>
<td></td>
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</tbody>
</table>

A. Common behavior

In order to assess common behavior I observe the patient’s motivation for therapy and the behavior that emerges from the combination of making music and the possibilities, limitations or problematic behavior of the patient. I consider:

- Protecting competencies: Those qualities that are healthy and defends a patient in a proper manner from harm
• Self-esteem and self-concept: How much ego-strength, self-reliance or self-confidence a patient has when he has to perform an action.

• Concentration proficiency: Besides the length of concentration, I observe the intensity and span of the concentration.

• Reflective abilities: Is a patient aware of what he does and what impression he makes? Does he have any insight?

• Structural and shaping capacities: What arrangement does a patient need to make music. Can he experiment? How sound his improvisations? What musical forms are audible? Does he need extra support to improvise, what kind of help? Does he or his music get entangled, chaotic or confused? Does he use examples? How (emotional) stable is a person?

Example of the assessment of common behavior:
A patient has just been hospitalized after serving his sentence. He refuses to participate in any therapy, activity or observation program. Only for music therapy he makes an exception, because he loves to play the guitar. I observe how he reacts to music as a therapeutic tool. Does it influence his motivation (and in what direction? Does he refuse to ever play a single instrument again, or am I able to motivate him to participate in other therapies as well?) Will he become hostile, splitting, afraid, or does he react realistic when I reflect on or describe his (musical) behavior.

B. Musical behavior
When I examine musical behavior I mainly focus on how the forensic patient works and acts musically: how he handles instruments and assignments, and his working methods (musicality, the use of tempi, rhythm, melody, harmony, shaping, et cetera). My main interest is in the behavior, which appears through and within the music. The patient responds in his own, unique way to music. I mainly focus on overt behavior and conduct, register this behavior and will make an interpretation only after ascertaining this behavior as being habitual.
Example of the assessment of musical behavior:

I ask a patient to play a rhythm on the djembee (I am no more specific than that). I observe whether he accepts the assignment, what he adds, refuses or makes up. Is he careful or careless with the instrument; do his rhythms fit a beat; is it repeating, repeatable? Does he play impulsive, agitated, expressive, searching or does he follow a wait-and-see policy.

C. Social-emotional behavior

When I assess a patient’s social-emotional behavior I especially pay attention to his reactions to the establishment of the therapeutic relation. How and what kind of contact does he make verbally, musically, behaviorally, and emotionally? My main interest lies in the verbal, musical, behavioral and emotional interaction with me, as a music therapist, and as a woman. Their active behavior in interaction is very important, for all offenders have caused victims. I establish whether there is any empathy present; whether the patient has any insight in the way he relates to other people; whether he has a clue of the influence he has on other people, as well as other people on him, and the impression he makes on people.

I consider:

- Emotional balance: Does the patient expose any sudden behaviors? Is he impulsive, restricted, dramatic, or narcissistic? Is their congruency between the expressed emotions and the perceived ones?
- Interaction with the therapist: Does the patient imitate, follow, initiate? Is the patient friendly, hostile, or indifferent? Is he able to listen to instructions, or to the music?
Design of the program

Introduction to the program

The program contains six individual sessions. In the first session, I explain what I will assess, how and why. I try to be as open and explicit as possible.

Example of the introduction: 91

“As you know music therapy is a part of the observation- and assessment program of this clinic. I am here to help you make music, even though you might have never touched an instrument. I watch and listen to your attempts to make music and how you listen. You can hardly do anything wrong in here. I look for what instrument, what kind of music or what musical situation (playing together or separate) gives you joy, even if you have never made any music. I assess what this has to do with you as a person and about your behavior. I will give you assignments, but please feel free to bring in your own ideas or musical wishes as well! I will tell you anything that strikes me, not always immediately but if you have any questions, please feel free to ask! So, do you have questions? No, than what would you like to start with now that you are in this room with all these musical instruments.”

Structure of the sessions

My observation program consists of 6 sessions. It constitutes:

1 Getting acquainted, explanation of music therapy and the observation process, establishing a work-relation
2 Establishing a work-relation, (shallow) exploration of common behavior
3 Assessing common behavior and related feelings (pathology)
4 Assessing offence-related behavior and feelings (pathology)
5 Exploring treatment possibilities and impact (covering up)

91. This is a fragment from my introduction of the music therapy program to a patient. My intern took down minutes from the session. I leave out all the “uhs” and “uhums”, as well as the reaction of my patient.
6 Concluding observation program; discussing the assessment- and observation-rapport (to seek an agreement for future treatment goals and objectives with the patient; conceal explored behavior and feelings if the patients will not continue with a therapy-program.

In the sessions I always relate to the interests and capacities of a patient. By unassuming and creating moments of success I carefully build a (short-term) work-relation. I assess which instruments; activities or (musical) shaping allows the patient to work the most intense with his problems. The most important part in this assessment is keeping an optimal balance between exploring a patients (pathological) behavior (which can be very confronting) and to keep him motivated to participate. This requires from me flexibility, mitigation, giving trust and humor.

Of course I do not always succeed in exploring offense-related behavior in the third session, due to major resistance, impenetrability or incapability of the patient. Most of the time this results in a longer observation period or in another treatment-indication.

**Examples of musical assignments**

I regularly offer a number of standardized assignments for the first two or three sessions. These assignments reveal different aspects of a patient’s action-behavior. I adjust the assignments to the skill level, capacities or

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92. I cherished the hope to create a complete standardized observation program. There was however a too large range in the variety of disorders, pathology, reflective insight, offence, treatment-motivation and character of the patients. A proper validation of an observation report was only possible if a specified assessment and investigation took place. I also decided to meet with patients on an individual bases during music therapy, because I could more easily relate to their offence. Perhaps the first two or three sessions could take place during group-music therapy (especially when you have to deal with a major congregation of patients). To work more in-depth I prefer to work on an individual bases as well. It all so helps to respect privacy regulations.
clearly observable problem or limitation of the patient. Below, I provide some examples of the most frequently used music therapy assignments, which reveal a lot of information about the ways of functioning.

From the fourth session onwards I hardly use any standardized assignments, because I try to focus more specific on problem-areas. Here I assess what problem-behavior is linked to offence-related behavior. What behavior is most striking as being pathological? Is it apparent in the musical behavior and related to the offence? Forensic patients have a bunch of peculiar behaviors. Nothing and no one can cure them from all their problems. Treatment is pinpointed to declining offense-risk. Taxation of offense-risk itself is already a very difficult matter. So we focus on the behavior that appears to be related to the offence.

**I. Drum-set assignment**

This assignment provides a first impression of a patient’s frustration tolerance. The patient is invited to try to play the drum set, at least once. I watch the first reaction of the patient when he steps behind the instrument and sits down. Does he immediately dare to play? Does he wait? What is the first thing he plays (does he listen to tone, timbre, beat, rhythm?)? How does he structure himself while exposed to such a number of instruments? Can he ask for help? How does he ask for assistance? If I play an example, what does he do with it? How does he react? What seems to be the parts that caught his attention? What and how does he memorize?

- *Example* of the first drum-set assignment:
I will present you a moment of a music therapy session of patient A. He has overcome his first boasting on the drum set and asks me whether I can teach him the rhythm I just played for him. I explain what he should do: Right, left, hands, feet. He has major problems coordinating his body, but he does not give up and continues his effort. His perseverance is big and this frustration only seems to make him more determined. The stress is rising. Strain is evident in his muscle tension and audible in the beats following one another faster and faster and more cramped. He does not stop before I advise him to and even than he is reluctant. His behavior gives me the first information about this patient’s concentration. He can concentrate himself well, but looses track of his concentration span and does not recognize the moment it wears down. Information about his skills: his left-right coordination is all right, his hand-foot coordination is underdeveloped; he has perseverance that seems to make him unrestrained. Information about his emotional balance; tension is apparently easy to rise. Of course I will not jump to hasty conclusions, but I will try to verify or falsify these observation in different musical assignments.

II. Drum pattern assignment

This assignment aims to make an assessment of the stability of a patient. This exercise gives a good first impression and a lot of common behavior. I teach a rhythmic drum pattern on drum-set or drum. What is his motivation to keep trying or give up? How well and how long can he concentrate? How aware is he of his span of concentration? How long does he persist? When does he give up? How difficult can I make the rhythm before he ceases to recall it? How are his gross motor-skils, his coordination (between hand-foot, hand-eye, left-right)? What happens if he does not succeed (immediately)? Does tension rise? How does tension manifest itself (physical, in mimic, verbal, emotional, in reflections, tics)? What happens after achievement? What reactions are visible?

93. An intern asked me once: “It is amazing how much information and assessment-hits you can perceive with one single assignment!” Of course, the reliability and validity of the information depends on the multiple replications in analogue situations.
III. Dalcroze assignment
This assignment aims to make an assessment of the leniency of a patient. Therapist and patient are playing on one piano together. Depending on the piano-skills of the patient I start with an exercise on the black keys. I ask him to play single notes alternately with me. As soon as one has stopped the other person can play a single note. I observe whether they get into a swing or not; how they react if they make a “mistake”, whether they stop if they want to.

IV. Piano improvisation assignment
This assignment aims to make an assessment of the interaction capabilities of a patient. I ask the patient to start in the same manner as the Dalcroze assignment and than switch to a free improvisation. The only task is to end together. This exercise gives me a lot of information about interaction, relation-building, accepting limits, autonomy, keeping and respecting boundaries. How does the patient listen? Does he wait for me, or dare to start alone? (How) does he react on my improvisation? Does he play his own improvisation? What musical parameters are observable?

V. Keyboard territory assignment
This assignment provides an impression of a patient’s capability to set and accept boundaries. I ask the patient to repeat the exercise, sometimes with a role switch or using a different scale. This time however I use more and more keys, hardly leaving the patient any space. Depending on his reaction I stop when he has no or hardly any key left or continue playing when he used adequate coping strategies. I discuss this incident,
help the patient to reconsider other solutions and check what a patient has learned from this situation during the next improvisation. This assignment often provokes analogies with offence-related behavior concerning relational offenses.

- *Example: Offence-related behavior.*

I recall one patient, mister E, who proved to be of the talkative kind during the first three sessions. His musical expression is very rigid and seems to be dominated by fear of loss of control. He is not aware of his severely disturbed stress-regulation (which is audible and visible in his musical behavior). He looses contact with me while playing and is not aware of his own nor my (emotional) boundaries (especially endings, irritation or boredom). He is constantly searching for harmony and peace. His (pedosexual) offences seem to derive from malfunctioning of his regulation of anger and tension and the inability to register and accept other peoples’ boundaries. His treatment will focus around these themes. His demand for harmony and peace will receive no extra attention, because this seems not to donate to the circumstances surrounding the offence.

**Documentation**

I write a written report about the assessment and observation period and I fill out a specially designed checklist\(^{94}\), which is additionally used to short oral reports. Schematically, table 1 covers the report. I go through my written report with the patient during the last session and try to put his comments in the report as well. The report is a description of those interventions that had good outcomes and those that proved to be invalid,

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\(^{94}\) Together with the research-team of our clinic and my colleague art therapist I have been working on a standardization of our observation reports. The first checklist we created offered us a large amount of observational criteria. We used it frequently as a checklist for our written reports. This makes our observations more measurable and explicit. When the research-team started developing Forensic Profiles (Brand and Van Emmerik 2001), we had no time to participate with our observation checklist due to an overcrowded music therapy program. Only recently we linked the creative therapy checklist to the Forensic Profiles.
and it contains those aspects that are necessary to validate the results and conclusion.

I describe how the patients handles assignments and what implications this has for his treatment. Concentration is an important issue for future development as well. As fourth issue I describe the way that the patient related to the instruments: his specific actions, reactions, rigid patterns, experimentations, action procedures and the possible connection between those actions, its mental representations and offence related behavior.

Subsequently, I analyze the patient’s improvisations. I check his musicality, which might have an impact on the results or can have consequences for future treatment. I make a thorough analysis of the emotional character of the improvisation (sometimes using the Improvisation assessment Profiles of Bruscia). I provide an analysis of the form and structure of the improvisations. Is a patient able to play alone, what does he use as a hold (familiar songs, explanations, examples, experiments, et cetera)? Is his playing structured; is there any pulse, beat, pattern, melody, harmony present? This gives an insight in a patient’s mental stability, his coping strategies and his ways of behaving and conducting himself.

I conclude with a description of:

1  Observed pathological behavior within the music
2  Conducts related to offence risk
3  Treatment aims and strategies
4  Prognosis of manageability and time-investment
5  Possible (contra-)indication for music therapy treatment
**Contra-indications for music therapy**

I have a strong opinion about contra-indications. The way I do that seems to be rather controversial. Besides those contraindications deriving from terminated therapies, I have three other reasons for termination. A patient is contraindicated for forensic music therapy if one or more of the following situations apply:

1. **His overt- and active behavior in music does not show any signs of offence-related behavior.** The absence of offence-related behavior can have different causes. For example a patient might lack any musical feeling or affinity with music, so he is not at all capable of handling the music as a tool for behavioral or emotional change.

2. **There is no evidence of a transfer of musical behavior to daily life during the observation period (even after prolongation or intensification of the music therapy).**

3. **A patient shows healthy behavior while making music and is able there to use adequate coping strategies when faced with unexpected situations.**

**Example of contra-indication form healthy musical behavior**

Let me give you an example of this last situation: Patient G. suffers from a severe drug addiction since he was 14 years old. He has lost any structure in his life, is not capable of making any plans for a day and is completely dependent outside-structures to live a life less criminal. He has murdered his landlord, because he was certain this man would attack him (when the man probably entered the kitchen to wash his dishes). He has played drums for many years in different juvenile corrections facilities. The first sessions in music therapy he acts like a whirlwind. He touches each instrument but only short before skipping to the next one. Not one of my interventions changes this behavior, whether I play, listen or speak to him. I link this to his daily-unstructured behavior. It is evident at the end of the observation-period that I have no influence on this behavior what so ever. The third session I ask him to sit down behind the drum set. Suddenly he is able to structure himself and starts playing different beats and patterns. He feels uncomfortable as I watch and observe him, but is willing to prove that he can structure himself on the drum set. He is not able to make a
plan of what and how he will practice, but while exercising, he works very structured on technical, physical and emotional problems he encounters. If I join him musically during the following sessions he is able to play whole songs and keep a steady beat (even if I slow down or speed up). He hates it when I experiment with his behavior. But as long as the musical structure is clearly present he can play along, rehearse and re-establish his old drum techniques. Of course offence related behavior is apparent during the process of making music. There is however not a single piece of evidence that my interventions make any kind of transfer to his daily life. Besides that I see a complete healthy pattern in his drumming techniques and the way we can play music if he plays the drum set. I do not want to intervene into this healthy behavior with therapeutic analysis and treatment.

**Conclusion**

I have presented to you some examples of the music therapy assessment of forensic patients. Music therapists can assess existing coping-strategies and offence-related behavior of a forensic patient clearer than a verbal therapist or group-worker would. This should be advocated more explicitly. This could be validated scientifically, using the Forensic Profile Lists. That is where the power lies of music therapy and that is our expertise and professional skill!

**Literature**


Lee, & S. Hoskyns (Eds.), *Art and Music: Therapy and Research* (pp. 138-151), London/ New York, Routledge
The Cradle

Most of us have spent many hours in a cradle, pram or cot. We use the phrase ‘from cradle to grave’ meaning a lifetime. Cradles are decorated, carefully positioned and adorned with cuddly toys, musical mobiles and soft furnishings. They’re the place that adoring parents gaze at their sleeping child with wonder. They become the outward demonstration of the inner caring of the parents. Cradles get passed down through generations and become a treasured part of some families’ heritage. They could be described as symbols of our species survival.

A cradle is designed to keep the baby safe and comfortable, and to operate effectively it needs to be supported in a way that will comfort the baby in the absence of the mother. It needs to have both strength and flexibility. The cradle is a significant part of the baby’s primary environment.

In this paper I want to use the image of a cradle held by the branch or bough, as in the nursery rhyme, to represent the total caring environment of an infant, which includes, “the motherhood constellation” (Stern1998), or “the primary maternal preoccupation” (Winnicott 1971). This is the complete duality of mother and child intertwined, and from this grows the infant’s total welfare.

Daniel Stern describes the importance of the motherhood constellation.
'The motherhood constellation remains, by far the prevailing psychic organisation for the immediate future, so whether or not it is desirable from a socio-cultural point of view, it is what must be taken into account therapeutically now'

(Stern 1998)

The broken cradle

In my practice I work with children whose traumatic experiences have brought them into the care system and who have been placed for adoption or long term fostering.

For these children the bough broke and the cradle fell.

I want to look at what happens to the child when the branch and cradle system fails. I want to present the causes of trauma and how this effects not only on the child but also the carers; and then to present the Music Therapy part of a Creative Attachment Therapy model that I am developing, together with an art therapist and a dramatherapist. The approach could be adapted for use with birth families but the issues are considerably different and there isn’t space to explore them here.

From my experience as an adoptive and foster parent, and from my studies and experience of other attachment focused therapeutic approaches with this client-group, I am developing a model that I am happy to offer for dialogue and debate.

But first I want to make it clear at the beginning, that I am aware that we all suffer traumas of varying degrees and I know that this means that many of us have come to adulthood baring the scars of past traumas. It
may be therefore that some of what I say will be painful to some listeners and I acknowledge and respect that pain.

So the cradle, representing the total environment of the infant, is held in place by the branch, which is made up of 4 support systems. They are physical care, emotional attunement, social interaction and spiritual holding. These four support systems all involve both the mother and the child, and the way the support systems interact forms the strength and the flexibility needed for secure attachments. If there is any temporary weakness in any one system, the others compensate. Infants don’t get a perfect environment or perfect parents, but these interacting support systems make a good safety mechanism, which means that ‘good-enough’ parenting is all we need for healthy social and emotional development (Winnicott 1971).

But when a combination of the systems that make up the branch and cradle are missing, or fail, the resulting traumas can affect the actual physical brain development of the child. Allen Schore, says that

“the early social environment, mediated by the primary caregiver, directly influences the evolution of structures in the brain that are responsible for the future socio-emotional development of the child.” (Schore 1994)

It does not require actual physical harm for a baby to be traumatised. A child is not born with the ability to regulate his own affect. This could be described as an emotional thermostat. For healthy development the child needs his mother to transfer this emotional thermostat directly to him - to down load it. She does this by her preoccupation with him, by giving
him signals about what is and isn’t safe, and by attuning to his distress. She moves him to a regulated state through nurture, comfort and holding. Schore tells us that a child whose affect is not regulated by his mother - the mother who is not emotionally available - can go into shock, and shock is trauma, and trauma affects the neuro-biological development of the child, and this leads to long-term negative effects. The four supports have all failed. The physical care of the mother is erratic, emotionally the mother and child are in discord, the social interactions are ambiguous and the spiritual holding of the mother is either self absorbed or directed elsewhere. The system breaks and the child is repeatedly traumatised. And the earlier the trauma, the greater the potential for long term damage.

There are three clusters of causes of trauma. The first is physical pain and significant harm. This includes not only physical and sexual abuse, but also painful medical conditions and treatments. The second cluster is the unavailability of the mother. This includes emotional or physical unavailability, post natal depression, the child being cared for by a series of carers, substance abuse of the parents or abandonment. The third cluster is the inability of the mother to protect either herself or her child from significant harm or repeated shock. This section includes the child witnessing violence, or seeing the mother in fear. The child may even become the protector of his mother and see himself as the parent.

The trauma that is caused by repeated experiences has different effects to the acute trauma of the single crisis event such as an accident or tragedy.
A child may suffer post-traumatic symptoms from acute trauma but this is less likely to affect their attachment patterns and working models.

**Working models**

When a child is the centre of his mother’s universe, and the branch and cradle are in place, he forms secure attachments and develops a positive working model. The child learns “I am loveable” “My parents will keep me safe” “I can get my parents to give me what I need”. He learns emotional security, social skills and respect for boundaries. But if the mother is unavailable, and has a preoccupation with other things, or herself, or if she creates or lives in, a violent and abusive environment; the bough holding the cradle breaks and the cradle is no longer a safe place.

The child develops disorganised attachments and a negative working model.

He learns “I’m am not loveable” “I may even be to blame” “I can’t trust adults to keep me safe” “I can’t get adults to give me what I need” “I must look after myself”. He learns trauma survival strategies of hyper-vigilance, dissociation and control.

Hyper-vigilance means that the child is in a permanent state of arousal. His body is ready for danger at all times, and he cannot relax. This is like the animal in a herd that keeps watch while the others eat and sleep, except that the traumatised child gets no respite because he does not trust that anyone else will keep them safe. This intense hyper-vigilance
affects the child’s physical bodily functions, his concentration, and his energy levels.

Dissociation means that the child has developed protective strategies so that at times of anxiety and danger he can separate himself from the pain. This could be by switching off, or going into another personality state that protects the inner child, or by erasing the memory of the trauma. The child is then able to use these strategies at any time of perceived stress and anxiety. They can block all feelings of pain, sadness and fear, but the difficulty is that these other protective personalities can take them over and be resistant to most forms of help. Here are some examples of what children have said to me about their dissociation. They are talking about another part of themselves.

“It’s like two armies fighting in my head, and they won’t let me out”

“When he’s in a rage and throwing things around I go to my bedroom and read a book”

“I didn’t hear you Joy, ‘cause she was whispering in my ear”

“I don’t let her go on holiday. She’d spoil it”

Controlling means that he does not trust any adults to keep him safe or even that they are safe, so he needs to be in control of his environment. The child needs to know what is happening at all times, how adults are going to react and what motivates and provokes them. He needs to understand what is expected of him so that he can decide how to take control and when are the best times to refuse co-operation to create chaos and confusion. Because it is when there is chaos that he feels most in
control. This can become convincing and complex, with the child behaving very differently in different settings. This also has a detrimental effect on the parents or carers who are struggling to keep their child safe. The child is resistant to their control and so needs continuous supervision, but all the time the child is rejecting this supervision. This increases the stress levels causing frustration and anger.

When a child has the seeds of a negative working model - which is his way of making sense of what has happened to him - he will put considerable energy into repeatedly proving to himself that he is right. He will ask for attention when he knows the answer will be ‘No’ so that he can say to himself “They don’t want me”; he asks for things he knows he cannot have; he destroys evidence of good work or praise; he rejects any suggestion that there might be another explanation for his past experiences - one that doesn’t blame him. The solutions the child creates to survive trauma become the presenting psychological problems of the child or adult coming for therapy. In her chapter about her work with schizophrenic and psychotic patients, Inge Nygaard Pedersen writes:

> Paradoxically, the solution the patients have often developed to cope with their life situations, may, at the same time, be an important part of their psychological problems. In this case, the cause of dysfunction is circular. Cause and effect determine each other in self-maintained sequences. (Nygaard Pedersen 1999)

John Briere lists seven major types of psychological disturbance found in adults who had been abused in childhood. These are:

- Post-traumatic stress
- Cognitive distortions
- Altered emotionality
• Dissociation
• Impaired self-reference
• Disturbed relatedness
• Avoidance
(Briere 1992)

It makes sense that these disturbances would have been evident in some way in the childhood of the patients and not recognised. But there are early warning signals of the effects of trauma in a child and these are important because the earlier the intervention, the better the chance of long term benefit. These warning signs include:

• Avoidance of eye contact
• Resistance to touch
• Self-soothing
• Inability to accept comfort
• Negative clinging behaviour
• Superficial charm to strangers

**The new cradle**

So if we place a traumatised child in a new cradle, on a new bough with highly motivated parents, what is the effect? Will this be enough to change the working model of the child, and for the child to learn that the world is a safe place?

The child has not developed a sense of trust in adults and has decided that he needs to keep himself safe. All adults are seen as potential abusers and that includes us as therapists. He is not going to be willing to let go of his tried and tested survival strategies that keep people at a distance, or
protect him from harm, to take a new set of survival strategies that rely on trust and respect. Dan Hughes, a consultant clinical psychologist in USA, writes:

In the family we are asking the child to learn how to enter into deeply engaging relationships with the adults who care for him. We are asking this of a child who was ready to enter into such a relationship as an infant but who then met with abuse, neglect rejection and humiliation. We want him to believe that we are different. We want him to trust and try again. (Hughes 1997)

But beneath the protective behaviours is a child who is hurting deeply, and those feelings need to be expressed in some form. So how?

Caring parents are right in the path of all their children, ready to attune to their child’s messages of need. So the substitute parents are ready and available to do this for their foster or adopted child. But when a child has been traumatised and wants someone else to express his fear and sadness he learns what is important to his parents and which buttons to press to make them sad, angry or afraid. Then he can transfer his feelings to his new receptive parents. They, then experience a form of trauma that they do not recognise; secondary trauma.

Secondary trauma is the trauma experienced by those who attend to or care for someone who has been traumatised. This is recognised for emergency staff that attend accidents but is less recognised for parents of traumatised children.

If the child has a negative working model - a back to front way of viewing the world – gentleness, kindness and nurturing may all be perceived as weakness. Aggression, violence, humiliation and chaos are seen as strength. This was the model he had lived with and now believes
in. So if the parents are perceived as weak they cannot be trusted to keep their child safe, and so he continues not only to reject them but also to provoke them to reject him. The result is a fragmentation that can split marriages, split families, split mother from child and can split whole teams of professionals who each think they each know the child but who do not see how the child reacts in other arenas. With a fragmented caring team the child continues to be in control, and will be resistant to integration or any positive close relationship with their foster or adoptive parents.

The parents, now affected by secondary trauma, may appear ineffectual, lacking in self-esteem and confidence, and present as hostile and uncooperative. They feel they are to blame because their ‘good-enough’ parenting has not had the effect they had hoped for. Their hope and aspirations for their family are disappearing down a drain that is sapping their energies and spirits. Professionals often excluded them from the decision-making about their child, and keep the therapy sessions confidential. I believe that this attitude to the parents prevents them from feeling empowered as parents and unable to change the cycles of rejection and distress in their home. The likelihood is that the child, presented with a range of people to help him, will try to manipulate the professionals to see his parents as the problem, and he hopes, therefore, that he will not be challenged about his negative protective behaviours.

The families that come to me for therapy are in the process of adopting or have already adopted children who have suffered significant early life trauma. They are struggling to make positive connections with their
The children range in age from 18 months to 18 years. Their behaviours range from violence, rage and destruction to silence, splitting and disconnection from the family. The parents have often reached the end of their resources for coping and many are considering asking for the child to be re-accommodated by social services. Several are anxious about the effect of their disturbed child’s behaviours on their other children in the family, whether adopted or born to the family. Sometimes these other siblings are being targeted and attacked and need to be kept safe.

**Creative Attachment Therapy Model**

I would like to present a therapeutic approach specifically for children who show disorganised attachment patterns and posttraumatic survival strategies that are anti-social and destructive. This is an approach only for children. Therapists working in adult psychiatry, who are also working with clients who are suffering the effects of early life traumas, should not use this approach. It is specifically for children who need to develop a trust in the adults caring for them and keeping them safe.

Therapy must be one part of a wider structure of support for the whole family, and the therapist needs to either have the skills to provide the other areas of support, or be part of a team that provide them. The areas of support are:

Information to help parents, teachers and any one else working with the child to understand the child, to understand theory of attachment, the causes and effects of early life traumas, and to be able to make sense of
why their child behaves like he does. This also means looking at the history of the child and his birth parents.

Looking after themselves – helping parents understand the importance of self-care so that they have the resources to care for their damaged child. This also means understanding the effect on themselves of living with a hurt child.

Specific strategies for managing and challenging the child’s behaviours that give the parents control and allow them to feel that they are able to keep their child safe.

Therapeutic space – for the child and one or both parents, to explore their relationship and to address themes of bereavement, attachment and celebration. The parents are there to resonate with their child’s pain, develop continuity between therapy and strategies at home, and to be there in session if the child needs their nurturing holding and comfort.

In this way parents become partners in the therapeutic process and feel respected for their major role in the healing of the child. Delaney and Kunstal say:

There is not a school teacher, nor a therapist, not a friendly neighbour, nor any other well intended individual that can make the difference in the disturbed child’s life the way his family can….. Given the importance of the family - foster or adoptive – it is mandatory that they are supported, nurtured, respected and recognised for their primary role in treatment of the child.

(Delaney and Kunstal 1993)

**Aims of therapy**

- To resonate with the child’s hidden feelings of fear and sadness
• To challenge the negative cycle of control and rejection
• To reframe the child’s negative working model
• To encourage positive interactions and attachments between parent and child

Structure

The structure is tightly controlled to keep the therapeutic space safe from the negative controlling behaviour of the child.

• The room and the environment, including the smell (I burn candles before a session) is as constant as I can make it.

• The timing of each session is flexible. The session ends when I say and not when the clock says. This is to prevent one aspect of control by the child. The child may use music as part of their resistance and know that as long as he keeps it up for a certain time he will go unchallenged. He may panic when he realises that he does not know what time the session ends, and then, as a therapist I may be able to access some of his hidden fears. I timetable 2 hours for each session but they usually last between 60 and 90 minutes. I endeavour that no child goes home distressed or over excited.

• The frequency of sessions depends on the stage of therapy, the distance travelled and the urgency of need. Some families travel such a distance that they stay in Bristol over a weekend approximately every 2 months, and then have 3 sessions over the weekend.

• At least one parent participates in each session to give continuity between strategies at home and goals in therapy.

• The balance between musical and verbal communication varies according to each family and the stage of therapy. The approach is generally directive but can include non-directive improvisation as appropriate to the stages of therapy. I will explain this further in a minute.

• There are simple rules of safety and politeness for the therapist, parents and the child. An example of this is that we must all use the name of the person we are talking to, especially when asking questions. This is to encourage the child to make a simple, but direct
interaction with another person, and is greatly resisted by children with attachment disorders.

- The child has restricted choices. Sometimes an activity involves playing instruments chosen by one member of the family. The child can decide whether or not to play what has been chosen for them, but they cannot choose to play something else.

- Every 5th or 6th session is a consultation with parents to review progress and discuss the situation at home.

**Content of sessions**

- Games, musical explorations of family scenes, events and confrontations, stories and journeys, musical dialogues, and free improvisations.

- Discussion of issues that are raised through the music

- Some sessions end with a behaviour target for the child to practice at home, and this relates to a behaviour shown in the session.

Recently a child took on a target to practice saying ‘Goodbyes’ because she had shown in her improvisations that endings were difficult and painful. Every simple ‘Goodbye’ was a trigger to the pain of the Goodbye she had had with her birth mother when she was 4 years old. Because she had avoided all farewell greetings ever since, she did not have the skills to simply say ‘Goodbye’ to family and friends.

**Process**

- Assessment, report and recommendations - three sessions plus a consultation with the parents. I am assessing the attachment patterns of the child and his family. I do this through structured musical activities of turn taking, following and leading, and holding- music while the child explores.

- Stage one - Engaging and Exploring. Through games I continue from the assessment to encourage turn taking and to introduce music as a safe medium to express feelings. Initially this will be exploring
feelings through story and fantasy characters or animals. Then we can relate it to the child’s or the parents’ own feelings.

- **Stage two - Challenging and Containing.** As the sessions get closer to expressing the hidden feelings of the child they become increasingly resistant and this resistance is challenged using music or other attachment therapy techniques. Sometimes the child and his parents are so stuck, and locked in hurt, that making music together is not possible.

- **Stage three - Nurturing and Attuning.** At this point the parents are partners with me in the therapy, and non-directive holding music becomes appropriate. This is musically holding the parent and child in a safe environment where they can begin to attune to each other.

- **Stage four - Encouraging and Reframing.** In this stage the child begins to feel safe enough to let go of his protective strategies. He begins to trust that the adults who care for him will offer him new strategies for keeping safe. He never truly lets go of the tried and tested strategies, which can emerge whenever there is a new situation, or something triggers the fear of their early traumas. These children remain vulnerable children.

- **Stage five – Celebration and Letting Go.** Celebration is a very difficult concept for traumatised children and they become expert at sabotaging family celebrations. When celebration is possible music is the perfect medium for it. In a final session with a family, I asked them what they would like to do, and they said ‘Play the 1812 overture’. They chose instruments and then sang, banged and crashed through the overture in a wonderful celebration.

Therapy does not neatly go from one stage to the next and most children cycle through stages before moving on. Some get stuck and are unable to move on, so alternative attachment therapy techniques may be employed, which include other creative arts. There may be a need for some intensive sessions - one a day for 3 or 4 days – to move a child on, or to challenge a particular behaviour. Alongside this will be the areas of support for the family that I have described earlier, and collaboration with school staff, if we can engage them. It is important that all the
people who care for, and work with the child have an integrated approach so that therapy does not become another fragment of the child’s divided world.

The supporting behaviour strategies are ones that investigate the message behind the behaviour, interrupt the cycle of rejection and distress and encourage the child to make positive choices. They do not include any rewards or sanctions. I am happy to discuss this further with anyone interested, but there isn’t time to explain them further here.

**Vignettes**

I want to share with you what the children and parents in my practice have taught me about what it is like to live with the effects of trauma.

Joshua came from a violent and alcohol abusing family. He had lived in chaos not knowing when he would next be fed or noticed. He came to therapy with his adoptive parents who had been unable to make positive connections with him. He was aggressive and rejecting. They were a strong professional couple that had experience of working with children. Through the music Joshua would take us on a journey to different places by different means of travel. There was always a journey but never an arrival. There were either major accidents or aborted landing attempts. Until one day we were all playing a free improvisation and at the end I made the comment that it seemed as though we were all on different planets. “Yes” shouted Joshua “and my planet is a war planet”. He started banging and crashing again in a chaotic way. I suggested that we
all join Joshua on his planet and that then we could go on a space journey and see what happened.

We did this with much noise and fun. The music, without direction from me, took off and became travelling music, which Joshua joined in. As we played, the music became quiet and more ordered. Joshua stopped playing and curled up in a chair looking very afraid. I stopped the music and asked him what had happened. He said, “We’ve got to a quiet planet but it’s very dangerous. There is a poisonous gas and you can’t see it. We’re all going to die. I want to go back! I want to go back!”

I could see the parallel between this story and his life story. How we continued is not as relevant here as what I learned from it. Traumatised children who have experienced violence feel safer when they can see the violence than when they can’t see it. Because they believe that there is potential danger all around there must be danger even in the peaceful places, and this is more dangerous because you can’t see where it is coming from. So what we perceive as a safe home, they feel is more dangerous because they can’t make sense of the peace.

I want to play 3 pieces from sessions with children and their adoptive parents.

The first piece I want to play is from a session with a mother and her nine-year-old daughter, Ellie. They had travelled up to two hours to get to therapy and by the time they arrived Mum was in tears and Ellie was angry and verbally abusing her mother, saying to me “Don’t take any notice of her crying – she’s just stupid”. Ellie had been hitting her mother in the car as they drove. They discovered that when they played
music together they were very much in tune with each other. This surprised them both and over the next few sessions I watched them become totally engrossed in each other. This moved from shared music to talking about their feelings and fears. They became physically affectionate and Mother reported that they could now have cuddles and fun times. This piece is a complete piece with Ellie playing the flute, myself on the guitar and Mum on the xylophone. It was particularly interesting to me because Mum and daughter are playing in different keys. Maybe being able to play in harmony and with resonance but still in different keys was, perhaps a key to their healing.

The next piece became a turning point in the therapy of Rachel. Rachel was 11 at the time of this example. She had experienced multiple difficulties before the age of 3 when she was adopted. This included premature birth, non-accidental injury, neglect, intrusive and painful medical treatment and several moves.

When she came to therapy with her family Rachel could only join in when she was pretending to be a teacher and telling us all what to do. Her musical contributions were chopsticks very loud, or she asked us to sing and play about her parents having sex, or abusive words directed at her brother. As the sessions went on Rachel and her mother could not play together. When one started the other stopped.

At home she was violent, self-harming, aggressive and manipulative. But at school she was the perfect pupil. This meant that people outside the family found it hard to believe what the parents were experiencing. It is hard to describe in a few minutes the struggle for Rachel and her
family to co-exist never mind operate as a family. Rachel’s parents could never go out together, they had not had a happy family occasion for several years and they did not believe they could survive as a family for much longer. Something was going to break.

In this piece the family have been playing a turn taking game and it evolves into a piece where each member joins the music in turn. Rachel, on the piano, is the last to come in. The family have had great difficulty, even fear, about inviting her to join in anything because of her ability to sabotage and destroy. This was the first piece of music we played where she joined in the family rhythm appropriately. That does not mean that she did not have opportunities to set her beat for others to join, but we had learned that letting her be in control was not safe.

Rachel is now just 13. Recently I was preparing a talk for adoption professionals. I asked her what she would like me to tell them and she said, “tell them it works”.

She is still a vulnerable child. Any new experience, anxious situation or misunderstanding can set her back, but she is a much loved member of her family, she contributes to the fun in the home, shares her feelings more appropriately and allows herself to be comforted. She is beginning to ask for help when she needs it. Sadly she has had a relapse of the medical condition she had as a young child. This is a severe test to her new trust in her parents and she is having to learn new strategies to cope with the pain. She is a determined young person.

There are danger points in the therapy. If a child does trust enough to let go of the protective behaviours that he has relied on to keep himself safe,
he will feel very vulnerable and insecure before he develops the skills that other children learned in the first few weeks and months of life. This can be very painful for him and also for his parents.

Emma is a 12 year old girl who had been aggressive, provocative and was a good thief. All these behaviours protected her from feeling the sadness of her traumatic early life and the separation from her birth family at the age of seven.

As therapy progressed she gave up her negative strategies but was overcome with the feelings from which she had been protecting herself. She said to me “But Joy it hurts”. I could not take that pain away, but we could explore it musically through improvisation and song, and I congratulated her for her bravery.

I want to finish with a piece of music played by a family who had adopted two girls, now aged 9 and 12. The oldest daughter, Clare, became too difficult to manage at home and she is now in care. The family were traumatised and bereaved but also relieved. They were angry that they had not been able to get Clare the help she needed. They are afraid for her prospects in care, and anxious for her younger sister, Lucy, who is still in the family. Lucy is torn between concern and loyalty for her older sister, and relief that she is now safe, and that the family are not living in fear anymore. This is expressed in this piece by a confusion of anger and exhilaration. Lucy is playing the piano. Everyone else is playing instruments chosen by her. Lucy said to her mother last week, “When are we going to have some more Music Therapy? I need some Joy”.
Conclusion

Music Therapists who work in adult psychiatry know the long-term effect of childhood trauma. Placing children in stable foster and adoptive homes is not enough to bring about a change in their distorted perception of the world, caused by trauma, and some need therapeutic help. Today I have presented factors, which indicate that a different approach to therapy with traumatised children, who have been placed in substitute families, could to be considered. This should include parents or carers wherever possible, and should be part of a wider package of support that is informed by an understanding of attachment, trauma and its effects, secondary trauma, and dissociation. More evidence-based research is urgently required, because the numbers of traumatised children placed for adoption is increasing, and the resources for these children to receive appropriate therapy is severely limited.

References


A Force of Nature: Complementary Theory in Music for Wellness

Hess, Susan J.
MA, MT-BC
Naropa University
Boulder, Colorado USA

Abstract

The use of music therapy in the field of "wellness" is growing yet it seems, at times, without the benefit of a theoretical orientation. This paper explores an interface between holistic wellness and music therapy that draws on theoretical foundations from Complementary Medicine. It covers a working definition of wellness and a brief history of the wellness movement in the United States. Complementary Medicine, Chinese Medicine and Indian Ayurvedic Medicine are discussed and Five Element theory based on Ayurveda is outlined. A complementary theoretical approach, applied to music for wellness and based on Ayurvedic Five Element theory, is explored. A Five Element template is presented for use in music therapy including its application in assessment, goals, objectives, treatment plans and documentation. A typology of musical elements and instruments based on Five Element theory is offered, and Five Element music for wellness is discussed. Current research in this area is noted. Five Element music experiences are given, including instrumental and vocal examples.
Introduction

During the course of my training at Naropa University and in subsequent exploration into holistic approaches to music therapy, I came across four theoretical concepts that have become fundamental for me and continue to inform the way I work. These concepts come from various traditions yet seem to have synergy when working in combination with each other. I offer these concepts as a prelude to the specific complementary theory to follow, that they might offer a deeper context for an understanding of "music for wellness."

First is the idea of “basic goodness.” This term comes from the view of the Tibetan teacher Chogyam Trungpa (1984) who founded Naropa University, and who says,

There is something basically good about our existence as human beings . . . . The human potential for intelligence and dignity is attuned to experiencing the brilliance of the bright blue sky, the freshness of green fields, and the beauty of the trees and mountains. We have an actual connection to reality that can wake us up and make us feel basically, fundamentally good. (pp.29,31)

I recognize this as a concept at the basis of natural wellness, and as the essential aspect of the client to which I relate in therapy.

The second concept that has influenced me is that of the “Music Child,” as presented by Paul Nordoff and Clive Robbins (1980).

The Music Child is . . . the individualized musicality inborn in each child: the term has reference to the universality of musical sensitivity . . . . This concept is not limited to the child with special musical gifts, but focuses attention on that entity in every child which responds to musical experience, finds it meaningful and engaging, remembers music, and enjoys some form of musical expression. (p.1)
I have come to understand that the “Music Child” does not just relate to children. I have realized that a “Music Self” resides in everyone and that accessing it is an integral task of the music therapist.

Third, the concept of “self-actualization” from Kurt Goldstein suggests that each person carries with him/her an “urge toward growth, understanding, and expression of creative powers” (Suter, p.276). This principle seems to point to the process of personal growth and development that identifies the healthy personality.

The fourth concept comes from Maslow and his work with “peak experience.” I find this notion fascinating and can relate it to “extraordinary” moments I have had in my life while playing music and while being in nature. I want to remain open to the possibility of my clients having their own such experiences in music.

In these transpersonal concepts, I have found reasons to search for goodness, musicality and untapped potential in every client I encounter. While they seem to address the mind-spirit aspects of practice, they do not specifically address the body-mind connection and my interest in the overall health of the client, both physical and psychological. As such, by maintaining this transpersonal context as a backdrop for another unique theoretical orientation that addresses spirit, mind and body, I have found a way to integrate my own personal philosophy into my work as a music therapist. In this way I am able to practice a holistic form of music for wellness that seems to be as effective as it is satisfying.
Wellness Theory and Practice

What is Wellness?

In 1958 The World Health Organization defined health as “a state of complete physical, mental and social well-being . . . not merely the absence of disease” (Rosato, 1990, p.3). Since then, the concept of wellness has been gaining recognition and developing in the U.S., beginning with the popularity of the physical fitness revolution in the 1960’s. The editors of the popular University of California Berkeley Wellness Letter (1991) say,

We chose the word ‘wellness’ because it conveys what we consider to be a primary goal: leading a full and productive life . . . . wellness represents something to strive toward - the optimum state of health and well-being that each individual is capable of achieving, given his or her own set of circumstances. (preface)

As such, wellness is a term that does not reference illness or the absence of disease, but represents a “continual process of attaining greater and greater personal well-being” (Rosato, 1990). According to Ardell in High Level Wellness (1986), a wellness model is different from a treatment model and exists on one end of an "Illness/Wellness Continuum"
The treatment model can bring you to the neutral point, where the symptoms of disease have been alleviated. The wellness model, which can be utilized at any point, directs you beyond neutral, and encourages you to move as far to the right as possible. It is not meant to replace the treatment model on the left side of the continuum, but to work in harmony with it. (p.298).

In Health Psychophysiology, Suter offers five factors of “holistic wellness” that address the “optimum function” of body, mind, and behavior. He says there are two physiological aspects of wellness, which
he identifies as 1) “super immunity” and 2) “physiological homeostasis,” defined as “the dynamic balance of the internal environment” (p.274). He considers the three psychological aspects of wellness to be:

1) “self-actualization” from Goldstein;

2) “happiness” as developed by Fordyce, and;

3) “behavioral competence,” based on Bandura's theory of “self-efficacy,” or the psychological factor underlying successful performance in the world. The “simultaneous achievement” of all five of these factors constitutes what he calls the “holistic definition of wellness” (p.285). "Holistic wellness,” then, may be considered a term that encompasses physiological and psychological fitness, health and well-being.

Music Therapy for Wellness

In 1999, The American Music Therapy Association recognized the category of Wellness in the Standards of Clinical Practice, defining it as “the specialized use of music to enhance the quality of life, maximize well-being and potential, and increase self-awareness in individuals seeking music therapy services” (Dileo, ed.,1999 p.144). Combining music therapy with a “holistic wellness” approach that addresses body, mind and spirit without focusing on illness, it becomes possible to begin to develop a model of “music for wellness.” However, questions are raised. If there is, indeed, no illness to address, how are goals and objectives utilized? How does a music therapist working with wellness actually assess, plan, treat and evaluate a session? How does one work
with concepts such as “physiological homeostasis,” "well-being," "potential" and "quality of life" within a music therapy context?

**Complementary Medicine**

Complementary Medicine has traditionally addressed the question of how to integrate the whole person into a health care program. Allopathic, or Western Medicine, is the medical approach that focuses on illness, specialization and finding a cure. As such, modern medicine is effective in areas that require critical care and treatment of trauma. Complementary Medicine, typically of Eastern origin, focuses on various aspects of healing in a spectrum from health to illness, including prevention, treatment, maintenance and maximization of personal potential. It can be singularly utilized, or act as a "complement" to Allopathic Medicine. The term "complementary" can additionally refer to a variety of approaches including but not limited to therapeutic massage, homeopathy, kinesiology, flower remedies, chiropractic, Reiki, Qi Gong, macrobiotics, etc., when they are used in addition to Allopathic Medicine. Alternative Medicine generally refers to similar approaches when they are used as an alternative to, rather than in combination with, Western approaches. Complementary Medicine shares common ground with Wellness in recognizing a *spectrum of health*, and particularly shares the areas of prevention, health maintenance and maximization of personal potential.

Two highly developed Complementary Medicine systems now being practiced in the West are, 1) Chinese Medicine, and 2) Ayurvedic Medicine. Chinese Medicine uses herbal remedies as well as
acupuncture, a treatment that has been recognized by the Western medical community as an effective adjunct to the medical approach. Ayurveda, the ancient healing system of India, is most notably offered in the U.S. by The Chopra Center for Well Being in La Jolla, California, and is also practiced by independent practitioners in health and wellness worldwide. Ayurveda uses diet, exercise and seasonal routine, as well as music, aroma, massage and other natural means, to effect healing and health. These two systems are rich in complementary theory and are rooted in ancient foundations that draw on natural phenomena as their source. At the core of Chinese Medicine are Ch‘i Energy, the pulses and Five Elements. Ayurveda works with Prana Energy, individual constitution and Five Elements. Energetic approaches focusing on Ch‘i and Prana are often used by practitioners of “sound healing,” however, it is Five Element Theory that I have found to be the most applicable to a wellness approach in music therapy.

**Five Element Theory**

Five Element Theory is based on the elements of nature and their natural interactions and balance. Earth, Water, Fire, Wood and Metal are the natural elements used in Chinese Medicine (Connelly, 1979). Ayurvedic Medicine uses the elements of Earth, Water, Fire, Air and Space or Ether (Svoboda, 1989). Very simply put, the interplay of these elements in the human Bodymindspirit (Connelly, 1979, p.15) and between the Bodymindspirit and the environment determine prevention, treatment, and maintenance approaches in both traditions. Balance is the goal. Considering the individual as a part of the natural world in this way
provides a unique perspective that does not require that he/she have an illness in order to have treatment. The unique characteristics of each element provide a way of viewing health as a natural balance, a balance that can be adjusted for optimum performance.

Ayurveda and Wellness

Ayurveda utilizes Five Element theory as a part of its broad approach to mind, body and spiritual health. David Simon, M.D., Medical Director at The Chopra Center for Well Being states that “it is not the specific . . . techniques that distinguish Ayurveda from other systems; rather it is the all-encompassing perspective that enables us to integrate healing modalities . . . .it is a common language into which every healing discipline can be translated” (Simon, 1999, p.4). Ayurveda has been practiced for over 5,000 years and comes from two Sanskrit words, Aye meaning “life” and Veda which means “knowing” and refers to the Vedas, “the world’s oldest extant literature” (Lad, 1984, p.18). It includes a metaphysical philosophy, practical treatments for physical imbalances, daily practices for mental clarity and disciplines for sustained self-improvement. “The practice of Ayurveda is designed to promote human happiness, health and creative growth” (Lad, 1984, p.18). Ayurveda can address Suter's five factors of holistic wellness through this perspective and through its Samkhya philosophy, of which Five Element theory is a part.

In the Samkhya philosophy, the Five Elements are a small part of a vast universal system of Cosmic Consciousness that includes all of creation. The Five Elements are Consciousness manifested as energy in matter
here on this planet. As such, each Element represents a unique manifestation of infinite Consciousness. *Samkya* philosophy also holds that “the five basic elements exist in all matter” (Lad, 1984, p. 22). From this it is understood that the Five Elements also exists within the human body. Balancing the Five Elements in the body can lead to homeostasis and the potential for superior immune function. Becoming aware of the Five Element qualities existing as energy in the mind can lead to self-understanding, self-healing, self-efficacy and happiness. Experiencing the infinite universal nature of the Five Elements can promote self-actualization, peak experience and "perfect health" or the place where “limitations which all of us accept cease to exist” (Chopra, 1991, p. 3).

The Five Elements address body, mind and spirit and can thus provide a lens through which “holistic wellness” can be viewed. They provide a common language into which the five factors of “holistic wellness” can be translated. Additionally, working with the qualities of the Five Elements can offer a more concrete approach to determining goals objectives and "treatments" or programming for a music for wellness client, as well as in assessing, planning and evaluating a music for wellness session.

**The Five Elements**

The unique qualities of each of the Five Elements, or “The Five Great States of Material Existence” (Svoboda, 1988, p.16), are discussed at length in various books on Ayurveda. This overview offers a very brief introduction to them and is not intended to be a comprehensive description. It is also worth noting here that it is the *quality of energy* of
each of the Five Elements that is being discussed, and not the actual material substance, per se. It is the qualities of the energies that become a common language, as they are identified in the Bodymindspirit in various ways. They are a common language due to their archetypal nature; generally everyone experiences each of these elements in some way. Let your experience of Nature assist you in developing an understanding of the Five Elements. Svoboda (1988) characterizes the Five Elements in this way:

- **Earth** the *solid state* of matter, whose characteristic attribute is stability, fixity or rigidity. Earth is stable substance.
- **Water** the *liquid state* of matter, whose characteristic attribute is flux. Water is substance without stability.
- **Fire** the power which can convert a substance from solid to liquid to gas, and vice versa, increasing or decreasing the relative order in the substance. Fire's characteristic attribute is transformation. Fire is form without substance.
- **Air** is the *gaseous state* of matter, whose characteristic attribute is mobility or dynamism. Air is existence without form.
- **Ether** [or **Space**] the *field* from which everything is manifested and into which everything returns; the space in which events occur. Ether has no physical existence; it exists only as distances which separate matter. (pp.16-17)

**Applying Five Element Theory**

**The Five Element Star Template**

You can remember the Five Elements by thinking of a “star” with each point representing an element (see Appendix, Figure 2, graphic). This five-pointed “star” can be applied to a wide variety of situations and conditions. For instance, in the ancient science of Ayurveda, the Five Elements are applied to Bodymind qualities and three types are
distinguished: Vata type, a person exhibiting primary qualities of Air and Space; Pitta type, a person exhibiting primary qualities of Fire; Kapha type, a person exhibiting primary qualities of Water and Earth (Svoboda, 1988). According to Ayurveda, every person exhibits a primary Bodymind quality or dosha, and Ayurvedic treatments work to balance excesses or weaknesses of any element within the Bodymind system.

Ayurveda and the Five Elements
In India, the Five Elements are also applied to such things as time of day, seasons, food and music. For example, the 24-hour day is divided into four-hour segments that demonstrate different elemental qualities. Thus, noon is considered Fire element time, while sundown is considered the time of Air and Space. Indian music, or “ragas,” based on particular melodic scales, are played in conjunction with these divisions at certain times of day, and enhance or balance the qualities of the hour (Chopra, 1991 p.156-157). Seasons are similarly accorded elements, thus summer is associated with the Fire element and winter is associated with Earth and Water elements. In this way, the Five Elements become a way to view and order one’s experience of the world.

Five Element Theory in Music Therapy
Five Element Theory can stand alone as a Wellness approach, can be used as a complement to other clinical or medical music therapy approaches, or can provide a wonderful backdrop for more in-depth music psychotherapeutic work. Using the Star Template, the Five Elements can be applied to assessment, goals, objectives, "treatment" or
programming, and documentation. In this way, the application of Five Element Theory can be done systematically and effectively.

**Assessment**

Using the Five Elements in *assessment*, the client can be assessed with regard to the prevalence of the qualities of each element in his/her Bodymind presentation, i.e. stable, stuck, fluid, intense, hot, light, cold, clear, etc. This assessment can be done by the therapist, or along with the client after educating him/her on the essential qualities of the Five Elements. Basic Ayurvedic assessments are also available in various publications (Chopra, 1991, pp. 26-31). It is worth noting that this kind of assessment is not intended to be a substitute for an evaluation by an expertly trained Ayurvedic physician. It is rather used as a framework or metaphor for understanding the tendencies of the client, and to bring increased awareness to his/her state of wellness. Musical assessment can also be accomplished by noting the elemental qualities of the kind of instruments, songs and improvisations that the client chooses.

**Goals**

Once an assessment is made with the client to determine which elemental qualities predominate, goals can be developed based on creating a balance. For instance, a goal may be to reduce the predominance of the Air quality by increasing Earth, or to increase the Fire quality overall.

**Objectives**

As the goals are established, objectives can be created, i.e. "The client will engage in Earth-increasing music experiences twice a day for a
week", or; "The client will practice Fire-increasing music experiences three times a week for a month."

**Documentation**

Documentation of the Five Elements can be included in clinical notes, as the elemental information observed during a session is written up.

**Treatment or Programming**

Music therapy treatment modalities can be based on the Five Elements by applying the Star Template to any number of music therapy interventions including instrumental improvisation, vocal improvisation, song selection, and song writing, etc. *Improvisation* based on an individual element can be used to develop awareness of its qualities, while improvisation based on all five elements can be used to discover interactions, balances and imbalances. In *song selection and song writing*, the star template can be applied when selecting music for focused listening, relaxation and visualization, as well as when choosing instruments for creative song writing. As a *complementary treatment*, a Five Element approach can be used as a complement to other clinical or medical music therapy approaches, providing a wonderful backdrop for in-depth therapeutic work. As a *primary treatment*, it can also stand alone as a primary wellness approach for work with the general population or in community music therapy. It is worth noting that the wellness model generally does not use the word "treatment," since it is a term that is more commonly associated with a medical model, thus the additional word "programming."
The Five Elements in Music

In working with music and the Five Elements, it is useful to apply the Star Template to musical elements and to musical instruments. For instance, rhythm, tempo, pitch and timbre can be considered in light of the Five Elements. Musical instruments, which originally come from nature, already seem to carry with them various natural qualities of the Five Elements. The Star Template can be applied to an instrument as a way to determine which element it best represents. The following is an outline of musical elements and musical instruments as they are assigned to the Five Elements. This is based on various researched typologies and in particular the work of John Beaulieu (1987), Frank Bosco (1992), Rudolph Steiner (1977), Hal Lingerman (1995), and on personal research (Hess, 1998). It also draws on the work of Carl Jung, his concept of “archetypes” and on how music and the Five Elements are essentially expressions of archetypal energies. (Warming, 1992).

Earth
Instruments: drums of all kinds; bass
Rhythm: 4/4 time, steady, heavy
Tempo: slow - Largo
Pitch: low

Water
Instruments: rain stick, ocean drum, low voice, low strings, low horns
Rhythm: 3/4 time, fluid
Tempo: medium slow - Adagio
Pitch: medium low
Fire
Instruments: shakers, rattles, percussion, brass, guitar
Rhythm: staccato, syncopated
Tempo: upbeat medium to fast - Andante, Allegro, Presto
Pitch: most penetrating for timbre

Air
Instruments: woodwinds, flute, high strings, high voice
Rhythm: changeable meter, open and spacious with rests
Tempo: moderate to fast - Andante, Allegro, Presto
Pitch: high

Space (Ether)
Instruments: bells, chimes, Tibetan & crystal bowls, gongs
Rhythm: none, open, non-rhythmic
Tempo: none, open
Pitch: high and resonating

Five Element Music for Wellness
Using these guidelines, music can be created using the instruments, tempo, pitch and rhythm of an elemental quality. For example, music based on Earth element can be created that expresses a certain solid, fixed and stable quality. The music can be created as improvisation or song, alone, in duet or in a group, etc. Each Element can be played according to its qualities, alone or in combination with other Elements. For instance, Earth instruments can be played with the fluid quality of Water instruments to create contrast and balance. The music can be simple or complex, depending on what is needed. The variations are endless, and can reflect a wide variety musical experiences. The guidelines can also be applied to recorded music and can be used to select
pieces that generally express elemental qualities, i.e. Water quality. Approaching music from this standpoint allows non-musicians to enter into a natural musical experience with a focus and language other than music notation. It seems to offer the imagination a landscape that can be painted in sound.

The guidelines for playing music with the Five Elements can be applied to treatment experiences in music therapy or music for wellness sessions. As the Element is musically experienced, insight can arise for the client as to how this quality is played out in his/her life. For instance, improvisation based on an individual Element such as Earth can be used to develop awareness of its qualities. An example may be a drumming session that emphasizes low pitch and slow tempo, and can be used to discover how the client embodies Earth qualities in his/her physiological and psychological makeup. Improvisation using all of the elements, including instruments from each type, can be used to discover and work with interactions, balance and imbalance. The elemental musical qualities can similarly be applied in selecting songs for focused listening, relaxation and visualization, and when choosing instruments for song writing, etc.

Another approach to music for wellness includes giving an “Ayurveda Body-Type Test” (Chopra, 1991, pp.226-31) to gain an overview of the client’s constitution, and then planning music experiences based on the results. As research for my master’s thesis, I tested subjects by Ayurvedic type and compared that information with scores from a "Sound Type and Music Evaluation" I created based on the Five Elements. While the
results were inconclusive, patterns began to emerge indicating a possible inclination of clients to choose sounds and music that balance their Ayurvedic constitution (Hess, 1998). More research is possible in this area.

Using the Star Template allows consideration of five different viewpoints and as such, five different ways to orient a session musically. Again, it provides a theoretical framework for a holistic musical approach to wellness. Within the context of the Elements it is possible to create music experiences that addresses Suter’s five factors. For instance, the session can be oriented physiologically and can use drums to increase Earth qualities for homeostasis and immune function. In fact, research has shown that there are drumming experiences that can, indeed, increase immune function (Bittman, et.al., 2001). The session can alternately follow a psychological emphasis, concentrating on increasing self-efficacy, happiness or self-actualization. The Space Element can be emphasized using bells to increase lightness and happiness, or the Fire element can be highlighted to increase courage and self-efficacy. Of course, the session can also address both physiological and psychological factors together. However they are used, The Five Elements and the Star Template become effective ways to organize an approach to addressing the client’s needs regarding wellness.

**Five Element Music Experiences**

Below are some examples of music for wellness experiences based on the Five Elements. I have found these useful in my practice. They can be used as is, or as a starting point for further development.
Earth
Using hand drums, play in duet with the client on 4/4 rhythms. Inquire about what habits and routines are working in her/his life, and which are not. Have the client hold the beat while you play opposite it. Is she/he able to hold it? Yes? No? Is this familiar in his/her life? Stand and play; walk and play; take time to be in rhythm together. How does this feel? Does he/she feel in or out of rhythm in life?

Water
In a small group, create a “water” improvisation together. Beginning with rain (rain sticks), move into a small stream (flat hands on drum surfaces), then into a river (add low voices) then to the ocean (ocean drum). Can add recorded sounds of water and include fluid movement. Inquire about flow in the client’s life. Does he/she take time for refreshment? How easy or hard this is? Is he/she able to give and receive?

Fire
I call this the “Fire Whoop!” In a small or large group, stand in a circle, each person holding a rattle or shaker. Begin with a slow tempo, gradually increasing faster and faster (the facilitator may want to use a drum to lead). When the fastest tempo is reached, allow a few moments for vocal “whooping” and letting go. Then bring the tempo down to a steady, quick beat. Have each person come to the center for a “Fire” dance with his/her rattle. After each person has taken a turn, slow tempo down to a stop. Afterward, there can be discussion about courage, bravery, and how fear, anger and insecurity are handled in life. Does he/she demonstrate assertiveness? Can she/he strongly step into life?
Air
In duet or as a group, go through a toning exercise. Take time to tone on different vowels at different pitches. Note which pitches are difficult for the client, and which ones feel more comfortable. Play with vocal slides, animal sounds and gibberish. Learn simple chants and songs; play with songwriting. Note voice quality. Inquire about how easy or difficult it is for the client to communicate with others. Is he/she comfortable with his/her own voice? Is it difficult to have fun with the voice?

Space
In a group, have one person play a crystal bowl while several others play individual resonator bells pitched to match the bowl. Ask players to allow space between the notes, letting them occur randomly. Ask everyone to close his/her eyes and envision the night sky. Imagine black space full of stars. Discussion can center on spirituality, inspiration and awe.

Five Elements
As a small group, have each person choose one picture from a selection of nature photos (I save photos from calendars just for this purpose). Put first picture in the center of the circle. Have everyone look carefully at the photo to see what Elements are represented, which ones are dominant and which ones are not. Choose instruments accordingly. “Play” the photograph, improvising on the qualities present, all the while focusing on the picture. Go around the circle, playing each person’s photo. Discuss the uniqueness of each improvisation. Non-musicians love this as a way to “play music!”
**Play the Day**

In a group, take time to observe the elemental qualities of the day. Is it hot or cold? Damp or dry? Does it feel quiet or active? Have each person choose an instrument based on an Element and create an improvisation focused on the environment.

**Gestalt Improvisation**

In duet, or as a group, the client takes time to observe how she/he is feeling today: agitated or calm; spacey or grounded; tired or refreshed? Interpret this according to the Elements, choose instruments and create an improvisation. Follow with discussion.

**Conclusion**

Five Element theory offers an orientation that can be effectively used in music for wellness. The previous examples are just the beginning in terms of the kinds of musical experiences that can be created based on the Five Elements. Try playing with their qualities, allowing them to inform you of their unique properties. The use of this model in music for wellness can offer structure and direction, while leaving room for creativity, discovery and therapeutic goals. The model fosters self-actualization and the opportunity for peak experience, while assisting with physiological and psychological balance. It seems to be a natural pathway to the inner Self, that place where the soul always sings.

**Address**

Please contact me for more information:
Susan J. Hess, MA, MT-BC
References


"Phrasing, phrases and phrase mongers" - A study on phrasing in music therapy

Hoffmann, Peter

In active music-therapy the improvised music indicates important dimensions of a client's performing and being in the world. How a client acts, relates and expresses himself can be experienced in the music within the mutual musical contact. Against this background a close look at the musical material provides insight for diagnostic understanding and therapeutic development. The specific form and character of the music which is created by the individual personality of a patient, his individual potential and his limitations, can be characterized again by musical aspects, by components like tempo, dynamics, rhythm, melody, harmony. In my clinical work with different groups of clients I experienced that the aspect of musical phrasing also is a meaningful component. In a literature review I realized that there were only few colleagues making remarks on this special musical component (Aldridge 1999; Ansdell 1995; Bruscia 1987), so I decided to investigate the relevance and the meaning of phrasing in a doctoral study (supervised by Prof. Dr. David Aldridge, chair of qualitative research at the medical faculty of the university of Witten/Herdecke).

By doing so I intended to clarify and to examine the basis of my therapeutic decisions and to contribute to my own clinical insight and work.

First let me start with a musical definition of the word phrasing:
Phrasing is a musical activity of structuring musical time. In musicology phrasing means to form units or segments, to group, to articulate musical structure and to elucidate the coherence of a musical structure (Eggebrecht 1984; Hoke 1962; Kreutz 1998; Riemann 1967; Sadie 1980). As you might have expected there is no overall definition over different periods in music theory. But two aspects are significant from a general perspective: Phrasing means

- to segment musical activity and/or
- to create coherence within these segments.

Phrasing usually is applied to the subdivision of a melodic line but can also be applied to other components. The activity of phrasing is performed by all kind of different musical parameters, by melodic and harmonic development, by pauses or caesuras, by changes in dynamics and by the timing of the player for example. Phrasing is important in at least two ways:

1. It supports the structure of a (composed or improvised) music. In a bad case it blurs it or makes it unclear.

2. Phrasing is an important element by which a musician expresses his individual interpretation. He conveys meaning by dividing and forming the musical material. Individual interpretation is very closely linked with the component of phrasing the music (as many research-findings in music-psychology underline (Behne und Wetekam 1993; Bruhn 1993; Kreutz 1998; Palmer 1997; Sloboda 2000; Stoffer 1985).

From a musical perspective phrasing supports the understanding of musical coherence and indicates the personal intention of a musician.

Now my question was: what is the significance of phrasing from a music therapeutic perspective?
To investigate this question I followed a hermeneutic phenomenological methodology in my study focussing on the improvised music. I analysed musical material of my own music therapeutic work with adult patients in psychiatry. The work has taken place in the psychiatric department of a General Hospital (the Gemeinschaftskrankenhaus in Herdecke, Germany) . The patients I have been working with were suffering from illnesses like:

- depression (reactive and neurotic),
- anxiety disorders, phobia,
- eating disorders,
- compulsive behaviour
- personality disorders and different forms of psychotic diseases (like schizzo-affective forms, manic depression, schizophrenia).

For the analysis of the music I used tape recordings of sessions. I collected around 120 representative episodes from different clients with a duration of 1-3 minutes. This collection should represent the range of possible activities and should cover contrasting examples of different modes of playing and structuring the music.

In analysing the episodes I focused on three stages in the first part of the study:

1 Description of the musical material: At a first level I described the music or the musical material concerning the mode of phrasing.

2 Description of the experience related to a mode of playing: I described the therapists’ experience of different modes of phrasing within the contact.

3 Conclusive Valuation
In the second part I tried to prove the evidence of my thoughts and interpretations by inquiries among 10 colleagues.

**First part of the study**

In the analysis and description of the episodes I could find different modes of phrasing in the activities of the clients. Within all the episodes I could define four different groups of similar modes:

- unphrased playing.
- indications of phrasing
- beginning of phrasing
- phrased playing

In this paper I will only focus on the contrast between phrased and unphrased playing.

Looking at the musical material or the musical organisation the episodes with unphrased or phrased playing were characterized as follows:

<table>
<thead>
<tr>
<th>Table 6</th>
<th>Unphrased playing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>description of the mode of playing</strong></td>
<td></td>
</tr>
<tr>
<td>In the playing there is no obvious structure, division or shape.</td>
<td></td>
</tr>
<tr>
<td>The playing activity is either</td>
<td></td>
</tr>
<tr>
<td>- remaining repetitive, uniform, monotonous or</td>
<td></td>
</tr>
<tr>
<td>- chaotic, random, „indifferent“ in the way, that there is no order or structure in the playing.</td>
<td></td>
</tr>
<tr>
<td>The quality of the playing can be either rigid or unstable.</td>
<td></td>
</tr>
</tbody>
</table>
When you listen to examples of phrased or unphrased playing you realize that the formal aspect of different modes of phrasing is combined with qualities of expression, perception and activity in the clients’ playing. These qualities can be experienced in the music, in the musical comovement with the playing of the patient. Within these qualities two aspects have to be considered

1. the quality of the musical contact and
2. the quality of the musical structuring as experienced.

So in a second step of the study I put into words my experience – as accompanying therapist - of the special musical quality for every musical episode. Let me illustrate the procedure and the methodology roughly with two examples (the written music can only be a weak illustration of the actual incident but may help to give a slight impression of the musical situation):

In the first example the playing of the client is characterized by a continuously repeated pattern with a falling triad. There is no obvious division or formation or a creation of coherence within. Tempo and dynamic don’t change. In accompanying this playing I experience the

<table>
<thead>
<tr>
<th>Table 7  Phrased playing</th>
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<tbody>
<tr>
<td><strong>description of the mode of playing</strong></td>
</tr>
<tr>
<td>In the playing there is a clear segmentation of units. The segments are characterized by a development of tension within. They are indicated by components like dynamics, tempo, sound, caesuras, beginning-ending, tension and dissolution of tension, by melodic development. Mostly several components support the segmentation.</td>
</tr>
</tbody>
</table>
activity as static, as non directed, the activity is isolated, there is no musical contact from the client, though there is an obvious awareness for the music. There is limited expression. There is no temporal perspective in the activity.
The next episode comes from the same client. There are similar formal characteristics, but there is a flexibility in changing the pattern by playing it in different registers, changing the rhythm and the notes aso. Within the episode it comes to a clear segmentation in the playing which is related to the segmentation in my music.

I experience in the mode of playing an intended and directed quality, an interest in the own and the mutual activity of the client, grown presence, orientation and contact.
Figure 32 Episode 2
I completed this kind of subjective descriptions in detail for all the episodes. In comparing the different modes of playing and combining them with the related experience I came to categories again. For the group of unphrased and phrased episodes my specification was as follows:

Table 8  Modes of phrasing: unphrased playing

<table>
<thead>
<tr>
<th>musical contact</th>
<th>musical structuring, grouping</th>
</tr>
</thead>
</table>
| The therapist experiences in the patients activity a clear limitation to get into contact and to create mutual contact. The therapist himself will experience that he can hardly reach the patient. Possibly he is able to relate to the structure of alternate movements of the arms or to relate to a musical structure which is orientated to the formal organisation of the instrument. The patient does not relate to the structure in the music of the therapist. | In the musical activity of the patient the therapist experiences a lack of coherence and organisation. He can’t follow an intention in the playing. The therapist experiences a tendency to a static or disintegrated temporal quality in the patients playing, clear temporal perspectives can hardly be experienced in the music. In the activity the therapist feels qualities like:  
  - disorientation,  
  - nondirectedness,  
  - instability,  
  - emptiness,  
  - poor communication,  
  - limitation in physical activity. |

..mode of playing in the experience of the therapist...
The resulting valuation of the two modes within the clinical context is as follows:

<table>
<thead>
<tr>
<th>musical contact</th>
<th>musical structuring, grouping</th>
</tr>
</thead>
<tbody>
<tr>
<td>The therapist experiences the client as partner, who is able to (inter-)act with an autonomous quality. There is a connectedness with the own activity or the mutual activity. He can either relate to or distance himself from the therapists music. The therapist might be able to follow the structures of the client and to relate to the patient’s music.</td>
<td>The therapist experiences a quality of presence and temporal directed activity in the musical activity. He perceives clear intentions in the patients’ music and may be able to meet and support them. In case this is not possible he experiences a significance and meaning within the activity for the patient himself. In the temporal quality of the patient’s music the therapist experiences flow, form and dynamics. An interest in the own activity or in the shared music is perceptible.</td>
</tr>
</tbody>
</table>
Table 10 Valuation: unphrased playing

<table>
<thead>
<tr>
<th>Valuation of the mode of playing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The nonphrased playing expresses a limitation in the potential to relate and communicate and to direct activity. The way of playing indicates, that the patient is disconnected to himself, the music or the therapist. He can’t direct and lead activities (they just happen). The playing expresses that the patient is not able to develop intentional possibilities. Presence or acting with a direction into the future is not or is hardly possible. There is a loss/limitation of temporal flexibility and synchronising capacity, there is a lack of temporal synchronisation with the surroundings.</td>
</tr>
</tbody>
</table>

Table 11 Valuation - phrased playing

<table>
<thead>
<tr>
<th>Valuation of the mode of playing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The phrased activity indicates - an ability to develop individual intention within the activity, - the use of individual possibilities for meaningful activity, - a connected activity and a clear orientation within, - an ability to experience, relate and create temporal coherence, - the ability to form and express, The musical activity indicates presence und directedness to the future.</td>
</tr>
</tbody>
</table>

Let me make three explaining comments in regard to the categorisations:

1. Of course a repetitive and monotonous playing as I described it for example with the mode of an unphrased playing doesn’t necessarily
express a limited or limited directed activity. This way of playing has to be seen as one of many possible modes of musical expression. But it does express a limitation if it is the only modality of expression because of an intrapersonal inflexibility. The differentiation as I put it has to be understood against that background.

2 Secondly I don’t intend to value the sense of a mode of playing by categorising. Against the background of an individual biography and of a psychopathological development a chaotic or stereotype playing can be seen as a meaningful coping with a personal situation and an adequate expression of a state of being. The therapeutic handling with these characteristics has to respect and cover that.

3 There also exists a „formal“ way of phrasing, by structuring in segments, practiced in a very mechanical and stereotype way, with a quality as I described it for the unphrased activity. This way of playing is similar to phrase mongering in speech. I valuate that as a sort of „unphrased phrasing“.

Conclusions
The findings of my study suggest that the concept of phrasing allows to describe individual aspects of formative creation. Beyond that it allows to describe

• the potential of structuring activity
• the temporal directedness and temporal orientation in the activity
• the connectedness with an activity
• flexibility and freedom in the activity
• intentionality and self-determination
• synchronisation of mutual activity.

The relevance of these findings is supported by research findings and clinical observations which show that psychiatric illnesses manifest themselves as temporal disturbance or disorder of time in many ways (Emrich 1994; Heimann 1989; Hoffmann 2001; Jost 2000; Mundt, Richter, Hees und Stumpf 1998; Münzel 1993; Payk 1989; Steinberg,
Krause, Lerch und Raith 1985; Tellenbach 1990; Theunissen 1997). This can be seen for example in a limitation of

- the quality of performing and structuring time,
- the individual experience in time,
- the direction of perspective in time,
- the temporal synchronisation with the environment,
- the autonomy in personal control of time.

The concept of phrasing meets those temporal dimensions in a musical context.

Comparing different episodes within the therapeutic process of one patient illustrates different modes of phrasing and underlines the development of different qualities in the process of therapy. By comparing different modes of playing in the process of one patient it is obvious that a growing ability to phrase is combined with

- a growing interest in one’s own activity,
- growing intentionality and orientation,
- growing presence,
- growing directedness in the activity,
- growing confidence.

I draw the conclusion that supporting the potential of phrasing within the process of therapy may help

- to regain ability to experience and create qualities of time and timing
- to lead to improved orientation
- to support a presence and connectedness
- to support growing intention in action
- to support the availability of temporal dimensions
• to support temporal synchronisation in social context
• to support the experience that is is possible to develop understandings, to actively shape one’s own life, to encourage personal autonomy and thus to avoid becoming dominated by time

My findings and my conclusions relate to the clinical work in psychiatric context. I suppose that these ideas might also be of relevance for other clinical fields (as for example the work in neurology, psychosomatics aso).

Second part of the study

In the second part of my investigation I asked ten music therapists to categorize 12 episodes from different therapies which were presented to them as audio-extracts. They were asked to use my categories of unphrased and phrased playing as shown before. The intention was to see whether music-therapy colleagues in the psychiatric field could follow the differentiation and the valuation of different modes of phrasing.

I presented to them the categories of unphrased playing (called mode A) and phrased playing (mode B) and asked them to mark the episodes accordingly. Episodes which did not fit to A and B should be marked with a C. After a second listening the C examples should be marked with a tendency to the mode A (as CA) or to B (as CB).

In the first table you can see that in most of the cases two thirds of the colleagues shared my classification (indicated by dark background):
Table 12 Inquiry 1 – description of different modes of phrasing

The next table summarizes the classifications to A and CA on one and to B and CB on the other side. It illustrates tendencies. The results illustrate a tendency towards a similar classification among the questioned and in comparance to mine (you can see a disagreement with my classification of example 3 by the interviewed persons).

<table>
<thead>
<tr>
<th>Episode No.</th>
<th>Mode of Play</th>
<th>A</th>
<th>CA</th>
<th>CB</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td></td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>CA</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>CB</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>B</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>A</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>B</td>
<td>1</td>
<td>1</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>CA</td>
<td>1</td>
<td>1</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>CB</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>B</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>A</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>A</td>
<td>1</td>
<td>6</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

A=unphrased playing  
CA=tendency to A  
CB=tendency to B  
B=phrased playing
Table 13 Inquiry 1 – description of different modes of phrasing

In a second inquiry I intended to prove/substantiate my valuation of the modes. The results are similar to inquiry 1.

As you can see, those examples I categorised as unphrased or phrased were similarly marked in the inquiry. But there were diverging estimations in the modes I categorized as CA or CB.

<table>
<thead>
<tr>
<th>Episode No.</th>
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Table 14 Inquiry 2 – valuation of different modes of playing

The following table again illustrates the tendency in the classification to the categories of unphrased und phrased playing. The results show an agreement within the group of the interviewed and also according to my classification (with the exception of episode 3 and 7).

<table>
<thead>
<tr>
<th>Episode No.</th>
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</table>

Table 15 Inquiry 2 – valuation of different modes of playing

Conclusion

The findings suggest that the concept of phrasing allows to describe individual aspects of formative creation, orientation within time and in dealing with time and the development of creative intentions within the
musical play. To support phrasing within the process of therapy may help to regain the ability to experience and create qualities of time and timing and may lead to improved orientation, growing autonomy, growing intention in action and the way to relate to others.

It seems that colleagues can follow the categorisation and valuation of different modes of phrasing in this study.

The findings of the study also underline the significance of the musical material in music therapy improvisations for diagnostic understanding and clinical work.

The concept of phrasing corresponds with physiological, neurobiological, psychological and social processes. Research findings in related professional fields illustrate a human disposition to phrase, to articulate or group, as in the physical activity of breathing, in the neurophysiological activity of grouping or segmenting in the activities perceiving or thinking activity, in the rhythmic process of all physical activities. There is also a correspondence to temporal processes. The phenomenon of time is of relevance because a successful use and availability of time and temporal dimensions seems to belong to succeeding life. In most of the psychiatric illnesses the availability of time and temporal dimensions is limited. This background underlines the importance and relevance of the concept of phrasing.

References:


Address

Peter Hoffmann
Institut für Musiktherapie
Universität Witten/Herdecke
Alfred-Herrhausen-Str. 50
D-58448 Witten

810
peterh@uni-wh.de
Common Interaction Frames; their meaning for developing social interaction in music therapy

Holck, Ulla
M.A., Ph.D.
Institute for Music and Music Therapy
Aalborg University, Denmark
holck@musik.auc.dk

Introduction; research focus

This presentation is based on a Ph.D. dissertation about music therapy interplay with children with severe functional limitations, including children with severe autism (Holck 2002a). These children are typically socially withdrawn and have also considerable difficulties in the area of communication, verbal as well as nonverbal.

The focus of my research is how to understand and describe meaning in music therapy interplay with these children. More specifically, my aim has been to identify some of the conditions, whereby actions can be understood as meaningful - that is, whereby the child and the music therapist can 'read' each other's actions as meaningful in the context. For this purpose I have applied existing communications theories and, in addition, I have analysed specific music therapy interplay, in order to describe interactions with a certain degree of mutuality.

Quantitative music therapy research has shown that music therapy with this group of children generally results in increased communicative ability - for example visual attention, use of vocal sounds, imitation or turn-taking (for example, Aldridge et al. 1995; Bunt 1994; Edgerton 1994; Müller & Warwick 1993; Plahl 2000). In addition, qualitative
interviews and tests in these same studies show that the children, as a result of music therapy, are seen to be more expressive and easier to 'read' by parents, teachers and/or music therapists.

The latter refers to the fact that these children typically have a way of expressing themselves that is difficult to 'read'. Where normally developed children exhibit many concurrent nonverbal cues in social situations, these children show few cues or mixed/conflicting ones. This is most extreme with children with infantile autism, who, for example, can look away or show an expressionless face, while at the same time reaching out for the person they want something from. Here it is important to point out, as autism researchers such as Schuler, Prizant and Wetherby (1997) stress, that only by interpreting the child's actions as intentional, can one help him to develop the ability to express himself clearly. In the clinical situation with children with communication difficulties, there is a delicate balance between, on the one hand, interpreting the child's often idiosyncratic expressions as attempts at interaction and, on the other hand, requiring that the child express himself more clearly - in order to encourage communicative development (Hauge & Tønsberg 1998; Schumacher 1994).

In research of music therapy interplay, it is important to be aware of this balance. If the aim is to prove music therapy's effect on the child, only clearly communicative expressions should be measured. However, if the aim is to analyse the interactive process between child and music therapist, one must consider whatever the participants themselves react to as communicative in the situation. Or, in other words, what it is that
makes the interplay meaningful for them to participate in. Not that we can know what the child experiences, but that his relative concentration, sustained interest and enthusiasm can show us that the interplay is meaningful for him.

**Theoretical frame; the pragmatic approach**

My theoretical approach is based on pragmatic communication theory, and the analysis is related to infant and autism research. In the following, I will briefly summarize the pragmatic aspect in relation to communicative processes, because it provides a useful perspective from which to understand the aspect of meaning in music therapy interplay.

The pragmatic approach states that the meaning of an action (a word, gesture or musical expression) is its specific application in the specific context (see for example Littlejohn 1999; Small 1998). The focus is on context and intention. The context tells the participants what a given action means, but also the intention behind the action.

The pragmatic aspect in communication processes has to do with both the ability to make oneself understood and the ability to participate in meaningful social interaction.

*The aspect of understanding* has to do with the ability to make oneself understood through conventional signs (verbal as well as nonverbal) related to the context. This means adapting one's statements depending on who the other person is, the nature of the relationship, what one assumes he or she already knows and with that, which internal or
pragmatic codes can be used (Littlejohn 1999). In this way, local cultures develop their own codes, that only the participants understand.

Children at a very early stage of development and specifically persons with autism have difficulties perceiving this level of human interaction, because it requires being able to see things from the other's perspective. Aside from this fact, however, we can, as Ruud (1998), understand the aspect of meaning in music therapy to be partially connected to the development of musical codes between child and music therapist. This means codes that are perceived as meaningful by precisely these two persons, because they have created them together, from session to session, and they both know that the codes refer to a particular musical (syntactic) 'order' or (pragmatic) intention.

The social-pragmatic aspect has to do with each person's basic ability and interest in making the (verbal or nonverbal) interplay 'work' on the social level - by showing interest in the other person's actions or expressions, responding to them and helping to keep the interplay going. The social-pragmatic aspect is seen as and guided by gestural or prosodic cues. For example, turn-taking is guided by a long series of mainly implicit nonverbal cues in the form of eye contact, nodding, smiles, prosody, etc. that indicate turn-taking, turn-giving etc. (Knapp & Hall 1992). In this way, social interplay is directed by continuous nonverbal feedback between interactive partners.

By focusing on the actions' function in the interplay (pragmatic meaning) rather than on their content (semantic meaning), Prizant and Duchan (1981) have shown that autistic children's echolalia in certain situations
acts as an attempt at turn-taking. Here the echolalia occurs together with a series of turn cues such as eye contact, leaning towards the other, etc. So even if the child isn't able to respond in a semantically meaningful way to the adult's statement, he understands that the adult wants something of him, and responds to the approach as well as he can. This can be called a social-pragmatic action.

This is of course an important point in relation to music therapy with children with communicative difficulties. These children's visual and musical cues - despite their often idiosyncratic appearances - can thus indicate a certain degree of mutuality, when seen as an attempt to participate in interaction continuation.

**Qualitative Observation Research; practices**

Following the pragmatic approach it makes sense to use Qualitative Observation Research, with reference to the ethnographic research tradition and Naturalistic Inquiry (Lincoln and Guba 1985). Generally, the aim of Qualitative Observation Research is to investigate the 'practices' of the persons being observed. These are found by investigating *what the observed persons need to know or to have experienced (often implicitly) in order to do what they are doing* (H. Wolcot in Silverman 1993).

For example, if a child walks over to a trampoline in the beginning of every music therapy session, sits down on it and waits for the music therapist to sit at the piano and start playing, this indicates that he is familiar with the trampoline, and knows that his actions and the
therapist's actions are connected to each other. Reversely, the music therapist's actions indicate that she knows what the boy expects AND that she can be sure that he will wait for her - which is not a matter of course for these children!

Even though this example may seem commonplace, it shows a small 'practice', that has been built up from session to session and therefore contains a series of more or less implicit expectations between the partners - which is a condition for understanding musical or interactional variations or humorous surprises. In this way, the practices are the 'local' context for interplay, because they make it possible for the partners to 'read' each other's expressions as pragmatically meaningful in the context. I will return to this example later.

**Common interaction frames; "Interaction Themes"**

Through a cross-comparative analysis of selected music therapy sequences, I have found a series of these mutually created interaction frames between children and music therapists that I have chosen to call "Interaction Themes" (decribed in my thesis (Holck 2002a), but also at the European Conference in Leuven, Belgium, in an preliminary version, (Holck 1999)). The musical material is in itself quite simple, but within the musical structure, the interplay has an improvisational quality, musically as well as interactively. Often the child takes the initiative while at the same time obviously anticipating the music therapist's participation.
Because the Interaction Themes are developed gradually from session to session, they bear witness to the interaction history the child and therapist have developed together, that makes it possible for both of them to 'read' variations/deviations in the other's actions. Through closer analysis, it becomes apparent that every Interaction Theme is make up of a series of smaller and relatively implicit practices between child and therapist, that to a great extent are guided by social-pragmatic cues.

In order to analyse these Interaction Themes, I have recorded music therapy interplay with two cameras and subsequently edited, so that both the child and the therapist appear in the same frame. First I have transcribed the auditive and visual material, then I have analysed the sequences horizontally and vertically. In the horizontal analysis, the material is divided into a series of episodes, which then are analysed parallel to the temporal axis in the material. In the vertical analysis the interactions are compared across the material, for the purpose of finding patterns in the material. (Pattern-generalisation is one of several qualitative ways of addressing the question of validity (Lincoln & Guba 1985, Silverman 1993), as repeated interactions between child and music therapist show that these actually are interactions and not arbitrary parallel incidents).

**Practices; example 1**
The first example is with a boy of 9 years with typical (infantile) autism. He and the music therapist have developed an Interaction Theme with a big drum (90 cm. in diameter) where he plays a certain small rhythmic motif. The music therapist typically accompanies with a counter-
rhythm. The boy interrupts the interplay often, by changing the tempo, moving his fingers across the drumhead, etc., but each time he returns to the little motif, played at approximately 80 beats per minute, and each time the therapist starts to play again after the interruption.

Historically this Interaction Theme has developed out of an earlier and much simpler theme, where the child and music therapist took turns playing a single beat towards the middle of the drum. They each played 2 or 3 beats and then the boy broke away from the turn-taking interplay. In contrast to this earlier Interaction Theme, that only lasted a few seconds, at the time of recording the boy is able to continue playing with the therapist for 5 minutes before breaking away. As it appears the length of the interplay has been significantly increased. He does, of course, as mentioned earlier, make small interruptions in the musical flow, but each time he returns to the familiar Interaction Theme - in a way that makes it easy for the therapist to join in. Later development of the Interaction Theme shows that he becomes even better at forming his musical variations, while at the same time his ability to enter into turn-taking interplay improves.

Based on the Interaction Theme, a series of small social interactions between child and therapist occur. I will describe here the most implicit of their practices. When I reviewed the sequence the first few times, I noticed that there were situations where the therapist reacted very quickly - and where it was impossible to see why she reacted so quickly at times, while other times not reacting at all. But by vertically comparing the
places where the boy looked in the direction of her/her hands, I discovered the following relationship:

(1) The boy looks at the therapist, at times with a certain movement, (2) the therapist responds, often with imitation, (3) the boy then sometimes reacts with increased visual attention and/or enthusiasm.

This means that the therapist typically reacts after having (more or less implicitly) received a visual cue from the boy, and at the same time her quick reactions /imitations elicit a positive reaction from the boy. Autism literature shows that even the most autistic children often react with spontaneous attention when their behaviour is imitated. In this situation, the therapist's interaction history with the boy makes it possible for her to 'read' his idiosyncratic expression quickly, so that she can respond spontaneously and well-timed. Moreover, there is no doubt that the music also enhances the quality of her timing. This probably has great significance for the child's chances of discovering the connection between his own and the therapist's actions.

**Practices; example 2**

The second example is about a 5 year old boy with atypical autism. Here the practices are much clearer, and the boy shows clear signs of early forms of intersubjectivity in relation to the music therapist (Trevarthen 1998).

Their Interaction Theme consists of the following; he jumps on the trampoline to the therapists piano accompaniment, after which she makes an (expected) 'sudden' break in the music. He stops jumping, and after a
few seconds, she plays a little calling motif on the deep dominant note. As he smiles, says "two" and starts jumping again, the therapist ends the break by counting "one - two - three - now".

Within this Interaction Theme, there are several practices that vary a little each time. As for example, when the therapist doesn't start playing again after the boy's first "two", but looks at him teasingly. He smiles and repeats the word "two", sometimes accompanied by an as-if jump on the trampoline.

As it appears, they have developed a 'local' pragmatic code between the two of them (the word "two"). There are also signs that the boy understands the therapist's use of the dominant in the break as a musical (syntactic) code. An example of this the therapist, instead of making an actual break, plays a cadence that ends with a chromatic scale descending to the dominant. The boy masters this musical variation, as he says "two" just before she reaches the tonic chord.

These common practices have a slightly different significance here than in the first example, where they primarily helped the therapist to understand the boy's cues as being just that. The boy on the trampoline is much more social and his social-pragmatic cues are much more readable. So here the common interaction-frame makes it possible for the therapist to vary her expressions and challenge his autistic need for sameness - in a way that he can manage within the structure, and that he enjoys!
Conclusion; results and clinical applicability

As mentioned earlier, quantitative music therapy research has found evidence of increased communicative ability such as imitation and turn-taking, and has at the same time pointed out that others often find these children easier to 'read' as a result of music therapy. It goes without saying that if the children can communicate more clearly, this will influence others' ability to 'read' them.

As a supplement to this quantitative knowledge, I have, from an interactional and ethnographical perspective, shown a series of interactional patterns between child and music therapist that they often engage in with a kind of tacit or implicit procedural knowledge. This knowledge of 'the way it is, when we're together' corresponds to the basic question of Qualitative Observation Research 'what do the people need to know or to have experienced, in order to do as they are doing?'

Dependent on the child's diagnosis, this knowledge ranges from purely procedural to more relational, intersubjective types of knowledge. The point is, however, that before one can measure a child's communicative improvement, there has to have been a series of exchanges that - if the therapy is to be successful - must be pragmatically meaningful for both partners to participate in.

From the qualitative perspective I have shown some of the factors that this meaningfulness is dependent on, in the form of common interaction patterns or practices that 1) are developed from session to session, at times implicitly, 2) make it easier for each partner to 'read' each other's
cues and 3) can gradually develop into more explicit (and intentional) communicative actions.

The greater the child's social and communicative difficulties, the more important it is for the therapist to be aware of developing common interaction frames, because these frameworks promote the child's (spontaneous) responses, and, perhaps especially, the adult's possibility for understanding them. In this way, the therapist can react appropriately and well-timed to the child's often idiosyncratic cues - in such a manner, so that the child discovers it.

Here it is worth pointing out, that mutuality is seen developmentally long before intentionality - as implicit social pragmatic cues. These cues play an important role in the perception of an interaction as meaningful. Even though the musical interplay may seem rigid, seen from the outside, it is important to see the distinction between compulsive repetition without interaction and narrow, yet still variable, interaction frames, that make small musical and interactional variations possible.

Common interaction frames are important for all kinds of interplay between people, but because it is difficult for these children to transfer knowledge from one situation to another, it is extremely important for the therapist to be aware of the historical aspect of interplay. Interaction frames, in the form of Interaction Themes, etc. are thus not only structures imposed from the outside, but rather 'expectation-structures', that the child and therapist gradually have developed together. In clinical work as well as in observation of clinical situations, the interaction patterns that are discovered become an important basis for interpretation.
Only through discovering repeated patterns (ground, themes) is it possible to observe changes (figures, variations). Likewise, it is only by having expectations, that we can discover variations or surprises as such (Holck 2002b). This is true for all relationships, but crucial for music therapy interplay with children with communicative difficulties.

**Literature**


Dangerous Music  -Working with the Destructive and Healing Powers of Popular Music in the Treatment of Substance Abusers

Horesh, Tsvia  
M.T.  
Ramot Yehuda Zoharim Therapeutic Community  
ISRAEL  
Tel./fax 972 5436 510  
horeshfamily@hotmail.com

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 loosing one's connection with reality, even onto death, 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.

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 anywhere from 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 all inclusive, drug free, therapeutic care for the addict, as an individual and as a member of society, and is based on the assumption that drug dependency is a mix of educational, psychosocial, 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.

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 enabled him to deal with frustration, to disassociate from an oppressive and demanding reality.

In making the transition from the culture of addiction to the culture of recovery, one 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 beginning stages of treatment, each client is encouraged to begin to identify his high-risk relapse factors - the personal cues, the "people, 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 co-dependency;
- **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 ethnicity, 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 stoned 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, 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, 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 addicts 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. This is 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 - whatever's on the radio. 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.

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
music do they like to listen to, they each spoke about relapses that were
music related.

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 more research and clinical
experience are needed.

The music that was pointed out as potentially dangerous was, basically,
of 4 different genres:

1 heavy metal
2 rap
3 rave, techno and house
4 Israeli Mediterranean music, a local genre of popular music, more of
which will be said later on.

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:

- 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.
• Young immigrants prefer heavy metal and rap from the former Soviet Union, most of who came to Israel 10 years ago or less.

• 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. Because of the scope 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?**

Try and remember how you feel when you listen to heavy metal music. Or, better yet, listen to some now. 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 present situation of reading a professional article. Many addicts don't have those capabilities, or else, they are not easily accessible. After listening to a song of the heavy metal group "Metalica", 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, and - 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 that has been done on the effects of heavy metal music on adolescents reinforces some of my clients' reactions. Jeffrey Arnett from
the University of Chicago, 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, 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 English 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 the 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, sink 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 in his room, alone. His mother knew that such behavior was 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. And yet 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 of 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 certain kinds of music that are so integrally bound to drug use as to make it nearly 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 the issue of 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 with the sometimes crucial 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.

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.

**The Road of Temptation**

Words: D. Zigman  
Music: traditional Turkish  
Singer: Ofer Levi

*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.

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.

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.

In the discussion that followed, I asked the people to relate to the emotions evoked by the song, and to their feelings during the improvisation. The atmosphere was tense; some people spoke about their painful memories, while other chatted with their neighbors, 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 addiction. This was not their usual behavior. The clients, having been in treatment 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 overwhelmed 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
behavior 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 fistfights 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.

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 at the underlying emotions, and appreciate the purging and organizing effect the improvisation had on them.

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 together created 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 in 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.

Comments will be appreciated!

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What happens in music therapy: An ecological approach and a theoretical model

Hughes, Philip
SRAsT(M), PhD

Look for his Powerpoint Presentation in the “Oxford Powerpoints” folder

ABSTRACT

This paper will first examine the perception of music in a music therapy session with reference to ecological psychology and music psychology. A summary is given of the complicating factors such as clients’ past experience of music, but also associations with musical idioms and the sounds of the instruments. This serves as a reminder that the theoretical positions (for instance music psychotherapy and ‘music as therapy’) which therapists use to inform their work, could lead to idealisations of a ‘messy’ reality. Notwithstanding this, a theoretical model is presented of what music therapists might be doing when they work in the two media of words and music, drawn from the author’s experience of mathematical modelling. The concept of bi-level optimisation is put forward as an analogy for the way the therapist has to think in two media at once, or at least in the same session, and ‘optimise’ the distance between therapist and client in both media, at the current point in the process of the therapy. A separate but related model is given of insight and resistance in music therapy, using ‘catastrophe theory’. The ideas may be of particular relevance to music therapists working in psychiatry and/or with psychosis; a clinical vignette is used to illustrate this.

INTRODUCTION

This paper has two strands, both motivated by the big question “What is music therapy?” As a relatively recently qualified therapist, I have found myself inevitably trying to work out my own response to this question, in the process of finding and consolidating my way of working in clinical practice. Thus as models of what happens in a music therapy session
they are personal to me, and there is always a danger they will seem obvious, or “so what?” The ideas will serve their purpose if they provoke some thought, and perhaps clarify some of the assumptions we sometimes make.

As a UK-trained music therapist I use improvised music as a means of non-verbal communication. In the search for a theoretical framework for this tradition of music therapy, (at least) two contrasting positions have emerged. In one the importance of verbalising where appropriate or possible is stressed, so that a model of a talking therapy, often but not always based on psychoanalysis, is vital. The other stresses the therapeutic value of music itself, so that it may be impossible or undesirable to try to verbalise what has happened in the music.

In this first section I want to point out the ways in which music therapy doesn’t quite fit into any particular theoretical framework, while in the second section I fail to resist the temptation to provide my own theoretical framework. Music therapy has always been a ‘practice’, and the value of a framework will be in stimulating ideas in practitioners, whilst the limitations of such frameworks should always be acknowledged.

**THE IMPORTANCE OF CONTEXT**

By analysing the ‘context’ of a music therapy session, I hope to understand the different expectations and preconceptions which therapist and client bring to the experience. Clearly, there is a therapeutic context which we as therapists hope to set. Defining this will in effect be yet
another definition of music therapy: my attempt at this would be the context of a developing relationship between therapist and client, expressed through music and (where appropriate) words, in which the therapist’s interventions are aimed at helping the client to achieve greater understanding of his or herself. This definition of the different roles of therapist and client will vary slightly according to therapists’ theoretical orientations.

However, there will be other contexts, expectations and preconceptions that intrude, that need to be overcome and/or acknowledged. At a basic level, we have associations that are brought to mind by any sound or instrument. The field of ecological psychology deals with how we perceive our daily environment, including sound. Gaver (1988 and 1993) has written about sound in this way, giving a framework for ‘everyday listening’: sound provides information about the environment, in terms (for instance) of the speed, size, direction of an approaching car. Categories of sound were suggested as produced by vibrating solids, gases and liquids, also the source attributes (interaction type, material, configuration e.g. shape/size). Gaver asked subjects to identify a range of everyday sounds, which they did very accurately. He also included some ‘implausible’ sounds, such as someone walking across a floor covered in newspaper; this was identified as walking on snow or gravel, or rhythmically crumpling paper – one person correctly identified the sound, and then rejected it as impossible.

The conclusion is that we use sounds to make sense of our world at quite a basic level, and it certainly seems likely that those associations will stay
with us even when we know that they are produced by musical instruments. In my experience, clients can compare the sounds of the instruments directly to everyday noises such as a door shutting, and this is perhaps trying to make sense of the somewhat strange experience of a music therapy session in terms of things they know well. Again, because the focus in the session is on sound, there may be a heightened awareness of outside noises which can be used consciously or unconsciously to distract from the process of therapy. Gaver’s categories of sound production and source attributes have their parallels in the categories of musical instrument, although the correspondence is not always exact – obvious examples are the rain-stick and ocean drum, producing quite convincing watery noises using non-watery substances.

Ecological psychology also has something to say about our perceptions of musical instruments as objects. Palmer et al. (1989) carried out four experiments where adults and children tried to identify the picture of an instrument which was played on a recording. Results were better for Western than the unfamiliar Chinese instruments, but identification of the family of each instrument was quite good (chordaphones, aerophones, idiophones and membranophones). The authors suggest an interpretation based on ‘affordances’, being in this case the combination of substance and surface layout specifying how the instrument should be played. Gibson (1977) defined ‘affordances’ as “specific combination of the properties of its substance and its surfaces taken with reference to an animal”.

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One conclusion from the Palmer et al. experiments seems to be that people are quite good at identifying how a sound was produced. This may be somehow related to the observation that clients in music therapy often display an affinity or preference for one instrument or class of instrument, although part of the process of therapy may be in beginning to explore more varied musical expression. Another client of mine had a fascination with the cymbals to the exclusion of any other instrument, and in the early phase of therapy would quite happily have played them on his own for the full session. My challenge was to find a way to move this fascination with a particular sound towards more interactive music-making.

The other finding of the Palmer et al. experiments was that there were, as expected, cultural factors: the instruments from the subjects’ own culture were easier to identify. Clearly, a client will find some instruments in a music therapy room familiar, and some less so. Leading on from this, the client’s previous experience of those instruments will influence their perceptions. Some percussion instruments may seem childish if they were last seen in school music; the piano or the therapist’s other instrument may bring associations of unsuccessful music lessons, and hence feelings of failure. The issue of skills and the perception of the therapist as a teacher is one of the commonest hurdles for client and therapist to overcome.

The cultural perception of instruments also leads, of course, to the issue of the musical cultures of the music therapist and client. Music therapy trainings help therapists to improvise in as flexible a way as possible, but
it is inevitable that they will be most comfortable in idioms which they are familiar with. There are various examples in the music therapy literature (for example Henderson 1991, Loveszy 1991, Mereni 1996, Pavlicevic 1994) where the importance of being able to adapt to an idiom from another culture is discussed. Whilst a therapist cannot necessarily become an instant expert in another idiom, for instance to the extent of learning unfamiliar instruments, he or she will probably be able to use the skills they have to respond sensitively to the client’s particular form of musical expression.

The musical backgrounds of the two parties are only one facet of course of the cultural issues involved in a therapeutic encounter. Other issues, which of course overlap with the talking therapies, are verbal cultural issues – whether therapist and client share the same first language, and whether there are different cultural assumptions about verbal interactions. Within British culture, there are many subtle differences in the way people interact verbally and many clues that we give away about our social class, ethnic background and regional allegiances – for instance, people from the North of England often say that they have a more direct, friendly style of verbal interaction than those from the South. As music therapists we are interested in musical communication but there are other non-verbal communications to be aware of, such as our body-language, and the way we dress.

These are all contexts which might be seen as ‘obstacles’ to the ‘pure’ communication in words or music which we might be aspiring to. Seen positively, they may provide fruitful work for therapy, in that the
exploration of obstacles to a relationship is the beginning of the exploration of that relationship. At the least, I suggest they need to be acknowledged. I defined a context at the beginning of this section which might be the one which the therapist is ‘aiming’ for: a developing relationship between therapist and client, expressed through music and (where appropriate) words, in which the therapist’s interventions are aimed at helping the client to achieve greater understanding of his or herself. To arrive at this context, music has to be understood as communicative, and that what the client plays may have emotional significance and meaning. Clearly this achieved principally by ‘doing’, by responding musically to the actions of the client. However, given that there is no universal agreement within music therapy on how to interpret the ‘meaning’ of a musical interaction, different therapists will approach this problem in different ways. If the musical communication is seen as having sufficient meaning in itself, and indeed is ‘untranslatable’ into words, the client may be encouraged to play without much recourse to
words. Other therapists may encourage the client to try to put into words what ‘happened’ in the music, the feelings which may have been aroused.
A THEORETICAL MODEL

Traffic and Music Therapy

I spent some years in my first career, developing computerised models of traffic, predicting in particular the way people choose routes, and the impact on delays on roads. The model of music therapy which follows is based very loosely on mathematical ideas from that field, but I feel it is important to stress at the outset what should be obvious, that it is not a mathematical model in the same way, but an analogy which I have found helpful and interesting. For myself, of course, there is also a pleasing symmetry in bringing together ideas from the two diverse parts of my working life.

There are at least two problems in traffic which involve ‘bi-level optimisation’, in other words trying to find the ‘best’ set of variables in two problems at once. For instance, the set of traffic flows on different roads through a town is assumed to obey the rule that drivers are trying to minimise their journey time. The set of demand variables, on the other hand, represents the number of people who want to travel between each possible start and end point in the network. This (we assume, again) will depend on the cost/time of the journey, so people choose their shopping trips for instance based on length of journey, as well as factors such as the choice and cost of purchases. The most accurate prediction will be found by satisfying both the demand and the flow assumptions at the same time, yet this is mathematically very difficult. We can find a solution by solving first the demands and then the flows, and repeating
until there is no change, and this will usually yield a ‘good’ solution, but not necessarily the ‘best’.

Since I began my second career in music therapy, I have been fascinated by the relationship between words and music. I now wonder whether the communication in these two media has something in common with ‘bi-level optimisation’. The optimisation represents the therapeutic aims of the therapist, who is trying to find the best place in the musical relationship and (at the same time) the best place in the verbal relationship, for the current phase of the therapeutic process. The best places in music and words may be quite different – for instance the closeness which is achieved in a musical encounter may be difficult to transfer immediately into words. Because we operate in one medium at a time, it may be difficult to see the best overall place to be, just as in the traffic problem.

**Distance in a Relationship**

The quality of a relationship clearly has many facets, positive and negative, which we might be able to call ‘variables’; I would like to project these many dimensions onto one, and call it ‘closeness’. A client is often referred because they find it difficult to achieve closeness in words, so the scenario where the musical relationship is closer than the verbal one may be common and appropriate, especially in the early stages of therapy; however, I suggest that this imbalance becomes uncomfortable if it is sustained. On the other hand, if the verbal relationship is much closer than the musical one, it is possible there is a temporary resistance to the client expressing themselves musically.
Again though, there are implications if this position is sustained: presumably the sessions are then operating more as a talking therapy, and should be acknowledged as such. In figures 34-36, these possibilities are shown by the lengths of the arrows joining the client and the therapist.

**Figure 34 Communication in words and music**
Figure 35 Closer in music than words
If the ‘distances’ in words and music were plotted, we could show the three positions mentioned above in graphs:
Figure 37 Graph – As close in words and music
Figure 38 Graph – Closer in music
A Clinical Anecdote

I found the concept of distance and closeness in a therapeutic relationship very helpful while I was training, when I saw a man with schizophrenia for nine months. He would often attend for part of the session, and would also periodically miss sessions; I felt there was a game between us as I tried to guess which sessions he would miss, and that I was gaining greater understanding as I was more able to predict this. Often we would achieve a closeness in one session, but I would be able to predict that he was likely to miss the next one. This feeling that he could only tolerate closeness on his terms, and for a certain amount of time, extended to individual pieces of music; there were many times when we had just
found a common music, when he would suddenly put down his instrument, leaving me ‘stranded’.

The comparison between the verbal and musical relationships is illuminating here as well; often he would object violently to an interpretation, or even storm out, and I had to work out whether my verbal abilities were indeed wanting, a real possibility especially as I was still training, or whether he found the insight too threatening, in the same way that the musical closeness seemed to be threatening. Verbal communication became easier as the musical relationship developed, but was probably led by progress in the musical communication.

**Insight as a Variable**

To extend these graphs, we now include the ‘optimisation function’, which in simple terms is ‘the thing we are aiming to maximise’. In music therapy, again this could be represented by many variables, which I will ruthlessly project onto one, called ‘insight’. We can imagine a graph of the level of insight possible for different positions in the musical and verbal relationships; when this is plotted above the 2-dimensional surface of the graphs in Figures 37-39, we have a contoured landscape. As therapists we are trying to find the highest point of this landscape at the current moment - to help the client to the maximum level of insight possible at that stage of therapy. So the graph of insight is not static – one possible scenario may be for the maximum to be for some time where the two people are close in music but not in words, to then move to closeness in both, and then to a healthy separation as the client works towards an ending.
Figure 40 The best place is closer in music
Figure 41 The best place is closer in words
Hierarchical Constraints

Without stretching the traffic analogy too far, there is one more comparison which may be interesting, or indeed we may decide that the analogy breaks down here. In bi-level optimisation problems, the two problems are often not completely ‘equal’; in the traffic example, once the demands are fixed, the flows can only take a certain range of values, so they are ‘constrained’ by the demands. In music therapy, an analogous statement might be that what is possible in the verbal relationship is determined by what has happened in the musical relationship. Some therapists will agree with this statement more than
others; I am not sure I agree with it, if it were to be taken as operating in every moment of every session. There must surely be times when the musical relationship is not progressing, and a verbal intervention moves things forward. On the other hand, as a summary of what is possible over the progress of therapy, perhaps the hierarchical view is a statement that as music therapists we are (generally) trained in musical more than in verbal communication.

**Catastrophe Theory, Insight and Resistance**

Catastrophe theory was developed in the 1970’s first by Rene Thom (1975), and then by others including Christopher Zeeman (1977), my supervisor for an M.Sc. in mathematics. The arresting title refers to sudden (rather than particularly negative) change; in nature many step-changes occur as a result of continuous changes in other variables, which were difficult to model mathematically before catastrophe theory. As catastrophe theory was popularised, it was used to model phenomena in the social sciences, where the variables are less quantifiable; a layman’s summary of such applications is given in Woodcock and Davis (1978).

In this tradition, I will use a ‘cusp’ catastrophe model to extend the previous model of music therapy to include resistance. In Figure 10 below, the surface is akin to a piece of paper, folded in an S-bend at one side, but not the other; it represents the possible states open to the client (at the current stage of therapy). As ‘communication’ increases, the client moves along the sheet of paper from the right-hand end. If resistance is low, then the client can move smoothly up the piece of paper and to increased insight. If resistance is high, however, there is a point
where the client needs to ‘jump’ to the upper part of the paper, and where of course the therapist’s help is particularly needed. Perhaps the therapist’s intervention at this point is to let the client know that they are not in fact bound by the two-dimensional surface of the paper!

**Figure 43 Catastrophe theory graph illustrating resistance**

This graph could be viewed as embodying the overall resistance in music therapy, or else we could think of a pair of graphs of musical and verbal resistance. For instance a client could encounter greater resistance in words than in music (or vice versa at different parts of the process).

**Non-verbal Clients**

Clearly the ideas described above apply most naturally to clients who are physically able to communicate verbally. So therapists working in
psychiatry may find the ideas more interesting, compared for instance those working with clients with severe learning disabilities, or advanced dementias. However, often clients’ receptive language is much better than their spoken language; the communication may be ‘one-way’ and as therapists we make judgments as to what kind or level of verbal relationship may be possible. One valid position is that the musical relationship is the one which empowers the client and puts them on an equal footing with the therapist - to use many words oneself emphasises the client’s disability. This position does not of course preclude the fact that we are thinking in words about the relationship when we reflect afterwards, and in supervision.

**Figure 44 Model of communication with a learning disabled client**
CONCLUSIONS

This paper has attempted to point out the ways in which clients’ and therapists’ perceptions impinge on the process of music therapy. The pure ‘transference’ model of psychoanalysis and the purity of the experience of musical communication may be ideals which we try to facilitate, but do not achieve, even though we may come close. The second half of the paper used some mathematical ideas to give pictorial views of how music therapists may be working within music and words at the same time. The writing of this paper been enjoyable, in bringing together ideas from my previous career with my present one, and helpful, in clarifying and developing my thinking on the process of music therapy.

ACKNOWLEDGMENT

The author is indebted to Dr Philip Barnard of the Cognitive Brain Sciences Unit, Medical Research Council, Cambridge, for some illuminating conversations in the early stages of writing this paper, in particular, in pointing out relevant parts of the psychology literature and helping to clarify my thoughts as to how they might apply to music therapy.

*Philip Hughes* is a music therapist, currently working for Rampton Special Hospital, in forensic psychiatry, and in private practice with children and adults with learning disabilities.
Correspondence may be addressed to the author by email (p.hughes10@ntlworld.com) or at the following address: Arts Therapies Department, Rampton Hospital, Woodbeck, Notts. DN22 0PD.

REFERENCES


Training in Music Therapy: Potential music therapist in potential space

Inada, Masami

1. Introduction

1.1. Music Therapy in Japan today
More than three decades have passed since Juliette Alvin visited Japan. Under the influence of her demonstrative play of music, various kinds of music activities were adopted to special education for handicapped children, both physically and mentally. Also her masterpiece “Music Therapy” was translated into Japanese in 1969, which was only three years after the original work had been published. Despite these early introductions of music therapy from Britain, these germinant music activities did not come into flower as music therapy, nor did people understand the importance of music as an agent of paramedical care; Alvin’s landing seemed to be too early.

In 1990s, however, music therapy suddenly came into spotlight. One of the main reasons appears to be that a new type of support system for elderly people was established in 1980s accompanied with the extension of life expectancy. The system is characterized by providing a few-month care and rehabilitation on institutional basis without special medication. Generally, people are able to utilize this type of nursing home to prepare for return to their own home after discharged from the hospital; it plays the role of the halfway point to back to their normal life.
In this condition, a variety of rehabilitation programmes are provided to meet the elderly people’s individual needs, and music activities have come to be taken in as one of the choices. Enjoyable sing-along and listening to music in old days are just two of the typical activities there, but most musical activities prevailing so far do not seem to have clear therapeutic point of view nor any theoretical basis. The fact holds true of any other settings for any other populations, such as for people with mental illness and children with special needs. Sometimes it seems to be that music activities are taken place for the activity leaders’ own sake, and that they tend to feel self-satisfaction through the activities. It seems urgently important that sincere music therapists should be brought up so that music activities designed in clinical settings can be appreciated as genuine therapeutic work.

On the other hand, the actual situation in Japan is that music therapy has not yet been well established as one of the paramedical occupations. Therefore, most music therapy students who have finished their training do not have opportunity to play an active part as professional music therapist. Nonetheless, there are more and more college students who want to learn music therapy. What does this phenomenon tell us? How can we respond to such a demand? One of the answers to be found is that the training for music therapist is sure to be the basis of all the occupations involving helping people, as well as the basis of all the occupations related to music.
1.2. Background and outline of “Training in music therapy”

The music therapy teaching programme the author has been engaged in was started in 1996 as one section of the department of music at a women’s college. This is the first music therapy course in Japan that holds systematized curriculum for four-year college education. One of the most important issues to run the course is that the trainer should keep the pace with the development of the students’ whole personality. The trainees are young, inexperienced and immature; in Japan, college students in the first grade are mostly under 20s, being in the middle of seeking each one’s individuality.

This paper focuses on the attitude of the trainer who teaches the young musicians, whose aptitude for music therapist is unknown but who may have infinite potential at this time of life. The illustration here is based on the author’s own experience as full-time teaching staff at college since 1996, and the theoretical framework of that is drawn from Winnicott.

The discussion begins with mother’s function in terms of mother-infant relationship, which will be applied to the trainer by way of psychotherapist and music therapist. Interactive work between trainer and trainee is discussed by being compared to mother-infant interactions and therapist-client relationship. Consequently, a unique phase of the function of the trainer will be suggested. Video excerpts will be also inserted (in the presentation).
2. Function of the mother

2.1. Winnicott and his mother-infant theory

Winnicott applied the developmental relationship between mother and infant to psychotherapy, and explored the function of the psychotherapist in mother-infant interactions. He found the common feature of the function between mother and therapist in that the therapist actively participates in the growth of his/her client’s personality.

The intention here is to make it clear that mother’s function, i.e. that of psychotherapist illustrated by Winnicott, will be able to be equally applied to both music therapist and music therapy trainer. Winnicott classified the function of the mother who participates in her child’s personality growth into three phases: holding, wearing, and surviving.

2.2. Three phases of mother’s function

2.2.1. “Holding”

In the situation where “holding” by the mother is sustained, the infant is secured in absolute dependence on the mother, and keeps omnipotent feeling. The infant is completely protected from any physiological obstacle or infringement of the external world. While being held perfectly in this way, the infant is able to gain the feeling of “going on being.”

Winnicott considers that if holding environment is not supplied by the mother during the first period of life, the infant will never be able to develop his/her emotional function and gain any way of maintaining his/her mental health. Holding environment is the indispensable condition in
which the infant will soon be able to obtain the basic relationship with the mother as object.

2.2.2. “Weaning”

The function of the mother shortly shifts from “holding” to “weaning.” At this stage, the infant is not able to feel omnipotence any more, as formerly being perfectly held and wrapped by the mother. Mother’s breast is no longer what he creates omnipotently, but it appears at hand after he craves it. The mother does not react as the extension of her child. A “good enough” mother does not respond to her child with perfect attunement, but begins to make him/her feel frustration without exceeding his/her tolerance threshold. The infant can be given an opportunity to experience his/her desire through this action of the mother. The infant notices the separateness with the mother by being emotionally weaned. Here s/he begins to experience the mother as object. At the same time at this stage, however, the infant understands that both oneness and separateness with the mother are simultaneously true. This opens the door to “potential space.”

The timing where the condition changes from holding environment to the environment in which the mother holds moderately but not perfectly, i.e., the time of weaning, is a critical point for supporting the infant’s mental and moral development. If holding environment is lost too much early, the infant becomes overresponsive, and defensive character will be strengthened; s/he will develop the stiffened personality. On the contrary, if holding environment is supplied longer than a needed period, experiencing moderate frustration or manageable uneasiness and conflict
will be barred, and the infant will miss the opportunity to learn how to deal with him/herself.

2.2.3. “Surviving”
The third phase of mother’s function is “surviving,” i.e., holding the situation over time. The infant experiences the mother as object who does not retaliate on him/her, just being there, when the infant imaginarily destroys the mother as inner object. Destroying and losing the mother causes him/her to have the feeling of guilt and concern. In this way, the infant cherishes his/her “true self” through the total reliance to the environment.

2.3. Application of mother’s function to music therapist

2.3.1. “Holding” by the therapist
A pulse is a division of time into equal, recurring segments. It represents homeostasis and the energy does not aim at any object. The pulse equates with the heartbeat that the infant feels when embraced by the mother.

In music activities, pulse is the most basic starting point for making music; it serves us with security, stability, and predictability. Bruscia describes that pulse provides a “ground” that holds, supports, controls, and equalizes energy and drives, and that it serves to ward off primal anxiety and fears of overstimulation (1987, p.451). The experience of feeling pulse corresponds to the state where a need or desire does not exist, that is, the feeling of “going on being.”

In music therapy, the therapist will be able to protect the client from fear of initial insecurity or the excess of stimuli by providing him/her with a
sequence of regular beats. In musical improvisation, for example, giving steady beats to the client enables the therapist to serve him/her with holding environment, and to facilitate his/her spontaneous sound-making.

2.3.2. “Weaning” by the therapist

Just as the mother who is nurturing her child with so-called “primary maternal preoccupation” changes into a “good enough” mother, so the time comes when the music therapist working with the client should shortly turn into a “good enough” therapist. In holding environment served by the therapist, the client’s musical reactions tend to match the therapist’s sound even in improvisational interactions. Completely synchronized actions may make immediate musical communication active, but will not contribute to meaningful emotional exchange. In order that the therapist can facilitate the client’s mental growth, it is necessary to encourage him/her to explore and expand his/her domain of freer expression. Thus, the therapist may have to try “musical weaning.” When we consider “weaning” as a musical phenomenon, it may be referred to a rhythmic pattern formed by the pulses driven to higher order. Bruscia states that the forming of a rhythmic pattern is the process of becoming disembedded from the pulse and that it is the leaving of one’s holding, nurturing environment (Bruscia, 1987 p.452). Nevertheless, any rhythmic pattern can avoid abrupt dissociation from the pulse when having the form of recurring movement. The repetitive rhythmic pattern produced in musical improvisation creates the world where the client simultaneously experiences the oneness and
separateness with the therapist, which leads to musical “potential space” created in collaboration with therapist and client.

2.3.3. “Surviving” by the therapist

Mother’s function of “surviving” corresponds to that of the therapist who survives s emotional world when s/he tests the certainty of reliance between the two. Sometimes the client may make a sudden sound which interrupts the flow of music being facilitated by the therapist, or may add completely heterogeneous sound to the music. For the client, these are intentional fighting for individualization, with the risk of losing the secure environment and the crisis of isolation.

When the therapist encounters that kind of situation, maintaining stable attitude enables him/her to show his/her survival to the client. Individualization of the client is not attained unless the therapist survives. The therapist has to be able to hold any therapeutic situation over time, by containing any responses from the client and/or providing stable, soothing sound or rhythm, for instance. When the firm reliance is established, the client comes to be able to accept uncertain musical changes, acquire flexibility to respond to unpredictable reactions, and enjoy more thrilling improvisation to be played.

2.4. Application of mother’s function to music therapy trainer

2.4.1. “Holding” by the trainer

In the case of music therapy training, for the trainer to serve holding environment, musical experiences with some higher level are expected. Improvisational activities with musical structure assure safety and
predictability, and give comfortable opportunities for self-expression to the trainees. Rhythmic patterns of ethnological nature, a variety of scales and modes, and idiomatic chord progressions enable the trainees to share rich musical experiences. In other words, both trainer and trainee are able to be “going on being” by being protected by these musical structures. Then both party can try to play in music and play with music, without threatened with the energy running outside the world.

2.4.2. “Weaning” by the trainer
To promote the phase of “weaning,” the trainer encourages the trainees to pursue a wide range of musical variation. Playful musical experiences will facilitate the trainees’ adventurous and challenging attitude of mind. For instance, trying to change the original rhythm or time of well-known precomposed pieces will give them a new experience of performance as well as a new taste of sound.

Around this time of the stage, it is also suitable to expand free improvisation. The trainees often find it difficult to be free from any structure of music, especially when they have been well trained as musician. The trainer must be able to give them appropriate advice for freer music-making.

2.4.3. “Surviving” by the trainer
At a certain point of working with trainees, a flood of questions may be directed to the trainer regarding her stance or standpoint as active music therapist. The time has come when the trainer is prepared to exert self-disclosure. This must be a challenge for surviving. The trainees may also project their personal problems and difficulties on the trainer, and when
the trainer survives, they understand that the trainer, as their senior, has passed through similar hardships, and that some of them remain unresolved. Then the trainees feel more equal to the trainer. “Surviving” is an important stage for the trainees to develop their professional attitude of mind, and it leads to establish “equal team” relationship between trainer and trainee.

3. “Playing” in “potential space”

3.1. “Playing” within mother-infant relationship

“Potential space” is the hypothetical concept by Winnicott regarding the domain created by earliest interaction of mother and infant. “Potential space” is the place where the infant is moderately held by the mother along with his/her ability to internalize the mother. Winnicott believes that the child can “play” in this potential space; it serves as a playground for the child, a place for creative experiences.

“Potential space” is also explained as the middle domain where the distinction between oneness and separateness of mother and child, or, between inner and outer reality remains unquestioned. In the space, the child experiences the boundary of “me” and “not me” in a flexible manner.

While playing in “potential space,” the child learns both to depend on his/her environment and to adjust him/herself to it, and makes preparation for gaining reliance and confidence at the same time. It is in this very space that “capacity to be alone” progresses: being alone in the
presence of someone. In this space, the child also obtains the ability to
develop his/her imaginative power and form symbols.

When the child has distrust or fear to the environment, “potential space”
turns into a threatening place for him/her. Where “potential space”
assumes the state of outer reality, imagination is pent up, vitality is
deprived him/her of, and the space cannot function as a playground. The
lack of imaginative play, or make-believe play is a typical example that
shows that imaginative power has not been cherished. On the contrary, if
“potential space” inclines exclusively toward the fantasy accompanied
with omnipotent feeling, the fantasy will become a “thing,” and playing
will take on obsessive actions.

3.2. “Playing” in music therapy
Winnicott states as follows.

*Psychotherapy is done in the overlap of the two play areas, that of the
patient and that of the therapist.* If the therapist cannot play, then he is
not suitable for the work. If the patient cannot play, then something
needs to be done to enable the patient to become able to play, after
which psychotherapy may begin. (Winnicott 1971, p.63)

Improvisational music created through the interaction of therapist and
client develops when their inner conditions resonate in musical space,
where there is the overlap of the two play areas. It is unnecessary to
question about which of the two has emitted the sound, or to whom the
sound is going to belong. The sound and emotional energy of both
therapist and client tend to flow between “me” and “not me,”
continuously being “attuned” (in Daniel Stern’s sense). Intensity and
pitch of sound, tempo, and rhythm constantly change along with
moderate deviation attempted by both party. This phenomenon is equivalence of what takes place in “potential space” created between mother and child. Here, playing of mother-and-child and music-making of therapist-and-client become equivalent, having the same word and meaning of “playing.”

3.3. “Playing” in music therapy training

It is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self. (Winnicott 1971, p.63)

Therapeutic procedure is to afford opportunity for formless experience, and for creative impulses, motor and sensory, which are the stuff of playing. And on the basis of playing is built the whole of man’s experiential existence. (Winnicott 1971, p.75)

According to the statements above by Winnicott, the focus will be moved to “playing” in music therapy training with relation to therapeutic situations. In order that the music therapy trainer can take on the function of the mother and bring up the trainees, it seems primarily important to make them feel less pressure, to encourage them to “play” music spontaneously (the word “play” is emphasized because of its Winnicottian meaning), and to lead them to share their feelings both verbally and nonverbally, whenever appropriate.

The following are some illustrations of the activities in the author’s class at college. For the trainees to be in “holding environment,” one of the
ideas the trainer can introduce is the concept of “Orff-Schulwerk.” Orff’s work for music education suggests spontaneous music-making with simple structure. Music in pentatonic scale on drone (sustained bass line) and ostinato (repetition of a fixed pattern of melodic phrase) provides the players with predictability, safety, and trusting relationship. The trainer’s attitude here is neutral confirming and accepting, just as that of the mother at the “holding” stage. The trainer being permissive, the trainees shortly start to explore their own idea in the musical structure, willing to risk change. Then there comes the next stage.

“Weaning” can be referred to inevitable imperfection of fit between mother and infant. For the trainees to experience well-dosed frustration, one of the suggestible ideas of music-making may be group improvisation with percussive instruments, members standing back to back with one another so as not to be able to rely on visual cues. Within the framework of interaction, they will enjoy playful atmosphere, having a tolerable amount of frustration and uneasiness that provides them with awareness of separateness.

At the “surviving” stage, the trainer promotes “equal team” relationship, by holding even a defiant situation over time in an unretaliative manner. The trainer may apply the same music activities as she does at clinical work, explaining that through the activities, she makes every effort to develop her own practice as active therapist. One of the effective ideas drawn from the clinical setting may be titled or referential (referring to something outside the music itself) improvisation.
The examples shown here are under the titles of “Amusement park” (the excerpt is “Haunted house”) and “Around the world” (the excerpt is from “the Arctic zone” to “A huge plain in China”). These titles were decided after impressive negotiations. Titled improvisation tends to encourage freer verbal communication both before and after music-making. Spontaneous actions, both musical and verbal, will lead to greater motivation and creativity in one’s whole life.

Table 1 shows the roles of music therapist and music therapy trainer in music activities, compared to the three phases of mother’s function:.

<table>
<thead>
<tr>
<th>Phases</th>
<th>Music Therapist</th>
<th>Music Therapy Trainer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holding</td>
<td>Providing stable beats to facilitate spontaneous music-making</td>
<td>Providing and sharing elements of structured music</td>
</tr>
<tr>
<td>Weaning</td>
<td>Promoting improvisational interaction with various rhythmic patterns</td>
<td>Promoting moderately unpredictable interaction through improvisation</td>
</tr>
<tr>
<td>Surviving</td>
<td>Containing any musical responses from client</td>
<td>Facilitating “equal team” relationship</td>
</tr>
</tbody>
</table>

3.4. “Delivering”

“Delivering” is the fourth phase of the function of music therapy trainer that the author suggests. Delivering generally means bearing a child, or transferring something to somebody. At this final stage of the function, it can be said that the trainer bears potential therapists, or transfers her role to the trainees.

When the trainees spontaneously start soothing, or loosely structured improvisation, it seems that the time has come when they are ready to “hold” one another, or to do “inner role-playing.” The latter implies that
one can be the part of holding and of being held at the same time. “Potential space” is being created among the trainees.

Two excerpts of untitled improvisation will be shown on the screen. The first one is being played in rather relaxed mood with rounded tune. The players seem to enjoy one another’s sound by not questioning which sound belongs to whom. The second one is played by three trainees. The student in the middle is just like a child who is playing alone in the presence of the mother. That is, the trainees on each side play the role of environmental mother, and the child has obtained “capacity to be alone.” Winnicott states that “capacity to be alone” is one of the most important signs of maturity in emotional development (1965, p.29). The trainees will mutually be able to bring up mature persons in musical experiences.

For strengthening and developing the potentiality of trainees in terms of spontaneity and creativity, pleasurable activities with some visual materials are also adopted when appropriate. For example, squiggle game from the idea of Winnicott expands interpersonal relationship in a playful fashion. Squiggle pieces belong to “me” and “not me,” because they are created between two persons. Another example may be collage work with verbal exchange. It promotes intrapersonal relationship, containing and/or releasing one’s inner feeling. It not only facilitates “capacity to be alone” while at work, but also encourages one to discover the self through verbal communication to others. One of the trainees once mentioned that she had never knew she was so bold in assorting such picture fragments as having very different tastes. Another trainee
expressed her cheerful feeling of using vivid colors, which she had never chosen for her clothes.

4. Conclusion

Alvin states that music therapist should possess the right personality, and lists some of the personal qualities essential to succeed in music therapy. They include a stable, mature personality, the ability to communicate, to share and to observe, to show warm sympathy and understanding without becoming emotionally involved, to have a sense of humour, to be patient and tolerant whatever happens (1966 p.159).

This statement seems to perfectly correspond to the mother’s function mentioned by Winnicott. When potential music therapists are trained to carry the personal qualities above, they will lead successful life whatever occupation they may choose after leaving college.

Davis and Wallbridge state as follows in relation to “potential space" created by individuals.

. . . the overlap of personal experience is what gives to social institutions and custom their character, stability and flexibility. The value to society of the potential space of each individual lies in the contribution that can be made in terms of personal creativity. This, of course, includes the creations of outstanding individuals in the arts and sciences who have so obviously enriched our culture, but equally significantly it includes a giving of the self in less spectacular areas of living and working. (Davis & Wallbridge 1981, p.66)

When the trainees accumulate rich experiences of holding and being held, of cherishing spontaneity and creativity, and of interacting in “potential space,” they will be able to realize their full potential and reveal their own unique goals. And more basic but more important
prospect is that the potential music therapist will be able to play the role of a container in any community.

References


The reflective Practitioner - an approach to Integration of Clinical Practice, Research and Training

Neugebauer, Lutz ; Janssen, Winfried; Schmid, Wolfgang; Hoffmann, Peter & Fachner, Jörg;

Abstract

As music therapists we are not only part of a professional community. we also contribute to the common body of knowledge. This applies to all areas that are relevant for the development of our profession: clinical work, research and training. Only by keeping in contact with colleagues and training places we can form feedback circles that inform clinical practice, research and training. As a University institute stating a concept of "life long learning" it is our task to promote and offer a structure which is supportive to colleagues, students and to ourselves. Our idea is that clinical practice, research and training are not separate, but belong together as a reflected practitioner has to connect all the three areas, without falling into three thirds. We believe that in our institute we have chosen a way of combining these areas in a way that is worth while sharing. Either to invite other colleagues to participate or to apply what is applicable for their own professional environment.

The Institute in it´s cooperation (presented by Wolfgang Schmid)

Let us talk about practical work with our clients, how they find their way to us and how our institute is integrated into local patient´s care.

To give you an insight in this, we decided to share with you René and his music therapy as an example of our work and the institutionale structure. Before René came to us, he was treated in the in-patient psychiatric ward for children and adolescents in the Community Hospital in Herdecke. Our Institute has it´s origin in this hospital and we still have a very close cooperation. Nearly all colleagues of the Institute work there once or
twice a week. We cover the fields: Adult-psychiatry, neurology, psychosomatics, intensive care, early rehabilitation and a psychiatric dayclinic. In the second year of their training the students have their placements in one of these fields and are supervised by the therapist who works there.

But we also have an out-patient-service within the institute, which opened Monday to Friday. Children and adults come to individual and - more seldom- to group-music-therapy. There is a waiting list and all therapists who work in the institute, offer places.

For group music therapy we are dependent on the cooperation with institutions where group therapy can be offered continuously and where we have hardly any organisational problems.

For two years now the Kämpenschule, a school for mentally disabled children and adolescents is our practicesfield for groupwork. Nearly 100 pupils are attended there by a highly engaged stuff of educators and it is a very good setting for our students group work. Twice a week we do four group and four single sessions. Often a teacher is present during the sessions so that there is a flow of information about the work between teachers, students and supervisors.

There are also activities in doing group music therapy with adult clients. Two colleagues offer for five years now open groupwork in the „Christophershof“, which is a residential centre for handicapped people.
Beside this we have a very close cooperation with a kindergarden for children with special needs. From there the children for our first year students come to the Institute for ambulant music therapy.

The list of our cooperations illustrates the status quo and is, as we think not static, but has to be adapted to the changing and different needs of clients, students and society. It helps us to save praxisfields and find new ones in relevant clinical areas. This is a good way to enter and stay in contact and exchange with teachers, doctors, carers and therapists and to be part of the german health system.

Back to the practical work.

**Case example: René (presented by Winni Janssen)**

**Training (presented by Peter Hoffmann)**

The work with Rene very nicely leads over to the training at our institute and to the aspect of practice within this training. The close relation to the reality of practice represents one of some fundamental ideas of the training:

- Although the training represents an academic study it is always related to or centred in practice and practical work. All the subjects are settled around practice experiences and relate to them. One assumption for this idea is that all the teachers are practicioners. That makes it also possible that teaching takes place in working places within or outside of the university. The importance of practice is also stressed by the beginning of the students practical work within the first weeks of the training. Our intention is that they collect practice experiences as much and as early as possible.
• We understand the training as a process of individual accompaniment of each student during a process of personal development and acquiring skills and abilities. Overall aim is to support each student developing his/her skills and his/her own personality.

• Although there is a stable frame we try to keep the content of training flexible. Our intention is to model the training and optimize content and form due to current necessities of each year, due to the needs of the individual student and due to new ideas developing. This idea requires a close and regular exchange with the students and among all the involved teaching staff.

• Our training is based on the principle of model-learning. The idea is to develop musical, professional and personal tools that students will be able to develop their individual interest and skills with self-confidence within the professional area they want to work in.

• We believe that learning doesn’t stop with final examinations. So we offer a service after training: regular exchanges among former students for example, but also supervision, advisory help and literature service, help and support in scientific work, publication service.

Basic intention in our training is to support students to use their individual musical and personal competence within a music therapeutic context. Main focus in the training lies on the

• development of musical competencies and skills
• the development of perception and the ability to reflect musical and personal process.

The training is a two year supplementary study for people who have completed a training as musician. Candidates have to complete a nursing-practice before participating in auditions which consists of three parts:

1 performing on the piano and singing
2 improvising on instruments and singing
3 a talk with members of the teaching staff.

Let me give a rough overview over the structure of the training and let me mention some of the content.
The structure of the training:
The training is a two year training divided into four terms, two terms each year. The first year is centred on observation and practical work with children (single therapy and group therapy work). The second year may include clinical work with adults in different fields like psychiatry, psychosomatics, neurology.

First year
Within the first year it is aimed to help students to develop an attitude of listening and perceiving. They get to learn different perspectives of describing musical and music therapeutic situations. Students observe sessions regularly and discuss their observations and questions with the therapists and are introduced to analyse tapes of these sessions.

Students start to work with kids in single and group work within the first weeks of training. They regularly meet their supervisors who observe the therapy in the working places in the beginning.

The practical work is embedded in a collection of different subjects with a musical focus. Students are introduced to different musical techniques, how to accompany a client in the way he or she needs it, to accompany groups, to establish group work, to develop improvising techniques or supporting activities in co-therapy. They also get the chance to explore the relation between musical techniques and the experience of special techniques from the perspective of a client. Additionly we offer fields for musical-self-experience but not within the teaching.

In other subject fields students are invited to compare and to combine different perspectives of therapeutic observations, own experiences,
theories about therapeutic work and medical knowledge. The medical subjects start with anatomy/physiology and pediatry, followed by psychiatry, neurology and psychosomatics.

**Second year**

In the second year of training the focus in different subjects is to reflect and communicate content of the practical work and to get into touch with scientific work and research. There they meet Jörg, David Aldridge. Within the second year students may start to work with adult clients or continue in other fields. Teachers take students f.e. with them from university to hospitals and other institutions, where they do their own clinical work. So the practice work of the students outside of the university is supported and supervised by teaching staff from the university. Complementary to the experience of new practice fields at time time students learn to work in interdisciplinary teams, they get to know different professional perspectives, they learn how to speak about their work, to write reports aso. In the fourth term the practical work is embedded by the scientific work, writing the diploma-thesis, preparing the exams.

During the training our students have to follow subjects of the Study Fundamentale of our university. The fundamental idea of it is that all students get to know different scientific, philosophical or artistic perspectives - different to the perspective of the subject they study.

After the first year there is an examination in form of a case presentation. This examination does offer a mutual reflection for students and teachers.
Students and teachers do discuss their mutual expectations before going on or not.

The final examination after two years of studying includes a case presentation of clinical work, different verbal examinations and a diploma-thesis.

Writing a thesis for the students means to get access to scientific methodology and scientific database.

And that leads over to the next field.

**Center of knowledge and competence (presented by Jörg Fachner)**

The first single case study on Rene we have heard earlier mentioned several aspects of his disease. He was a child with a developmental delay and a specific clinical picture, which is categorized as the diagnosis Asperger’s Syndrome. This diagnosis includes a communicative disorder of diminished eye contact. These issues might lead to the wish to get a deeper understanding of what this disease is about.

Diminished eye contact would be categorized as a nonverbal communication research issue, which has a broader meaning and would include facial expression, gesture and visual perception.

In our research department, one of our goals is to deepen knowledge and competence of reflecting practitioners. As one pragmatic consequence this means we are collecting and selecting qualified articles on these topics. We order interesting articles with a sound scientific method, which might be also close to music therapy practice issues, or deal with
same patient-therapist relationship patterns as we can observe them for instance in papers on nursing science. We are providing the current content of the scientific debate on those topics in order to offer preselected information for a reflecting practitioner.

One can explore our database on our website, which contains about 20 thousands sets of bibliographic data and information indicating whether this article is in our house. Furthermore, bibliographic data can be searched on our annual occurring CD-ROMs, which are published and updated every year. Most of full text articles issued on our CDROMs are prepared for download from our website as well. To publish your work on these CDs you are invited to send us your work.

In order to provide such a service, insight into the music therapy profession, its practice on the ward, in schools or mental health care institution, into different music therapy approaches is necessary. It is of great importance to discuss with ‘reflective practitioners’ to fit this service to the needs of the music therapy world. Therefore we do not focus only on our music therapy method taught in the house.

**Training issues and doctoral students**

And- surely this work is of importance for our students. Because this is a University course there has to be proof of their ability for scientific reflection. At the end of their training they have to write a thesis on a certain scientific topic of interest. After having read most of the standard textbooks during their study courses they are ready to ask more specific research questions about their interests which have developed in practice. Here over the two-year course we have accompanied them in study
courses and now some of them are ready to read and find articles about their research topic. Basic help to find literature and appropriate search strategies is the beginning, and then, if one needs other research material, like questionnaires, computer programs, hardware or observation equipment we would provide help to get started as well.

Nevertheless, their questions and ideas have to be treated within a framework of research and ideas that have been already done or not. It is a basic and essential process in research to sort out whether their ideas are their own or from others, to indicate and cite what someone has already done and what is their own original idea. You can observe common and average work, which repeats what is already there, or you might witness the emergence of an extraordinary idea, which comes into form and offers a new insight into a known topic. To separate a known idea from the new ones is part of artistic progress and hence this is another place where science and art meet.

Anyhow, as our main subject is art, our publications should have an artistic ambience. One of our colleagues in the research team is trained as a designer and she illustrates our words in books, posters and articles with a contextual artistic form.

Some of the students go further, they worked in an institution for a while and then they decide to graduate further or they want to deepen a research question during doctoral studies. Here the archive again becomes a vital source of knowledge, which can be researched. The questions that will be developed during research supervision at the Chair of qualitative research have an open focus on several issues of clinical work. Research is open to
different topics, but connected to same categories of knowledge and sometimes it is only after the third view that it becomes understandable why this research is connected to music therapy research.

**Cooperation**

But surely our job is not only to collect, preselect and maintain information resources. As a research department our aims go further into our own research ideas, to deepen our questions and of course to provide an argumentative structure for instance for insurance companies. It can be very helpful for parents to receive preselected scientific material, which helps them to argue with insurance agents about the effectiveness and a financial support for music therapy sessions.

We have done a study on children with developmental delay receiving music therapy. One group of children was treated with music therapy for three month while another group received no music therapy. After three months the children of both groups were rated with the Griffith scale of child development and then the untreated group received music therapy. Despite the ethical issues which always arise in such clinical research studies, our result clearly suggested a significant progress in those children treated with music therapy. Especially the hand-eye-coordination has shown improvements. Such research is a valuable tool for decisions whether a treatment of handicapped children should be supported from insurance companies.

Publication of our ideas and results might lead to further research cooperation together with other institutions concerned with similar topics. In this year we have started a systematic review project in
cooperation with University of Melbourne in Australia and University of Aalborg. Here we are reviewing music therapy research and his effectiveness on several diseases.

This was just a short view into the manifold issues of our research work. To witness our progress you might like to take a short look on our website. Last but not least in my actual function as the editor of the Online-Journal “Music Therapy Today” I would like to invite you to send us your ideas, news, comments and articles for online-publication.

Short Biography:

Prof. Dr. Lutz Neugebauer, head of the 'Institut für Musiktherapie, Universität Witten/Herdecke'; Winni Jansen, Wolfgang Schmidt, Peter Hoffmann teachers in the training at the institute. All are working as music therapists in different clinical areas (psychiatry, neurology, children) and following research projects.
A Choir’s Voice Whispers “The Tunes of Its Identity”

Jarjoura, Katy

My name is Katy Jarjoura and I am a Palestinian from Nazareth. I am here today to talk to you about my experiences of being a conductor and a music therapist in Israel.

My background

Let me give you a little background about my life.

In my adolescent years, I walked my first steps towards building a trusting relationship with music. It was through the wonderful musical instrument – the guitar. I was attracted to the flamenco style for it uses singing, dancing as well as playing as a means of expression. The lyrics are about personal experiences and sentiments. The Flamenco root word in Arabic is felagenkum which means the migrant farmer is coming. Flamenco reflects a certain attitude towards life that is very difficult to translate: Pride, Self Confidence and Style. I played intensively to a point where my guitar became an important component of my life and became my companion wherever I went and traveled. I was ready to spend hours with this companion, playing and composing songs; describing my emotions of love, ambivalence, conflicts and even pain and anguish.

Then I became a music teacher. During those years, I noticed that I did not compose much and this disturbed me. I did not know why. In 1988, I founded a high school choir and became the conductor for this group. As a conductor, I could choose the songs; organize order of singing and
emotional expressions through out the performances. The high school choir became well known locally and nationally and was invited to do several performances. The performances performed in Israel, always had a message to deliver. The aim was to make people of different cultures aware of the richness of the Palestinian and Arabic music.

In 1991, I completed my studies as a music therapist. I chose to become a music therapist for I felt the urge to connect the psychological and musical parts in me. Emotional expressions were not enough and needed further interpretations. Since that realization, I have been using the same approach with the choir. The endless dialogue between the educator and the therapist within me began. I realized that composing songs and singing were a powerful means of expression and this is what I had been doing all my life.

I work as a music therapist with children with various mental and physical disabilities in Nazareth and Haifa. Being the only Palestinian music therapist yet I choose to work with Palestinians. This makes me responsible and more committed to my community. There is no doubt that I bring myself into the music room but I am not the conductor. A child is free to use all means to express himself and be communicative, and has the right to be dominant and leading in our meeting.

**Ud al-Nad**

In 1994, I founded a group called “**Ud Al-Nad**” with the support of the Nazareth municipality. **Ud Al-Nad** is a plant renewing the top growth seasonally that lives for an indefinite numbers of years, and is used to
produce fragrance when burned. This group is composed of nine females, six males, some of which are from the high school choir and the rest are from the community. The vocalists are not musicians but they have a love for singing. They do not read score but have a great musical memory.

Identity and repertoire

Our repertoire symbolizes our identity as a national Palestinian minority living in Israel. We sing traditional Arabic songs, classical styles, Byzantine Christian chants, Islamic and Sufi songs. We are not limited to one type of music or singing for we feel the necessity to represent our rich culture. Therefore, we are constantly searching for the source of our voice, and linking it to the essential vocal training techniques. We use the songs that arise from the heart of the community, and put depth to the words by living their emotional meaning and send them back to achieve a profound influence in music and meaning. We use the voice and its echo without musical accompaniment. This creates a totally new and different experience.

Looking back at the history of the choir, I realize as their conductor, that the members are not just there to sing. There is a deeper goal for the choir’s existence. We try by our singing repertoire to ensure the preservation and continuation of our Arabic culture for we are part of the Arab world.

Most of the work done with Ud-al–Nad is to give the verbal content its emotional meaning. A verbal phrase improvised on the same scale
communicates significant character differences and emotional colouring. Prosody is the rise and fall of pitch, bringing attitude, implication and colour to what we say and engage the listener in. Nevertheless, it is the timbre of the voice that unveils the emotions, state of mind, and moods.

There are many ways of singing the same tune for there are different qualities of voice with which a tune can be sung. It is the colour, the quality, the timbre of a voice that arises its emotional content.

The message of Ud- al-Nad is a universal one, which means that we need to be fully conscious of what we sing, to think deeply of it and its effects, and to aim for the most profound expressions. This is vital for preserving our Palestinian culture while living in Israel.

**Preparation of performance**

Minutes before the performances, while getting ready to walk on the stage, the performers are anxious, and sometimes breathless. When the performance actually starts in the first few minutes the level of anxiety lessens and the power of singing prevails. If the performer is having a personal crisis then the verbal and vocal channels may contradict and incongruence occurs. Here the incongruence reveals the truth about the personality of the vocalist rather than the singing. This is the reason why it is important for us to be aware of our present emotional state and try to control it so as not to convey confusing and ambivalent messages to the listener.

Since the beginning of the second intifada, on September 28th, 2000, it became difficult for Ud-al-Nad members to commit themselves to
rehearsals. The political situation accelerated and on the first and eighth of October 2000, three citizens from Nazareth were killed by the Israeli police force. The question of belonging and the confusing issue of the Palestinian identity while having the Israeli citizenship, the unbreakable bond with our Palestinian people in the occupied territories was in danger. Because of the terrible situation, we became confused about our role as a choir and what we can do about the pain and feelings of insecurity.

**Voice workshops**

Voice work is not easy by itself for it makes us uncover deep feelings of the unconscious. The voice is able to dive inside the body and touch many hidden emotions. This led us to do a lot of voice work in order to encourage free vocalization, writing and movement. The elements of discomfort, pain and insecurity aroused. Because the vocalists felt related and “being with” others who share the same elements they were able to release their emotions. The trust among us allowed the musical voice training to become therapy. Therapeutic workshops became dominant for a while instead of the actual voice training. Being a Palestinian music therapist and a conductor enforced this kind of work for my approach to the choir began as a musician but is now more tending toward therapy since we cannot ignore the political events happening around us.

The ten components of vocal expression {loudness, pitch, pitch fluctuation, register, harmonic timbre, violin, free air attack, disruption,
articulation) form the core of voice movement therapy system founded by the voice movement therapist system, Paul Newham.

It is both an analytic profile for interpreting voices, a psychotherapeutic means by which to investigate the way psychological material is communicated through specific vocal qualities, and training system for developing the expressiveness of voices and a physiotherapeutic means by which to release the voice from functional misuse.

The most significant use of this system is not only to analyze what one hears, but to enable the human voice to acquire the skills and powers to manage the various combinations of vocal qualities. "When this is achieved, the voice is able to serve both artistic procedures by bringing greater vocal flexibility to the process of singing and is also able to express a greater range of emotional and psychological experience" (Newham, 1999, p.99).

"Because these vocal components are rooted in the elementary physiological and mechanical operation of the voice, they can be applied with equal efficacy whether analyzing vocal expression in a therapeutic setting or vocal styles in an artistic context" (Newham, 1999, p.100).

We started doing voice workshops in order to express all our feelings.

The voice work preparation was on vocalization of sounds and movement and then gradually molding them into a melody that reflects psychological and emotional state. This authentic experience created an authentic melody and some vocalists wrote words to it. Each one had his song or melody and sang it simultaneously. The different ingredients that
compose the voice such as loudness (loud to quiet) pitch (low to high) pitch fluctuation (fast to slow) register (falsetto or blended) were present.

“An authentic expression of trauma necessitates vocal but non-verbal expression which means a return to an infantile mode of expression. Yet for many people, the contents of the heart are simply beyond, beneath or above words.” (Newham, 1999, p.105).

As for closure, each one performed his work and the rest were his audience. The audience, that is the vocalists were to focus on the timbre and the colouring of the voice. They had to give feedback - not to judge but to share the experience they went through while the other was performing. The vocalists were astonished of the work created and asked to continue the sessions.

Not until February 2001 that Ud-al-Nad choir was able to perform an evening titled Swallow – Bird of the brick. This evening embedded singing, improvised dance and poetry. As a conductor, when I am preparing for a performance, I go through the agony of determining the theme that abides with our Palestinian reality, searching for the songs, and their order of performance in order to convey a message. The main theme of that performance was around mercy and the inquisition on humanity. I consider it a breakthrough for Ud-al-Nad since poetry and dance were new to our repertoire. It was the integration of the expressive arts. Each vocalist chose a significant part of a song and sang the words in such a way that it reflected the emotional turmoil of that individual. The songs were changeable, for the inner feelings were inconsistent.

This voice work helped the vocalist to feel true and natural and in accordance with how he/she is experiencing life. Songs were chosen and
sung as a protest to injustice and gave form to rage. We discovered that we could not express ourselves outside our cultural and linguistic forms. “The experience of authenticity, the search for a song that matched the inner feelings helped the vocalist discover what was already there but made it more apparent.” (Ruud, 1998, p.43).

When performing for foreigners and Israelis, we perform who we are, and where we come from as Palestinians. The dresses and costumes, the Arabic language and the authentic instrumental accompaniment reflect our identity. The presence of an audience different in culture and language makes us more visible to ourselves. We have explored our relationship with other Israeli choirs and conductors while constructing our identity.

**Workshop with the Efroni**

In June 2001 the conductor of the Israeli choir- the Efroni from Tel-Aviv, Maya Shavit, proposed a joined project with Ud al-Nad regardless of the age differences. The Efroni’s singers are school girls and our choir has mixed singers above 18. The singing styles of the two choirs are different too. The two choirs became one and were then divided into mixed sub-groups.

Workshops consisted of body awareness and vocalization exercises. These exercises were chosen to help ease the tensions and to cross the barriers between participants for the first encounter. Each participant had to concentrate on the self by connecting the body, mind and soul. Then, the sub-groups improvised sounds and rhythms. This experience was less
threatening, pleasant and communicative. Each group performed its creative work for the others.

It was better than expected and the atmosphere was friendly.

Both choirs met and worked twice until the political situation accelerated to a point where the whole project was at stake.

The psychological pain of the ongoing situation, the trauma as the result of the accumulation of emotional energy that was oppressed made it difficult for Ud al-Nad to come to rehearsals and sing. We all felt helpless and motionless. Again, the aim of the rehearsals was to be a means for expressing pain and anguish with authenticity and intensity but it was still difficult for us to do it.

Performance June and July of 2002

By the end of June 2002, Ud al-Nad performed one evening, in Nazareth and it was entitled “Sing louder”. This was a very therapeutic experience for all participants, since the singing experience facilitated the release of pain and brought the vocalists to the discovery of empowerment. Moreover, this was passed on to the audience.

The repertoire was songs of empowerment that inspire hope and give voice to the soul. We were able to express in songs the unspeakable. The singing became a source of strength for our emotional awareness and a sense of belonging to our society.
Both the repertoire and the voice work are a process that facilitates communication and expression, as well as developing and restoring the inter-and intra-personal integration of the vocalists and with others.

On the 21st of July, 2002, Ud Al-Nad participated in the Jerusalem festival, Songs of Freedom, in the Old city of East Jerusalem. The title of our program was "Since.... I am not an atheist." The lyrics composed and the music in the program were from the outstanding Lebanese composer, Ziad Rahbani, which ironically describes the social, economical and political instability of the situation. The lyrics are addressed to those living under oppression and fighting for survival in their daily living.

**Conclusion**

In conclusion, Ud al-Nad is a unique choir group, for we do not only concentrate on singing different styles from the Arabic culture but we are extremely connected to the societal present situation, specifically Palestinians living in Israel. We need to have our say through singing and we try to sing the solo songs collectively for we believe it is more powerful.

Our own voice feeds back messages to us through our own ears. Our voice reaffirms who we are, how we are feeling and what we are seeking. The voice serves an important function in maintaining our sense of identity, for the sound of our voice reminds us of who we are, it reinforces our sense of self.

Changing the voice has the potential to alter the way others perceive us and the way we perceive ourselves. Through singing, a person can be
voiced outwardly in the world for others to hear. Singing rather than speaking voice brings highly emotional dimension. Singing allows for the discharge of emotions of greater magnitude than talking.

The vocalists consider the voice work as their therapeutic refuge and their singing as their identity. Personally while writing my paper, I realised that singing and composing is what I have been doing all my life. I transferred my own singing and expressive repertoire to the choir.

As the conductor of Ud al-Nad, I consider the choir my therapeutic voice. Having an inner dialogue between the musician and therapist in me makes me wonder about the balance between the two. Recently the therapist is outgrowing the musician but the dialogue continues.

References:


Neurorehabilitation: a tool for understanding complex needs of handicapped human beings - Music Therapy concepts in relation to these needs

Jochims, Silke

Abstract

Neurorehabilitation nowadays starts on intensive care units. Still being in coma, the patient is in need of physical, sensorial, cognitive, social as well as emotional stimulation and treatment. Rehabilitation concepts mostly include physiotherapy, occupational therapy, speech therapy as well as neuro-psychology. They all focus mainly on: a) functional aspects, b) deficits. On the whole rehabilitation concepts omiss to look at resources of the patient and to consider social as well as emotional aspects of the illness. This paper will discuss a) the models of deficit orientated versus resource orientated therapy schools in the medical as well as the psychotherapeutic field, b) different concepts of music therapy stressing on psychotherapy or functional recovery or communication or sensorial integration or cognitive stimulation. If instead of a one-sided concept the patient’s actual needs for recovering and growing is leading the music therapist’s decisions, he might decide to work on the functional aspect as well as on the sensorial, or the cognitive, or the social or the emotional one. The proposal is, to change our current thinking of either being a psychotherapist or doing functional training into an understanding of the complex, quickly changing needs of the patient which leads to a concept of doing psychotherapy as well as functional training, of working with resources as well as on deficits. This concept tries to bridge the splitting between somatic and psychological treatment, between resource or deficit orientation. Music therapists seem to have the potential by the help of their medium to serve both sides.

Treatment goals in a multidisciplinary medical team

Working on a medical ward in Germany, a music therapist might feel the limitation of his theory-background, which seems to be hardly
compatible with somatic-medical theories and treatment goals. Roughly said, he might put emotions or communication or relationship in the centre of his attention, whilst the medical team focus the attention on the body itself. Overstating I would say, that in medical fields the functioning body is the only part of the human being which is in the centre of interest. The psyche is not only not payed attention to, but preferably looked upon as being a disruptive factor within the healing process. Quite often body signs are interpreted on a physical level, although not seldom physical symptoms are caused psychologically.

On the other hand music therapists, in Germany working preferably in psychiatry or psychosomatic hospitals, tend to forget about the value and the necessity of a functioning body by in some cases disparaging physical signs as somatization which is not always true. If you focus on emotions for instance you are depending on functioning muscles of your client: non vocal, vocal and facial expression, even eye-contact are headed by different motor channels. In conclusion: you need motor skills when working on emotions, on communication or relationship. Not really appreciating functional aspects it may be the reason why music therapists, at least with the identity of a psychotherapist, are seldom an integrated part of the medical team and normally not looked upon as being necessary for the process of healing. Both sides seem to me as sticking on their defined theories being limited in combining them.

The multiprofessional team of a neurosurgical rehabilitation hospital usually consists of medical professions plus neuropsychologists who like to focus on the psyche without having learned a psychotherapy method.
On which side within this multiprofessional team could be placed the music therapist? In Germany 29% of Neuroreha hospitals have installed music therapy, but only quite a few of them are trained to be psychotherapists (Pöpel, Jochims et al 2001). In our research study it came quite clear about, that the head doctors want the music therapists to be trained as well in psychotherapy which shows that a music therapist is seen as the connecting link between the medical and the psychological point of view. In fact my training as a psychodynamic orientated music therapist – Psychodynamic Psychotherapy methods are a great group of therapies, which are theoretically orientated on Psychoanalysis, but practically deviating stressing mainly on the actual interactional behaviour itself (Reimer, Rüger 2000)– this training helps me in adapting to the patients needs by having learned to understand and to translate the patient’s signals in a deeper sense and to react to them. Thus I am very often asked by the team how to respond to difficult behaviour as for instance destructiveness or restlessness instructing other professions how to deal with a patient.

**Treatment goals in Neuro-Rehabilitation**

Neurosurgical rehabilitation seems to be a helpful source for every profession to understand the complex needs of human beings: a relative of mine, herself being a psychotherapist, had a stroke, her right side being completely paralyzed. I myself tried to help her by going into dialogue about how this event might cause sorrow and despair. But in fact she herself did not want to speak about her feelings, she wanted to be helped to move again. For the first year after the event her main interest
was the restoration of her former functioning body. "If I can move, my life will be much better because of not being dependent on anybody."

*Self-determination is extensively dependent on a functioning body.*

When being seated in a wheel-chair, you cannot do what you want to do, you are dependent on somebody who is available for help. **The extent of self-determination is an essential part of the quality of life.**

Now, after two years, my relative is open to speak about the psychological effect of her limitations. Obviously there is a time, when the psyche comes into the focus of the person, but for the beginning the physical restoration is of the utmost interest. **It is the quality of life the client is longing for when being determined to functional training.**

Working with brain injured patients, this brain damage being caused by hypoxia after reanimation, by stroke, road accidents or aneurysma blooding for instance, you learn a lot about life in general: about the value of your own mobility and your cognitive functioning, about the powers of recollection being the key for experiencing yourself as a person in time and history, about the extremely helpful support of the senses for understanding the own body scheme including the body-boundaries and the world around me in nature and meening, about the pleasure of being able to explain yourself to others by the help of language, which gives you the feeling of a social being. **Generally spoken when working with acquired brain damaged patients you learn the value of being physically, sensorially, cognitively, communicatively, socially and emotionally healthy.** All these aspects of human life are normally damaged simultaneously after acquired brain injury. This causes a loss of quality and enjoyment of life. Even if recovering you
will never be the same as you have been before and you will never be able to follow the same life-goals as you did before the event. This needs to be worked through in the sense of emotional adapting to chronic illness. Sensorial, cognitive, functional and linguistic stimulation and training – the classical concepts of Neuroreha treatment - is not enough for achieving a better quality of life. **Emotional aspects in the sense of support and help for coping with disease has to be added to the traditional treatment techniques.** *In conclusion it means, that life quality depends on functional, as well as on sensorial, as on cognitive, as on communicative, as on social and as on emotional abilities or functioning. A head injured person is in every moment searching for the best quality of life he can achieve in the same intensity as we do every day as healthy beings.*

**Music Therapy concepts in neurosurgical rehabilitation:**

Music Therapy in Neurorehabilitation is a quite new field for music therapists at least in Europe. America has a longer tradition for music therapists in this special field. Therefore let’s start to look through American Music Therapy Concepts first:

Michael Thaut (Thaut 1999) calls his concept: “Neurologic Music Therapy“ and defines:

- Neurologic music therapy is defined as the therapeutic application of music to cognitive, sensory and motor dysfunctions due to neurologic disease of the human nervous system
- Neurologic music therapy is based on a neuroscience model of music perception and production and the influence of music on functional changes in nonmusical brain and behavior functions
Treatment techniques in neurologic music therapy are based on scientific research and are directed towards functional therapeutic goals. His concept is clearly focussed on functional recovering which includes sensorial and cognitive functions. Communicative, social and emotional aspects are deliberately excluded in his concept.

Concetta Tomaino (Tomaino 2001) focusses on the aspect of cognitive stimulation via music which includes aspects of attention span, memory and connection to the „Self“. „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. 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 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“ (p. 2).

Tomaino broadens the indication list for referral to music therapy: „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...“ (p. 1) Listed are: cognitive, emotional, functional and communicative problems. Not on the list are sensorial deficits as for instance perception disorders or aschematia.
Dorita Berger points out why music helps reconfigure neural networks impacting three distinct levels of physiologic adaptation. She is placing particular emphasis upon sensory integration within perception training leading to behaviour modification while being aware of the music’s ability to influence emotions and moods. She concentrates within therapy situation on sensory issues, mood and emotion being side-effects (Berger 1999). She emphasizes that for her it seems necessary to look for more than contact, which means to go beyond the Nordorff-Robbins approach.

In Europe Dagmar Gustorff from the Nordorff-Robbins School focuses when working with comatose patients on stimulation of communicative patterns leading to contact and relationship (Gustorff 2000, 2001). Considerations about sensorial perception and cognitive stimulation are included, but not the main goal. They are – as I understand it – side-effects of her treatment concept. Just as Wendy Magee of the U.K. working with patients with Huntington disease (Davis, Magee 2001), who focus as well mainly on communication skills or alternative expression. Both may for instance miss the patient’s need for emotional relief as well as the support in behavioural problems caused by perception disorders. Comparing the focus of Tomaino, the link to the self, combined with the technique of using familiar songs and the focus of Gustorff or Magee, to meet a person in his personal stage of being, combined with the technique of free improvised music, the difference in techniques are understandable for me by the difference of goals.
I myself focussed on the emotional aspect of chronic illness caused by head injury plus the re-construction of the functions of the Self. „Cerebral lesions affect the organ required for coping with disease. It is possible to establish contact with the intact „inner self“ of the cerebral reduced patient via a preverbal medium remaining on a concretely active level. This offers a chance to achieve emotional coping with disease even if the cognitive faculties are restricted“(Jochims 1995, p. 29). I left out all functional, physiological and sensorial aspects, adressing mainly to problems of Self – Other – Interaction and problems of coping with disease. But identity and a feeling for a „self“ cannot be reestablished, if there is no ability to produce a sound, not by voice and not by movement as the consciousness of a „self“ is being based on the principle of cause and effect:“ I sound-therefore I am“. In this case movement stimulation as a precondition for a growing consciousness of a „self“ has to be started with. Everybody who uses only one technique or focus on one aspect, should have in his mind that he omits other aspects of the overall goal of improving the patient’s quality of life.

In fact some years ago I could not see the value for the patient to increase motor functions within music therapy. I had to learn by the patient himself that increasing his motor functions would help him more in brightening up his inner state than pointing out the emotional problems and focussing on emotional coping. I had to learn that in some situations he would benefit more of giving sensory stimuli in order to reestablish sensory integration than focussing on the emotional aspect of the inability in sensorial integration. In other words: I had to learn that
achievement orientated training is sometimes more in the service of life quality than psychotherapeutic accompanying.

Looking at music therapy concepts in general, it strikes me that all described concepts focus on some aspects, but miss out others. If you put all concepts together, it would in fact reach the allover needs of a brain-damaged person in the perspective of gaining the best possible life quality. As far as I am able to overlook the world wide music therapy scene, all the described concepts are a mirror of music therapy concepts and schools in general. Some schools stress on functional, some on sensorial, some on communicative, some on psychotherapeutic goals— if you think of the five international models and the panel of founders, which took place in Washington World Congress 1999. Is’nt it time to put all these little bits together, isn’t it time to integrate these concepts?

Our medium holds a range from motor skill training to psychotherapy techniques. Let’s put the patient and his needs in the center of our considerations instead of sticking on theoretical frames. Let’s put the very rich possibilities of our medium together so that we can serve more fruitful the patient’s interest in growing life quality.

Deficit or resource orientation in medical models

A controversial point in healing concepts is the question of deficit versus resource orientation.

Within the medical field, you find both principles: the orthodox medicine looking exclusively on deficits or symptoms, whilst the natural remedy as well as traditional asian medical therapy systems as Acupuncture or
Ayurveda, are relying on the self-healing power, supporting resources within the body itself (Pschyrembel 1990, Maharishi Ayur-Ved 1989). The bio-resonance-therapy for instance, theoretically related to Chinese medicine, records electromagnetic vibrations of the body, and separates healthy from sick vibrations. The healthy vibrations will be amplified and given back to the body in order to weaken the sick vibrations (Dörfler 1989). This is indeed a simplified description, but the main point is to start the healing process by strengthening healthy parts of the organism. Different views and ways of healing cancer fit into this perspective: will you cure through maximum damage of the tumour or through support of self-healing tendencies, or will you combine both ideas as Carl Simonton claims for in his book „Getting well again“? (Simonton et al 1978)

Another example: a research study compared German and Dutch children doctors curing acute inflammation of the middle ear (source: „Süddeutsche Zeitung“ Nr. 82, 2002,p. V2/9) In Germany nine out of ten children get antibiotic drugs, whilst in the Netherlands only three out of ten get these drugs. The rest gets comforting words and a pain-killer just in case they need it (Forster et al 2002). Being compared, at the end Dutch children are not inferior to German kids in overcoming the inflammation. Dutch doctors rely on self-healing powers of the body itself, German doctor’s don’t. A British study about the same question shows, that three quarters of parents are willing to rely on self-healing mechanisms instead of antibiotic drugs. This study teaches us, that relying on resources within the organism is often, but not always helpful – still three out of ten children get drugs in the Netherlands. **Deficit orientated orthodox**
medicine is not better or worse than alternative courses of treatment. It is one way of healing which in some cases seems to be necessary. Resource orientated alternative treatment is another way, in other occasions being of more help for the patient.

In reality at least in Germany we have the situation that doctors and patients tend to think in categories of „either/or“ instead of „as well as.“ You go to a doctor for alternative treatment or orthodox medicine. Nearly none of them is able to change his point of view, to change between deficit and resource. The looser is the patient himself, who is not able to overlook himself what would be best for him in this very moment.

**Deficit versus resource orientation in psychotherapy schools**

Within psychotherapy schools we have the same situation:

Psychoanalysis historically focusses on deficits, being interested exclusively in conflicts originating in early life. „Human behaviour – looked at under the standpoint of a conflict“ characterizes Kris very shortly the Psychoanalysis (Kris 1975, p.6). Classically Psychoanalysis does not work on future prospects strengthening for instance the positive potential of a client. In fact the conflict will never be solved. Not seldom the objectives of patient and analyst diverge wildly as the patient is associating with the treatment start the goal of a more delightful existence whilst the analyst has his eyes on the patient’s ability to bear the everyday unhappyness, which is clearly a referral to the deficit.

Have the psychoanalytical techniques been fixed on the interpretation of intrapsychic conflicts, they are beyond the scope of those patients, whose
problems started earlier in their life, caused by a difficult or damaging or at least problematic relationship between mother and baby. Balint emphasizes, that this is not a conflict, but a deficiency, which cannot be analysed away. In this case the concept is to start again, the relationship itself being the focus of intervention. This concept sounds much more positive than the conflict theory. But still it is a deficit being focussed on (Kächele, Buchheim 2000).

In research studies Grawe (Grawe 1999) could verify, that activation of resources in different therapeutic constellations has a central role in bringing about positive changes within the client itself. He postulates a paradigm change in every psychotherapeutic technique from problem-orientation to resource activation. As resources he defines: “motivation, goals, wishes, interests, beliefs, system of values, taste, attitudes, knowing, culture, abilities, habits, styles of interaction, physical signs as appearance, strength, persistence, financial possibilities and relationships. All these aspects symbolize the scope of possibilities of a person, in which he or his positive potential for satisfying his basic needs, could move around. “ As essential for resource-activation is the turning to existing abilities. Overlooking research studies of the last five years predominantly in USA he counts as main factors for having an effect in psychotherapy actualisation of problems, coping orientation, resource activation and motivational clarification. This is a combination of deficit and resource orientated psychotherapy. As research studies verify, the main basis for effective psychotherapy is the quality of relationship between therapist and client.
which refers to Psychodynamic Psychotherapies. If the relationship is being stable and holding, it can be the starting point for conflict orientated work. A change in habits and personality is particularly possible on the basis of this positive therapeutic basic position. This leads to the attachment theory, where the teamwork is emphasized, not the conflict. The goal would be a new beginning in relational issues on the basis of being securely attached within the relationship between therapist and client. „There is no question about, that those well researched therapeutic parameters as acceptance, emphaty, working allience, exposition to conflicts and resource activation can contribute to modify peu a´peu the maladaptive basic attachment behaviour through a successful therapeutic process. We already have impressive results by Fonagy concerning the symptoms of Borderline“ summarizes a german Psychoanalyst (Kächele 2000, p. 48). Encouragement of personal growth, a new beginning in life and the ability to enjoy the pleasures of life are the goals of resource orientated psychotherapy methods as for instance Gestalt Therapy or Integrative Psychotherapy. But: as so many professionals keep telling: if the therapist leave the client idealizing the therapist/client relationship and ignoring reality, then he will miss the point and spoil the therapy. Turning to the point of conflict, claryfying that this is only a short time helping relationship for nurturing and basic trusting, will be crucial. The conflict of not being enough nurtured and attached at the time of normal growth must be worked through, otherwise a personal growth cannot get going. This means again, that only a combination of deficit orientation and resource activation leads to
The point is that one theory should not be replaced by the other, but supplemented.

The patient and his needs in the centre

If the needs of the patient are the focal point, our identities as being a functionally or cognitively or emotionally or communicatively orientated therapist and our concepts have to stand behind these needs. Of course a partly or fully paralyzed person is emotionally in pain because of not being able to move. But is it enough and is it the right time to accompany his emotional pain or could our medium help in another way and do more for his future life by offering for instance to play actively an instrument which includes the training of motor skills plus sensory integration? The psychotherapist’s viewpoint, movement stimulation or motor skill/coordination training or perception training would be less essential than emotional aspects of illness, has to be rethought. The scientific viewpoint, that communicative, emotional, cognitive and social aspects would be less important than functional training, has to be rethought as well.

There are a lot of patients who never reach the stage of emotional coping with disease. Are they not in the centre of interest for music therapist’s with psychotherapeutic identity? If you change the viewpoint, but not the medium itself, music is a phantastic and helpful medium for initiating plus coordinating movements, as M. Thaut points out (Thaut 1996). Concerning apraxia actively played music or handclapping to music is a joyful way for learning intentional hand movements, as Cochavit Elefant showed us in her moving video about music therapy with Rett
Syndrom (Elefant 2001). The point is to realize the complex actual situation of the patient and to respond to it. For example: a patient being quite capable of motor skills and able to move around, but being extremely desorientated, is not helped by a functional training because this might lead to the situation him falling down steps or running on the street. At the end the consequence of his desorientation in combination with mobility will be the transfer to psychiatry which is in fact the wrong place for him! The physiotherapists in my hospital tend to stick on their concept of functional training not being able to see the actual needs of the patient to get back orientation before getting back motor skills. For other patients, for instance being in vegetative state, it might not be helpful to get out of vegetative state if you realize their desastrous surroundings they would come back to. It might be in the interest of the patient to leave him in the state of not corresponding to our world. There could be found a lot more of examples. What is necessary within the medical team is to be flexible enough to adapt the treatment goals to the patients needs.

You may fail the patients needs as well if you stick exclusively on the deficit or the resource. I myself like to start with movement resources, which is very often a small thumb movement being stimulated by a very little instrument, the crack frog. This can give the patient the feedback of „I sound, therefore I am“ which is the starting point for rebuilding identity. On the level of body perception this can give him the feedback of “I have a hand and this is my hand...“ Thirdly he may realize that he is able to do something which is a crucial point for supporting the wounded self-esteem. But: If I stick too long on this movement resource I might
miss the patients need for regaining a complete body scheme. On the other hand: being fixed on deficit orientation you would train exclusively the lost part of the body helping to reduce the aschematia, but eventually demoralizing the patient which might manifest a resigned retreat (Jochims 1995). Why not combining resource orientated with deficit orientated objectives? Are we flexible and trained enough to be able to adapt the concept to the patients needs? Are we actually able to change the objective from experience orientation which is at times very necessary to exercise centration, which is at other times the necessary way to help the patient?

**Underlying images of human beings**

Orthodox medical concepts and behavioural Psychotherapy are based on achievement orientation combined with a mechanistic image of human beings. Humanistic and psychoanalytic schools as well as Chinese or Indian or alternative medicine are strictly against mechanistic thinking, stressing on in depth, holistic views. Who is wrong and who is right? I don’t believe that there is a „wrong“ and a „right“, both images of human beings are right or wrong at times. An achievement orientated treatment needs to see changes in the patient whilst the humanistic schools claim for themselves to accept everybody as he is. **You need both attitudes when serving your client on his way of development**. Actually I cannot see the humanistic schools accepting the „status quo“.

Even they need the patient to change in mind, habits and behaviour, as the demand of those who pay for psychotherapy is, that psychotherapy has to have an effect on the client which means that he has to change or at
least modify his maladaptive behaviour. If he does not change they tend to blame the patient instead of adapting their goals and treatment techniques to the patients abilities and needs. This happened for example erroneously to the older generation of above 50 years who were told not to be capable of psychotherapy because of their lack of flexibility. I would dare to summarize, that all treatment concepts – medical as well as psychotherapeutic – generally base on change and development of the client.

But as far as I can see there is no concept for the situation somebody is not able to change- no matter if in depth or mechanistic images of human beings are leading the therapist’s attitude. Within neuroreha the question of attitude towards a not developing patient is a crucial point: how do we feel and how do we communicate, if somebody does not achieve anything, if he stays as he is? Do we still accept him as a member of the social life who is worth to be loved? The insurance system at least in Germany stops paying for rehabilitation treatment in the moment of developmental standstill which is in my eyes an expression of not accepting a person in his being. Anybody of the reha-team needs to see at least some small steps in development for being able to keep on the treatment. In fact you get depressed, if you never see a success of your commitment. This team members need hinders openness and acceptance of persons without progress. In my hospital physiotherapists and occupational therapists for instance change every half a year the ward because they can’t stand the non progress for a longer time. On my part it is extremely hard to work a whole day without any observable result. One smile a day is nurturing, but most days you don’t get it. In
neurosurgical rehabilitation it is very often to be seen, that those who stay for instance in persistent vegetative state, are forgotten, not addressed to, not of interest anymore. The question of accepting somebody without any obvious change is a question which occurs in psychotherapy as well as in functional training situations. It is not only a question of achievement orientated treatment, it is indeed a question of ethics, which should be adressed to the society as a whole (Jochims 2000).

Discussion

The bracket which is linking all different approaches to the patient is the process within the relationship comparable to the definition of L. Bunt and his team in his paper „Musical interpretation and the therapeutic relationship“( Gaggiero, Zanchi, Bunt 2001). The german Psychoanalyst Rüger defines „Psychodynamic psychotherapy- methods meet the patient at that point where he is suffering directly and is searching for help- in his actual present“( Rüger et al 2000,p. 10) . If the therapist is able to hold and to contain, to challenge or to make demands, to support or to confront, and if he is able to sense the actual signals of his client – D. Stern calls it „affect attunement“ ( Stern 1985) - he will be able to decide in the moment of meeting what will be the focus in this very moment. Every day the goals have to be adapted to the needs of the patient in accordance with personal growth and quality of life. Concerning children´s growth, John Aply writes:“ Essential vitamins for continuing healthy growth of the whole child include a good relationship (you are loved), good supervision (you are secure), respect as an individual (you are you), encouragement and recognition of effort and
achievement (you matter) , increasing responsibility and social
envolvement (you are growing into society)“( Aply 1978). I can easily
see a comparable situation between children’s and and brain damaged
adult’s needs.

If you stress exclusively on deficit training, you may be in the danger of
spoiling the relationship. But if you never focus on deficits you may miss
growing needs of body and cognition ,which could be understood by the
client as „you don´t matter“. If you exclusively support a patient without
confronting him for instance with his behaviour you may provoke his
transfer to psychiatry. If you exclusively confront him he might loose his
self-confidence and might not feel to be accepted. It is a question of the
right dosage which makes a relationship stable so that a client can
grow and develop . Focussing on deficits,not matter if functionally,
sensorially, cognitively or psychologically, has to be looked upon at
times as working for more life quality. Aphasic patients for instance,
who must feel extremely excluded of social life, need a lot of support via
alternative interaction , which is so easily done in music therapy, as they
know all familiar songs sometimes even with text. An imminent
depression can be prevented by music therapy. Of course you start with
their resource, sounds, music, songs ecetera. But couldn’t be included
some deficit orientated goals by helping him to achieve a „yes“ or „no“
concept following the way from preverbal to verbal language? Very often
connected with aphasia is apraxia, the inability, to use the hands
purposeful. If you combine singing familiar songs with active play on
instruments (movement songs, yes/no stories) , you combine resource
with deficit orientation.
The actual personal emotional state is very often a decisive factor for deciding whether to strengthen self-esteem or offering more practice and training in motor-, sensory- or cognitive skills, or going into affective dialogue or focusing on emotional problems in coping with disease. A body perception disorder for instance might create such a disturbance for the patient, that it would be of more importance for him to reduce the deficit than to strengthen his self-esteem. Not until the boundaries of „either...or“ concept thinking is removed by „as well..as“ thinking, we will be able to serve the needs of severely ill patients better. There is no problem to change between functional training and emotional support, as long as the relationship is the key for your decision being coherent in the sense of a holding and caring environment which gives the space for developing in personal growth. This might be the main difference between medical professions and psychodynamically trained therapists: the crucial point is the way of reaction to the patient, the way of understanding yourself as being one part within the healing process. Emmy van Deurzen, an English existential psychotherapist, defines the role of the therapist as „professionalisation of motherhood“ (E. van Deurzen-Smith 1996, p.17). The process within the relationship with all the ingredients I listed above – you are loved, you are secure, you are you, you matter, you are part of society - including therapeutic behaviour defined in bonding theory, is the basis of treatment.

References:


Address

Silke Jochims, Dipl. Music Therapist, Claudiusring 4 i, D-23566 Lübeck
e-mail: jochims-musik@gmx.de
Katz, Simona

In this paper I propose to discuss a problem that I judge to be central in a music therapist’s clinical practice, and which I know to be shared by many colleagues. How to confront situations in which music, as the specific expressive medium, goes missing from the therapeutic setting.

Whoever works in a psychodynamic approach might have to face periods, sometimes long and important ones, during which instruments will have no role to play, in which the patient will refuse, or will simply not be interested in the use of music as a medium of communication and elaboration.

I am convinced that this type of situation can give rise to confusion as to the specific role of M.T.’s, a confusion which, if not faced up to seriously, can have a negative influence on the therapeutic process itself. For the M.T. to find music rejected can lead to a loss of confidence in one’s own professional role, or, on a deeper level, in the value of what he has to offer, and thus, maybe, in his own worth. If this happens, then he could find that he has really lost his ability to adapt himself to the needs of the patient and, therefore, the ability to carry out the therapy in a fruitful way. It does not suffice, it seems to me, to become accustomed, to “tolerate” this type of situation, as though it were a kind of “inevitable unforeseen”. Often, in fact, the rejection of the music, language that is inextricably connected to the identity of the therapist and the atmosphere of the setting, will have a meaning that it is important to
understand and to integrate. And this will be impossible without a deep acceptance of what is happening, and what is not happening, within the therapeutic process.

And the answer is, in the final analysis, relatively simple, because everything is music, and we, can listen and give ourselves an explanation of the score that is performed during the hour of therapy. The score gives us a further level of understanding and a further possibility of decoding within the inner world of the patient that we have in front of us. If we are able to listen with empathic musical attention, if we are capable of giving an empathic musical response, we will be able to avail ourselves of a further instrument of communication with our patient.

What do I mean by the score that is developed during the hour of therapy? I mean the alternation of sounds and silences, the alternations between consonance and dissonance, the changes of dynamics. I mean the rhythms of the interactive exchanges, I mean the musical reading of the contour and the rhythm of the movement. I mean learning to listen to the voice, also in speech, and the breathing, as in a song.

In this we have a privileged channel because the infinite possibilities of expression and interaction provided by the experience of sound form the basis of the most remote experience of a human being. At birth they mingle inextricably with experiences furnished by other sensory modes, leaving, in this way, an indelible linkage. Daniel Stern (1985) teaches us that “Infants appear to have an innate general capacity, which can be called AMODAL PERCEPTION, to take information received in one sensory modality and somehow translate it into another sensory modality
… the abstract representation that the infant experiences, are not sights and sounds and touches and nameable objects, but rather SHAPES, INTENSITIES and TEMPORAL PATTERNS, the more Ôglobal’ qualities of experience. “ (Stern, 1985:51)

In integrating these experiences through the interaction with the mother, the newborn “experiences these qualities from within as well as in the behavior of the other person.” (Ibid: 55) It is within this exchange that the nucleus of the emergent self is formed.

The capacity to share the experience of this nucleus with another human being forms, therefore, the base for the construction of an integrated self. But the prerequisite for this sharing is to be found in the ability of the other human being (the caring figure) to “sense“ the internal state of the nucleus.

Thus it is this acquiring, radar-wise, the global experience through musical parameters that I believe to be the first and fundamental therapeutic act for which we, M.T’s, have been specifically trained.

I remember myself at the age of 10, 15, 25, busy repeating a passage thousands of times so as to achieve a perfect matching between the two hands on the keyboard, or in tears perceiving the correspondence between a Schubert modulation and my inner adolescent turmoil. I remember the infinite work, never mechanical, even if supported by a technique, to obtain, with my violinist, John, a total fusion between his and my diminuendo – rallentando – sparendo in an adagio cadence of Mozart’s. I believe that this part of my preparation played a fundamental role in the capacity to sense the internal music of the patient’s message,
musical or not, and to respond in an appropriate and curative manner. I am leaving aside, due to lack of time, all the fundamental questions relating to the difference between artistic and therapeutic sensibilities, and the training needed to construct this difference. I refer here to the nucleus of the sensibility.

How, then, can this ability to “sense“ becomes curative? Let us devote a moment of attention to the centrality of the concepts and terms that are intimately connected to musical experience, such as they appear, not in a text by Mary Priestley, but by Heinz Kohut (1984).

In the psychology of the Self the healing process consists, first of all, “in the opening of a channel of empathy between Self and Selfobject.” The first and fundamental step in building this channel consists in the perception, on the part of the analyst, of some of the things that the patient experiences. To understand this inner state, the therapist has, on his side, the instrument of empathy, which Kohut defines as “vicarious introspection.” Kohut himself speaks of repeated experiences of HARMONY between Self and Selfobject. Only when these experiences of harmony will be repeated in a sufficient manner and quantity, will the patient be able to stand the withdrawal of the empathic ACCORD (Kohut,1984:96), by means of episodic empathic failures, the acceptance and elaboration of which will bring about a subsequent state of EMPATHIC SYNTONY. Through harmonies and disharmonies, the therapeutic process concentrates, therefore, on the here and now. Any optimal frustration, successfully overcome, increases the recovery capacity, helps to restore existing structures and to acquire new ones.
Daniel Stern gives a *musicalissima*, explanation of the empathic process. (1985, 145.)

The first step to be able to provide an empathic response is to enter into a state of RESONANCE with the feeling state of the patient. One must, therefore, create within oneself a state of emptiness, like in the resonance box of a cello, and of utmost concentration, in order to be able to resonate with the inner state of the patient (let’s think about the beautiful expression of Mary Priestley’s “the therapist as a nodal point”) (Priestley, 1975:195).

The second step adds to intuition a more cognitive element and includes “the abstraction of empathic knowledge from the experience of emotional resonance”.

The third step includes the integration of empathic knowledge into an empathic response. I think that the precision of the empathic response can be enriched by a specific musical knowledge. And I am not referring only to the ability to improvise on instruments. To know how to give an empathic response expressing it even without words, if necessary, can be of fundamental importance in this, most delicate, moment. It was Stern, and not a M.T., who coined the *musicalissimo* term of “Affect Attunement” to indicate the act through which the mother, out of awareness, matches the affect that lies behind the action of the newborn, thus giving him the sensation of sharing his affective state. The parameters on which he bases himself are: Absolute Intensity, Intensity Contour, Temporal Beat, Rhythm, Duration, Shape.
Without wishing to mix affect attunement with empathy and its effects, I should like, nonetheless, to enlarge upon Stern’s terminology. That alongside ATTUNEMENT he places, in a manner that is partly parallel to Kohut’s empathic failures, the MISATTUNEMENTS (purposeful or true), the UNAUTHENTIC (and therefore ineffective) ATTUNEMENTS and the OVERATTUNEMENTS.

Even in this rapid review I can see an endless field for work for the M.T. who knows how to read the score that is played during the hour of therapy and who is able to attune, misattune and again attune himself. Even if the score is not on the pentagram.

**Adam: Background.**

But let us verify my words within the ambit of clinical practice.

The example I shall speak about today is taken from my work in a Mental Health Center for children in Jerusalem. The Center uses a clearly psychodynamic approach and regular meetings with the parents accompany the work of play therapy.

At the beginning of the therapy Adam was eight years old and was suffering from "selective mutism". From earliest childhood Adam had refused to speak to adults outside the close family circle. This was why he was referred to me, in the hope that the alternative language offered by music would be able to create a communication bridge and would, at least, taken Adam out of his isolation from the world of adults. Throughout the entire therapy, a year and eight months, we met regularly, once a week, for fifty minutes. I met Adam’s mother about
once every three months, while a colleague met her once every two weeks.

Adam is the son of a Philippine domestic worker and an American citizen whose profession is unclear, who divorced four years before.

He was born into a family situation that was far from serene, after an unplanned pregnancy, as a result of which the couple got married. From what the mother, let us call her Betty, told me, there was an unequal relationship with the father, with, on one side an affective dependence on the part of the woman and on the other an economic dependence on the part of the man. The father, in fact, in spite of nourishing countless grandiose plans, was actually incapable of keeping a job, and Betty carried the entire economic burden.

According to what Betty told me, with a calm face and soft, sweet tones, after the birth of the child, relations between the couple became even more strained. The father took no notice of the newborn baby and, in fact, complained about the inconvenience that the child caused with his needs and his crying. Very soon Adam learnt to fear the father’s shouting and the occasional slaps he gave him. Later Betty admitted to me that she, too, when frustrated and tired, was not always able to control herself and in extreme cases she would give the child a little hit “ but only on his buttocks, just like that, to explain better to him …” Betty related these things with participation, but without a trace of emotion in her voice, almost as though her words in English were separate from the story of despair that I could see, however, in the expression of her eyes. In the Philippines, where she grew up, she explained, children must learn
early to obey their parents. Silence and restraint of one’s feelings are considered an integral part of civil life and of respect for adults.

When Adam, at the age of two, was taken to a small creche, he did not communicate with the teacher, nor did he do so later, in kindergarten. By the time he reached first grade Adam had closed himself up even more. By now in third grade, his lack of communication with the teachers put his school behavior and achievement beyond the norm. All the efforts of his teachers, who truly wanted to help him, were frustrated by Adam. Only the other children were the go-betweens and interpreters between Adam and the world of adults. Doubts began to appear as to his cognitive potential and the possibility of having to transfer him to a Special Education school.

Betty had understood for some time that the problem was serious, but the father refused to ask for help. Only recently, as a result of mistreatment suffered by Adam while in his father’s company, was Betty able, on her own initiative, to ask for psychological treatment for her son, with the approval of the court.

With great naturalness Betty spoke of the fact that Adam did not have a mother tongue. She spoke English with the father, who forbade her to speak Philippine with the son. She spoke in her mother tongue with few close friends but the dominant language of the surrounding environment continued to be Hebrew, and it was in this language that Adam expressed himself when speaking either with his parents or the children at school. Betty answered him in English. It is interesting to note that for Betty it
was absolutely natural to speak to her son in a language that did not belong to either of them.

Listening to Betty created for me a greatly confused score. Too many languages, too many sounds, none clearly identified as an integral part of Adam’s own identity. Such a linguistic cacophony cannot fail to have an impact on the sensation of the self, before it has become defined (it is not by chance that the symptom is particularly prevalent among children of immigrants – Cline & Kyself, 1988).

The linguistic instability also reflected directly the affective instability in his home. A message was transmitted to the young child: that home without linguistic or affective identity has no room for your sounds. Here there is not way of speaking a “connecting language”. Do not disturb, do not express yourself. Otherwise the unstable father shouts and raises the dynamics of his gestures, and even the quiet mother can turn against you.

And if already at home life is so difficult, who knows what destructive forces could emerge from the outside world! By maintaining his silence, I imagined Adam creating a sound-proof barrier around himself, in which he could cultivate his own Self like a flower in a hot-house.

I think that the silence allowed him not to reveal, any of the unhappy dynamics at the center of which he found himself. Very often one of the roots of Selective Mutism lies in the need to keep the secret, to preserve one’s loyalty to a precarious family unit or a weak mother (Meijer., 1979). When the mother is oppressed, sad, humiliated, the child feels the need to show her an absolute devotion on his part, and the proof that he will
not betray her. He must be able to preserve the idealization so as not to risk losing his own grandiosity. In such a case the symptom also has a phobic connotation. The child fears the sound of his own voice, because he is not sure that he can control himself and thus not reveal his own secret.

Silence is, therefore, primarily a defense against the risk of losing control, of allowing the unforeseen to happen. Preventing other people from co-creating one’s own reality, one creates an illusion of omnipotent and total control.

But silence also expresses an extreme need to wound, to strike, to avenge oneself. A terrible aggression, a passive aggression that strikes simultaneously both without and within. A paralyzing, a sacrificing of oneself on the altar of wounding and controlling.

The clinical process.

Before the first meeting with Adam I was especially nervous.

And everything went much worse than expected. Not only did Adam not open his mouth, but he remained, as though petrified, on the threshold of the door. Trying to summon all my composure, I continued to demonstrate a calmness I was far from feeling; I took off his coat, as though he were a mannequin, and I sat him down on the floor, near the instruments. I did not perceive a muscle of his body or his face move, he reminded me one of those terracotta statues of Chinese soldiers. Only his eyes, very black against the white, moved from time to time, expressing a spark of life. Taking for granted that he would hear me, I spoke softly to
him, introducing myself and the purpose of our meeting, playing briefly on every instrument and offering it to him, to show him the possibilities placed at his disposal. No gesture responded to my gesture. I sat down at the piano and played a short improvisation for him, in an effort to reach him through my music.

I showed him the papers and the colors. Silently I called upon all the gods and all the supervisors to send me a stroke of genius. But no idea came, and while the hands of the clock turned ever so slowly, I found nothing better to do than to sit down on the floor next to him, and to accompany him in his silence.

The second meeting also went by in this same way. At the third meeting, all of a sudden, I had an intuitive feeling – that I should seek an even more indirect means of communication, a means so special and intimate as to by-pass his shell of silence. And I asked him, “Would you like us to remove the shell from the piano and see what its tummy is like?” He gave a definite nod and climbed up on the seat to help me “free” the piano. The naked piano revealed its secret intestines to us and let us into its belly. From there, from the inside, came Adam’s first sounds. At first they were timid pizzicati, then glissandi, then drumming on the chords. There followed an invitation to meet, to run toward one another, to the holding and embracing of my sounds with his. I cannot explain in words what happened. It is as though Adam had suddenly let himself go, thanks to the magic of the depth of the primacy. It was not in a hard and real room that we were to meet, but only inside the belly of the piano, with its velvet and soothing sounds, and its secrecy, that had created a
protective womb for us. So protected as not to fear its secrets, so protected as not to require control or aggressiveness. So primary as to overcome all language barriers and the sense of not belonging. And in this way I also discovered an important pattern in Adam: either totally distant and closed or totally near, open, and, therefore, vulnerable. At the end of the hour I was careful to have Adam help me close up the piano’s belly again, “We must put its shell back on, now that we have uncovered its tummy, we know how delicate it is.”

During the subsequent meetings the miracle continued. Adam ran to remove the shell and launched into long improvisations. Some elements of evident symbolism were added; one of Adam’s favorite games was to find the correspondence between the chords and the keys, between the “inside“ and the “outside”. Not only was there music in the belly, but the same note could also be obtained, without danger, from the outside.

With great joy he discovered that the lowest C on the piano remained blocked. Adam chased after that C and laughed madly at my frustration at not obtaining a sound from the blocked key, and he laughed even more when I, with patience and devotion, released the key and made its sound heard again. He immediately started the game afresh, surprising me and infecting me with his laughter. As I understood it, his joy derived from “practicing“ around his block, his silence, voluntary and involuntary, at the same time. And he was full of joy at being able to engage another human being in this practicing, without eliciting anger or uncontrolled reactions, only a great desire to be with him.
Another favorite game of Adam’s was to sit together with me under the keyboard of the piano, after having removed the “lower-shell”, to build around us a kind of a house made up of musical closeness and intimacy. It was a bit like being two twins inside the same womb. Above all, when we began to listen, very attentively, to the resonance of each of the instruments on the others. How the sound of the gong made the chords of the piano’s belly vibrate, how the piano made the drums and gong vibrate. And how the big drum could, with one blow, make all vibrate together. All these correspondences came to be expressed without the need of a single word, and from there, inside, joined together, we were not afraid of a great intensity that makes waves, even rollers, of vibrations connected one to the other, nor of silences interrupted only by little tremors of sound.

The origin of our connecting language was not in the known and closed place, the mouth, the vocal chords, perceived by Adam as something threatening, to be kept under control, but in an alternate source, relaxed and rooted within the feeling of “being together”. It remained important not to “betray” the mother in this intimacy, and more than once at this stage Adam brought her inside at the end of the hour, showing her, wordlessly, our space.

I suppose that the experience Adam went through was one of “connectedness”, as Sterns describes deriving from to the “core-relatedness” experience (developing between the age of 2 months to 7 months), a deep connection with a “self-regulating other”. ”This feeling
do serve as an emotional reservoir of human connectedness” (Stern, 1985: 241)

Adam by now came running into the room, smiling from ear to ear, making noises in taking me by surprise and scaring me. Then he would re-enter our common sound shell.

One day, he suddenly added an object that was much more concretely rooted in his daily reality: a ball. He began using it as a producer of sound, rubbing it against the piano chords or making it bounce on the drum. But soon he began throwing it to me, and I to him.

By gestures he showed me the basic rules of the game: a door to be used as a goal post. My unease at the abrupt distancing of the instruments was mitigated by the fact that Adam started to accompany the game by vocal sounds. Joy, disappointment, intensity of concentration; the sounds came from his mouth and no longer from the instruments, and I could not fail to perceive this as progress.

Less than three months had elapsed from the first, utterly mute, meeting and, one day, Adam came into the room like a whirlwind, shouting “BOO” at me. I jumped, an affect attunement run between us. He picked up the ball and started to play. Soon the silence became a useless obstacle. First whispering in my ear, as though afraid of the sound of his own voice, and then, acquiring confidence, speaking in a loud and clear voice, Adam began to communicate the rules of the game to me. As though nothing had happened, he shouted the words that accompanied the game between us, in an ever-increasing rhythm. “Goal, corner, out, fault, hand…” These were the first words uttered by Adam. I, greatly
moved and incredulous, felt in a confused way that I should do nothing else but accompany Adam’s new “music”, the most desired and the most denied, that of his words. I was happy, and a bit afraid, as though it were a mirage.

But what was it that had broken through Adam’s wall of mutism? I think that I can say that my total attunement to the needs expressed by Adam through his silence and his music helped him to make contact with a primary feeling of security and acceptance, in which hearing his own voice lost its threatening, anxiety and loss of control valence. The “softness” of the sound waves by which, together, we had surrounded ourselves, had pervaded and suffused the “hardness” of the corresponding words. Words, that could be so alien and unequivocal to become comparable to the hardness of the silence as a weapon.. In our world of sounds it was no longer necessary to wound oneself in order to wound the other.

But things were gradually changing.

Here is an “vignetta” from that time: seated at the opposite ends of the room, close to the imaginary “goal posts” of our field, looking intently into one another’s eyes, we begin to beat a rhythm, first with our hands, then on the drums. The rhythm is fast and random, chaotic, and full; the dynamic fluctuates between a piano and a mezzo piano. All at once Adam throws the ball very hard against my drum, making me really jump. My connection was to the sudden bursts of anger on the part of the father that came to interrupt the calm, even if full of confusion, routine with his mother. In communicating my feelings verbally, my words
were, “I got a fright, it is scary when something happens suddenly, something that you can’t foresee, specially if you are close to one another, and relaxed. Perhaps I did something wrong, without meaning to.” A knowing smile, as if to say “You have finally understood.”

The great vitality, expressed by the rhythm and intensity of Adam’s games, I understand to be like a great joy in preserving the intimacy and the sense of connectedness, but, at the same time, in freeing himself from the constraints of that same womb in which we had been together before, so close as to almost lose the demarcation between our movements and sounds. Here we were correlated, but counterpoised. Now we were beginning to relate to each other in an intersubjective relationship. “Sharing attention, sharing intentions, and sharing affective states”, according to Stern. (1985,128)

And together with his vitality and his joy, Adam was beginning to express his own anger. But instead of throwing it inside with his silence, he threw it against me, more than that, against my music.

My musical proposals were, more and more frequently, coming to nothing. From being a central channel in the relationship, music became something of mine that I tried to propose whenever I saw the opportunity, but Adam just let it go. Perhaps music became one with the mother’s language, Philippino, which probably made sense to the newborn Adam’s ears, but had subsequently lost meaning, up to the great refusal.

About six months after the beginning of the therapy, meeting after meeting, drums and piano remained in their places unused, and the ball became our “Solo” instrument. Our encounters evolved into long
football games during which my patience and my capacity for adapting myself to the circumstances were sorely tried. While during Adam’s intensive training my football proficiency gradually improved, I asked myself what had happened to our lovely games with the piano chords, where were the confused and vital rhythms of Adam’s music? I asked myself where was the use of my musical knowledge, my academic degree, thanks to which I had been hired? I asked myself whether I was to blame: perhaps it was I who had not been sufficiently creative in inventing new ways to communicate musically with Adam’s inner world, perhaps it was I who was not professional enough. While I was learning to shoot from the left, I asked myself the same old question – but whom does the music serve – Adam or me? I asked myself whether my role with Adam had not come to an end, now that he was talking. Perhaps I should have passed him on to the hands of one of my colleagues, a psychologist. Already in raising these questions with myself, I felt that the right reply could not be to drive away from him the only adult with whom he had shared that world of sounds, so intimate and diffuse, as to have allowed him to shed the armor of the symptom. Neither could the answer be imposing on him a language that was not his own; he already had languages enough, nor could it be my being forced to invent musical “gimmicks” that were not a natural development of the therapeutic process.

Little by little I came to understand that my disappointment, my feeling of being rejected, were taking the place of my attunement towards Adam. And perhaps it was here that lay one of the keys to understanding what was happening; by refusing the music, Adam provoked in me the
reaction that rendered ineffective my principal therapeutic instrument: he made me deaf, mute and ineffectual. He therefore also committed an act of projective identification.

One day, during one of my by now pathetic efforts to carry out an act of mirroring through the drum, Adam shouted at me repeatedly, with full voice, “SILENCE!!!!” There was something so vital, authentic and free in that shout! Reducing me to silence, Adam could shout, “I need you speaking my language: the music of football!”, and without fear of breaking our closeness. And if Adam could shout, well, that was the only really important thing.

Accepting the game of football as an integral part of Adam’s therapeutic process, I began to observe the heights, the rhythms, the changes in dynamics, and the contour patterns. I realized that I could understand many things. Part of my reactions became simply a part of the game itself, others I decided to verbalize, so to create, together with Adam, a common vocabulary of feelings, thoughts and sensations. Soon I also noticed that his vocabulary was limited for a child of his age. The lack of linguistic stimuli, or was it an organic problem in language development? Another of my hypotheses as to the causes of the origin of the mutism, was added: that it served as a refuge from the frustration resulting from a disparity in his use of verbal means as compared to his peers. (Steinhausen & Juzi, 1996)

In football Adam oscillated between a great sense of contraposition, with powerful kicks and fast pace that expressed a strong will to hit me, to beat me, and even to humiliate me, to moments of great softness in which
he only wanted to be near to me, even to teach me, to improve me, during which the closeness, and the short, light kicks became also opportunities for physical contact. At times I felt that he treated me like a child of his own age. I went along with him, trying to stay close in every situation, submitting to his need for control, but without permitting him to cancel me out or to humiliate me, expressing by sound and words everything that was happening, within and without…

During the last meeting before summer vacation, about ten minutes before the end, Adam interrupted the game. Using colored cushions he constructed a little house for himself. He slipped inside and asked my help to shut it hermetically. I spoke to him from the outside of how protected he must feel there, shut up, but also alone, isolated from me and from the world; and Adam, smiling from ear to ear, moved the cushions aside to make room also for me.

The music came back triumphantly when we met again after the six weeks’ vacation. In the frenetic joy at finding himself again in the room, Adam started running around madly, giving indiscriminate kicks, until he ended up hitting the punching ball. I felt that these were not punches giving vent to aggression, but rather and expression of diffuse vitality, or motility. (Winnicott, 1950-5:211.) I went to the piano and started to match his rhythm with an improvisation made up of strong and clear chords; to my amazement, Adam raced towards the instruments and began to play, with a concentration typical of the first period, but with a much more articulated sound production. His chaotic rhythm was contained by my clear and rhythmical chords. He communicated clearly
to me that this was what he wanted, holding and intensity, so as to be able to let himself go to the chaos and to the vitality. In this way we arrived at such a crescendo that my chords became transformed into sound clusters, played with my whole arm holding down the entire keyboard. The rhythm had to remain regular, while Adam played, with all his strength, in a diffuse and chaotic manner, on all the instruments. He became red in the face and sweaty, as though satiated, and he reminded me of the ecstasy of the newborn after a long suckling at a breast overflowing with milk. Satiated with the music, satiated with the primary closeness, the total adaptation, Adam went back to his football game. Music was the ground for our relationship; from this ground Adam could grow up and experience himself as a boy, also in his psycho-sexual development. In summing up a meeting of that period, we shall see how much Adam was telling me about himself:

He comes in running and surprises me while I am improvising at the piano; he shrieks to frighten me and I react with a shriek and a startled jump. Then he takes off his shoes and invites me to do the same. I do it and he, pleased, tells me that without shoes I will play much better. We begin kicking the ball around quickly and harmoniously, like in an improvisation in which my response to his play improves the performance. Gradually his energy becomes more aggressive; suddenly I notice how much he has grown physically lately. He starts to direct his kicks at me and says, “Come closer, only if you are nearer I’ll be able to kick it inside.” I stress that only when he feels close he can hit with assurance of reaching me. He makes a series of goals, becoming enthusiastic about his own skill; I try to strike a balance between
defending my goalpost and admiration for his strength and ability. All those contents are amplified through an intense vocal exchange. Duets expressing vital enthusiasm, or frustration, or aggression, sometimes physical pain. When I point out that our time will be up in five minutes, Adam looks at the cushions and tells me, “Do you remember the little house?” And I reply, “That house where one can be well protected without being alone and isolated?” “Next time, “ Adam says, with a smile. But this time, too, we had been together in the little house, of sounds and games.

The theme of the house became fused with that of the ball: we had to kick, each into the house of the other. This also meant to bring forth, through vocal sounds, the intensity and rhythm of the movement, from one’s own inside, to the inside of the other. To my understanding this was an important practicing of the relationship: going out and coming in, passing through a vast gamut of feelings, retracing experiences rooted in the immediate or remote past. My intention was to offer him affect attunement, an experience that “goes far beyond just participating in another subjective experience. It involves changing the other by providing something the other did not have before it, or if it was there by consolidating it. “ (Stern, 138). Rejection and acceptance, desire to dominate, and the desire to help one another, to control and to hit out blindly. *Forte* and *piano*, sudden silence, delicacy and violence, blows and caresses, sharing space or separation. To close one self up and to open oneself. In this connection, during this long period Adam started a new pattern:’ at the end of the hour he rushed to leave the room before me, and he closed me inside holding the door from the outside with all
his strength. He did it with ever-greater force, forcing me into a proper struggle, in which the element of physical contraposition was becoming all too real. Adam did not want to let me go out, so as not to face the risk that, going out, I would not be there for him and, perhaps even more importantly, that going out from our little house, he would risk non to remain inside me. Once again the theme of control, so as not to face the unacceptable void, to preserve a union both omnipotent and without time limits. Gradually I made it clear to him that this game was not part of our rules; reassuring him, expressing in words every time what I felt to be the meaning of his act, I told him also that I was not ready to have a “real” fight. Slowly Adam accepted this, continuing the pattern, but in a less obstinate way, more like a memory of an important ritual.

By the time the end of the second year of therapy approached, Adam, acquired growing security even outside the room. His life was gradually becoming normalized: at school he had started to talk to the gym teacher and with the teacher assigned to him on an individual basis. While he was better able to enter into a relationship with the outside, he took the risk of bringing into therapy his moments of closing up, of mutism, that I had not seen for some time. We were thus also given the opportunity to work on the anxiety associated with loss of control that resulted in violence and desire to humiliate, as well. (I learnt from the mother that the father, after Adam’s birth, when referring to her on the telephone, would say, “I have the Philippine”, creating an aura of ambiguity – servant or wife?).
Here is an example of one of these situations: during one of our ball and house games, Adam one day “orders” me always to pick up the ball, even when it falls on his side of the field. I clearly perceive a desire to humiliate me, making me play a subservient role, and I also perceive the destructiveness of this act. To be the selfobject also means to remain an object worthy of being idealized. In a courteous way I explain to him that I am not ready to be a ball-girl, and that each of us, as usual, will pick up the ball according to where it drops. The expression on his face became closed and obstinate, almost cruel, and he said, “then I won’t play any more.” This frustration of his desire for omnipotence drives him to close himself up more and more; stunned, I see him as though contracting and closing himself within the shell of the cushions, trying to shut it hermetically, like a soft protection against hard reality. To my questions, seeking to understand his feelings, he does not respond. His aggression is not, however, projected only inwardly: Adam is careful to leave a crack open, a hand, a foot still remains outside and feels for the ball; I make it roll gently towards his hand and he throws it angrily, with a strangled sound, against me. I send it back softly and with a long and sweet sound, and we go on this way for a while. When this rhythm in the duet is established, I add a verbal mirroring: it is impossible that I am capable of not doing exactly what he asks. “You are very angry with me because of this. It is safer to close oneself up in the soft house and from there to try to hit me and punish me.” Inside of me I feel that the womb is still the only safe place and I feel Adam’s suffering and impotence.

Slowly, Adam comes out and begins again to play.
Today Adam speaks with strangers, with his teacher, in class, even in front of everybody. The teaching staff is beginning an evaluation, which had been impossible to carry out until now because of Adam’s mutism, as to the type and extent of his learning disabilities, while nobody still doubts that his I.Q. is completely normal. The mother, who now describes him as much more open and easier to manage, has a new companion with whom Adam has a very close relationship. There are many more examples and important parts of the therapeutic process that I could cite, but time is short and I hope that I have clarified the problem I faced, and also the response that I have given it.

The conflicts and voids that drove Adam to develop his symptom found expression in the therapy, expressed either musically, through playing, or in words. My attunement to these conflicts and voids was made possible only by means of an open, fluctuating internal situation that allowed me a “resonance“ with Adam’s inner movements, an empathic understanding and successive therapeutic reacting. This resonance only becomes possible if on the part of the therapist there is total concentration on the patient. A major obstacle in finding this kind of attitude within myself was represented by the “abandonment” on the part of Adam of the musical means in a specific sense within the transitional space. Only after having lived through, and subsequently analyzed and understood my difficulty, and having repeated this process over and over again during the two years of therapy with Adam, was I able to attune myself and resonate. By means of the examples cited, we have been able to see how, in fact, the musical medium continued to play a fundamental role: my type of attunement as M.T. evolves, in fact, through musical
parameters, even when these are expressed through games, movement and words. Intimacy and separation, control and freedom, closeness and distance, idealization and humiliation, aggression directed within or without, growth and regression, these are some of the contrasts that we shared during the hours of therapy, using as communication channels such parameters as rhythm, duration, intensity, level. The universality of these parameters, their profound linkage with the most remote origins of the formation of the self, permitted a deep communication between Adam and me, contributing to touch upon his selfhood and enabling him to develop a new way of being together with the world; by sharing words.

**Bibliography**


A Song For You: Integrating Children with Autism in Childcare Classes

Kern, Petra
Dipl. Sozpaed., Music Therapist BVM, MT-BC
University Witten-Herdecke, Germany
University of North Carolina at Chapel Hill, USA
1 Address correspondence to Petra Kern, 302 Saint Thomas Drive, Chapel Hill, NC 27517. Email: PetraKern@prodigy.net

Abstract

This presentation describes two studies evaluating the efficacy of music therapy interventions for the integration of young children with autism in an inclusive childcare setting. The interventions used individualized songs, sang by teachers and caregivers to assist the children in daily transitions and routines. For two children the study involved the morning arrival routine; for another child the study involved managing daily routines (e.g. hand washing, clean up). The aims were to: (a) address problematic routines, (b) increase peer interaction (c) evaluate the effects of songs on children’s functioning, and (d) evaluate having caregivers rather than therapists implement the songs. Direct observation and single-subject experimental designs were used. The use of songs was effective in changing the children’s greeting-time, independent performance in daily routines, and increased peer interaction. In this session, the collaborative strategies for implementing the intervention, the role of music therapists in inclusive childcare setting, the development and function of the songs, and the evaluation of the therapy by the teachers and parents will be discussed. Video and audio excerpts will be shown.

Background

The project occurred at the Frank Porter Graham (FPG) Child Development Institute childcare program, which is affiliated with the University of North Carolina at Chapel Hill, USA. FPG has a long history of doing research, providing training to professionals, demonstrating innovations and serving children in inclusive settings.
The childcare program enrolls about 80 children from 6 weeks of age to 5 years old. Approximately 33 % of the children have disabilities, and children with and without disabilities are enrolled in the same classes and in each class of the program.

In this context Dr. Mark Wolery and his colleagues conceptualized, developed and implemented the Center-Based Early Intervention Demonstration Project for Young Children with Autism in the FPG childcare program (Wolery, Watson, Garfinkel, Marcus, & Coburn, 2001). The design of the project was a cooperative venture between FPG Child Development Institute and Division TEACCH of the University of North Carolina at Chapel Hill, USA. The project goals were (a) to develop a model for serving children with autism in inclusive child care classes, (b) to provide individualized support and assistance for families, and (c) to train others to use the model.

One focus of the Autism Project was to demonstrate techniques for successfully including young children with autism in regular child care settings. To this end, I developed several music therapy based interventions for children with autism who showed interest in music. The music therapy interventions attempted to follow parts of the Autism Projects conceptual design. As such, the interventions were done in inclusive classrooms, using the integrated therapy approach (McWilliam, 1996). This means each classroom contained children with and without disabilities and the interventions were embedded in the ongoing classroom routine. The rational for this procedure is threefold: (a) to minimize stigma and isolation, (b) to capitalize on children’s naturally
occurring learning opportunities, and (c) to increase the number of experiences that promote learning (McWilliams, 1996; Wolery & Wilbers, 1994). The music therapy interventions have been designed and implemented in close collaboration with the teachers. The following steps were done together: (a) defining the problem, (b) identifying the goals of intervention, (c) planning the intervention, (d) consulting and supporting the teachers during implementation, (d) engaging in follow-ups (Bruder, 1996). Specific goals, strategies and procedures of the music therapy interventions have been individualized for each participating child with autism. Since children with autism respond well to predictable routines and structure, both elements have been included in the intervention (Quill, 2001).

These strategies are effective ways of allowing children with autism to improve their skills and use their strength to act independently in the daycare routines. Further, parents and caregivers have been included in the intervention and supported through frequent communication and provision of emotional support.

The Role of a Music Therapist in Inclusive Childcare Settings

In the following two studies, I consulted with the teachers, and helped the teachers implement activities and strategies based on music therapy principles. This raises the question, “What is the music therapist’s role in an inclusive childcare setting using an integrative therapeutic approach?” In the past, occupational therapy, speech-language therapy, physical therapy, and special education were all done through the integrated therapy approach. The professionals in these disciplines consulted with
teachers, and helped the teachers implement activities and strategies based on their professionals’ disciplines. A part of these research studies was to determine whether teachers were effective in implementing principles from music therapy to improve experiences of children who had tremendous difficulties during classroom routines.

There are at least four possible roles we can play to improve the lives of children in inclusive school settings.

1. The 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.

2. Providing a mix of direct therapy and consultation with 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 music therapists, but they may benefit from knowing what we have learned.

3. Train other professionals such as teachers or occupational, speech and physical therapists, and to consult with them about specific children. This is non-traditional role of a music therapist, 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.

4. 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 increase our credibility when working with professionals from other disciplines.

**Morning Greeting Routine Study**

Along with the defining deficits in social skills, language/communication skills, sensory responses, and limited repertoire of behaviors, children with autism often have difficulties making transitions (TEACCH, 2002). One big challenge for two children diagnosed with autism was making the morning transition into the classroom. It was difficult for them to leave their parents or caregiver and they lacked the social and language skills that would enable them to greet their classmates and teachers. In collaboration with the classroom teachers and the parents, we developed a music therapy intervention to ease the children’s transition into the classroom and to facilitate the development of appropriate greeting skills. Music therapy has many potential benefits for children with autism. Music can support positive social interactions, facilitate verbal and non-verbal communication, enhance success-oriented opportunities for achievement and mastery, and music is often a strength for children with autism (AMTA, 2002, Gottschewski, 2001, Warwick 1995).

**Participants**

The target children were a 3-year-old African-American boy, Phillip and a 3-year-old European-American boy, Ben. Both children were diagnosed with Autism Spectrum Disorder, using the Psychoeducational Profile-Revised (PEP-R), (Schopler, Reichler, Bashford, Lansing & Marcus, 1990) the Autism Diagnostic Observation Schedule (ADOS)
(Lord, Rutter, DiLavore & Risi, 1999), clinical observation, and parent interview. Phillip was functionally non-verbal and used the Picture Exchange Communication System (PECS) (Bondy & Frost, 1994) to communicate. Ben also used the PECS, but he started to develop some functional speech. The children tended to have difficulty with transitions and breaks in their routines. Often both children had tantrums during the morning arrival time. Phillip would scream, slam the door, refuse to enter the classroom, and lay on the floor. Ben would hold on to his caregiver, cry and ignore efforts of the teachers to welcome him. Peer interaction was mostly negative for Phillip. He was a large boy, who sometimes used aggression or took toys away from other children to start interactions. His peers seemed to be afraid of him and often declined to play with him. Ben had a lack of interest in peers and a poor understanding social rules or conventions. Peers often ignored him and went about their play. Neither child engaged in play unless supported by the teachers.

Classroom peers were similar in chronological age to each child. Typically developing peers as well as peers with special needs were in each classroom. Their participation was voluntarily. Classroom teachers as well as the children’s primary caregiver participated in the study too. The following video excerpt shows Ben prior to the established morning greeting routine and intervention.

Goals of Intervention
Because of the challenges Phillip and Ben experienced during the morning greeting time, the following goals were established.
1 Provide individualized support for a successful transition from home to daycare class.

2 Develop a predictable routine and structure for this transition.

3 Implementation of the intervention by teachers in the daily classroom routine.

4 Increase peer interaction.

5 Add further Individual Education Plan (IEP) goals.

6 Include parents and caregivers.

**Development and Function of the Songs**

I composed an individual song for each child, incorporating the goals of intervention. The melody, rhythm and harmony of the songs mirrored each child’s personality and emotional state musically. Both children showed a great interest in music and seemed to be nurtured by certain musical pieces. For example, Ben stopped crying when listening to music software on the classroom computer. I taught the teachers the songs and some principles of music therapy to implement the intervention in the daily classroom routine. The demands of the transition were composed to the following five steps:

1 The target child enters the classroom independently and is greeted by his teachers or peers.

2 The target child greets a person (teacher or child) in the classroom.

3 The target child greets a second person (teacher or child) in the classroom.

4 The target child says “goodbye” to the parent/caregiver and the parent/caregiver leaves the classroom.

5 The target child engages in play with a toy or material found in the classroom.
Figure 45 shows Ben during three steps in the transition time: coming into the classroom independently, greeting a peer, and engaging with a toy and teacher.

“Song for Ben”
by Petra Kern

A

Good morning to Ben, good morning to you.
Good morning to Ben, it’s good to see you.
The songs reflected this structure and routine in a musical AAABA form and the lyrics followed the steps. Social interaction was supported by greeting at least two peers through the songs, and by handing over a picture symbol showing a stick figure waving “hello.” Additional IEP goals were verbalization for Ben and choice making for both children. Choice making was practiced by choosing two different peers to greet, a toy to play with, and a weather condition at certain points of the song. Verbalizations were practiced by saying or singing “hello” to a peer or “bye-bye” to the caregiver. The parents and caregivers played major roles in the procedure, by taking the children to school, participating in singing, greeting peers and teachers, and waving good-bye.
Research Study

The intervention was evaluated through a single subject research design (Aldridge, 1994; Aldridge 1996; Holcombe, Wolery, & Gast, 1994; Kazdin, 1982; Wolery, Bailey, & Sugai, 1988). The specific questions that were addressed were as follows:

1. Does the use of an individually composed greeting song increase appropriate independent performance during morning arrival routines of children with autism?

2. Can a classroom teacher learn to use music therapy principles in a particular routine?

3. Will the greeting song increase peer interaction (evaluated for Ben)? An A-B-A-B withdraw design for Phillip and an A-B-C-A-C withdraw design was used for Ben to evaluate the effects of the individually composed greeting song sung by the classroom teachers, the caregivers and peers. Effectiveness was determined by comparing baseline performance (A phase) with intervention performance (B phase). For Ben, the intervention needed to be modified (C phase) by eliminating the “goodbye” part.

The following five categories of behaviors were coded for each of the five steps of the greeting routine on a specially developed data sheet: (a) Independent response, (b) Prompted response, (c) No response, (d) Error, and (e) Inappropriate Behavior.

Data were collected live during the morning arrival time. The data collection occurred over two months for Phillip and over three months for Ben. Inter-rater agreement (across phases) ranged from 71% to 100%, with a mean of 95%.
The following video excerpt 2 shows Ben during two intervention sessions.

## Results

### Outcome Data-Ben

The results of the study show that during baseline (A phase) Ben had one independent response, which was entering the classroom. The implementation of the song (B phase) did not change his performance. When the intervention was modified by eliminating the good-bye part (C phase), the number of Ben’s independent actions increased immediately. Ben entered the room independently and greeted two peers. After withdrawing the song, Ben’s independent behavior decreased. Re-introducing the modified intervention, Ben exhibited a high level of independent performance. There was no peer greeting during baseline (A phase). However, as soon as the song was introduced, at least two peers greeted Ben during his arrival time. Neither the changes made to the intervention, nor the withdrawal of the intervention returned the peer’s behavior to baseline conditions (A phase).

### Clinical Statements-Ben

During the initial intervention (B phase), Ben cried a lot and became upset as soon as it was time to say good-bye. Several times, he picked up a crying baby doll and said “see you in the afternoon” much like the lyrics of the song. Humming the melody of the song calmed him, but did not change how he performed the greeting routine.
After the modified intervention Ben started the day in the childcare center without crying. He seemed to be less fearful and appeared in a happy mood. He laughed, smiled and jumped joyfully up and down. He started to verbalize peers names and sometimes greeted more than two peers or teachers. He seemed to enjoy social interactions and activities related to music. For example he mostly engaged in drumming with a teacher and peers, when ending the greeting-routine.

The song motivated peers to want to interact with Ben. Peers gave positive comments regarding Ben’s behaviors such as “He doesn’t cry any more!” or “He did a good job!” The caregiver who took Ben to school said, ”I think this was perfect for Ben. He had a hard time leaving me in the morning, but with the help of the ‘Good Morning Song’ the transition became much easier for Ben.”

**Outcome Data-Phillip**

The results of the greeting routine intervention showed that during baseline intervention (A phase) Phillip entered the classroom independently and found a toy with which to play. With the introduction of the song (B phase), Phillip steadily became more independent. A withdrawal of the intervention immediately decreased Phillip’s performance. By the second day of withdrawal, Phillip had returned to his initial baseline performance. Re-introducing the song increased his independence once again. On the last day of intervention Phillip performed all of the steps of the routine by himself.
Clinical Statements-Phillip

After the introduction of the song, Phillip started his day in the childcare center without negative response from peers. He increased his independent performance and understanding of the morning greeting routine, but the concept of saying good-bye remained difficult for him. He would sometimes wave good-by or verbalize “Ba” for good-bye, but rarely when expected in the routine. His teacher did not make the changes in the melody that indicated the good-bye part, which was a crucial element of the song. No major tantrums were observed after introducing the songs in the morning greeting routine. Phillip seemed to be in a much better “mood”. Positive peer interactions increased.

Peers seemed to like the song and wanted to take part in the musical activity by greeting Phillip or by filling in the weather condition. Often more than two peers wanted to be greeted so this verse had to be extended. Phillip started to verbalize “hello” and good-bye”. Parents of other classroom children would participate. One mother commented “Prior to the study my child was intimidated by Phillip’s behavior at greeting time and I was thinking of taking him out of the class. With the music therapy intervention, my child would run to school hoping to arrive before Phillip so that he could participate in singing the song. I am very pleased to see this happen”. In both cases, teachers have been able to implement the songs to a certain extent, which has benefited these children with autism. However, ongoing consultation and feedback from me during the implementation of the intervention was necessary.
I would like to close the Morning Greeting Routine study by quoting the lead teacher: “Transitions into the classroom were stressful for the children, parents and teachers. The ‘Hello Songs’ allowed us to implement a simple intervention each day. The songs are great and helped all of us tremendously.”

**Multiple Step Tasks Study**
Another example of how songs benefited a child with autism is evident in the Multiple Step Tasks Study. The childcare day has many transitions and involves managing daily routines. These routines require that a sequence of different steps be followed. For one child with autism establishing complex routines like hand washing or clean up was troublesome. In her book “Autism: An Inside-Out Approach” Donna Williams (diagnosed with autism in her adulthood) describes how she used familiar songs to memorize complex routines by including each step of the routine in the lyrics. She states: “If the person comes to sing known tunes, verbally, or mentally, songs can be a good way to carry along a sort of ‘map’ by which to trigger the sequence of steps involved in doing something” (Williams, 1999, p. 299).

We developed lyrics to ease the steps of hand washing and used a pre-composed song for cleaning-up.

**Participant**
Andy, a 3-year-old European-American boy, diagnosed with autism was also enrolled in the FPG Child Development program. Andy was an adorable boy with a lot of great skills. However, his communication was
limited and he needed assistance with managing several daily activities. He used the Picture Exchange Communication System (PECS) and other visual cues. Andy also had some difficulty attending to language unless it involved a familiar song or physical routine. Andy’s favorite things were to identify letters, numbers, shapes, and listen to music. He seemed to love to sing and dance to music and fill in words of songs, if paused while singing. His classroom teacher described him in the following way: ”Andy really responds well to music. He makes eye contact with me as soon as I start a melody. Singing songs with him during major transitions in the classroom helps him to understand what to do next.” She also noticed that Andy would stiffen his legs and body, flap his arms, whine, try to escape and avoid transition if she just used words in the same situations. He transitioned easily, when the routine was sung to him, but did not follow the same multiple step tasks independently.

**Goals of Intervention**

Since Andy was so responsive to music, we decided to use songs to improve his skills for managing multiple step tasks.

The goals of intervention were as follows:

1. Provide individualized support for successfully following multiple step tasks within classroom routines.
2. Develop a predictable routine and structure for the multiple step tasks.
3. Implementation of the intervention by teachers in the daily classroom routine.

We used the familiar tune “Row your boat” (American Traditional) for hand washing. The teachers used this tune already for soaping his hands but incorporated the whole routine by describing the following seven
steps in the lyrics: (1) Turn the water on, (2) Wet your hands, (3) Get the soap, (4) Wash your hands, (5) Rinse your hands, (6) Turn water off, and (7) Dry your hands, as you can hear in the audio excerpt 1. For cleaning up toys after playing we used the familiar song “Clean up!” (Barney and Friends), as you can hear in the audio excerpt 2, and expected Andy to follow six steps which were: (1) Get up, (2) Pick up something (3) Put it away, (4) Pick up something, (5) Put it away, and (6) Go to where a teacher wants him to go.

Research Study

To evaluate the effectiveness of the songs versus the spoken word, I used an alternating treatment design (Holcombe et al., 1994). The advantage of this single-case experimental design is the rapid comparison between two treatment conditions. I altered the condition S (song) and condition L (lyrics) day by day.

The specific questions that were addressed were as follows:

1. Does the use of familiar, pre-composed songs including individualized lyrics increase independent performance for a child with autism during multiple step tasks?

2. Will the use of familiar, pre-composed songs including individualized lyrics be more effective than simply using the lyrics to manage multiple step tasks?

3. Can a classroom teacher implement the intervention in the classroom routine?

Six categories of behavior were coded for each of the steps of the multiple step task on a specially developed data sheet: (a) Did it, (b) Did not do it (c) Did it with prompts, (d) Negative verbalization Yes/No, (e) Escapes, and (f) Skipped the part.
Data were collected live before breakfast for the hand washing and shortly before circle time for toy clean up. The data collection occurred over two months. Inter-rater agreement (across phases) ranged from 67% to 100% with a mean of 99%.

The following video excerpt 3 shows Andy during the multiple step task: Clean up using just words, using a song.

**Results**

**Outcome Data**

The results of the multiple step task, “Hand washing,” show that Andy’s independent performance increased during both conditions. Prior to the intervention Andy just would soap his hands only with help from his teacher. Learning occurred by implementing the routine. He performed a maximum of five steps out of the routine independently, but never seven in a row. The song produced greater independent performance, particularly in the beginning.

The results of the multiple step task “Clean up!” show that in condition S (song) his independent performance was consistent. In all of the sessions Andy completed four steps of the six-step routine independently. The steps Andy completed independently twice were “Pick up something” and “Put it a way”. In Condition L (lyrics), Andy initially had one independent response, which was “put something away.” Continuing with the intervention, Andy’s performance increased to four steps, but immediately decreased afterwards to two independent steps.

Overall singing the songs was more effective than just using the lyrics.
The classroom teacher was able to implement the familiar song in the classroom routine.

**Clinical Statements**

The familiar song seemed to motivate Andy to follow through the multiple step tasks without any inappropriate behavior. It is important to note that the first step “Get up” and the sixth step “Go to where the teacher wants him to go” almost never occurred. The reason for this was that Andy was already sitting on the floor where he cleaned up his toys. During the classroom routine a short free time between cleaning up and circle time was given because the class was waiting for two more children to join them for circle time. The whole class engaged in the hand washing and clean up activity at the same time. Using these songs, Andy was able to complete the tasks along with his classmates and was thereby fully included in the classroom routine.

**Final Conclusion**

I measured the effectiveness of two interventions based on music therapy principles by using single subject experimental designs. The level of impact achieved through the interventions was high; demonstrating that songs can be used as tools to increase the independence of children with autism in classroom routines that have been difficult for them. The individualized songs increased peer interactions during the morning greeting-time. In both studies the songs had positive effects on the children’s functioning. The teachers were able to implement the interventions with consultation and feedback from the music therapist.
References


**Short Biography**

Petra Kern is a board certified music therapist and got her formal training in Germany.

Currently she works as a researcher at the University of North Carolina at Chapel Hill, USA were she conducts research projects in Early
Childhood Intervention and Music Therapy. She is also a doctoral candidate of Prof. Dr. David Aldridge at the University Witten-Herdecke, Institute of Music Therapy, Department of Qualitative Research in Medicine. She has done clinical work with a wide range of population. She has worked with children in an interdisciplinary intervention program, the elderly in nursing homes, and in several institutions for adults with mental retardation. Petra Kern also teaches music therapy and conducts continuing education courses and workshops in the field of music therapy.
Kim, Jinah
University in Seoul, Korea. Since qualifying as a music therapist, She has worked with people with special needs, from very young children to young adults specializing in autism both in England and Korea.

Abstract

‘For all human beings a parting is like a little death.’ Alvarez (1992)
Many children within a broad range of the autistic spectrum show difficulties in dealing with holidays, breaks, and the ending of therapy. This difficulty is often intensified when the child has precarious awareness of what ending means, yet lacks the capacity for self-regulation. Preparing for parting often brings unbearable terror and dread that the child cannot contain, nor articulate in words. This paper will explore and examine issues of ending in music therapy and how this kind of difficulty is addressed, contained and transformed in the mutual music making process between the child and the therapist. The role of music and the therapist will be discussed, focusing on three main aspects; implications of the mutual music making process: tuning in and moments of merging; music as container and transformer of unbearable feelings; transference and counter-transference issues in dealing with endings. The case studies in this paper with audio excerpts, which include both short and long-term individual psychodynamic music therapy in the U.K and Korea, will illustrate a number of significant clinical features on this subject.

1. Introduction

“Daniel, We have one more session left. Next week will be the last session.” I had been preparing the ending for about a month, and Daniel, an 11-year-old autistic boy, had only shown his usual awkward smile so far. He was a relatively high functioning autistic boy, however, both his expressive and comprehensive language ability was limited. Therefore, I
asked him, “Daniel, how many sessions are left for us?” “10 sessions…12?” His voice murmured. I explained and asked him the same thing 3 times more and his answer changed from 10 sessions to 2 years, then ‘I don’t know, I can’t remember’. A slight sign of puzzlement appeared in his shy smile. Then he wanted to play. When we started playing, myself on the piano and him with the drum and the cymbal, he started playing the tune, which he used to play in the early times of music therapy. After the first playing, he began to sing ‘one foot in the grave’. By accompanying him on the piano, I realized how difficult an experience it was for him. It seemed what was too hard to comprehend in words, could be explored and expressed in music. This, in turn, enabled the child to feel and think about the issue previously ‘incomprehensible’ and ‘un-thinkable’.

Jinsoo, a 6 year old, non-verbal boy with pervasive developmental disorder not otherwise specified, also did not show any signs of awareness when I told him that the day was our last day in music therapy. Jinsoo was in his usual mood and behaviour, pacing up and down in the room. Then a little later, he approached me, pulled my right hand towards him, then almost bit off my index finger. The pain was so acute that I could not even utter a word. Through experiencing the pain inflicted on me, I knew that he understood the meaning of the ending.

As Autism spectrum is a neurological and developmental disorder, showing wide range of ability and individuality, each child has his own patterns of communication, and that of dealing with difficult situations. Endings including holidays, breaks, and the ending of music therapy, are
inevitable and often difficult situations that every therapist and client has to face. In psychodynamic music therapy, endings are announced and prepared in advance so that their effects can be dealt with in the session. In dealing with endings, I have recognized particular issues emerging and repeating over and over again in a similar, but never identical way. I am going to talk about these issues that the children brought to endings in music therapy. Endings can bring up some of the most profound issues in life itself – primal fear of death and dying, the pain and the subsequent loss. This is especially true when the child forms close relationship to the therapist and the therapy itself, yet lacks the capacity for emotional regulation, nor has established a secure internal world.

In order to enhance the understanding of these particular phenomena, I am going to describe some fundamental aspects of mutual music making process in music therapy and link these to issues of endings in different stages of music therapy. The role of music and the therapist in helping the child to cope with endings in music therapy will be discussed and illuminated through clinical vignettes.

The children, I describe here, have autism spectrum including autism, pervasive developmental disorder not otherwise specified and asperger’s disorder. I will refer the children within this broad range of syndrome as the child, and use ‘he’ unless the client I refer is a girl. For confidentiality, the children will be referred to by alternative forenames.
2. Implication of mutual music making process: tuning in and moments of merging

Autistic children are often very difficult children to play with even in music therapy. The children lack the motivation to cooperate with people and to explore the environment. Unlike the old belief that the children might be musically gifted, and respond better to auditory stimulation than visual ones, many children, with whom I have worked, did not show any particular interest in music. Some children even prevented me from playing at all. Sam was one of them.

Sam was an 8-year-old highly complex boy with autism and severe learning difficulty. He was an extremely difficult child to draw into musical interaction. He prevented me from making any sounds, nor did he play. Therefore, the first meaningful interaction through sound occurred only after the first half term. He curled up his body in a foetal position on the floor, which he occasionally did in the session. When he did that, I felt both excluded and fascinated despite the fact that I did not know what was happening. He was wrapped up in his own bodily sensations, pushing his abdomen in and out, gibbering rather dreamingly, and tapping the radiator. I mirrored back his tapping and vocalizations when there was silence. Recognizing my sound, which matched his sound, Sam began to tap the radiator leaving a gap for me to mirror him back. This led us into quite intensive turn taking. After this initial interaction, he was less resistant towards my making contact with him through my voice.
Regressive play as it was. Winnicott (1971) states that such play takes place between total phantasy and absolute reality - the intermediate area. Alvarez (1992) adds that we, the therapists, might need to carry such hopeful phantasy for the child. Then how do we do that?

2.1. Musical Attunement
In improvisational music therapy, the therapist meets the child through improvised and responsive music of her own. Whatever the child does in that precise moment - impulse, bodily movement, voice, or instrumental playing - can be mirrored and matched with the therapist’s music. Musical attunement plays a central role in facilitating self-expression, emotional communication, and a therapeutic relationship between the therapist and the child. Musical attunement is not merely copying what the child does, it is more to do with the extent to which the therapist’s music is synchronized with the child’s ongoing activity and focus of attention, etc. Even therapist’s decision to mismatch the child is based on her attunement to his developmental needs. Therefore, music making process is inherently child-initiated activity whether the child intentionally participates or not.

2.2. Therapeutic Intimacy
Non-verbal and musical interaction between the therapist and the child is often compared to mother-infant interaction. A mother and infant reciprocating same rhythmic sense and expression of self is in essence analogous to the way the therapist who responds to the child in music therapy (Trevarthen, 2001, 2002; Robarts, 1996). As music carries emotional value and allows two persons to relate to each other at the
fundamental level, sharing affects and meanings in time becomes possible, bringing a sense of intimacy between them. The sense of intimacy can bring an unexpected dimension to the therapy as well. When working with young children, who are just coming to the point where they discover the moment of pleasure in relating to the therapist in music, the child’s seeking physical contact with the therapist is often unavoidable. Like the intimate nature of mother and infant interaction, the younger and the more developmentally delayed the child is, the more primitive patterns of relating come to be played out in the session. Many children climbed up on my lap, or touched my breast, and some even explored my body in music therapy. David Mann (1997) points out ‘the sensual-sexual components’ of mother-infant, therapist-client relationship citing Wrye and Welles (1994); ‘the early sensual bond between mother and baby, when marked by reciprocity and attunement, makes separateness tolerable and engenders baby’s love affair with the world’. In addition to that, mutual music making process can become quite sensual for the child who is already obsessed with his bodily sensation. This certainly affects the therapeutic relationship.

2.3. Sense of Oneness
Mutual music making process offers the supreme moment of merging as one in music, though not always. Such a musical process can bring a sense of oneness, we-ness, or togetherness. Sobey (1996) recognizes the danger of merging in the music that the child might use the musical interaction as a means of maintaining ‘autistic aloneness’ or ‘undifferentiated oneness’ with the therapist. While most people enjoy
both separateness and the moment of oneness, autistic children do not seem to have such flexible capacity. For example, Sam was either too close or too distant from me, but could manage nothing in between. It is quite common that once the children found some musical activity bearable, even enjoyable, they have a tendency to ritualize those activities. Indeed, the matching music that I made in response to Sam seemed to fill him with a thrill of being at one with me. Then, his playfulness often became explicitly sensualized and ritualized. Alvarez (1992) points out that such burst of happiness can be a vital turning point for very deprived children. She talks about the child’s need to experience positive aspects in life such as hope, security and pleasure that these can offer a critical point to overcome the familiar pull towards death and despair (Hamilton, 2001). She also warns that the therapist needs to keep the firm boundaries on the perverse and the morbid quality of the child’s ritualization.

3. The music therapist - once idealized, then becoming a rejecting object

In clinical improvisation, child’s outward expression, initiation, etc can be reflected in the therapist music. The child, then senses that the therapist’s music has something to do with himself. Responsive music of such a kind often encourages the child’s motivation to respond. This process highlights ‘projective identification’ phenomena in music therapy. The process is based on identifying part of self with another person. In music therapy, it starts with the therapist empathetically identifying some aspect of the child with her music, then the child
identifying her music as part of his. When the child had hardly experienced, or limited experience of sensitively matching responses from another person, both the processes of musical attunement and the therapist become very important to the child. Music making process becomes not only interesting, but also very exciting to the child. The child often displays thrills and ecstasies, when the therapist got things right in her music. It is not hard to see that the child becomes very excited to come to music therapy. Youngho, a 6-year-old boy with PDDNOS, started asking me same questions over and over again. “Can I come to music every day? Can I stay with you till 10 o’clock in the evening?” After reciprocal interaction on the piano, he began to ask me again “can I come with my dad?” He had a difficult relationship with his mother who found hard to love him, and a permissive father. Now he wanted to make his own perfect family in music therapy.

I have experienced that the therapist is often experienced and treated either as an idealized mother or in some ways even a lover, according to the developmental stages of the child. Some music Therapists also consider their role as ‘music mother, mothering or parenting’ and go in length describing how the quality of a good mother and what she does is analogous to what a good therapist does in music therapy. Sometimes the child appears to become more attached to the music therapist than his own mother, which leaves the mother feeling rather resentful, especially when the mother feels inadequate with the child. Therefore, it is important to help the mother to be able to play with her child in a sensitive and responsive way.
Jinho, an energetic 6-year-old boy with PDDNOS, was referred to music therapy by his over-anxious mother. Communication and social difficulties, self-abusive and violent behaviour, and overtly sexualized behaviour were the reasons for referral. He had limited language ability – he knew many words mostly commercial product names in advertisement – such as Samsung Refrigerator, Acha Karaoke, but was not able to use words communicatively in relation to people. Soon he began to develop passionate love for music therapy and the therapist. In his excited moments in music therapy, he would shout ‘Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, Sunday, Music Therapy!’ over and over again. Then I would make up a song ‘everyday music therapy, I wanna have music therapy everyday.’ Reasons for referral and his communicative ability dramatically improved within 3 months time. Then I began to notice a strange dynamic between his mother and me. His mother always brought him by herself and waited outside. Then she began to tell me triumphantly how she managed to get him to do things at home. ‘If you don’t do this, Kim Jinah sunsaeng-nim (Therapist is usually called ‘sunsaeng-nim’, which is synonym for ‘teacher’) won’t see you. She told me so. Then, you won’t have music’. His mother paid her gratitude to me for helping her son so much, but I sensed her uneasiness and conflicts, then suddenly she ended music therapy after 5 months. Now I realize how she must have felt to see her son forming intimate relationship with another woman who only sees her son twice a week for only half an hour, while she has taken care of him for all his life, and still has a difficult relationship.
Whoever decides the ending and whatever the reason for it, the child seems to feel that the same person, who cared and loved him in music therapy, is rejecting him. In fact, by announcing and preparing the ending, the therapist pushes the child away. There were occasions when external circumstances brought the ending to the therapy such as the therapist’s leaving, the child’s moving to another place, holidays, mother’s decision to quit the therapy, etc. Jinho seemed to feel that it was the therapist who was cutting him off. Therefore, the therapist became not only the bad object, but also a threatening, persecutory one. During the last month in music therapy, Jinho displayed very aggressive and sexualized behaviours towards me, which I will return to later in this paper. It is also a paradox in music therapy that as soon as the child gets better (whatever the better is), he is destined to be dismissed. Therefore, there is always a sense of resentment in addition to coping with all the difficult feelings.

4. The trauma of Parting

I have seen some autistic children having more difficulties in managing holidays, breaks, and the ending of the therapy than others. Tustin (1992) and Alvarez (1992) describes such experiences as something similar to ‘little death’ – ‘being annihilated’ or ‘falling endlessly into the bottomless pit’. The child’s terror and panic on endings might be too frightening and overwhelming to him. Tustin (1992), who identified autism as something close to the infantile version of post traumatic stress disorder originating from the child’s traumatic bodily separation from the mother, talks about the feeling of ‘being broken’. Since autism is a
developmental disorder, and the use of improvised music is similar to early human interactions, the process of mutual music making often appears to put the child in touch with his infantile needs and feelings. This heightened sense of infantile self and vulnerability is often dramatized when the child is aware of the brokenness between him and the therapist. This feeling of being broken is often intensified when the child faces various endings in music therapy. When the child’s ego is not strong enough and has not yet internalized good enough objects, the very issue of dying and survival comes to the surface. Manic way of adhering oneself to the therapist, or taking refuge under the therapist’s skin and music is frequently observed. Some children, who are better equipped to deal with such issues, explore these issues through playing music and are able to verbalize a little more. Mike, a 9-year-old, autistic boy with severe learning difficulties, said to me, ‘it’s too late. You broke my heart’ for the last 2 months of music therapy. These intense feelings, whether repeating early infantile trauma or not, can be dealt with by a sensitive and responsive therapist who is ready to work with and go in depth and length to understand the child. When the child feels these feelings can be contained and understood this helps him to develop the capacity for symbolization. Tustin (1992) claims that psychic catastrophe can become a psychic opportunity. The provision of mutual music making process certainly offers such opportunity for the child. The following will address a number of significant clinical features and phenomena concerning endings in music therapy through various clinical vignettes with different children at different developmental stages.
4.1. Brokenness in normal sessions
In addition to the different types of endings, many autistic children have very little tolerance for anything less than a perfect therapist, or important adults around them (Reid, 1999; Alvarez, 1992, 1999; Tustin, 1992). Sam perceived my attempts to differ any element of music from him, as a threat. The problem was that he not only had hardly any capacity to tolerate frustration and disappointment, but also he knew very well that I was capable of matching and synchronizing with him in the music. A sense of betrayal comes into my mind now when I think of it again. Obviously musical attunement increased his awareness of himself and me and made a primitive level of sharing moments of playing possible. However, he always insisted that we played the same instrument in the same way together, which was felt to be ‘perfect oneness’. If I tried something different in our playing together, his rage at signs of difference, thus signs of separation, was uncontrollable. Anything outside of his expectation including school holidays in music therapy seemed to be felt by him as total disaster and an unbearable brokenness.

4.2. Pre-mature ending
Meltzer (1975) talks about the auxiliary ego function of the mother and the therapist to the infant and autistic child. When the child has formed a somewhat close relationship to the therapist, but has not yet internalized enough good experiences, the announcement of the ending can be traumatic. This is so only when the child has the precarious awareness of what it means. Many children acted in their terror, rage, panic,
desperation in music therapy. Instead of a psychological process of projection commonly observed in the psychodynamic working mode, the children often discharge their affect by physical enactment. Some turned to inanimate objects to get comfort, and some viciously attacked the therapist, but mostly they were shocked.

Sam was my first autistic child I worked with after being qualified as a music therapist. One typical reaction to school holidays, thus break from music therapy, was that he would desperately cling to the smooth surface of a thick mattress in the therapy room as if he was hanging onto a steep cliff where there was nothing to hold onto. He would get extremely agitated, then would dramatize by saying ‘hang on’. When it happened for the first time, I did not know what was happening. Like many people identified, working with autistic children is like an archeological work. Sam once cried unstoppably for no apparent reason for days, then only days later his mother discovered that he remembered the dead cat, which he saw a week ago in the park. This type of delayed response and seemingly unrelated timing makes it hard to understand the child. When he clung to the smooth surface of the mattress for the first time, I had no idea that it was about the ending. However, his action caused me to feel desperate to help him. In retrospect, now I realize how pathetic he was that he could not even try to cling to me, but clung to an inanimate object, which could not help him. To him, I must have been a rejecting therapist who threw him out of music therapy by announcing the break. Therefore, each break was felt to be traumatic for Sam. As therapy progressed, he became more able to cling to me than to this mattress, which was a hopeful sign. However, his clinging to me often felt like vicious attacks.
When feelings are too overwhelming for the child to contain, and he has little capacity for conscious self-regulation, the behaviour of the child is like erupting volcano, which easily overwhelms the therapist as well.

For Jinho, who had 5 months of music therapy as mentioned earlier in this paper, the trauma of ending was extreme. It was extreme perhaps partly due to his mother’s manipulation of him. For the last month of music therapy, Jinho tried to push beaters into every hole of the instruments, his body and mine compulsively. At first, the act reminded me of ‘penetration’ so strongly, therefore, in my counter-transference, I felt I was viciously intruded upon by him. He also attacked me physically so that I had to literally restrain him. Once idealized, and somewhat identificatory love, now turned murderous. He even pushed me to the floor, and tried to climb on to my body as if he was trying to have sexual intercourse with me. He, then, once even tried to strangle me. When I firmly prevented him from hurting me, he began to hurt himself in front of me. He pushed a beater deep into his throat while watching my reaction. The pain caused his eyes to well up tears and he giggled uncontrollably. All the while in my counter-transference, I was shocked and unable to think clearly. Object relations theorists often talk about baby’s attacking mother that the most important job of the mother is to survive. Then it suddenly dawned on me - how shocked he was that nothing seemed to get through to him in that crazy moment. I was being pulled into his desperate acts, and pushed to feel and react to his insane acts. What drove him insane? These disturbing acts were in some ways his attempt to communicate with me. Contemporary child psychotherapists agree that when feelings are too overwhelming and
painful, the therapist may have to carry that with her and digest it for a long time even long after the actual therapy ended. I began to think about what the sexual act means for the small child like him in particular. Fromm (1957) states love as ‘the overcoming of human separateness’ act, and ‘the desire for interpersonal fusion that is the most powerful striving in man’. Jinho in his desperation, no longer allowed me to improvise on the piano, and tried to link himself physically to the therapist. The sudden frightening hole between us had to be filled in. After a period of shock, I began to feel his frenzy desperate act as not just shocking, but unbearably painful. As I began to digest the experience and communicate my understanding to him in simple words and simple singing, he became less desperate. On our last day, surprisingly he sang a short improvised song with clear sentence “Now, it’s time to be separated, what am I gonna do”. I was very moved both by the words and the melody, which contained his integrated and creative self. His voice was calm and full of sorrow, but still the sadness was contained within us and in music.

4.3. Exploring and searching in music
Sometimes, the child becomes very sensitive towards the ending process, yet is able to explore what it means to him in his play intensively. Lyle was a 4 year-old bright asperger’s child when I first met him. He attended small group music therapy for a year. Lyle was an extremely stubborn and aggressive child that most staff at the center found him hard to deal with. There are two types of behaviour in autistic children if I may oversimplify - ‘fight or flight’ types. Lyle was a fighter in every sense, an
assertive and searching child even up to the last minutes in music therapy. As ending approached us, nothing seemed good enough for him that he picked up and dropped instruments on the floor all along. Then when it was time to finish, he played the piano with me in desperation. I talked about his need to play the piano before it’s too late..and what the piano means to him. Then he suddenly started to talk about ‘many people dying, my grand dad dead, heart stopping, brain stopping…’ in a rather panic streaked gibberish way. I told him that what he said was very sad and painful. Then for the first time, he commented on our good-bye song. “This song is really sad…we are dying.. many people are dying”. The last day in his therapy, he played instruments rather intensely, then went in and out of the room as if he was practicing his leaving the group. Then he began to dance vigorously in a circle. I improvised with the piano in support of his dancing. Sinason (1987) claims that some forms of dancing and physical activity are an attempt to create a second skin in the face of primitive loss. His dance was both intensely absorbing, and poignantly contained. He, then came up to me, wanted to put a stick inside of my mouth going down all the way to the private part of my body to clean all the germs. It was both seductive, mesmerizing infantile attack, as well as manic reparation on me. What was he making me into? Could he bear to hear germ filled mouth of the therapist? As he struggled to the last minute in his way of coping with ending, I struggled with him. Then we came to the final good-bye time. He sat in front of the xylophone with his back to the piano where I was. Even after the good-bye song was over, he continued to play the xylophone. Therefore, I accompanied him with the piano, mentioning at the same time, ‘it’s very
difficult to finish because it’s your last day in music therapy.’ He nodded. The music was serene as well as painfully beautiful, yet containing. After the playing, he went into a foetal position on the floor and stayed there. In my counter-transference, I felt a baby inside. He wanted me to take him to the door (he never asked me to do that before since he always went out by himself), but on the way, he stopped to tie his shoelaces twice, which were already well tied, however. Perhaps he needed to tie-up his intense feelings fully opened in music therapy before he went out.

4.4. Mourning for the loss

Sometimes, it is hard to know whether the child understands what I say even if the child has the language ability. The child may understand the literal meaning of ending, but still has no idea of the consequence of what it means. Sumi was an 8-year-old autistic girl who had been in music therapy for 2 years already. During the 2 years of small group music therapy, she had been developing very well. Like Jinho, she was an energetic, rather hyperactive child, who loved to come to music therapy twice a week. In the course of music therapy, her communication and language skills, and her capacity for self-regulation improved well. Unlike Sam, she had never shown difficulties about holidays and breaks. She was a generally happy child with a very supportive mother and father. Her mother and I had discussed about ending the therapy partly due to the institution’s policy and partly because she was developing well and adjusting quite well to school life even though she still have some difficulties. Those difficulties will be life long difficulties, and I felt she was ready to work on those with helps from her family. Therefore, I
considered this ending was timely. For about 2 months, I prepared her for the ending, but I was not sure whether she understood what ending meant. Perhaps, she assumed it was like the short break from music therapy as before. However, 2 weeks after the actual ending date, I received a call from her mother. Apparently, every Tuesday and Thursday, she still insisted on coming to music therapy. In a month, I got a call from her again, this time her mother was crying. She explained that Sumi had been crying uncontrollably for days, became very depressed, and that day she even attacked her teacher at school. She was never a violent child. During that month, her behaviour deteriorated. She cried at school and at home and often shouted ‘Let’s go to music therapy’. It seemed she did not know what ending meant, and then she was mourning the loss. Because of the inconsolability of her mourning, her mother and I arranged ‘up to 6 months fixed term once a week individual therapy’ to help the child and prepare her to the ending. When she returned, she was at first exhilarated, then slowly began to show moments of real tenderness and care towards me. There was one moment that I almost fell asleep, and she simply put her hand on my lap and looked at me with patience. Wonderfully strange that she was not only able to forgive my failing to attend her in that moment, she was also behaving like a big sister looking after the therapist. There is a false and true reparation on Klein’s concept. True is based on love and respect for the object. She was behaving a head taller and this second ending, she was able to leave me and music therapy peacefully. It was a completely opposite case from Sam that he could not believe that we could return to each other in music
therapy after the break, while Sumi could not believe that she could not return to music therapy anymore.

4. 5. Importance of remembering

Alvarez (1992) puts an emphasis on the importance of reminding the children of the availability and presence of the object. As Sam was in individual music therapy with me for 2 years, little by little his dealing with endings became more communicative.

It was our last day for spring term that he made a crying face without any tears and started rocking for the rest of the session. It was the longest rocking I have ever encountered in two years with him. He looked in panic state and at the same time oblivious of me. He made me feel desperate also that I tried to talk to him first not to lose him into this bottomless spiral of rocking, but he did not seem to hear me. Occasionally, I heard his breathy voice coming out and his voice going up and down in pitch. Among his gibberish self-talking, I heard him saying ‘Remember’. The word struck me so hard at that time. Previously he tried to hold onto the mattress, which could not help him. This time, he was holding onto his memories of music time together in music therapy. A few weeks ago, when he was in his omnipotent happiness, he pronounced that he had wonderful memories. Indeed, inspired by his utterance, his voice, and rocking rhythm, I improvised a song ‘Remember’ in verse form as follows;

- 1st verse; Remember, remember we had music together, we had music together.
- 2nd verse; Remember, remember we are having music together, we are having music together
3rd verse; Remember, remember, we are going to be back here in April, we are going to be back here in April.

As his rocking went on, my singing continued. On a few occasions, I was out of breath, so I missed the last word ‘in April’ of the last verse. So far, he looked oblivious of my singing, but as soon as I missed the last word, he looked at me and said simultaneously in tune ‘In April’. Reid (1999) talks about autistic children seemingly switched off from the world, but intensely attuned to anything ‘not me’ experience. In my experience with the children, I found that the children appear to be more acutely attuned to the therapist’s state of mind than I to them.

He looked desperately upset when I needed to stop singing to just breathe. It was as if the moment the music stopped, the moment became empty and lifeless. It was as if my singing was an oxygen tank, the lifesaver, and a bridge between his desperate world and my relatively sane world.

Due to looking at him rocking endlessly, I felt more and more physically sick and dizzy. At some point, I was unable to think or feel. The mind-numbing quality of his rocking was so powerful that he numbed his own mind, and numbed mine. The rocking might be one of his survival defense mechanisms to fend off unbearable feelings. I felt the need to talk to him and remind him that I was there for him. While talking to him, I felt the need to hold him physically since I sensed that he could not stop rocking. I put my hands under his hand so that he could feel I was there. I initiated clapping and he began to clap back to me. Then he began to speak in his choking voice ‘…huh, huh….years and years……for ages…..’ I was not sure whether he meant he felt he had to wait for ages,
or he had suffered year and years in that dreadful state. The important thing was that he let me know something had been going on for a long time. After the spring break, another half-term break for summer term approached. He was in pain, but he was able to remind himself to remember.

4.5 From music to symbolization
Endings can be catastrophic, but it can also offer an opportunity for creative growth as well. Chris, an 11-year-old, high functioning autistic boy, developed a strong attachment to the therapist and music therapy. He had only 3 months of short-term music therapy. It is often amazing how the children knew instinctively about the impending events. Just one week before I broke the news of my leaving the center, he began to talk about his godmother, who will become his mum if his mum dies. Chris appeared to have a fear of losing good objects – firstly his mum, then through experiencing music therapy, now he somehow seemed to sense the impending ending even before I announced it to him.

When I broke the news the following week, he was agitated and panicky about what was going to happen next, therefore he became very anxious about time-tables. Then Chris chose to play firstly the drum and the cymbal, the bongo, secondly two Nordoff-Robbins reed horns, and birdcalls, thirdly the xylophone, all with my piano accompaniment. These were three different pieces of music, which he named as ‘summer, autumn, and winter’. It indeed represented our therapeutic relationship that last summer during which we prepared our potential meetings, then we started music therapy in the beginning of autumn, and now it was late
autumn, just before the winter. His play seemed to explore all these
events with his current moving feelings. He was reluctant to play the
spring, since it represented a new term, a new therapist, and his
reluctance towards changes in life. He played the spring rather quickly,
and then he wanted to play all four seasons again. This time, he played all
the instruments in turn, which felt as if all the seasons were coming
together. He named it ‘the 5th season’. In this 5th season, past, present
and future seem to exist together and all the feelings can stay together. It
was beginning of his creative symbolization. He never put titles on what
he played before. Now the awareness of an impending ending made
every second of music therapy time precious to him. Segal (1957)
explains on symbol formation that it is ‘an activity of the ego attempting
to deal with the anxieties stirred by its relation to the object’. Therefore,
experience of the separation and the loss of the object triggers symbol
formation. The pain of loss and separation was not denied, but accepted
and experienced by him. His capacity to bear such difficulty was
supported by good experiences we had together in mutual music making
process. The following weeks, he played ‘day and night’, ‘ups and
downs’ and ‘nature’. It was both poignant and delightful to experience
and share the feelings through mutual music making process. Alvarez
(1992) states paradoxical quality of symbol formation that true symbol is
experienced as related to and representing the object, but also
fundamentally different from the object. His increased capability to
connect and symbolize what we played and what the music meant to him,
enabled him to make sense of what was happening to him and overcome
the difficulties in dealing with the subsequent separation and loss. For the
last day of our session, however, he was very agitated. He told me that he wished one minute be 20, or 10 seconds only. He only wanted to practice ‘silent night’, but no improvisation that day. Indeed, in his mind, the ending of music therapy would bring a period of silence and darkness. It was very hard for him to stay in the therapy with me while he knew too well about the ending.

5. Conclusion

Every relationship has its’ beginning and ending and this is part of living, however, painful. I was in a way privileged to work with the children I have presented in this paper since most of them had language and were able to show and lead me into their world. They are extraordinary children even considering their debilitating condition. Their fear and rage at ‘feeling broken and separated’ made me aware of the fundamental dilemma in therapeutic encounters and relationships in music therapy. This has helped me when I worked with non-verbal and more severe cases of autistic children.

I have presented different children in different developmental stages and mental capacity in dealing with endings in music therapy. The use of improvisational music often seems to bring powerful emotions, infantile needs and feelings, and strong bonding between the therapist and the child. In some cases, the child, however, does not readily show how attached he is to the therapist. In some cases, it is only through endings, the therapist begins to see the relationship clearly in crisis. By presenting this difficult issue of endings, I have aimed to explore and re-organize my own experience of endings with these children. In doing so, I firmly
believe in the containing and the transformational power of the musical experience, which comes directly from the loving nature of reciprocal interaction in music. Both the therapist and the music become the containing and transformational objects.

Again, the improvisational music therapy process allows both the therapist and the child to know each other quite intimately by sharing moments of creating music together. Professor Cho Jae-chun, a world leading animal behaviorist, talks about knowing and loving in his beautifully written book – The Discovery of Ant Empire (1999) that if you knew someone or something in depth, in his exact word ‘enough’, you are bound to love the object. Even for the child notorious in his deficit of sharing his attention, feelings, and communication with other people, this sensitive and responsive musical way of relating opens the gate for the fundamental level of communication and human relationship to grow. Through building up a good experience and good objects in this musical-interpersonal experience, one can help the child not only to deal with a difficult situation, but also to make the best of the catastrophic experience leading to creativity and symbolization.

References


Electronic Musical Instruments - a rôle in Music Therapy?

Kirk, Ross¹; Hunt, Andy¹; Hildred, Mark¹; Neighbour, Matt¹; North, Felicity²

¹ Music Technology Group, Dept Electronics, University of York. Y010 5DD, UK.

2 Ensemble Research
Ensemble Research is a special interest group associated with the MTG concerned with the application of music technology to Music Therapy and Special Needs Education (www.ensmblerearch.org)

1. Introduction

The use of music technology to provide new approaches to the provision of musical instruments for use in music therapy has been evident for about ten years. Given this experience, it is appropriate for those involved in the use and development of the instruments to look back over the evolution of this genre of music-making and to look forward to the new perspectives offered by technology.

This paper reviews present use of music technology in music therapy, specifically asking the question "why use it in music therapy?". This is then followed by a retrospective description of the techniques used by the Ensemble Research Group in this field, before using this as a basis for a critique of the potential of electronic instruments in therapy. The paper then describes recent work undertaken by the group to address issues identified by the critique. The new work includes the production of a new class of audio visual instruments.
2. **Music Technology: Why use it in Music Therapy?**

One of the main strengths, as well as one of the main problems in the use of music technology is that in many ways, it offers a 'blank sheet of paper' in terms of the construction of musical timbre, and the means of interaction with sound. Specifically, it offers the opportunity to *decouple* the nature of gestures used in music performance from the resulting sound in a way which is not possible with conventional acoustic instruments.

In acoustic instruments, the appropriate performance gesture is an integral part of the nature of the instrument. We thus are invited to strike a cymbal to make a prominent percussive statement in performance. We strum a guitar to provide a chordal backing to a melody line. In contrast, using the electronic systems described below, it is possible to use (for instance) small physical movements to control large expansive sounds. An example might be to use 1cm of movement of a finger tip to play the timpani part in Strauss' Also Spracht Zarathustra, used in the introduction to the film '2001 -a Space Odyssey'.

An extension of this concept is that we can *configure* musical instruments to match the physical and cognitive requirements of an individual. It thus becomes possible to produce a pentatonic 'flute' improvisation based on the player’s head and neck movements interacting with sensors placed on the headrest of a wheelchair.

We are able to produce new timbres and soundworlds using electronic instruments, which are not available in acoustic instruments. This in turn opens up new genres of music, possibly more amenable to use in
improvisation by clients not previously adept in performance with acoustic instruments.

In the words of music therapists who are members of Ensemble Research:

The value of electronic instruments lies in the ability to build or adapt instruments for individuals—not everyone can play a piano or drum. The new sounds have different dynamics which open up exciting possibilities, especially for those with difficult associations with tonal music. The use of electronics provides also provides opportunities for quantitative evidence of practice by recording the signals produced by the electronics during performance. In fact, the new instruments provide such an open range of possibilities in gesture and sound that the major problem may lie in our (lack of) imagination and experience in the way in which they may be used.

3. Review of Techniques Used by Ensemble Research in the use of Electronic Instruments

The following is a largely historical perspective of the use of electronic instruments which have found application in music therapy. We see these instruments as an adjunct to the use of normal acoustic instruments, not in any way as a replacement for them. However, as indicated above, their use does open up new possibilities in the practice of therapy.

We present this historical perspective to set the context for a critique of electronic instruments as they might be used in musical performance and therapy. The critique appears in a later section of the paper.

Instruments developed at the University of York and within Ensemble Research as used as exemplars within the historical perspective.
3.1 MidiGrid

Since the mid-1980s electronic musical instruments have been equipped with MIDI (Musical Instrument Digital Interface), which allows keyboards (and other instruments) to be connected to computers. It works as a form of musical morse code, with information about each note played being coded and sent from one machine to another (see Fig 1).

![MIDI Diagram](image)

**Figure 46 Typical use of MIDI (Musical Instrument Digital Interface)**

Many computer programs have been written to allow musical information to be stored and edited on a computer, rather like a musical
word processor. These programs are often called sequencers as they enable people to build up sequences of music, track by track.

MidiGrid is a different sort of computer program that allows users to trigger musical material freely using the computer's mouse. More information can be found from www.midigrid.com. As shown below, the screen shows a grid of boxes, each of which contains a nugget of music that is triggered as the mouse cursor moves over it. Hand gestures are thus converted, via the mouse, into notes, chords and musical sequences (tunes). The range of movement can be customised so that more or less of the client's physical action can move the mouse cursor around the grid. The grid can be set up in advance to consist of any number of boxes containing any musical material (including that played in from a keyboard). Other MIDI instruments (e.g. electronic keyboards, drums or wind controllers) can be used to trigger the musical material in the boxes, so - for instance - notes on a keyboard can be used to activate several pre-recorded sequences of music.
Figure 47 Use of MIDI with the MidiGrid software instrument

Musical Boxes
The grid can be shaded to separate different areas of notes, for example one area consisting of melodic notes and another containing chords.
Figure 48 Screenshot of MidiGrid showing performance interface and control icons

Band-in-a-box

In fact, the grid can be arranged to allow an assortment of instrumental sounds to be present on the screen. Thus the user can freely explore several timbres by moving the mouse to different areas of the screen. Anything that is played on the grid can be recorded and placed into a box of its own as a sequence. Further recordings can be made which involve sequences, and thus complex layers of musical material can be rapidly constructed.
Figure 49 MidiGrid pattern containing assorted instrumental sounds in the differently shaded boxes

Harp strings
The following diagram shows a grid pattern that consists of a web of individual notes which form scales (when played up and down) and arpeggios (when played across). A harp-like sound is used, and flurries of notes can be easily generated by gentle mouse movements. In a series of tests in the children's centre at York District hospital, a 2 year old blind girl with severe learning impairment moved the mouse rapidly and even
began talking to it. Therapists noted that this was her longest recorded concentration span without one of her regular seizures.

![MidiGrid pattern containing arpeggios (left-right) and scales (up-down) on a harp-like sound](image)

**Figure 50** MidiGrid pattern containing arpeggios (left-right) and scales (up-down) on a harp-like sound

**Use in Music Therapy**

In Music Therapy, MidiGrid has been used to:

- allow free improvisation on a palette of sounds
- constrain the musical material
- allow access to people with limited movement
- build up layers of recordings
- enable groups of musicians to play together
MidiGrid was built into the mobile Music Therapy van, devised by Mary & Raymond Abbotson and used as part of the North Yorkshire Music Therapy centre's service.

3.2 MidiCreator: Sensing Movement
MidiCreator is a device which converts the various signals from electronic sensors into MIDI. Based on a music technology student’s project, it was subsequently developed by the York Electronics Centre, the commercial arm of York University's Electronics Department (and also a member of Ensemble Research). Assorted sensors are available which sense Pressure, Distance, Proximity, Direction etc. These are plugged into the front of the unit, which can be programmed to send out MIDI messages corresponding to notes or chords. Thus movement is converted to music.

More information can be found from www.midicreator.com.

Figure 51 MidiCreator box converts from assorted input devices into MIDI signals which can be used for musical control
When a grid of pressure sensors is placed on the floor a 'carpet-grid' is formed. Each pad can trigger a note on a specified instrumental sound. When these notes are routed through the abovementioned MidiGrid software, entire musical sequences can be triggered from different areas of the floor. This forms a fascinating 'floor-based' instrument which people of moderate movement can explore. In some cases people have driven their electric wheelchairs over it to achieve the same effect.

3.3 CAMTAS: Monitoring and Analysis

As explained above, the electronic instruments intercommunicate using the 'dots and dashes' of the MIDI musical 'morse code'. If these MIDI messages are recorded into a computer system, then we have an inherent record of all of the musical activity which took place during the session. Depending on the way MIDI is used, this could include gestural information from (say) MIDICreator, as well as musical note data (pitch, dynamic, timbre) from a musical keyboard or MIDIGrid.

The CAMTAS (Computer Aided Music Therapy Analysis System) produced by Adrian Verity working within Ensemble was designed to do this.
Figure 52 The CAMTAS system in operation

It captures all MIDI data supplied to it and displays it as a 'piano-roll'-like display, as shown in close-up in Figure 53. In the example shown in the figure, the musical data produced by the therapist is shown in horizontal bars of one colour, whilst that produced by the client is shown in another colour. The dynamic used by either (forte / piano) is shown in the intensity of the colour. This information can be saved onto the computer's hard drive. The therapist can then use the stored data to analyse musical interaction using the CAMTAS display after the session is finished.
Controls are provided to 'fast-forward' and 'rewind' the data, allowing the therapist to scan for significant musical events. The system also includes controls for a video camcorder which is kept in synchronisation with the MIDI data by CAMTAS. Thus if the therapist fast-forwards through the data to a certain point, CAMTAS will fast-forward the video to the corresponding point. The video display (and its sound track) provides a useful record of events which would not be captured in the MIDI data, such as the sudden interference caused by low-flying aircraft. The video display is shown in one corner of the computer screen.
The data is stored in a standard MIDI file format which makes it compatible with other music software running on the computer. For example it is possible in principle to have the session data printed out as a musical score by another piece of software, although the quality of the result may in some cases be somewhat deficient.

CAMTAS also stores its data in a form which is compatible with standard database and spreadsheet software such as Access and Excel. The more refined archiving and numerical analysis tools available on these systems can therefore used for research and analysis associated with case histories of particular clients and pathologies.

Used in conjunction with MIDICreator (see Figure 54), the data archived need not be limited to records of musical sessions. Sensor MIDI data associated with (for example) environmental control systems could also be archived within CAMTAS, to form part of the assessment of clients' activities, perhaps extending over many years.
4. Critique of MIDI based Music and Electronic Instruments

Whilst we would acknowledge that electronic instruments have a valuable contribution to make to the practice of music therapy (as outlined above), it is also important to be clear of the limitations of these instruments. Only then will we be able to make progress in furthering their evolution.

MIDI was originally designed as a standard to support the playing of electronic keyboards (pianos, organs) and many of its limitations stem from the implicit assumptions regarding this style of playing. A pianist
controls the dynamic of his or her playing through the force with which the keys are struck. This translates into the speed (velocity) with which the fingers move immediately prior to impact. Hence loudness (dynamic) in MIDI is controlled by a part of the MIDI message called 'velocity'.

Once struck, a keyboard player often has very limited control over the subsequent evolution of the sound - it emerges in a way which is characteristic of the instrument; the style of interaction of the performer is a secondary factor in this evolution, even if it is used at all.

The MIDI based sounds, which are available from most commercial synthesisers reflect these implicit assumptions. The velocity is used to set the initial loudness with which the sound is launched. The sound then evolves in a predetermined, static fashion, and the player has little influence over this evolution. The result of this is that repeated attacks of a note all sound identical, maybe with a little variation of volume. This sounds unnatural and unmusical, since we associate minor variations as an important characteristic of natural acoustic instrumental sound.

These implicit characteristics can play havoc with other instrumental techniques. For example a reed (wind) player often initiates a note with an impulsive attack at the reed to break it into vibration, and then shapes the note on a continuous basis throughout the evolution of the sound. Use of a reed-based wind controller with a conventional synthesiser would then result in a sound which is overly loud to start with, which cannot then subsequently be controlled so that it conforms with the
original performance intention. The result is an inhibitively unnatural result.

Other unnatural responses lie in the way in which the various parameters controlling the sound are presented to the performer. This is often carried out in a simplistic fashion, where for example one control may affect volume (only) whilst another will affect pitch and so on - a one for one association between controls and their associated parameters. This is in contrast with real instruments where one gestural action may affect many of these parameters simultaneously in various subtle ways. The one-for-one scheme may be inspired by a wish on the part of the instrument designer to make the instrument 'easy to play', but it is a debatable point whether this simplicity is in fact a desirable thing, or whether it the simplicity will merely result in an instrument lacking in expressive capability. Ease of use and expressivity may be opposing factors in instrument design, with no simplistic compromise between the two.

The voicing of the sounds provided by commercial synthesisers are sometimes not particularly inspiring, perhaps relating more closely to 'muzak' than any new, exciting sound world. This is a pity, since it need not be necessarily so. It is possible to create electronic sound with as much acoustical interest as the familiar orchestral instruments, but which could not be produced by any known instrument. This opens up potentially radical possibilities in performance, including therapy, particularly when we include new dimensions for interaction.
Electronic instruments are often criticised for their lack of visual appeal. A new electronic 'instrument' may often appear as a bundle of sensors embedded in a maze of wires connected to an anonymous collection of black boxes which are then connected (more wires) to loudspeakers placed prominently 'over there'. If there is more than one instrument, the sound of the whole ensemble will often be mixed together in the one set of loudspeakers, producing a sonic jumble. This is in marked contrast to natural acoustic instruments where the sound is localised to the instrument itself. It is therefore possible for the performer to lose the intimate cause and effect relationship so important in good music-making. The number of wires also has important consequences in terms of reliability and time taken to set the ensemble up.

Perhaps the most important consequence in this scenario is the difficulty in establishing a relationship with an anonymous technical jumble. Contrast this with the visual, sonic and tactile appeal of a violin or saxophone as it is taken from its case!

5. New Approaches to Sound Worlds

The description above of the limitations of electronic instruments may appear as a damning indictment, precluding their use from any sort of serious music making in therapy or performance. However, as also identified above, Ensemble's music therapists and performers have also identified the considerable potential benefits to be derived from the use of electronic instruments. They had found some of the General MIDI sounds which have an evolving (albeit predetermined) character to be of
particular interest and value in their work. A specific sound falling in this category, available on many synthesisers is called 'ice rain'.

The challenge for the instrument designers in Ensemble was to address at least some of the limitations identified above, taking 'iced rain' as a starting point. We identified the individual sonic elements within ice rain and built them as individual components in another synthesiser environment known as ‘Reaktor’ (www.native-instruments.com). Reaktor allows the instrument designer to build sound from very elemental synthesis elements such as oscillators, filters and envelope generators, in such a way that MIDI signals (e.g. from MIDICreator) can directly interact with any (or all) of the individual elements. In the case of ice rain this meant that control of specific elements of the sound could be continuously controlled from sensors attached to MIDICreator. New dimensions of the sound could be focused upon and explored, resulting in sounds which although related to the original (ice rain), were sufficiently different to be considered as new sounds in their own right. If the sensors were not used, then the Reaktor implementation produced the normal ice rain sound.

The sensor based continuous control had been specifically requested by Ensemble’s therapists, and dealt with some of the limitations of standard electronic instruments, especially continuous evolution of sound discussed above.

The implementation we achieved means that one performer (e.g. a therapist) can play music on a keyboard using the timbre controlled by another performer (e.g. a client) using sensors. The use of sensors to
modify ice rain’s timbre could not have been achieved with the sound output from standard synthesisers.

Once this approach had been established, it rapidly became apparent that a new mode of musical interaction had become available which may have particular value in therapy.

The timbre produced in the ice rain example ranged from the conventional sound produced by commercial synthesisers, through organ and harpsichord timbres to abstract ‘electronic’ sounds, all under the control of the ‘client’. The timbre thus ‘handed down’ had a radical effect on the keyboard player. The harpsichord sound naturally suggested a baroque style of improvisation, the organ sound a fugue-like style, whilst the electronic sound encouraged an avant-garde electroacoustic performance. The style of the music played on the keyboard in turn influenced the nature of the sound produced by the ‘client’. It was clear to external observers that a close interaction through the sound was established between the performers. Clearly the controller of timbre was not inhibited or distracted by the need to play ‘notes’.

6. New Approaches to Sensing Interaction

The methods of construction of sound used in Reaktor allowed the designer to build arbitrary configurations of elemental sound components, constrained only by his or her imagination in striving for a particular sound world. A similar philosophy can be applied to the construction of gestural systems.
A set of elemental gestural components sensing (say) rate of change, position, direction, points of flexure can be set up in environments such as Reaktor to process the sensor MIDI signals from systems such as MIDICreator. These components can be interconnected and made to influence one another through the interconnection medium so that one gesture affects more than one sound output in various subtle ways, just as gestures interact within real instruments. Perhaps more significantly for use in therapy, since the gestural components are constructed in exactly the same environment as the sound synthesis, it is possible to connect the gestural outputs to any sound synthesis generator input. There is a complete interleaving of gesture and sound, and continuous control over all aspects of the sound is possible. The specific association between gesture and sound is completely at the discretion of the instrument designer. This is quite unlike conventional synthesisers where very limited control is available, often restricted to switching notes on and off.

These environments offer the scope needed to construct new instruments useful in therapy: the ability to make new sound worlds with an acoustical 'depth' comparable to conventional instruments, where the means of interaction can be customised to the needs of the individual. This can be achieved without any inherent restriction or limitation in the design of the instrument - only that which is desirable for its intended use.
The sensors can be built into specially designed instrument bodies or 'shells' such as the one shown in Figure 55, designed by Jonathan Phillips of Ensemble Research.

Figure 55 The ‘Shell’ instrument, responsive to touch
This simplifies the wiring and aesthetic problems identified earlier in this paper, and builds an identifiable visual and tactile 'character' to which the performer may relate.

7. Audio-Visual instruments
We now have the possibility of performing image as well as sound, given that today's computer systems are adept at handling real-time image generation and processing. The images can be produced in exactly the same environments used for the synthesis of sound and gesture processing. Thus an image could react (change shape, colour, extent
etc.) to a user's movement (driven by the same electronic sensors described earlier). This could open up new dimensions in therapy. Imagine an audiovisual drum whose surface can be played in the conventional manner (with sticks or hands) but also acts as a projection surface for a multicoloured pattern. As the drum is touched and played, the pattern reacts at the same time that the sound is generated.

We would like to hear from any therapists who feel that such an instrument may have value in their work. Just because the technology is available does not mean that it necessarily will be of value in every discipline, but it is worth pondering whether it might offer new avenues of therapeutic pursuit.

8. Conclusion

We stand at a defining moment in the history of the design of new electronic instruments. Whilst the conventional MIDI based offerings from commercial suppliers have serious limitations which will limit their use in therapy, other tools such as Reaktor are becoming available which allow a less restricted approach to the design of musical interaction. We can also add the synthesis of image and quantitative evidence-based monitoring to the repertoire of therapy practices.

This approach will open new interactive sound (and image) worlds and developments in the practice of therapy which are not so much limited by the capability of the client, but by our own imagination in designing the new instruments, and our willingness to use them in practice.
Fabian is a schizophrenic patient now 38 years old.

He was 14 years old at the beginning of his illness. At this moment his parents has separated. They both were university teachers.

Fabien’s delirious appeared at the same time. He tore his clothes apart. He was very impulsive, broke every things at home and tried to commit suicide. He for example had locked himself in the bathroom, to his mother who tried to enter, he bluntly answered : “I’m killing myself” ; he had cut his carotid.

He is hospitalized during a whole year in a university specialised service. Then, he is treaded by therapists during five years in a outpatient clinic.

His mother gave him a room without any window because she was afraid that he would jump out of a window.

However, a new hospitalization was necessary because of a violent and suicidal behaviour.

Fabian showed a loss of relational investment and a slow and progressive fall of intellectual efficiency. He also markedly showed diminished interest in significant activities and felt a detachment or estrangement from others.
He stayed 10 years in a closed specialised service. Then, he returned to his mother’s home and went every day in a outpatient clinic.

In this place, he cuts himself off by reading and listening to walkman. He shows a loss of any kind of emotion.

He has a very heavy neuroleptic treatment with many secondary effects. Under the influence of treatment, he shivers a lot.

Fabian rejects all relations with nurses and other patients. He is permanently highly tense, very anxious and hides from others.

He has only two poles of interest: reading and listening to classical music. He can live because of the intense pleasure he gets from music; he reads in order to identify himself to the hero.

He has numerous obsessionnal rituals in his behaviour and is always afraid of feeling threatened by others or to attack them.

Two years after, Fabian asks to learn the piano.

I see a very thin man who speaks hesitantly or not at all; his hands shakes.

During the first sessions, I put the emphasis on the fact that learning how to play requires time, exercises and discipline. He answers always: I will exercise and play.

As he never learned the notes and as he is very slow, I ask him to practice reading music 20 minutes per day.
Fabian’s thin and long hands look like articulated woods. He doesn’t accept physical contact and therefore I must use a pencil to bow his very stiff fingers. I hear a nice sound as soon he puts his fingers on the keyboard, he has a beautiful sense of touch and I tell him so as to encourage him.

However he is unable to learn the notes because of his bad memory and we work both in a very slow way. He doesn’t speak and can’t take his eyes off the score.

During a few months, I alone speak to him about explanations in order to fill the auditory space.

He begins to read G clef and some notes of F clef after 10 months. During all the time, he came once a week and it was a challenge for him to maintain interest for learning. He plays very slowly, his shivering hands are disabling but he differentiates half and quarter notes and soon eighth notes.

I tell him that the shivering cannot be heard (he plays very slowly) and I register him a little moment in order to show him. In hearing it, he is overjoyed and it is the first emotion I can see. He begin to speak and tell me: “I stayed 10 years in a psychiatric ward, it was a period of social isolation. I ignored these mad people and from this time I have no more relation with others. I hate being in groups. I want to buy a piano”.

At that time he tells to the psychiatrist that he feels isolated and idle and asks to take german lessons with a psychologist inside the outpatient clinic. He begins to study Wagner’s tetralogy and from this begins to
inquire about filiation, mother-son relationships; since his parents’ separation when he was 14, he never saw his father, he refuses to see him. He has a symbiotic relationship with his mother and she says about him: “he is a lovely fellow”.

At every session I repeat to him that he has a beautiful touch and that his quivering doesn’t be heard in order to give him self-confidence

At the end of the first two years, the psychiatrist writes in the medical records:

“Anxiety has been reduced, he tries to get new contacts”.

Why teaching piano in musictherapy?

Patients with schizophrenia tend to perform more poorly than normal controls on a broad variety of cognitive and neuropsychological tasks. They demonstrate a generalized deficit with psychomoteur slowing. Attentional dysfonction is an important feature in schizophrenic illness. They often reflects anxiety about aggression, competition and so on. Detachment may take the extreme form of out of body experiences during the illness.

Orienting to novel stimuli is a challenge of changing the inhabilities to utilize knowledge to shape action.

Learning the piano is an example of linkage cognitive processes such as concentration, attention, motivation, working memory, visual-spatial analysis (through pieces of piano music ans the keyboard for example).
Putting an artistic activity through therapeutic contract increases a thinking activity, in a formal way by musical code then in an abstract way by musical interpretation.

With these patients I have decided to use Feuerstein’s model for the problems I am dealing with. Feuerstein established “learning mediation” for children who have had traumatic experiences.

First we must find our guidelines. Playing a musical instrument helps the patient become aware of what he can and can’t do. The reading of the score develops (in incessant looking back and forth between the score and the piano), a fine judgement which will become selective, meaning an expending onto other situations.

This type of learning employes a capacity to organize the stimuli into a higher hierarchy. This deductive behaviour will become generalized: learning the causal links which unite different events and little by little in a therapeutic project, becoming aware of the relations which unite the symptoms to the mental conflicts.

The second point concerns the retauration of “narcissism” through the use of the idea of competence, of the idea of confrontation with the challenge of winning and through the idea of sharing.

Learning music encourages a person to be more self-confident and pushes him ahead. There is work to be done and the person must figure out how to get the job done. As he progresses he gains confidence in what he is doing and learns to meet greater difficulties.
The third point deals with the increased socialization

- through listening to music in a group setting. It is a well-known fact that listening to music increases vigilance as well as the capacity for attention.
- through playing an instrument which brings the person into direct contact with sound through space and time.

The fourth point relates to behavioural problems with impulsiveness. The playing of an instrument creates habits which counteract to much impulsive behaviour. The music therapist’s role is to encourage change and to maintain progress through the idea of hope.

I had 4 aims for Fabian:

- resocialisation
- cutting off his symbiotic link with his mother
- giving him new relationship with his father
- and finally allow him to be autonomous and live alone.

After two years of music study, I notice that an individual change has occurred, he correctly reads G and F clefs, but his play is still low. He begins to speak of music but never of himself. He speaks about music as a sacred place.

I use this music zealotry and his avidity for understanding how music is structured and also his admiration when I explain him how an harmony develops and fades away to set the stage for developing our relationship and the therapy.

After these first two years, he tells me that his mother will agree to buy him an electronic piano.
He begins to speak of his father and says that he is a mad and dangerous man.

Fabian converses more and more during the next six years. He progressively understands that he must separate from his mother and he dares to think that he may have his own dwelling.

At some moments, he feels very depressed and is disgusted with human nature.

At the piano, results are very thin, I ask him to progressively increase the daily length of piano playing in order that he will have a goal to make progress. He does it very regularly.

I emphasize when he does something well, for example his nice touch.

In order to study somebody else other than Wagner, I propose him some Bach’s scores and explain him the harmonic structure. He begins to read music treaty.

He is very excited with the musical writing, its strict rules and he projects himself in it. He will try to go to Bach’s concert, but when here he is frightened and afraid that he could yell. He cannot stand the mob.

I encourage him to keep on with his outside endeavours and to accept failures, waiting for future successes.

He tells me that he want to go to London.

At the end oh the fifth year, he went three days to London and was able to go to a concert. And he came back very happy.
I notice that he did in London what he is unable to do in Paris, wandering outside for example.

After this journey, he agrees to play before others in a Christmas party.

During this time, therapy sessions with the psychiatrist become longer. He speaks about piano pieces he is studying from Bartok, Bach..., speaks about his music therapist, saying that he misses her during her holidays.

His clinical treatment is considerably reduced.

I take advantage of this amelioration to invite him to participate in the choral. He accepts, however soon after, he says to his psychiatrist, the choral was too childish for him. But nevertheless, he remains and sings with the others and even gives them some advice. After some months, he participates rather well in the group. And tells to his psychiatrist he feels well integrated.

The next year after having been one year in the choral: I propose him to join the clinic group “outside visits”, he agrees.

He now has a better skillfulness in piano playing, because his treatment has been reduced again.

At this time, the clinical evaluation appears very promising.

About the choral he says: “it is better that wandering in the service corridors. I don’t like loneliness any more. I feel I am beginning a new life”.

The psychiatrist writes in the medical records: “Fabian changes at a high speed” and he describes a good development of his verbal expression and
a progressive deshinibition. The psychiatrist adds: “Fabian is beginning to play his own partition”.

Now, we may discuss during a one hour session. I try to renew the relationship with his father, but he always refuses this idea. He always speaks very negatively of him.

After a concert in the ward, he complains to the psychiatrist that the patient’s group did not applaud one of them, and adds that this was impolite, he states that he is not talking about himself.

The psychiatrist writes in the medical records: “the narcissic feeling appears”.

His study of piano playing has showed him that music belongs to plain life. In being busy working, he is beginning to understand his own place as a subject. By playing, he may even have failures and he now accepts to shaw them before others; however playing music is by itself pleasure.

At home, his mother frequently goes away, that makes him happy.

He tells to his psychiatrist that his musictherapist asks him to sometimes stop hearing music in order to relax the ears.

In July 2001, he says: “I spent ten years here. I don’t know if I am heal, but I matured”.

In my presence, he looks free and speaks easily, however he never shows what he feels about me.

To the psychiatrist, he says he is anxious for my health and that he feels bored when I am away.
He tells about the concert preparation, but, finally refuses to participate; he thinks that he does not belong any more to the life of the outpatients clinic.

Two months after, he leaves the clinic. He comes back one a week to attend his musictherapy session and one a month to see the psychiatrist.

After three months he stops going to the musictherapy session and meet only once a month his psychiatrist.

He is wandering in Paris’ streets, every day. Lastly, he rents a studio for himself where he goes only a part time for the moment.

He is said to be clinically stable.

**Conclusion :**

After eight years of musictherapy, I consider that at least 3 of my aims are obtained.

- Fabian has his own studio
- He is separated from his mother
- He is socialised and autonomous

Only the aim of his relationship with his father has not been obtained, but he speaks of him in a more appeased way. He seems more independant but only the futur will tell how far he has progressed.

**Bibliography**


Lawes, Martin
England
Email: martin.mt@virgin.net

Prelude

... Kate says she wants to sing a song and comes over and stands by me where I am seated at the piano. Her voice is powerful and expressive as she begins to improvise whilst I accompany. One phrase in particular is very beautiful and touches me at the core of my being.

I worked with Kate, who is on the autistic spectrum, for two years. The way she expressed herself and communicated most intimately in this song and others, had to do with the aesthetic quality both of her voice and also of her melodic line. Neither the most accurately notated version of what she sang nor the most comprehensive verbal description could, however, capture the essence of what she did and how it impacted on me. I struggled with the question of how to think about this in terms of its therapeutic significance, but also wondered whether it was really only a side-issue as far as the essential therapeutic work was concerned? Such questions as well as my own personal experience of music (Lawes 2001), set me thinking about the matters which I will be exploring in this paper.

Introduction

In music therapy, there is a spectrum of opinion on the place of aesthetic considerations in the work. It is quite often said, for example, that the aims in music therapy are primarily non-musical. Thus Elaine Streeter
writes about the need for therapeutic judgements to prevail over aesthetic decisions in the way the therapist improvises music in response to the client (Streeter 1999), and Mercedes Pavlicevic is keen to differentiate what makes clinical improvisation different from improvising with another simply for fun. But Pavlicevic also writes of therapists being trained to create music with their clients that is as aesthetically pleasing as possible whilst not compromising clinical considerations (Pavlicevic 1997). Furthermore, Gary Ansdell writes about moments of beauty in his clinical experience as being important and even transformative. He also writes about beauty as being a ‘fallen theory’ in the arts therapies in general, which is a paradoxical situation in that these therapies arose out of their respective fine arts, where aesthetic considerations are often at the heart of the matter (Ansdell 1995).

One thing that highlights the problem of the significance of the aesthetic aspect of music, is that music does not obviously represent anything in the way a picture or words might; yet music can articulate such a rich experience of meaning. My intention in this paper will be to try and shed some light on this by exploring the aesthetic aspect of music in a very specific way. To do this, I will refer to some of the recent psychoanalytic thinking that has emerged in England in the last ten or fifteen years in relation to the nature of creativity and aesthetics: in particular the work of Donald Meltzer and of Hanna Segal, both of whose thinking was influenced by Freud, Klein, and Bion.

In Part 1, I will explore the relationship between aesthetic experience and emotion, and consider the place of this in the developmental process and
in therapeutic work. Following this in part 2, I will explore how the aesthetic/emotional aspect of music can be understood to be constituted by the rhythmic interplay of its harmonic and dissonant elements. In part 3, I will consider how the therapeutic relationship itself can be understood to be an aesthetic encounter. Then in Part 4, I will move on to think about some of these matters in relation to my work with Kate, introduced above.

**PART 1: THE LINK BETWEEN BEAUTY AND EMOTION IN THE DEVELOPMENTAL PROCESS, THERAPY AND THE ARTS**

Meltzer, in the book he wrote with Meg Harris Williams in 1988: *The Apprehension of Beauty: The Role of Aesthetic Conflict in Development, Art and Violence*, has some very interesting things to say about the arts and the nature of aesthetic experience which he sees as being at the very heart of human life. What I present here will be my own understanding and development of some of his essential points95.

Meltzer believes that, as human beings, our most developmentally significant and meaningful emotional experiences occur because of the impact of what he describes as the beauty of the world. This link between beauty and emotion means that, according to Meltzer, emotional experience is essentially aesthetic in nature (Meltzer 1983: 29). Our aesthetic/emotional encounter with the world begins very early and Meltzer even postulates that proto-aesthetic experiences may commence in the womb when the foetus is

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95. Apart from where I reference other of Meltzer’s works, the summary I present derives from my understanding of his thinking in *The Apprehension of Beauty*. 
‘rocked in the cradle of the deep’ of his mother’s graceful walk; lulled by the music of her voice set against the syncopation of his own heartbeat and hers; responding in dance like a little seal, playful as a puppy . . . (Meltzer & Harris Williams 1988: 17)

Meltzer thinks that such early levels of experience may find representation in the song-and-dance genre. It is in the newborn baby’s encounter with its mother after birth, however, that the aesthetic/emotional impact of the beauty of the world becomes central in the developmental process. The mother’s outer beauty impacts directly on the baby, most especially her breast, her face, her eyes, her embracing arms, and her voice. These are also manifestations of her inner beauty, which for the baby is her ability to provide maternal love and care. The passion of this first love encounter is, however, an experience where pleasure and pain are inextricably bound together, and this is because for the baby, the mother is very enigmatic. Meltzer tries to capture something of what the baby might experience through poetical means:

Her [the mother’s] outward beauty, concentrated as it must be in her breast and her face . . . bombards him [the baby] with an emotional experience of a passionate quality, the result of his being able to see these objects as ‘beautiful’. But the meaning of his mother’s behaviour, of the appearance and disappearance of the breast and the light in her eyes, of a face over which emotions pass like shadows of clouds over the landscape, are unknown to him . . . He has, after all, come into a strange country where he knows neither the language nor the customary non-verbal cues and communications. The mother is enigmatic to him: she wears the Gioconda smile most of the time, and the music of her voice keeps shifting from major to minor . . . Even at the moments of most satisfactory communication, nipple in mouth, she gives an ambiguous message, for although she takes the gnawing away from inside she gives a bursting thing which he must expel himself. Truly she giveth and she taketh away, both of good and bad things. He cannot tell whether she is Beatrice or his Belle Dame Sans Merci . . . (Meltzer & Harris Williams 1988: 22)
This leads to a psychological conflict, which Meltzer terms the aesthetic conflict\textsuperscript{96}: 

which can be most precisely stated in terms of the aesthetic impact of the outside of the ‘beautiful’ mother, available to the senses, and the enigmatic inside which must be construed by creative imagination. Everything in art and literature, every analysis, testifies to its perseverance through life. (Meltzer & Harris Williams 1988: 22)

Meltzer thinks that this aesthetic conflict is essential in stimulating the baby’s developmental process. For although the mother’s outer appearance is fully accessible to the senses, what goes on inside her, behind her outer beauty, is not. This leads to the spectrum of pleasure and pain referred to above. Thus, although there is ‘love at first sight’ aroused by the aesthetic impact of the mother’s outer beauty, hate is also aroused. This is because the baby’s uncertainty about its mother’s unknowable inner intentions easily tends towards distrust, suspicion and doubts about her. Perhaps it is worth saying that though a newborn baby does not even begin to have such sophisticated concepts as this, experiences that occur in adult life (in the context of intimate relationships) which might be described in these terms, can be understood at depth to re-evvoke the dynamics of the very earliest levels of pre-verbal experience as illuminated by Meltzer.

The pain of this uncertainty about its enigmatic mother, however, is what stimulates the baby’s desire to get to know and understand her, and it is this that, according to Meltzer, is central in motivating the developmental

\textsuperscript{96.} Meltzer’s view represents quite a drastic revision of Klein’s theory of development. He believes that the Depressive Position and the Aesthetic Conflict occur at the beginning of life, and that the baby’s inevitable withdrawing from the beauty and pain of the latter leads to the splitting processes of the Paranoid-Schizoid Position.
process. Thus eventually, intersubjective relating begins as mother and baby evolve a way of sharing inner emotional states and communicating, and this begins to make the problem more manageable and bearable. The concept of Dynamic Form, which has been explored in music therapy particularly by Mercedes Pavlicevic (Pavlicevic 1997), is a way of thinking about what underlies the pre-verbal repertoire of vocalisation, of gesture and so on through which mother and baby interact emotionally. Through this intersubjective relating, the infant becomes familiar with what Meltzer calls the deep musical grammar of language through which emotional states can be directly communicated. Later, on this foundation, the young child learns the shared linguistic vocabulary of his or her culture, and this is then superimposed on the deeper musical level of language.

Thus communication with others and understanding them becomes increasingly possible as we grow up. But in our ongoing encounter with other people and with life in general, we cannot know and understand, let alone control everything. Thus when anything engages our interest in a passionate way because it is experienced as an aspect of the beauty of the world, we wish to ascertain its authenticity and to know it in depth. Yet as soon as we want to do this we come up against its ‘heart of mystery’, and must learn to tolerate our very limited capacity to know anything for certain.

**The meaning of music, outer and inner**

Thus it is not only in the baby’s experience of its mother that the aesthetic conflict manifests; in fact as adults, it is at the core of many of
our most important and meaningful life experiences. For those of us who feel passionately about music therapy, for example, both music and the therapeutic process can be experienced as aspects of the beauty and mystery of the world.

Music has both an outside and an inside: its form and its content. As far as its outer ‘surface’ is concerned, music is simply that which is directly heard in terms of pulse, rhythm, melody, harmony, timbre and so on, which in the way that they are all combined together make up the aesthetic form of music. It is a relatively straightforward matter to describe this.

The inner meaning of music is not something that can be perceived in the same direct way, nor is it possible to find a meaning that everyone will agree on. In music therapy, for example, the music can be thought about as being therapeutically meaningful in a variety of ways. One focus is on the music having some kind of (unconscious) psychological content including the dynamics of a transference relationship (Priestley 1994, Streeter 1999). Another is in terms of the way an interaction in music can articulate Dynamic Forms of Feeling (Pavlicevic 1997).

On the other hand, Nordoff and Robbins (1977), developed a music-centred understanding with little recourse to ‘extra-musical theories’ (Ansdell 1995) to elucidate the therapeutic significance of the music. In fact Nigel Hartley suggests we do not need to understand or solve the mystery of music at all (Pavlicevic 1999), and writes about there being something at the centre of improvisation that cannot be verbally interpreted (Hartley 1998). Gary Ansdell suggests that a problem that all
music therapists face is the difficulty of using words to describe musical processes (Ansdell 2001).

Interestingly, Meltzer describes a similar dilemma in psychoanalytic work, in terms of accurately describing the ‘ineffable . . . heart of the matter’ of what occurs between patient and analyst. Compared with the complexity of this, he says that, ‘our descriptions . . . are fairy tales both in their simplicity and crudeness’. Furthermore, although there are various theories, which it is tempting to think explain things, in reality these only try to describe what happens ‘using the grossly unsatisfactory medium of language’ (Meltzer & Harris Williams 1988:23). In other words, there is ineffable mystery at the heart of any therapeutic process, whether or not music is involved.

**Creativity in the therapeutic process**

Perhaps the biggest mystery of all is that of the creativity of the unconscious mind. This is the ‘heart of mystery’ within us all, through which, according to Meltzer, meaning is generated at the aesthetic level of experience when we dream at night (Meltzer 1983). In relation to the creativity of the therapeutic process, Meltzer describes how an essential part of this occurs through the interaction of his and his client’s minds at an unconscious level; it is as if his client presents a dream and he then allows himself to have a dream in response. Meltzer’s co-author Meg Harris Williams describes it in the following way:

> He [the analyst] has to put aside his ‘knowledge’ – what he knows about the patient, what he knows about psychoanalytic theory – and for that period has to become an artist rather than a scientist. Instead of
searching for knowledge, he must wait for inspiration. It is the feeling for beauty that is growth-inducing, inspiring. This is what organizes the . . . conflicting emotions into a meaningful pattern . . . Bion and Meltzer both stress that if this ‘reverie’ is engaged in with sufficient determination, then ‘a pattern will emerge’ – possibly in the form of a dream-like image, the analyst’s dream which contains the meaning of the patient’s emotional experience. The therapeutic potential of psychoanalysis depends on this actually happening at the present time in the session . . . For the emotional truth of a situation is captured by artistic means – in the dream resulting from reverie [my italics].
(Harris Williams 1999: 133)

In music therapy, although the therapist’s conscious use of therapeutic technique and understanding is important (‘scientific method’), the therapist’s trusting in the aesthetic/emotional unfolding of the music arising from the inspiration of his/her unconscious mind (‘artistic method’) in response to the client can also be important. It maybe understood as a way of accessing the creativity of the unconscious minds of both therapist and client in interaction together, which Meltzer feels is so essential in the course of effective therapeutic work.

The paradox of this aspect of the work is that the therapeutic progress is furthered by a focus on musical/aesthetic considerations in which the therapist may not be able to explain or therapeutically justify why he/she plays in a certain way in response to the client. Although such ‘artistic methods’ need to be balanced with a more ‘scientific’ approach, the two, I think, can work concurrently. As Meltzer points out, however, in the current cultural and political climate, the sciences are respectable in a way that the arts are not. Thus it is all too easy to feel pressurised to show how therapy is a science (which of course it in part is) and almost apologise for the artistic aspects of the work (Harris Williams 1999). These consequently seem often to receive little attention in the music
therapy literature. I also think that our difficulties containing the aesthetic conflict can make us all tend to devalue and/or misunderstand the aesthetic aspects of our work.

**Psychological health and the aesthetic level of experience.**

In *The Apprehension of Beauty*, Meltzer writes:

> The psychopathology which we study and allege to treat . . . the impact of separation, of deprivation, emotional and physical, of physical illness, of Oedipal conflict . . . of chance events, of seduction and brutality, of indulgence and over-protection, of family disintegration, of the death of parents or siblings – all of these derive the core of their significance for the developmental process from their contribution as aspects of the underlying, fundamental process of avoidance of the impact of the beauty of the world, and of passionate intimacy with another human being [my italics](Meltzer & Harris Williams 1988: 29)

In fact, Meltzer believes that,

> Mental health consists essentially in being able to preserve this area of passionate intimate relationships, the aesthetic level of experience. (Meltzer 1983: 44)

We have seen above how the aesthetic level of experience first assumes importance when the mother’s ‘beauty’ evokes a passionate response in the baby in which there is a spectrum of emotion: love, hate and the yearning to understand. From Meltzer’s perspective, the most significant emotional events in human life always have these three components. The desire for understanding that stimulates the baby’s whole developmental process, can be understood to lay the foundations for both the scientific and artistic quests for knowledge throughout life (Harris Williams 1999). The use of the creative imagination (‘artistic method’) allows the conflicting emotions aroused by the aesthetic conflict to be accessed,
organised and contained. The sense of aesthetic/emotional truth discovered in this way, can fulfil the desire ‘to know’, and articulate an experience of meaning beyond the reach of scientific understanding and methodology. Understanding and living out of such truth is essential in preserving the health of our emotional lives, preventing them from being poisoned and eroded by the lies that are generated in the destructive parts of the personality, when the aesthetic conflict is not contained (Meltzer 1983).

Elsewhere, in relation to my own therapeutic journey, I have given a detailed example of the process of engaging with the creativity of the unconscious mind, by making use of the 'artistic method' to discover a sense of emotional truth articulated through music (Lawes 2001).

PART 2: RHYTHMS OF HARMONY AND DISSONANCE

In her book Dream, Phantasy and Art, Hanna Segal explores her understanding of the nature of aesthetic experience in relation to the creative arts, and although her thinking is related to Meltzer’s, her perspective is also a little different (Segal 1991).

Her idea, in brief, is that we each carry deep within us the memory of a harmonious internal world experienced at the outset of our life. For all of us, the destruction and loss of this experience is an inevitable part of our developmental process. Although Segal stresses the inner aspects of the experience, in terms of relationship, she is referring to the baby’s loss of its unity with its mother experienced in the womb and at those times after birth when it experiences its mother as being an extension of itself. Segal
thinks that creative artists, at depth, are concerned with reconciling the longing to experience such an ideal beautiful harmonious merging of self and other, once more, with the reality of being separate. As the artist faces and integrates the truth of this experience during the creative process, s/he establishes, in a creative and imaginative way, a sense of the wholeness, and Meltzer would say, beauty and mystery, of the loved mother experienced as a separate other. At the same time, the harmoniousness of the inner world is rediscovered in a way that integrates the experience of its being lost and destroyed. It needs to be stressed here that Segal is thinking about the aesthetic/emotional meaning of mature creative work, in terms of the containment and processing of very deep levels of unconscious psychological experience. The dynamics of this can be understood to underlie what ‘on the surface’ may be a completely unrelated content.

Segal’s understanding is that this containment is established through the balanced interplay of what I will describe in musical terminology as an artwork's harmonious and dissonant elements97. The artist evolves rhythms of connection in his/her work to (re)establish a sense of harmony and wholeness, without denying ‘dissonant’ realities relating to experiences of loss and separation and to aggressive impulses. Segal thinks that the aesthetic aspect of art is constituted in this way and that when successfully achieved, the artist has been engaged in a process of

97. As far as music is concerned, I am giving these words quite broad meanings in this context encompassing the whole spectrum of musical elements, ‘dissonance’ being that which opens up new possibilities but also tends towards the (temporary) disintegration and disorganization of musical structure and continuity.
psychological integration, having much in common with the therapeutic process.

What I call the ‘rhythms of harmony and dissonance’ (or ‘harmony containing dissonance’) that constitute the aesthetic form of an artwork, hold together such opposites of human experience as love and hate, joy and sorrow, being together and being separate, order and chaos, life and death. It is this that generates a sense of truth, fulfilling the desire ‘to know’ as explored above. Such use of the creative imagination (‘artistic method’) helps preserve our emotional health, and helps limit misguided and psychologically unhealthy attempts to penetrate, or even do away with, the essential mystery at the heart of our encounter with the world and with ourselves.

As an example, Segal cites Picasso’s great painting Guernica, a picture of utter destruction and desolation in response to the Spanish Civil War. She explores how in his sketches for the finished work, Picasso found rhythms of connection between the broken-up, devastated elements that enabled him to produce a great painting. The potential of such artworks to move us and contain such depths of truth and meaning relates, according to Segal, to the way in which the artist has been able to integrate and represent universal human experiences, which ultimately have the infantile origins she describes. Such art can be life affirming in response to suffering in a way that nothing else can.

**True art, false art**

Segal does think, however, that when the artist is too defended against the pain of facing the truth of his/her inner psychological reality and
experience of the world, the result can inhibit the creative process, or be reflected in the final product. She quotes Rodin:

Ugly in art is all that is false, artificial, that which aims at being pretty . . . instead of expressive. That which is mawkish, precious . . . all that is parody of beauty or grace, all that lies . . . When an artist, to add beauty to nature, adds more green to the spring, more rose to dawn, more cadmium to young lips, he creates ugliness because he lies. For an artist worthy of his name all is beautiful in nature because if his eyes accept without flinching all external reality – it reflects without fail like an open book all internal truth. (Segal 1991: 97)

In other words, the aesthetic aspect of art can both be a deceptive illusion (the pretty art that Rodin refers to) that hides or distorts the truth, or something that reveals the truth. But there is in fact no simple or obvious dividing line between the two, even in the case of the most sublime art; as Picasso said, ‘art is a lie which makes us realise truth’ (Jaffe 1988). Thus, because of the nature of the aesthetic conflict, there is endless confusion, disagreement and uncertainty when it comes to determining the inner meaning and value of what lays behind the outer aesthetic of much in the arts, whether popular or so called serious.

It can be the same in music therapy. In relation to the aesthetic of Kate’s music that I will be discussing below for example, on one level it seemed to communicate a great depth of feeling that could at times be disturbing in its intensity of beauty and pain. Yet on another level, I doubted my assessment of it; was it simply the imitation of a pop idiom, lacking authenticity and integrity? Although this could be understood at least in part as an unconscious communication from Kate of her experience of the aesthetic conflict, my own personal difficulties containing the latter also influenced my thoughts in a way not entirely helpful to the
therapeutic process. Thus I do think that it is important to work to contain our doubts, suspicions and uncertainties about the music and the therapy, if an authentic therapeutic engagement is to take place; we cannot always know and understand what is going on ‘below the surface’.

As a final point here, one of the challenges facing the creative artist who is attempting to develop an aesthetic form to articulate truth, is that as both Segal and Meltzer point out, the creative process ‘necessarily involves [facing] great anxiety’ (Meltzer & Harris Williams 1988: 209) associated with states of psychological disintegration and fragmentation. In my own experience (Lawes 2001), what is evoked at depth can be the loss and destruction of the beauty of the world, which as Meltzer says, is so precious, but also so fragile and vulnerable to being destroyed. I believe that such anxieties can also be experienced by both client and therapist in the course of clinical work, in relation to aesthetic of the music produced.

PART 3: AESTHETIC ENCOUNTER IN THERAPEUTIC WORK

Meltzer believes that the newborn’s initial emotional experience is an unbearably powerful passionate response to the beauty of the world, which can be absolutely overwhelming unless modified by the mother’s reciprocity. Not only does the mother impact on the baby, but the baby impacts on the mother as well. Meltzer expresses it thus:

The essence of its baby-ishness is the potentiality to become a Darwin, a George Eliot, a Rembrandt, a Mme. Curie, a human being. Its baby-ishness impinges directly on the imagination and sets us peering into its future. This ravishment, the love-at-first-sight that it can evoke is, I
contend, the sine qua non of the baby’s tolerance to the aesthetic blow it receives from the mother. (Meltzer & Harris Williams 1988: 57)

Surely for all of us, such an experience is at the very heart of our sense of well-being, originally established through the mutuality of our earliest love encounter in infancy, and re-established in the context of important friendships and intimate relationships throughout life. Meg Harris Williams, referring to work with premature infants, suggests that the ‘primal, mutual experience of “beauty” between mother and child is essential to the baby’s ability to develop as a human being, and, in the case of premature infants, even its ability to survive’ (Harris Williams 1999: 133).

As we have also seen, Meltzer feels that avoiding such intimacy is at the heart of all his client’s problems and that the therapeutic task is to try and help the client re-engage with the aesthetic/passionate level of experience in the context of the therapeutic relationship. As music therapists, many of our clients ‘labelled’ with physical disability, learning disability, autism, mental illness, challenging behaviour, old age, and so on, may not seem to be very attractive members of society in terms of their outer presentation. Thus, many may have completely lost touch with, or have never had, any sense of being beautiful as human beings. This reminds me of a comment by Neville Symington about his work both with psychotic patients and also those with learning difficulties. He said that all these patients have

wanted to discover whether at heart I really want their existence on this planet or, if honest, would I prefer that they drop off the edge of the world and disappear from my sight for ever. No amount of supervision
or technical improvements will alter this situation one bit. (Symington 1986: 320)

It seems to me that the client’s participation in the mutual aesthetic encounter lying at the heart of the music therapy process, can provide an important opportunity for healing. In this sense, the deepest aim of music therapy could be described as being to help the client work towards bearing the beauty and mystery of an authentic encounter with another person (the therapist in the context of the transference relationship) and with themselves, which does not deny or do away with the reality (dissonance) of human suffering but can begin to transform it and make it more manageable. Such an encounter will be a reciprocal one, which requires of the therapist an ability to bear the beauty, mystery and suffering of the world as encountered in the person of the client and in themselves (see Hartley 2001: 140).

It is important to say here that although the music can make a deep aesthetic impact on the client, the therapist or both at times, this does not by any means depend on the aesthetic form of the music being ‘finished’ at the level of high art. It is because the dynamics of the therapeutic relationship inevitably evoke the earliest aesthetic/emotional encounter between mother and infant in the way that Meltzer describes, that the music can have an aesthetic impact that it would not necessarily have to an ‘outsider’ (see art therapist Joy Schaverien’s exploration of the ‘aesthetic countertransference’ [Schaverien 1992]).
PART 4: KATE

Now I intend to explore Kate’s material introduced earlier, particularly in relation to the aesthetic aspect of her music and its impact on me.

Background

I started working with Kate when she was ten years old and saw her once a week for thirty-minute sessions at her school (for children with mild learning difficulties). She is on the autistic spectrum and was referred by her teacher because of disturbing and difficult to manage behaviour. This involved, among other things, seemingly unprovoked outbursts of verbal and physical violence to other students and staff. She lived with her parents at weekends, but with a foster family during the week as things had got rather strained at home.

The work

Firstly a play sequence from the middle period of the work:

. . . Kate is holding two drumsticks together. “I love you . . . I love you too” ‘they’ say to each other and then begin to dance rhythmically on a tabletop, never separating even for a moment. I play some accompanying music on the piano, but the harmoniousness of this scene does not last for long as Kate moves over to the cymbal and spins it violently. She takes the sticks and holds them over it, trying to balance them precariously at the centre. “No . . . don’t let me go . . . please . . . no!” one says desperately to the other. Then Kate lets go of the sticks, which are thrown wildly apart as they fall off the spinning cymbal and onto the floor. Kate emits a piercing scream . . .

This play sequence graphically illustrates the problem Kate brought to her therapy. The two characters in her play sequence seemed to be fine so long as they were dancing around inseparably with not a jot of space between them. In the different ways in which she explored this
experience over the weeks, Kate seemed to be trying to establish a relationship of absolute harmoniousness, through the simple rhythmic continuity of her characters dancing as though they were one person; perhaps she was ‘remembering’ the time when she was ‘rocked in the cradle of the deep’ of her mother’s womb before birth. The problem was that this unity never lasted for long. There inevitably came a time when they had to separate, and for Kate’s characters this seemed to result in a catastrophic falling apart, in which the continuity of their ‘going-on-being’ (Winnicott 1971) or ‘rhythm-of-safety’ (Tustin 1987) was destroyed.

In fact, when Kate first began music therapy some months previously, this story of harmonious togetherness and dissonant separation had been enacted directly between us in the therapeutic relationship. For the first few sessions she played percussion and I played piano. As we shared a pulse, rhythmic and melodic ideas together, my counter-transference experience was indeed as though we were ‘dancing’ joyfully together as one, in some beautiful paradise. Then after the eighth week, Kate utterly rejected the therapy and me, refusing to come for several weeks. Even when she did return, she did very little music for a whole term. I suspected that, whether for constitutional and/or environmental reasons, this story of a beautiful harmonious togetherness and its loss/destruction had probably been at the core of Kate’s experience of relationship and of self for most of her life.

Thus Kate acted out her problem directly in the dynamics of the music therapy relationship, which for a while destroyed the musical connection
between us. The continuation of the sessions, however, did eventually allow her to find a way to represent her experience symbolically as I have described. But she did not interact directly with me in this and the ‘dissonance’ of her experience remained raw and unintegrated.

It was around that time (eight months after we first met), however, that she began to sing quietly, and this represented the beginning of her re-engagement in a therapeutic musical relationship. She started to make up song/stories, often about love, abandonment and death (quite often her death). Although, I accompanied her at the piano, our encounter remained quite indirect and my counter-transference was of being ignored for much of the time. It was as though she could relate to me as an impersonal background musical presence, evidenced by the evoked harmonic connection that quite often occurred, but not as a person with whom she could interact in the music.

As time went on, however, Kate's vocal confidence grew, and one day, to encourage her to interact more directly, I suggested that she might like to make up a story, which we could then work on together to set to music. She immediately came up with an idea. In her story, Kate stands by the ocean, wishing that she could swim like the mermaid she sees in the water. When the mermaid pops its head out and suggests she swim too, Kate explains that her swimming costume has a hole in it, and she fears drowning because her arms do not work properly. But the mermaid gives her a swimming costume and encourages her to take the risk and try to swim too, which she does.
This seemed to me to be the story of what was happening in the therapy, where Kate was beginning to risk engaging in a more direct musical/verbal interaction, in spite of fears that she might be overwhelmed (drown). The musical idiom that she was developing, influenced by the style of popular singers and underpinned by the musical containment that I provided, gave her a musical 'skin' that allowed her to begin to articulate her aesthetic/emotional experience of self without 'drowning' in the accompanying music that I played. Such a leap of faith as Kate's story suggests, is also what I have increasingly found is required of me as a music therapist, in terms of engaging effectively with my clients in the music. This leap of faith has become easier to take as I have been more able to stay with not-knowing, containing the aesthetic conflict and my doubts and uncertainties about the therapeutic value of what may be occurring in the moment.

Nearly two years after we first met, the time came when Kate and I both knew that our work together would come to an end because she was due to change schools. What was extraordinary was the way in which her music-making really flowered during the few last weeks of our work together. Kate now had a strongly-developed musical identity, and for the first time, it was truly possible to listen, respond and adapt to one another as separate people, who could play creatively in the ‘potential space’ (Winnicott 1971) between us.

To illustrate this, I have chosen a musical example from a session just a few weeks before the end of our work (“Figure 1”). In Kate’s improvised vocal line, there is a rhythmic interplay of harmony and dissonance, a
pertinent example being where she sings ‘and I will [al]ways love you’. Here the word ‘love’ is sung on the note E, sustained in tension with my accompanying my first-inversion D major chord before it resolves. Such things enabled her music to articulate both the beauty and the pain of her experience at the aesthetic level, the ‘dissonance’98 of separation now being an integral part of the expressivity of her singing, rather than its being projected in such a disturbing way as it was via the scream in her play-sequence99.

98. Kate’s use of ‘dissonance’ here is of a mild nature; for a deeper, more ‘open’ use of dissonance, see my paper already referred to (Lawes 2001).

99. I worked with Kate when I was a student at a time when I had not really begun to make use of the ‘artistic method’ in relation to my clinical work. This was of central importance in my own personal therapeutic musical journey (Lawes 2001), but it has taken a few years to begin to assimilate this ‘method’ into my working practice as a music therapist. Therefore, I do not focus on that aspect of the musical interactions in Kate’s therapy, nor on how her music developed in relation to my musical response from its tentative beginnings.
In relation to her work with children like Kate, Francis Tustin has written about the importance of creative activities such as music in helping the child contain and process their extreme states of beauty and terror, associated with harmonious oneness and catastrophic separation. Once the agonising experience of loss can begin to be accepted and contained, it becomes an important part of their aesthetic sensitivity. As
overwhelmingly intense emotional experiences can be given aesthetic form, life as a separate person becomes more manageable. The child becomes less inclined to continually seek an experience of harmonious oneness (which can never be found in everyday life), and to reject potentially nurturing relationships with others, who also inevitably confront the child with the experience of separateness (Tustin 1992).

Aesthetic reciprocity
When I first met Kate, she rarely looked directly at me. But during the last weeks of our work, when we listened together to recordings of her songs, we were able to sustain eye contact, which for me had a sense of our mutual appreciation of each other as separate people not merged together. This felt important.

The words in the song I quote, which she sang so passionately and intensely, seem to be partly about a longing for the experience of being a beautiful, loved human being in the eyes of another. My sense was that Kate had been unable to internalise such an experience in a healthy way in infancy, in the context of the reality of separateness, and the beauty and pain of the aesthetic conflict, all of which is normally an inevitable aspect of human relationship right from the beginning of life. In the absence of such a healthy grounding for her personal development, she often expressed how she hated others and felt hated herself. I also think, however, that in the music and through the way we were able to listen to the recordings together, she was able to begin to have a personal aesthetic encounter without it becoming too overwhelming. Paradoxically, I think that this was possible because Kate’s musical articulation of self allowed
her to interact intimately in the music and yet retain her separate identity. This she could recognise as we listened to the recordings and looked at each other across the space between us. To put this differently, because Kate became able to tolerate the existence of a space between us when we were together, she achieved what at an infantile level is the first essential stage in developing a separate identity (Meltzer et al, 1975: 98).

Furthermore, although the ending of the work felt sad and was perhaps a little premature, it was not a catastrophe. In the lyrics of her song, Kate seemed to be suggesting that there was something good (the mutuality of an aesthetic encounter) that could be held onto and remembered.

A few weeks after Kate sang the song that I have been discussing, I saw her for the last time. She was with her mother then, who asked Kate whether she wanted to ask me anything. Kate put her hands over her face and said “I’m autistic”, words she had never used before in my presence. But I replied that I did not think that this was all of her. I said this because it seemed to me that she had been able to use music to articulate something of her aesthetic/emotional experience of relationship in a way that was far from being pathologically autistic. When I first worked with Kate, her behaviour was so disturbed that she was excluded from her class for almost a whole year, and I remember a classroom assistant telling me that she could not believe how anybody could be so full of hate as Kate seemed to be. At a presentation I later gave about my work at the school, the staff were very moved when they heard a recording of Kate’s music. I too had been ‘touched’ by what she did, and reflected how music had given her a remarkable way to experience herself, to
communicate and make an emotional impact on others through the aesthetic of her voice and her music, very different to that achieved through her penetrating scream or aggressive behaviour.

The very last thing I said to Kate was how much I had enjoyed making music with her. In fact, I think that the heart of the work was helping Kate begin to (re)establish what child-psychotherapist Sue Reid describes as ‘the beautiful experience of being in mother’s mind a loved beautiful baby’. Reid continues:

I think there is a deep rooted fear that any ‘confession’ of a beautiful experience will be automatically met with words like idealisation and with attempts to suggest that we have missed what lies behind it. I think it is time to make love, beauty, pleasure and appreciation respectable concepts in the psychoanalytic work and literature. For without an appreciation of beauty linked with love there is no impetus to live life, to enjoy it and to seek and embrace experiences. (Reid 1990: 51)

Surely the same could be said in relation to music therapy?

**Conclusion**

It is often said that music is before or beyond words, for example in the way a therapeutic musical relationship can articulate dynamic forms of feeling related to pre-verbal emotional communication between mother and child (Pavlicevic 1997). Music can also articulate an even deeper level of encounter, that of aesthetic experience with its developmental origins long before intersubjective relating has even begun, and this is what I have been exploring in this paper. The core theme has been the aesthetic conflict, which as we have seen, can be understood to set the whole developmental process in motion. It is inevitable in infancy,
however, that the overwhelming intensity of ‘the dazzle of the sunrise’ (Meltzer & Harris Williams 1988: 28) and the pain of the aesthetic conflict cannot be sustained for long.

Only in adult maturity is there sufficient ego-strength to tolerate ‘not-knowing’, a capacity that ‘is constantly called upon in the passion of intimate relations and is at the heart of the matter of aesthetic conflict’ (Meltzer & Harris Williams 1988: 20). Thus, although as adults we may operate at various cognitive, emotional and social levels, we need to be engaged with life at the aesthetic level, which remains essentially beyond words and understanding, if our lives are to have meaning and if we are to be psychologically and socially healthy. This means we need to be able to contain the aesthetic conflict. Music, perhaps more deeply than anything else, can help us do this, as we learn to bear both the beauty and the pain of being alive.

References


Music Therapy for Educators: Are we informing or training?

Leite, Teresa  
Ph.D.  
Lusíada University and João de Deus School of Education  
Portugal

“Today, it would be nice to do something out of the ordinary…  
To look in the eyes of a stranger while I walk on the street and talk with  
him about both our lives….  
To listen to the sounds of the world and dance to the rhythm of its  
beauty…  
Listening… dancing…. playing…..”

Unknown author

Introduction:”Adventures of a Music Therapist in the  
Education System”

At a time when so much effort and interest is dedicated to delineate the  
identity of music therapy as a discipline, to describe its specific  
applications and to create its unique theoretical body, it seems out of  
context that I come to you to speak about the forever evolving frontier  
between music therapy and other disciplines, more specifically, its  
interface with education and music education. However, for those of us  
who work at that frontier, describing the commonalities with other  
disciplines becomes as important as it is to identify the theoretical  
foundations and the methodological principles of our own.

I invite you to join me in a reflective walk by the border, that theoretical  
and yet very real land of merger between those music practices which are  
part of an educational project, those which are part of a therapeutic  
project and those which keep on being part of both, all of them at the
service of personal growth and the development of human creative potential.

I am a music therapist and a psychologist. Every week I travel between the world of those who are studying to be psychologists and eventually psychotherapists and the world of those who are studying to be teachers or to improve themselves as such. And lately I have been getting more and more involved in the training of those who are studying to become music therapists. In the field of music therapy, we take these training issues very seriously and we work hard to achieve a common ground of what is a music therapist and what he/she has to know in order to become one.

All this being said, every day I go home feeling certain that I am doing good by talking to all of these people about music therapy and inviting them to participate in what could become music therapy experiences. Yet, at the same time, I remain intrigued with exactly how am I doing good to these professionals and the people they will work with, and at the same time I worry about what they will do with this new information and how good will that do to the people they work with.

I repeatedly ask myself the question: Should I be informing educators about the field of music therapy and its applications, so they can enrich their knowledge as educators, learn to identify potential candidates for music therapy intervention and work together with music therapists towards a common goal? This aspect is an important one, but it seems to me that something else happens in my introductory music therapy courses with teachers that goes beyond this goal and could actually
become a professional asset for them. I am referring to the enthusiasm that builds in these professionals as they become aware of how they could change their practices in order to increase the performance of their students or to integrate those who are isolated from the class as a group. In that perspective, an introduction to music therapy course has the potential to create meaningful changes in a teacher’s approach to problematic students and open them up to a more individualized and creative approach to the curriculum and all educational activities.

However, as a music therapist, I am concerned that, by providing them with introductory information and experiences related to music therapy, we are encouraging teachers to implement certain activities that will touch on delicate, if not difficult, aspects of the student’s functioning without being included in the multidisciplinary therapeutic approach that is needed in order to help the individual to improve or maintain his/her state of health. Wengrower (2001) points to an important difference between therapy and education as working paradigms, one of them being the value that therapists attribute to privacy and the need to provide freedom of expression and a different timing when working with particular individuals. These are aspects that a teacher rarely has the opportunity to contemplate, for he/she works in a paradigm that is primarily centered on the class.

Inclusion, the practice of educating children with disabilities within regular school settings, is a concept that teachers often struggle with, reporting feelings of anxiety and frustration associated with their lack of
training and knowledge in pathology, as well as their inability to include such children in their activity plans.

What follows are the most frequent goals established by teachers as they attempt to delineate alternative approaches to a child identified as problematic, independently of the nature of the problems they have identified for that child:

- Increase attention and concentration abilities
- Promote the child’s adjustment to – and acceptance by – the class as a group
- Increase their interest in the proposed academic or educational activities
- Promote a state of positive humor and pleasure with the activities

In my classes and workshops we often discuss the importance of these goals in the work of both therapists and educators, as well as the potential that music activities have to facilitate progress in these areas, if conducted in a specific way. In that sense, and taking into account the fact that music therapy consists of using music to achieve non-musical goals, it would seem that therapists and educators working with music would work in similar ways. However, in the way my students organize musical activities towards the achievement of the previously mentioned goals, a fundamental difference between music therapists and educators arises, namely, the approach to the child (better said, the subject) in presenting the musical activity and the way this same activity is conducted.

While the therapist draws from the child’s own ideas and experiences and behaviors to decide the activity and the musical material that it is to be
used, executed or created – constantly adjusting it to the child even as the activity unfolds, the educator uses the educational goal itself and a collection of children songs and games to then bring the child into that structure or content. Furthermore, therapists tend to facilitate the child’s participation by making their task easier while educators tend to create a certain degree of challenge to the child in the areas that were identified and problematic for that child.

These observations have led me to believe that I often run the risk of contributing to the creation of a distorted idea of what music therapy is, given that we often resort to the same type of activities and we insist on the idea that the music repertoire can be drawn from the musical material that the child or adult is already familiarized with. Furthermore, for those teachers who already work with music and children with special needs, their work is inevitably very close to the area that Maranto (1993) called Educational/Developmental Music Therapy, given that it is aimed at improving the quality of life of those individuals with special educational needs or developmental delays. The only difference – a quite significant one – is the fact that such a teacher is not likely to have any training in music therapy or even in the pathology of the people he/she works with.

Given what was said above, it is my belief that we need to provide teachers and educators with ideas on how they can carve their activities to children and adults with a variety of problems, but we also need to bring them to clarity on the differences between an educational approach and a therapeutic approach, especially if we take into consideration how
much of the literature includes methods that draw from an educational approach into the methodology of Music Therapy as a discipline.

In this attempt to “negotiate our own borders” with the neighboring disciplines, we need to reflect on the definitions of music therapy, music education and the role of music in education.

Music Therapy, Music Education and Music in Education and Special Education: “Who we are, how we are trained and where we work”

In the latest version of his book “Defining Music Therapy” (1998), Kenneth Bruscia discusses the difficulties of defining music therapy and presents a large collection of definitions, drawn from the music therapy literature. A few aspects are strongly emphasized in these definitions: the systematic use of music, the use of music for therapeutic effects, the process that results from making music in the context of a therapeutic relationship, and the fact that it must be carried out by a music therapist. These are important aspects to consider, for they still leave a wide margin for discussion in regard to whether special education practices can be included in these definitions, as well as the work of music therapists with people who have not yet been diagnosed with any type of disorder.

The current definition of the World Federation of Music Therapy (Ruud, 1998) is presented in a way that allows for the inclusion of a wide variety of practices, form the treatment of mental disorders to the maintenance of physical and psychological well-being in both normal and handicapped individuals.
The systematic use of music involves an assessment of the individual(s) who is(are) going to be subject to the intervention, the elaboration of a treatment plan and the evaluation of the effects of such intervention. “Therapeutic” may involve treatment, education or rehabilitation, and, if seen from a humanistic point of view, it may involve the improvement, maintenance or restoration of a person’s health. The therapeutic relationship is that which is established with a professional who is qualified to conduct the relationship towards the previously mentioned goals, named as therapeutic.

Let us take a moment to reflect further on what we understand as a therapeutic goal in music therapy.

Lecourt (1988) has defined music therapy as “a sensorial sound approach - with therapeutic goals – to a certain number of psychological difficulties and mental disorders”. She considers music therapy as mostly a form of psychotherapy, emphasizing the therapeutic relationship and the working through of emotional and relational difficulties through the three-pole relationship between patient, therapist and music. From her point of view, the work that is aimed at educating or learning through music experiences falls under the category of expressive and/or artistic psychoeducation.

This would imply a clear distinction between the work of a music therapist and a music educator who works with people with pathology, given that only the former would be addressing emotional and relational issues through music activities and only the former would be establishing a therapeutic relationship with the client.
However, Bruscia defined several areas and levels of practice in music therapy (1998). Among those, he described didactic practices as “those focused on helping clients gain knowledge, behaviors and skills needed for functional, independent living, and social adaptation” (…), “where the main goals of the program are essentially educational in nature and learning is in the foreground of the therapeutic process”.

According to this perspective, one could argue that a music teacher with special education training could be doing music therapy interventions if he would come across one or several students with special needs and aim to use music experiences with goals that go beyond the acquisition of musical competencies.

Rosalie Rebollo Pratt (1993) discussed the need for a multi-dimensional model of training for music therapists. In this model, music therapists always end up working at the interface between music therapy and one of three disciplines, i.e., psychotherapy, special education and medicine. Nevertheless, the topic of discussion in the literature always revolves around the training of music therapists working in these areas. The issue of how much and in what way should we train other professionals who work at the same interface remains neglected in the literature.

In-services are proposed as a way of informing other professionals in our multi-disciplinary teams about our work. However, many of us conduct introductory courses with educators who are apparently meant to be informative, but often end up generating ideas for intervention on the part of such professionals who work with impaired subjects in their institutions. In this context, an important concern arises: Are we
providing them with basic information about our work or are we unintentionally encouraging a form of intervention for which they are not sufficiently trained?

In order to define what constitutes a music therapy intervention, attention is given to the practices that are conducted by music therapists, psychotherapists and music educators, and the way in which music is used in such practices. Franz Schalkwijk (1993) differentiates music therapy practices from music activities by stating that in the first ones, music is used as a kind of psychotherapy and priority is given to the relationships between the client and the therapist throughout the music making activity. Music activities would be those practiced with the aim of music education or music development, and those could be carried by any “well-trained musician with an open eye for the needs of the clients” (p. 78).

There are several articles highlighting the value of a music therapist’s work in educational settings. Smith & Hairston (1999) conducted a survey of music therapists working in the American School System and discussed the importance of their work in addressing the wide variety of disability cases included in regular school settings. Dena Register (2001) goes beyond the scope of music therapy itself to speak of the positive contributions that a music curriculum in early education programs may have in maximizing reading and writing skills. In this article, the expressions “music lessons”, “music therapy” and music curriculum” were used interchangeably, without much specification of what the sessions consisted of, other than situating them in the developmental
music therapy category of practices (Maranto, 1993). This study is then demonstrative of a possible application of music therapy at the level of primary prevention (Wengrower, 2001), where music can constitute a way to maximize the acquisition of pre-writing and reading skills by children at different levels of verbal competency. This study describes practices of teachers carrying out activities provided by the music therapist. Despite the difficulties of standardizing the intervention among the professionals, this article illustrated a model of equal intervention by educators and therapists, with music functioning as an assistant in the global process of learning (Register, 2001).

Wilson & Smith (2000) conducted a survey of how music-based assessments were being used in the school settings. This article discussed the value of music therapy practices and tools as expanded ways of assessing children with disabilities and special needs within the regular school system. The author made reference to the collaboration of clinicians and educators in the development of musical and non-musical indicators that would complement the already existing tools for assessing development-based strengths and weaknesses in the child (p.111). Based on this idea, one could argue that school teachers and music educators could benefit from learning about the music therapy assessment techniques that would complement the role of other educational assessment tools.

In a survey of music therapy practices in school settings, Smith & Hairston (1999) refer to the fact that such music therapists, much like music educators, participated in individualized educational programs and
worked on both therapeutic and educational goals with the students. Their differences then become visible in the class/session structure and in the practices themselves.

Nevertheless, it seems as though the ultimate question of specificity for our field becomes the definition of what constitutes a music therapist, and what type of training brings the professional from whatever title they previously had to assume the identity of a music therapist (Pratt, 1993). The training of music therapists is not the central focus of our talk today, but instead I propose to discuss the role that music therapists can play in the training of other professionals, such as teachers and music educators, keeping in mind that by participating in such programs we are not training music therapists. The important question becomes: If we are not training music therapists, then what are we doing, and how can we best accomplish our task?

**Training Issues: “Short Courses, Workshops and Other Worries”**

Much has been said about music therapy training and the certification of music therapy professionals, but the inclusion of music therapy courses in other training programs has been neglected in the literature, even though many education and music programs include music therapy courses in their curricula (Colwell & Thompson, 2000).

For those of us working in the field of education and special education, training becomes a particularly pertinent issue, for we often end up carrying out the same musical activities with the same goals as the educators and music educators, especially if we work within a humanistic
frame of reference or a developmental model, helping the person to develop to his/her maximum capacity as a whole and well-adjusted individual. From this point of view, it could be that in some educational settings the only thing that will distinguish a music therapist from an educator or a music teacher working with people with a specific disorder could be our training. In these settings, the differences in training most likely originate fundamental differences in the way we conduct the relationship that takes place in the unfolding of the music experiences and/or in the emphasis that is given to the music phenomena in and of themselves.

- A music teacher would tend to emphasize the music aesthetics and the technique of handling the music instruments
- An education professional using music would tend to emphasize the global development of the person with disability or the acquisition of specific competencies through musical activities
- A music therapist would tend to emphasize the relational aspects of the music activity or the psychological processes of the individual as he participates in such activity

However, there is a wide variety among music therapists in regard to their previous training, which will highly influence his/her work – even after the specific and homogenizing training that a music therapy program is supposed to provide - making it lean towards a more psychotherapeutic approach or a more educational approach. On the other hand, the continuing education and the work experience of a music teacher or an educator can certainly bring him/her close to the frame of reference of a therapist and transform his work into a seemingly therapeutic approach to the people he/she works with, especially for those who work with people with special needs and/or a significant
degree of pathology. Introductory music therapy courses, workshops and music therapy didactic programs can certainly have such an effect. In these circumstances, three important questions arise:

1. At which point does the educator who takes music therapy courses in his continuing education become a music therapist? Probably never.

2. Is he/she doing ethically appropriate and eventually effective work? That is the question for which we have no answer.

2. Does it happen that such educator progressively transforms his/her work to match a therapeutic approach to the individuals he works with? Probably often.

In order to guarantee that the music teacher and the educator who receives introductory training will either produce effective therapeutic work or delineate clearly and appropriately the boundaries between their contribution and that of a music therapist to the well-being of the people they work with, the music therapists that provide such courses need to clarify the distinction between psychotherapy and special education. Also, programs need to be designed and presented in a way that will leave no ambiguity in regard to the competencies of the participant and the appropriate scope of his/her interventions once he finishes an introductory music therapy program.

The Outline of a Research Project: “From the original idea to the participant’s experience”

In an attempt to look further into the suggested model for music therapy introductory courses for educators, a survey was conducted with a sample of 136 educators who participated in a four-session introduction-to-music-therapy course as part of the curricula of a one-year program that would complement their original education/teaching degree. Of those, 47% (N=64) were elementary school teachers and the remaining
53% (N=72) were kindergarten teachers, designated in Portugal as Early Childhood Educators. Almost no participants had any formal music training. This study is currently undergoing the stage of data analysis.

The course consisted of four sessions (two-hour sessions for teachers and three hour sessions for educators) with the following format:

1 One hour of lecture, dedicated to the following topics: Definition, principles and applications of music therapy; music therapy methods and techniques; planning, assessment and evaluation in music therapy practices; music therapy with children: types of pathology, intervention challenges and contributes of a music activity approach

2 One to one-and-a-half hour of experiential activities, focused on the following experiences: Dealing with instruments and rhythmic structured activities; music and expressive movement; singing and song-playing; free improvisation and the association between music and symbolic expression

The goal of this study was to gather feedback from the participants in such course in regard to three main aspects:

1 Their perception of the course and its usefulness in their work and their personal lives;

2 Their ideas and intentions for an eventual application of what they’ve learned in their current work practices

3 Their definitions of psychotherapy, education and of the difference between the educator who uses music in his/her work and the music therapist

A questionnaire was handed out to all participants at the end of this short course, which they filled out anonymously and in written form. Although data is still being analyzed and no formal results are available from this study, a brief content analyses of the participants’ responses calls our attention for two interesting aspects, already explored in this paper: 1) the way teachers and educators understand the contribution of such course to
their future practice, and 2) the perceived difference between a music therapist and an educator who uses music in his/her work with the children.

As for the first aspect, we asked the participants the following question: “From your point of view, what is the usefulness of a music therapy module in a course for teachers and educators such as this?”. A large number of participants focused how the module came to increase the range of activities they could now use with their children, while others focused on the “different way of using music” that would allow them to handle those children with difficulties who were included in their regular classes. In this regard, many participants mentioned how this course came to change their approach to music activities, emphasizing the creative, the exploratory and self-expression, more so than the entertainment and the music learning aspects.

In regard to the second aspect, the following question was asked: “In your understanding, what might be the difference between the work of a teacher/educator who uses music in his/her daily work with the children and the work of a music therapist?”. The responses can roughly be divided into the following categories:

1. A difference in training, where the therapist has specialized training in dealing with pathology cases and the educator is seen as either having less training than the therapist or as a specialist in a different area, namely, child development and academic education;
2. A difference in the people they work with, as the educator works with normal children and the therapist works with children who present emotional and/or developmental problems;
3. A difference in the goals they establish for the use of musical activities, with therapists using music to “treat” or alleviate
psychological problems and educators using music to stimulate the child’s interest in music or to facilitate learning in different areas;

4 A difference in the way they use music in their activities, the educator working mostly with groups and focused on the leisure and playfulness aspects, while the therapist takes a more individual approach and focuses on the child’s problems and how they take form in the child’s musical production.

There were some questions that were specifically aimed at gathering participants’ ideas on how they envision a possible application of what they’ve learned with this course in their daily work. This data has not yet been analyzed, but it is seen as an important component of this survey, for it will provide us with important information on whether the participants will incorporate some useful music therapy principles into their work as educators or actually attempt to do therapeutic interventions, which is one of our main concerns with these courses. The other aspect that remains to be analyzed has to do with the participants’ personal experiences throughout the course and how they envision an eventual contribution of this course to their personal and professional development. This information will be crucial in planning future courses and will provide us with some clarification of the issue of whether such courses should focus on activities and technical aspects or constitute opportunities for experiential training and personal development for teachers and educators. This issue will be discussed further in the next section of this paper.
Implications for Practice: “In the end, what do we do and where do we go from here?”

There is very limited literature available on the effect of short and introductory music therapy courses on the practices of teachers and educators. In a study dedicated to surveying the inclusion of music therapy information in music education training programs, Colwell & Thompson (2000) emphasized the important contribution that music therapists can make to the training of music educators, which was outlined in two major aspects: 1) the specific knowledge of disabilities that music therapists have and 2) the contribution towards a change in the teacher’s attitude towards children with disabilities and their inclusion in the regular classroom. Throughout the literature, the issue of inclusion becomes an important topic of discussion and it is argued that music therapists can play a very important role in the development of the educator’s positive attitude towards disability, which can in turn be crucial to the success of the inclusion of such students in a regular education setting.

Hilda Wengrower (2001) wrote about the inclusion of creative arts therapies in educational settings as an encounter of two different cultures, that of therapists and that of educators, having a different identity as professionals, holding a different perception of the children they work with and having different values and goals for their work. In my work with teachers, I often feel that “shock of cultures” and wonder how we can overcome it in a way that will be good for both the educators and the children they work with.
According to Wengrower, the therapy culture is primarily focused on the internal experience of the person and his/her distress and anxiety. The therapist sees his/her role as “accompanying the person in a process of change while accepting her in her uniqueness and her distress” (p.110). The core of the therapist’s work is in the relationship that is established with the client and attention is given primarily to the qualitative information that arises within the interactive music experience. On the other hand, the educator is primarily focused on the class and the common educational goals that he/she has for the children, according to their age and developmental level. The core of the teacher’s work is not just to provide information, but it does revolve around the student’s learning process and the activities provided, establishing quantitative goals for the students to reach within each area of improvement.

This is an important contrast, which often becomes visible in my courses. We may be working on the example of a particular song activity and while I find myself drawn to examine the emotional quality of the child’s singing and the symbolic content of the song, the participant teachers will be mostly concerned with whether the group at large learned the proposed words to the song or acquired the movements that go with that particular song. Also, sound exploration activities are often led as “games” with right and wrong answers, and sometimes even with a competitive ingredient that is meant to engage more children in the activity, while I tend to emphasize the creative aspects of instrumental improvisations or sound exploration activities and reduce competition on order to diminish the child’s anxiety.
As Schalkwik (1993) stated, “superficially, the many ways music is made may look alike, but the goals and objectives are not always adequately developed” and the difference between the work of a music therapist and that of a music educator “is mainly in the intention of the techniques used, rather than in the exact musical procedures”.

One of the aspects that I emphasize the most in my classes is the opportunity that musical activities provide for the participation of a group of children with a wide range of musical and other capabilities. The use of easy-to-handle instruments allows us to integrate those children who present significant delays in their motor and cognitive development in the same group as other children who present a higher level of cognitive skills or even musical competencies.

Teachers are very sensitive to this idea, for they are primarily concerned with the integration of such children in the larger class group. However, the emphasis that is given by the creative arts therapist to the expressive meaning of the child’s musical production or even the use of such activities to further our own relationship with that child are aspects that a teacher tends to neglect. These are subtle and yet very important differences in the way one can lead a music activity that would become more visible through the execution of such activities with the teachers themselves, drawing from their own choice of music repertoire and their own participation in music making activities.

The biggest challenge in conducting introductory music therapy courses with teachers is to generate ideas on how they could apply music therapy principles in their own work when they have no music training and no
therapy training. I always try to make very clear that without those, one cannot aim to conduct any kind of music therapy intervention. In that process, I often run the risk of discouraging them and diminishing their interest in the course itself. However, this apparent disappointment can be resolved by emphasizing the concept of prevention, which comes into play at two different levels:

1. As introductory level music activities widen the scope of participation for those children with special needs or difficulties, they provide the teacher with a multidimensional setting in which to observe the child as a whole and assess his/her strengths and weaknesses in a more detailed fashion, while diminishing the child’s anxiety, for she/he is much less aware of the evaluation component during music playing than in other academic activities. By discussing pathology and therapy in the context of these music activities, we are improving the teacher’s ability to identify and assess children with particular problems, who can then be referred to the appropriate services;

2. By conducting expressive and creative music activities with the teachers themselves, we are increasing their awareness of how music can contribute to our well-being, especially when conducted in a way that emphasizes self-expression and interpersonal relationships. We are also making them fully aware of the benefit one can draw from a music experience even when one does not have any music training. Once she/he has experienced such phenomenon, the teacher will be particularly sensitive to this aspect in his/her work with the children.

In an ideal world, schools would all have teachers, music educators and music therapists that would provide the full range of benefits that music can bring to the personal development of children, adolescents or adults. Also, in an ideal world, teachers would have at their reach a wide variety of clinicians and other professionals who could work with all children identified by the educator as having problems or particular difficulties.

However, in the real world – and particularly in a country like Portugal – such services are often unavailable or overcrowded. In this situation, the
school becomes a good opportunity for observation, diagnosis and even intervention in certain cases. As long as we are all aware of the limitations of dealing with problematic cases in an educational setting, the more tools a teacher has to identify such cases and work with them, the more he/she can contribute to those children’s lives. Music activities can function as one of those tools, even when the teacher’s music and therapy competencies are very limited. The challenge is then upon us to promote the intercultural encounter between therapy and education, learn each other’s language and come across with the creative arts message that music can be used primarily as a creative experience and promote a particular way of relating that will benefit the development of the normal child and the child with problems in all its dimensions.

Music therapists who work directly in educational settings bring the creative arts therapies perspective into the school, exchanging their knowledge and experiences with the educators. Side by side, they work with the same subject, i.e. the child, and their challenge is to create room in the institution for their different approaches to the child and their different uses of music. Those of us who introduce teachers and educators to music therapy bring knowledge and experiences into the educational setting through a sort of “relayed process”, for we work with the teacher, providing him/her with some knowledge of our discipline and inviting him/her to experience music from a different perspective, which will hopefully contribute to the way they work with the children from then on.
There are risks and benefits in doing such work. On one hand, we run the risk of being misinterpreted, as we present them with only a sample of our work, which may then be interpreted according to the values and priorities of educational intervention, rather than a therapeutic one. Music activities and experiences that are carried in a therapeutic setting, emphasizing the value of an individualized approach to the child and an interactive approach to music, are often "imported" into the classroom, losing their therapeutic potential simply by being applied to a large group of children with a universal goal for all of them.

However, if we focus primarily on didactic music therapy experiences that will have an experiential value for teachers as people, we will have the strong advantage of "planting the seed" of using music towards relational and personal satisfaction goals, which will hopefully bear fruit in the way those teachers will later work with their children in need of help.

In an article about integrative arts experiences in the training of educators, Valente (2001) proposed a holistic model of training that is focused on the teacher’s development as a creative being. The author gathered statements from teachers who had undergone this model of training. They reported that participating in such practices led to increased diversity in their educational practices, higher motivation on the part of the students and better academic outcomes. In the same article, emphasis was given to the relayed effect that such model of training had on the students, for they transformed the teacher as a person and a professional. Most participants reported an increased awareness of
themselves and the needs of their students, as well as a significant improvement in class participation when the teacher adopted a more creative and holistic approach to the curriculum (p.144).

The value of experiential practices in training and in therapy has been widely recognized in the literature (Lett, 1998; Stephens-Langdon, 2001). It is my experience that teachers who participate in experiential music sessions seem to apprehend in a more accurate way the principles of music therapy and later produce assignments that reflect a more flexible and psychologically minded approach to children with disabilities. Much like the children themselves, they often come out of group improvisation experiences with an exhilarating feeling that “they too could make music” (Wengrower, 2001). The frequently mentioned humorous line “next week we will call the producers and publish our own CD!” is a sign of how these experiences can decrease their performance anxiety and increase their self-confidence in regard to creative activities.

At each step of my journey with such population, I hesitate between 1) a pragmatic and technical approach, using the little time that we have to provide them with practical guidelines and music activities that will help them in their work with disabled children, and 2) a humanistic and experiential approach that would focus primarily on providing them with music experiences aimed at unblocking their creativity and using music for their own well-being.

My preference as a music therapist clearly goes to the latter approach, although I am often faced with one significant difficulty, that is, the participant’s fear of being evaluated and their own judgmental approach
to their own and their peer’s music production, which significantly reduces their willingness to participate in experiential music therapy activities. We return to the idea of the education paradigm: “In the culture of school-based education, everyone is under constant evaluation” (Wengrower, 2001).

However, I have come to understand that it is my challenge and responsibility as a music therapist to help my students (who are themselves teachers) overcome the rigidity of an evaluative approach and free themselves to participate in music experiences that are worth specifically for their experiential meaning and not the demonstration of skills or competencies. I believe that if we can cross that barrier in the limited context of an introductory course, I have planted a seed for them to carry to their own educational settings and provide their children with experiences that are free from evaluation and focused on personal meaning and interpersonal relationships. If that alone is accomplished, I can consider my course successful!

In summary, it is my belief that when we offer introductory music therapy courses to teachers and educators, the implications of our work go beyond the immediate goal, which is to inform them of the existence of music therapy and its applications. We must then reflect upon these implications in order to produce the most benefit to the participants in such courses and the students they will work with.

If we focus on teaching them a few techniques and activities, given the short amount of time that is available to us, we run the risk of such techniques losing their therapeutic value when applied by someone who
works within a paradigm that is different from that of the creative arts therapist. It is my belief that we should provide them with experiential classes where they will experience music as creative and social beings. We must then invite them to reflect upon the contribution of such experiences toward their development as people and as teachers. This way, the therapeutic and preventive power of music will be carried within the person of the educator, who will then incorporate such values into the way he/she will conduct his activities with the students.

For this work to be successful, we, as music therapists, must be clear about the boundaries between music therapy, music education and music in education. If we are clear about the differences and the similarities among our practices, we can then use our music therapy knowledge towards the use of music practices that are carried outside of the music therapy setting by other professionals towards the development and well-being of children with and without disability.

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Interesting Quotes

Citar:

Damasio – integracao musica-emocao-sistema neurologico

Arquimedes Santos, Emilio Salgueiro,

O poder universal da grande música (…) é proveniente de uma coincidência prodigiosa: esta música serve como uma luva nos códigos secretos através dos quais o corpo transmite os seus sinais ao cérebro e dado que os códigos do corpo e da música são os mesmos, o cérebro trata as mensagens desta música como se fossem do coração e não do ouvido”

António Damásio, 1995 – O Erro de Descartes
Music Therapy in Spirituality

Magill, Lucanne

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”.

(Click here for download ; 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:

“When I am in the presence of music, I hear the voice of God;

When I am in the presence of music, I fly like a bird;

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
A Creative Response to Loss (Music Therapy with Bereaved Siblings)

Mayhew, Jane  
MA SRA(s)T(M)

Check for her Powerpoint presentation in the Oxford Powerpoint folder

Intro

Loss and grief are a part of life, and for some a part of early childhood. Facing loss, presents complex emotional, cognitive and organisational challenges. The Department of Education in the UK estimates that two children in any school class of thirty will have suffered a high degree of loss. This includes family death, divorce and relationship breakdown.

This paper focuses upon the death of a child in a family, and the impact that has upon the surviving sibling. It will explore the ways in which music therapy and the creative process can be beneficial to bereaved siblings, discussing the development and evaluation of a short-term (ten week) bereaved sibling group.

Setting

I work as part of a multi-disciplinary team in a children’s hospice, in East Kent, South East of England. The team includes medical staff, play specialists, a family support worker, social worker and trained volunteers. The purpose of the hospice is to provide care for children and young people, from birth up to the age of nineteen, with life-limiting conditions. Medical diagnoses include muscular dystrophy, metabolic and neurological degenerative conditions. However, many of the
children’s conditions do not have a clear diagnosis. Referrals are accepted from social services, the medical profession and parents. The hospice provides respite and terminal care, and also offers bereavement support to family members after the child’s death.

There are twenty-seven children’s hospices in the UK and seventeen music therapists work part time at these hospices. It is typical for music therapists to work with the child who is ill. However, within the hospice, music therapists will also work with, parents, siblings, grandparents, staff, students (nurses and music therapists) and bereaved family members.

At the hospice where I work, bereavement support plays a large part of our care. In the four years since the hospice has been open, approximately three hundred and thirty children have been referred and sixty-eight children have died. Each family is offered bereavement support that meets their needs, which include,

- Family visits
- Individual counselling
- Parents support groups
- ‘Holding on/Letting Go’ Grief support weekends for children
- Music Therapy (Individual / group sessions)

The majority of my bereavement work is with siblings. Parents, hospice staff and teachers can make referrals for individual music therapy sessions. Before starting my work with bereaved siblings, I felt that it was important to acquire further training on bereavement practise and

100. Jessie’s Fund has set all of these posts up.
theories. This training came from specialized organisations such as the Child Bereavement Trust and Cruse.

I also wanted to read about other music therapists’ work with the bereaved. In comparison to the increasing amount of literature now available on music therapy and palliative care, there is only a small amount of material which focuses on music therapy with the bereaved (Smeijsters:1999, Burke 1991, Bean:1992).

Earlier this year, the Association of Professional Music Therapists produced a leaflet entitled ‘Music Therapy for the terminally ill and bereaved.’ The Association also produces a member’s list of qualified music therapists in the UK. This gives information regarding the places of work and different client groups. Out of the twenty-four client groups listed, ‘bereaved’ is not specified. Perhaps this is an indication of the contemporary nature of this work in this country.

Chava Sekeles (1999:188) provides a comprehensive understanding of working with the bereaved, in her paper, ‘Working Through Loss and Mourning in Music Therapy.’

She presents a case study of a client who was referred for music therapy with a diagnosis of ‘pathological mourning.’ Sekeles describes pathological mourning as ‘the unsuccessful expression of grief by individuals who are unable to complete the natural stages of bereavement.’ (ibid..)

Bereavement has specific concrete manifestations. The intensity of attachment to the person is replaced by intense sensations of emptiness,
which feels physical, as well as emotional. It is understandable that early studies of death (Nagy: 1948) found that it was personalized in the figure of the Grim Reaper. The Grim Reaper illustrates the idea of a figure taking someone away, reflecting the sensation of being robbed and needing that robber to blame.

John Bowlby’s research in *Loss, Sadness and Separation* (1998) has shown that grief that is not worked through in childhood, will inevitably have repercussions in adult life. This can manifest itself in a range of ways, for example, when adults experience difficulties in building trusting relationships, to later psychiatric illness, or underlying depression and anxiety (Simos 1979:27, Smith *et al.*, 1995:76). Bowlby’s theory of attachment and loss explains reactions to loss in terms of early experiences, which determine how bereaved people cope with loss.

I feel that it is useful to outline the mains stages of the grief process, as it is important to understand normal responses to grief compared to pathological mourning. These stages, in some form, accompany all losses and transitions whatever one’s age or understanding. Bowlby has categorized four stages of grief in bereavement; the length that each individual might remain within each stage is variable.

**Four Stages of Grief in Bereavement** (Bowlby 1980:85)

1. Phase of numbing that usually lasts for a few hours to a week and may be interrupted by outbursts of extremely intense distress and/or anger.

2. Phase of yearning and searching for the lost figure, lasting some months and sometimes for years.

3. Phase of disorganisation and despair.
4 Phase of greater or lesser degree of reorganisation.

Bowlby goes further to say that it is important for an adult to have ‘available a person on whom he can lean and whom is willing to give him comfort and aid.’(ibid.p.290) He then stresses that ‘what is important for an adult is even more important for a child.’(ibid.) The risk factors associated with the experience of loss are well researched in adults who have lost a spouse (Parkes, 1986) but are less clear with children who have lost a relative or friend (Sood & Weller 1992, Fristad et al., 1993).

Losing a brother or sister can make the world seem like an unpredictable and unsafe place. The surviving sibling may feel out of control and rely entirely on adults for information. Adults may struggle to be honest with children, wanting to protect them from the realities of death, which may not always be helpful for the child. At the time of death, the surviving sibling is confronted by reactions of parents, other siblings and the extended family, as well as their own responses. Their parents may become over-protective or over invest in their care. Therefore the relationship between the parent and the surviving sibling changes.

A further useful illustration of how people respond to death is found in Margaret Stroebe’s (1993) proposed ‘dual process model of coping with loss’. This illustrates how people engage in both ‘loss-oriented’ and ‘restoration-oriented’ grieving activity, depicting oscillation between the two reactions.
Both parents sustain the loss, but their grief experience may be different. In general a child’s response is far more transient, as they may become preoccupied with other things, other than completely with the loss. Their response to grief is dependent upon their developmental stage and understanding of death. It is not difficult, as Bowlby suggests ‘to see … that a child’s ego is too weak to sustain the pain of mourning’ (1998:292).

I will briefly discuss the understanding of death for children aged between six and eleven years, as these are the ages of the children who attended the bereaved sibling group.
6 – 8 YEARS
Most children would have developed an awareness of death as having a cause, of being irreversible and as something that can happen to anyone. They are more developed verbally and may convey a cognitive understanding. However, they may appear to be unaffected and also have irrational thoughts linking ‘naughty’ behaviour towards sudden death.

8 – 11 YEARS
Children’s understanding of the finality of death is nearly equivalent to that of an adult. An important factor is the child’s deepening realization of the possibility of their own future death and the fear that this creates. This is particularly relevant when an older sibling dies and the surviving sibling reaches that age.

Where grief is not processed, parents or schoolteachers might pick up problems with behaviours. Yet, even when these problems are identified it is difficult to find support groups specifically for bereaved siblings. From gaining greater understanding in bereavement issues, I began to explore how creativity could aid the grieving process. There is not scope in this paper to make a full exploration of creativity and focus is therefore upon the importance of the creative act in relation to loss.

In Playing and Reality, Winnicott (1971:65) stated that it is ‘creative apperception more that anything else that makes the individual feel that life is worth living.’
He seems to stress the importance of creativity and the value it can hold in life. In times of bereavement it is difficult to find any value in life. Winnicott further explains that creativity is ‘universal’ and ‘it belongs to being alive’ (ibid.). This ‘creation’ could be, as Winnicott describes,

‘… a picture or a house or a garden or a costume or a hairstyle or a symphony or a sculpture; anything from a meal cooked at home’ (ibid..:67).

The psychiatrist, Dr. Anthony Storr links creativity and imagination in his book *Solitude* (1997:123), suggesting that the ‘creative imagination, can exercise as a healing function.’ This ‘healing function’ is illustrated when one studies how particular artists have used their form at times of bereavement. It could be suggested that their art forms are used as a process of ‘repair or re-creation’; this is demonstrated in the works of the poets Tennyson and Cowper.

Alfred Tennyson (1809 – 1892) was twenty-four years old when his close friend suddenly died. His writing, such as *In Memoriam* and ‘The Two voices’, inherently expressed his grief. Tennyson was able to retreat to poetry which he used as ‘a narcotic for an existence made temporarily meaningless.’ (ibid.:132). Perhaps Tennyson was able to find moments of ‘being alive’ through writing. His further works, such as *Ulysses* and *On a Mourn*er also seemed to be directly born out of his feelings of loss. It is suggested that his poetry had some form of ‘therapeutic affect’ on his life,

‘In creating harmonies and the symbolic order of the poems, he [Tennyson] was able to perceive momentarily some kind of unity and wholeness that was applicable to his own life, and so it remained for him until his death.’(ibid.)
It seems that Tennyson was able to use his art form as a way of restoring some meaning to his life rather than escaping from his pain. This may also be true of another English poet Cowper. In the later stages of his life, William Cowper (1731-1800) wrote a poem, ‘One the receipt of my Mother’s Picture Out of Norfolk’. Cowper’s mother had died when he was six years old, but on ‘receipt of the picture’ memories of early loss were triggered:

What peaceful hours I once enjoy’d!
How sweet their mem’ry still!
But they have left an aching void,
The world can never fill.’

It could be suggested that the arts can be used as a way of expressing a searching and longing for what is lost and from it something new is born, something different is created. Storr believes that,

‘by creating a new unity in a poem or other work of art, the artist is attempting to restore a lost unity, or to find a new unity, within the inner world of the psyche, as well as producing work which has a real existence.’ (ibid.:123)

In focussing upon the ‘role of music in facilitating grief’, Katherine Ryan (1995:45) adapted the following list from the work of McIntyre and Raymer,

Affirmation  •  Music promotes affirmation of life when faced with loss
             •  Music can be created which affirms life and confers meaning

Control  •  Music offers child choices to obtain control over self and his/her situation

101. William Cowper Olney Hymn I, lines 9-12
• Music offers child a sense of control over a powerless situation

Uniqueness • Music can assist child to discover and affirm his/her uniqueness
• Music can be created by the child that promotes ownership

Remembrance • Music evokes memories
• Music promotes commemoration of a loved one who died
• Music promotes creation of new memories

Awareness • Music promotes awareness of here and now
• Music promotes awareness of others
• Music promotes awareness of interactions with friends/strangers
• Music promotes awareness of building new relationships

Bereaved Sibling Music Therapy Group
I facilitated the bereaved sibling group with an experienced volunteer from the bereavement team. As she had had no previous music therapy experience or musical training, I felt that it was important to spend time with her before starting the group and we explored the following areas;

• Week 1: Experiential music therapy session.
• Week 2: Introduction to music therapy principles
• Week 3: Observation of an open group, brief understanding of group dynamics
• Week 4: Discussion of bereavement group, themes and who would attend.

The importance of providing a nurturing and safe environment for the children was paramount. The sessions took place an hour and a half after
school had finished and most children had rushed to get home and changed before coming to the group. Drinks and biscuits were provided for the children before the group started. This was not part of the session time, and it became quite typical for the children to arrive ten minutes before the session began. Environmental and time boundaries were in place and adhered to each week and further boundaries, such as confidentiality and safety were discussed with the children during the first session.

This work was quite different from the more usual hospice sessions, which can often be irregular in attendance and duration, due to the children’s medical conditions (Edwards:1999, Ibberson:1996). This group followed the more typical therapeutic pattern. It was a closed group, which took place on a specific day and time. There were ten sessions, each lasting for an hour, over an eleven-week period, with a one-week break during half term. The sessions took place in an oast room, which is a circular room with a high ceiling. The room was set up the same each week, with chairs placed in a circle and the instruments placed in the middle. The instruments included, a clavinova, guitar, metallophone, windchimes, various drums (including ocean drum, split drum, tom toms and standing drum) tambourines, bells and shakers.

Criteria
It was important to decide whom the group would be for and the following criteria was devised;

1  Children living in close proximity of the hospice.
For children who had had a brother/sister who had been referred to the hospice.

Sibling’s bereavement had been more than one year.

Up to eight children within a similar age range.

The process of setting up this group was very different from the more usual referral procedures, where the referrer usually contacts a music therapist. Here, we sent letters to parents informing them of the purpose of the group, enclosing cards to the children, giving information about what would happen in the group. We sent seven letters and cards and five positive responses were received. Two declined because they were moving out of the area.

This table below illustrates further thoughts, regarding setting up the group and who attended.

Table 17 Bereaved siblings who attended the music therapy group

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th>Place sibling died</th>
<th>Deceased sibling anniversaries (birthdays / death)</th>
<th>Related Childre n attendin g group</th>
<th>Known to Facilitato rs</th>
<th>Own birthdays</th>
<th>Visiti ng hospic e</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>11</td>
<td>M</td>
<td>Hospital</td>
<td>No</td>
<td>Sister</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>B</td>
<td>11</td>
<td>M</td>
<td>Hospice</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>C</td>
<td>10</td>
<td>F</td>
<td>Home</td>
<td>No</td>
<td>Sister</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Objectives of Bereaved Siblings Group

The objectives for this group were adapted from the section ‘Working with Bereaved Children’, found in Pennells and Smith’s book *The Forgotten Mourners* (1995).

- To provide a safe environment in which children feel comfortable to express and communicate their feelings, musically and verbally.
- To provide the children with a safe place to identify, express and become more comfortable with the many aspects of grief.
- To give children tools to cope with grief and assist them in expressing and normalising feelings within a group setting.
- To form new relationships with others who may be in a similar experience.
- Facilitate the children’s understanding of feelings and offer a supportive environment.
- To provide a means of identification with others, to evoke associations memories, imagery and fantasy.

Structure of Group

Each week, a familiar structure was followed. The sessions started with a musical or verbal greeting, then calendars were coloured in. It felt important for the children to have a visual reminder of how many sessions they would be attending. During the first session, each group member made a calendar (a picture divided up into ten sections). Each section would then be coloured in each week. The main part of the session focussed upon one or more of the following:

<table>
<thead>
<tr>
<th>D</th>
<th>7</th>
<th>F</th>
<th>Home</th>
<th>No</th>
<th>Sister</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>6</td>
<td>F</td>
<td>Hospital</td>
<td>No</td>
<td>Brother</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Table 17 Bereaved siblings who attended the music therapy group
• Musical games
• Discussions
• Referential improvisations
• Titled improvisations
• Free improvisations

Each session ended with a musical and/or verbal group interaction. I shall explore briefly elements of the main content of four sessions in order to give an overview of group’s musical and verbal responses. There is not time in this paper, to discuss fully group dynamics.

**Musical Games**

Many of the musical games were adapted from Amelia Oldfield’s book *Pied Piper* (1991), for example ‘warriors and peace makers.’ In session two, the children divided in two, one side chose loud, dominant instruments and others were asked to select instruments that produced quieter sounds. The group played simultaneously and the quieter side tried desperately to make themselves heard, for example shaking egg shakers with great gusto to be heard above the drums. Some children found it so frustrating that they could not be heard, that they gave up and stopped playing altogether. I wondered whether some of this experience was a reflection on how they coped in grieving for their siblings. When told about their sibling’s death they would have experienced the reactions of those around them and perhaps they felt that they were not being listened to or that there was little space within the family for their own grief.
Discussions

Bruscia (1998:9) states that,

Music can provide a nonverbal means of self-expression and communication or serve as a bridge connecting non-verbal and verbal channels of communication.

The children acknowledged that some things were very difficult to explain and improvising seemed to serve to ‘intensify, elaborate, or stimulate verbal communication.’ (ibid.) In session three, two boys discussed how hard things are to talk about, connecting this with their understanding of ‘heaven and hell’ and the reality of their experience;

‘I know why its hard to explain how you feel, cos it’s sort of like, its like to explain sort of, if there’s a heaven or a hell.’
‘Its hard to like believe that there is a heaven. It’s hard to believe that.’
‘It’s hard to believe like, what has happened is real’
‘Yeah’
‘Or you like try and pinch yourself, to see whether it’s all dream or something, I can’t really explain it.’
‘Its like you try and wake up but you can’t, cos she’s not here’

Referential Improvisations

This term is taken from Brusica’s definition that a referential improvisation is ‘one that portrays of represents something non-musical, such as an idea, feeling, image or story’ (ibid.:7). I asked the group to choose instruments that they felt represented their family members in some way. It may have been the shape, texture, size, or sound of the instrument. The children worked independently and when they re-
grouped we found the dramatic similarities in their selection of instruments, shown in the table below,

Table 18  Referential improvisation (session four)

<table>
<thead>
<tr>
<th>Instrument chosen</th>
<th>How instruments were played</th>
<th>Family representation</th>
<th>Verbal reflections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drums, tambours, woodblock.</td>
<td>Slowly, loudly</td>
<td>Daddy</td>
<td>‘Always cross’ ‘Shout a lot’</td>
</tr>
<tr>
<td>Rainstick, ocean drum, windchimes, metallophone.</td>
<td>Quiet, glissando’s, free flowing</td>
<td>Mummy</td>
<td>‘Always crying’ ‘Gets upset’</td>
</tr>
<tr>
<td>Keyboard, egg - shaker.</td>
<td>Precisely, very thoughtful</td>
<td>Sibling that died</td>
<td>‘My sister used to make sounds like this’</td>
</tr>
<tr>
<td>Mixture of above instruments (metallophone, windchimes, keyboard, drum)</td>
<td>A little chaotic, some quiet.</td>
<td>Self</td>
<td>None</td>
</tr>
</tbody>
</table>

From this improvisation and the discussions that took place afterwards, the children realised that each of them had lost a sister. It was interesting to discover that they were not, unlike adults, preoccupied with the sister’s age or condition/illness.

**Titled improvisation**

Following this session, the children decided to improvise freely together, choosing to title their music ‘sisters.’ This was the longest free improvisation, lasting over twelve minutes, undulating continually in dynamics and texture. It felt as if the music was going to stop and then it
would suddenly restart again and again. Figure 2, below, illustrates the first two minutes of the improvisation; solo playing merging into group sound. The spiral depicts the length each instrument played. It is also a way of indicating how the children seem to gather each other up, picking up small rhythmic and melodic ideas from one another. I wondered whether their individual playing was an acknowledgment of their personal grief, which they were able to move forward and share into a group experience.

Figure 58 ‘Sisters’
As discussed earlier, the children seemed to oscillate between talking and playing and vice versa. The music seemed to provide a springboard from which verbal dialogues could take place. They had shown interest in finding out how they had heard about their sister’s death. I have listed below the issues that were raised because of the details with which the children remember the event.

- Where they were and what was in the room, (what was on the telly, computer games, décor of room)
- Who else was there, (and how other family members reacted)
- The time of year (Christmas, near a birthday)
- Who was told first (relatives, other siblings)
- Who told them (mummy, daddy, a nurse)
- What happened next, who were they with, where did they have to go
- How they responded (‘I cried’ ‘I didn’t’) and how others responded around them (‘I saw daddy cry’)
- Finding out why their sister or brother died (feeling that the death was unexpected, unprepared)
- What they couldn’t do (go to school, go to a friend’s birthday party)
- Who found out next, wider family members and circle of family friends, (feelings of chaos and everyone being told and knowing what had happened)
- Seeing their sibling when they had died (temperature of room, smell)

The focus was very much on what happened at the time of their sister’s death and it seemed to reveal how difficult it was for the children to think about what was happening in their family now. This may have been the first opportunity the children had had to share these details outside the family unit. They spoke very openly but did not include any of their feelings or emotions. It
seemed that the role of music within this group was to help turn ‘frozen emotions … into dynamic forms that live in time’ (ibid.:8). This is illustrated in the following extract.

From this figure, you will notice the prominence of the drum and cymbal and also the dip in the music. Before the improvisation the group had been reminded that there were two sessions left. The ending sessions seemed to be come as a surprise to the children and there was a sense that time was running out. The music sounded quite chaotic, with an underlying feeling that there was a ‘battle’ amongst themselves, to find space to be heard. The drum and cymbal played a repetitive rhythmic pattern, which seemed to block out other group member’s music. Moments before the music ‘dipped’ to the solo keyboard (played by the therapist) a child had started crying. The volunteer comforted her and it seemed the group faced the uncomfortable decision, not knowing whether to continue playing or not. The music re-started when child ‘A’ returned to playing the drum and cymbal. The child who was crying did not play but was able to stay in the group. When the music stopped the children reflected how they felt; ‘I couldn’t stop. Every time I tried to go over it was like a shield was blocking me’ said J, which his music had clearly demonstrated. His thoughts of a ‘shield’ seem to depict some form of protection, perhaps he had set himself limits with what he could cope with. Other children also reflected physical sensations, which could relate to the experience of physical manifestations of bereavement,

‘I didn’t feel good,’
‘Neither did I, I felt sick in my stomach, in my mouth, ugh.’

‘I felt chilly.’

**Ending**

Ending the group inevitably triggered emotions associated with their past experiences of separation and saying goodbye (Barnes *et al.*, 1999:96). The final session felt similar to the first with feelings of apprehension and also excitement. To evaluate the group, I asked the children five questions, which they discussed amongst themselves and wrote down comments (see list below),

- **What do you think this group has been about?**
  - Our own music, learning about our sisters, learning to deal with problems.
- **What has been the best part of this group?**
  - Talking about my sister, don’t know.
- **What has been the worse bit about this group?**
  - Don’t know
- **What would you have liked to have done more of?**
  - We would like more talking about our sisters, we would like more music.
- **What would you to happen next?**
  - Come back again, whole group, we could have more, more, more !!! But it won’t be the same (different) I would like to have more weeks here.

The evaluation was a helpful way to assess the benefits of the group and to think about changes that could be made in future groups. The need to have space to communicate their feelings is apparent in their response to question four. It also became clear that the parents needed a separate
space for support and they informally set up their own group while waiting for the children.

**Concluding thoughts**

My hope is that this paper has given a brief introduction to group work with bereaved siblings, highlighting the importance of understanding contemporary bereavement practise and theories, and the affects the death of a sibling has upon a child’s life. Although other bereavement work takes place in children’s hospices, this group was the first of its kind in a UK children’s hospice. It seems that within society one is required to ‘get over’ and ‘move on’ after loss, clichés that do not allow space and time for grief. Within this group there was no set agenda, no programme or theme. Group members had all shared a similar experience and were given space and most importantly time, to express feelings and share information in a non-threatening, safe environment. Other areas of my work have been influenced by this study, as loss in its many forms, is a cardinal issue in all music therapist’s work.

**References**


The Influence of Gamelan (Javanese Traditional Music) on Newborns in Indonesia

Natalia, Johanna
B.A.
Faculty of Psychology, University of Surabaya
INDONESIA

Abstract.

The effects of gamelan (Javanese traditional music) on the emotional responses of newborns are examined. Sixty (60) newborns are divided into experimental and control groups. The experimental group of 30 Ss receives gamelan (Javanese traditional music) from audio tape for 2 days continuously. The control group of 30 Ss receives no music. Each group is observed for 2 days. Results reveal that there are no significant differences in heart rate, respiration rate, and mean crying pattern between the experimental group and control groups. However, weight and sleep pattern are significantly different between the two groups. The experimental group sleep more soundly than the control group. They also gain weight faster than the control group. The subjective impressions of mothers, nurses, doctors, and the researcher are also taken into account in forming the general conclusion that the emotions of the experimental group appeared to be calmer than the control group.

From our adult perspective, birth must be a difficult experience not just for the mother, but also for the baby. Think of all the newborn has lost: a warm, safe environment with a free and constant supply of food, and nothing to estrange him or her from the world. Suddenly the newborn must breathe, eat, and suffer separation from his or her environment.

According to the theories of many personality experts, these extreme changes could cause serious and long term psychological injury (Kartono, 1979). Birth is the most traumatic event in life. Therefore, it is very important to know everything related to birth to help the newborn.
Not just to understand about the physiology, but, more than this, how to give the best treatment during and after birth so that they can adapt to their new environment better (Jonxie, Visser, & Troelstra, 1964).

One of the things the newborn has lost is the sound of the mother’s body: the rush of blood and fluid, the heartbeat, breathing. This music accompanied the foetus continuously since before it could sense sounds. Suddenly it is gone, replaced by the unmediated tumult of the world. Is it possible that the newborn would be comforted by playing some kind of appropriate music?

The first years in a child's life are critical in developing his personality, including emotions. A baby’s emotions can be seen as his or her means of communication with others. He or she expresses his or her feelings, needs, and wants through his or her emotions (Hetherington & Parke, 1983). Feeling is an important thing for a baby (Nordoff & Robbins, 1985). Communication of emotion occurs through facial expression and sound (Carlson, 1986).

In addition, Worthman (Keasey, 1981) suggests that an array of physiological signals including: vascular changes, hormonal changes, respiratory changes, circulatory changes, visual changes, sweat gland changes, and muscular changes can also communicate needs or emotions.

The development of the newborn depends on interaction between biological predisposition and experience that is prepared by the environment (Atkinson, R. L., Atkinson, R.C., & Hilgard, E.R., 1987). Newborns receive many new stimulations. These new stimulations are checked against experiences they have had, including their experiences...
in the womb. According to Piaget, he or she is assimilating, which is one part of his or her adaptation process (Tedjasukmana, 1987).

Newborns can hear very well (Butler & Golding, 1986). According to Meredith, by the second trimester, the development of the foetus is nearly complete. The heartbeat strengthens and its sensory receptors begin functioning. The foetus is sensitive to touch and will react to it with muscular movement. The foetus’ sense of hearing also functions, and it will react to loud sounds in the mother’s environment (Hurlock, 1985). Melson & McCall (Deutsch, 1982) found that the heartbeat of babies changed when they played a melody. A study by Salk (Leach, 1981) shows that a newborn's crying decreases when a record of a heartbeat was played. The researcher assumed that the babies found the recording comforting because it reminded them of the womb. According to Brackbill, Adams, Crowell, & Gray, other rhythmic sounds like lullabies seem to have the same enjoyable function as a heartbeat (Leach, 1981).

Shuter, Dyson, & Gabriel (1982) suppose that children are interested in beautiful sounds since the very beginning of life. But apparently they do not like Rock Music, as evidenced by hard kicks that the baby made in the womb when Rock Music was played (Verny & Kelly, 1981).

*Ki Soetarman*, a gamelan musician from Surakarta (Central Java – Indonesia), says that the most important parts of gamelan are its rhythm and lyrics. They can influence the audience. There are feeling parts in gamelan: *nyês, sêngsêm, and sêrêng*. It is good that someone give gamelan with *nyês* and *sêngsêm* feeling to put a baby to sleep. The rhythm will soothe them so they can sleep soundly.
This research investigates the possibility of maintaining the “music” even after babies are born. It is hoped that the taped music played to newborns could be associated with the "beautiful music" of the womb. They could be calmer because the music reminds them of a very enjoyable place that gave them enjoyable feelings. It could make their adaptation to the new environment better.

Method

The independent variable of this research is the presence or absence of gamelan music and the dependent variable is the emotion or degree of calmness.

Gamelan music is music contained in the Klenengan ACD-014 and ACD-085 (Lokananta Recording) cassette. The music was played for two days continuously with mean sound levels at 65 – 75 dB.

A degree of calmness is the baby’s general emotion reaction pattern which should be stable when he or she feels happy and comfortable in the environment. This can be measured from: (a) heart rate: count of heartbeats per minute which is taken every six hours, (b) respiration rate: count of respiration per minute which is taken every six hours, (c) difference in weight: difference in weight between the first and second days after birth, (d) crying pattern: duration of crying per day in minutes, (e) sleep pattern: duration of sleeping per day in minutes.

The population for this research is normal newborns with an Apgar score between 7-9. The sample for this research is 60 newborns 0-2 days old.
which separate into 30 newborns for the control group and 30 newborns for the experimental group.

This research uses observation techniques to gather data. Observation was carried out for two days. The mothers themselves noted every time their baby started and finished crying. The same was also done for when their baby went to sleep and woke up. Besides this, subjective opinions from the mothers, doctors, nurses, and researcher gave added information about the newborns’ emotions.

The design of this research is randomized to the extent that whenever a baby happened to be born and the experimental room was empty, that subject joined the experimental group, and vice versa for the controls. The data in this research were analyzed using a \textit{t-test}.

\textbf{Results and Discussion}

Results of the data analysis for indicators of degree of calmness in newborns in St. Vincentius A Paulo Surabaya Catholic Hospital appear in the table below:

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|}
\hline
\textbf{Indicator} & \textbf{Control's Mean} & \textbf{Experiment's Mean} & \textbf{t} & \textbf{p} \\
\hline
\textbf{Heart rate} & 117.7541 & 119.3307 & -1.036 & 0.304 \\
\hline
\textbf{Respiration} & 44.9954 & 48.9620 & -2.734 & 0.008 \\
\hline
\textbf{Sleep pattern} & 874.3000 & 988.9000 & -1.782 & 0.080 \\
\hline
\textbf{Crying pattern} & 75.5167 & 81.3000 & -0.378 & 0.707 \\
\hline
\end{tabular}
\caption{Results of the Data Analysis}
\end{table}
Detailed interpretation of each indicator is shown below:

**Heart rate**

According to Arnand & Hickey (*Schwartz, 1999*) The adverse effects of stress in a baby are reflected by heart rate variations, increasing oxygen consumption and decreased blood oxygen levels as well as marked blood pressure fluctuations, failure to thrive, and increased levels of agitation.

Data analysis showed that there was no significant difference in heart rate between newborns with gamelan music and no music. Probably this is because there were too many observers gathering data. It may made different standards among them. Each observer had him/her standard. This weakness may also made the heart rate data not reflected the real fact.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Previous Mean</th>
<th>Next Mean</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control’s weight I</td>
<td>3098</td>
<td>2943</td>
<td>5.834</td>
<td>0.000</td>
</tr>
<tr>
<td>Control’s weight II</td>
<td>2943</td>
<td>2960</td>
<td>-0.588</td>
<td>0.561</td>
</tr>
<tr>
<td>Control’s weight III</td>
<td>2960</td>
<td>2942.272727</td>
<td>2.230</td>
<td>0.037</td>
</tr>
<tr>
<td>Experiment ‘s weight I</td>
<td>3131.333333</td>
<td>3011.724138</td>
<td>4.511</td>
<td>0.000</td>
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<tr>
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<td>3055</td>
<td>-5.477</td>
<td>0.000</td>
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</table>
Respiration

Arnand & Hickey (Schwartz, 1999) said that uncomfortable feelings in newborns were indicated by increasing oxygen consumption. In this research, there was no significant difference between newborns with gamelan music and no music. As with the heart rate, too many observers and the different standard among them may made the data invalid.

Sleep pattern

A baby will sleep more soundly if he feels comfortable (Gunarsa & Gunarsa, 1989). This research supports that theory. There is a significant difference between babies with music and no music (p < 0.100). Newborns given gamelan music sleep more soundly than those who are given no music.

As Ki Soetarman says gamelan with nyêś and sêngsêm feeling can soothe the baby. The rhythm will soothe them so they can sleep soundly. Thus, the research supports the idea that newborns gain some comfort from listening to music.

Crying pattern

The principle form of negative verbal communication between the baby and others is through crying (Hurlock, 1988). When they wet the bed, they cry; to call their mother because they need something, they cry.

Results show that there are no significant differences in crying patterns between newborns with gamelan and no music. Though the lack of difference does not support the hypothesis about the usefulness of gamelan music, note that newborns always cry because they are hungry
whereas the mother’s milk usually does not flow fluently in first days of childbirth. It make the baby always cry. Gamelan music seems not decrease their discomfort because the source of that feeling is in their internal condition (hungry).

**Weight**

Another indicator of a newborn's emotions is good and fast physical growth. If a newborn's emotions are good he or she would drink more. This physical growth is shown by an increase of weight (*Mazie, 1992*).

The graph (Figure 59) below shows that newborns with gamelan music tend to maintain, moreover, increase their weight more than newborns with no music.

**Figure 59 Weight graph**
Calm emotions in general

In general, it could be said that gamelan music tends to affect the emotions of newborns who are in an adaptation period. The degree of calmness of newborns with gamelan music tends to be higher than those with no music.

In fact, statistical analysis shows that there is a positive influence of gamelan music on some indicators related to emotions (sleep pattern and weight). Moreover, from qualitative analysis based on subjective impressions of their mothers, nurses, doctors, and the researcher it was found that gamelan music seemed to make newborns sleep more soundly and in some cases drink more. If observation time were added and observer standards were more strict, the differences between the two groups would probably be more striking.

From this research, it is hoped that everyone who takes care of babies directly could give gamelan music to them, especially to the newborns. Thus, the environment would be easier and have a positive influence on them.

Bibliography


Recording from the Womb. The “Womb Song”, web site : [http://www.asoundbeginning.com/audio1.htm](http://www.asoundbeginning.com/audio1.htm)


**Mini-biography of presenter**

<table>
<thead>
<tr>
<th>Name</th>
<th>Johanna Natalia</th>
</tr>
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<tbody>
<tr>
<td><strong>Education</strong></td>
<td></td>
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<tr>
<td>1986 – 1989</td>
<td>St. Albertus (Dempo) Catholic Senior High School, Malang, Indonesia</td>
</tr>
<tr>
<td>1989 – 1994</td>
<td>Faculty of Psychology, University of Surabaya, Surabaya, Indonesia</td>
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<tr>
<td>Work</td>
<td>1994 – now</td>
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</tbody>
</table>

**Address:**

Office  
Fakultas Psikologi  
Universitas Surabaya  
Jl. Raya Kalirungkut - Tenggilis  
Surabaya 60293  
Jawa Timur  
Indonesia  

Home  
Jl. Pasar Besar 35  
Malang 65118  
Jawa Timur  
Indonesia
Thanks and dedications

I dedicate this simple work to those who are very meaningful and very influential in my life:

1. Cyrillus Anondo Siswojo, my late father
2. Elizabeth Triasih Widjaja, my mother
3. Johannes Tjahjono, my brother
4. Cyrilla Siswajanti, my sister
5. S.M.A.
6. Fr. G.A.M. Harjoko, O.Carm, my late family’s spiritual director
7. Fr. Albertus A. Herwanta T.W.N., O.Carm, my spiritual director

Thanks for having made me as I am …

Thanks to Prof. Dr. Erwin Sarwono, M.D. who always supports me to develop …
Also
Special thanks, of course, to Denise Grocke, B.Mus, M.Mus., PhD., RMT., MT-BC, FAMI for her kindness to support me to go to the international world …
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 medical and psychotherapeutic intervention. 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, and its theoretical background are presented in this article.

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 treatment 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

Theoretical background

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 therapy 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 21  Goals according to the phase model by Lueger (1995)

<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>
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<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>
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<td>Activation of “remembered well-being”</td>
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<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>
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<td>Phase II: Improvement of symptoms (5 sessions)</td>
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<td>externalization of pain in music increase of musical flexibility</td>
<td>Symptom improvisation Variation of musical parameters</td>
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<td>imaginative activation and reproduction through music</td>
<td>Ritual improvisation Daydream improvisation Musical family symbolization</td>
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Case study

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.

Table 21 Goals according to the phase model by Lueger (1995)

<table>
<thead>
<tr>
<th>Phase III: Improvement of general functioning (3 sessions)</th>
<th>Learning and implementation of flexible/alternative forms of behavior and experience</th>
<th>Training of adequate forms of interaction through non-verbal techniques</th>
<th>Reality improvisation and Musical role play</th>
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<tr>
<td>Generalization</td>
<td>Stabilization of therapeutic accomplishments and preparation of end of therapy</td>
<td>Musical self-portrait and treatment evaluation</td>
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</table>
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 considerably, 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  
Tel: 06221 / 83 38 60- 68  
Fax: 06221 / 83 38 74  
e-mail: anne.nickel@fh-heidelberg.de
Verbal Processing in Music Therapy

Nolan, Paul
M.C.A.T., MT-BC, LPC, Director, Graduate Music Therapy Education
Hahnemann Creative Arts in Therapy Program, Drexel University,
Philadelphia, Pennsylvania, USA

Introduction

Verbal processing, for the purposes of this paper, relates to the talking that facilitates the therapeutic process during, and in response to, music making or music listening. It allows for an opportunity to integrate non verbal with verbal realms of expression, such as when a client develops a connection between interpersonal events experienced in the music and patterns that occur in his or her everyday world. (Nolan, 1989, p. 177) Verbal processing also provides the client with the opportunity to give voice to formerly inaccessible, or not yet fully conscious, affective and cognitive material brought into awareness through musical means.

Generally speaking, verbal processing in music therapy is used to 1) further the continuation of both, client awareness and interpersonal processes initially stimulated by musical experiences in therapy; and 2) to re-enter the music with an enhanced readiness to further explore where the music and the relationship may lead. Sometimes the therapist verbalizations serve as inquiries, or questions, other times as interventions or interpretations. The clinical videos used in this presentation at the 10th World Congress of Music Therapy use both questions and interventions. They illustrate some of the ways that verbal processing contributes to client and therapist understanding of the
affective, cognitive and relational material which surfaces during the musical experiences in music therapy.

Verbal processing may occur in a wide range of expressive approaches. At times the verbal processing may include only the therapist’s words or may occur in the form of client or therapist spontaneous singing. It is not restricted to spoken discourse. It is not a translation of the musical events into words. Therapist and client discussion ought not to shadow the aesthetic, spiritual and other ineffable manifestations of the music therapy experience. In some music therapy orientations, or approaches, it is believed that verbal processing is contraindicated or unnecessary due to the tenant that the musical experience intrinsically contains all that is needed for client change or growth. Within forms of music therapy which use verbal processing there is the risk that talking interrupts the musical process or may serve a defensive function for the therapist.

This paper is restricted to music making and music listening forms of music therapy. Guided Imagery and Music, which uses verbal exchanges before, during, and after, the music listening, sometimes into the next session(s), will not be included in this short paper. The reader is referred to Goldberg (1995) for an overview of the Guided Imagery and Music Process and for examples of the verbal exchanges within that form of music therapy. It is hoped that this initial exploration of this topic will generate additional follow-up in such areas as how verbal exchanges, including verbal processing, vary within the different models of, and approaches to, music therapy.
Background Literature

Stark and Lohn (1989) found several ways that therapist verbalizations enhance the integrating effect of dance/movement therapy by connecting the individual’s movement expression and experience to conscious understanding (p.111). Their article provides many purposes for therapist’s verbalizations during therapy sessions that are valuable for the music therapist. Literature devoted to this topic in music therapy seems scarce. Although a great deal of the published case reports of music therapy describe verbal discourse during various segments of the therapy session, there is very little published which sets out guidelines, methods, or suggestions for verbal processing of the musical events in therapy. At best, portions of clinical articles give a glimpse of the therapist’s thoughts about the purpose, or function, of verbal processing. Music therapists typically encourage discussion regarding both the musical events as well as the client’s response to the musical events. Some therapists use listening to a tape recording of the music as part of verbal processing.

In reference to the discussion following music making, Bruscia states, “the discussion enables the improviser to project the feelings expressed musically onto the words and to consolidate them into more clear – cut and manageable forms.” (1987, pp. 561-562) Priestley, whose use of verbal processing in Analytical Music Therapy is summarized by Bruscia, (1987) develops client verbal responses to the improvisations in terms of the “outer” (events in the music) and “inner” (emotional and associative responses) experiences. Often listening to the tape recording
of the improvised music allows for the feelings expressed musically to be translated into words (p. 128). Nolan (1989) found verbal processing to be an important aspect in working with women who have eating disorders. Verbal processing of the musical experiences in groups allowed for exploration of their roles within the improvisatory music group and enhanced reality testing. With the addition of listening to the tape, verbal processing helped in disrupting cognitive distortions while enhancing group cohesion (pp 177 –178). Gardstrom (2001 offers didactic suggestions on the therapists use of verbal processing, which she refers to as a “complimentary skill” in musical improvisation. She describes the use of a verbal counseling approach known as a “probe”. Gardstrom finds the probe to be helpful to “acquire information about another individual’s experience.” (p 85) The probe is identified as one of ten verbal response skills in the human relations counseling model. Gardstrom divides examples of probes as questions within a variety of domains such as cognitive, physical – motoric, and emotional. Although the probe appears an open – ended inquiry, Gardstrom suggests that the probe does not always need to be used as a question. Amir (1999), following her qualitative analysis of musical and verbal interventions used by 6 music therapists she states that “musical and verbal interventions make up the music therapy process. These are two different modes of experience and communication that complete each other” (p 169).

The primary purpose of this paper is to encourage music therapists to develop ways to facilitate verbal processing using exploratory questioning, interventions, and structuring approaches as a part of the
therapeutic relationship. To help us keep therapeutic technique in its proper context Stark and Lohn cite Strupp, a psychotherapist, who found that the degree of empathy in the therapist was more important than a particular verbal technique or therapeutic activity (p.105).

**Verbal Processing as an Intervention**

Below are some of the purposes for verbal processing in music therapy. It seems that most of the examples that I have found in the literature represent the use of verbal processing as a method of inquiry used by the therapist. These questions seem to serve the purpose of allowing the therapist to learn something about the client. The statements below suggest ways that verbal processing can serve as interventions within a wide range of therapeutic orientations or styles.

1) **to elicit a verbal response relevant to the music experience.**

This is important in working with people who have dementia, psychosis, mental retardation and other disorders that have restricted cognitive processes as a clinical feature. This purpose is also relevant for clients with speech-related disorders. Since music seems to activate several areas of mental functioning, inhibiting verbal processing may be defeating the purpose of enhancing client functioning during music therapy,

2) **to establish or increase awareness about:**

   A) **music**, including the physical, emotional, or overall aesthetic experience, memories or other associations. By speaking about these they become more real in a cognitive way whereby the client can accept and
own the emotional experience while in the presence of another (the therapist).

B) one’s musical behavior, such as how he or she fits in with the overall music, where in the musical experience did the client feel comfortable, and how one’s musical choices is relevant. This realm can be a pre-interpersonal way to experiment in relating to others thru the music.

C) the interpersonal process in the music, both the client – therapist relationship and between members of a therapy group are integral to the inherent healing

D) the inner process. This can include the relationship between the musically experienced self and the verbally experienced self. This distinction is based upon the assumption that the musical self often reflects a higher functioning person than the verbally expressed self (Nolan, 1994). One outcome of verbal processing while listening to the tape of the music from the session is to help further integrate these two experiences of the self; (Nolan 1989)

3) in groups: facilitates Yalom’s “curative processes” (1995). This depends upon the level of functioning of the members of the group and the length of time available for treatment;

4) to allow a client to more fully experience a change of thinking or feeling as so the client may discover, accept and “own” the felt change in her or his response to the music therapy experience;

5) to return to a more defended state. A basic understanding in music therapy is that music frees up one’s defenses. Clients in vulnerable
situations, such as in medical hospitals, prisons, or in situations where there are expectations placed upon their behavior following the music therapy session, can use this supportive purpose of verbal processing as a way to gradually shift mental states from a process – oriented state to a content – oriented focus.

**Facing the Silence**

I agree with Gardstrom when she states, “one of the greatest challenges faced by music therapy students is the developing of verbal processing skills” (p.84). Indeed, students seem confused, fearful, and intimidated when they are met with silence after a music experience in therapy. Why is this not usually the case when they are faced with initiating a musical process with their clients? Perhaps factors related to the therapist’s sense of control play a part in this temporary anxiety that they experience.

Music therapists begin as musicians and usually music becomes a way for ourselves to be heard in the family. When we played music at home we had some control of the shared auditory space. Our family members usually could not avoid hearing us, and, hopefully, they often enjoyed hearing our music. We, like others, are often not as successful in being heard through the use of words alone. In music therapy we are comfortable in creating a space where we and our clients are encouraged to hear each other and we model for our clients a level of comfort within this medium. I frequently hear music therapy students ask, “what am I supposed to say” when they face the silence after the music. Yet, I rarely hear them ask “what am I supposed to play” in initiating a musical interaction. Perhaps we are seeking the level of control that we feel in the
music within the verbal realm as well. We may find it to be threatening to not have that control, especially in our role as a therapist.

Amir (1999) places emphasis upon the transition from music to words and suggests that this very same silence be heard as a non verbal communication. In this way, it can be an effective bridge to the verbal mode. Clients and therapist can take a breath in this silence as a way to shift mental states. Music therapists, in their relaxation from this centering use of a breath, may begin to experience for themselves that they may not have to do anything. In the silence, simply being in the role of the therapist is doing something. They may then find that many times, out from the silence, the client begins to speak about the musical experience. This can place the client in an active role, rather than as the passive respondent to the therapist’s inquiries. Israel Zwerling, the noted psychiatrist and advocate for Creative Arts Therapies, stated after hearing a music therapy clinical case presentation that there seems to be a neurological process which triggers a desire to speak after making music.

The therapist’s voice, when it initiates verbal processing, ought to be heard as coming from the music it follows. Reflecting the dynamic level, timbre, energy level and even the phrasing can provide a smooth transition and preserve the mood qualities while entering into the verbal realm. Sometimes commenting on the music holistically, without having to introduce questions, serves both to acknowledge the musical experience and allows for client – to - client or client – to – therapist verbal communication.
Directions of the Therapist’s Words (or “where is the therapist going?”)

Before we speak in a therapy session we ought to know what it is we want to learn about the client or what it is we want to communicate to the client. It often helps to ask ourselves, “in what directions are our words heading”? I have intentionally avoided including into this paper specific statements or questions to use in verbal processing. It is hard to imagine a prescriptive series of questions to be interchanged and used following all musical experiences in therapy! The music therapist must choose her or his own words and inflection based upon what is important to address. Is it our intention to gather information, test an observation, attempt to stimulate inter group discourse, provide feedback or structure to a client?

We are able to use verbal processing on a variety of levels depending primarily upon the reason for treatment, treatment goals, the therapeutic contract, and any other parameter which structures the direction of therapy. In addition, the client’s cognitive, emotional and communicative resources are also major considerations that guide the therapist’s directions for the use of verbal interventions as a part of verbal processing.

1) Orientation: the therapist, or the client, is making a decision about an aspect of the musical experience, deems it to be relevant, and directs attention toward that aspect. This orientation can also be directed to the music, the self in response to the musical experience or to the overall therapeutic setting, or field, as well.
2) Validate: the client’s observations, feelings or appraisals are confirmed within the music and within the musical relationship.

3) Connecting the client: links a musical expression to a feeling, memory, image, or symbol or to connect a musical expression to that of other people in the group,

4) Interpretive: the therapist or the client gives a response to the music or a response is given to a statement made by the client in order to connect with, or get closer to, a larger issue related to a treatment goal.

5) Supportive: therapist builds upon a client strength. The therapist offers positive feedback to build, or strengthen, ego functioning and encourages client awareness of these strengths.

6) Confrontation: therapist refuses to participate in the reality as expressed by the client because it moves away from the client’s experiencing of her or his growth or potential.

**Pitfalls to Avoid / Ways to Nurture the Processing**

There are clear distinctions between therapist verbal behaviors and attitudes that facilitate or block therapeutic processes. During the World Congress conference presentation the participants join with the presenter to create a list of therapist verbal and non verbal behaviors during verbal discourse to avoid. This list of Pitfalls to Avoid is followed by a list of approaches which may nurture verbal processing. Some of these items appearing in the lists below derive from supervision groups, supervising music therapy interns as well as from my own clinical experiences. It is quite possible that some of these items, given a change of context, may
not belong in their list. However, for those who are beginning to delve into more intensive verbal processing these lists may serve as a preliminary guideline. Several of the following “Pitfalls to Avoid” items will be familiar to clinicians in that we know that they are areas we ought to avoid but we often catch ourselves heading in that direction.

**Pitfalls to Avoid:**

1) in a group setting, do not conduct the verbal processing as several consecutive one – on –one interviews, conversing with one client at a time before proceeding to the next client.

2) avoid asking more than one question in a statement.

3) avoid changing the verbal processing into an interview;

4) avoid responding to the countertransference – induced - “therapist”-voice inside our head which tells us to “act and speak like a therapist”,

5) avoid making the music therapist become the main focus in the verbal processing,

6) avoid feeling responsible to provide the “answer” for the client,

7) avoid limiting your attention to the highest functioning client in the group,

8) don’t believe that the “real therapy” takes place only during the verbal processing

9) avoid talking for much longer that 20 seconds at once, (thanks to Michael Rohrbacker!)
10) avoid the providing of interpretations to clients just because they have arisen into your own consciousness,

**Nurturing the Processing**
1) provide validation and statements of empathy,

2) make connections between a client and the rest of the group,

3) inhibit your own need to talk,

4) make statements about the music which are supportive and true,

5) make comments about the whole musical gestalt to help clients begin to speak about the music and of their involvement or responses,

6) allow clients to first discuss what it was like for them to play the music; discuss their roles within the music and their awareness of the own, as well as the other, instruments and of the people playing them,

7) try to avoid questions about feelings until the client has led the discussion into that direction. The premature linking of a client’s musical behavior with a feeling, or vice versa, can often times seem to be confrontational and may result in client resistance,

8) know when to back off and avoid power struggles and do not take aggressive or resistance statements personally,

9) before making interpretations consider the client’s overall patterns. Do not make an interpretation based upon one behavior,

10) when the group is engaged in supportive, relationship - building verbal discourse, do nothing, but stay present,
11) encourage clients to link verbal statements to the preceding musical events when there are similarities,

12) encourage clients to speak to each other, not just to the therapist.

The music therapist who wishes to develop skills in verbal processing can benefit from the study of group therapy methods. However, facilitating verbal processing in music therapy is different from conducting traditional verbal group therapy because of the influence of the music upon each client as well as upon the therapist. Also, one goal of verbal processing is to re-enter into the music. Music therapists will enhance their verbal processing skills by understanding how musical expressions, or musical behaviors, within the music therapy relationship integrate with other realms of conscious and unconscious human experience.

Perhaps future areas of inquiry will include an investigation into how musical processes influence verbal processing. Additional attention into how we use our words can benefit our therapeutic effect while providing for a greater understanding as to how our clients are affected by the musical relationship.

**Summary**

Verbal processing, the therapy-based verbal communication between therapist and client during and after the music making or listening experiences in music therapy, seems to occur in most models of music therapy applications. It is considered to be an essential competency by the American Music Therapy Association. Verbal processing is
demonstrated in an overwhelming amount of the clinical case study literature, yet there is very little written regarding suggestions, guidelines, or the development of technique. Verbal processing serves therapeutic goals in allowing the client to add form and cognition to affective, imagery, symbolic and other phenomena from being in the music with the therapist. Verbal interactions within, or following, the music can provide shifting of ego states, heighten client connectivity with others, enhance reality testing, as well as provide the therapist with additional evaluative feedback of the effect of therapy. Music therapists, through education, supervision and experience can learn methods to consciously choose wording and processing directions to limit drifting into countertransference.

References


**Suggested Reading:**

From South Devon to South Africa- Music Therapy in Palliative Care

O’Kelly, Julian
Senior Music Therapist, Rowcroft Hospice

In this paper I would like to share my thoughts on what we might learn in western palliative care music therapy, from the way music is utilised in traditional African society, where music connects strongly with both the spiritual sphere and with a strong sense of community.

In my work as a music therapist for Rowcroft Hospice in rural South Devon, I have been inspired by a visit to our twinned hospice, which operates in the rural area surrounding Port Shepstone in South Africa, by a recent encounter with an African shaman in Ashburton, and by an encouraging post modernist and cross disciplinary thread being spun by writers from music therapy, musicology, and ethnomusicology. Writers and clinicians such as Gary Ansdell, Penelope Gouk and Simon Frith move on from structuralist / rationalist mind sets to embrace and learn from diverse musical cultures, sharing a common view of music as a social process.

In many ways, Gary Ansdell’s thought provoking article in the BJMT ‘Musical Elaborations- what has the new musicology to say to music therapy?’ has inspired my thinking, providing theoretical pointers to a new ways of conceiving music therapy; an open minded approach best described by Ansdell himself as:
• A critique of *rationality* itself: of the perceived certainty that more ‘knowledge’ and ‘reason’ yields more truth...that the confident perspective of the Dead White European Male can be relied upon. Instead comes a pragmatic ‘practical reason’ and intersubjective ‘truth –within-a –situation’.

• A critique of generality- a backlash against ‘totalising systems’..and generalising (scientific) explanations. Instead is an emphasis on the local, specific and unique nature of human events.

• A new vision of man, defined more in terms of relationship than discrete essence- and of the primacy of information, meaning and signification in the human world.

Ansdell feels that a new metaphor for music should inform us as therapists. Instead of ‘structure’ we should turn our attention to ‘ecology’ as a guiding metaphor:

‘An ecology is a balance of linking forms and processes in a context that sustains them and guarantees diversity’ (Ansdell 1997)

Norwegian music therapist Trygve Aasgaard, elaborates on this metaphor in a recent article exploring his work in palliative care:

‘I use the metaphor of “ecology”, whose etymology is the Greek word for “home” or “household” to stress the interdependency between the patient and other people- relatives, staff, even other patients- and between people and other environmental factors in a hospital’ (Aasgaard 20001)

**African ‘Music’**

In many African cultures, there is no word for music- it is so interwoven with everyday life- dance, celebration, ritual and spiritual activity that you find our conception of music is subsumed within a more inclusive
word such as the Swahili/ Bantu term ‘ngoma’. To quote the Danish ethnologist Steen Nielson:

‘Ngoma’ is a Bantu word, but it appeared that its primary meaning is “drum”, “dance” and “festivity”- all words having something to do with music, but according to our concepts other things as well. The inner coherence in the concept ngoma is so strong, however, that it really is impossible to isolate music from other elements’ (Nielson 1985)

By attempting to directly compare the Western use and meaning of music with the African we are confronted with how far removed we are from a society which draws so much performance and participation in music, as we did ourselves in pre-renaissance times. There have been encouraging changes in the last few decades; pop culture and post modernism have expanded participation in music making away from only the reified realm of the composer, sight reader and concert hall attendee. However it is hard to find many examples of music playing a central and unifying role in community life in Britain today, unless we look to perhaps the community of football supporters during our recent attempts at world cup glory!

**Spirituality and music therapy in Africa**

‘Africans do not see their music as a comfortable art in which one can bask and enjoy, but rather as a powerful force of divine origin’ (Dauer 1969)

In Africa, there is only a small contingent of music therapists working within the parameters of music centred / psychodynamic or behavioural models, and yet we find a widespread use of music in healing
ceremonies, rituals, and exorcisms. Although inextricable from pantheist and monotheist religion, these practices work towards similar goals as western music therapy. This phenomenon has been highlighted recently by Dr Anthony- Ekemezie Mereni in his research into African traditional music therapy. In his article ‘Kinesis und Katharsis’ he explores the connections which may be made between traditional African, and western music therapy practice. His conclusion also provides us with a broad overview of how music is linked with spirituality in this work:

‘..recourse is made to music not only for the direct purposes of healing in the cases of ailments that Western pathologists would place in the category of psychosis and neurosis. In several instances, no serious medical intervention or medicinal prescription may start unless the gods/spirits are first directly contacted in order to ascertain the correct intervention to be undertaken. This practice represents the much-discussed use of music in oracle and divination rites….

Whatever the case, the role of music is to reorganise the personality of the recipient, to alter his or her state of consciousness placing him or her in the right mood for psychological transformation’ (Mereni 1996)

To paint a fuller picture, I could now quote from the accounts of writers such as Janzen and Friedson on the use of music in African healing, across various regions of Central and Southern Africa. However, my interview with Chartwell Dutiro, a Zimbabwean musician, Shaman and PhD ethnomusicology student residing in Devon, echoes much of the information which can be gleaned from the literature, but perhaps in a more authentic manner. The mbira he refers to is known to us somewhat
derogatively as a ‘thumb piano’- a small instrument of ancient African origin, with rows of hand forged, tuned metal keys. Like ‘ngoma’, ‘mbira’ seems to be an inclusive term referring to the performance of the instrument in both spiritual and secular contexts.

To my question ‘what can we learn from the central role of music in his native Shona culture’ he answered:

‘I’m not sure I can pin down your question in terms of answer. I don’t want to sound like I’m patronizing, like cultural imperialism or something, I just have to explain as a Shona person growing up in Zimbabwe. Music is total to me; it is everything- I can’t do anything without music. Mbira is a sacred instrument...Mbira has never been written down, it has been passed from generation to generation. And when we play mbira we play mbira in ceremonies; not only ceremonies, sometimes for pleasure- we play mbira in different occasions.

I would like to specifically explain the mbira. Mbira is a ceremony where we play music for the whole night, and where I grew up, mbira is the central point, but in other parts of Zimbabwe, people can sing and drum too in a ceremony.

The mbira calls the spirits of the ancestors to come and posess on the people who are living. When I talk about possession here, I know possessed has been, sort of overloaded with wrong explanations, because when I talk about possession it might sound like Dracula, or something like that, but here I’m talking about the spirits of my ancestors, my great grand father or great grand mother..the spirits come and then they possess
on someone, and then they talk through this medium to the living, and they give them guidance...daily guidance.’

Chartwell continued to explain how this guidance might be to do with matters of nature, health, relationships or business matters.

Hoping to make some connections with non-spiritual conceptions of music and music therapy, I then asked him if he was able to separate the spiritual elements of his work in explaining the social and therapeutic function of music, as illustrated in participation and performance of mbira music. He replied:

‘I can’t, and I tell you why...I’m like a messenger. Even now in my house before I go out and perform, I have to kneel down in my little shrine and ask the ancestors...I say to them “may you loosen my fingers, so that I play the instrument properly”, and if I don’t do that it won’t be a good gig in so many ways...but if I do that it’s like magic, some of the things that happen when I am performing that are beyond my control. I can’t say it belongs to me because if I say that, I would have a very big ego because some of the things are quite magical’

I was wondering if Chartwell could explain our western thirst for music of other cultures, especially African, as evidenced by the popularity of festivals such as Womad, the sampling of African music in pop and ‘New Age’ music, even in television commercials:

‘I think it’s the spiritual aspect. You know when I talk about playing music for the whole night it sounds like we are just playing music, it’s more than that – it’s rhythm of life. It’s the community.'
When we play music, we are looking for this rhythm of life really. And when people sing together like that, music is like the platform for all these people to express themselves, so in Shona music, you might have a fixed set of lyrics, but once you do that, people express themselves, though the music, spontaneous lyrics. I might just wake up here and sing a song, and my wife would know exactly whether I’m in a good mood, because of the lyrics I put in the music. At the same level, it’s also a way of identifying culturally with this common thing which is spiritual. So people gather as a family as a community, and that’s the thing that has disappeared in the west.

I teach in schools, I talk to the children, and say when we eat in Zimbabwe we eat together. I say I’ve got two brothers and a sister..we all eat in the same plate, and we wash our hands and we share..nobody should be greedy, and they say ‘‘oh I couldn’t do that with my brother or my sister’’- and when I ask why, they say: ‘‘because they are greedy’’ So you find out that there is too much individualism- each one, its about “me, me, me’’

**The South Coast Hospice**

Rowcroft Hospice is officially twinned with the South Coast Hospice in Port Shepstone, South Africa, which I was able to visit recently with a view to both an raising awareness of the role of music therapy in palliative care, and learning as much as I could about traditional African life and music.
After a week of providing workshops and lectures for staff and patients at the Hospice, I was given the opportunity to spend time with nurses and community care givers, who provided much needed assistance to those living with Aids in the surrounding rural areas.

The Aids problem affecting primarily the poorest black populations of South Africa has far exceeded the worst projections made by health experts a decade ago. By the South African government’s own estimation 10% or 4.7 million people were affected in 2000, a figure that is likely to have risen considerably now. Latest figures compiled by the South Coast Hospice, which serves the worst affected area of KwaZulu-Natal suggest that as much as 40% of this region’s population is now HIV positive (South Coast Hospice 2002). This figure is more likely to be even higher given the stigma attached to diagnosis.

In the face of such enormous challenges, the nurses and caregivers provided me with a salutary lesson in the important role both spirituality and music might play in this setting. At 7.30 am, following a discussion of the community visits planned that day, a sudden hush fell over the ward meeting room. With a powerful voice the leader of today’s team, Sister Francisca began singing in her native Zulu tongue. Before long the whole room erupted into song with all the staff providing rich harmony to Sister Francisca’s lead. Francisca later translated this gospel song to me, which was sung to both encourage the nurses to be mindful of the work that lay ahead, and ‘bond’ them in a unique way:

Remember Me O Mighty Lord
When I cross the sea, and it raises its waves against me
When its danger is drowning me
When my days are numbered
When I am coming closer to the end
Let me see you oh lord
And let me grow closer to you

Singing was very much part of the daily routine for nurses at the Hospice- they would also sing in the community transport vehicle, and sometimes with patients. This type of activity appeared to offer a great spiritual and emotional support to the staff.

I also felt the singing, especially when witnessed or even when heard in the background, could potentially benefit both ward and community patients. When Aasgaard explores the concept of ‘music environmental therapy’ he could easily be discussing the above:

‘Musical activities can create new relations between the participants…to see authorities absorbed in some artistic or musical activity helps to humanise the impression that patients and relatives have of those in power’ (Aasgaard 1999)

Later in my visit, I was given a tour of the local orphanage run by catholic nuns, the Thembalutha Children’s home. By now I had visited aids patients in the poverty stricken rural areas, witnessed some very distressing scenes which I will never forget, and felt very much like a powerless observer. Using music therapy, as I understood it seemed to me rather redundant when encountered with so many families coping with the double bind of extreme poverty and an AIDS epidemic.
A secondary problem of course is the huge numbers of children left parentless, sometimes with only frail grandparents to care for them, sometimes at the mercy of an over stretched social service and charitable sector, providing them with placements such as this children’s home. The loving care they received from the nuns was plain to see, all the more remarkable given the few resources they were able to utilise in this work.

At the end of the tour, I was able to spend some time with the children. The connection I was able to make, though simple rhythmic play and vocalisation (few of them spoke any English) was for me a spiritual experience hard to articulate in words- hopefully the following goes some way to describing what happened:

In the bare main room of the care home, a circle of 8 children ranging in ages from 3 to 13, most HIV positive, were all joining in with a musical game. The game appeared to involve a complex clapping rhythm, dancing, and taking turns to be the ‘the leader’ in the middle of the circle, where each child would improvise their own dance. Keen to be involved in this exuberant performance, I began copying their clapping rhythm, with the addition of a loud syncopated clap, which they soon noticed. Without any instruction, they all turned to face me, and began echoing the different rhythms I clapped with uncanny accuracy, copying subtle changes in dynamics and my body posture- there was no catching them out!

At once I had the feeling of being ‘let in’ to their world, through our shared music, and also gained a sense of how transcendent such simple music could be in this context. The musical games played by these orphans, which I felt privileged to be part of, seemed to bind them together as a family, providing fun and laughter, self and group expression. In many ways the experience reminded me of music therapy group work, and yet the sheer spontaneity of the event, and the sense in which it sprang from such a vibrant musical culture, also reminded me how far we are in the West from this type of connection with music.
I’d like to summarise at this point what these experiences have shown me about how music is utilised in traditional African culture:

- For many Africans, music is, to quote Chartwell ‘total’, an integrated experience which permeates everyday spiritual and secular life.
- Music plays a vital role in bonding communities and family relationships, and in providing group cohesion and identity, for example in the singing of the South Coast nurses, Chartwell’s sung communication with his wife, and in vocal/instrumental performance in healing rituals.
- As a consequence of the above, music which carries therapeutic value seems to occur everywhere, not just in the music therapy room or in private listening, and often quite spontaneously as I experienced in the children’s care home.

On my return to England, I was determined that my African experience was not to become a mere memory, but that it might inform my future work. Witnessing the way music ‘is’ in Africa has encouraged me to explore ways of extending the therapeutic value of music beyond my well equipped therapy room at Rowcroft and also to be more mindful of the potential benefits of working with family members and carers.

‘Music in the Chapel’ the Rowcroft In-Patient Music Therapy Group

Inspired by my African experience, and the idea of ‘music environmental therapy’, I began by establishing a weekly music therapy session in the Hospice Chapel, which is conveniently located near to Rowcroft’s 18 bed inpatient unit (I.P.U). My music therapy studio is situated near our day hospice, which is often a prohibitive distance for inpatients, especially those who are bed-bound.
At any one time depending participants wishes, this group might be creative, recreational, receptive or reminiscence based, with an ‘open door’ policy, so patients, relatives and staff are welcome to come and go, choose songs to sing, music to listen to and share. The ‘open door’ also allows for the sound of music making to subtly permeate the ward area. However, especially when improvisation provides the basis of the group, I close the door prioritising a safe closed therapeutic environment over the benefits of the ‘music environmental therapy’ touched on previously.

The following example accounts for one such occasion involving three generations of one family- a 55-year old woman bed bound and in the terminal phase of her illness, her daughter and mother. The Case Study also highlights, in my view, the benefits of a flexible approach utilising both recreative and improvisational techniques, rather than subscribing to one ‘totalising’ music therapy approach.

During my weekly visit to the inpatient unit, where I attempt to introduce myself to all patients, I met Mary; a woman whose wonderful sense of humour and positive out-look on life belied the harsh reality of her situation. Mary was nearing the end of her long struggle with breast cancer and she would soon leave behind her 80 year old mother, Edith, and daughter Jane, in her mid 20’s.

In our first encounter, Mary seemed very interested to talk about music; for some time she had collected recordings of chamber music and medieval plain song, which she found particularly soothing. She agreed to come with me to the chapel and share with me some of the CD’s she was listening to. At this point, Mary shunned the idea of improvising on any of the range of tuned and un-tuned percussion instruments- she felt ‘ too self conscious’. However, the process of listening to and sharing her favourite pieces, enabled her to talk in some depth about the feelings the music brought up for her- and memories, both happy and sad.

During this first session, utilising music listening or recreative / receptive techniques Mary spoke of her concerns for Edith and Jane.
She wished they had not had to suffer such a painful ‘long goodbye’—her life with them for the last two years seemed to have consisted of many visits by them to hospital and hospice wards, or caring for her medical needs at home. With this in mind, I suggested they all came to the chapel for my next weekly session, in the hope of facilitating, if only for a while, a meeting which might connect with Mary’s ‘healthy’ side.

For the family session that followed, the nursing team assisted me in moving Mary’s bed into the chapel. She began by surprising all of us, by sitting up and demonstrating considerable energy and rhythmic ability as she played a set of African drums by the bed. Soon, Jane joined in on a large xylophone, followed by Edith, echoing Mary’s rhythm on the snare drum. Then I in turn supported the three generations at the piano, providing harmony and counterpoint to the improvisation whilst attempting to reflect the enthusiastic style of their playing. After a while, it was hard to tell who was following who—the music seemed to have a life of its own. This spontaneously created music lasted an astonishing forty minutes, after which Edith claimed she felt like they were ‘an orchestra’; sentiments echoed by Mary and Jane.

This case study illustrates that however far removed we may be from the inclusive nature of music in traditional African culture, we should not be afraid to draw on the ability of spontaneous music making to bring individuals or family members together at a difficult time. The success of this family ‘musical meeting’ typified by mutual response, free expression and creativity inspired and gave me courage to suggest music therapy to many families since. Participants are often surprised with the unique way in which improvisation can bring family members closer together, and illuminate the ‘healthy’ aspects of the physically ill family member in a meaningful way. Indeed some time after Mary passed away, Jane requested a recording of this session, which would appear to have offered both Jane and Edith a positive memory of Mary at a time when the balance of attention could have easily been dominated by her illness.
Palliative Care Music Therapy in the South Devon Rural Community

The catchment area of Rowcroft stretches 50 to 60 km into the beautiful rural area of south Devon. With the help of the Towersey Foundation, a charity dedicated to supporting music therapy in palliative care, I have run community groups for palliative care clients and their carers in village and church halls in these outlying regions. One aim of these groups is to make music therapy more accessible to those in the outer reaches of the catchment area, who may often be physically weak and find transport problematic.

During one day I may make several home visits to a clients, or sometimes a bereaved relative, which may or may not involve music therapy. By doing this, I have found a good ‘trade off’ is often made whereby losing the benefits of my well resourced therapy room are compensated for by the security and control offered to the client from receiving music therapy, or simply a supportive conversation, in their own home environment.

The morning visits are then followed by a group session in a community hall utilising a mixture of creative and receptive techniques, with attendees often drawn from the morning’s home visits. Also present are volunteers, and sometimes a community or Macmillan nurse to help group members with any special health care needs. One nurse commented on how useful she found meeting her patients in this informal group setting, noting how some found the relaxed setting more conducive
to expressing their feelings to both her and other group members, in contrast to the hospital or even hospice setting.

These groups also utilise to benefits of community music. To close the group, I often draw on the skills of local musicians to provide an additional musical experience for attendee’s – this might range from a harpist, a school music ensemble or members of the local brass band. In doing this my aim is to provide a positive musical experience for clients who may find attending music concerts problematic depending on the nature of their illness.

‘Changes’- a Family’s Story

Finally a recent example of work with the 13-year-old daughter of a Rowcroft client, which is indeed family’s story over the last 6 months of the father’s life. The father who I will call Jim was a regular attendee of both creative groups I ran for the day hospice, and later my inpatient groups. I met Jim just prior to a discharge from the in-patient unit at Rowcroft. He had surprised us all with how he had recovered so well from a period of illness related to his brain tumour- indeed well enough to take part in a sponsored cycle ride some weeks later. His family were of course very pleased to have him home once again, however Jim discussed his concerns regarding his 13 yr old daughter with me, before leaving the unit (I will call her Kate).

Recently, Kate had begun shutting herself away, slamming doors and appearing withdrawn. Despite the frequent opportunities they offered, she was unwilling to discuss her feelings regarding Jim’s illness with
either of them. Kate had always been a very sensitive child, and they sensed her reluctance was in part due to a feeling that her parents were already coping with a stressful situation, which she didn’t want to add to. Jim and his wife felt Kate might benefit from music therapy, as it may offer an alternative avenue for her to express her emotions and discuss her father’s illness.

During my first session with Kate, we exchanged few words; instead we built up a rapport through an energetic musical improvisation lasting 1 hour! In our second session, Kate informed me of how our first improvisation reminded her of her ‘life history’- with happy peaceful stretches punctuated by loud and ‘out of tune’ moments relating to her dad’s illness. This discussion provided the raw material for the song ‘Stronger’ written in a Blues style. All the words below were provided by Kate-I simply provided a musical accompaniment:

    Stronger
Verse 1
People try to cheer me up and in a way it works,
Yeah people try’n cheer me up and in a way it works,
But still there’s just a part of me and boy oh boy it hurts
Verse 2
So maybe I’ll sit down and listen to advice uh huh
Yeah, maybe I’ll sit down and listen to advice uh huh
But I got through all of this all on my own yeah baby I’m free
(Chorus)
Troubles all my life, I’ve wondered how much longer,
Ups, downs and round arounds, they only make me stronger!
Kate had of course not ‘got through all of this’ on her own, however this self-affirming creation of hers acted as a perfect catalyst or bridge for a more open discussion of her feelings with her parents, her friends, and even her music teacher.

Towards the end of Jim’s life, his wife and Kate would visit him daily in the inpatient unit. Often, after a visit, Kate would spend time with me in the music therapy room, where we might improvise, write songs, or just talk. From this period, lasting 2 weeks the following song evolved:

‘Changes’
Verse 1
Change, change, its all around
Wherever you look and whatever the sound
It’s always there wherever you go
Nothing stays the same
Verse 2
Stop, pause, listen think
Try to find the missing link
Whoever you are and whatever you do
Nothing stays the same
(Bridge)
So find the time to listen and think
That changes you make are the chances you take
Chorus
What if the world would stop..
What would we do to fill the time we’ve got?
What if the world would stop..
What would we do?
Enjoy the time we’ve got
Kate was able to share this recording of her song with her father and all the family a few days before Jim died, and it was played during his funeral. Many people on hearing this song describe its effect as ‘spiritual’, ‘meaningful’ or ‘uplifting’ words which could easily describe the effect of the song at the time for Jim and all those who cared for him.

**Conclusion**

‘Whatever language might be involved (eg psychoanalytical, religious, artistic), the embodied act of making music opens up realms within and beyond individuals, providing access to the unconscious, the soul, to the divine, or to the spirit realm: in short mediating between the material and immaterial worlds’ (Gouk 2000)

My intention in writing this paper has been to draw upon my experience in South Africa, to suggest what we might learn from society whose everyday connection with music seems to play a vital role in many areas, emotional, social, spiritual, and indeed in family and community life. I have used this experience to inform and inspire my work in the U.K, by expanding my practice into the community and in family work. However, the comparative experience has also highlighted the spiritual dimension for which music, whether it occurs in music therapy or naturally and spontaneously as in other cultures, can play a vital role in palliative care.

Witnessing Kate’s bravery, and the way her song could so vividly illustrate the power of the human spirit in times of unspeakable tragedy, took me back to the experience of the simple music I made with the
children at the Thembaletha Children’s Home. For myself, the sessions that produced the song ‘Changes’, as with so many other events in my work seemed to have an element of spiritual guidance to them. Whether it was my ancestors, Kate’s ancestors or some other spiritual power, it is the mystery behind this creativity, to which music is central, which paradoxically helps me understand why music is so important in work with the dying, whether they be in South Africa or South Devon.

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WORMHOLES and GIM: Why linear notions of time are inadequate in therapy.

O’Leary, Catherine

In a society that is governed by clocks it is no surprise to me that one of the main areas of enquiry, both scientific and philosophic is into the nature of time.

Carl Jung thought of the unconscious as our regulating system. The more one went in one direction with consciousness, and suppressed the unconscious, the more the unconscious was likely to make itself felt to try and balance the one-directedness of consciousness.

In his essay on The Transcendent Function, (CW, 8 para 135), Jung writes ‘The definiteness and directedness of the conscious mind are extremely important acquisitions which humanity has bought at a very heavy sacrifice, and which in turn have rendered humanity the highest service. Without them science, technology and civilisation would be impossible, for they all presuppose the reliable continuity and directedness of the conscious process’. Further on, (para159), he says ‘directedness is absolutely necessary for the conscious process, but (as we have seen) it entails an unavoidable one-sidedness…Since the psyche is a self-regulating system, just as the body is, the regulating counteraction will always develop in the unconscious’.

In our attitude to time we are a one-direction society. Time, as we measure it, almost universally for the first time in human history, is the
time that is reflected in our mortality: linear time. We are born and at some time in the future we will die. It is apparent to me however that our experience of time is anything but linear. It is in fact extremely difficult to live consciously moment-by-moment, within the flow of linear time. Our minds, consciously and unconsciously ignore the boundaries of the present moment. And yet I feel we give enormous credibility to clock time and do not pay enough attention to what is gained by our ability to think and feel beyond the present moment. The opposition of a sense of time awareness, and awareness of our mortality, and the sense of timelessness, or something that goes beyond our current understanding of linear time is a fundamental error. What about ‘both-and’ rather than ‘either-or’.

Our imagination indicates that the way we use and relate to time generally is simple and exclusive. I feel we should be looking towards a more subtle and inclusive, conscious understanding.

But, as Jung suggests, the exciting fact is that one-directedness will produce a counteracting balance. So it does not surprise me that many scientific breakthroughs are being made regarding the nature of time.

What is it that is breaking through? I suggest it is a collective unconscious balancing of the contemporary psyche. It is no coincidence that it is our society, so time bound, the first society to have a universal measurement of time, that now sees there is not one time but many different times in the universe. The imagination of the scientist is rescuing us and balancing our perspective on what time is and therefore what life is.
Therefore I will begin this talk with a brief outline of the recent history of time in physics. Next I will talk of time in therapy and finally I am going to show how reflecting on time and having an awareness of the broader framework of time can help with understanding clients who, by virtue of the therapy we offer, or some crisis in their lives operate out of different time levels to that of ordinary linear time.

In the 3rd century BC Aristotle developed the idea of a perfect earth–centred universe. Ptolemy, in the 2nd century AD refined this idea. Ptolemy’s ideas remained unchallenged until the 16th century. In 1514 Copernicus, a polish priest, suggested that the sun was the centre of the universe and that the planets orbited the sun.

Early in the 17th century Galileo observed the moons of Jupiter orbiting Jupiter and felt that it proved that not everything had to orbit the earth. He fully supported Copernicus, but was put under house arrest by the Catholic Church and forbidden to teach or write on the subject.

Newton believed that time and space were separate entities, absolute in their own right and existing without reference to us. In Principia Mathematica, published in 1687, he wrote, “Absolute space, in its own nature, without relation to anything external, remains always similar and immovable. Absolute, true and mathematical time, of itself, and from its own nature, flows equably without relation to anything external.” Actually his calculations showed that there was no absolute space but he was unable to believe this as it because it disturbed his ideas about God. Chown (2001) in The Universe Next Door quotes Martin Amis as saying ‘the history of astronomy is the history of increasing humiliation’.
Having come from the theory that the earth is the centre of the universe, new giant telescopes at the beginning of the 20th century lead to the discovery that our sun was only one of about 100 billion or so other suns in our galaxy, the Milky Way, and that the Milky Way was only one of 10 billion other galaxies. That was about 80 years ago and now at the beginning of the 21st century there is the idea that our universe is but one universe in the multiverse, millions of universes of every possible combination of physical laws. And as Edwin Hubble observed in 1929 our universe is expanding.

In 1905 Einstein proposed his theory of Relativity $E=MC^2$ the equivalence of mass and energy. ‘In the general theory of relativity space and time are seen to be essentially the same thing’ (Chown, 2001). Einstein called them two faces of the same coin. The notions of absolute space and absolute time were abolished forever. The term for the new understanding is space–time. We usually think of space as having only three dimensions. Space-time has four dimensions, time being the fourth.

Space-time is curved by gravity. One of the discoveries of the 20th century was that there is much more gravity out there than can be accounted for with the stars and planets. The universe is full of dark matter, in fact it seems there is about 90% dark matter and only 10% visible matter. Einstein’s calculations around black holes showed that a black hole had an opening at either end. This implied to some physicists that time travel was at least a theoretical possibility. The tunnel in the middle of the two ends of the black hole is called a wormhole. Einstein
felt there must have been a flaw in his calculations but experiments carried out in the 1980’s to disprove the possibility of time travel kept showing that on the contrary it is theoretically possible. So if you could travel in one end of a black hole, through a wormhole and out the other end of the black hole you might end up not only in a different time but also in a different universe. There is one suggestion that black holes are not only very large structures but that they are also very tiny and everywhere. So we may be living in the midst of billions of wormholes.

With the new ideas of relativity ideas on causality also had to change. There is no direction of time in space-time, therefore there is no before and no after. In space-time all events are interconnected but the connections are not causal. They cannot be as there is no direction in time. Causality is limited to linear time. Notions of three dimensional space and linear flowing time are most useful tools in understanding the world around us but they are less successful in dealing with the wider universe or in dealing with the smallest elements, the fundamental building blocks of the universe.

At the same time as the physicists were developing the relativistic theories of time and space, psychologists were looking at the inner experience of time. Jung eventually felt that the theory of causality was limited in trying to explain certain experiences to do with time, such as ESP, premonitions and synchronistic experiences. He begins the chapter on Synchronicity, (CW 8) by referring to modern physics. ‘The discoveries of modern physics have, as we know, brought about a significant change in our scientific picture of the world, in that they have
shattered the absolute validity of natural law and made it relative. Jung coined the term synchronicity ‘to designate a hypothetical factor equal in rank to causality as a principle of explanation’. Now remember causality is linked to the flow of linear time. What Jung was trying to describe were experiences outside of this time. He wrote ‘to the psyche, time and space are elastic and can be reduced to almost vanishing point. The concepts of space and time are postulated by the conscious mind. They became fixed concepts in the course of his development thanks largely to the introduction of measurement.’

At one stage Jung compared the ego’s hold on reality, thinking it was the centre of the personality, as being similar to thinking the earth was the centre of the universe. The real centre is the Self, but without the ego the Self cannot be known. As the Self pushes from a timeless zone into the time-bound zone the ego must recognise what is not ego. Growth comes from taking the new perspective on board and instead of it merely replacing the old one, a synthesis is formed and the new outlook transcends both positions. This is the way of individuation. In order for this to take place one has to have access to unconscious material as well as conscious. This comes through dreams, creative works and experiences like slips of the tongue, but the very best access Jung felt was through active imagination.

One of the most important of Jung’s theories on time is Synchronicity (CW 8).

He defines synchronicity as a ‘psychically conditioned relativity of space and time.’
‘Synchronicity therefore means the simultaneous occurrence of a certain psychic state with one or more external events which appear as meaningful parallels to the momentary subjective state and, in certain cases vice versa.

Synchronicity consists of two factors:

• An unconscious image comes into consciousness either directly (i.e., literally) or indirectly (symbolized or suggested) in the form of a dream, idea, or premonition.

• An objective situation coincides with the content.”

In his paper on The Unconscious (1915) Freud proposed the timelessness of the unconscious. ‘The processes of the system Ucs. are timeless; i.e. they are not ordered temporally, are not altered by the passage of time, in fact bear no relation to time at all. The time-relation is bound up with the work of the system Cs.’ He explained that the unconscious was timeless because there was no change possible in the unconscious. Change was only possible when material from the unconscious was brought to consciousness. The dream state is also a place of timelessness, where there is no difference between past, present and future.

Differences between Freud and Jung included differences in their attitudes to the experiences of timelessness in their clients.

For the psychoanalysts the original tensionless state of the infant, where there is instant gratification, is one that the ego constantly longs for. In this state there is no awareness of time and no awareness of death. Therefore returning to this state, either in mystical experiences or experiences induced by various substances for example, is either a regressive tendency or an attempt to outwit death.
For Jung the Self is the guiding and ordering force in the personality, it is the source of wisdom. Therefore states that allow the unconscious material into consciousness are always viewed positively even when these states may be difficult or unusual.

‘Man needs difficulties. They are necessary for health’ (CW 8 para143). He needs to recognise the directedness of the conscious ego. Directedness implies one-sidedness and is linked to ordinary time and limits. The self, the guiding, ordering force is not linked to ordinary time. It is timeless.

In the second half of the 20th century, with the development of transpersonal psychology in particular, there has been a great deal of interest in experiences of time which go beyond the level of normal time. Ken Wilber is one of a number of therapists who have attempted to map out these other levels of consciousness. In his simplified map of The Basic Structures of Consciousness, he outlines ten levels of consciousness. Four of those, the psychic, subtle, causal and ultimate levels, are beyond the personal realm in the transpersonal realm. These are the levels on which synchronistic events occur up right up to the highest mystical experiences of one-ness.

As I was preparing for this talk I read many different papers on the notion of time in psychotherapy. One thing struck me forcefully was that while many experiences of time were discussed, the emphasis first and foremost is on having a very strong ego, a complete acceptance of the flow of linear time. No matter what one believes about death or transpersonal experiences, there is no doubt that mortality and ordinary
time go hand in hand. Only when this is intact can other experiences of time be accepted as non-pathological. Only with a secure ego can other experiences be seen as other and thus help further growth and understanding. However the intact ego is seen as the end result for some therapies and the beginning of growth for others.

How does a sense of time develop? Timing is experienced before time by the infant in the sensitive responses of the mother to its needs. As the mother’s timing moves towards coinciding with the rhythms of daily life, a space enters between need and gratification of that need for the infant. Delayed gratification is part of the growing-up experience. As space is introduced between the mother and the baby, so is time and so is tension. Different experiences of how timing and time are handled at this stage will influence the attitude to time in the future. Time is also linked to mortality. Experiences of loss during different developmental stages also may affect the time experience.

As musicians and music therapists I believe we are in a particularly good position to explore, experience and describe time. As musicians and music therapists we are used to working with many levels of time simultaneously. Think of playing a piece, there is the duration, the length of time it takes to play, the timing of the piece, the rhythm and rhythms of the piece and the subjective experiences of time in terms of duration and also memories, expectations and associations.

In a session it is very similar only more complex as there is more than one person. If the therapy is long-term this can lead to a sense of immortality. The boundaries of the session on the other hand may induce
feelings of insecurity, though they are necessary also to stay in touch with reality. ‘Winnicott has emphasised that the analyst expressed love by his interest in the patient and hate in the temporal rigidity and in the fees.’ (Kafka 1971). I see therapy as an interplay of timeless and time-aware levels. Both experiences of time are important. In his book ‘Jung and the post Jungians’, Andrew Samuels says that ‘the experience of oneness, both-and, is essential for psychological change.

Timing on the part of the therapist is as important as time management. Timing is linked to the unconscious elements more and time awareness to the conscious.

Working with GIM in particular highlights the different experiences of time. GIM is the ideal vehicle for growth. In the time aware setting of the therapeutic session, the method facilitates access to the timeless world of the self. Past, present and future are contained within the wholeness of the imagery. The approach taken to the material produced is not the time-bound analytic reductive method of psychoanalysis but the more constructive synthetic way of analytic psychology.

My own theory and experience of time is that time is a space, a where and not a when. All time is present in that space. To think of time in terms of a past a present and a future is only to project onto something we do not fully understand a useful structure, but it is not always the most useful structure in therapy. When all time is present it makes sense to be able to access the future just as easily as the past.

There is one situation where time as a place becomes very evident it seems to me, and that is around death. In my experience when one is in
the presence of the imminent death of a family member or someone very close, there is a sense of no time and all time being present at one and the same time. I call this state a healing space. There is often a sense of things falling into place, or a sense of being guided in this time. I believe it is because there is no place for the ego in the presence of someone dying. There is therefore less of a barrier to the Self. There is something very precious about this experience, and even in the presence of enormous sadness it can feel like a gift.

Case study

It is now time for my case history. In it you will see that the experiences of time can be explained in terms of synchronicity, but not of causality. The time experienced in the sessions made no distinction between what in normal consciousness we term the future, past and present. In allowing this information it was possible for my client to integrate material from the unconscious into consciousness and use it to arrive at a new solution.

Jane was 60 and had heard of GIM from a friend. Her mother’s mental state was deteriorating and she now felt there was no longer any hope of developing the relationship she had always longed for. Her father had died the year previously and she had brought her mother to live close by her, but the reality of the distance between them in terms of relating was extremely distressing. Jane was an artist and a therapist. Her parents were members of a fundamentalist Christian group throughout their lives together and she had been brought up in this extreme lifestyle. The only music that was allowed at home was religious music acceptable to the
group, and theatre was strictly forbidden. Jane however did manage to
nourish her creative abilities and eventually went into the theatre as a
director. She married young and had three children, one of whom died of
a cot death at seven weeks. It was while she was directing her first opera
that she had an affair, which lead to the break-up of her marriage over a
period of a couple of years. Jane agreed to let her husband have custody
of the children. Although the main theme of the sessions was her
mother’s health and her fears relating to her mother’s death, the sessions
were actually all to do with loss. The loss of the relationship she had
never managed to have with her mother. The loss of her father who had
died the year previously; The loss of her son who had died, the loss of her
husband and the loss of her children, although she had always kept up
contact with them. Most of all she grieved for the loss of what she called
‘the wasted years’, the time between her first affair which had cost her
her family and also her career, as she left the theatre in her effort to get
away from her lover, and the present. About two years before GIM she
had dedicated a rock to her son who had died but she had never shared
that with her former husband as they no contact with each other.

In the 6th session she imaged sharing this rock with him and it seemed
very important that she do that in reality. After this session she managed
to make contact with him, take him to the rock and she apologised for
having left him 30 years previously. Jane worried about what she would
do if her mother died. One of the difficulties concerned who should be
present at the funeral and who should be informed.
During session 7 imagery emerged that lead to what was to be a rehearsal for her mother’s funeral. In her imagery a group gathered that included the important people from her own life including her ex-husband and her children. I would like to read you some extracts from this session. She had come to a point in her imagery where she imaged a coffin in a church. The program was Mostly Bach and she is just going in to the 4th of the 6 selections on the program, the Little Fugue in g minor. ‘Just before this music started I imagined that in the coffin was my parents and they sat up together and that they could dance…….They never danced together. My parents are wearing their wedding clothes. My mother is wearing this lovely filmy dress, wax orange flowers; and my father is looking really cocky in his best suit.

(The music changes) I’m beside my father’s grave, which has been opened up for my mother. It’s on the hill. It’s a beautiful day and we can see for miles out over the river, and there’s just my brother, Tom and me and maybe Jim and Sheila, Ann and William and the funeral people.’ I ask how she is feeling. ‘Fine, glad that it is over. We go to the pub by the river, maybe the one where my father celebrated his 80th birthday. He was a great one for celebrations as much as his teetotal principles would allow. It’s the last time I need to go to London.’

Jane arrived at the next session, (session 8), having had a very difficult night the night before. She was finding it very hard she said, to realise her mother had never really cared for her, and now she never would. She was thinking of a new work of art she would make to express her anger. She wanted to make a hanging with a lot of house dusters. The duster
stood for the house-proud and small-minded woman. She began the session with the image of a duster. “The duster flew out of my mother’s hand as if it had got wings. It flew up and suddenly there was a great flock of them flying in that sweeping formation that you sometimes get with birds. Swooping and turning” I ask where she is. “I’m watching from the ground. There’s some sense of them being very angry. There was a flash of me playing the piano angrily as a child, and then the bird dusters took over again. I feel as though they are gathering into a formation. The swooping is beginning to gather into a particular form, a form for leaving, for migrating. They settle on a wire and every so often they shift, rise up and shift again.” I ask if this leaving is all right with her. “Yes it’s the time, the season. They’re flying south away from the winter.”

When Jung was writing on synchronicity and talking of a case where a flock of birds appeared at the moment of death in a family, he says ‘If one considers that in the Babylonian Hades the souls wore a ‘feather dress’, and that in ancient Egypt the ‘ba’ or soul, was thought of as a bird, it is not too far-fetched to suppose that there may be some archetypal symbolism at work.” Jane’s mother died, sooner than expected, between this session, session 8, and the next.

She held the funeral just as she had imaged it in session 7 and she felt enormously grateful for the creative way it had come together for her first of all. She had made contact with her husband unaware, on the conscious level, that her mother would die so soon. Having made the contact he was present at the funeral as he had been in the imagery and was a great
support to her. It was the first time that the parents and the children had been all together for 30 years. She felt none of this could have happened without the GIM sessions.

Throughout all of this I felt there was something else playing in the background to do with Jane’s relationship to music and that we had not really touched on yet. Since I had been working as a music therapist I had never met anyone as sensitive around music. In the beginning I felt she was almost afraid to listen in case she would be touched too deeply. She was frequently critical of the music and often moved to tears. It wasn’t until the 10th session however that the enormity of what was contained in the music for her began to become clearer to me and a whole different music-image landscape began to reveal itself.

The session after her mother’s funeral, (session 9), ended with her imaging a village scene with a church. The doors of the church were open. She entered and there was a couple on the altar. She went through the church and came out on a hillside where there was a woman playing a pipe to a snake. She said it felt like coming home.

The next session, (session 10), she came in very excited. She had realised the village scene at the end of the last session was the opening scene of Cavalleria Rusticana and that the couple in the church getting married were her parents. Her mother was happy again now, reunited with her father. What she told me next felt very very important. It had that numinous quality to it that Jung says is associated with synchronistic events. On the way to the session she had reached back in her car where she had about 200 tapes and picked one at random. Turridu’s aria from
the opening of Cavalleria Rusticana played out in her car. This one act opera tells the tragic story of a broken marriage and betrayal. This was the first opera she directed, the opera she was directing when she had the affair which lead to the break-up of her marriage, the loss of her children and eventually the loss of her career. She had not even realised that she had this tape, but it was as if the theme of the opera had been playing in her life for 30 years. She had now come full circle, she had imaged the scene again, she had spoken to her ex-husband again and the parents and the children had had time together for the first time since they had split up. The music had been hidden, but now that her grief was out in the open the music had surfaced. What was suppressed in the unconscious was allowed to come to consciousness. Given the proper setting with a sympathetic form of therapy, i.e. GIM, synchronistic events occurred which aided with supplying material for the conscious mind to integrate. There is no causality here. The opera was not the cause of the direction her life took, but it was an image of her journey as well as being part of that journey. What enabled Jane to pick up that particular tape in her car was something from another level of consciousness, another level of time. A time where all time is present and the connections are other than causal, a time we all have access to. A circle had been closed for Jane. The sounding of that aria was an ending and also a beginning as she moved on to other areas of exploration.
Time is the issue of the day. Physicists talk about the arrow of time to describe the process of entropy, the order in which things decay and we grow old and die. This the result of the universe moving from a state of presumed order, before the big bang to a state of more disorder, as the results of the big bang continue to spin away from each other. There are other possibilities but what if the universe collapses in on itself again, in the big crunch, forming a black hole like those that are there already. This reverses the arrow of time and so time would run backwards, while it would still appear to be running forwards. These are some theories of contemporary physics. I enjoy it because in my own life and in the lives of my clients I have witnessed experiences of time, which do not fit in neatly with the ideas of causality, or linear time.

Just as it has been important for therapists to have their own therapy to deepen their understanding of the dynamics of relationships and their own internal processes, so I believe it is important to reflect on time, one’s experience of time and one’s philosophy of time, and that it is also important to become aware of current theories of time, scientific as well as therapeutic in order to have a framework to understand and allow the experiences of those with whom we work.

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**The Last Performance**  
*Thomas Hardy*

‘I am playing my oldest tunes,’ declared she,  
‘all the tunes I know,  
Those I learnt ever so long ago.’  
Why she should think just then she’d play them  
Silence cloaks like snow.
When I returned from the town at nightfall
Notes continued to pour
As when I had left two hours before:
‘It’s the very last time,’ she said in closing;
‘From now on I play no more.’

A few morns onward found her fading,
And, as her life outflew,
I thought of her playing her tunes right through;
And I felt she had known of what was coming
And wondered how she knew.

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‘It’s a Family Affair’: Systemic Thinking and ‘Doing’ in Music Therapy

Palmer, Hilary

This paper is offered as food for thought. It does not present absolutes, methodology, or prescribed techniques but instead poses ideas and ways of thinking about the way we work with families and practical suggestions of how some of those ideas might be put into practice. I come to this paper from a dual position of being experienced and yet a novice. I am a relatively experienced music therapist with six years working practice and yet I am also a trainee - in the field of family and systemic psychotherapy. I was helped enormously by my supervisor when I began my advanced family therapy training. She said training is great because you are allowed to get it wrong sometimes, and it’s okay when you do so as long as you grow from the experience. I have been given leave to think creatively and explore, to take risks and to experiment a little. I have found that the family therapy profession have embraced my ‘music therapyness’, they have been respectful, intrigued and keen to use my skills, musical and non musical, to enlighten themselves as to the nature of music therapy. This has been both refreshing and unexpected. As music therapists there is a danger that while on the one hand we are eclectic to the core, on the other hand, I believe, we are often in danger of being slightly precious about our way of doing therapy. So it is from this position, from these beliefs and experiences that I speak.
Systemic thinking does not view a problem system as a collection of people but of a network of meanings. Family therapists believe that: “symptoms, problems and difficulties arise in the context of relationships, and are understood in terms of interactive and systemic processes. The main focus of intervention emerges from these patterns of interaction and the meanings given to them” (Association of Family Therapists Code of Ethics and Practice). It is therefore the therapist’s job to search for multiple and differing perspectives in order to highlight difference and open up the possibility for change. The meaning of the system is not the individual people but the interactions between them. It is the similar to the notion that an isolated note gains meaning through its relationship with other notes. There are many schools of family therapy thinking. Today I will dip into the theory, ideas and different schools of thought that seem pertinent to me as a music therapist, at the current time. I apologise for the lack of historical and theoretical context that this brevity of this paper does not allow time for.

The core of this paper is a clinical example of work with a mother and child as this is probably the most common family group convened by music therapists, so will be pertinent. I will then go on to consider techniques that may be helpful when working with larger families and also explore ways of thinking about individuals.

Kitty has a very rare syndrome\(^\text{102}\) and has exhibited behavioural difficulties since she was a toddler. Her behaviour has been reported to become worse with each passing year. Her behaviour presents as a need/
desire to control everyone and everything around her and she is also verbally and physically aggressive. At the time of referral Kitty was in continuous respite as her mother could no longer cope with her at home and was anxious about her own aggressive feelings towards Kitty. A residential placement was being considered and Music therapy was one of two occasions in the week when Kitty and Ruby saw each other.

Kitty’s mother Ruby presents as kind, calm, confident and strong. Ruby states that every report on Kitty is negative. She feels she can contain Kitty but that it is difficult and she is sad that she does not feel close to Kitty. Ruby feels she has exhausted the Health and Education system and that her relationship with Kitty is ‘damaged’. Ruby believes Kitty has no strengths or positive attributes.

The problem was very much seen to be Kitty and her behaviour. This was the perception of the family as well as the Health and Education systems. However, the dominant discourse that this family presented was one of great loss. The primary level of this involved a divorce and the death of two people very close to Kitty, and Ruby over a two year period. On a meta level I was curious about lost narratives, the lost family life, the loss of a ‘perfect child’ after a diagnosis was made, the lost aspirations for Kitty due to her learning disability, the loss of a childhood for her sister Jasmine who has helped with Kitty’s care, and the loss of independence and a sense of being a good enough mother for Ruby. There were also life cycle considerations. Kitty turned sixteen during the course of our work together and thoughts for the future were in mind, the idea of Kitty becoming an independent adult would not be
realised and there was the possibility of problems occurring by life cycle events being out of synchrony as mentioned by Goldberg (Goldberg et al 1995). I was also interested in the possible effect of societal beliefs regarding disability, parenting and family life and how these shaped or contributed towards the family’s discourse.

In order to convene this family, it was essential to consider Kitty’s learning disability and adapt the sessions accordingly. Kitty was physically a 15 year old girl but emotionally and cognitively she was operating at a much younger level. These differences in development had to be ‘held’ successfully if the work we were to do was to help Kitty integrate these, often confusing, aspects of herself. Kitty is very easily distracted with a short concentration span. Kitty’s communication is good, but she presents as more able than she is due to her speech being fluent, therefore language and concepts need to be kept simple. Kitty has great difficulty in waiting, in turn-taking and in interacting positively.

The use of music caught Kitty’s imagination and her sense of fun, and she was able to remain in each session for 30-40 minutes. In order to maintain Kitty’s attention it was important to keep the sessions stimulating. In her first session, in which Ruby could not come, Kitty chose a small colourful drum, she sounded the drum twice with her hand and then threw it on the floor. I externalised this action immediately. The drum was certainly misbehaving and Kitty and I would not stand for it. Kitty thought this was hilarious. Gradually the drum became more sneaky, and slipped around on Kitty’s lap, and each time it fell it was at a much slower pace which gave me time to catch the drum, stop it from
falling, talk to it, tell it how we would like it to behave, suggest how it might be feeling and place it again on Kitty’s lap. The use of instruments to externalise Kitty’s behaviour and her fears continued throughout her sessions and Kitty was keen to introduce Ruby to some of the music therapy ‘characters’ e.g. the naughty drum, the sad drum, the scary cymbal, the worried xylophone, the beautiful bell etc. Through the supported playing of these instruments, Kitty’s feelings began to be acknowledged, communication between Kitty and Ruby was explored, and positive interaction experienced and developed allowing for Kitty and Ruby’s perception of each other to be broadened and Kitty to move beyond “problem saturated ways of seeing” herself (White & Epston 1990).

Instruments were also used symbolically. I asked Kitty and Ruby to choose instruments for each other and say why they had chosen them, e.g. in one session Ruby chose the tambourine for Kitty because it was pretty, it made a loud noise and it had ‘lots of bits to it’. During the same session Kitty chose the drum for her mother and with excitement explained that she had chosen it to represent her mother’s foot steps coming up the corridor to join her in music therapy. I also attempted to use the instruments in a sculpt, asking Kitty and Ruby to personify each member of the family through an instrument and to place the instruments in relation to each other, in the room, to represent emotional distance, as they see themselves now and as they would like to see each other in the future. Kitty could focus a little on this activity, but it engaged Ruby to a much greater extent. When the instruments were in place each person could be given a voice by the playing of various instruments in various
combinations and there was, as Hoffman (1995) describes: a “shift from personal narratives to meanings that people produce in concert with one another”.

Within the improvised music, musical conversations developed which allowed for Kitty and Ruby to interact in a fun and non-confrontational way. In the latter sessions Kitty asked to play music for us while we listened. The witnessing that Ruby and I provided, would be described by Cox and Theilgard (1997), as endorsing Kitty’s sense of being present. She played with great care and appeared to very much enjoy her captive audience listening and acknowledging her music. Ruby commented that it was the most focused she had seen Kitty. Through this process Kitty allowed herself to be seen in a new light, as someone who could communicate positively and beautifully. In contrast, Kitty also enjoyed being played to, especially when she was tired or in a ‘bad mood’. These moments were a good opportunity for Ruby and I to discuss how we thought Kitty might be feeling and what sort of music she would like to hear. The activity allowed for Kitty to be very much nurtured by her mother in the sessions and have her feelings acknowledged and explored. As trust became established Kitty began to speak about her grandfather and how she missed him. From this I began, with their consent, to help Kitty and Ruby to begin writing songs for Kitty’s grandfather. Ruby was very involved in this process and was helpful in prompting and reminding Kitty about good past times they had had and things that Kitty might like her grandpa to know now. The songs were also helpful in bringing in a different voice to the sessions. What would grandpa say?
An important part of each session was the goodbye song. This song was an improvised song in which I sang about what had happened in the session, the good parts as well as the difficult moments. Kitty was captivated by these songs, often asking for them to be repeated and telling me if I had forgotten anything important. I also used the songs as an opportunity to pose open questions, which incorporate things I had been left wondering about, and was surprised when Kitty attempted to answer the questions while I was singing. In this way I could take on a similar, but more subjective, role to that of a reflecting team used in family therapy and Kitty could be self reflective about the session she had experienced. On one occasion Kitty was picked up after the session by her class teacher. She asked that her teacher come in and listen to the goodbye song. By bringing a member of the larger system in it allowed Kitty’s teacher to also understand what things Kitty had found difficult as well as giving Kitty an opportunity to share her achievements and feelings and have these acknowledged. This was also helpful for Kitty’s transition back to class.

In convening this family I adopted, adapted and used various approaches. I used structural family therapy techniques in my use of sculpting to facilitate a change in the way Kitty and Ruby perceived each other. This way of working is also described by Priestly (1994) in her essay describing her work with a couple Inge and Fred. Time needs to be taken over sculpts to do them well. They can be very powerful and it is important to have established a good therapeutic alliance and understanding before commencing on one. Sculpt can also be done over time and returned to and are not suitable for everyone. I feel the most
important thing is that a sculpt has got to have the possibility of a positive outcome, a ‘how things might be different given time’ scenario. The therapist needs to check that whatever techniques they adopt it is used to help promote insight and offer possibilities for growth, this is particular so when doing a sculpt involving a large family group where there is the potential for one family member to become scapegoated and as a result watch the painful unfolding of how his/her family view the emotional distance.

In early systemic thinking much attention was paid to circular causality (Watzlavwick et al 1967,1974) In thinking about Kitty I found it helpful to consider circular causality in exploring how the beliefs, actions and feelings of the family were interconnected and how meanings were created. For example:

A constructivist view states that a different way of seeing things is essential for change and I was conscious that the experiences gained through the music therapy process triggered Kitty and Ruby to begin to
reframe themselves and interrupted the problem saturated cycle. Choosing instruments for each other allowed for an insight into the individual lens of both Kitty and Ruby, and an exploration of their perception of each other. The same could be the case when choosing instruments to represent the self. In doing so, each person’s expression of ‘self’ can be acknowledged and validated. The validation allows beliefs to be confirmed and each person to let go and rethink. In thinking about ‘self’ this technique also explores how we want to be seen and how we think we are being seen by others. In Music therapy the therapist is an integral part of the music making and it was important for me to consider my role in making the dyad of Kitty and Ruby into a triad physically, verbally and musically.

Remaining on the theme of ‘self’ but in the context of social constructionism, I was conscious of Kitty and Ruby’s notion of self changing in the new environment of music therapy. Through looking at strengths within their interactions within the sessions, I hoped to encourage subjective discourses, to explore what other ‘things’ worked, and to attempt to counter the dominant discourse of failure and loss within the family, and the larger societal dominant discourse concerned with learning disability and correct ways of behaving/parenting. Learning Disability in itself is a Social Construction and I needed to consider how much I was hide bound by my own beliefs of change with this client group and by the beliefs of the school in which we were not only holding our sessions but in which Kitty was seen as an infamous part.
Within the skills used within the session the externalising methods adapted from White and Epston (1990) appeared to be particularly helpful. Kitty had been very ‘entangled’ within her own pathology both through her own and the wider system’s eyes. Separating her from this and offering other possible options to her idea of ‘self’ enabled her to experience some control over her own behaviour and begin to explore more positive alternatives. In other ways the sessions also took on a narrative flavour as each musical improvisation could be described as a “mutually validating conversation” (Dallos & Draper 2000).

Historically, in Western society, the learning disabled population have been oppressed and considered as worthless and ugly. These labels have left clients disempowered and disenfranchised with people having little sense that their voice is valued. Freud (1904) stipulated that people with cognitive disabilities where incapable of benefiting from psychotherapy and the residue from this prejudice and hostility, although receiving some redress, can still be felt today. The main redress has been given to this by the Arts therapies professions which have left other psychotherapies behind in their automatic inclusion of the learning disability population. For our clients it is highly important to bear in mind how the residue from past beliefs, e.g. blaming parents for a child’s disability, may have effected or still be effecting the family system. It is also important to consider the current internalised prejudices of society and the bearing these have on each member within a system. Fidell (2000) also brings our attention to the danger that the client with a learning disability may have become the family’s scapegoat and that family therapy used injudiciously could cause further stigmatisation.
As Vetere (1993) points out, we know more about the stages of grieving following the birth of a child with multiple disabilities, than we do about family strengths and coping resources. In my work with Kitty’s family, I hoped to facilitate the discovery and recognition of resources for coming to terms with the past, coping with the present and moving forward to the future. Through the use of family therapy and music therapy techniques a way of working creatively with the family was offered, which allowed Kitty, Ruby and myself to contribute to the therapeutic process using the same ‘language’.

Herbert Brun, composer, stated that speech exists to bring about that without which speech could not happen (as quoted in Hoffman 1995) just in the same way, I believe, that perhaps music exists to bring about that without which music could not happen. In my work I very unapologetically use both words and music and one or other will be used to a greater or lesser frequency depending on what feels appropriate for each individual, couple or family.

I am currently interested in Karl Tomm’s internalised other concept which involves meeting yourself as you exist in significant others and in doing so gaining deeper knowledge of another person. Priestly (1994) speaks in her analytical essays of a client playing her mother or her father. In doing so she hopes to promote insight and understanding of the clients feelings towards the parental figure, allow for expression of this, and open up pathways to explore transgenerational influences on present life. Internalised other work, is currently, as far as I know, only done verbally. It involves interviewing someone who is responding from the
position of another, not pretending to be them physically, but attempting to think and feel like them in order to answer the therapists questions. Could the same be done through music? The verbal therapy includes feedback at the end of the session and it can either be done with the ‘other’ that is being represented present or with an individual on their own. In music therapy if, say, Tom was being internalised by Mary. Mary may improvise with the therapist as Tom. Afterwards a discussion could follow involving both Mary and Tom. Questions to Tom may include: Is that how you thought you’d sound? Did anything surprise you? How would you like it to sound? and to Mary: How easy was it to be Tom? What degree did you feel able to enter into Tom’s experience? The therapist is thus exploring what degree of congruence there is between Tom’s inner experience and his experience as an internalised other. It is important to note that this work would not be suitable for people who are psychotic or in a paranoid state. It has worked successfully with young children but I do not know of it being used in learning disabilities.

Priestly (1994) describes her work with a couple, rather than an individual only, as helpful in opening up alternative and possibly fruitful ways of interacting with each other, with the advantage that work can continue outside the sessions creating opportunities for joint growth. Individual therapy plays a vital and important role for our clients but I see two main difficulties with it. Firstly when seeing an individual on their own there is the danger of pathologizing and of seeing a difficulty as born of, existing in isolation with, the client. Secondly, there is also the potential of doing a great piece of work with a client but because the
system has not changed with the client it is difficult for the client to maintain the positive changes or receive maximum benefit from them. This does not stop me doing individual work, I see lots of individuals, it just makes me feel particularly mindful of the larger system when I do.

Individual work can be done with a systemic head on. Understanding of family dynamics in itself can be helpful in identifying where change needs to happen as well as, if you work psychodynamically, being a valuable help in making sense of transference feelings. All the techniques used with couples and families can be used with an individual with the larger system in mind. The system may be family, school, work and society which is set besides the clients culture built of race, ethnicity, religion, class, age, beliefs, expectations, music, language, ways of doing love, ways of doing pain and ways of healing. Each aspect needs to be kept in mind, bought alive and made meaningful in the therapeutic space where it interfaces with the therapists system and the therapists culture.

My next systemic music therapy venture has been born from my work as a trainee family therapist on an honorary contract at an adolescent mental health unit. I used to work at the unit as a music therapist and I am there now in my family therapy capacity. The family therapy team use a model where a one way mirror is used and two therapists convene the family whilst the rest of the team sit behind the mirror observing and listening carefully. The team behind the mirror may come in and reflect their thoughts to the family or may adjourn during the session to discuss their ideas with the therapists doing the face to face work. It was in this capacity that I met Isabel again, a 14 year old girl who had once been an
active member in one of my groups. Isabel gave consent for me to remain in the team. In the family session I observed, with Isabel and her father, it became clear that Isabel had great difficulty putting her feelings into words with her father and responding rationally to his kind, calm and rational questions. Isabel spoke with negativity about her absent mother. The therapist spoke to Isabel about her music therapy experience and asked if she would find it useful to work in this way with her family. Isabel and her father thought this was worth a try and Isabel even agreed to meet with her mother in a session if music was available to use. Isobar’s mother has agreed but has requested a verbal meeting first. So here I am just about to do music therapy in a family therapy clinic. It is a new situation which fills me with questions? How will I use the reflecting team? How will my past experience of work with Isabel help or hinder Isobar’s ability to use the music? How will Isabel and my previous relationship effect my ability to form a sound therapeutic alliance with her parents? How much structure will I need to keep it safe? Where do the usual therapists that convene this family fit in? Will the family feel comfortable enough for the music to be helpful?

In writing this paper I was conscious of Pavlicevic’s stance that as music therapists we range in extremes from a position that refuses to import theories from other fields to those who borrow liberally - and not always convincingly - from other theoretical frameworks to describe music therapy. I started my family therapy training because I found myself working with families and wished to understand more about family processes and how families were being convened in other fields. I was intrigued and curious. I know many music therapists working with
families and perhaps the challenge is to adopt theory that remains loyal to practice and genuine in its participation’, as Pavlicevic describes, whilst also remaining curious, open to new learning and willing to expand our repertoire in thought, deed and word.

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FRANCESCO PALMIROTTA, psychologist, philosopher, music therapist manages a residential Centre of Psychotherapy and Psychosomatic Music Therapy in Bari and in Borgo Solinio (Cassano delle Murge, Bari), area rich in archeologic evidences from Magna Grecia. He is the president of the Ontic-existential Maieutic Association and of the Psychosomatic Ontosophy Association, which operate in the Music Therapy and Psychotherapy fields. Since many years he has been dedicating himself to the professional training of the psychomusic therapeutical sensibility of many specialists as psychologists, doctors, teachers, artists, managers, etc.
He first pointed out the relation, between dream and Freud’s tumour, as psychosomatic event. Together with other specialists he founded a college for children (supported by Planet Society – UNESCO) in which he experimented the potentiality of oneiric intelligence in the development of child being identity.

**Summary**

Harmony is the creator principle incarnated by the greek concept of Eros as the tending to deification through the individual life. In mythology Eros has existed forever and together with his soul: Eros and Psyche were the identical hypostasis. For this reason the life of the soul naturally opens to the individual and collective wellbeing, to the harmony as inner therapeutic sound.

The life of the soul by the ancient greek and the Pythagorean School has meant as capacity of inner vision; that was looking at the reality through a precise intention of connection between the subjective and objective world that generated discoveries (many of those still scientifically valid) in different fields of knowledge and that indicated the action in the history.

Music touches the human soul, opens spaces of inwardness, but music therapy is the exact consciousness of this passage to the inner vision and the love of the soul through the sounds.

By this, the need in this article to precise the philosophical and historical course of that principle of Greek harmony which anticipated the principle of self organization of the matter (Schroedinger) and the psychosomatic Ontosopy one.

“You know me and I know you!”_ It all started this way, twenty years ago, when a psychology student from Rome University entered for the first time in the office of a psychotherapist in order to start training. The allusion to the Delphic “Know yourself” was too obvious. That student was right from the Magna Grecia, Southern Italy. Unfortunally, the wisdom of those ancient teachers had been removed from his consciousness. Teachers who sowed and cultivated the extraordinary
flourishing of Art and Science Civilization: the Cosmogonic Harmony which nourished and developed the roots of the Western Culture.

Then, like other people, the student was not aware of the Harmony creator of the Universe and the human beings. Harmony directly derived, according to Esiodo and other thinkers of his time, from the god Eros.

Recently, astrophysicists have rediscovered that the sun emits a vibrations, a “note”, which lasts 24 hrs. It is the same amount of time the Earth needs to do one rotation upon its axis. We can poetically assume that the sun sings and plays music while the Earth dances over its Armony. Peraphs, only a poetic burst coming from a phylosophycal meditative Life-Nature orientated mind can express the core, the essence of those visions experienced 2500 years ago by the ancient teachers who founded the Western Culture.

How can a vision, after thousands of years, still motivate the meaning of the knowledge-reality?

How could the visionary movement of some “Intelligentsia”, who lived 600 years B.C., create the most important religions in the world? Because of Lao Tze in China, Moses in Egypt, Buddha in India, Pitagora in Magna Grecia, we all are experiencing the power of their visions. Their theory (means go for God, search for him or find him again) coincides and finds itself in the meaning of a creator principle who loves and creates with love and wants, because of that love, the harmony of the creation. Somebody here may think: “Exactly the contrary of the wars or of every warlike instinct!” The student’s mentor did not realize the whole psychic meaning of that statement “I know you and you know me”, even
if he visibly startled on his chair. Eros, the creator uncreated god, has existed forever and together with his divine soul (cp.Plotino): Eros and Psyche were the identical hypostasis. In mythology, Psyche was, on one hand, the human pulsation emphasizing deification all through the individual life (Paideia according to Jager), on the other hand, it was the identical divine substance drawing to itself the uncreated and primordial Light of the Universe.

It is the same visionary, phylosophical selforganization principle of the matter enunciated by E. Schroedinger. In both cases this fundamental and unifying idea was lost both in physics and in psychology (psych_). In mythology, Eros and Psyche synthesized the knowledge process, shaping and forging the Harmony, like the Sun and the Earth reciprocally mould each other in order to create life and us, the human beings.

The cosmogony movement and the dynamics of Eros and Psyche nourishe not only the person but everything is metaphysical or/and transpersonal: Psyche is both individual and universal. We don’t feel it is paranoiac or excessive to perceive in an individual in psychotherapy the result of many systemic, historical, cultural, biological, materialistic interactions. One aberration that alienating systems and their institutions do against the individual Being, the individual and collective Being Psyche in Harmony, is splitting and isolating him from the harmonic dynamic of the intuitive Reality.

Even if Love for Psyche and Psyche for Eros are still the immovable “Engine” of the civilization dynamics, they are constantly subdued to the “forche caudine” bye sectarian tendency which splits the Being who
shows himself evolved in respect of the silent and implacable increase of schizophrenia (46 millions of schizophrenia according to the WHO’s statistic evaluation).

In the ancient myth, at the roots of the western Culture we can find the answer to the confusion encompassing the mental and psychosomatic health of the human Being. However, it is an answer which needs to be administrated with maieutic wisdom, there is no need for a rivolutionary aggressiveness. Instead what is needed, is an intelligent innovative aggressiveness, respectful of the principle of the health’s self-organization which every individuation has in it-self. The mythologic dynamics between Eros and Psyche represented for the teachers of that period, the way to exit from any kind of individual or collective problem. We are thinking of Eraclito’s Enantiodromia, the unifying movement of the opposite principles and the currents coming from the East and the West. The idea was launched: it is possible to unify in order to find ourselves as a sense of Reality, so we can then start searching again for more knowledge. Eros is love that enlights the knowledge: he is the God allied with Zeus in defending Psyche, taking her out from hell and getting her close to Zeus who meanwhile kidnaps and joins Gaminede symbol of corporeal and formal beauty. The Light (Zeus) love (Eros), the handsome (Gaminede) and Soul (Psyche) are together the ideal process for human history: this is what is lacking when we refer to war for war, to death for death, to schizophrenia for schizophrenia.

The myth’s transformative movement, as it was consciously administrated by the Greek and Magno Greek culture, was stopped by the
Roman christian civilization. Because of that, the barbarity of the medication drugs, at all cost, was set and so the depreciation of the Psyche-Soma-Being wisdom. That is, the natural ability of self-organization was more and more replaced by a therapeutic and expropriating mechanics which rationalizes and endorses what is “outside” of the human being. The individual and collective potential, the psychological and etymological poison-remedy at the service of those who knew how to use it in therapy for the extasis, was taken over by the material meaning of the drug. Pharmakon was for Greeks the music which Pitagora provided to cure emotional disorder. Farmakon was a theatrical way with the intention to develop the knowledge of one’s own self, it was love for knowledge. It was the healing process! Eros was the therapon, the final part of Love’s impulse, it was the appolineo “know your self”. Only those who knew theirself, one’s own self or shining principle, could be able to love. Because of his familiarity and intimacy with soul the light’s principle would flow from the invisible God. The reason why Eros would join the creative light of the Universe, the enlightenment, the wisdom, trying to achieve the deification of the human being, is quite similar to the Big Bang’s theory and the everlasting physical Universe. What I am saying is that two opposite extra-physical theories were easily accepted by the teachers, creators of the Western Culture. In the greek language the sign PH, sophos, wisdom, phanes-light, phonos (sound-voice) phisics, wasn’t there with out reason. It was a transformational need for the personal and transpersonal Psyche orientated to can get the Olimpus that is, the human Psyche, through Love for life and knowledge, and walking the path to reach deification
(Paideia). The farmakon, the individual imbued with all the negativities of the Polis, would be expelled during the seasonal rituals. After that he would be reaccepted into the community in a symbolic way just like the Lamb of God, Christ, and Jerusalem’s Easter.

Those rituals were intelligently provided in order to enhance human civilization. Today, this kind of process-journey doesn’t happen in physical therapy and psychology schools. This because, we forget, sometimes consciously, that the aim of therapy is the solution of the symptom presented at the first encounter (entry symptom) or at the following ones related or not to the first, it is the health self management, it is creativity and wellbeing, it is the Psychic Eros: the love for the living soul. Eros intention determines the acme, the value, the authenticity of a Real civilization of the Psyche. We all have the right to Psyche civilization, a Psyche which is everywhere, in our relationships, in Nature, in the Cosmos. At the end of the millenium, our civilization is lacking both an authentic cosmic meaning of Eros and a natural meaning of the individual and collective Psyche. Darwin and Wallace were thinking in the same time, in different places the Evolution theory; Newton and Leibnitz invented in different ways, in the same periods but in different places, the infinitesimal calculus. There are many examples about how the drive of the Human Psyche for Reality-Knowledge moves like a superindividual sphere of action and conceives intuitions of the Real, beyond space and time limits. B. Russel, during the last years of his life admitted he did not touch the depth of the Pythagorean number. E. Schrödinger wondered how could so much true and scientific knowledge come from a school like the Pythagorean, considered idealistic, and
real (for some the infinitesimal calculus intuition happened because of the Pythagoras’s Theoreme).

Democrito’s intuition of the atom goes through the milleniums, and it still is today the object of penetrating research and debates in physicists. Today, Music and psychological based therapies are still razionalized and rebuilt from the Greek and Italiota philosophic Universe. Just a few examples to show how the millenium was marked by those powerful visions of those sage teachers of Humanity who lived peripatetically around 2500 years ago. However, the most extraordinary symbolism removed from our Life experience is Eros embracing Psyche.

Today, Love’s cultural aspects in psychology, music therapy and psychotherapy come from the humanistic Psychology of Maslow and Fromm’s neopsychoanalysis.

Rollo May states, in his book “Love and Will”, that the armony of the spheres or the music of the spheres in the Pythagoras’s concept contained some on sexual love. It is probably true since in the Pythagorean School teachers were both male and female, married or not. However, it is important to understand the meaning of sexual love in Magna Grecia. It is quite difficult to imagine that the only civilization, according to Jung, creator of the God of Love, that is Eros, referred to him only as genital complement, merely to the sexual embrace. on the contrary, the writings, the theories and the myths tell us that is not the case. Eros is not Afrodite. He is the strongest - of all Gods, he is his own divine soul, he contains his own image. Eros, Creator of the Cosmos can only be a Pythagorean idea since an idea about Love-Soul- Harmony, according to Pugliese
Carratelli, did not exist in the warrior Culture hand down to us by Homer. Actually, modern archaeologists divide the philosophical core of the western civilization into two groups. The First one, the Homeric, stands for a destructive, disharmonic warrior philosophy. The second, the Orphic-Pythagorean, stands for creative, pacifist and harmonizing philosophy. Dionisio was the God of the prophet-dancers who crossed Europe involving people of every culture, absorbing and sharing knowledge and extasis. It is a sin that the dance of S. Vito, the Tarantism, historical-natural heir of those old visionary philosophical-theological intuitions, could be for long time considered psychiatric syndromes.

A true theory which explains “reality” should solve “Reality”.

Many myths and psychological and music therapeutic theories are not helpful to transform in healthy and full-grown reality a human being’s crisis. For this reason should be disregarded. There are mythological processes or human thoughts which carry thousands years old alienation. They contain the seed of the non-sense and so they are not useful for the psychological and psychosomatic real world. Such is the androgynous myth, the myth of Er and in many cases some passages of the tale of Eros and Psyche.

Then, we have to search for and to study in depth the meaning of Psyche in those schools of thought where the western civilization roots seem to have proliferated. Based on the recent archeologic discoveries the most appropriated school to our purpose seem to be the ones of Pythagora, Talete, Parmenide, Eraclito, Anassagora and other pre-socratic philosophers. In South Italy, Pytagora’s school seemed to be by far the
most well known and versatile. He coined words like: cosmos, number, phylosophy, monad, mathematic, music therapy, etc. At this school, Psyche was identified with number, monad, Love, Harmony and Soma. Now, if we give to the words generative capacity the meaning of significant wisdom of things and the world, we can infer that Pytagora was trying to stimulate, in his disciples, curiosity for knowledge.

Through his own dialectics he was able to obtain an healthy movement in the search of the earthly true Being.

It is obvious that this quality is welcomed from any teacher, therapist and every human being. However, it is not clear how Pythagoras and the Pythagoreans intended and used the psychological vision in order to discover, meditate and generate new ideas in every knowledge field. Because, and this is the incredible part, even according to Schrödinger: they were, among all the other schools, the ones who discovered more about natural, human and cosmic reality. Then, the ancient teachers’ secret, which created the roots of the Western culture, resides in their capacity of envisioning the Ontic Reality.

They all had a good developed sense of the psychological vision and, of course, a great life experience. To understand what they visioned we need to infer that they followed the Paideia of Mnemosyne and the Horphic thin plates more than Oedipus King’s tragedy. The Mnemosyne’s initiating cultural myth directly introduces us to the imago theory that is the invisible world into the physical one. And, between the two there is a natural contiguity, just like between astronomy and meditative philosophy, once cultivated by the Pythagorean schools. The
importance of Mnemosyne and the way to find, through images, the meaning situated into the vision deifying human has been given to us since the Fourteenth Century by the humanistic culture. Philosophers like Giordano Bruno, Tommaso Campanella, Marsilio Ficino and Pico della Mirandola, adopted a method for the mnemonic visualizations which was associated with the culture and wisdom of their times. This method was called: mnemotechnique. I believe that the relationship between Pythagorism, Mnemosyne, mnemotechnique, humanism and the significance of the images and myths for the therapeutic phenomenology and psychological knowledge, is missing in the modern techniques like relaxation, yoga, autogenous training, imagology and the productive imagination. I am referring to Jacobson, yoga’s western teachers, Schultz, Klaus Thomas, Freud and Jung.

The self-organizing tendency, inherent in the physical matter, see, for example, the finalistic and coherent “principle for life” in biology (Maturana and Varela) and the same tendency in physics of the particle (E. Schrödinger), activates the self-organizing core of the psychosomatic and psychological energy strength. This tendency might be the outcome of a universal principle or law which was called by the Greeks Eros, by the Christians, God, by the native Americans, Manitou, and by the Induist-Buddhists, Brahma, and finally called by each society with their own language, but always with a divine meaning. I believe that the sphere of action of the self-organizing tendency in a human being can be called: Psyche.
When we hypostatize Psyche as a real entity (because it is a real energetic entity) strangely or naturally we obtain physiological benefits in terms of psychological and psychosomatic health. It is exactly like when we hypostatize Eros because divine path in the human being, that is the wisdom of the divine being (Ontosophy) which guides the Ego in the path of Life. If we assume that Eros and Psyche are only masks, that is unreal images, we haven’t explained the self-organizing principle of the matter, the one of will and love (cp. Galimberti). The will to the good things, and, finally, the Darwin’s evolution theory. We have to breed, to develop the best to improve our species. It is said that Socrates was instructed by Diotima about things regarding love, she wasn’t a mask but a felt wisdom.

She had the idea of the “coniuctio” (Agape) between Eros-Therapon and Erota-Philosophon, that is between healing Love and Eros who loves and enhances the love for wisdom and knowledge.

For us modern therapists, it might be interesting to know that at the origin of the Western culture existed the idea of the therapeutic relation Love-Soul, that is the authentic love of Psyche which therapeutically works in order to establish psychological and psychosomatic health. We can ask to ourselves: “Why for more than two millenniums was the therapeutic idea based on Love-Soul substituted by the mechanicistic and banal one? I feel that the war has hystorically prevailed over the authentic culture of the humanity. The Pythagorean were, for example, persecuted like the Jews and all the societies and ethnic groups who tried to give to civilization a real meaning, better than the dominant one.
But, the instinct to the order, harmony, health, Psyche always reborns and works to rebuild love by searching for the true, healthy life, for the Being-Psyche, for the light of the human wisdom. The tendency towards a “to be” civilization is fundamental in respect of the “to have” civilization (cp. E. Fromm and A. Maslow). A clinic example of my psychosomatic approach referable to therapeutic love happened with one of the musictherapists of my team.

She had been suffering for more than three days with pain in her ovaries. She mentioned it before, we started a family session. I acknowledge that without making any comment. However, during the session I played and talked about Eros-Therapon, precisely about the therapeutic love that was happening within the couple. The two participant at certain point felt an higher psycho-existential meaning about their relationship. Once the session was over my assistant and I started the abitual supervision of the dynamics evolved during the session. At a certain point I directly asked her: “Is your pain over?” After a long pause and inner examination she said: “Yes, it is. I don’t feel pain any more”. Later she was asking herself how could this happen. The symptomatic remission, even if in its subjective contents, has the scientific value of a therapeutic successful action. I told her that the Psychosomatic Music Therapy intention develops through the natural action sphere of Love between human being in a state of mature consciousness with a psychosomatic vision.

Given all the symptomatic remissions I have withnessed and intentionally stimulated, during Psichosomatic Music Therapy sessions, I should say I am not surprised by this natural psychodinamic of well-
Being. What actually surprised me is the patient’s struggle to keep it in his/her life; set backs to the alienated consciousness are possible. Splits of Mind-Body can be explained by thousands of years of psychosomatic alienation which still survives in the Ego and obstructs the healthy roots of the psychoerotic consciousness of the western civilization.

The killing war and the riviving Eros are two opposite dynamics constantly present in mankind, but I don’t believe that the problem is because of the Death instinct opposed to the Life instint. This is what I believe in. Because of the lack of Eros-Psyche consciousness in people’s life, a daily alienation occurs which impairs the Intelligence-Reality to go back to the original meaning. When we cut off Love from its natural harmonic potentiality, by an alienation of two millemnia, the outcome is hatred, illness, war and death. This is the conclusion of an alienating circuit from which a constrained Ego, doesn’t want to come out.

If we, the misic therapists, begin to reclaim, in our culture, the right to Psyche as therapeutic Eros possibility (Love which creates the Harmony of the social-cultural sphere of action from the generative roots of the divine Eros) we will regain, day after day, our own sanity and that of the humanity as a whole, and anybody to whom we refer. The resolved cases based on the Psychosomatic Music Therapy approach, could be a contribute to stimulate the scientific consciousness, the real value of the therapeutic Eros and Love which cures as a principle and performs in the very human being.

My son Iori Felice at the end of a conference about Love asked and in the same time affirmed: “Are you Eros?” I replied: “Yes, I am what each
man and you are: The Psyche Being who loves and the real dream of the matter.”

The Ego Psyche is the Ontosophy, the wisdom of Being. The human being’s wisdom of Love is the fruit of which the Earth is pregnant for the third millennium.

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The title of this paper emerges from my living and practising as a music therapist in South Africa for the past eleven years. Here is a social and cultural context whose indigenous cosmology has spawned a particular healing practice that includes music: that which I call here African Traditional Healing.

Since Music Therapy theory and practice emerges from a Western cosmology, and since these two traditions co-exist in South Africa, I have long wondered how and where Music Therapy and African Healing can position themselves in relation to one another. At the same time, though, I am not assuming that this regional co-existence and co-incidence necessarily results in the two being similar, or even connected with one another.

This paper attempts to draw parallels between the cosmologies that inform each practice, and to describe each ‘in relation with’ the other. This is in keeping with the Traditional African belief of Ubuntu which means that each one of us is created and exists through our relation with one another; and in keeping with Western notions of inter-subjectivity, as signalled by Martin Buber’s understanding of I-Thou: that Spirit moves between, rather than within, individual persons (Buber 1958(1937)).
Introduction and setting contexts.

Like most nation states on the African Continent – or indeed, in the world - South Africa is hardly culturally or socially homogenous. This renders the term African Traditional Healing complicated, to say the least, even if we know that some healing rituals are widespread in Central and Southern Africa. In this paper, however, the word ‘African’ is used to describe those persons and societies whose cosmologies and social values are informed and bound by the indigenous cultures of South Africa. The term ‘Traditional’ is used as a counterweight to the notion of ‘Modern’ societies, and here refers to societies whose and beliefs pre-date the colonization of South Africa by Europeans, and that show no little or no Western influence (Coplan 1985; Stokes 1997).

Another regional idiosyncracy needs to explicated because of its powerful influence on both Traditional African life and so-called Modern African life in South Africa, and this is the urban and rural distinction. Peculiar to South Africa prior to 1994 was the coercive system of labour migration, needed to meet the needs of urban Modern economies after World War II. Whilst retaining strong ties with its rural origins, urban life began to grow social structures, values and musical cultures that emerged, and became distinctly urban. This musical urban South African culture was first documented by David Coplan’s book In Township Tonight! in 1985.

At the same time, though, as Coplan himself acknowledges, urban culture also impacted on rural life, so that while urbanization can be understood as a de-tribalisation of indigenous rural people, rural life
became transformed into what Coplan calls ‘rural urbanisation’ (Coplan 1985). We begin to see that to speak in terms of ‘African’, and ‘Traditional Healing’ remains somewhat complicated in a regional context that norms and values of Modern, industrialised and post-industrial Western societies whilst also retaining aspects – possibly significant aspects – of Traditional African life. At the same time, though, the ‘Modern’ – ‘Traditional’ duality is a convenient pivot on which to rest two broadly different practices and cosmologies: those of music therapy and of Traditional healing.

However, I want to use this mutual influencing between rural and urban social and cultural values as a metaphor for the increasingly complicated and possibly spurious excercise of drawing too clear distinctions between ‘Traditional’, and ‘Modern’ life in South Africa: in any case, most urban contexts – as in many countries in the world – have become a melting pot of Traditional, colonial, Modern, global and metropolitan cosmologies and cultures (Stokes 1997)

The complicated co-existence and frequent collisions of the Traditional and Modern cosmologies are illustrated by a vignette.

**Vignette**

South Africa has recently been in the grip of a social and political furore, the result of young men dying during their initiation at an initiation school. Initiation is a Traditional rite of passage into manhood, and is found across all Traditional cultures in South Africa. It is the nature of the furore that is of interest here: in a television documentary, officials from the Department of Health in Gauteng Province emphasised that
Modern day South Africa is a country in which both Traditional and ‘Modern’ belief systems and values co-exist, and at times collide, as in this instance.

It is precisely this co-existence and collision of meanings and cultural values that underpin this search for a confluence between Music Therapy and African Traditional Healing. The complexities of attempting to explore these two practices in relation to one another – rather than within their own distinctive conceptual frameworks – necessitates some further clarifications, this time to do with the concepts of ‘Self’, ‘Music’, and ‘Illness’, Health’ and ‘Healing’. These are explored briefly as social phenomena, before presenting aspects of music therapy practice and African Traditional healing, to close this paper.

**Filtering Meaning: Music, Music Therapy and Self**

In considering the nature of ‘meaning’, I position myself within the discourse of ‘post-structuralist’ sociology. In other words, rather than understanding systems of meaning as independent of persons and social groups, these systems are seen as generated by social groups in an ongoing process of ‘patterning’ beliefs and values. Here, meaning is understood as socially constructed and highly context bound, and as existing in reciprocal relationship with our collective experiences of the world. Also, social meaning is constantly affirmed, constricted, extended and challenged within social communities: with the more economically and political powerful sectors of society being invested with their systems of meaning dominating social discourse (Martin 1995; Billington, Hockey et al. 1998).
Another understanding of social meaning is put forward by anthropologists, who contrast the notion of ‘universal’ with ‘culturally conditioned’ beliefs and habits; also described as the ‘scientific’ and the ‘cultural’ approaches. Here, in talking about musical meaning and experiences, anthropologist Judith Becker suggests that both views of meaning are necessary: since early interactional patterns with our immediate social group, such us our family develop within us particular systems of experiencing, and giving meaning to, our social world – including music. At the same time, Becker suggests that human beings seem to have an imaginative capacity to ‘enter into a much wider palette of human possibilities’, suggesting that, as she puts it, ‘humanistic particularity’ and ‘scientific universalism’ might co-exist, rather than themselves exist as a duality (Becker 2001: 140).

This dynamic view of social meaning has also impacted on the generating of meaning to do with ‘music’. The discipline of (Traditionally Western) musicology has more recently explored music as a dynamic phenomenon, engaged with, and engaging persons and social relationships – as crystalised by the title Christopher Small’s Musicking (Small 1998) – in contrast to the ‘Modern’ view of music as separate from human persons who create, perform and listen to it (Cook 1990; Frith 1996; Ansdell 1997; Cook 1998) (Martin 1995).

**Selfhood: Matters of Spirit**

If we consider the meaning and nature of ‘Selfhood’ within Traditional Southern African societies, we are instantly faced with the presence of the super-natural. In contrast to the Modern understanding of human
beings as individuals with a physical, mental and emotional life, distinct from other individual persons and with a clear beginning and end, the ‘Traditional’ person (whatever that means in these culturally complex times) exists as part of a complex and collective hierarchy of beings, physical and spiritual, which inform, propel, and powerfully influence daily and collective living. This living does not ‘end’ with death, but continues in another form, both before birth and after death.

Thus, according to indigenous Traditional meaning, the African person is animated by natural and supernatural (or material and spiritual) forces, which co-act within and between persons. The ancestors – or the spirits whose deaths precede those of the living person - are those to whom all turn to for guidance and support. These spirits need to be wooed / appeased / befriended with ongoing and collective public events, in the forms of Traditional rituals, observations and festivals. Failure to observe and sustain collective rituals may result in illness, social calamities or even natural catastrophes such as droughts, floods or fires (Shaw 1999).

Thus, in South Africa, magical and superstitious beliefs (e.g. of witchcraft) co-exist with Modern rational and secular view of the human being.

However, it would be far too simple to emphasise only the differences between Traditional African cosmologies and those Modern life. For example, In ‘Western’ life, Christian cosmology understands that Guardian Angels ‘arrive’ at birth in order to ‘look after‘ us throughout our lives; and the ‘Communion of Saints’ is generally depicted as a collection of spirits, some of whom are ‘higher’ in the hierarchy of
‘holiness’, having achieved the status of ‘sainthood’; whilst others, lower down the hierarchy, are ‘souls’ of those who have pre-deceased us. Similarly, outside the religious sphere, the practice of Western psychoanalysis invites us to ‘remember the past’, and bring not only the past into the present, but also our dreams, fantasies, and images – which Traditional Africans might well understand as aspects to do with our ancestors and spirit world. Christian festivals and rites such as ‘All Saints’, ‘All Souls’ and the celebrations of Easter, can be understood as having to do with honouring the ‘ancestral spirits’, as do the naming of towns, roads, and the erecting of monuments and statues: all of these can be seen as enhancing our Modern sense of collective social continuity that includes the ‘non-physical’ past.

**Selfhood: society matters**

As well as being linked to the spirit world, Traditional indigenous persons belong to cohesive tribal groups. This powerful social link to other persons, epitomised by the notion of Ubuntu, is the primary experience of Self, in contrast to the individual physical existence of the ‘Modern’ person (Blacking 1973). However, anthropologist Clifford Geertz, has the following to say about the ‘Western’ concept of being a person:

“The Western conception of the person as a bounded, unique more or less integrated motivational and cognitive universe a dynamic centre of awareness, emotion, judgement and action organised into a distinctive whole and set contrastively both against other such wholes and against its social and natural background is, however incorrigible it may seem to us, a rather peculiar idea within the context of the world’s cultures.” (Geertz in Billington et al, 1998:42)
At the same time, we know that the Modern individual also experiences powerful feelings of collective social (if not tribal) identity as evidenced recently during the Football World Cup in Japan – Korea. Here, the ‘global’ world became a distinctive collection of ‘tribes’ each expressing powerful sentiments through ‘tribal’ war-paint, chants and behaviours – and this by members of Modern societies that emphasise individualism at the expense of collectivity.

If we think about the discipline of music therapy, we can see that whilst, like (Western) psychology and psychoanalysis, music therapy emerges from a cosmology that emphasizes ‘the individual’, ‘self-development’, ‘self-actualization’ and ‘autonomy’, these emphases on ‘Self’ may, in fact, hide another kind of collective, social Self, as evidenced in more recent psychological and psychoanalytic literature.

Since the 1980s, some literature in developmental psychology and psychoanalysis emphasises the role of relationship in helping to grow and define the person. In other words, whilst the ‘Traditional’ European view of the individual as self-contained – which, incidentally, makes it possible to think of ‘self-and-other’, this very ‘self-and-other’ seem to be linked in such a way that there is no self without the other. Martin Buber’s I-Thou as contrasted with I-it has resonated with the notion of inter-subjectivity, as described by studies about the form and nature of human communication. Buber talks of ‘Spirit’ being not in the ‘I’, but in between the I and Thou (p.57), and also suggests that ‘A person makes his appearance be entering into relation with other persons (p.85) (Buber 1958(1937)). Here, we can see that ‘my’ subjectivity does not belong
exclusively to me, but rather, is created through my experience of being ‘in relation with’ another human being (Ansdell 1995; Pavlicevic 1997). In other words, I am a subject because of my experience of connectedness with the ‘other’ (Trevarthen 1980; Trevarthen 1993; Trevarthen and Airken 2001); and this resonates with literature in sociology that emphasises the notion of identity as being co-created by the individual and society, instead of residing within the individual – a point taken up by music therapist Even Ruud in his discussions on musical and social identity (Hargreaves and North 1997; Ruud 1998).

Moreover, we might consider that the very existence of ‘sociology’ as a discipline suggests a Modern ‘belief’ – at the very least – in the value and power of collective living, and of individual meaning – being socially constructed. Also, as we saw earlier, the ‘powerful myth’ of the Western person as a self-contained individual, is being challenged within sociology (Billington 1998); (Crozier 1997).

I want to now leave this brief discussion on the notion of the Modern and Traditional understandings of “self”, and visit various notions to do with illness, health, treatment and healing according to the two cosmologies that inform this paper.

**Illness and Health: Considering Cosmologies**

The discipline of sociology understands health and illness as embedded in the cosmologies that underpin social norms of behaving and relating. Here, generally speaking, disease or illness has to do with times of change within a person’s life that are seen by society as being
‘undesirable’ according to the norms of that social group. In other words, illness and health are context specific, rather than ‘objective’ and standardised phenomena found all over (and anywhere in) the world. So, for example, whilst giving birth may be viewed in Traditional African society as a brief interruption to the carrying out of social duties and tasks, childbirth in Modern societies often involves medical intervention, hospitalisation, and is generally followed by a withdrawal from the sphere of ‘work’. It would seem that in most societies, changes that result in being unable to fulfil one’s function in the work-place or one’s role as family provider or carer, are generally viewed as having to do with being ‘unwell’. Also, most of us are familiar with the young child who is ill and cannot go to school, but at the same time is well enough to eat ice-cream and play energetically with the new puppy. Here, within the social context of school the child (for whatever reason) is unable to fulfil her social role as a pupil, which she herself translates into ‘being ill’. However, within the family context, her role (of youngest in the family who identifies with the puppy, like her the youngest animal around), apparently functions intact. She is ‘ill’ in the school context, and ‘well’ in the home context – at the same time. This makes sense if we understand illness and health as context-bound. If instead we think of illness as an objective phenomenon, independent of social contexts and roles, then we’d think that the child is being a hypochondriac.

Generally, ‘medicine’ of whatever practice, gives shape (and name) to illness and disease, so that we come to understand our illness through socially constructed mapping of ‘health’ and ‘ill-health’ – and ‘cure’.
The Traditional African understanding of illness is that it has to do with the spiritual as well as the physical (Swartz 1998). Also, illness has to do not just with me as an individual person, but rather with my entire social sphere – and this includes the ancestors and spirits. Thus, the illness in a human body affects that person’s collective life, and also the spirit world.

The Western bio-medical view of the body as a ‘mechanical’ system can, of course, be seen as a reflection of the mechanistic and scientific worldview that underpins Modernity: here is a distinction between mind and body, and between ‘my’ body and that of others around me. Illness, in other words, belongs to ‘me’ as an individual person. Even here, though, the influence of ‘Modernity’ doesn’t prevent myths and beliefs about illness from finding a voice, as evidenced by even the ‘scientific’ understanding of how some illnesses and diseases work (Hardwick 1998). Western medicine, with its mechanistic view of the body, understands the notion of psycho-somatic illness. Freud understood that certain neurotic symptoms could be manifested – or rather – somatised by his patients. Leaving aside psycho-somatic medicine, we might also consider a secular version of animating – and animated spirits in Western medicine: ‘viruses’ and ‘bacteria’ are ‘bad’ organisms that ‘invade’ our bodies from the outside, and make us ill. Treatment here usually involves destroying the ‘bad’ organisms. Psychiatry also speaks in terms of ‘hallucinations’ or ‘voices’ inside psychotic patients’ heads, that patients describe as bad thoughts entering their heads from the outside. Medicine speaks of genes or genetic material, which is ‘passed on’ from
generation to generation, which we can image as external material that effects good – or bad – physical and mental characteristics.

What we see in all of this is that what it means to be ill and to be well is rather complicated, and socially prescribed! And, if illness and health have to do with being a social person, and societies are invested in keeping its members as functional as possible in terms of their social roles, then an issue emerges, to do with how Modern and Traditional societies sustain their health, and prevent ‘ill-health from happening.

Cured or Treated? Healing thoughts

One of the themes of this paper is that almost every kind of meaning we can think of is context bound. Like illness, healing is context bound and culture-specific rather than prescribed by universally determined meanings of illness. Also, if Illness in broadest terms, has something to do with changed social roles, and as removing us from our social sphere, and these roles are determined by that very social group, then it follows that healing has to do not only with addressing and repairing illness or disease, but also preventing these, both within and between persons. Both within Traditional African cosmologies and Western urban ones, Healing can be seen as upholding and reinforcing social norms and values.

Here, we can see that both Traditional and Modern societies ensure that social health is maintained, each in their own way. Traditional African communities schedule collective rites of passage (like initiation), group festivals, ritual cleansings to ward off evil spirits, and to thank and woo benevolent forces. Modern Western societies, have parallel rites,
disguised in secular and ‘religious’ forms: they institute preventative health programs of sanitation, clean water and food hygiene, usually by Departments of Health. Moreover, Christian services spend time ‘praying’ for the sick to be cured; while Medicine thinks of annihilating or ‘expelling’ forces – whether viruses or voices. Also, Jewish services of atonement at Yom Kippur, and the Roman Catholic sacrament of confession can each be understood as a ‘cleansing’ of the self, for sustaining a life of ‘goodness’, and a warding off of ‘evil’ or ‘unclean; thoughts and deeds. Similarly, Christians processing through the streets of their towns and cities (for example at Corpus Christi) can be understood as a ritual cleansing of the social spaces from that group’s sins and misdeeds – not unlike the Traditional African rituals that cleanse social spaces and appease the ancestors, renewing the group’s commitment to keeping ancestors happy.

In each instance, these can be understood as the community or social group managing and avoiding incidence of illness, and keeping the social space cleansed, in order to discourage malevolent spirits – or bacteria – from wreaking havoc with its people’s ‘health’. Here, as a tangent, I would like to suggest that those of us who invest substantial sums in purchasing vitamins, African potato or Echinacea subscribe to the ‘placebo’ effect in many instances; and invest our (apparently rational) beliefs in advertising and marketing. These can be seen as rather sinister secular persuasions that our (individual and self-contained) bodies are at risk of constant ‘attack’ from nasty ‘outsiders’, and we’d better do something about this, and remain a functional member of society.
I’ve been attempting to draw parallels between Traditional - indigenous modes of social understandings of illness and preventative health, and the more Modern, urban rituals that ensure social cohesion and the ‘cleansing’ of social spaces. I now move to the last part of this paper, which considers the nature of ‘healing’ and ‘therapy’, in order to draw this paper to a close.

**This business of ‘Healing’**

In most societies, healing – in the broadest sense – is done by persons who (like music therapists, doctors and Traditional healers) undergo apprenticeships. These apprenticeships or trainings are generally at the hand of experienced healers, whether a Professor of Medicine, an accredited and registered Music Therapist, social worker or physiotherapist, or an experienced and socially sanctioned Traditional healer (Buhrmann 1979; Ross and Lwanga 1991; Maiello 1999). The process of becoming a ‘healing practitioner’ (in the broadest sense) usually begins with a ‘call’ – whether a dream; an inner vocational sense or ‘knowing’ that we want to do the work that we do. For most practitioners, the end of training culminates in a social celebration, whether a graduation ceremony or a party, and our entry into the practice of healing is generally mediated by a socially sanctioned group such as the Health Professions Council, State Registration or the local village accepting us to become based in their locality. Let’s now conclude by exploring the role of music in this ‘healing business’.

The work of ethnomusicologists (Blacking 1973; Chernoff 1979; Blacking 1992; Mereni 1996, 1997) alert us to the Traditional sub-
Saharan view of music as sustaining life, and as creating, affirming, sustaining as well as reflecting social relationships. Music psychologists whose work is generally contextualised in Modern, Western societies, have been exploring what it means to ‘be musical’ – and have shown us that the ‘folk view’ that being music is a ‘gift’ with which we seem to be born, is alive and well, even in apparently rational and fact-based cultures (Sloboda, Davidson et al. 1994; Sloboda 1999).

The practice of music therapy (and here I am thinking of Improvisational Music Therapy) is described in a recent text in the following terms:

Music therapy provides a framework in which a mutual relationship is set up between client and therapist. The growing relationship enables changes to occur, both in the condition of the client and in the form that the therapy takes….. By using music creatively in a clinical setting, the therapist seeks to establish an interaction, a shared musical experience leading to the pursuit of therapeutic goals. These goals are determined by the therapist’s understanding of the client’s pathology and personal needs. (APMT definition in Bunt & Hoskyns 2002: 10)(Bunt and Hoskyns 2002)

If we take a closer look at this definition, then we see that, within the cultural complexities of South Africa societies, music therapy and African Traditional Healing have in common an understanding of the person ‘in relation with’ the therapist. It is within this relationship - in other words, in the ‘space between’ therapist and client that, to re-quote Buber, ‘the spirit moves’. Music is central to this event, not as an ‘imported’ object that exists independently from therapist/healer or the client/patient, but as a mutual event, co-created by both persons. Like Traditional African healers, the music therapist has a body of knowledge that is the result of many years of training, and absorbing of ‘knowledge’
and ‘techniques’ from the ‘elders’ of the profession, who have published
texts about their work. The insistent emergence of a movement within the
music therapy profession, that calls itself Community Music Therapy,
resulted in a Keynote Forum of that name at the 10th Music Therapy
World Congress at Oxford in July 2002. (See Pavlicevic’ Report entitled
“Keynote Forum: Community Music Therapy in these proceedings) .

Community Music Therapy insists on the client’s social and cultural
realities being a part of the music therapy theory and practice, and rejects
what Gary Ansdell has termed the ‘consensual model’ of culturally-
neutral music therapy theory and practice. Thus, the person’s socially
constructed understandings and experience of ‘self’, of illness, health,
and of music are taken into account by both therapist and client (Ansdell
2002). Also, rather than clients’ problems or ‘pathology’ being understood and treated as part of the Western Medical Cannon of
‘disease’ (of which, for example, the DSMIV is a proud example), like
African Traditional Healers (and like psychotherapeutic work), the music
therapist listens closely to the client’s contexts and music-making. In
other words, the ‘problem’ and ‘the cure’ is to do with the persons in the
moment.

What does any of this mean for an evolving music therapy practice in a
multi-culturally complex nation such as South Africa? Some aspects of
practice are beginning to emerge, some three years after the instituting of
the country’s first Music Therapy training programme at the University
of Pretoria. These include an emphasis on familiarity with clients’ social
and cultural backgrounds, and a respect and acknowledgement of social
and inter-personal norms that may be significantly different from those of the therapist. Also included as part of the training are learning Traditional African songs and dances, and a flexibility of therapeutic approaches, which may result in music therapists disinvesting themselves of ‘Traditional’ – i.e. ‘Modern’ - music therapy roles in the session, and taking on, instead, the roles that the client’s Traditional culture might assign them, such as teacher, elder, or ‘doctor’ (in the broadest sense).

Another social and cultural complexity is that, in medical establishments such as general and psychiatric hospitals, patients find themselves within contexts that practice Modern scientific medicine, and here, as with other professionals in these institutions, there is a mutual adaptation of cosmologies and norms by both the clients and therapists, resulting in a negotiated ‘culture of healing’, of which music therapists become a part.

In conclusion, then, the confluence between African Traditional Healing and Music Therapy can be seen as having to do with acknowledging their cosmological and social distinctiveness as well as their common ground. Here though, I’d like to suggest that even if the two practices have things in common, they are not necessarily inter-changeable.

Perhaps, here, the point made by John Janzen needs some comment. His criticism of music therapy in South Africa is that it cannot bring itself to ‘….work with African musical therapy’ (Janzen:2000:61). Possibly Janzen fails to understand that concepts of self, illness, health, and healing are deeply embedded in the ongoing daily life of any (and all) social groups, whether Traditional, Modern, African or not, and are not readily accessible – or on offer - to ‘outsiders’. In Traditional African
life, Traditional healers are bound to their social groups through associations that includes their ancestors, as well as their being bound to the ‘soil’ of the spirits whom they invoke. Here, even for Traditional African healers to enter into hospitals, or to practice outside their physical sphere is problematic – and I would suggest that it would be disrespectful for music therapists to ‘work with’ Traditional African Healing customs that are entrenched in those societies and communities.

Engagement with African music therapy (whatever that means) is not a matter of ‘learning about’ it, or ‘observing it’, and of adapting frameworks for working with African patients. On the other hand, music therapists work with many patients and clients from Traditional African cultures, and this happens in a mutually negotiated relationship, with both therapist and patient co-creating a way of working that is beneficial and healing.

As I hope to have shown in this paper, African Traditional healing emerges from a distinctive and rich, complex set of cosmologies; within a regional context that encourages all Southern African cultures to adapt and shift in order to accommodate one anothers’ values and systems of beliefs. At the same time, music therapy on the African continent needs to acknowledge that aspects of its practice are embedded in meanings that pay little heed to cultural context and distinctive social values (Ansdell 2002; (Ruud 1980; Pavlicevic 1997) (Stige 1998). It is this exiting, paradoxical co-existence that needs to be nurtured and tolerated: one where music therapy and African Traditional healing can sustain their distinctiveness, and at the same time resonate with one another.
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Report On Keynote Forum: Towards Community Music Therapy?

Pavlicevic, Mercédès

Panel: Brynjulf Stige, Emma Wintour, Gary Ansdell, Leslie Bunt, Nechama Yehuda, Rachel Verney, plus around 200 music therapists.

Chair: Mercédès Pavlicevic

Abstract:

In recent conferences, writing and informal discussions we have noticed the steady emergence of new forms of music therapy practice, along with equally new discourses and theory to elaborate and research them. These practices are engaged 'community music therapy' projects which are especially sensitive to the social and cultural contexts in which clients and therapists live.

We do not just mean by this conventionally-defined music therapy placed in community settings, but rather practice which is defining broader agendas and arenas for music therapy: music therapy as community action, as a social and cultural force. Such practice is calling upon a new repertoire of inter-disciplinary theory: from sociology and anthropology, social and cultural psychology and from the contemporary social psychology of music and the New Musicology. This Keynote Forum aims to investigate how different national schools of music therapy have developed 'community music therapy' practice and theory, and its future relevance for the further development of music therapy in Western and non-Western settings. Overall the question to be asked will be: Is Community Music Therapy the new paradigm for music therapy in the 21st Century?

The Report:

(This report is compiled from the statements prepared by the Forum panel as well as from the feedback of the seven groups that were formed by the (plus-minus) 200 participants. The Forum discussions portrayed the diversity of music therapy discourse and the multi-cultural nature of
music therapy. This report attempts a summary of the event, and includes contradictory statements: these reflect the lively and complex textures of the energetic discussions. The report draft was circulated to each of the panel members, for comment and editing. MP.)

The Format

The participants (around 200) were divided into seven groups, and given 30 minutes to address questions prepared by the panel. Each ‘participant group’ was requested to formulate their answers onto flip-chart, and to appoint a speaker, to report back to the plenary. At the end of each group’s report, each member of the panel presented their prepared responses, and the Forum ended with a plenary discussion. The even was lively and energetic, and generated a buzz around Community Music Therapy. This report has woven together the responses from each of the groups as well as each panel member’s response.

The focus questions that informed the Keynote Forum were as follows:

Prior to this event, the Panel was asked to read texts by Gary Ansdell (2002) and Brynjulf Stige (2002), and respond to the following questions:

1 Is the definition of Community Music Therapy (CoMTh) anything new in music therapy? Is it useful?
2 Is CoMuTh a challenge to current music therapy models?
3 How can the concept unfold? What are your visions?

During the Forum, the seven Participant Groups were asked to focus on the following:
1 What do you understand by Community Music Therapy?
2 What is your vision of Community Music Therapy?

(Rather than addressing each question, which would result in repetition and overlap of ideas, this report presents the main themes of the Forum. MP)

**Community Music Therapy re-visits limits**

Music therapy generally operates within a ‘consensual model’ (Ansdell 2002): i.e., informed by theories that are allegedly culturally ‘neutral’. CoMuTh challenges this model, in the sense that social and cultural contexts need to impinge on music therapy theory and practice. CoMuTherapy’s challenge may involve re-visiting the limits of what constitutes illness and health, healing and therapy, and notions of ‘music’ and ‘community’.

Music Therapy generally takes place within a boundaried space, created by theory, professional standards, and therapeutic norms that include time, physical space, confidentiality and the institutional context within which music therapists work.

This boundaried space may be understood as ‘limiting’ in the sense of clarifying what does and does not happen within sessions, both protecting and enabling the therapist-client relationship.

The boundaried space also sets up dualities that include

- private and public space: what belongs ‘inside’ the session and the work, and what belongs ‘outside’.
- Institution (within which the work happens) and society (outside the institution)
illness / disability / disorder / needs and health / ability /
- Music therapy and other caring professions
- Music therapists and community musicians
- Traditional treatment models and ‘preventative’ health care

Thus while ‘limits’ (in the sense of therapeutic norms, and contextual and theoretical frameworks) are necessary and containing, they may also be confining.

CoMuTh is a response to social, political and cultural currents ‘outside’ the music therapy profession. These call us to revisit the dualities resulting from the ‘consensual limits’ of current practice.

**Community Music Therapy and ‘Culture’**

The term ‘culture’ is enormously complex, and multi-levelled. The challenge to CoMuTh is to retain the term’s multi-levelled meanings, and reflect these in theory and practice.

The **institutions and clinical contexts** within which we practice have their own cultures, informed by regional and social understandings of ‘illness’ and ‘wellness’. These multiple cultures impinge on music therapy theory and practice, discussions with professional colleagues, writing up case material, reporting and researching the work, and writing about music therapy.

At the same time, the **music therapy profession** is a culture in itself.

Music Therapy has its own ‘**global’ culture’, evidenced by the profession’s capacity to generate a common discourse specific to the
profession. At the same time, the professional culture is diverse, containing (and at times excluding) a range of theories and practices.

This diversity is twofold:

• straddling national, regional and linguistic contexts (e.g. practice underpinned by psycho-analytic, cultural or medical models); as well as

• reflecting regional, national and ‘cultural’ differences.

CoMuTh can be understood as an attitude of ‘listening’ to diversity, and broadening our tolerance of professional and theoretical differences. These attitudes do not necessarily compromise the very diversities that enable the professional culture(s) to remain both diverse and ‘global’ at the same time.

CoMuTh acknowledges, and responds to, clients’ social culture and musical identities which may directly challenge ‘global’ and ‘consensual’ therapeutic norms, limits and boundaries.

CoMuTh calls for a more dynamic engagement with, and exchange between music therapy and society in the broadest sense, understanding that social, musical and political cultures may be specific to regional / linguistic / institutional contexts and also global at the same time.

CoMuTh enters into society and become part of existing and ongoing social and cultural discourses.

CoMuTh sees itself as part of the forces that address – and contribute to – changing social currents; whilst also allowing itself to become changed by social and political currents.
Music, Music Therapy and ‘Community’

Like ‘culture’, the word ‘community’ is over-used and has a multiplicity of meanings:

- The word itself has cultural nuances, both global and context specific.
- Professional contexts and professional discourses themselves colour the meaning of the word ‘community’.
- Even if we do not have a common approximation of the term ‘community’, there are questions around what constitutes ‘community’: this includes a sense of ‘belonging’, and this belonging is generally to a ‘group’. Also various communities co-exist and traverse one another, so that clients (and therapists) may belong to various communities at once – e.g., religious, ethnic, regional, professional.

CoMuTh takes into account the various communities which surround (and support) music therapy practice. These communities include the professional body of music therapists, the ‘caring professionals’, the institutional community, community musicians, and the client’s various communities.

CoMuTh understands music therapy practice as an agent for creating a sense of ‘belonging’ to a ‘group’. This may mean working with clients’ musical, social and cultural identities, and supporting clients’ re-integration within their musical, social and cultural communities. This pragmatic practice may include working outside the institutional context, within socio-cultural contexts, and liaising with local musicians and community workers. Here, Community Music Therapy straddles the ‘boundaries’ traditional to the consensual model of music therapy, and
helps and may accompany clients with their passage from the institutions to life ‘outside’.

CoMuTh sees itself as acknowledging, creating and generating community – with all the contradictions and complexities that this entails. Within the community of music therapists, CoMuTh hopes to sustain professional differences, and opposes defining itself.

**Definitions and Visions**

(Attempts at ‘defining’ CoMuTh were generally seen as being too definite and restricting. Here, a range of statements is presented to do with defining (or not defining), and as visions of, CoMuTh. MP)

Community Music Therapy:

- avoids becoming a new model or another model of music therapy
- reflects changing attitudes within the music therapy profession
- responds to needs external to the profession
- contains professional diversity
- makes links with other arts therapies
- makes links with community musicians and artists
- embraces social and cultural commitment.
- Has an attitude of listening and integrating differences within the profession
- Cannot be defined (and may be a British (hot air) balloon)
- Does ‘preventative’ work as well as ‘treatment’
- Is possibly connected to the move to de-institutionalisation
- Challenges and reduces the ‘distance’ between therapist and client – possibly acknowledging contexts and realities ‘outside’ the music therapy room
• Reclaims the arts and music as part of music therapy
• Can create ‘healthy’ institutional environments for clients and staff alike
• Interfaces with social and cultural thinking
• Leads to a more musical phase of music therapy
• Challenges the ‘consensual model’ of culturally neutral practice and theory, and may be incompatible with this.

Finally, Community Music Therapy offers a conceptual umbrella for the gathering of music therapists to debate, compare, argue and differ. The lively disagreements and energetic buzz of this Keynote Forum allowed all of these.

References


Report compiled by Mercédès Pavlicevic.
The role of attention and metaphor in Guided Imagery and Music

Perilli, Gabriella Giordanella

Introduction

Guided Imagery and Music - GIM, developed by Helen Bonny (Lindquist Bonny, 2002), is considered by different authors from different theoretical perspectives, Junghian, psychoanalytic, transpersonal, etc. I am the only one who use GIM from a cognitive point of view (Giordanella Perilli, 2002). For this reason my contribution is aimed to present you some elements, such as attentive function and metaphorical process, which could clarify some aspects of this method.

Embodied Schema

According to second-generation cognitive sciences, the human being is viewed as a complex open system for acquiring new information through concrete body experiences, structured by imaginative schemas. (Slide 2) These schemas serve as models to organize our experiences with motor and perceptual components (Johnson, 1987). The schemas may be related, for example, to movement, balance, and rhythm, or generally speaking to change (Giordanella Perilli, 2002). (Slide 3) The schema of balance emerges from structure of bodily and perceptual events. The schema of movement is characterized by a directional process toward an end. The schema of rhythm furnishes a temporal organization to neurophysiological and psychological events (Giordanella Perilli, 2002).
Metaphorical process to develop personal identity

The next step for new knowledge development, or meaning making, is metaphorical elaboration of these embodied schemas, which are stored in our memory, that is moving an imaginative schema from one realm of experience to another. This process involves projection and using metaphor to create new patterns of meaning, when a person perceives commonality between information (Giordanella Perilli, 2002). For example an anxious person may perceive a fast music “as if it were anxious”, and may create or evoke scaring images associated to such emotion (i.e. a vortex).

(Slide 4) Pertaining to creative, fundamental, cognitive process, metaphor is an imaginative structure, based on the body in interaction with its environment.

Stern (1985) writes that metaphors function in mother/child attunement because human beings have the ability, known as synesthesia, to transfer characteristics common to one sensory domain into another, so that a sound can evoke an image, or the opposite can happen. (Slide 5) Following Bowlby’s opinion, in the mother/infant relationship, styles of attachment and care (organized or disorganized) constitute patterns of recurring behavior which form non verbal imaginative schemas for mental representational states of the various types of relationships, and furnish the interpersonal counterpart of self consciousness, with basic affects and emotional qualities (Bowlby, 1969). For this reason, metaphors, developed in early period of life, refer to the contents of experience and represent inner working models, as configurations of self,
roles, and interpersonal relationships. Thus, in therapy it is important to carry them to a conscious level if they are no more useful for a creative adaptation.

Since metaphors can be elaborated during the entire cycle of life, GIM, as experiential therapy integrating music, imagery, relaxation and interpersonal relationship, can offer a scrumptious opportunity for new healing metaphor construction. (Slide 6) In fact sounds and music are integral components of early life, as a variety of studies have demonstrated, in that they solicit emotions and provide a means for connecting a human being to the environment, and attuning with significant others. In doing so, sounds and music contribute to the formation of non verbal imaginative schemas, with rhythmic, kinesthetic, and affective components, and by consequence, to the development of metaphors connecting sound-music and interpersonal experiences, stored in long-term memory, basis to organize our biographical identity. Metaphors could be related to the Interpersonal Motivational System operating at each time, regarding attachment/care, agonistic behavior, sexuality, and cooperation, to define roles and relationships (Giordanella Perilli, 2002).

It is the present author’s opinion that a similar process happens through GIM experiences.
Attention as golden gate to inner world

The other fundamental element in GIM I would like to underline, is attention, (Slide 7) a complex cognitive function which is the golden gate to our life experiences and, of course, to therapeutic change and growth.

In this regard, GIM facets stimulate, develop, and maintain client’s attention in many ways, allowing clients to participate actively to their session and therapeutic process.

At the beginning, the preliminary conversation between client and guide defines a specific issue to work with. The relaxation step helps to concentrate selective attention to inner stimuli. At this point the guide proposes, to complete induction, an object, an image, an emotion, etc. which serves to focus client’s attention and prepare to shift to music experience. The chosen musical program will contribute to activate, maintain, and deepen client’s attention by different musical components and extra musical associations, facilitating to turn attention to traumatic memories by a non ordinary consciousness state. The music temporal characteristics may be relevant to entrain client’s temporal schema. Since such rhythmical – temporal characteristics involve many sub - cortical and cortical areas of brain, so attention could be oriented or re – oriented at various levels (physiological, cognitive, sensory – motor, emotional, etc.) during ordinary and non ordinary consciousness states. Obviously emotions evoked my music and imagery are basic to maintain attention.

During the listening experience, by verbal dialogue and interventions, the guide helps the client’s attention to complete an exploration and discover new elements and resources to afford difficult situations, and elaborate
new alternatives in imagery first and afterwards to transfer new solution in practical life.

In the postlude phase, the conclusive dialogue, developed in an ordinary consciousness state, fixes client’s attention to vivid images, which can be associated and integrated to client’s own difficulties, bringing a new meaning and understanding to cope with life events.

In GIM experience different aspects of attention are developed and, finally, ability to pay attention to both own inner world and to external stimuli, i.e. music, perceived as a whole, useful to change own perspectives and to acquire new knowledge regarding self and environment.

In summarizing, I can say that GIM, as experiential method, evokes metaphors, arises and maintain attention in different consciousness states, and by personal interaction is conducive to a thorough exploration of inner world and creative change.

**From theory to practice: a case study**

The following case study will illustrate the above concepts, bringing theory to practice.

Dorothy is a nice and smart fifty year old woman in career. She is married and has two children. D. comes to GIM to work out depressive emotions associated to affective problems with her husband. She tells that, during past ten years, she has had depressive episodes and panic attacks, alleviated by drugs. She already has had group and individual
psychotherapy; she practices yoga and many sports (sailing, tennis, diving, etc.)

During almost one year she has had twenty one GIM sessions and seven verbal ones.

Usually, the first session offers a whole picture of personal inner world. By starting, Dorothy experiences to be in a dark grey whirlpool with a black hole in the middle, and many objects all around. She feels very anxious that she might be sucked in. In the postlude she spontaneously associates this image and feelings with her mother’s death happened when she was three year old, telling that previously she has already worked with this issue, thinking to have definitely overcome it.

At this point it is clear that the critical issue is not her mother’s death but the consequence in her attachment/care system: changed from secure, being a deeply loved only child, to disorganized for both parents. Regarding her mother because her absence was understood by Dorothy as temporary and linked to her good or bad behavior, as her grandmother told her; concerning her father, depressive feeling for his loved wife’s loss, caught him totally, in a way that he could offer his daughter only scaring and disorienting look. During childhood, a baby seems receiving back his image emotionally and dynamically modified by meaningful relationship with his parents, especially through his mother’s look and eyes, for learning and developing an adaptive and articulated self construction. When this mirroring is lost, child’s self image remains blocked without interpersonal counterpart, like Narcissus. According to information received from her grandmother that if she were good her
mother could come back and his father would not leave her to go far away to work, Dorothy did big efforts to be good, without any effect, so she became confused and not trusting on her ability to behave and cope with painful events. She used to dissociate herself from reality, using for example whirling movement to disorient herself and loose consciousness. She felt absolutely bad and wrong, and depending from other people’s support, for example, to sleep in order to avoid panic attack. For many years, D. has had a dream concerning an enormous dark eye. In this situation Dorothy develops a depressive syndrome and a mild Dissociate Consciousness Disturb, consisting in a disoriented state of consciousness, a loss of sense of self unity and continuity in time and space, and poor integration between self identity, memory and consciousness. At the beginning of GIM process, D. shows no awareness regarding her feelings and thoughts. She appears confused most of time concerning her inner world, while in her professional role, D. has logical, analytical thinking modalities, using coping ability in creative and constructive way, as chief manager of a biological research group. Besides, she remembered only a very few events of her childhood.

A narrative of Dorothy’s GIM experiential process

During GIM process, many themes are expressed with various metaphors composing the whole life narrative. For sake of clarity and simplicity, together with Dorothy, I choose one basic theme to be followed in its metaphorical evolution, that regarding attachment and loss, since many Dorothy’s images are kinesthetic and referred to a pre - logic stage of life
when body movements communicate child’s inner states and needs. Now is the Dorothy’s journey told as an unfolding story.

The preparing step: the exploration of inner world

(Slide 8) Listening to Ravel’s, Introduction and Allegro, D. finds herself in a dark grey whirlpool, afraid and blocked in her body, seeing many objects all around, feeling very anxious to be sucked in a central black point which reminds her a big eye dreamt for years. Again with Debussy’s Nocturne – Sirènes, she experiences being in a dark swirling eddy, but now Dorothy feels pleasure. The two pieces by Duruflé, In Paradisum and Notre Père, evoke the metaphor of a nocturnal image of the vibrating universe: D. feels intense and joyous commotion while vibrating united with infinite space and music. With 2nd Symphony, by Vaughan Williams, here again D. feels deeply anxious, bodily trembling, blocked into a coffin, wishing to become “very very small”. Only with Grieg, Cradle Song, she goes out by a light, free to ride a bicycle with a friend of her. In different sessions, D. succeeds to copy with many difficulties: she gets out a house where she feels afraid to be crashed by Brahms’ music (3rd Symphony, Allegro con brio) and (Slide 9) getting on a sailing boat, she manages it in a heavy ocean waves, during a storm, landing safety in a little island (Slide 10). Or she finds herself at a water fall top, and takes the risk to jump down, always with unusual body movements and associated feeling (Slide 11) to be in a wrong place or (Slide 12) to act in a wrong way. Very anxious, she escapes to a very scaring thing evoked by Brahms, Piano Concerto 2 – Allegro non troppo, and arrives at a cliff edge, afraid to fall down. (Slide 13) So she lays
down on the grass, with her body tightened by many threads but trying to
creep toward (Slide 14) a dark wooden to hide from a “big eye” looking
at her from above. She receives an hatchet to cut the threads and release
her body. Instead she cuts her body. (Slide 15) Becoming a waving
thread of energy moving very fast, she is, now, above in the sky with
dead people, looking disgusted at her bloody body in the grass. (Brahms,
German Requiem, Part 1, 5). She would prefer to remain there, but when
music changes, listening to Brahms, 4th Symphony (Andante moderato),
she decides, with a big effort, to come down and join her hurt body. Then
(Slide 16) Dorothy jumps down in the ocean to wash and clean herself.
She gets out young and beautiful, walking with her straight head towards
the wooden to search a house.

**The working step: going beyond surface**

At this time of her journey, Dorothy seems ready for a pivotal moment.

(Slide 17) At very deep sea-bottom, Dorothy is seven month old, going
up (Brahms, 3rd Symphony – Allegro con brio) she grows up and (Slide
18) meets her mother, feeling and touching her “flesh”. Deeply moved
they hung and kiss each other with love (Nielsen, 5th Symphony Excerpt
of 1st Movement). Dorothy knows that it is necessary to say good bye to
her mother, otherwise she will remain with her mammy for ever. Now
she feels ready to go up at sea surface. Doing so she grows until her
actual age and body dimension. On the shore she goes at the same place
where she cut her body, but now she feels as a whole, a unity. Standing
up she sees the same wood but in proportion to her height, it appears like
grass. Coming back to the shore, Dorothy notices a house she did not see
the previous time, so she goes inside to rest. After a period Dorothy rebuilds the house as she likes. When in a difficult and unusual way she arrives at an oriental market, without knowing the reason of such a trip, she finds Aladino’s golden lamp. Taking the lamp on her breast, she feels surprised understanding that there are no wishes she wants express, but, very moved, she realizes that the lamp itself is the most important thing for her life: love.

After many other experiences, in the same house at the shore, Dorothy looks at a mirror seeing her image as (Slide 19) an ugly “Beast”, bent and suffering (Brahms, 4th Symphony, Andante moderato). D. breaks the mirror, puts its sharp pieces in a heavy sac, bringing it, with difficulty and anxiety, into the ocean. After a stormy, sea – waves polish and bring back her little mirror pieces, now become beautiful stones.

**The disclosing step: the crucial understanding**

The second time Dorothy meets her mother when (Slide 20) she is almost a one year old baby (Britten, Simple Symphony – Sentimental Sarabande). Her beautiful mother smiles, wearing a white shirt, a tartan skirt, and a pearl necklace: this image is so vivid, different from any picture Dorothy saw, representing the only real recollection she has of her mother. Her mother picks her up from the baby cart, hugging Dorothy and taking her on her soft breast. Listening to Walton, Touch her soft lips and parts, D. feels protected and loved, while she looks at her mother, touches her tender eyes, (Slide 21) wishing to go into their black hole, that is inside their pupil, she recognizes them as those she has
dreamt for years, and the pupil as the black hole she saw in the middle of
the whirlpool at the very beginning of her GIM journey.

Now Dorothy understands her mother’s emotions: enormous joy and
depth desperation, since she knows she is going to die and leave her loved
child alone, the same emotions she associated with the black hole or eye,
feeling pleased or terrified.

(Slide, 22) With Strauss, Death and Transfiguration, Dorothy finds a red
rose in a garden, as love and gift.

When she comes again to her house at the seashore, she notices a big tree
nearby, never seen before. D. climbs and seats over a brunch. During a
stormy weather, the father-tree takes off from land, floating with
whirling movements. Dorothy embraces its trunk, which feels warmed
by her body, but watches beyond her face, and she cannot catch its
attention in any way. So she decides to leave the tree which helps her to
go safety into the ocean, nearby her comfortable house.

**The growing step: from down to up**

Dorothy’s journey goes on.. (Slide 23) As on old bent pilgrim, wearing
torn, Dorothy arrives at a mountain, like Moses (Sibelius, Swan of
Twonela). She climbs it, and with big effort reaches the mountain’s top,
where she can stand up, bare, and free, since her torn were transformed
into water. Rolling down, she is again at the mountain’s foot, (Slide 24)
feeling well in a kind of soft beige environment, like her mother’s breast
(Dvorak, Serenade in E Major – Larghetto).
Then, with Bach, Toccata and Fugue in D minor for Organ, (Slide 25) Dorothy receives energy and light from a source, an antenna, preparing to engage a battle together many other people. Since she does not understand the reason for the battle, she goes out the crowd and washes her body to strengthen it, since she is still afraid, not sure to stand up by herself. Into the river in a bent position, Dorothy feels extremely anxious (Vierne, Carillon de Westminster), disoriented and confused. From the river she arrives at a pool; (Slide 26) she sits at its edge with her head on her chest, moving her face as a pendulum. Going to loose consciousness, saliva goes out from her mouth covering her face. Disgusted she touches her face and falls down (Slide 27) into a purifying mud, which covers her body totally (Slide 28) (Beethoven, 3rd Piano Concerto – Largo). Now feeling better, Dorothy stands up and stretches her body, (Slide 29) rinsing it under a clear blue water fall, together her partner. Subsequently, she comes back to the same river from which she departed, landing and (Slide 30) wearing a white bathrobe. Feeling tired but satisfied to have arrived she decides to stay and relax in the sun. (Slide 31) With Beethoven, 5th Piano Concerto, 2nd Movement, Dorothy flies in void space and puts a light ball on her breast to energize herself. Energy arrives as waves also from people down on the earth, and D. opens her bathrobe using it as a sail to take that energy. She walks nearby the river in a white clear air, getting off her bathrobe, standing up with her head straight. At this point Dorothy feels surprised observing how she walks easily following the path nearby the river.

With Faure, Requiem (In Paradisum), she sees golden things all around, as her mother’s skin. Wagner’s Lohengrin (Prelude to Act I), Dorothy
becomes very small as a butterfly experiencing change in time and space, and when she regains her dimension she jumps into vibrations which are all around her.

**The final step: the monster is a trick**

Dorothy arrives in a beautiful, sacred cave, enlightened by Aladino’s lamps (representing love). There is a calm lake which reflects Dorothy’s actual face but she is afraid to be sucked in (Ives: Unanswered question). She tries to find an exit, but she feels scared by something, perhaps a monster into the lake (Alwyn: 5th Symphony, 1st Movement). If the monster would emerge, there could be an explosion in the lake so that its water would invading the entire cave, submerging everything, and, then, extinguishing the flames which help Dorothy in finding the exit. She stops quietly in a niche, aware that it is worthwhile to find a solution to win the enemy without engaging a harsh battle, so she looks around on the walls, noticing pre historic paintings depicting two lovers and an arrow.

Feeling re-assured by the fact that for centuries love has been in this cave, following the flame, Dorothy sees a narrow short tunnel ending with a light, a passage bringing her up out the cave. Outside, she meets her husband; (Slide 32) they walk together hand by hand, really watching each other, feeling moved. But arrived at his car, her husband goes away leaving her alone on the road, by night. (Slide 33) With Messiaen, O Sacrum Convivium, Dorothy feels deeply sad to be abandoned, nevertheless she decides to go on and to come back home by herself.
While looking at the brilliant and clear nocturne sky she knows very well, she is aware to be a small creature but part of universal grandiosity.

In the postlude consideration, Dorothy associates the monster in the lake to her suicidal idea, considered a way to join lost loved people. At this point she realizes that this is a trick, while the solution depends from using her own resources to find an exit and go on the road, accepting to be alone without feeling desperate and lonely, since every human being is part of universal life.

It is important to clarify that this last session followed Dorothy’s husband decision to leave his family, and that after that GIM experience, she was able to use operational thinking modalities to solve problem and to cope creatively with life events, finally breaking the unhealthy vicious circle related to attachment and loss.

**Conclusion**

Dorothy’s experiences allow us to recognize some embodied schemata, those related to movement, balance, rhythm, and change. They are present in many metaphors associated to Dorothy’s self concept and consciousness states, elaborated as self body representation modified by social and perceptual experience (kinesthetic sense). For example, only after many sessions Dorothy is able to stand up and move straight, without rolling or doing unusual movement and position.

Through music, relaxation, and an organized – secure relationship with the guide, Dorothy was motivated to go deeply down into her uncomfortable, disrupting memories and, through metaphorical images,
she represented and communicated herself (houses, beast, etc.). Moreover she developed new metaphors to acquire new knowledge about her integrated self and the environment, experienced as a whole unit.

Comparing the first with the last Dorothy’s session, some basic differences appear evident: in the first she finds herself passively into a very scaring situation (the black whirlpool), while in the last here again she is afraid to be sucked in, but she is outside the lake and acts to find a solution, aware of the dangerous consequences of disrupting events, knowing how to prevent and change them, using her own resources. Finally she is conscious to be a human being part of universe. Synthesizing modification in her attention through GIM journey, Dorothy says: “Now I look inside and listen to emotion”.

A final consideration for Dorothy’s relationship with the music used in her Guided Imagery and Music sessions (Bruscia, 2002; Bruscia, 1996). She was quite responsive to music components and different styles, for example listening to Brahms’ composition, often she felt intensive emotions and had sublime images (to be crashed, to manage the sail boat in a rough ocean, to cut her body, to look at the Beast, but at the opposite, to go deep into the ocean as baby encountering her mother). Duruflè, Bach, Vivaldi, Messiaen evoke her metaphors of transpersonal, cosmic energy and universal unity.

I know that, following Madre Teresa’s idea, I can do only something for someone, and this I do here with my contribution.
References


Address

Gabriella Giordanella Perilli, P.hD
Vicolo Casale Lumbroso, 82
00166 Rome, Italy
E.mail giordanellagp@libero.it
Terms and criteria for assessment and evaluation with a neuropsychological perspective

Persson, Lars & Smideman, Gunnar
Sweden

INTRODUCTION

Music therapy of today is thirsty for clear methods of working and clear methods of assessing the results of the effectiveness of the therapy. We would like to describe the Swedish FMT-method, Functionally Oriented Music Therapy, and its approach to treatment and evaluation from a neuropsychological perspective.

First some important basis in our approach.

When we talk of an individual, we can look upon him or her mainly as an individual involved in a communicative process with the surrounding. He or she receives information through his/her sensory systems and gives out information (gives different types of answers) through some kind of motor activity. What kind of answer he/she will give depends on what emotions the information will evolve and what cognitive processes that will initiate.

The emotions and the cognitive processes that will take place are due to the level of emotional and cognitive maturity, but primarily depend on the individual’s ability of distinguishing perception. At the same time the motor answer is due not only to the motor development and talent but also to perceptive ability as well as emotional and cognitive level of functioning.
Perception itself is an advanced complex consisting of different sensory systems that are dependent of each other in comparing analyses that occurs in the associative areas in the back of the cerebral cortex. In the process of evolving an understanding of the environment and building concepts it always takes information from at least two sensory systems in combination to get a useful picture. Therefore an ideal elaboration of all the different sensory systems is necessary to achieve a balanced perception that is basis for the understanding.

Motor activity is also directly involved in the perceptual process through mechanisms as sensory adaptation and lateral inhibition. Those are different processes that occur in the sense organs in order to focus and distinguish specific stimuli for a better interpretation of what are the most important aspects at the moment.

Perceptual development is result of motor activity. And so is also emotional and cognitive development (you learn about surface quality, weight and size by grabbing different objects; you learn about distance and time by moving towards objects and so on). This means that the level of motor control limits the possibility of development of those other functions. At the same time the level of motor control is due to the level of functioning in these other areas. The development of functions from each of these four areas is coherent and does depend on each other.

Accordingly the motor activity and the ability to control motor activity mirror other functions as perception, emotions and cognition. And that is the reason why you also can use observation of motor activity in a controlled situation as a significant instrument for assessment.
What you need is a situation with a number of specific challenges with a strong tension that works on any functional level and which “provokes” to a motor answer. These challenges need to be similar for different individuals, so there is a basis for comparison. They also need to be independent on verbal instructions for a solution by the client. The last condition is necessary to get round problems with verbal understanding.

THE FMT-METHOD

Funcionally Oriented Music Therapy, the FMT method, has existed for 25 years now, and it is the creation of one man, a pioneer called Lasse Hjelm. He is living is Uppsala in Sweden, today 75 years old and still active in the development and refinement of the method.

There are today over 120 therapists educated in the method in Sweden, and almost 100 in Finland.

FMT can be described as developmental. The method is an approach to identify and treat functional deviations. Observations and changes are related not to physical age, but to developmental age and corresponding levels of cognitive abilities, motor skills, etc.

The FMT-method offers an opportunity to create a limited and structured flow of input, and it is adapted to the client’s individual conditions and to his or her level of functioning. This process is placed within a room with no other disturbing visual or verbal stimuli, where the therapist present drums and cymbals placed in specific patterns for the clients.

In the method each of these patterns are connected to a specially designed melody that the therapist play on the piano. Lasse Hjelm calls these
melodies codes, and there are 20 such codes in the method. There is no fixed tempo or rhythm – the client decides this. The structure in placement and melodies, is a frame of security, where it is easy for the therapist to observe the level and status of the client, and also easy to guide the client to the next step in his or her development.

The position of drums and cymbals presented to the client is based on different logical structures that he/she is expected to discover. After solving these problems the client must plan his/her actions so that a musical interaction can take place with the therapist. The therapist can challenge the client’s wish for musical interaction by presenting new patterns and by placing more drums or cymbals in front of the client.

Each pattern of placing has its basis in a neuropsychological development perspective. Examples of such bases are reading direction, eye to hand co-ordination, breathing, cross-movements, interhemispheric interaction, hand development and so on. As therapist I don’t give any instructions, and since no verbal instructions are given in the FMT-therapy, it challenges the client’s ability to solve the problem by him- or her self. In the FMT-method we always treat the clients individually to satisfy the specific needs of each person.

The codes – or simple melodies – are also a security for me as a therapist since I don’t have to improvise or emotionally analyse the improvisations of my client. I can give my full attention to the observation and to plan my next step in the therapy.

We offer a frame of logical patterns and melodies that are the same every time, but within this frame communication occurs. Meeting the client can
be done in my way of answering to the client’s way of playing the codes. Each client has his or her way of playing in tempo, rhythm, accentuation, and so on, and as a therapist I adapt my playing of the codes to this. So of course this gives a great opportunity for communication, and the great advantage in having seen perhaps hundreds of clients playing that particular code and placement, and have that as frame of reference. I don’t have to worry about remembering earlier improvisation.

Functionally oriented music therapy is today used in a lot of different areas. There are therapists working in schools, in hospitals, in schools for mentally retarded, and client groups are for instance persons with learning disabilities, dyslexia, birth related injuries as CP, ADHD, muscular diseases, Rett Syndrome, Down Syndrome, Autism, Asperger Syndrome, brain damage due to traffic accidents, strokes or other diseases and dementia. During the last few years there has been treatment of persons with schizophrenia at two hospitals in Sweden.

The reason for this wide field of application is not that we think we are presenting something magic. List like these in music therapy can give an unserious impression: -Is the therapy treatment for everything? It is important to remember what I mentioned earlier: we look upon and stimulate the development of basic neuromuscular processes. These processes are common for all people during our development, and that is why the method can be used on so many target groups.
ASSESSMENT AND EVALUATION

When you work as a music therapist you are confronted with different problems represented by different clients.

How does a music therapist describe what he intends to do, his aim with the treatment and what he actually does during the therapy session? How does he do that for others among which a great number usually are educated in a natural science tradition? Terms like intuitive understanding and empathic comprehension doesn’t always fit in with a natural science paradigm. In those contexts you need a concrete terminology that is descriptive in some kind of measurable parameters.

You also need some kind of objective values as basis for adequate evaluation. That is not only to convince others of the quality of your work, but also as guidance to make sure for yourself that you are working in the right direction with the client.

In the field of music therapy there are no common standards for either assessment or evaluation today. We think that this lack of common standards is likely to limit the establishment rate of music therapy in different fields.

In other disciplines there are different methods for assessment, but all of the commonly used test batteries are afflicted with difficulties for us as music therapists.

In the first place often-used tests have the problem that you as music therapist are dependent on other professions for assessment and evaluation. In the second place most psychological tests have its
drawback to rely on verbal communication, which means you can’t assess functions independent of speech. In the third place that kind of tests are quite fragmental and only makes it possible to assess separate functions.

In fact there are no tests at all that by a long way can be used to assess the full range of what you and the client are dealing with. For example one can mention the problem with frontal lobe injuries where a patient can pass the whole range of test batteries with results within the range of average or even above average. Still he is not capable to keep a work or has the capacity to function in social life. Phineas Cage is one the classical famous cases that reflects this problem.

Referring to these described difficulties the FMT-method suggests a number of criteria for assessment which primary focuses on expressive functions; pure motor activity. These criteria are significant, objective in terms of possible to observe in specific situations for anyone with right guidance, and they are to a certain extent measurable. The criteria are used within the FMT-method both for assessment and evaluation.

Important is that in assessment we don’t speculate or make judgements of what causes the difficulties or disabilities have. The main concern is the actual level of functioning. That actual level is then the starting point for treatment.

Nevertheless do the latest neurological research show significant correlation between several of the FMT criteria and the maturity of specific areas of the nervous system.
THE FMT-CRITERIA

Out of 25 years of practical experience and the basic theory behind the FMT-method, Lasse Hjelm started about 15 years ago to formulate a number of so-called FMT-criteria. The criteria describe important fundamental conditions for a general, normal motor level of functioning of the individual. In terms of functionally disabled persons, it is rather a question of development phases in a certain order, not that it has a correlation to a specific age.

The FMT method uses the criteria to evaluate the client’s difficulties. We usually range the difficulties in four levels: 0. none, 1. noticeable, 2. large, and 3. extreme.

It is important that we already here establish that the criteria are not clinically tested or based upon objective standard levels. The criteria are though built on observations of hundreds of different clients for more than 15 years. The evaluation made according to the criteria is the therapist’s personal tool for evaluation. They also help the therapist to write his/her assessment of the client and the improvements being made. And the most important thing is perhaps that their simplicity makes them understandable for persons who are not music therapists. The criteria I will present are the ones that are adapted to clients of a certain level of functioning. There are also other criteria that we use for clients that are more disabled.

I will talk shortly about each of the criteria, and I will present some video samples on how I work with clients in the special code and placement we use for cross movement.
Stability is the capability of holding the body upright with motor control, where the feet have a stable rest at the floor and the ischium has a stable contact with the chair. In other words the stability is built on a developed proprioceptive-, tactile- and vibration perception, where the individual experiences his/her body in relationship to the floor or the chair, and to the movements he/she is doing.

The concept of stability also comprises balance.

Side difference. There is normally a difference in the functional level of the body halves, due to the cerebral dominance. When there is a notable difference in the level of functioning between the body halves, it causes considerable difficulties. Since the difference has a sensory-motor base, it will cause difficulties both in motor skills, cognition and perception. The difficulties will be seen in the way the client controls the body, in posture, walking and stability. It will also cause problems in the integration of senses when there is a difference in the level between body halves.

There are not only people suffering from, for instance a stroke that has side differences, it is also often observed among many other groups of clients.

Separated movements. When a person has an advanced motor skill, he/she can perform and control separated movements simultaneously on the left and the right side of the body. This ability is one of the conditions of advanced human behaviour and is built upon a well functioning communication between the cerebral hemispheres.
A simple example of this is to let one hand actively hold the paper and the other write with the pencil.

**Release of the trunk.** The criterion refers to the ability to separate the movement of the upper part of the body from the lower and keeping the stability. The ability to “rotate”/move the upper part this way is important for the balance and the ability to perform separate movements of the sides of the body. It also supports the ability of cross movements.

**Cross movement** is a motor ability on a high level of development. The ability requires a co-operation between the lateral visual perception and the proprioceptive perception. The client must be on a level of maturity that can handle the integration between cerebral halves. It also requires a co-ordination in the connection between motor nerves of supporting parts of the body such as the trunk, ischium and legs and the part of the body that is crossing.

Having problems with cross movement is also something we often have observed to have a connection with reading difficulties.

**Integration of perception** In the FMT-criteria the observation is done concerning the ability to apprehend, distinguish, locate and interpret stimuli. This observation is done by changing the placing of drums and cymbals, and putting them at different heights and widths. This gives a signal to the therapist of the client’s ability to apprehend, but also his/her ability to assess direction and distance. The “quality” of the clients playing, often changes when the degree of difficulty increases.
Hand development. The tactile sensory receptors in the mouth and in the hands are used in the early development of an infant to investigate different objects, to form a conception of the things themselves and their quality. This sensory exploration stimulates cognitive and motor development. Experience leads to actions, which create opportunities for new experience, an interaction that leads to maturity.

By observing the client the therapist knows in what way he/she should place drums and cymbals to promote a “normal” motor development of the hands, and following the discussion above perhaps also help the client to promote his or her cognitive development.

It is surprisingly many normally functioning people that have noticeable deviations in their hand development. It is also often seen among persons with dyslexia.

Logic thinking and understanding models. The client is offered the opportunity to solve the problem of seeing logical patterns in the way the drums and cymbals are placed.

Here we have a great tool for seeing the cognitive level of the client, or to be mere precise, his or her ability to solve logical problems.

Total co-ordination. This criterion refers to the co-ordination of locomotion and thinking. The therapist tries to observe the client’s ability to plan his/her actions, to adapt and prepare for an appropriate motor activity, a so-called pre-motor activity.

Here wind instruments are used, to enhance the ability to co-ordinate movements with arms or legs and exhalation. The wind instruments are
also used to stimulate nerves and muscles around the mouth and the breathing organs.

**HOW THE FMT-CRITERIA CAN BE USED**

The FMT-criteria may very well be used for both testing, and for evaluation, but with a slight difference. Out of an FMT-analysis it’s possible for me to give an opinion about a clients difficulties, and abilities. In this document of assessment I give expressed comments concerning functions connected to the nine criteria.

For evaluation of treatment on the other hand, I use a scale from zero to three to describe the level of difficulties within respective criterion. That is for caparison between different sessions to value the progress in treatment.

The values have yet no scientific significance but are used by each FMT-therapist as his or her own comparison scale, which he/she establishes by experience by assessing and treating several clients. Still the figures can be used in some extent as objective values, as the differences they describe are noticeable in terms of angle of pronation, foot position, rotation range and so on. The great importance in this context is the change. Important is that the values within respective criterion are not strictly comparable with each other. The whole range of difficulties that is connected with the figure two within the criterion stability is not comparable with the figure two within separate movements.

The observations are strictly limited to motor activity and perception. We don’t give opinions of other things than those that are directly noticeable.
With other words we don’t do any interpretations. The document of assessment along with examples from videotape can then be used as a valuable help for understanding different difficulties and for treatment, but still are no verdict or judgement. It tells about what is and nothing else, which has the advantage that the assessment can’t be misused.

**OBJECTIVITY**

Reading of behaviour is often used in the area of assessment or diagnoses. The interpretations are done according to different theories on which they are dependent. Not seldom are the interpretations written down and will follow the client as a judgement that to some extent determine how the client will be treated further on by all future disciplines.

Interpretations rely on individual opinions of both how to read the client’s behaviour and how to understand what causes it according to a specific theory. From many points of view they are pronounced subjective. Therefore they are scarcely to be used by others as appropriate guidance.

Other problems with interpretations are that theories are developing and the basis for making judgements develops with the course of time. That means that that kind of assessments or diagnoses is perishable goods. But they are seldom used as that.

Important in this matter is to be ware of what layers of the therapist and the client that in fact can get truly in touch. You can, this far, never get in direct contact with another person’s emotions or cognition. The only
thing you really can do, is perceiving the client’s expression of his/her emotions or cognitive capacity in different forms of motor activity. What is possible is a direct interaction between the areas of perception and motor activity. And that is for both the therapist and the client. The other areas are filtered through perceptive ability and the ability of motor expression.

Neutral assessments that are usable for others and that in some degree are objective therefore need to be stopped by detailed observations of the motions and the motor functions and observations of reactions on different types of stimuli. Interpretations on that ground may then be done by others, but ought to be used only by themselves in benefit for a good planning of treatment. On the other hand it is truly possible, as in the FMT-method, to treat the observed digressions by aiming directly at motor activity. By the special FMT-treatment you also will reach dysfunction connected to emotional and cognitive functions through the development of motor functions and perception.

EMOTIONAL APPROACH

The main concern on motor activity and perception doesn’t mean that you as an FMT-therapist keep insensible for emotional expressions of all kinds. On the contrary the FMT-therapist follows the client all the way in his/her performing within the limit of the basic structure and gives direct feed back on emotional expressions in form of tempo, dynamics, smoothness and so on. That gives the client a strong feeling of security and affinity.
The FMT-therapist’s approach and response is even more sensible and emotional in the sense of being a genuine direct reaction on the clients emotional expression. It does not make a detour through intellectualisation.

The scientific position is maintained throughout the sessions by holding up a basic structure and keeping the focus on observing the client’s motions and motor activity in every action. The therapist gives specific challenges and reacts on every nuance of answer from the client at the same time as his/her concentration is held on observation of the client’s repertory of locomotion.

**LONG-RANGE PERSPECTIVE**

This approach gives an opportunity to maintain a long-range perspective and at the same time catch the moment and meet the client in the presence at his/her actual emotional, cognitive, perceptive and motor status. This last outlook seems otherwise to be a major problem in many therapies, verbal or based on music as means.

When you focus on behaviour or emotions in therapy, you have to make choices all the time if you should respond by supporting an emotional expression or react out of an intellectual analysis of the actual expression in a long-range perspective. You can’t do both at the same time. Either of the attitudes you have chosen at each moment will be directly reflected in your reactions and will affect the next step. By following and supporting the actual emotional expression you might loose control over the
structure. And by keeping the structure you might loose the emotional tension and also the opportunities to get a breakthrough in treatment.

It’s possible to get through those difficulties by choosing a different angle. By holding a clear structure concerning motor development that is adapted to the client’s actual level of functioning there is a full range of possibilities to interplay with the client’s emotional expressions within this structure. The behaviour in itself and the actual emotional expression is then not the main concern but a channel for communication, which is the necessary stimulation for at general development of different functions.
Towards a Definition of Resistance in Improvised Music Therapy with Psychiatric Patients

Pilz, Wolfgang

About the emergence of this project

This project arises from my own clinical practice as a music therapist in a psychiatric hospital. I and a professional colleague did music therapy sessions with adult patients according to the method of Nordoff/Robbins for several years. In the hospital we had only one therapy room and one office. This was a good opportunity to hear tapes of therapy sessions together.

We observed that we often used the same words for some distinct musical phenomena in the musical interaction between patient and therapist. These phenomena occurred in the music of patients with various diagnoses and biographies and seemed to be independent from the chosen musical instruments and from the general attitude of the patients towards this form of therapy. This means, for the musical phenomena it was not important whether the patients liked the therapy or not.

To give an example (patient A): a patient plays the drum, the therapist accompanies her by playing the piano. With the therapeutic aim to give her more freedom in playing he makes a ritardando in his melody. The patient seems to stay in the musical relationship and goes first with the ritardando. Suddenly she makes a small break and than continues playing
using the first, faster tempo. This phenomenon appears several times within the improvisation.

We used to say: “Did you hear that he/she goes away?” or “He/She evades!” or “She’s returning to her usual patterns.” We had to communicate this phenomena to the teams of psychotherapists, medical staff and so on. Sometimes we used the DAT-recorder for this communication. However, we thought it could be more helpful to translate the phenomena into an understandable language of psychotherapy.

A closer analysis of the tapes and comparison with case studies of psychotherapists revealed that the observed musical phenomena could possibly be described as "resistance".

**Question and meaning of the project**

Therefore, a question arose and formed the beginning of my doctoral study:

Is it possible to use the psychotherapeutic term “resistance” for phenomena heard in musical interaction?

If you could answer this question with “yes” you would have made a kind of analogy between different forms of therapy. Creative Music Therapy uses no words, but the processes in therapy are similar to those seen in psychoanalysis or other forms of therapy using words.

The psychotherapeutic term “resistance” is used for a newer form of therapy which uses no words. The term should not be used
indiscriminately. My aim in this study was to say exactly what is meant with resistance in music therapy and how it relates to concepts of resistance in other existing forms of therapy. I wanted to contribute to the communication between schools of therapy. The processes in this form of therapy could be more understandable if you can translate distinct phenomena into verbal language.

Music therapy is not isolated from medicine, psychology, psychotherapy and should be able to describe processes in a language both common and scientific.

**What is meant by resistance in psychotherapy?**

The term "resistance" has a long tradition in psychotherapy, especially in psychoanalytic therapy. Therefore, my observation of resistance was compared to definitions quoted in the psychotherapeutic literature.

In the beginning of psychotherapy, Sigmund Freud defined resistance as obstacles in the process of therapy. Resistance in therapy is a result of suppression and you may find sources for resistance in each psychic resort according to Freuds theory of psychic structure.

Summarized, one may find the following common sense about resistance in psychotherapy:

- The use of the term resistance depends on context.
- Every school and even every therapist may define resistance for themselves. Each behavior or act may be called resistance.
- Resistance is an obstacle in the therapeutic process of patients who themselves want therapy. The most important form of resistance in psychoanalysis is silence of the patient.
• Resistance is unconscious.

Some different points elucidate common differences between methods of therapy:

• For some authors, resistance in therapy is necessary, for others you should try to avoid it.

• Some authors write that resistance accompanies the whole process of therapy, others think it is only seen in distinct periods.

• Some assert that only unconscious acts are called resistance, some say any obstacle could be called resistance.

• Resistance may be overcome by making it conscious. To the contrary, many therapists say that resistance can be overcome unconscious.

• Therapists may understand resistance as a form of defence on the part of the patient. There, resistance is the outward form of the inner defence in therapy. Others, however, stress the point that resistance would not appear without the interaction of therapist and client. So resistance is seen as an interactional phenomenon.

• Description and interpretation of resistance are often confused.

• Until now, resistance in music therapy is mostly negatively connotated. Many authors emphasize that music therapy overcomes resistance easily.

My own definition of resistance

Applying a constructivistic epistemology, aspects from wide-ranging literature on therapy were chosen which seemed most appropriate for improvised music therapy in order to come up with a new definition of resistance.

The term “resistance” should be used for phenomena in the musical interaction between therapist and patient. They won’t appear without a therapist who accompanies the playing of the patient. This phenomena occur in the playing of the patient as limitation in the freedom of doing
(action) and may be described with musical terms (such as: “he plays slower, louder, loses the rhythm” and so on). These limitations are heard repeated, not only once in a process. The reasons for these limitations are not found in mental handicaps, influence of drugs or organic diseases. Because it is a phenomenon of interaction, stereotypic musical behavior without relationship should not be called as resistance.

Resistence is the leaving of the musical relationship by the patient. It is only resistance if the patient seems to understand the communicative meaning of the action but he doesn’t act consciously (as a musician would or as the therapist does). The occurrence of resistance is influenced by the therapist. It is perhaps possible that a therapist is able to play his music in a way that no resistance will appear.

The definition should be used only for musical phenomena – not for the other kinds of behavior such as always choosing the same instruments, coming too late and so on.

The term resistance indicates that there are phenomena in the process of musical therapy which are known in other therapies, too. Silence, for example, has a similar function and meaning for psychoanalysis as this musical phenomena has for creative music therapy.

Of course, resistance is connotated negatively. Therapy would be easier to do if there were no resistance. But perhaps it is necessary for the process.

Possibly the therapist himself shows resistance, too – but this was no point of my project.
Resistance may be described in the context of a specific improvisation of individuals. The psychiatric diagnosis, age, gender, history of life and so on have only little influence on the appearance of resistance.

A short overview of the definition:

1. phenomena of musical interaction
2. limitation in the freedom of doing (action)
3. phenomena are heard repeated
4. leaving the musical relationship
5. not conscious

After setting the definition it was tested for its clinical feasibility by having assessed taped audio sequences of therapies by a panel of experienced clinicians.

**What kind of examples and what patients?**

All therapies of three years of clinical work had been taped. However, only a small part of it was suitable to document resistance. The following criteria limited the selection:

1. If the therapists tries to accompany the whole doing of the patient, no resistance will occur. If he offers possibilities of musical action for the patient, resistance to these offers may appear. Only those parts of the tapes were suitable where the therapists make such an offer.

2. The examples should not be longer than about six minutes because resources of time and concentration by the clinicians are limited. Within this short example, one should be able to hear the same kind of resistance several times.

3. This small part should be representative, typical and characteristic for the single patient.
4 Only patients with five or more sessions in music therapy were chosen. Otherwise, patient and therapist may know not enough each other to speak of resistance.

5 Because of the definition that diagnosis, age, gender and instruments won’t influence the appearance of resistance, there should be a broad variety of diagnoses, ages and so on within the examples.

6 Only examples of patients who came to music therapy of their own free will, who had their own motivation and accepted the setting and kind of therapy were chosen. That resistance occurs with patients who do not come voluntarily to therapy would be apparent and of trivial importance.

7 Resistance is not confined only to my work. An example from the work of my colleague was therefore also presented.

What kind of consultation with which clinicians?

I developed two kinds of interview: Each interview began by describing the aim of the study and presenting the definition of resistance.

Method 1: After hearing the whole example (five to six minutes), the clinicians had to judge about five short examples (20 seconds) by making a sign on a paper: is it resistance or not? For these short examples I had an exact hypothesis which of them represented resistance and which not. This method can be used within groups. So I had the advantage of including many participants.

Method 2: The judges had to hear the whole example. After any ten seconds they heard a number and had to decide in each interval if they heard resistance anywhere by making a sign on their paper.

Both methods were repeated for several patients.

My project was a kind of work in progress: the second form came out of the results of the first form. Some clinicians found it a bit too hard to say
simply “yes” or “no” about the short examples. In the second method they could decide on their own if there was somewhere resistance. And they could take the tapes with them, hear them at home and take as much time for their decision as they needed.

If it makes sense to use the term “resistance” in this form of music therapy, it should be possible to communicate the construct not only for specialists and professionals but also for other persons interested or involved in any way in the treatment of patients. This was intention of the study. Therefore the panel of interviewed persons included psychiatrists, psychologists, students of speech therapy, music therapists, nurses.

Altogether 112 persons took part in one or even both of the methods of interview.

**Results**

Only a small part of the complex results can be described here. I want to stress three points, using examples of patient A (described above):

**results referring to the patients and form of resistance:**

It was possible to describe a certain musical behavior as “resistance” in several examples. In the case of patient A, resistance means that she cuts the musical relationship (i. e. rhythm and dynamic of patient and therapist coinciding) by interrupting her playing suddenly and then begins with fast playing, not respecting what the therapist is doing. The panel affirmed my hypothesis. They heard “resistance” at the same moment as myself.
This leaving of tempo and rhythm is often heard in improvising with psychiatric patients. Therefore, these examples are partially representative for resistance in general in creative music therapy with psychiatric patients.
Resistance could be exactly and distinctly described for three patients of the study. With the other patients I had different results, in some cases there was no confirmation for this concept of resistance.

**Results referring to the interviewed persons and groups:**
Although there was some general agreement to my concept and construct of resistance, I could find several significant differences in the judgement of the persons depending on their professionality. The tendency of these differences can be seen by a second view on the results of patient A. The music therapists are more careful in affirming the use of the term “resistance”. Some of them even seem to deny this concept and find “resistance” nowhere. Many of them showed scepticism when discussing the definition. On the contrary, members of other professions are more open in using the concept. They even hear resistance when I didn’t expect it. They have no scruples about the connotations of the term. The best agreement with my hypothesis was found in the group of colleagues of the psychiatric hospital where the therapies were done. Perhaps they knew more about the patients and what I meant because they knew me and my work for several years.

**Results referring to the two different methods presenting the examples:**
My study touched the discussion between “quantitative” and “qualitative” research. The more exactly the episodes were chosen the more clearly the results seemed to be. Therefore, the results of method one were clearer than that of the second method.
This can be shown with a look on the results of patient A (interviewed persons: 22).

**Figure 61 Results Patient A**

For the first method you have clear results. The participants verify the hypothesis that the second and the fifth short example represent resistance.

Some of the judges could also use the second method for the same patient (students of music therapy and professional music therapists in Muenster and Heidelberg).

The first method seemed to influence the participants more. The same moment first sounds as resistance, later, heard in the whole context, some of the judges seem to be more cautious or perhaps not yet concentrated.
Three years later – what’s left?

This was a kind of constructivistic study. The aim was not necessarily to be objective about resistance, but to find agreement, suitability and appropriateness for a term in psychotherapy. I’ve asked other persons whether they may find my construct of resistance viable, useful, communicative or not.

For some musical phenomena in a specific context the term “resistance” seems to fit. Of equal importance to the study, I could show that many clinicians agree to my construct of resistance in certain cases. In other cases I had to revise my constructs. These results are also important.

Science is not about finding only one objective result or one valid solution, but searching for a consensus of opinions between subjects. This definition of science might be more appropriate to the topic “psychotherapy”.

The last few years I have been working with children, no longer with adults. Children seem to be much more spontaneous, incalculable. At first I hoped I could give some new examples of possible resistance. However, I found it impossible to find exactly defined examples of resistance in therapies with my young patients. Maybe I have changed as therapist, too. Since I finished my project, listening to the tapes again and again, I have revised my work, finding more often new creative ways to overcome resistance in the beginning.

The first question of the project has not lost relevance for me: How can the musical phenomena in creative music therapy be communicated in
clinical work? Therefore, I still find it sometimes useful to speak of resistance in therapy.

References:


Name, address etc.:
Dr. phil. Wolfgang Pilz, Dipl.-Musiktherapeut
Am Kloster 19a
D-06406 Bernburg
phone/fax: ++49-3471-353206
email: PilzWolfgang@t-online.de
Good afternoon, ladies and gentlemen,

certainly you all know some tunes with various variations on a ground. This afternoon I will present you some variations on an empirical ground. The title of the presentation is not only a reference to a musical form but expresses also a relation to the concept of Grounded Theory as it has been developed by Glaser & Strauss (1967) and Strauss & Corbin (1996). The transactional theory that is presented is anchored on the empirical ground of music therapy treatments. In reflecting the findings of these studies by a transactional theory, conditions and consequences of actions, interactions and transactions are specified and different layers of relation in music therapy treatments are revealed.

As in the tunes, first I will present the ground. This is the clinical research, that has been conducted. Then on this ground the first variation deals with the aspect of evaluation in differentiating the dimensions of effectiveness, efficacy, and efficiency. The next variation presents the multi-method approach of the studies and shows the triangulation of some central findings. Corresponding to the multi-method approach the
transactional theory is presented in a multi-level model. The last variation describes different layers of relation and the relations of different layers in music therapy. They will hopefully contribute for a further understanding and explicating of some music therapy treatment effects.

So the transactional theory on an empirical ground will hopefully be a contribution for describing, explicating and understanding some of the music therapy treatment effects.

The empirical ground is formed by several clinical studies in different music therapy settings, that had been conducted in the last four years in Munich. In the music therapy department of the center for social pediatrics in munich I conducted a reversal study with two treatment phases. In this study I included a group of 12 multiple handicapped children aged 2;4 to 6 (5;10) years.

In this study two single case studies have been conducted. Eva Schlimok (1999) analysed the role of gaze for joint attention and intentional communication with a two and a half year old girl with infant cerebral palsy and mental retardation. Kari Åsebø (1999) studied the development of preverbal communication of a five year old boy with autistic syndrome and mental retardation in the course of the music therapy treatment.

Kathrin Fendt (2001) analysed how music therapy is fostering social and communicative abilities in the early intervention with a five year old blind girl.
Dominica Fuchs (2001) evaluated the contribution of the music therapy treatment for improving communicative competencies of a woman with post apallic syndrome in a clinic for neuro-rehabilitation.

Sigrid Keller (2001) studied how the fostering of perceptual abilities through music can develop the social competencies of a severely handicapped blind 12-year-old girl.

Myriam Schwarzbart (2001) analysed how the speech development of a seven-year-old boy is fostered by a music therapy treatment in a preschool integration group.

The central method in all of these studies has been the method of video microanalysis. On the photo you see the technical equipment for video microanalysis. In all studies videotapes of the music therapy treatments have been analysed with specific category systems.

And all of these clinical studies evaluated aspects of efficacy, effectiveness, and efficiency of music therapy treatments.

Evaluating the music therapy treatment means to assess if and in what extent an intervention leads to the intended treatment effect. On the other hand, evaluation also means in a more comprising, fundamental sense, ‘finding the value’. So the aim of evaluation is both analysing what works and understanding how an intervention succeeds or fails. For assessing what works and how it works it is possible and useful to differentiate between three dimensions of evaluation:

Effectiveness is the dimension that concerns the functioning of specific interventions under everyday conditions. Effectiveness studies examine
if a specific treatment reaches the intended aims under normal conditions and under what conditions or for what kind of groups it is the best treatment.

Efficacy is the dimension that concerns the functioning of specific interventions under ideal conditions. In efficacy studies ideal - sometimes randomized - conditions are created that permit to assess if and how a specific treatment reaches the intended aims and if this success is the result of the intervention.

Finally efficiency is the dimension that concerns the costs of a specific treatment. In efficiency studies the relation of costs and benefits are examined in a cost-analysis. In a cost-minimization analysis the treatment is compared with other treatments. Cost-effectiveness means the effectiveness in avoiding special treatments and a cost-utility-analysis examines the increasing quality of life that is gained by a specific treatment (Roth & Fonagy, 1996; Wolke & Schulz, 1999).

As these dimensions of evaluation relate to specific conditions they are connected with the specific contexts that are studied. To assess the effectiveness of a specific treatment the interesting parameters have to be analysed under everyday conditions, that means in a situation at home or in a clinic. The parameters, that are examined in this context, are on a macro level. Effectiveness studies assess the improvement of communicative competences in a familiar context, at home or in the ward of a clinic.

In studying the efficacy the improvement of communicative competences is analysed under ideal conditions in the context of a music therapy
session, where the child or client is provided with specific assistance by the music therapist. On this more specific meso level the analysis also can be more specific and detailed.

On a micro level the communicative competences can be analysed in a still more detailed way. Efficacy studies on this level can examine how the music therapy treatment contributes to improvements in communication abilities in the context of the communicative exchange between music therapist and client.

To connect these different levels of macro-, meso- and microanalysis it is necessary to use different sources of data and to combine different data qualities in a multi-method approach.

This kind of combining data sources and data qualities is characterized by the term triangulation (Patton, 1987). Originally from the science of land surveying triangulation means to improve the quality of measures by combining three or more angles on one phenomenon.

In the reversal study I conducted, there have been psychological tests and data of interviews with the parents on the macro level - including data sources of child and parent.

On the meso and micro level there have been observational data of music therapy sessions by microanalysis of videotapes - including data sources of the music therapist and the child.

On the meso level have been data of rating scales - completed by the music therapists, and subjective data of unstructured comments on the music therapy session - also given by the music therapists. As
multimethod approaches are monitoring qualitative and quantitative indicators of process and outcome they generate a synergy effect. A multimethod approach cannot guarantee a successful evaluation, but it will enhance the scientific reliability and the clinical relevance of the findings.

In the following I demonstrate the triangulation of some central findings from the reversal study in the center for social pediatrics. The details are published in the book ‘Entwicklung fördern durch Musik’ (Plahl, 2000).

On the macro-level the changes in the communicative competences of the children have been assessed by a semi structured interview of the parents. The context of the assessment was the functioning of the children at home under everyday conditions. The results from the parent’s interview mirror the perspective of the persons to whom the child relates most closely.

After the first music therapy treatment phase the parents reported an extension of communicative abilities. Which means that the children used a broader variety of communicative means.

They also reported more intentionality in the child’s expressions. This means the children succeeded better in expressing their needs and so regulating their own and their parent’s behavior.

The parents constated a more intensive relationship to their children and they reported more independence in their children’s behavior - which is connected with more self esteem and self confidence of the children.
The second measure of communicative competences on the macro level was the communication test ESCS. Early Social Sommunication Scales (Seibert & Hogan, 1982).

This test has been completed at the beginning and at the end of the two treatment phases.

Here you see the mean scores for the whole treatment group, that increase significantly on the 0.01 level in between one treatment phase and in the course of the whole treatment.

Which means that the children improved their prevarbal communicative competences both in shared attention and in behavior regulation - the two dimensions of the ESCS.

On the meso level in the music therapy session the intensity of interaction and communication has been assessed by the rating scale Music Therapy Profile (Plahl, 2000).

This rating scale has been completed by the music therapists after each session and consisted of 20 bipolar items describing the dimensions of

- activity and attention
- contact and relationship
- emotion and relaxation
- and of expressive behavior.

Comparing the red columns, that show the mean scores of the first treatment phase with the green columns of the second treatment phase there are clear increasements. Especially on the dimension of emotion/relaxation and on the dimension of expressive behavior, that is significant at the 0.5 level.
On the micro level the findings of the video microanalysis reveal, that the frequencies of all communicative activities increase significantly at the 0.1 level comparing the beginning and the end of each session both for the first and for the second treatment phase.

Here you see the observed frequencies of communicative acts for the beginning and the end of each treatment phase differentiated in the modalities of gestures, vocalizations and activities with music instruments.

In the course of the treatment the frequency of musical activities in the second phase is topped by the frequency of vocalizations, which demonstrates the development to more conventionalized communication behavior.

A similar result is found in the single case study of Eva Schlimok (1999) for the frequency of joint attention.

Here both the comparison between the beginning and the end of the music therapy sessions and the comparison of the two treatment phases reveals a clear increasement in the frequency of joint attention.

The most important finding on the micro level is the increasement in the percentage of intentional communication. Intentional communicative acts are all communicative activities on musical instruments, that are followed by a gaze to the music therapist and so signalling communicative reference after a communicative contribution.
The red columns show the clear decrease of non intentional communicative acts and the green columns demonstrate the significant increase of intentional communication.

This result has also been found in the single case study of Kari Åsebø (1999).

Here the percentage of intentional communication of a five year old autistic boy clearly increases from the beginning to the end of the music therapy sessions and in the course of the treatment from the first to the second treatment phase.

In combining the results of micro- and meso level the findings converge with each other. Which means the triangulation is successfully achieved.

Here you see on the left diagram the score of the item *Vocalizing* on the rating scale *Music therapy profile*, that has been completed by the music therapist after each session and on the right diagram you see the frequency of vocalizations assessed by the video microanalysis.

In the course of the treatment a clear increase in rating the item *vocalizing* on the *Music therapy profile* can be observed, which is almost linear. The videoanalysis does not present such a clear trend for the whole group.

However a comparison of the subjective ratings of the music therapists with the objective findings of the microanalysis reveals impressive similarities - especially the decline in the second session of each treatment phase.
The triangulation of all three levels reveals that the results of the parents’ interview are confirmed by the results of the communication test, of the rating scale and of the video microanalysis.

These findings are answers to the question of efficacy and effectiveness: they describe to what extend music therapy is facilitating the development in early intervention.

The results of the study show, that the examined children significantly improved their ability to express their needs and desires, to regulate their own behavior and the behavior of their partners in a more intentional and therefore more effective way and to gain by this way more selfconfidence, independence and more intense relationships to other persons. This represents both an improvement of living quality for children and parents and a prevention of secondary disorders caused by deficits in communicative competences. Here we have aspects of an efficiency evaluation.

Now we leave for a meta level and elevate to the transactional theory on this empirical ground. In developmental psychology there is a long historical tradition that is guided by transactional thinking (Altman & Rogoff, 1987). Transaction means - in contrast to interaction - that actors and their environments cannot be separated. And the focus of analysis are the changing relationships among actors and context. Transactional processes are comprising - in a transforming way - the acting persons and their backgrounds (Werner & Altman, 1998).

The theory of Lev Vygotsky (1978) for example stressed the mutual involvement of child and social context. In his tradition there is both an
emphasis on the analysis of change in longterm individual development as an emphasis on transformations over short periods of time.

In a transactional view the actors and their sociophysical context are interdependent and mutually defining, neither can be understood without the other. Development and change are seen as an interplay of biological, psychological, sociocultural and physical environmental processes (Werner & Altman, 1998).

In the dimension of time transactional theory is focussing on developmental changes. Temporal qualities are integral to phenomena, and both change and stability are assumed.

So on the meta level of transactional theory there are the dimensions of context and time that constitute the actual and future performance of a specific phenomenon.

In the multi-level model I developed, the dimensions of performance are differentiated for the specific contexts on a macro, on a meso and on a micro level.

On the macro level the fundamental processes of transaction in a broader sense are considered: this is including the actions, interactions and transactions of proprioception, perception and participation.

Proprioception means the perception of the body and includes physiological phenomenons. These are transformed by vibration, sound, and rhythm in musical contexts. Proprioception is the re-sonance of sound and movement in the body. From the beginning of human life in the uterus.
Perception comprises the sensual and esthetic aspects of a specific performance. Obviously there is a close connection between proprioception and perception, this is between the sensual input and the body-experience.

Participation describes the social aspect of music performance. As music is a genuin social activity some use the term *musicking* or the verb *to music* to express the participatory constructions of musical performance (Ansdell, 2001; Ruud, 2001).

So music can be understood as a transforming co-constructed process between two or more person or as a transforming constructed process in one person.

On the meso level the music therapy context can be described by the three dimensions that had been used for characterizing ‘good’ coordinated interactions (Tronick, 1989).

These interactions are coherent, which means they provide a situation that is a sustaining frame for the client or child.

They are characterized by synchronicity, which means they resonate actions and affections of the client or the child. And they are characterized by reciprocity, which means there is a mutual exchange of turn taking between the music therapist and the child or the client.

This kind of context enables to move frequently from affecticely positive, mutually coordinated states to affectively negative miscoordinated states and back again and is thus providing a central condition for therapeutic change.
On the micro level of this model there are three basic dimensions of communicative processes in music therapy.

The first condition for communication is the ability of focussed and joint attention. This means attention for the activity, for the other person and for the own person and her emotional states.

Intention is the dimension that makes communication effective. Only with intentional actions it is possible to express personal needs, wishes or demands. Only with intention it is possible to transmit a message to another person.

Finally invention is the dimension of individual expression and creativity. By musical inventions for example it is possible to transform actions, feelings and thoughts and to transmit these specific transformations to others.

These transactional features - the transformations of actions, feelings and thoughts and the transmission to other persons - make it clear that also on a micro level of analysis the dimensions of the macro level and the meso level are of influence.

Transactional processes are understood in a horizontal way concerning time and changes in development. And they are understood in a vertical way concerning the mutual changes and exchanges in physiological, psychological, social and cultural dimensions (Werner & Altman, 1998). Thus the transactional view reveals different layers of relation on the three levels. On the macro level the processes of proprception, perception and participation are both transforming each other and by that
way transforming themselves. They are not independent of each other which means that participating in a musical activity is transforming the perception of the created music and the proprioception of the experienced music. In consequence these changes have influence on the future participating in music and so on.

In her single case study Sigrid Keller (2001) made an attempt to take into account different contexts and examined how different musical and sensoric contexts influence the attentional behaviour of a severe handicapped blind girl. Here you see different percentages of focussed attention in relation to the perception - and probably proprioception - of neither sound nor tactile sensation by touching her hand or face, the perception of sound only, the perception of tactile sensation only and the perception of sound combined with tactile sensation.

The results show the highest percentage of focussed attention for the condition of sound perception only. However the sound environment is effective only after it has evoqued transformations in the subject’s internal processing of environmental experiences.

Obviously this is only a first step in the transactional direction. At the moment we still lack the methods for measuring the transactional effects on both client and music therapist in the process and so specify their relation.

In a transactional model the music therapist and the client or the child cannot be thought separate. So the context of the music therapy situation is always influenced and thus transformed by the client’s/child’s and the therapist’s proprioception, perception and participation.
Depending on the aim of the music therapy treatment the therapist attempts to create a favorable context for the client’s / the child’s change or development in proprioception, in perception and in participation.

To achieve this a specific kind of relation is established in the music therapy session. This layer of relation is characterized by the coherent frame, by the synchronizing resonance and the mutual exchanging reciprocity of the situation.

The following interaction grafic demonstrates how these patterns of interaction are established in the music therapy session.

The category system for the computerized microanalysis of music therapy sessions KAMUTHE, that I developed, consists of four categories for the child and three categories for the music therapist. The behavior of the music therapist is categorized in musical, verbal and nonverbal communicative behavior. The communicative behavior of the child is categorized into gaze, vocalizations, musical activity, and gestures.

Here you see the interaction analysis of a dance, that is repeated some times. The music therapist is creating a sustainable frame of coherence by accompanying her dancing with a song, by praising the child after each dance session and by asking her before the next session if she wants another dance. The child, a four year old girl with Cornelia-de-Lange-Syndrome, that is not able to speak obviously is especting the question and is signalling by a gesture that is referring to the music therapist her wish for repetition.
A detailed analysis of behavioral and musical aspects can specify the contribution of music and musical elements to the therapeutic intervention that can be observed in the music therapy process. However this is only a pattern of relations and not a feature of causal relationships. The different elements are not seen as pushing or causing one another, but rather as working together or fitting together as total unities (Plahl, 2002).

The interaction pattern of this music therapy sequence is characterized by an impressive pattern of coherence, symmetry and reciprocity. The rhythmic changes in the communicative behavior of the music therapist facilitate joint attention and reciprocal reference. Here you see the musical, verbal and nonverbal behaviors of the music therapist and here the gaze pattern of the child, her musical activities and her gestures.

Here you can see three patterns of synchronizing:

First the music therapist is accompanying the child’s play on the guitar by a song

Then the music therapist is playing herself the guitar and the child is gesturing her wish to have the guitar again. Finally the gaze of the child to the therapist is responded by the confirming gesture of noding her head. It is this responding structure of the music therapist’s behavior - in rhythmically accompanying and answering the child- , that creates a sustainable frame and reinforces the child through the synchronized resonance.
A still more detailed analysis of reciprocities reveals the elements of a musical dialogue. This graphic shows the interaction pattern of a sequence from the ninth session with a five year old autistic boy. The communication pattern of this sequence clearly demonstrates a dialogical structure. The boy is signalling his communicative reference by directing his gaze to the hands of the music therapist after finishing his contribution. This musical dialogue is characterized by reciprocal turn taking, that is very well tuned and by musical contributions, that are shaped both by the own preceding contribution and the contribution of the partner.

You will see the musical score on one of the next charts. The music therapist has succeeded in creating a balanced responsive relationship with the boy.

On the micro level finally the layers of relation concern the processes of attention, intention and invention. These relations are formed and transformed by the relations on the meso and macro level. The attentional, intentional and inventional activities are dependent from the processes of participation, perception and proprioception as they are mediated or transmitted through the music therapy situation.

To be concise we are here on a construct level, because attention, intention and invention cannot be easily observed but have to be operationalized to be measured. The interaction analysis and the empirical data show that the co-constructed music therapy context with coherence, synchronicity and reciprocity creates a balanced responsive
relationship in a therapeutic frame that is fostering these important processes.

As important as the layers of relation that are established with other people are the relations to the social and physical contexts and the temporal experiences.

Here you see the score of the interaction you saw two charts before. The temporal dimension in the transaction of the autistic boy and the music therapist are obvious: The motive that the boy invented is answered by the therapist. Her answer is followed by a variation of the first motive by the boy again. This is inspiring the therapist for another variation on her side. Which is followed by a rhythmic variation by the boy and so on. In this temporal relation are stable and changing elements that constitute the specific character of the invention. The variety in his musical play and the communicative reference to the music therapist show, that the autistic boy has reached a level of communicative exchange in music that he cannot reach in verbal communication.

Video excerpt of this situation.

The multi-level model of transactional theory describes, how specific layers of relation in music therapy constitute therapeutic effects. The transactional view of this model further reveals relevant aspects of performance and context contributing to the effect of music therapy treatments.
In a transactional view events can be seen from multiple perspectives; and each perspective contributes to an understanding of the total event. This also means that events are constructed in different ways by different participants (Ginsburg, 1980). None of these ways is the best or single correct interpretation. Researchers should study events from all of these perspectives. And events can be analysed at many different levels from micro- to macro-analysis. There is no single level that is the only possible or the only correct one. So to achieve a holistic view of a phenomenon it is necessary to use multiple levels and perspectives.

As in the tune there is no variation without a ground - there is no theory without an empirical ground. Also vice versa: To develop and change the empirical ground needs the different and sometimes complex variations. Like this the empirical ground of music therapy research needs various theories to be further developed, changed and transformed.

As the transactional theory I presented is a genuine theory of change it is hopefully transforming the empirical ground in an inspiring way!

**Literature:**


Abstract

This paper is about using the physioacoustic method and music therapy in drug rehabilitation. Four young drug addicts took part in the research project. Through the treatment method used in this research the participants got in touch with their emotions that had been denied for a long time. From the first treatment on memories started to activate in the participants minds. It was a new experience for them to get acquainted with their own self and to let their thoughts out. This brought up new insights for the participants.

Introduction

In this Congress Paper I will use my Master’s thesis that I have done in the University of Jyväskylä. In my work I experiment the functioning of a rehabilitation method for drug addiction based on a physioacoustic method and music therapy. Research of this kind has not been done before in Finland. Four young victims of drug addiction took part in this research. The data consists of eight individual therapy meetings with each participant. With this research I try to find out how a person with drug addiction experiences the rehabilitative treatment based on physioacoustic method and music therapy and what kind of material rises up to conscious during the process. One aim is also to clarify to what extent the participants’ experiences are similar and how their experience will possibly give expression to the participants’ addiction problem and its reasons.
Method of Treatment

The method of treatment used in this study consists of three different elements. Firstly there was the use of physioacoustic method combined with listening of music which was then followed by a therapeutic discussion. The combining of the physioacoustic method and the listening of music provides the participant with a very holistic experience that awakens both physical and mental sensations, thoughts, images and memories. The sharing of the experience with the therapist and the integration of treatment to the participant’s own life situation can open totally new perspectives and views to the addictive behaviour.

The physioacoustic method is a treatment method developed by Finnish group of experts. The late pioneer of Finnish music therapy Petri Lehikoinen played an important role in developing this method. The physioacoustic device uses low frequency sinusoidal sound. This low frequency sound comes from a specially designated computer. The sinusoidal sound is the simplest acoustic information containing only one sound wave. There is no sinusoidal sound in our everyday environment because normally the sounds of our environment are so called sum sounds in which several sound waves are mixed. (Lehikoinen, 1996, p 31.)

Similar methods to physioacoustic method have also been realised in other countries. These are for example the Japanese Body Sonic, the Norwegian Vibro Acoustic and the American Somatron TM and MVT TM (music vibration table) (for example Skille, 1989, 1992; Wigram & Weekes, 1990; Wigram, 1996).
In the physioacoustic method the frequency range varies from 27 Hz to 113 Hz. According to Lehikoinen the efficiency of this method is based on the exact ability of controlling the device and the body’s sensitive ability to react to low sounds. The penetration of the low sounds in solids and in fluids used in the physioacoustic method is very good. Because of this the physioacoustic stimulation stays regular and therefore the tissue has enough time to react to the sound waves. The treatment is also very gentle and this allows it to be used when manual treatment is not possible due to pain. The physiological effects of the treatment can be seen in muscles, inner organs, nervous system and in the cells. (Lehikoinen, 1996, p 32.)

The physioacoustic method produces the state of deepened relaxation which can also be called altered state of consciousness. In the altered state of consciousness the person becomes more receptive and allows unconscious material to flow into his/her consciousness. Cognitively, one moves back in the developmental hierarchy from the waking, rational, reality-oriented, secondary process thinking to primary process when more imagery and fantasy arises into awareness. In the altered state of consciousness the ego becomes receptive to both inner and outer stimulation. This way memories and emotions that have been unconscious for years can come to consciousness. Listening of music in this process can assist in the getting in the altered state of consciousness and it can awaken images, memories, thoughts and sensations in that altered state of conscious. (Fromm, 1977, pp. 373-377.)
This kind of state of deepened relaxation that can be established by the physioacoustic method is also ideal for emotional learning according to Fromm (1977). For emotional learning it is also important that the ego is open and receptive and that the attention is not directed to any certain thing but the unconscious material is let to flow freely into the conscious. In this kind of relaxed state the gate between the unconscious and the conscious opens more than in normal state of being awake. However, it is important that afterwards the work happens in the level of observing and judging ego so that the individual is able to evaluate and integrate these new contents that arose to his consciousness during the altered state of consciousness. According to Fromm (1977) it is important to move from the secondary process to the primary process and back again because feeling without thinking does not lead to emotional learning or an emotionally healing experience. (Fromm, 1977, pp. 373-377.)

Listening of music in music therapy can be realised in many different ways. In this rehabilitation the listening of music was combined with the physioacoustic method. The aim for listening music in this case was to awaken images and emotions in the listener and therefore activate symbolic work that is based on the primary process. The function of the music was also to help the participants to get into the altered state of consciousness in which the touch to ones own unconscious would become possible.

I used four different kinds of music in the rehabilitation. They were Silk Road IV by a Japanese composer and musician Kitaro, Naked and Quiet by Jukka Leppilampi and Space Waltz by Pekka Pohjola both Finnish
composers and musicians. The fourth kind of music that I used was a collection of classical music. I chose these pieces of music because they represent different styles of music and because with experience I have realised that they bring up lots of images.

There was always a discussion between the therapist and the participant after the physioacoustic treatment and listening of music that was combined to it. In this discussion the therapist shared the participant’s experience about the treatment. In practice it happened so that the therapist opened the discussion asking the participant for example “how do you feel?” or “what’s in your mind?” After this the discussion went on freely so that the therapist tried to help the participant with his questions to unravel the physical and mental experience, images and thoughts. The aim of the discussion was also to integrate the arisen contents from unconscious with the participants situation in life at that particular moment.

**Participants**

There were four persons in seek of rehabilitation that took part in this research of which two were men and two were women. I will call them Jussi, Pete, Riikka and Sari.

Jussi is a 29-year old man who lives together with Sari and he has two children who live with their mother, Jussi’s ex-wife. Jussi meets his children regularly. Jussi has a line of profession but he is unemployed at the moment. In the beginning of this rehabilitation project Jussi had just
finished a rehabilitation period in an aftercare. Therefore this project served him as further rehabilitation. He hadn’t used drugs for six months.

Pete is a 19-year old young man who lived with his mother when this project begun. During this process however he got to move to an apartment by himself. Pete didn’t have a steady girlfriend or children. Pete had passed comprehensive school but his further studies were interrupted. In the beginning of the rehabilitation Pete was unemployed and also lacked a student place. He was planning to take part in a working experiment. Pete had been without using drugs for a week when he came to the first interview. He had no previous experience in any kind of treatment or rehabilitation.

Riikka is a 19-year old young woman who lives alone. Her father and stepmother were in the prison when she started in the project. Riikka´s mother and little brother lived in the neighbourhood and they see each other regularly. Riikka had neither boyfriend nor children. She had also passed comprehensive school and she had started studying several professions however she had dropped them. In the beginning of this rehabilitation Riikka was unemployed. This rehabilitation project was the first time she searched for professional help to her addiction. When she came to the first interview she hadn’t used drugs for two weeks.

Sari is 23 years old and lives together with Jussi. They don’t have children together but Jussi’s children visit them regularly. During the rehabilitation Sari was studying by apprenticeship contract of which she had passed a half. Sari had been on a half year period of rehabilitation in
an institution with Jussi therefore also in her case this project served her as further rehabilitation. She hadn’t used drugs for six months.

In the use of intoxicants the participants have both similarities and differences. The first actual narcotic that all of them used regularly were hashish. Pete started when he was 12, Sari at the age of 14, Riikka at the age of 15 and Jussi when he was 16. The fact that they started smoking hashish was linked with their friends or changing of friends. The next narcotic for all of the four was amphetamine. Riikka, Sari and Jussi had started using amphetamine after two years of using hashish. Pete smoked hashish for four years before moving into amphetamine. However, Pete was younger than the others when he started smoking hashish. All of the participants have also tried other narcotics like LSD, cocaine and heroin for longer or shorter periods.

**Research Method**

The central aim of this research is to find out more information and understanding in relation to drug addiction and its treatment. The research is qualitative in nature which is grounded on hermeneutic interpretation and understanding of the phenomenon. Data based categorical formation is used in the data analysis.

The research was made in co-operation with the social-and healthcare of the city of Lahti. They chose the four participants and supervised this project. The different backgrounds of the participants made it possible to research how this treatment method would work for clients in different phases of life. The data of the study was collected during the clinical
process in spring 2000. The data consists of 8 individual therapy sessions with each participant, all together it makes 32. Therefore the data consists of 32 taped discussions and the therapist’s own notes. The main data, the 32 taped discussions were literate on the computer. After this a computer program was used in the data analysis.

In the data analysis every participant’s process of eight therapy sessions was divided into three different phases: the first phase (sessions 1-3), the middle phase (sessions 4-6) and the final phase (sessions 7-8). Each phase was analysed by means of how the participants felt about the treatment and emotions, sensations, images, memories and thoughts that arose during the process. The precategory of data analysis consists of the theory of four levels of experiencing by Bruscia (Bruscia, 1998, pp.497-498). These correspond roughly to the four functions identified by Carl Jung (1933/2002): sensing, feeling, thinking and intuiting (Jung, 1933/2002, pp. 91-96.) Bruscia sees these four levels of experience as a whole and as layers that are on top of each other. The better a person can use all of these four levels the more holistically is he able to deal with his experience. According to Bruscia (1998) the sensory level involves spontaneous description of immediate physical experience with no elaboration of it. The affective level involves spontaneous elaboration of immediate physical experience within the affective domain. The reflective level involves self-observation and elaboration of sensory and affective experiences within the cognitive domain. The intuitive level involves spontaneous integration of sensory, affective, and reflective experiences. (Bruscia, 1998, pp. 497-498.)
When the research data was analysed and categorised under four levels of experience interesting changes came up in the emphasis of the levels of experience in different phases of the process. This made me more interested in causality behind the changes. In this state of the analysis I, as a researcher, had to do my own journey in the large field of qualitative research. I started forming lower categories to the levels of experience which is typical to grounded-theory. Through which the material could get more exact. Under sensing I got sensations connected to the physioacoustic treatment, sensations connected to the music and sensations connected to the participants own life. Feeling was divided into five lower categories. They were feelings connected to the physioacoustic method, music, images, to their own life and to the whole treatment in general. Thinking was divided into seven categories: addiction, relationships, music, images, self-examination, work and rehabilitation. There was only little material that could have been categorised into intuiting and therefore there was no need to make any lower categories. After this phase in the analysis the changes in the process became much more understandable and also new views opened into the hermeneutic approach.

This kind of methodological flexibility is characteristic in the qualitative research because the research process is a living and changing process. It is impossible to know what the research will bring up beforehand and therefore the methods have to be adaptable for the needs of the research and not vice versa.
Concerning the credibility of the study I want to emphasise that the research consists mainly of the participants own authentic comments, thoughts and discussions with the therapist. This material is complemented by the therapist’s own notes from the therapy sessions.

Interpretation is an essential part of hermeneutic method which is always in some sense subjective. However, concerning also this research we can talk about so called controlled subjectivity. The researcher functions as some kind of instrument in the collection and analysis of the data. According to Aigen (1995) this requires open-mindedness, thoroughness and insight. The researcher does not decide beforehand what will come out of the data but is open-hearted to the information that arises from the data and evaluates his work all the time while analysing and interpreting it (Aigen, 1995, pp. 296-297). The evaluation can be seen as the heart in the qualitative research from the point of view of the researcher. Continuous appraisal allows the focus, context and the methodology to emerge in a way that will allow the phenomenon under investigation, in this case drug addiction, to unfold and reveal itself in its own way. (Bruscia, 1995, p 424.)

**Results**

The emphasis in the four levels of experience in the different phases of the process changed in an interesting way, which is seen in the following figure.
Figure 62 The levels of experience in different phases of the process.

There is seen the change in the amount of the different levels in the different phase of the process in the above figure. In the beginning of the process thinking was emphasised. In the middle phase the feeling and thinking were more balanced. In the last phase the situation was quite the same. There were mentions connected to sensing in the first and in the middle phase quite the same amount. The experiences connected to sensing diminished a little bit in the last phase. Material that could be categorised into intuition was very few. The reason to this could have been that intuition is the most difficult to define because of the bedding
of the layers of the experience. Intuition is about spontaneous integration of sensing, feeling and thinking (Bruscia, 1998, p 497).

In the next figures we can see each participant separately in the different phases of the process. In the first phase Jussi’s, Pete’s and Sari’s figures are very similar to each other. The difference in Riikka’s figure is that feeling was emphasised only once and thinking was very strong element in her process. In the middle phase sensing was in the same level as in the first phase except from Riikka. Feeling and thinking were balanced for all of the participants in the middle phase. The biggest changes happened in Riikka’s and Sari’s process. In Sari’s case feeling rose to a more important level of experience than thinking. At the end the situation stayed almost as in the middle phase. It is also noteworthy that for Jussi feeling was more important in the last phase than thinking. In Pete’s case the situation was the opposite.
Figure 63 The first phase of the process (sessions 1-3)

![Bar Chart for the First Phase]

Figure 64 The middle phase of the process (sessions 4-6)

![Bar Chart for the Middle Phase]
The physioacoustic method came up to be an important producer of sensation. It brought up very positive and strong bodily experience and sensations of pleasure in all the participants. During the treatment process the participant often came to therapy in a depressed or distressed state of mind. However, with the help of the physioacoustic method their physic-psychic condition changed into a more positive state without exception. By the emotions wakened up by the bodily sensations the participants’ feelings about their own life started to come into their consciousness while the process was progressing.

The music that was listened during the physioacoustic treatment was also an important producer of sensations besides of the physioacoustic method. That also activated feelings and on the other hand images and
memories which took the participant closer to emotions connected to their own lives.

The combination of the physioacoustic method and the listening of music awakened the participants’ senses in a very holistic way from the first treatment session on. According to Caldwell (1996), when we treat addictions and talk about them, we often forget about the fact that our body with our senses is the most important part of the addiction behaviour. Withdrawing from our bodies is the beginning of addictive behaviour. (Caldwell, 1996, pp. 19-32.) With this Caldwell refers the neurologically proved fact that the bodily sensations function as awakeners of our emotions (for example Damasio, 2000). Therefore when we become estranged from our bodily sensations we also become estranged from our emotions.

The combination of the physioacoustic method and listening of music seemed in the light of this research a very useful method to the drug addicts to get in touch with their own body and emotions. In the beginning of the process thinking was emphasised as a level of experience and thinking was somehow separate from the emotional world of the participant. In the middle phase, when feeling activated, thinking started to link more clearly with the participants’ own emotions that had arise during the process.

There was a huge growth of feelings connected to the participants’ own lives in the category of feeling in the middle phase. The situation remained that way also in the final phase. The reason for this is probably the fact that a certain trust to the therapist and to the whole treatment had
been established during the first phase. In the beginning it was easier to talk about the sensations awakened by the sound waves and music than for example about ones own feeling of guilt. When the trust increased it became easier to talk about emotions connected to ones own life with the therapist. The fact that emotions in all started to rise up during the process could be another explanation to this. First the feelings were more clearly connected to the physioacoustic method and music but when the process got further the emotions started to connect more and more with the participants’ own lives.

Caldwell (1996) talks about the addiction spiral that begins with an intolerable experience. A deep sorrow that Sari brought up or Pete’s distress brought up an image can be this kind of intolerable experience. It is typical that this kind of experience is felt to threaten ones physical, mental or emotional survival. An intolerable experience stimulates a fight or run reaction that makes us search for relief to the situation (Caldwell, 1996, pp. 29-30). This kind of emotions could be tolerated because of the sensation of security created by the structure of the therapy.

The participants brought up that there were lots of hidden and denied emotions in their lives. Trying to control situations and experience through denial is the second phase of the addictive spiral according to Caldwell (1996). We avoid feelings and body sensations that may prolong the upset. Maintaining the control requires a lot of energy because all the time we have to choose our experience and feelings according to what is acceptable. (Caldwell, 1996, pp. 30-32.)
The participants felt that during the treatment they could process things that they had left unprocessed. Riikka told for example that when she had fooled about in the city under influence of alcohol or other narcotics she couldn’t think about her actions for a long time. They caused distress so that she couldn’t process her actions. Negative feelings were to be denied. She could not live with those negative feelings. According to Caldwell (1996) the rejection of feelings is the third phase of addictive spiral. If as a child our anger threatens the working of the family system, our membership in the family will be in peril until we rid ourselves of it. Along the feeling goes also part of our self. This is how some feelings change in the person’s world little by little into wrong and not wanted feelings. However, denial of feelings requires an amazing amount of energy and finally makes us hate ourselves because of the feelings that are not accepted by the environment. We must also reject any experience that threatens our self-hatred. Because self-hatred becomes crucial for survival, we must work to maintain it with all possible ways. (Caldwell, 1996, pp. 30-34.) In Riikka’s case this came up very clearly. She blamed herself about everything that had happened in her family. The denial of feelings caused psychosomatic reactions in both Riikka and Sari. Riikka told many times that she had thrown up when something unprocessed started getting out from the inside of her. She felt that the unprocessed things and and the negative feelings connected to them never left her in peace even though she tried to escape from them. According to McDougall (1999) psychosomatic symptoms are sometimes connected to drug addiction problems. It is probable that psychosomatic vulnerability increases with people that use action as protection against psychic pain
when recalling the emotion or reflection would be a more suitable way to deal with it. (McDougall, 1999, pp. 81-93.)

The competence of this rehabilitation method is seen in Riikka´s next comment. Good conditions for processing even difficult emotions are established with the help of physioacoustic method and listening of music. The altered state of consciousness based on a state of deepened relaxation that is established during the treatment creates possibilities for free association. The participant thinks that even surprising and unexpected things come out with this method.

“I´ve sometimes sort of felt like I don´t wanna mess with my childhood or anything today when I´ve come here, but then I suddenly realize just that I´m just like, that it just drifts to that sort of things. Well, it has been easy and so. It hasn´t been sort of, that I had to dig out that I´m gonna talk about this and this. But suddenly one´s just realized, what I probably repeat all the time, about things I´m talking. It´s some how surprising, that I´ve had feelings like that in chair too, so it just drifts to those things and then we just talk about them.”

During the treatment all of the participants reflected well their sensations and emotions in the level of thinking. This happened from the first session onwards. The images that the music brought up surprised the participants for example. From the first treatment on memories started to activate in the participants minds. It was a new experience for them to get acquainted with their own self and to let their thoughts out. This brought up new insights for the participants. In these situations the therapist was some kind of mirror that reflects thoughts back to the participant and with his questions makes the participant think about things even further and from new perspectives. The therapist asked the participants for example about what made them use drugs. All of the four participants felt that it
was about escaping the reality. Life was boring without narcotics and using drugs made life much more fun. According to Caldwell (1996) using drugs can be seen as the fourth and final phase of the addictive spiral. The last phase of the addictive spiral has to do with the domino effect brought on by marginal experiencing. Because we exert so much energy on controlling and rejecting our “wrong” experiences, we have fewer resources available that enable us to tolerate any experience. A lot of our time and energy goes into maintaining a defensive wall against an unacceptable and forbidden feelings, sensations and thoughts. Drugs are a relief to this kind of situation. When using drugs the control loosens and we feel freer for a while. Through this, a feeling of illusion is also created in which we feel that we are taken care of. (Caldwell, 1996, pp. 30-36.) However, when the use of narcotics increases, fears and anxiety seem to be the chief experience of a drug addict.

There was only little material that came up from the data that could be categorized as intuition. Only Pete had some of this kind. There is no clear reason for the lack of intuitional material. One reason could be the fact that it was not so easy to identify intuition as a level of experience from the data. Sometimes it was very difficult to make difference between thinking and intuition and most often that kind of material ended up under the category of thinking. Therefore it is possible that some other researcher would have found more material under the category of intuition than what the results of this research bring up. However, during the data analysis I felt that maybe drug addiction and lack of feeling and intuition could be connected to each other. During the process emotions started increasing and it would have been interesting what would have
happened if the process had been longer. The therapy process in hand was very short, only eight sessions. I believe that with a longer period of time changes could have been seen also in the intuition.

**Discussion**

Through the treatment method used in this research the participants got in touch with their emotions, emotions that had been denied and repressed for a very long time. During the treatment process feeling as a level of experience got on to the same level as thinking which was first a very dominating level of experience. The activating of feelings started with the bodily experience provided by the physioacoustic method and listening of music. Little by little feelings connected to one’s own life started to increase which clearly brought up some new perspectives and depth to self-examination by thinking.

Through the physioacoustic method and listening of music the participants reached a state of deepened relaxation that can also be called the altered state of consciousness. In this state images and memories that had been unconscious for years rise to conscious. Through the altered state of consciousness preconditions to emotional learning were established that was a part of every participant’s process. The therapeutic discussion played an important role in this during which the participants could evaluate the material that had rise from the altered state of consciousness and integrate it through thought to their own conscious mind. Central aspects for the success of this process were the trust and safety created by the therapist.
The main meaning of this research in my opinion is that it brings new information about the methods and possibilities of music therapy in the treatment and rehabilitation of drug addiction. The methods of music therapy are in some extent used in addiction rehabilitation in Finland nowadays. However, research from this area is still very few and therefore this research will be useful and hopefully helps those music therapists that work with people with addiction problems to justify their work even better. This research was done in co-operation with the social and health care of the city of Lahti and I believe that the results of this research will increase the use of music therapy as a rehabilitation method.

A restriction of this research might be the fact that only four participants took part in it and the process itself was very short, only eight therapy sessions. A longer process and more participants wouldn’t have been possible in these circumstances.

When we evaluate the credibility of this research we must remember that in qualitative and in hermeneutic research results are always views and interpretations of the researcher. There is no absolute truth. Some other researcher could have taken up something else from this material than what I have done. During the data analysis I let the voice of the participants be on the main role and I wanted to see what that tells us about drug addiction and the addicts’ empirical world. Problems connected to identifying, standing and processing feelings rise up from the data, which I started researching through different theories. Psychodynamic and body psychotherapeutic based theories helped me to
understand my research data better and more deeply and broader than before. (for example Caldwell, 1996; McDougall, 1999.)

Conclusion

Today there had been plenty of talk about the brain transmitters, like dopamine, and their connection to drug addiction. Dopamine is a transmitter that regulates the experience of pleasure which is emancipated when using drugs. It’s been said that in that case addictive behaviour is saved as part of the brain function. (for example Kiianmaa & Hyytiä, 1998; Ahtee, 1998.) This kind of findings and observations are very interesting and give us new perspectives in understanding addiction. However, we have to remember that these phenomenons are often about consequence and the reasons are somewhere much deeper. There is a great danger to lose the whole picture of the treated person in neurobiologisize addiction problem. If addiction problems are more and more seen as problems in brain function, the treatment method will probably be medicine that alters brain function. In this case however we forget that a human being is much more than a brain producing chemical reactions. A human being is also a social and feeling creature that needs other people to learn new things about his life and himself. Creativity and play belong to a balanced life and that is what the people with addiction problems have to find again in their lives.

How are addiction problems created then? This is a question that I have been thinking about during this research process. Is it about genetic tendency or about the weakness in the personality’s structure? While the research proceeded, a model was created in my mind. To my model I get
support from the psychodynamic theory (for example Granström & Kuoppasalmi, 1998). Could it be that an addiction problem is a consequence of the failure of the first addiction relationship? With this I refer to the early childhood’s symbiotic relationship to a parent through which the child’s self experience is created and established. This first addiction should end to a differentiation from the parent and at this point an inner image of a care taking parent has been created. However, it is possible that for different reasons the first addiction relationship and the differentiation from it does not function as expected. In this case the consequence is a deficiently developed personality that needs outer addiction objects to maintain the inner balance. (for example Granström & Kuoppasalmi, 1998.) According to Caldwell (1996) there are three different ways that the addictions can be created in. Firstly, addictions can arise from repeated intolerable experiences of not getting our needs met. The second reason can be that one is punished for feeling pleasure at need gratification. In my opinion these two ideas can be combined with my idea of the failed first addiction relationship. The third reason that Caldwell (1996) presents is consistently working without resting. In all the previous reasons are about the fact that the person lososes contact with his own emotions either with denying or rejecting them from the conscious. But in fact the emotions do not disappear anywhere and rejecting them requires harder means and narcotics when the time goes on. (Caldwell, 1996, pp. 37-38.)
References


This paper deals with a research work, carried out in different times, concerning two groups of instrumentalists: nineteen violinists and nine flautists of semiprofessional level. The general context was provided by psycho-physiology of music and of musicians. In particular, our interest was focussed on musical performance as related to the posture taken by musicians — in our case, violinists and flautists. The methodological framework was given by Ruggieri’s “Psyco-Physiological Integrated Model”, as applied to the relation between music and the executor’s posture. The hypothesis was that there is a definite connection between the different manners to organize the posture the instrumentalist holds during the musical performance, and the varying quality of the produced sound: *Not a single movement of the body can be separated from the postural context in which it takes place*” (Ruggieri-Katsnelson, 1996). A psycho-physiological model, by integrating the study of posture, movement and the role of muscles, can offer a scientific theory basis for future research work in this new and open field.
The practical application of Ruggieri’s integrated psycho-physiological model is shown in section 1 an 2, focussing on violinists and flautist respectively. To begin with, however, it may be useful to define a few concepts which are necessary for illustrating the experiments.

**INTRODUCTION: A FEW DEFINITIONS**

**The concept of posture**

By posture is meant the overall position of body and limbs in relation to each other, and their orientation in space (Ghez, 1994).

In the framework of the integrated psycho-physiological model it is preferable to refer to posture experiences, rather than to posture alone. According to this model, in fact, posture is not only related to the control of upright standing, but is at the same time the result of the stimulating activity of the motor control system, as well as the basis for the reception of fundamental information. In this context, apart from single stimuli from periphery (organs, vestibules, eyes, etc.) to centre, information derived from posture *in toto* are also subjectively relevant. In other words, posture attitude as such represents an important stimulus-situation which can evoke subjective past experiences of psycho-physical stability or instability. The perception of stability/instability is a favouring or inhibiting basis for an harmonious psycho-physical development. Such a basis, in turn, is the favouring or inhibiting condition for the development of inter-personal relations. Posture, therefore, also appears as a modulator of human behaviour.
Mental image and body as a “structuring process”

The body image plays a fundamental role in adjusting the relationship between posture and movement, as well as in organizing body movements in space.

The psycho-physiological hypothesis assumes that the body representation, which is produced at the brain level, plays an active role in modulating the body’s peripheral activity. In this way, it continuously controls the tonic activity of all muscles and the basic posture attitude. The body thus becomes a reflection of the body image. On the other hand, body activity is again transformed, in a continuous feedback process, into body representation and self-consciousness. These processes are the foundation of the Ego construction.

This perspective is a marked departure from a scientific tradition which identifies the body with anatomy, and defines it as the structure within which psycho-physiological processes take place. According to hypotheses based on the psycho-physiological model, instead, the body is seen as a “structuring process” (Ruggieri 1987). Using a musical metaphor, Ruggieri describes the body as an orchestra in which the sound itself produces playing instruments. As a psycho-physiologist, Ruggieri places the crucial focus of observation in the analysis of such an orchestral co-ordination.

Resting

The compensation dynamics enacted by the Central Nerve System to avoid falling down largely depends on the way a subject rests on a
support. Resting is therefore related to the concepts of balance, weight and gravity.

In the framework of Ruggieri’s model, resting does not only mean enacting a mechanical-physiological event. It rather appears as a “psycho-physiological entity” in which the mechanical-physiological dimension is intertwined with other psychological processes strongly marked by the subject’s history and past experiences.

Resting means, above all, reducing tensions in order to counterbalance gravity in the most economical way. In psycho-physiological terms, resting is a dynamic process by which the subject passes from a suspended, tense condition over to a condition of tonic relaxation. This relaxed condition is made possible by the existence of a structure on which to rest. Such a process is characterized by a continuous, swift sequence of tension and relaxation of muscles supporting the resting structure. When muscle tension increases, the structure becomes self-supporting; when, however, muscle tension decreases, the structure discharges its weight to its supporting basis. Weight unloading is immediately followed by a tonic bounce to resume the lost tension. This, in turn, sometimes provokes a new discharge of weight-tension. A tension-and-discharge process is thus generated which may synchronically involve different body areas or the body as a whole. This process also results in a continuous shift of the gravity centre, since the body weight is successively discharged to different parts of the supporting basis. A continuous change of such parts can be observed, which causes a series of micro-oscillations and, with them, variations in
the muscle tone resulting in isometric contractions. Isometric and isotonic contractions represent the two forms of activity of the muscle system.

In the light of these observations, the muscle system can be seen as a provider of information on body activity and muscle tone combinations. According to the psycho-physiological model, resting makes the unification of different levels possible. The possibility of materially resting is a necessary precondition for other harmonious motor, dynamic and relational operations.

In the light of these basic assumptions, the experimental situations referred to above are analysed in two separate sections.

SECTION ONE: VIOLINISTS

(by Dr. Silvia Ragni)

The musician’s body, as construed later in this paper, is often absent from music discourses, although it is a musician’s first and foremost instrument of expression. Through his or her body, a musician gets in touch with the musical instrument in order to produce a sound. Yet the body is usually absent from the performer’s perception, as well as from the teacher’s pedagogic approach. Traditionally, teaching systems tend to selectively focus on those parts of the body which are directly involved in the performance, — namely, fingers, hands, arms, rather than on the body as an integrated unit. Similarly, one finds a stress on mechanical movements rather than on psycho-physical experience. It is only over the
last few decades that more advanced didactical approaches have tried to overcome such limitations, which at times make a musician’s training quite difficult.

**Posture in violin teaching according to various Schools**

Since the sixteenth century, different violin Schools have appeared. They have largely stressed and variously interpreted the style of holding the instrument, and the role played by different parts of the body, — particularly left hand fingers, right wrist and elbow, in obtaining technical skill and in producing a pleasant sound. Approaches have been changing over time, along with general set up, taste for rhythm, and the nature of music pieces which have marked the history of our music.

The next paras give a very brief outline of Schools which have produced major techniques and methods of practicing the violin. (Porta, 2000)

**From early times to late eighteenth century**

Violin emerged as an important instrument both for sacred and profane music in the late sixteenth century. Since then, a need was felt for the elaboration of teaching and performing techniques, and various Schools began to take shape.

Violin was born in Italy; Corelli and Tartini founded their respective Schools.

In Austria, Leopold Mozart (1719-1787), Wolfgang Amadeus’s father, wrote a treatise entitled Versuche einer gründlichen Violinschule, in which he distinguished between two ways of holding the violin.
Niccolò Paganini (1782-1840) was celebrated all over Europe. An artist and a matchless virtuoso, he elaborated the violin technique to the utmost; some of his works are still considered as of highest difficulty. Paganini had a very personal playing style, outside the pale of current norms. This gave rise to mysteries and secrets which flourished around his figure over time. His posture on the violin was quite unique.

“His body weighed entirely on his left leg, his left elbow was firmly placed against his body with a marked twist towards the right. [...] His left shoulder was strongly projected, his right arm ‘still and close to his body’: he used to raise it only to play arpeggios; his wrist was markedly bent upward.” (Porta 2000)

At that time, virtuosity prepared violin playing to the quest for a greater sound which began in the early twentieth century.

New Schools and methods
From the late eighteenth century onward, new Schools came up and a new teaching method appeared, the so-called “violin physiology”, which aimed at studying the nerve impulses, muscles and tendons involved in playing.

Our scientific work was first introduced by a French author, Dominique Hoppenot. A few years ago she wrote an essay entitled The Inner Violin, from which the following quotation is drawn:

“In more than twenty years of violin teaching I have collected a number of observations which have never stopped raising questions in my mind. [...] Since I first got in touch with musicians seeking my advice, I noticed signs of a particular suffering, which forms what I might call ‘the
For many, too many of them, violin is synonymous with suffering.

*Even without realizing it themselves, they develop a sad and painful relationship with an instrument which represents a real tragedy to them, ever since they start practicing it, thereby falling victims to a sort of slavery. Their suffering finds expression in various forms: they feel frustrated because they cannot express themselves, they feel unable to solve particular technical problems, they feel alienated from themselves in distressful performance situations. I perceive this suffering whenever musicians take up the instrument to show me the nature of their problem. They produce a poor sound, cannot communicate any authentic vibration or sincere expression; their body is shaking, their face is twisted. Sometimes they have no pleasure in playing, their sweat is excessive, their worries prevent them from understanding their own self and lucidly following the musical exposition. [...] They are not at ease with their instrument, nor with music, nor at times with themselves*” (Hoppenot, 1981, p.7).

Dominique Hoppenot inaugurated a new era in violin teaching: she took us along to the very core of our times and showed us what it means to be a violinist today.

This very brief outline has shown the gradual development in the violinist figure over the centuries, from an almost lifeless and “dissected” being to a man in flesh and bones, with his various psycho-physical components integrated into a unit. Hoppenot, in fact, made us discover the violinist’s inner world, — a world so familiar to all students of violin who have to face, during their daily practice, the difficult problem of expressing themselves in music through their instrument.

The aim of the *violon intérieur* approach is to reach the student’s mind and show him or her that a different attitude toward the instrument is possible, by which he or she can touch the “*inner cords.*
The first step to take in that direction is *conquering the body*: the body is sadly missing in the current teaching methods for string instruments. Instead, one can only communicate one’s own inner riches through a body balance. This balance requires the free movement of muscles and the absence of contraction, since the activity and position of arms and hands suffer from the lightest unbalance among these components. The first thing to achieve is stability around one firm axis from head to feet. Feet have to support the weight of the entire body, and therefore they should rest on the ground with their whole surface. This will enable slight bounces during the performance (Hoppenot, 1981).

Legs are like a “transmission belt” between feet and trunk. Knees should be slightly turned to the outside, in order to favour the opening of chest and shoulders. The spine should be consciously kept straight by the violinist, so that its vertical line may not divide the body in two. The image of a plumb-line hanging from head to coccyx through the body, as suggested by Hoppenot, may help the violinist feel the unity of his or her body.

**EXPERIMENT**

**Introduction**

This experiment was conducted during Jorge Risi’s international violin Master Class in Strasburg, thanks to the Maestro’s kind invitation.

The aim was to verify whether different postures lead to changes in the way music is performed. The terms of reference refer to aspects of perception and attention: whether postural changes occur when the
performers are asked to concentrate on the various parts of the body indicated during the experiment. The expected result was a change in the intensity, pitch and length of the sound of the instrument.

The research work was carried out with the help of sound analysis equipment.

**Hypothesis**

The hypothesis assumes that by concentrating on various body parts during a musical performance, the characteristics of the sound of the instrument change in intensity, pitch and length.

The hypothesis also takes into account the possibility that the performer’s sense of pleasure with regard to the various indicated body parts could also change.

**Sample Group**

The sample group consisted of 20 violinists, 7 Spanish and 13 French, all participants in the international music course. Their ages ranged from 18 to 28 (average age 19.5). The level of proficiency of all the musicians (8 male and 12 female) was similar.

**Variables**

The following body parts were chosen to carry out the experiment:

1. abdomen
2. both knees
3. right knee
4. left knee
5. buttocks
Selection of the scale

The scale of *A-major* was chosen as a dependent variable, played ascending and descending, beginning on the 2° open string.

This tonality is particularly suitable to this instrument for a number of reasons:

- It is possible to begin on an open string (in other words, free, with no fingers on it) and play it in first position, thereby creating a comfortable situation for the violinist;
- It is the best way to acoustically represent the instrument: the A4 corresponds to the diapason (440 hertz) as well as being the note used to tune the instrument. The frequency band within the interval of the scale chosen corresponds to the best acoustic sounds of the belly of the violin.

To achieve greater control of the variable as well as controlling the disturbance variables, the musicians were asked to play a scale without vibrato at a time of 60 the quaver (beats per second) reading the score with the following indication: *with a détaché bow* (playing successive notes with alternate down-bow and up-bow but not staccato, using the whole bow).

Recording equipment

A Shure SM 58 microphone was used.

Sounds were recorded on a digital DAT “Sony mod. TCD-D7” recorder with a sample frequency of 44.1 KH.
Later on, data were transposed on a computer with a Wave File using the audio editing programme, Cool Edit Pro, version 1.2.

**Setting**
The experiment and recordings were carried out in a partially soundproof classroom on the first floor of the Institute in which the course was being held, isolated from the other classrooms on the floors above.

After carrying out three tests to organise the experiment with three violinists not included in the sample group, the microphone was positioned. It was placed to the side, 50 cm. above the bow of each musician: this was the best position to record the sound emitted.

The microphone was fixed to a rod along which it could slide so that it was at the same distance from each performer. The correct recording levels and the exact point where the performer was to stand were also established.

**Procedure**
All components of the sample group were tested individually.

Before beginning the experiment, each participant was informed that this was not a proficiency test.

They were all allowed to use their own instruments to avoid problems of non-familiarity interfering with the results of the experiment.

Identical tuning was carried out for all performers using an electronic tuner, calibrated on a 440 Hz diapason.
Once the instrument had been tuned, each musician was asked to assume his/her usual position and play the scale of A-major indicated on the musical score while standing on the spatial co-ordinates chosen for the recording.

After the first performance (baseline for the other tests) the performer was asked: “to play the same scale paying particular attention to …” (the body part indicated by the experimenter).

After every performance the musician was asked to answer a self-evaluation question (on a scale of 1 to 10) relating to "the sense of pleasure associated with the indicated body parts."

**Elaboration of the raw data**

In order to analyse the data it was necessary to carry out a series of complicated operations to compensate the small number of musicians in the sample group.

These operations were carried out in the electronic laboratory of the Department of Psychology with the help and assistance of Mr. Dino Moretti, a technical operator at the Faculty of Psychology.

The sounds recorded with the DAT instrument were transposed on a computer as a Wave File and sampled at 44 KHz. They were then recorded by using an audio editing programme, the Cool Edit Pro version 1.2. This programme was used to visualise the entire scale.

For this research work the C sharp of the scale was chosen, specifically C#4, corresponding to 554.36 Hertz (a conventional value) on the basis of the following criteria:
• Instrumental technique: C#4 is played in first position with the middle finger: a finger with a strong joint suitable for playing. This corresponds to a “down-bow” (from the heel to the head of the bow) and in the indicated (ascending) sequence is considered comfortable to use since it is the third sound emitted when the initial adjustment phase is over;

• Harmonic reasons: in an A-major tonality C # corresponds to the modal note or character note that determined the tonality. Therefore it is truly representative of this tonality.

All the C# of the ascending octave played by the 20 violinists were extracted and copied in a specific musical File. Careful attention was paid to the various body parts indicated by the experimenter as well as the “free position” chosen as a baseline. 10 tests per musician were analysed, amounting to a total of 200 tests.

Spectral analysis was carried out on these sounds using the above-mentioned Cool Edit Pro version 1.2. The following parameters of sound were recorded:

• **Intensity**, measured in decibel;

• **Length**, measured in minute seconds;

• **Frequency**, measured in Hertz musically expressing the pitch of the first harmonic or fundamental note. This corresponds to the intonation of that sound.

In order to carry out a statistical analysis, the latter values were then changed into their logarithmic values.

A chart was plotted for each parameter showing the values corresponding to each position of every musician.

The “free” posture was considered as a baseline value.
Data Analysis

In order to analyse the data an ANOVA for repeated measurements (alpha = 0.05) was carried out for every parameter consideration: intensity, length and pitch of the sounds. The group average was calculated for each position and a comparison was carried out for each parameter.

No statistical differences were observed for any of the recorded parameters.

These results were confirmed by using the Buonferroni procedure.

Post-hoc comparisons were also carried out.

The following results were recorded:

Results

1. Intensity:

Table 23 Comparison between the position of the ABDOMEN and LEFT KNEE

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdomen</td>
<td>-15.172</td>
<td>4.147</td>
</tr>
<tr>
<td>Left Knee</td>
<td>-16.977</td>
<td>4.503</td>
</tr>
</tbody>
</table>

P-Value 0.0061

Table 24 Comparison between the position of the ABDOMEN and BUTTOCKS

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdomen</td>
<td>-15.172</td>
<td>4.147</td>
</tr>
<tr>
<td>Buttocks</td>
<td>-16.765</td>
<td>4.880</td>
</tr>
</tbody>
</table>
Table 25  Comparison between the position of the RIGHT KNEE and the LEFT KNEE

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Knee</td>
<td>-15.478</td>
<td>4.348</td>
</tr>
<tr>
<td>Left Knee</td>
<td>-16.977</td>
<td>4.503</td>
</tr>
</tbody>
</table>

P-Value 0.0153

Table 26  Comparison between the position of the RIGHT KNEE and BUTTOCKS

<table>
<thead>
<tr>
<th></th>
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<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Knee</td>
<td>-15.478</td>
<td>4.348</td>
</tr>
<tr>
<td>Buttocks</td>
<td>-16.765</td>
<td>4.880</td>
</tr>
</tbody>
</table>

P-Value 0.0223

Table 27  Comparison between the position of the KNEES and the LEFT KNEE

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
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<td>Knees</td>
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</tr>
<tr>
<td>Left Knee</td>
<td>-16.977</td>
<td>4.503</td>
</tr>
</tbody>
</table>

P-Value 0.0493

Table 28  Comparison between the position of the LEFT KNEE and SHOULDER BLADES

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left Knee</td>
<td>-16.977</td>
<td>4.503</td>
</tr>
<tr>
<td>Shoulder Blades</td>
<td>-15.671</td>
<td>4.607</td>
</tr>
</tbody>
</table>

P-Value 0.0440
2. Length:

Table 29 Comparison between the FREE POSITION and the SHOULDER BLADES

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free Position</td>
<td>1.514</td>
<td>0.318</td>
</tr>
<tr>
<td>Shoulder Blades</td>
<td>1.655</td>
<td>0.453</td>
</tr>
</tbody>
</table>

P-Value 0.0300

Table 30 Comparison between the position of the KNEES and the SHOULDER BLADES

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knees</td>
<td>1.503</td>
<td>0.495</td>
</tr>
<tr>
<td>Shoulder Blades</td>
<td>1.655</td>
<td>0.453</td>
</tr>
</tbody>
</table>

P-Value 0.0193

Table 31 Comparison between the position of the LEFT FOOT and the SHOULDER BLADES

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left Foot</td>
<td>1.527</td>
<td>0.255</td>
</tr>
<tr>
<td>Shoulder Blades</td>
<td>1.655</td>
<td>0.453</td>
</tr>
</tbody>
</table>

P-Value 0.0483
3. Pitch:

Table 32  Comparison between the FREE POSITION and the ABDOMEN

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free Position</td>
<td>2.747</td>
<td>0.004</td>
</tr>
<tr>
<td>Abdomen</td>
<td>2.745</td>
<td>0.003</td>
</tr>
</tbody>
</table>

P-Value 0.0283

Table 33  Comparison between the FREE POSITION and the LEFT KNEE

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free Position</td>
<td>2.747</td>
<td>0.004</td>
</tr>
<tr>
<td>Left Knee</td>
<td>2.745</td>
<td>0.003</td>
</tr>
</tbody>
</table>

P-Value 0.0171

An ANOVA was also carried out for the self-evaluation questions for repeated measurements (alpha = 0.05) with regard to the sense of pleasure felt in the various positions during the experiment.

No significant statistical differences were recorded.

The Buonferroni procedure confirmed these results.

Post-hoc comparisons were also carried out. The following results were recorded:

4. Post-hoc

Table 34  Comparison between the FEET and the LEFT KNEE

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
</table>
CONCLUSIONS

Interpretation of results
This research aimed at verifying whether by calling attention to various body parts during a musical performance there was a change in the resultant sound.

The results of the statistical analyses show no significant differences between the considered variables.

The post-hoc comparison of the mean averages of each performance provide data that may be useful in future research in the field of musical performances.

General Conclusions
Notwithstanding the size of the sample group, this exploratory research does provide certain evaluations based on theories regarding the role of various body parts during musical performances and supported by

Table 34  Comparison between the FEET and the LEFT KNEE

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feet</td>
<td>4.250</td>
<td>3.401</td>
</tr>
<tr>
<td>Left Foot</td>
<td>2.400</td>
<td>3.283</td>
</tr>
</tbody>
</table>

P-Value 0.0186

Table 35  Comparison between the KNEES and the LEFT KNEE

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knees</td>
<td>4.100</td>
<td>3.417</td>
</tr>
<tr>
<td>Left Knee</td>
<td>2.400</td>
<td>3.283</td>
</tr>
</tbody>
</table>

P-Value 0.0304
teaching material, musical literature and the integrated psychophysiological model.

With regard to the intensity of sound, it may be noted that on average the abdomen has the highest average intensity in the group, while the left knee has the lowest average value.

From the comparison between the abdomen and the left knee, and the abdomen and the buttocks, it is possible to theorise that, when concentrating on the former, a more intense sound with greater volume can be produced.

Based on the psychophysiological model, this variation could be explained as a possible postural readjustment permitting tensions to be discharged and organised as well as greater use of the part in question as a support. This would lead to a greater volume of sound. In fact, to play loudly it is not necessary to press hard, but to allow maximum vibration of the string. Playing harder only provides the illusion of producing a more intense sound while in fact only greater rigidity is achieved.

The two knees perceived contemporarily are the next body part after the abdomen to produce greater intensity of sound. A comparison between both knees and the left knee could indicate the possibility of producing a more intense sound when both sides rather than one side of the body is perceived, thereby providing support, discharge and ‘rebound’.

A significant comparison between left and right knee and right knee and buttocks would seem to indicate that the right side of the body (where the
bow is held) encourages an increase in intensity compared to the left side of the body (which instead supports the violin).

The fact that the value of the shoulder-blades is significant compared to the left knee appears to confirm the importance of a point of integration of movement upon which to rest, again compared to the left side of the body.

All these comparisons appear to show that the left side of the body – due to the fact it supports the violin – is less important for the intensity of sound compared with the central parts (abdomen, both knees and shoulder-blades) or the right side of the body that corresponds to the side that supports the bow. In this group it appears that the right side is more suited to producing a more intense sound and therefore exercising greater pressure.

As concerns the length, the significant differences between the shoulder-blades (with the highest average value) and the free position (with the lowest) appear to confirm the hypotheses of the teaching profession (Hoppenot, Menhuin, etc.) that has pinpointed in this area of the body the point of integration of the bow and the violin: a point of both horizontal and vertical convergence between opposing forces.

Attention to this part of the body, rather than to no part in particular, leads to the hypothesis that tensions decrease and permit the possibility of perceiving this ideal configuration. In turn, this affects the length of the bowing and therefore the time necessary to execute it.
The comparison between shoulder-blades and knees would appear to be similar. It was noted that the knees affected intensity. It could also affect the length of the sound, making it shorter. The more intense the sound the shorter it is, unless the sound is voluntarily made longer and more intense at the same time. It is more difficult to interpret the comparison between the shoulder-blades and the left foot, even though this data could always be explained by the importance of laterality.

As far as height is concerned, it was noted that the position of the abdomen produced a sound that was more in tune compared to the free position. This data would confirm the psycho-physiological hypothesis that the abdomen is the organisational core of tension and by concentrating on it a more intense as well as a more tuned sound can be produced, probably thanks to the possibility of support. The comparison between the left knee and the free position appear to confirm the teaching hypotheses. The left knee, on an axis with the left hand, could be used by the violinists in the group as a reference point for the left hand, thereby permitting an improved position of the instrument and therefore the possibility to intone the sounds better compared to a situation where this reference point was absent.

Regarding the self-evaluation of pleasurable feelings, the post-hoc comparison highlighted the maximum average value of the group as being the position of the feet, following by the knees.

These data seem to support both the psycho-physiological and the teaching hypotheses. In fact, the feet represent the base supporting the violinist’s body upon which it is possible to discharge with ‘rebound’
which permits “the leap”, in other words musical expressivity. The fact that they are followed by the knees again confirms this supposition: another strategic point for elasticity immediately after the support provided by the feet. The fact they are two symmetrical parts confirms the musicians’ need to feel that the body is an integrated whole, not made up of two “half-violinists” as described by Hoppenot. In fact, feet and knees appear to be the base and elongation towards the body of a triangle upon which to rest.

Therefore, it is not surprising that both feel more pleasing than the left knee even if this is the knee that the violinist probably tends to mistakenly “press” when playing.

SECTION TWO: FLAUTISTS
(by Dr. Loredana Terrezza)

In this section, the parameter under investigation is timbre, a complex parameter in which all the elements of every wave come together and are organised: frequency, phase and intensity.

As far as concerns the evaluation of the emotional expressive components in music, of the gestalt sounds obtained, a second experiment was conducted in which the test subjects assessed a series of sounds based on sensations and adjectives provided for them. Previous research has supported this hypothesis:

The first (Ruggieri-Veroli '84) hypothesised different configurations of musical stimuli, giving rise to 1) different emotional responses, 2) different conceptions of duration, 3) between the temporal and emotional
processes there could be a strict relationship, in so much as aesthetic judgements are formed on the basis of actual values; relaxation-tension, pleasure-displeasure, sadness-happiness, stasis-dynamism.

The experiment consisted of playing six extracts taken from instrumental pieces, each lasting for twenty seconds and divided into two rhythmic groups (4/4 and 3/4), to a sample of forty people.

After hearing each phrase the subjects were first asked to reproduce the length of the sample by pressing a button twice (once at the beginning and once at the end). Afterwards they were asked to give an aesthetic judgement by putting a mark on a prepared sheet of four polarised adjectives.

The data from the experiment confirm the hypothesis.

Another experiment dealing with the emotional responses to musical stimuli was carried out using a single note repeated at different speeds (Rossi '82).

The experiment revealed that notes played at higher speeds produce feelings of joy, happiness and excitement.

Other experiments have been conducted on the semantic differentiation of timbre.

Pratt and Doak (1976), starting with a list of nineteen words, commonly used verbal attributes to describe timbre.
Using a checklist procedure they got down to seven adjectives: rich, melodic, colourful, bright, penetrating, clear and warm. These were reduced to three (bright, rich, warm) and their opposites (dull, pure, cold). In addition, they found that synthetic tones from various spectra came to be classified on a scale, the extreme ends of which were the adjectives bright-dull.

A. Roger, Kendal and E.C. Carterette (1993), carried out an experiment on the verbal attributes of timbre produced by different wind instruments (oboe, soprano clarinet, soprano sax, trumpet and flute).

The first part of the experiment consisted of playing the same short melody, simultaneously played on two instruments, to a group of music students who were then asked to assess the quality of the timbre.

Next, non-musicians were asked to listen to several scales (taken from eight scales on ten different instruments) and to give a judgement based on a list of bipolar adjectives (compact, weak, pure, heavy, violent, cutting, complex, etc.)

In this experiment too brightness was the most used adjective of discrimination.

Many experiments have been done upon this parameter. Amongst other things they have dealt with perception, the relationship between the combined elements and the adjectives used to describe them.

However, experiments on the connection between the way in which something is played and the resultant sound are almost non-existent. It is to this field that this experiment offers a contribution.
EXPERIMENT
This experiment is intended to discover whether differences in the physical posture of a musician result in differences in the method of music recital.

It is divided into two parts:

The first part focuses on perceptive attention in which, transferring attention to different parts of the body during the exercise, the quality of the sound produced changes.

The idea is that concentrating on one part of the body (focal point) alters posture.

The data were analysed according to which analytical instruments were used and the parameters of the sound itself.

The second part of the experiment, based on the integrated psychophysical model, considers aesthetic judgement. This is a complex and integrated process in which the emotional responses of the subject are recorded in relation to given stimuli. (Ruggieri Veroli ’84).

PART ONE

1. HYPOTHESIS
The hypothesis behind the first part is that if a flautist concentrates on a single part of their body whilst playing then the qualities of the sound also change. In particular with respect to *timbre*. 
2. DESCRIPTION OF EXPERIMENTAL GROUP

The sample group consisted of nine flautists who were in their sixth or seventh years of studying under Maestro Schiviavone at the Conservatorio di Musica di Santa Cecilia in Rome. The age range was between 18 and 23 years old.

3. INSTRUMENTS USED

3.1 VARIABLE S - THE CLASSIC POSTURE FOR A FLAUTIST

In the classic posture for flautists the instrument is held horizontally on the right hand side and at a slight incline. The thumb and index finger of the left hand hold the uppermost part of the flute, nearest the head, whilst the thumb of the right hand supports the main body of the instrument (its tail).

The flautist positions himself at 30 degrees to the music stand, the left foot in front of the right. The left elbow is thus forward and raised, the right elbow lowered, so as to keep the wrist straight and reduce tension in the shoulders. In this way the fingers can move quickly and lightly over the keys.

Thus the body forms a diagonal starting from the left foot and finishing at the right elbow; the torso turned to face the right. This lowers muscular tension, the focal points lying on the diagonal (taken from G. Gatti’s Manual and personal experience).

Based on this knowledge and following on from studies related to focal points (V. Ruggieri and G. Sera, 1996) the list of body parts selected is:

- the shoulder blades
- both feet together
• the abdomen
• the right foot
• the left foot
• both knees together
• the right knee
• the left knee
• the spinal chord (sacral region)

3.2 SCALE SELECTED (Xi) E flat (Mib) major was chosen as a controlled variable. It was chosen in order to control as many variables as possible. It begins in a comfortable position; the fingers in a resting position (the little finger of the right hand fixed, the thumb supporting) making it easier to play, and starts from the third position in the key. The scale was played over one octave, ascending and descending, and played legato (smoothly) to reduce differences in timbre caused by technical difficulties when played staccato (detached), a breath being taken after the eighth note of the ascending phrase.

The tempo was fixed at 80bpm on the metronome to allow for reasonable exhalation on each note.

3.3 RECORDING EQUIPMENT
• 2 “SHURE-SM 58” microphones.
• The sounds were recorded on DAT using a “Sony PCM-500”.
• They were then transferred onto a computer at 90% fidelity, using “SOUND-Forge” version 4.0.
• All sounds were normalised at 80% until objective analysis was completed.
4. SETTING
The experiment was carried out in the laboratory of the School of Electronic Music Composition, under Professor R. Bianchini, who helped in the sound recording along with two experimenters.

Four tests were carried out during set up on three flautists who did not form part of the experimental field.

These helped determine the best positions for the microphones:

the first was placed above the end of the flute, where the sound comes out, at a distance of 45cm. The second was positioned 60cm the G sharp key so as to catch the best sound while avoiding recording the flautist's breathing.

Two kinds of measurement were thus taken for each sound which were analysed and reproduced in the subsequent spectral analysis.

5. METHOD
The test subjects were asked to warm up the instruments standing in an upright position. As soon as they were ready they were asked to play the scale of E flat major as written on a manuscript. They were allowed to choose their normal position (Freestyle).

1 After the first exercise they were asked to repeat the same scale, this time thinking about a specific part of their bodies, as directed, and keeping their eyes shut. They began when they felt ready.

2 After each exercise they were asked to give a value, from one to five, representing how far they had succeeded in concentrating on the indicated focal point whilst playing. One corresponding to minimum concentration and five to maximum.

3 Each new test was selected at random.
4 The exercises were all carried out in front of the musical manuscript in order to avoid free musical expression, which can often create difficulties or inhibitions in musicians who come from classical training backgrounds.

5 Each musician used their own flute.

6 **PREPARATION OF RAW DATA**

1 To analyse the data it was necessary to perform a number of lengthy operations, which accounts for the limited size of the test group.

2 "Point Shop pro version 4.12" was used to convert the sounds into a graphical format.

3 The most representative note from each scale was selected for analysis based on these graphs and the given criteria for the technical style for playing the flute; the modal (the third note in the scale), in this case G(3) which corresponds to 390Hz. This note is also comes at the most comfortable part in the passage for the flautist in terms of breathing.

4 For all of the test subjects, the G notes from the ascending part of the scale were extracted and superimposed for each exercise according to which focal point had been indicated by the experimenter.

5 From these data a spectral analysis was carried out for each individual note using "Cool Edit pro" version 1.0.

6 The intensity of the individual frequencies were examined, thus giving the spatial parameters of the timbre.

7 The intensities of the base (lowest) frequency components were translated into quantitative terms using a program written in BASIC, "Readgran: la quantificazione dei picchi spettrali (the quantification of spectral peaks)", specially designed for this experiment by Professor R. Bianchini. The program evaluates peaks in intensity of frequency, which were numerically translated for all frequencies greater than -75dB.

- The intensities of individual harmonics were transformed back from dB (logarithmic quantity “20 log10”) to the original unit of measurement, the Watt, to permit statistical analysis of real data measurements.

- Other data were obtained to follow the progression of the base frequency and its intonation for every variable X.

Visualisation was made possible using "C. Sound" which isolates the progression of individual harmonics.
Subsequently the average value for each base note was calculated, using a program specially designed by Professor Bianchini.

If we consider the free-form position as the base-line, the tables were constructed by subtracting from this the base frequencies for each part of the body. Nine for each test subject.

**DATA ANALYSIS**

The "T Student" test was used on the group to compare the average values, in so far as the subjects in the group numbered less than 30.

Comparisons were made between:

- The relative average sound intensity for G(3) corresponding to the ten physical postures in each subject. These were obtained by taking the sum of the intensities of the harmonic components and the base.

The differences were not statistically interesting.

The average intensities of the individual harmonic components (fc) were compared for each of the 10 body positions; statistically significant results were found between the G(4) of the right foot and of the left knee:

<table>
<thead>
<tr>
<th>Table 36 Intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Right foot</td>
</tr>
<tr>
<td>Left knee</td>
</tr>
</tbody>
</table>

Average difference = .245; $T = -2.439$; $P. Value = .0406$
The number of harmonics equal to \( x_i \) was selected, the differences taken from their values.

Statistically significant differences were found between: both feet - left foot, the left foot - left knee:

Table 37 Intensity

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both feet</td>
<td>.489</td>
<td>.495</td>
</tr>
<tr>
<td>Left foot</td>
<td>.507</td>
<td>.447</td>
</tr>
<tr>
<td>Left knee</td>
<td>.603</td>
<td>.385</td>
</tr>
</tbody>
</table>

Both feet - Left foot: Mean Diff. \( = - .298 \); \( T = 2.808 \);
\( P \)-Value \( = .0229 \)
Left foot - Left knee: Mean Diff. \( = .243 \); \( T = .0475 \)

The same procedure was applied to the sum of the different frequency component numbers. Significant differences were found between the freestyle - right knee:-

Table 38 Frequency

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free-style</td>
<td>2.889</td>
<td>.782</td>
</tr>
<tr>
<td>Right knee</td>
<td>3.556</td>
<td>1.130</td>
</tr>
</tbody>
</table>

Freestyle - Right knee: Mean Diff. \( = - .667 \); \( T = 2.309 \);
\( P \)-Value \( = .0497 \)

The sums of the harmonics were also considered, the differences in values were significant between: both feet - left foot; both feet - spinal chord:

Table 39 Harmonics

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std.Dv.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left foot</td>
<td>6.889</td>
<td>1.364</td>
</tr>
</tbody>
</table>
The T Test, applied to intonation data and so to the average progression of the base frequencies, gave rise to statistically significant averages between: shoulder blades - feet, shoulder blades - knees, shoulder blades - left knee, right foot - left knee; the highest mean value (furthest from the base-line) was that related to the shoulder blades, the lowest was that related to the left knee.

### Table 40 Intonation

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder blades</td>
<td>2.497</td>
<td>1.918</td>
</tr>
<tr>
<td>Right Foot</td>
<td>2.348</td>
<td>2.046</td>
</tr>
<tr>
<td>Both feet</td>
<td>1.169</td>
<td>1.466</td>
</tr>
<tr>
<td>Both knees</td>
<td>1.076</td>
<td>2.22</td>
</tr>
<tr>
<td>Left Knee</td>
<td>.948</td>
<td>1.996</td>
</tr>
</tbody>
</table>

As far as concerns the self-evaluation values for the group referring to perceptive attention, the statistically significant average differences were found between: shoulder blades - abdomen, shoulder blades - left foot, both feet - both knees, both feet - right knee, both feet - left knee, abdomen - right foot, abdomen - right knee, abdomen - left knee, left foot - both knees, left foot - right knee, left foot - left knee. The highest
average was that relative to the abdomen, the lowest to the shoulder blades and right knee:

Table 41 Self-evaluation

<table>
<thead>
<tr>
<th></th>
<th>MEAN</th>
<th>Std. D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHOULDER BLADES</td>
<td>3.556</td>
<td>.882</td>
</tr>
<tr>
<td>ABDOMEN</td>
<td>4.667</td>
<td>.707</td>
</tr>
<tr>
<td>LEFT FOOT</td>
<td>4.556</td>
<td>.726</td>
</tr>
<tr>
<td>BOTH FEET</td>
<td>4.333</td>
<td>.866</td>
</tr>
<tr>
<td>BOTH KNEES</td>
<td>4</td>
<td>1.118</td>
</tr>
<tr>
<td>RIGHT KNEE</td>
<td>3.556</td>
<td>.882</td>
</tr>
<tr>
<td>LEFT KNEE</td>
<td>3.778</td>
<td>.667</td>
</tr>
<tr>
<td>RIGHT FOOT</td>
<td>3.667</td>
<td>1</td>
</tr>
</tbody>
</table>

Shoulder blades - Abdomen :Mean Diff. =-1.111; T=-3.162; P. Value=.0133
Shoulder blades - Left foot: Mean Diff. =-1; T=-3.464; P. Value=.0085
Both feet - Both knees: Mean Diff. =.333; T=2; P. Value=.0805
Both feet - Right knee: Mean Diff. =.778; T=2.401; P. Value=.0431
Both feet - Left knee: Mean Diff. =.556; T=3.162; P. Value=.0133
Abdomen - Right foot: Mean Diff. =1; T=2.449; P. Value=.04
Abdomen - Right knee: Mean Diff. =1.111; T=2.857;
P. Value=.0212
Abdomen - Left knee: Mean Diff. =.889; T=2.874;
P. Value=.0207
Left foot - Both knees: Mean Diff. =.556; T=3.162;
P. Value=.0133
Left foot - Right knee: Mean Diff. =1; T=3.464; P. Value=.0085
Left foot - Left knee: Mean Diff. =.778; T=5.292;
P. Value=.0007

PART TWO

1. HYPOTHESIS

Among the hypotheses to be confirmed, the musical gestalt obtained in the first experiment, place should be given to different emotions and different semantic judgements given by a group of listeners.
The evaluation of the expressive components in music considers the whole scale, based on a series of adjectives and bipolar sensations, judged on a continuum.

2. EXPERIMENTAL SUBJECTS
1 Two groups of subjects were used, one of musicians and the other of non-musicians.
2 The first group was composed of students from the Conservatorio di “Santa Cecilia” in Rome.
3 The second group consisted of Roman citizens, chosen at random from the population, educated to at least middle/high school level.
4 The test sample was of forty people: twenty musicians and twenty non-musicians.
5 The age range was between 25 and 35 years old.

3. VARIABLES
In the first part of this work, attention was paid to singling out and choosing the most representative scales from the previous experiment.

The choice was made based on the results of objective examination carried out before; the scales played by subject number 1 were chosen, whilst he was being asked to concentrate on the following parts of his body: Freestyle position, Abdomen, Knees, Left foot, Both feet, Shoulder blades.

4. INSTRUMENTS
4.1 APPARATUS
- The scales were put onto a Recordable CD CDR-80/700 MB.
- They were played on a SONY, C.F.D.-360
- The sound level was set around volume 7++. 
4.2 MATERIALS
In order to evaluate the sounds of the different scales a form was devised consisting of: 1) semantic differentiation based on a choice between bipolar sensations grouped around the concept of pleasing-displeasing and 2) a series of adjectives.

1) For the SENSATIONS, reference is taken from research conducted on the enjoyment of music (Tesseralo 1979, Rossi 1982, Ruggieri-Veroli 1984, Ruggieri 1987).

<table>
<thead>
<tr>
<th>PLEASURE</th>
<th>DISPLEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>JOY</td>
<td>SADNESS</td>
</tr>
<tr>
<td>CALMNESS</td>
<td>TENSION</td>
</tr>
<tr>
<td>DYNAMISM</td>
<td>STASIS</td>
</tr>
</tbody>
</table>

1) Each sensation is marked on a continuous scale from 1 to 5, depending upon the strength of the feeling (one is maximum pleasantness; five maximum unpleasantness; three = indifferent).

2) The adjectives were drawn from research on Timbre (J.Pierce 1990, Pratt e Doak 1976, Roger-Kendal and Carterette 1993):


5. PROCEDURE
1 The tests were carried out in the Psychophysiology clinic, under the professorship of Prof. V. Ruggieri, Faculty of Psychology, “la Sapienza” University, Rome.

2 The stereo was placed 80cm from the subject who was sat between the two speakers.

3 They were then instructed to listen to the scale with their eyes shut and concentrate on the sound. At the end of each scale the experimenter
stopped the stereo and presented the subject with the previously described form.

4 For each of the subjects the order of the scales was random. The duration of the whole test for each subject was five minutes.

6. DATA ANALYSIS AND RESULTS

In the first table are the mean values and standard deviations for the test group for each of the seven scales, graded according on the bipolar sensation scale:

Table 42 Sensation

<table>
<thead>
<tr>
<th></th>
<th>HAPPY-SAD.</th>
<th>PLEASANT-UNPLEASANT</th>
<th>CALM-TENSION</th>
<th>DYNAMIC-STATIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABDOMEN</td>
<td>M 2.9</td>
<td>M 2.125</td>
<td>M 2.425</td>
<td>M 2.975</td>
</tr>
<tr>
<td></td>
<td>SD 1.128</td>
<td>SD 0.822</td>
<td>SD 1.035</td>
<td>SD 1.05</td>
</tr>
<tr>
<td>KNees</td>
<td>M 2.975</td>
<td>M 2.5</td>
<td>M 2.85</td>
<td>M 2.8</td>
</tr>
<tr>
<td></td>
<td>SD 1.097</td>
<td>SD 1.038</td>
<td>SD 0.975</td>
<td>SD 1.018</td>
</tr>
<tr>
<td>FREESTYLE</td>
<td>M 2.9</td>
<td>M 2.375</td>
<td>M 2.55</td>
<td>M 3.1</td>
</tr>
<tr>
<td></td>
<td>SD 0.982</td>
<td>SD 0.952</td>
<td>SD 1.131</td>
<td>SD 1.105</td>
</tr>
<tr>
<td>LEFT FOOT</td>
<td>M 2.5</td>
<td>M 2.275</td>
<td>M 2.925</td>
<td>M 2.35</td>
</tr>
<tr>
<td></td>
<td>SD 0.877</td>
<td>SD 0.751</td>
<td>SD 0.997</td>
<td>SD 0.949</td>
</tr>
<tr>
<td>BOTH FEET</td>
<td>M 2.425</td>
<td>M 2.2</td>
<td>M 3.025</td>
<td>M 2.775</td>
</tr>
<tr>
<td></td>
<td>SD 0.984</td>
<td>SD 0.939</td>
<td>SD 1.165</td>
<td>SD 1.143</td>
</tr>
<tr>
<td>SHOULDER BLADES</td>
<td>M 2.7</td>
<td>M 2.22</td>
<td>M 2.675</td>
<td>M 2.75</td>
</tr>
<tr>
<td></td>
<td>SD 1.137</td>
<td>SD 0.939</td>
<td>SD 1.163</td>
<td>SD 1.006</td>
</tr>
</tbody>
</table>
These data were then subjected to the statistical procedure of Multivariaed Analyses for factors (F. Anova).

From the results the following significant statistics arose:

- For the bipolar couplet of DYNAMIC-STATIC, between the mean score of the Freestyle scale and that dealing with the Left foot, Mean Diff. = .75; Crit Diff. = .466; P. Value = .0017.

- For the couplet HAPPINESS-SADNESS:
  - Abdomen - Feet: Mean Diff. = .475; Crit Diff. = .457; P. Value = .0419.
  - Knees - Left foot: Mean Diff. = .475; Crit Diff. = .457; P. Value = .0419
  - Knees - Feet: Mean Diff. = .55; Crit Diff. = .457; P. Value = .0187
  - Freestyle - Feet: Mean Diff. = .475; Crit Diff. = .457; P. Value = .0187

- For the couplet CALMNESS-TENSION, the significant results were:
  - Abdomen - Left foot: Mean Diff. = .5; Crit Diff. = .476; P. Value = .0396
  - Abdomen - Feet: Mean Diff. = .6; Crit Diff. = .476; P. Value = .0137.

No other significant results emerged from the other two groups.
A descriptive statistical analysis was carried out on the adjectives. The frequencies for individual adjectives for each scale are recorded in the following table:

Table 43  Frequencies

<table>
<thead>
<tr>
<th>ADJECTIVE</th>
<th>ABD.</th>
<th>KNEES</th>
<th>FREE</th>
<th>LEFT FT</th>
<th>FEET</th>
<th>SHLDRS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PENETRATING</td>
<td>8</td>
<td>11</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

Figure 66  Posture
There were no real differences between the two groups - the musicians and the non-musicians.

The adjective which seems to describe the Abdomen, Knees and Shoulder blade best is "penetrating".

The Freestyle scale is best described as "warm".

The Feet scale as "compact".

A graph of the frequency distribution can be found on the next page:

<table>
<thead>
<tr>
<th>Adjective</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>DULL</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>WEAK</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>ROUGH</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>COMPACT</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>BRIGHT</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>SHARP</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>DISPERSED</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>COMPLEX</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>PURE</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>CUTTING</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>HARSH</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>VIOLENT</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>WARM</td>
<td>5</td>
<td>5</td>
<td>9</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>HEAVY</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>SOFT</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>
CONCLUSIONS

In my opinion, based on the results and data obtained from the test group under the given conditions, the initial hypothesis could be confirmed.

They open up the possibility of conducting further development of research, based on the theory to which I referred, and we can conclude that shifting concentration to various focal points in the body changing posture also changes the quality of the sound produced.

Furthermore it is possible to note that focusing on lower body parts, such as the feet and the abdomen, compresses the sound, and makes it more dynamic and softer. This probably results from an increase in the number of harmonics, more intense and balanced between similar or unequal relationships. On the contrary, higher body parts seem to be connected with less harmonic sounds and a lesser intensity, besides, these tend towards an increase in sound with respect to intonation of the baseline, leading to the thought that higher body parts respond to and amplify higher frequencies.

It would be interesting in the future to do more work on the relationship between focal points in the body and sound frequency (pitch).

The next study will be conducted on a group of flautists to see if using different flutes has any effect, with analysis on the individual subjects themselves.

All of this points at future work on the posture of the flautist, aimed at developing a better sound quality in which sound could be considered to
be the gestalt narcissistic representation of the individual who produces it using either instrument or voice.

**EPILOGUE**

Data illustrated above represent the first results of a fascinating study that the authors wish to continue in the future. Based on the psychophysiological model and teaching experiences, musical performances should be examined in more depth.

Hopefully, this type of research work will contribute to making good performances less mysterious, more accessible and a source of greater satisfaction for those who dedicate their lives to music.

**References:**


The Dance of Belonging; An Adoptee’s Exploration of Identity Through The Bonny Method Of Guided Imagery and Music

Reher, M.

Abstract:

Having spent many years exploring her issues through verbal and cultural means, this client, an aboriginal adoptee, experienced a more complete transformation and healing when she entered into a Bonny Method of Guided Imagery and Music (GIM) series. A summary of her sessions is presented here. Many aspects of this transformational series are explored, including issues of early childhood trauma, loss and grief, and belonging and identity. Her Native Indian background and spirituality are a continuous thread of exploration throughout the series.

Introduction

The Bonny Method of Guided Imagery and Music is defined as a music-centered exploration of consciousness. It offers persons the opportunity to integrate mental, emotional, physical, and spiritual aspects of well-being, as well as to awaken to a greater transcendent identity. A GIM session begins with conversation between the client/traveller and therapist/facilitator. Following this, the facilitator provides an induction of relaxation and focusing suggestions, to help produce a deeply relaxed or altered state of consciousness in the client. A specially sequenced program of classical music is then played. While he/she is listening to the music in this deeply relaxed state, images in many forms may arise in the traveller, from a deeper level of consciousness. These are focused and encouraged by the guide/facilitator, who offers supportive and resonant comments while serving as an active witness to the unfolding experience.
At the same time, the facilitator takes a written transcript of the flow of imagery, which is being expressed audibly by the traveller throughout the session. At the completion of the music program, the facilitator helps the person return from a deeply relaxed state and begin integrating the session experiences into his/her life.

This is the story of a woman named Karen, who participated in ten GIM sessions over a twenty month period.

**Client Background**

Karen was 42 at the time she sought me out for work in the Bonny Method. I knew her in the community as a person of First Nations background who had a strong connection to her spirituality and a willingness to share it with others by occasionally leading ceremonies or rituals. She lived with her Native partner Peter, and their 9 year old son, Simon.

My client had just completed her second Vision Quest on the reserve of her biological relatives. Although still high from this, she felt there might be something more to explore about her early childhood and Native roots. Karen stated she knew her problems intellectually, but wanted to work at them in a different way, on a deeper level. Her goal was to access her unconscious and to develop additional methods of questing in order to heal.
Family History

Karen’s biological father was Russian. He had become irrational and violent during the period of Karen’s infancy and was institutionalized at this time, with a paranoid schizophrenic diagnosis. He died 36 years later, still in the institution.

Karen’s mother was Native Indian, from a reserve in Saskatchewan, a central province of Canada. Despite the fact that she had a family of five children with her Russian partner, she was never told what happened to him when he was taken away.

In her biological family, my client has four older brothers: Lenny, James, Joel and Tom. All five children were apprehended shortly after the dad’s breakdown. They were all placed into foster or adoptive homes, where each one suffered abuse and trauma. Current information about them can be found in Figure 67.

Karen is the youngest, and was six months old when taken from her mother. She was put into seventeen homes, over the next eleven months. The Ministry policy at the time was to keep placements short-lived, so “no bonding” would occur.

At seventeen months, she was placed permanently with a proper yet loving British family. Karen remembers incidents of hiding with her then foster mom under the bed. Mrs. T. was afraid the Ministry would come to take Karen away, or to give her back to her biological mom, who paid periodic visits to her daughter. After a psychiatric report that stated it was in Karen’s best interest to stay with this family, and the fact that it was
government policy at the time to adopt out all Status Indian children, a court-ordered adoption took place in 1964, when my client was six or seven. Because Karen’s mother never agreed to sign the adoption papers, Karen refers to this incident as being “stolen” from her mother.

**Figure 67 Family Tree**

Current Information about the brothers, as related by my client:
- **Lenny** is leading a marginal life as a high-functioning drug and alcohol user and paranoid schizophrenic.
- **James** is the father of 5, and there is lots of physical and psychological abuse in the family.
- **Joel** withdrew at the age of 21, and is currently psychotic, with angelic and child-like behaviour. He is in an intermediate care home.
- **Tom** is in the army. Influenced by his adoptive mother’s negativity toward his biological roots, he has ignored his family all these years, until recently.

Her mother, at the time we commenced our work, was very ill. Although Karen’s mother was open to her and related to her in different ways,
Karen had little contact with her, and was never able to have meaningful talks with her about the past. Karen’s sense was that her mother blamed herself for everything, but was unable to face or talk about any of it.

The GIM series

Information about the Bonny Method series which Karen completed, including the titles which were given by her at the close of each session, can be found in Table 44 and Table 45. Also included is an overall progression of themes.

Table 44  Series of GIM Sessions

<table>
<thead>
<tr>
<th>Session</th>
<th>Date</th>
<th>Music Program</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>May 1999</td>
<td>Quiet</td>
<td>“Higher Love/The Gift”</td>
</tr>
<tr>
<td>2</td>
<td>June 1999</td>
<td>Nurturing</td>
<td>“The Ceremony”</td>
</tr>
<tr>
<td>3</td>
<td>Oct. 1999</td>
<td>Grieving</td>
<td>&lt;Mother Loss&gt; (therapist’s title)</td>
</tr>
<tr>
<td>5</td>
<td>May 2000</td>
<td>Recollections</td>
<td>“Release/Embrace”</td>
</tr>
<tr>
<td>6</td>
<td>Sept. 2000</td>
<td>Creativity I</td>
<td>“Cleansing the Wounds of Loss”</td>
</tr>
<tr>
<td>7</td>
<td>Oct. 2000</td>
<td>Peak Experience</td>
<td>“The Dance of Belonging”</td>
</tr>
<tr>
<td>9</td>
<td>Nov. 2000</td>
<td>Explorations</td>
<td>“White Thunderbird Woman Walks”</td>
</tr>
<tr>
<td>10</td>
<td>Nov. 2000</td>
<td>Positive Affect</td>
<td>“Granny’s Ceremony”</td>
</tr>
<tr>
<td>11</td>
<td>Dec. 2000</td>
<td>Series Review</td>
<td></td>
</tr>
</tbody>
</table>
Table 45  **Series of GIM Sessions**- Thematic Evolution of Series

<table>
<thead>
<tr>
<th>Session</th>
<th>Thematic Evolution</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 and 2</td>
<td>Setting the stage</td>
<td>Karen receives the fortification needed to undertake the journey ahead.</td>
</tr>
<tr>
<td>3 to 5</td>
<td>Dealing with immediate losses</td>
<td>Both Karen’s biological mother and father-in-law die during this period.</td>
</tr>
<tr>
<td>6 to 8</td>
<td>Loss of family (biological)</td>
<td>The family of origin is explored, with all of its grief and intense connections.</td>
</tr>
<tr>
<td>9 and 10</td>
<td>Integration, affirmation, and healing</td>
<td>Insights into own essence, and transgenerational pain. Client is acknowledged and witnessed.</td>
</tr>
</tbody>
</table>

I have chosen a portion of four sessions to describe in greater detail, to mark key points in Karen’s process, and to give you a flavour for the quality and essence of her series. The music which I play while reading excerpts from her transcripts, is a portion of the music that was actually playing while she was imaging.

**Session 1.**
This initial session began to set the stage for the coming journey, and included imagery of a healing ceremony.

**Session 2.**
Karen arrived in a tearful state, and was experiencing symptoms of menopause.

The stage continued to be set. In her imagery, Karen sees herself as a little girl walking with her granny through the prairie grass. Granny gives her messages of complete support, kindness, love and wisdom. She gets out her bundle, a red blanket, a “woman’s pipe”, and leads Karen through a ceremony in which she prays and cries to the four directions, and
speaks words of strength and wisdom about the changes Karen is going through. They stand and gaze down the mountain. They are suddenly up very high on this mountain, and Karen can “see the world…feel the wind…see the universe, all the stars, the sun.”

Granny and Karen walk to a pool of water and Karen sees herself reflected back as an older person, and she looks like her granny. She says, “I see me. I’m getting older. And it’s O.K. My hands are like hers. I feel the beating of my heart, and hers. She’s holding me, stroking my cheek, while we look in the pool together. My eyes are like hers. I see the kindness in my smile, and hers.” Continuing to puff on the pipe, Karen becomes aware of “all these people” around her. Granny tells her they are her relatives, her ancestors, in shadow form. They stand and regard her (a Native custom of see-ing, acknowledgement and support). Upon departure, Granny reminds Karen to remember she is there always, in the wind…whales…birds…the rain…and trees.

This session was about the essence of Granny who was present throughout, offering loving support and menopause ceremony tools. Karen was little, then big, and finally had a vision of the future in her pool reflection (where she looked like Granny). She received support from the outside (Granny/ancestors) to rise up and grow to meet her higher calling.

**Session 3.**

Halfway between sessions 2 and 3, Karen’s biological mother died. Karen had experienced a rock-bottom depression, and was also very worried about her brother Lenny, that he would die or come to harm in
his life on the streets; wanting to help, but knowing she couldn’t. Her desire for the session was to have some peace around her mother’s death, and her brother’s state.

The imagery in this session included being in a traditional sweat with her uncle, an elder sweat-keeper. There is imagery of her mother’s spirit, and guidance and support from Granny and other elders. Karen begins the process of healing her current losses.

I learned at this point that both of Karen’s grandparents had been medicine people. She had first discovered and become re-united with her aboriginal relatives when she was in her late 20’s. Karen was especially close to her granny, who first came to visit in 1986. She visited repeatedly after that, and her playful positive nature influenced everyone in Karen’s blended family. Granny’s medicine/healing bundle was passed on to Karen in 1993, at the feast following Granny’s death and burial. Karen’s connection to her grandmother was acknowledged at this time, and she was cited as “the one to carry on the line”.

Although her safe and stable adoptive home was a crucial factor, it is also possible that the existence of this granny in Karen’s life played a large part in saving her from going a route similar to any of her siblings. The role which Granny played in Karen’s imagery, supported this hypothesis.

**Session 4.**

Karen reported that she was in a strong space, working again after a period of depression and illness. Although she didn’t mention it in the pre-session talk, she informed me afterward that Peter’s dad had
pneumonia, and she was very much feeling like he would be “the next one”.

There was a greater depth in this session and I felt Karen’s trust in me was growing. Before we began, she did a smudge ceremony of us both. This is a traditional First Nations ritual which utilizes smoke from burning sweetgrass, for cleansing of the spirit. I felt that this quickened the altering of her state of awareness, and put us both in a state of readiness for opening to the psyche.

The imagery of this session described Karen as “bridge”, to create/mend the family she never had. There were the beginnings of inner resolution, following her mom’s death. Premonitions of her father-in-law’s death were in evidence, and there was a sense of coming hardships.

My client felt that the morning’s session had really opened the door to the spirit world.

**Session 5.**

Both Peter and Karen were dealing with family tragedies and anxiety. Karen had had a bad night, and she was reluctant to come for her appointment, afraid of what she “would get”. But she came, a demonstration of her courage and her commitment to herself.

In the imagery of that session, Karen’s mom experiences intense grief as she talks of her husband and his violence and suffering, and how she felt she had let the kids down. She asks Karen to help Lenny to understand. “Share the wisdom,” she says. “Lenny will always be haunted.” Karen reassures her mother and expresses her passion for her. She says, “Mom,
I’ll never forget you...try to tell me about the past.” Her mom says she was young and on the run. She was frightened. Karen says, “Thank you, for all the things you did right” and her mom says, “Karen my girl, I love you.” Her mom is really crying, now. Karen hugs her and says, “I feel the love that only a mother can give.” As she moves off down the beach, her mother fades, a little silhouette in the distance, so alone. She waves and tries to reassure Karen, “to go on”.

As she continued to heal current losses in this session, Karen experienced intense emotions – towards her mother, and through both her mother’s and Peter’s grief over his dad. There was imagery predicting the death of Peter’s father, and goodbyes were said. From an aunt, Karen received reminders of her gifts and her heritage, to help her deal with her losses, and the living of life.

**Session 6.**

Karen’s father-in-law died six weeks after the last session. Karen said she was afraid but anxious to go, and “ready to do this work”.

In this session, Karen began the process of grieving the losses of her early life. As a child of 5 in her imagery, she met with brother James, but could never quite catch or find him. She then began grieving the loss of her brothers and family. She experienced acute separation and loss, pain and emptiness – that huge empty bucket; the void of her matrix. She also felt a deep connectedness with James. Previously, she only allowed herself to feel this type of connection with Granny, whereas this time, this sense of deep connection expanded to include James.
In this session, Karen also experienced the healing forces of wind and water. Peter guides her through a dramatic cleansing ritual, as she wraps oil and cedar all over her body and finally fully immerses herself in the water.

My client felt that this was a watershed session, which had lanced a huge well inside her. She said that over her life she had stuffed inside herself both the way she loved people, as well as the way she was abused. This session opened up both. She stated she had never felt so integrated – her mind, body and emotions experiencing all at once.

That night, Karen had a nightmare. It included image fragments which had plagued her for years, but which she had never been able to make sense of. Now she realized she was uncovering sexual abuse memories of herself at the age of 4, while in a temporary home. She felt that specific imagery from her GIM session that morning had triggered this dream.

Session 7. “The Dance of Belonging”.
When the music begins, Karen sees herself as a little girl. She’s wearing a little dress and is pushing a little stroller with dolls in it. She has a little Mother Goose book (all actual objects from Karen’s childhood). Big and little Karen are running together, laughing, playing, searching for magic. The little girl can’t believe someone will play with her like this. She starts to cry, and says “Don’t leave me!” Big Karen consoles and rocks her and says, “I’ll be here inside of you.” Karen says to me, “I know that no one ever loved her like this.” She tells the little girl that it’s not her fault. The little girl asks if Karen can take her to see her family. Karen picks her up and carries her, while she hides her face in her shoulder,
afraid to see. All the time, big Karen is reassuring and nurturing little Karen.

One by one, the brothers emerge from behind the trees. James (8) is introduced. The little girl says, “I’m suffering, I’m scared,” then jumps out of Karen’s arms and hugs James. He cries. She says, “I feel like I’m going to die, I’m so happy. I know the love we have, is just there. There’s no other love like this.”

Karen and James go forward to meet Tom (5). Little Karen touches hands with Tom. “We open our hands, and they’re just the same.” Joel (8) and Lenny (9) step out. Joel is giggly and teasing. Lenny says, “No I can’t, Karen, I just can’t bear this… I feel like I might fall apart.” Karen tells him, “You’ll bear the burden of this memory, but you won’t fall apart.”

Karen walks with Lenny, expresses worry and a wish that she could change everything. She says she’ll take him to the reserve one day, and hopes that one day he’ll be free like the wild horses that live there. She expresses love and a promise to pay him back one day, for saving her life as a baby. The parting is painful.

Big Karen picks up the little girl and comforts her. She says, “My chest can’t hold my heart. It just hurts.”

After the music, Karen acknowledged the intense unique bond she feels with her brothers. She said that she knew this deep in her psyche during her childhood, and that she missed it.

In this session, Karen’s strengthened inner and higher self had become a wise, compassionate adult. This enabled the child Karen to do the
courageous work of meeting each sibling, intensely feeling both the losses and the connectedness. This work was towards the re-building of matrix.

**Session 8.**
Karen arrived to report that brother James’s kids had been “abducted” by social workers. Although she acknowledged the difficulties in the household, she was distressed at the continuing cycle and the realization that the apprehension happened the same month and with the same number of children as her own family of origin. She said that no one’s ever given James help over being taken away as a child, and abused. She was feeling devastated, broken-hearted, incensed, and utterly helpless. Karen was also plagued by disturbing dreams. She was shaken with the feeling of being so completely helpless and disempowered.

The imagery of this session dealt with James’ grief, loss and healing. There was a wolf everpresent, for protection and spiritual healing.

This was a transitional session, moving from grief, to affirmation for Karen. For the first time in the series, Karen performed her own ceremony, with elder affirming witnesses. By taking the part of healer, she was able to address her current feelings of disturbing helplessness.

**Session 9.**
In the imagery of this session, Karen found herself in a special outfit: flowing skirt, moccasins, calico blouse, and a special red shawl with a white thunderbird on it made for her by Granny. Granny tells her how
beautiful she is, smudges her, and tells her to keep the shawl with her and wrap it around tightly, that it will help.

In the post-session, Karen said the outfit symbolized “who I was meant to be.” For the first time, she could see herself without “the shrouds I’ve worn to get by.” She was big, and beautiful. She said in wonderment, “I felt like myself.”

Karen later commented that this session was an experience of bliss, an extraordinary emotional and spiritual high. Indeed, it was a session of integration and affirmation; of experiencing the essence of Granny once again – love and medicine; of seeing herself as she really is - “whole”.

The clothing was an outward manifestation of this: Wapsi Panashi Equay or White Thunderbird Woman, a name given to her by her grandmother many years earlier. Now was time to wear the outfit, the role; to offer love and healing to others, as Granny had done to her. Karen began this healing with James.

**Session 10.**

My client reported feeling anxiety and a fear of rejection by the community, after an incident which she had interpreted as racist.

In the imagery, Karen sees herself walking with her mother, on the reserve. Her mom has her arm around her. She kisses her, and says “my girl.” She’s so tiny. “Why were you so confused in this life?” Karen asks. Mom says she doesn’t really know, and then immediately transforms into a little girl, on the grounds of the residential school. Karen can see her, sitting on the bed, crying. She goes over and wipes the tears. Such a
sweet little girl...ragged clothes...thin mattress. Karen holds her. Strokes her hair. Kisses her. She’s so sweet, and so broken. “You’ll be alright,” she tells her.

Karen looks around at the faces of hundreds of others, many of whom are aunts and uncles. They seem very alone. Little girl mom asks Karen if she will take her home. Karen hugs her and says she wishes she could, that it would have been better. She leaves her mom looking through the gate. “It’s like she’s in prison,” she says. “I’m just so helpless.”

The scene has shifted back to the reserve, where Karen sits at a table at Granny’s house. Granny is sad and quiet while she works, kneading dough. My client says, “This must’ve been how lonely it was for her when her kids were away (at the residential school).” Karen puts her arms around her and kisses her.

They both sit down, and Granny rubs her hands together. She then unwraps her kerchiefs, and commences to make protection medicine and perform a ritual. Granny puts the medicine in leather, wraps it and tells Karen to pin it over her heart. Placing it under her bra strap, Granny holds Karen’s face in her hands, and kisses her. She says, “It’s protection. That medicine will protect you.” She sings, one of their songs.

Karen says, “I miss you so much, Granny. So much.”

103. Residential School definition: A residential school was a boarding school for aboriginal children operated by churches, under mandate from the government of Canada, to assimilate aboriginal children into mainstream Canadian society. During the tenure of this system, children were removed from their families, communities were disrupted, languages were lost, and many people endured different forms of abuse. The negative effects of the residential school system will take more than one generation to heal.
Karen goes to visit her Great Aunt Alice, and several deceased female relatives greet her. They tell Karen they all love her and my client replies, “I lost you all too soon. You’re so wonderful to me.” The women walk together outside the reserve, and form a circle. Granny talks of the protection medicine, and prays with all her heart over the soup she is heating. In reverence, she wishes for Karen, peace and contentment.

The scene has shifted to the Sundance, and all these women are still present, along with other relations. Karen sits with her granny in her nest. Granny blows on her eagle whistle. Karen says, “I can feel the vibrations going through me. I’m just so happy.” She looks at all the beautiful colours in the centre of the Sundance. The buffalo skull. The big drums played by her uncles. Feels the hot sun on her face.

Elder George is right in the center, his arm raised, praying. In a crying voice, breaking with emotion, he says, “Now at this time we witness this understanding Wapsi Panashi Equay has of her life and her PEOPLE!” It was a sacred moment, and all those witnesses from the spirit world were nodding in acknowledgement.

Karen gets up and dances with her granny, who hands over her eagle whistle. She blows it, and Granny says, “Remember, that bird is always free. Remember the medicine of the eagle—it will never leave you.” She puts the whistle around Karen’s neck, who says “Migwidge, Granny.” Granny touches her face, looks in her eyes and says, “Little one, so precious.”

“Migwidge, Granny.”
In this session, Karen received stark insight into the confusion and pain of her mother’s life, and insight into the loneliness of her Granny’s life, as a mother. It is as though Karen had a bird’s eye view of these life experiences related to the residential school, and the trans-generational grief of her mother and grandmother and others. The remainder of the session was full of healing and completion, including the Sundance, which acknowledged her growth (Tree of Life), and her deep internal understanding.

11. Series Review - Imagery Process
This series was rich with recurrent images which embodied Karen’s healing and transformation - ceremonial, cleansing, bridging images, and Granny, to name a few. Some months after the close of our work, I asked her which images had made the most difference in her healing process.

She stated that the emerging theme and pattern, which only became clear when I hypothesized about it in the series review, was the most striking for her. To go from the early images of wounding and loss, all the while recipient of numerous healing ceremonies and supportive love, through to the final sessions when she herself became the healer, and subsequent real-life interactions with her brothers, was a transformation of huge magnitude.

She felt that she was now initiated, and entitled the series, “The Initiation”.
SUMMARY

Adoption

Both during and after the series, my client had many insights as to what her purpose was in doing this work and what she is learning. At the forefront for Karen was the reality of being adopted. The core issues surrounding adoption are identity, belonging and loss. Suicides are high among adoptees (especially Native adoptees), because they don’t know who they really are.

Even though Karen’s adoptive family was stable and loving and might possibly have been responsible for preventing further unforeseen trauma, the net effect of adoption on Karen was a pervasive sense of unbelonging, confusion and wounding. She felt a fragility in her psyche, as to who she is. Who was she raised (in this case in a proper English family), and who was she born to be? She felt that the person of the adoptive name which she goes by, was created so that she could survive her childhood.

My client marveled at the process which unfolded during the GIM sessions. She felt the images which arose were consistent with who she really is, not the Karen T. of adoption. She had begun the deep and ongoing process of integrating a fragmented psyche, and discovering who she really is. This represented a true healing of the wounds of adoption for her.

Karen has had years of counselling and has herself presented at many adoption conferences. She has read many books, all of which have valuable information, but very little about how to heal the wounds. It was
not until her experience with the Bonny Method that she was able to break through and finally convert her intellectual knowledge into genuine physical, emotional and intuitive knowing and healing.

Karen has discovered and had deep experiences in her Native Spiritual traditions the last several years, and these have represented her first foray into the realm of identity. There are numerous rituals in the First Nations culture, such as sweats, which bring people together and reinforce identities. My client called these “rituals of belonging”, whereas she called the Bonny Method a deeper “ritual of healing”. She wondered, “how can I perform a ritual of belonging, if I don’t belong to myself?” For Karen now, the two go hand in hand. She felt that the Bonny Method has tremendous potential for helping adoptees of all cultures to address the issues of identity, belonging and loss, and to heal.

An adjunct to her own healing and growth is the seemingly mysterious quality of growth in other parties present in her imagery. Since completing her series, Karen has had more than one phone conversation with both James and Lenny, which qualitatively are in a different realm from her pre-GIM discussions with them. Her style of communication is different now, but so is theirs. The mutual responsiveness is unprecedented to this degree in the family, and extremely positive. It seems as though the healing has extended beyond the boundaries of her own person.

The connection with James continues to grow, and several aspects of Karen’s imagery are beginning to manifest in uncanny ways. Most striking and important are the burgeoning changes in her brother, who is
starting to overhaul his life, in response to the catalyst of losing his children. It is as though suddenly the “light has gone on”. He has stopped drinking, and for the first time he is showing interest in his roots. Last summer, he and Karen went to a native retreat camp together, for the healing of family wounds experienced as a direct or indirect result of the residential school system. As she builds these new bonds with her brother, she can now serve as witness and companion to him, as he embarks on his own healing journey.

**Culture**

My client’s people are called Anishanabe which translated means “the immaculate people”. It was a name given to them by the priests, describing their first impression of them. Karen informed me that the missionaries found the Anishanabe to have inner musings; to run and behave like children; to be whimsical. It seems that in those times, the dream life was almost as important as the waking life to the Anishanabe. Later, missionaries perceived this openness to the spirit world to be potentially evil, a blight and something to get rid of. Subsequently, our non-native culture dished out the years of residential school tyranny. This created further unbelonging and wrested away any remaining traits of innocence, whimsy or identity with the dream world.

Karen felt that part of what she’s learning to do now, in her GIM and otherwise, is to recapture those qualities as embodied in her granny; to learn once again how to dream, how to receive messages from the psyche, how to linger and really see them and how to be guided and
healed by them. The Bonny Method is helping her to reclaim her lost cultural strength and personality.

Creativity
In addition, Karen spoke at great length of a seemingly unrelated (and un-sought) benefit of her GIM experience. Before coming for sessions, she had been in what she felt to be a blocked state. All of her creative endeavours were a struggle, and did not flow easily. She feels now there is less mystery to her creativity. It is as though she “knows the hole to go down”, to the place where inspiration rises and creativity is born. A creative stream was unleashed during her GIM process and continues to this day, including several big creative projects.

And the ripples continue…
I would like to close on a personal note. Similar to the mysterious quality of growth occurring in her brother James as a result of her own healing on a psychic level, Karen’s work also affected me, her therapist, on a very deep level. As she was growing and changing, so also was I growing and changing. Not only did I gain new and intimate awarenesses of adoption and First Nations issues. My work and self-image as a therapist was changing also. The profundity of her work took me to a conference in Canada, and now across the ocean to this one. I am here simply because I think her story is one you could find anywhere in the world, amongst adoptees or First Nations people. As I was affected, so might someone in this audience be affected, who might then go home and practice in a different way, with new insights.
I have been a practicing music therapist for 25 years. Still, I stand in awe of the therapeutic process. The capacity of the human psyche to heal the organism, and its capacity to affect change beyond these boundaries, is truly awe-inspiring. Perhaps it only happens when we, as therapists, are truly, and fully, part of the process, allowing our clients to touch, to inspire, and to change us.

References


Suggested reading on the Canadian Residential School system:

Abstract

In degenerative brain diseases like dementia, persons experience problems in communicating. These problems can have serious consequences for the single person, as it is difficult to meet and validate psychosocial needs. – It is difficult for the person to express basic needs or simple requests, and it is difficult for the person to feel recognized and understood. This can lead to isolation, anger, panic, sorrow and/or resignation.

Using songs in a music therapeutical setting can be a way of enabling ways of communication adjusted to the person. A setting where demands are not overwhelming the person, and where focus is not on neurological deficits, but on remaining abilities and resources.

In the following I will refer to dementia, symptoms of dementia, dialogue, communication theory, psychosocial needs in persons suffering from dementia, and at last show some video examples of response.

The background of this paper is a Ph.D.-study at Aalborg University where I focus on individual music therapy with persons suffering from dementia. Since 1995 I have worked as music therapist at a gerontological care unit in Århus, Denmark. It is a care unit with 24 residents with different psychiatric symptoms or dementia sufferers with BPSD: Behavioural and Psychological Symptoms of Dementia. The data collection for the study was done at the unit and covered individual music therapy sessions with 6 persons, where each person participated in 20 sessions.
Data consisted of questionnaires completed by staff, video recordings, and pulse measurements. The study was approved by Ethical Committee in Århus country and by the Danish data registration committee.

The prevalence of dementia increases with age. The population of persons older than 65 is increasing. In US only 4% of the population were more than 65 years old in the year 1900. Now, at the turn of the century, the number is about 11%, and estimations predict that in about 30 years a fifth, 20%, of the population will be over 65 (Zillmer & Spiers 2001). About 1% of the group of 65 years old suffers from dementia. This percentage increases dramatically with age, and in a population of persons over 90 years 30-40% will suffer from dementia (Bekkelund 2002). The fact that percentage of older people is increasing means that the number of persons suffering from dementia will be increasing. In recent years in Europe an increasing number of publications and research studies concerning music therapy with dementia clients (Ridder 2002) point at an increasing interest in this area. I now want to describe why music therapy can be a relevant method in dementia care.

Dementia is a syndrome representing nearly 100 different diseases. Further diagnostic criteria can be found in DSM-IV (*1) or ICD-10 (*2) where the main feature is described as loss of cognitive or intellectual function. As a very general rule of thumb we can talk about 5 main symptoms of dementia, the five As: amnesia, aphasia, agnosia, apraxia, and agitation.

- **Amnesia** means loss of memory, e.g. loss of old memories (retrograde amnesia) or loss of the ability to encode and learn new information (anterograde amnesia).
• **Aphasia** is a partial or complete loss of language abilities.

• **Agnosia** is inability to recognize the form and/or function of objects and people.

• **Apraxia** is impaired cortical motor processing and inability to perform voluntary actions despite adequate amount of motor strength and control. (Zillmer & Spiers 2001)

• **Agitation** is not the only behavioural and psychological symptom associated with dementia, but it is a symptom that reduces quality of life for the sufferer and makes dementia care very demanding and challenging. Among other behavioural and psychological symptoms of dementia (BPSD) are depression and psychosis ([www.ipa-online.org](http://www.ipa-online.org)).

The different symptoms occur very differently according to type of dementia. Alzheimer’s disease is often associated with anomic aphasia, characterized by word-finding and -naming difficulties. The way the person talks can be illustrated as “word salad”; there seems to be no meaning in what is said, but the way things are said sounds quite “normal”. In these cases semantic meaning has disappeared but phonological and syntactic aspects of language seem to be preserved.

Other types of dementia, e.g. vascular dementia can show very little sign of aphasia, or the opposite; showing signs of global aphasia, according to which parts of the brain that is most inflicted. Some persons will show signs of nonfluent aphasia, where they clearly know what they want to say, but can’t find the word even though it is “just on the tip of the tongue”.

The many different dementia diseases, where some have more or less predictable features than others, have one thing in common: on later stages of the disease most persons suffering from dementia experience problems in maintaining dialogue. David Aldridge even have called dementia a dialogic-degenerative disease:
“… rather than neuro-degenerative diseases, we are faced with dialogic-degenerative diseases” (Aldridge 2001a).

In dialogic-degenerative diseases following symptoms of dementia mainly disturb the communication:

- Semantic anomic aphasia
- Expressive speech deficits
- Speech comprehension deficits
- Attention and orientation disturbances
- Response latencies

When we consider the word *dialogue* it stem from the Greek *dia-logos*. Logos means word, thought or reason. Logos is *within* (dia). We can see logos as some kind of topic that two subjects have a shared focus or understanding of. In a music therapy setting we can imagine the client and the therapist as two subjects, and then logos/”the topic as a third common subject/object” (Gurevitch 1998, p. 31).

In trying to understand different aspects of communication I want to include a model of interpersonal communication and interaction. The model is used by the Danish psychologist and psychotherapist Esben Hougaard (1996) and is based on Karl Bühlers classic psychology of language (1934) and the Bateson group’s communication theory (Bateson et al. 1956).

If we focus on one subject (the client) we can imagine that he gives a communicative signal e.g., that he nods and says “yes”. The client communicates by responding to the therapist or by expressing a message. His “yes” can have 3 different functions. First, it can function as a *statement* relating to the exact semantic meaning of the word. Second, it
can function as an emotional *expression* that shows if the client is engaged, shy, sad, angry, etc., and third, it can function as an *act* that has an influence on other subjects.

In communication it happens that we do not talk the same “language”, we do not understand or we misunderstand what is said or signalised, and the dialogue is broken. If two subjects have a mutual understanding of the topic, their communication will be a dialogue. According to the model communication can happen as linguistic messages (the semantic meaning - *What* is said), as well as para-linguistic (e.g., tone of voice, pacing, pausing, emphasis, timing, prosodic contour - *How* something is said) and nonverbal expressions (e.g., gesture, posture, and facial expression).

In the process of understanding the subject the therapist can understand the messages from a logical, psychological, and pragmatic point of view. Mostly the psychological and the pragmatic understanding will be combined and we then speak of *emotional function of communication, the communicative process* (Hougaard 1996), or *social-pragmatic aspect of communication* (Holck 2002).

The term dialogic-degenerative disease has made me focus on dialogue, communication and interaction, and I now want to return shortly to the degenerative disease; dementia. Research on dementia is dominated by pharmacological, diagnostical, and ethiological approaches. We need to understand the different dementia diseases in order to render proper care, and hopefully we will find measures against the disease in the future. But music therapy can also attribute to important research by focussing at a social-pragmatic level, and in the last decade we have seen more and
more research in this direction; in the direction of person centred care, of humanistic and qualitative approaches.

An example here is Dr. Tom Kitwood (1997, 1999), university of Bradford, who in his research wanted to gain insight into the subjective world of dementia. As a result he defined a cluster of five great psychosocial needs – comfort, attachment, inclusion, occupation, and identity – which come together in the central need for love (Kitwood 1997). I will not describe the needs in detail, but refer to Kitwood’s work. Instead I want to ask the question how it is possible to fulfil these needs if the person with dementia does not understand my “topic”? – if the person does not understand my statements, my expressions and acts?

“When dialogue fails then we have alienation and despair. The maintenance of the self degenerates through isolation … 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” (Aldridge 2001).

In dementia care it is possible to fulfil the psychosocial needs if we are aware of our ways of communication. “The fulfilment of one of these five needs will involve, to some extent, the fulfilment of others” (Kitwood 1997), and as an example here I suggest that we see the psychosocial needs as the “topic” for the communication with the person with dementia.

The consequences will be that the music therapist - apart from linguistic meaning - is able to focus on expression and act, and let the “topic”
consist of para-linguistic messages and nonverbal signs. This will give the person suffering from dementia a possibility to understand and feel understood, to express needs, and to experience that needs are understood.

The use of music gives us an extra tool or dimension as the musical being together allows the music therapist to work and understand at a social-pragmatic level with persons with dialogic-degenerative diseases.

I now want to give some short examples of communicative signs. My focus is on the participants’ responses in the music therapy setting where I sing familiar songs to the participant or with the participant. I will show examples of postural, gestural, facial, visual and vocal responses.

The six participants seen in the video clips suffer from cortical dementia (Alzheimer’s disease, Pick’s disease) and mixed dementia (vascular dementia, VaD with frontal symptoms). Apart from Pick’s disease the diseases mentioned here represent the most frequent diagnoses.

On the FAST scale (Functional Assessment STaging, Berry Reisberg 1999) ranging from 1 (healthy) to 7 (needs 100% care) the six participants in the study all are placed on stage 6.

They require assistance in clothing, eating, feeding, toileting, and bathing. They have poor reality orientation, but have some residual memory left. They are mobile, and are able to do simple practical activities in daily life.
The participants score between 0 and 5 (out of 30) on the cognitive test: MMSE (Mini Mental Stage Examination, Folstein 1975. See Aldridge 1996).

The CMAI (Cohen-Mahnsfield agitation Inventory, Cohen-Mahnsfield 1996) consists of 29 agitated behaviours each rated on a 7-point scale of frequency ranging from 1 to 7.

(1) Resident never manifests the behaviour

(7) Resident manifests behaviour several times an hour

All participants show sign of physically aggressive/non-aggressive and/or verbally aggressive/non-aggressive behaviour.

**Video clips:**

5 external music therapy assessors have analysed 8 selected video clips and based on this I have defined categories of *response* and categories of *quality of response* with help of the computer programme ATLAS.ti ([www.atlasti.de](http://www.atlasti.de)). This is a research in progress and in the paper here I will present some ideas of the video analyses.

**Comments on video examples:**

(For ethical reasons I am not allowed to show the video clips in public/on internet. I am allowed to use them for 5 years for teaching purposes and at congresses, after which the video material is to be deleted.)

1. Postural response, Rpo  -(among other responses)
Rpo-Qor-per (Q: orientation towards other person) - leans towards music therapist, sits down beside music therapist.
Rpo-Qse (Q: sedative) – leans back
2. Gestural response (foot), Rfo
Rfo-Qbe (Q: beat) – bops foot up and down in beat
Rfo-Qph (Q: phrase) – marks the end of a phrase/the ending of the song

3. Gestural response (hand), Rha
Rha-Qph (?) – adjusts glasses at the end of a phrase
Rha-Qbe – taps the beat with the hand
Rha-Qre – recognises the “symbolic” movements of the song

4. Gestural response (head), Rhe
Rhe-Qbe – nods in beat
Rhe-Qph – marks the ending of the song (or Rhe-Qim – imitates music therapist’s movements)

5. Facial response, Rfa
Rfa-Q+ - looks happy. Open facial expression, is playing
Rfa-Q÷
- looks sad

6. Visual response, Rvi
Rvi-Qbr (Q: break) – looks away
Rvi-Qor-per – looks at music therapist, eye contact

7. Vocal response, linguistic/para-linguistic, Rvo
Rvo-Qem÷
- making a sound, sounds sad
Rvo-Qem+ (Q: emotional) – laughs
Rvo-Qbe – comments in the same metre as the song
Rvo/co Qdi – vocal comment, relevant to the song text, directed at music therapist

8. Vocal response, singing, Rvo/si
Rvo/si-Qpi (Q: pitch) – sings in pitch
Rvo/si-Qph – ends the phrase by singing it alone
Rvo/si-Qim (Q: imitation) – sings together with the music therapist, repeats music therapist

9. Vocal response, improvising, Rvo/imp
Rvo/imp-Qini (Q: initiative) – shows initiative by starting to sing on his/her own
Rvo/imp-Qdi – he asks a relevant question by singing. She sings to herself but then orientates herself towards the music therapist and sings to her. Music therapist joins in the dialogue by her movements
Rvo/imp-Qaw (Q: aware of relation) – is aware of relational aspects, knows that music therapist will be there for the last time

By observing responses and quality of responses the small video examples show that these six persons suffering from moderate to severe dementia show ability to interact, to communicate, to listen, and to respond appropriately in the music therapy setting.

Although they suffer from a dialogic-degenerative disease they communicate using gesture and voice. The music is the “topic of conversation” in different ways, and the music enables the participant and the music therapist to meet and have a shared focus; to understand and feel understood. These ways of communicating give possibilities to fulfil psychosocial needs in persons suffering from dementia.

References:


Web connections:

www.ipa-online.org

www.atlasti.de

*1: DSM-IV see: www.behavenet.com/capsules/disorders/demdis.htm
*2: ICD-10 see: www.informatik.fh-luebeck.de/icd/f0.html
In the spring of my third year as Assistant Professor of Music Therapy at Arizona State University (ASU), I received a “form email” from a woman, Susan, church choir director for a group of musicians who were residing in a homeless shelter and receiving help from a local church outreach program she called the choirhouse. Susan was asking of all the ASU faculty if any would come and be a guest speaker for her choir. Rehearsals for her group were a half-day on Saturday, and included lunch. With the promise of a free meal, I agreed to speak with her group about music therapy and facilitate some interactive music experiences for the choir members.

I expected to see the type of homeless people I had seen on the street—unclean, maybe hallucinating, acting out psychotic behaviors, confused, on drugs. What I found were about fifteen people, young children through middle aged adults, well-groomed, polite and eager to make music. Several teenagers and adults came out to my car offering to help me carry my bags of instruments, and I remember feeling self-conscious in my relatively sporty “yuppie” car, in contrast with the poverty-stricken urban setting. As I began to take the various percussion instruments out
of the bags the choir members and their children, realizing I did not object, began to play them. Within seconds, a completely unfacilitated percussion improvisation had begun. I had never met a more receptive group.

After several minutes of organized, highly musical rhythmic improvisation, the music faded. I introduced myself and explained my version of what music therapy is and answered questions as we sat around long, worn tables in the church basement. Figuring the group may be able to relate to the spiritual nature of a simple and powerful song, and knowing they all had at least some experience with singing, I introduced a modified song-writing experience with a pre-composed tune. The choir members “jumped in” to the exercise, verbally and musically expressing feelings of hope, sadness, joy and spirituality, with fluidity and with respect for each other and a willingness to engage in the process. After lunch, the choir presented me with a song they had practiced, a thank-you card with a small collection they had taken for me, and assistance back out to my car with my bags and cases of instruments. I had been completely drawn into the experience, and mentally replayed that initial meeting frequently over the coming days, describing my newly discovered passion to anyone who was interested in hearing. I wanted to help the choir members by providing a therapeutically-oriented safe space for them to share their struggles, hopes, creativity, and ideally, solutions, in their journey toward a stable home.

I invited members of the choirhouse to volunteer to join a music therapy group where they would be participants in a pilot research study run
through the ASU Music Therapy Clinic. The project began in July, 2001, and with input from participants we named it, “Adults in Recovery” or “AIR.” In addition to being addicts and alcoholics in various stages of recovery, they were also recovering from the “trauma of homelessness” (Goodman et. al, 1991) and the series of events that led them to require the service of a homeless shelter and outreach program.

**Background Information**

In the US, as many as 2.5 to 3 million people are homeless, with the numbers rising (2000, Brush and McGee, 2001, McCabe, Macnee, and Anderson). One nurse found that 45% of his clients in a homeless shelter had a mental illness, (2001, Majka) and others have reported that substance abuse is strongly associated with homelessness (2000, Brush and McGee). Bobby Burns tells a moving personal account of his struggle with alcoholism following a childhood marked with abuse. He gives a portrayal that brings to life the “statistical” factors that led to his homelessness and demonstrates the need for support in recovering physical, emotional, and spiritual losses (1998, Burns).

As qualitative researchers and arts therapists have noted, there is value in giving voice to the human story (1996, Kenny, 1996, Amir). This paper attempts to tell the story of the music therapy process of three men who have lived in a homeless shelter and are making efforts to transition into a more stable home life. They were chosen for this paper because they showed the most consistent attendance and personal investment in music therapy over the course of nine months.
Participants for the AIR pilot project met the following criterion:

1) They were members of the choirhouse church choir, which was the referral system to AIR and was part of an outreach ministry for current and former shelter guests.

2) They were not actively using drugs or alcohol, specifically on the days of the music therapy sessions.

3) They were making an attempt at drug/alcohol recovery.

4) They were not in an intimate relationship with any other member of the AIR group.

5) They were at least twenty-one years old.

The video tape begins with improvised music that was created after three months of weekly two-hour sessions. The improvisation was recorded on cassette tape and transferred to video, and I apologize for the sound quality. Hopefully you will get a sense of the excitement and closeness of the musical interaction you are listening to while the title page comes up. You are hearing an electric bass guitar played by Mark, drum set played by Henry, xylophone played by Terry, and myself playing bongos.

The first person I’ll introduce is Terry, who was playing xylophone on the recording you just heard. On the first group meeting of AIR, Terry immediately went to the xylophone and began playing it enthusiastically, as if he had found a long-lost childhood friend and had years of catching up to do.
In Terry’s initial interview with me the following session, he shared some of his past with me. At the time of the interview he was twenty-six, and had a four year-old son who lived with his former girlfriend in a neighboring state. His two sisters and his grandmother live in the same, and his mother lives in a different state. His father, who was not very involved in his life, died when Terry was a teenager, and this was a very difficult time. His father’s death marks closely to the time that Terry began using drugs. Terry’s drug of choice is methamphetamine, although his more recent drug episodes have been with crack-cocaine, which he says is easier to obtain. He was incarcerated for drug transporting, and when he was released from jail he sought the services of the church based shelter, and was asked to join the choirhouse when the director found he could sing. He has had his thyroid removed when cancer was discovered, and he doesn’t always take his thyroid medication.

Terry is charming and easy-going. He is generally mindful of his appearance, and it seems to be an indicator of difficult times when he is not well-dressed. Terry worked as a plumber’s apprentice for most of 2001, and was laid off in early 2002. He was the only working member of the choirhouse, and had managed to purchase an older Volkswagen micro-bus in the fall of 2001. Purchasing a car was one of the goals he stated in the initial interview in July. He often used the van to help the other choirhouse and AIR members attend programs.
The following are quotes from transcripts of Terry’s initial interview, where he was asked general questions about his interests, life experiences, and personal history.

First, Terry talks about music:

What I love is hip hop... Music is, music is everything... Music’s outside-the birds, everything is praise...(As a teenager) I just sang, every now and again. But, you see, I wasn’t into singing, you know? I was into rhyming, beats... See, my main goal is to be able, by any means necessary, get the equipment that I wanna (have) in order to make music...

I need to learn, you know, I don’t really know how to, you know, sing. I mean, I think I could sing, but, I know that there’s a lot of things I don’t know- about certain notes, about how to use my diaphragm...And then, I didn’t know how to sing around different voices that may or may not know how to (sing). So I need to know that. I need to learn...

I really don’t have a favorite instrument. I wanna learn ‘em all. I wanna learn the piano first of all. Because I think that’s the most important instrument. And, uh, xylophone is really climbing up there!

Terry talks about the impact of the death of his father. After talking about how he’d kept his pain inside, he described an unexpected rush of saddens when he was in prison:

I didn’t know how rough it was until after I got through hurtin’ everybody, hurtin’ myself. (I) broke down a little bit- I talked to the pre-sentence lady - I started cryin’. The weird thing is...I mean, you grieve,
whether you want to or not. It’s how it manifests itself— is it anger? Is it you know, depression? I wanted to self-destruct... it’s like a domino effect.

Terry’s comments regarding prison:

I was transporting weed. Mary J...And I got caught. Which was a blessing. Saved my life. I was out there- doin’ too much...So, I’m not mad about prison, I’m just mad at my life... I’m not stupid...And I don’t want- I don’t want to jeopardize my future and my son’s future..

The next AIR member is Henry, very reliable, recently married to a woman he met in the shelter who is also getting her life back together. He’s in his mid-fifties, a Vietnam veteran, and a career military man. In addition to his work in the air force, he has had a singing career, but was not able to maintain either career when his mental and physical health deteriorated. Henry has a history of depression, heart disease, and a seizure disorder, for which he is currently taking medication. Past drug use involved PCP-phencyclidine-(a hallucinogen that can make users physically stronger, paranoid, violent and out of touch with reality, as well as cause seizures.) He has also abused crack/cocaine, and he continues to drink alcohol in moderation against my advice.

Henry seems to be the unspoken leader of the group. He is usually very upbeat and is a self-proclaimed, “instigator.” It appears easy for Henry to give suggestions, confront others, begin musical “jams” and act as musical director to get a particular “sound” that he wants. Henry is the only AIR member who has established housing outside of the shelter,
first living in a studio apartment, then moving into a one bedroom apartment in a middle class residential area with his wife.

Here are some of Henry’s own words taken from transcripts of his initial interview. When asked about his own personal history with music, Henry responds:

First I was in church. And, church choir. Elementary school, high school, vocal groups, duets. High school choir. A cappella vocal group in Vietnam.

Henry continues with his personal history:

Next, I was... in Grand Forks, North Dakota, this was in the Air Force. I had a vocal group there...we had a back-up band played base and local counties and such- won the first place competition to audition for the “Ted Mac” Empire in NY... went on tour. But they didn’t use the song that I was singing, that won first place..

(at the interview he begins singing) “Old Man River”... and continues talking:

I used (Old Man River) several times at the singles night on Air Force Competitions, and it did win first place. Ah, I was stationed in Japan, I was singin’ with, ah, the band on base, and we played different bases all over Japan...then I left Japan and came back to the States. I was stationed in Las Vegas...And, uh, I enjoyed it, stationed there for a while, singing in Air Force Base clubs. Then, I moved to Los Angeles, retired from the military-temporarily for three years. I came out of the military, at that time, that’s because I had this lung ailment that evidently came from
Vietnam...Called trichinosis. So that’s why I was retired at the time when I was doing the LA singing...And I got married just before I got out of the service. That’s the first part of the problems with marriage ‘cause (of) lung disease.

But then, after, I did an album with a rock ’n roll drummer named Buddy Miles- he used to play with Jimmy Hendricks... Just as we were just about to complete the album, the Air Force said my health was stable, so I could go back to the Air Force. But then when I got back in the Air Force, I went into “Recreation and Entertainment” and with the recreation center set up shows...Then I got stationed in Korea. And, I was singin’ seven nights a week over there... singin’ Korean songs.

Henry continues his story, which takes place after he has returned to the U.S.

This period, I’m trying to reconcile with my wife, and the kid there in LA, they will not stay with me. Depression, ah, my heart started running out, so I had to have a micro-valve... irregular heart beat- so slow- when it got down real low, and I had seizures... but then, I was depressed... anyway, I came out of the service this last time with heart problems and everything, but I still only got thirty percent disability. Anyways, after getting out of the service...I was moving back to LA, to be near my wife hoping that we could work this out...But, uh, she didn’t and uh...I was on a very low income. It was horrible...anyway, uh, I started singing again in LA. But my heart was still bad. It was hurting too much, I would be on stage gasping for breath...then it just (got) too taxing. And I started
getting back into church again. And as I did that, let the entertainment thing go.

The last AIR member to be introduced today is Mark, our bass player. He is usually quieter than the others during conversation. He seems to prefer making light of issues rather than talking too seriously. His main goal for himself has been to improve his musicianship and get a GED- a high school diploma. He was also in the military, but only for a short period. During music, he clearly leads with his bass, beginning improvisations and connecting with the other members, especially whoever is playing drum set. He has never been married, has no children, and owned a small business until he became very involved in drugs. He denies that the drug use had any correlation with the loss of his business. He has been and continues to be waiting for an operation that will help repair his back from a car accident. He is in his middle forties.

Here are some of the transcripts from Mark’s initial interview, beginning with music:

Basically, it was, ah, me, starting out with my first guitar after I got out of the military. I taught myself how to play. I played piano a tiny bit, so that helped a little bit...My practice was the bass, so that’s what I’ve been sticking with...I basically grew up with rock ‘n’ roll...And, I can’t materialize it, but I like jazz. I just can’t play it yet. But, that’s what I’m leaning towards.

Mark talks about his family:
Never been married, no kids. I have a grandmother and a sister that lives here... My parents are still in Chicago...(I was) born in Texas, raised in Chicago. Been here about five years, going on six years. You know, it’s not a... close knit family. You know, we do stay in touch, sort of. I’m the one that doesn’t really kind of stick with the program. I’m guilty of that part. You, know, that’s kind of like me, though, the cowboy... I kind of got into this rut that I’m in. That’s the reason that I’m staying where I’m staying, which is the shelter.

Mark’s physical and medical problems:

I was in a car wreck two years ago which has unabled (sic) me to work, so I’m trying to get social security to kind of lend a hand to kind of get me back on my feet, which I’ve been waiting since November for...And, so far, it still hasn’t helped. But, I need to have surgery done to correct a torn rotator cuff, but the V. A. won’t do that until, the way they put it is, my “social order” is pretty much stable, as far as my residence... ‘Cause the shelter is the type where you can...get kicked out...and you’re trying to rehabilitate (from an operation) on the street, so they won’t do it...I’ve been at this shelter four months, they give you six months, so, it’s getting close to that time to do something.

Mark continues, telling how he lost his business and went to jail:

I eventually got caught, and got put in jail for it for a couple of months, over tickets that weren’t paid...My truck got stolen, all my tools got stolen, so I didn’t have insurance or anything...You know, social security doesn’t want me to try to work because of this injury...so, I don’t try to work...you know, because I don’t want to ruin my chances of...
the operation)...But, basically, that’s the rut I’m in... this living the shelter life month to month... It’s kind of stressful, you know. Depression sets in...This stress, depression and anxiety, I’ve been carrying for twenty-five years...This happened to me in the military twenty-five years ago... But I’ve been keeping it inside. I just found out I shouldn’t do that... I’m finding out that it’s supposed to be the other way, you’re supposed to let it out...

**Method**

I knew that I wanted to use the AIR group for research, but I wanted to run the clinical aspect of it as closely to my typical way of working as possible. I kept session notes, with my reactions to sessions on separate pages, and made many audio and video recordings of sessions. There was a slight difference in how I typically document sessions- I noticed that my session notes were longer than in the past, and contained greater analysis in the “reactions” pages. I also kept a personal journal for the first several months. After completing ten months of weekly sessions with a few weeks off for holidays, I began viewing and re-viewing tapes and session notes with a “fresh perspective.” Looking back, it might have helped the therapy process to do an in-depth review much sooner. I had looked through past session notes periodically, but not as in-depth as during the data analysis portion of the project. However, I think was more able to see the larger picture because of waiting to do the data analysis. I believe the learning gained will help me deepen my clinical work, which will be valuable to future clients.
The emerging themes were uncovered in words and phrases generated by myself, the AIR participant Henry, and another music therapist, Dorothy, after either one or a combination of the following data analysis was used:

1) watching a video taped segment one or more times and commenting verbally or in writing

2) listening to audio tape one or more times and commenting verbally or in writing

3) review of comments made by myself and the other reviewers

Emerging themes were also gleaned from:

4) statements from participants taken directly from session dialogue, found quoted or paraphrased in session notes or heard on recordings

I chose the taped segments that would be reviewed, and I analyzed the data. In many places, words had to be interpreted or “translated” from musical excerpts, and this was the most interesting and challenging.

I chose the reviewer, client/participant Henry, mainly for practical purposes. He is a good communicator, he is available and easy to get in touch with (has a phone and a stable residence,) he keeps appointments and arrives on time, and he is eager to be involved with anything related to music. I chose Dorothy for peer review because she is an experienced music therapist who has worked with under-served and psychiatric patients, and she has learned symbolic and interpretive skills that apply to music and human interaction through her clinical work and advanced
GIM training. I respect her work, and feel she is honest and does not hold back her opinion, even if it is different from mine.

**Some of the guiding questions were:**

1. How does music therapy add to the recovery experience for homeless/shelter guests?

2. What does MT add that is different from the “choirhouse” music, support, and social experience?

3. What is the meaning or significance of music for musically inclined guests in a church-based shelter?

4. How does a music therapist provide a voice for a person in recovery and transition from homelessness?

**Subsequent questions that arose are:**

a. Does music provide “normalcy” for those who have a musical background and are living “outside the norm?”

b. Can music, especially for its’ spiritual and creative properties, also be considered a “basic need” even when the “basic needs” of food, clothing, and shelter are not being met?

c. Where does music therapy provide a spiritual connection?

After listing approximately one hundred and fifty key words and phrases, I searched for commonalities and made groupings. I looked for words that had similar meanings, opposite meanings, or were somehow related. The first theme that emerged from the lists of words was “Emotional Expression.” Words relating to or describing “emotion” and
“expression” came up many times for the reviewers, participants, and myself. The numbered categories grew out of the many other statements. For each category there are sub-categories.

**Emotional Expression**

1. The category of *grief and loss* evolved out of the words: helpless, hurtin’, forlorn, left out and depressed, which are the “sub-categories.”

2. The *joy* category came from reviewers and participants describing verbally, demonstrating by appearance, or musically expressing: happiness, humor, lightness, euphoria, or laughter.

3. *State of being* grew out of a need to represent the physical, environmental and situational. For example: stressed, energized, comfortable, anxious, safe and mellow, etc. are sub-categories under states of being.

**Beauty/Spirituality**

1. The first category in the “Beauty and Spirituality” theme is *aesthetic*, which came primarily from the music, with words like: groove, love, beauty, boring, doesn’t work, sounds good. Only one phrase, “nice-looking” was non-musical. This came from how “together” and involved in the process the participants looked while they were each writing their own songs. They were working independently, but were still very much together. Music was even involved in how the group appeared visually, because it was how they looked when they were involved in the creative process of writing a song.
2. **Character** - this category is about the personal traits that were noticed, such as: having “heart” a person who “shines,” being “open” and being “pleasing.”

3. **Faith** - the elements that led to the category of faith included: perseverance, home, simplicity, overcoming difficulty and being optimistic despite hardship.

4. The *altered state* category includes trance, music that sounds “psychedelic,” and times when the music and overall session, “jelled.”

**Relationship**

1. Support - support showed up many times, in many ways, musically and in session dialogue, and in reactions by reviewers to music and session interactions. Support was listed as all supporting each other, and times when all were supporting one. Items in this category are: understanding, being helpful, providing and receiving encouragement, listening, leadership, following, guidance, community, etc. Support was shown in the assistance participants gave each other outside of music therapy, such as helping with transportation or giving others small loans or donations.

2. The category of *closeness* covers the sub-categories of intimacy, sharing, playing together, celebrating, safety, similarities, honesty, exposing one’s “real” self, and showing interest in another. Closeness seemed to be created most easily with music, although it was found in dialogue as well.

3. **Difficulty in relating** was represented in actions of blame, denial, dominance, inability to act as a “cohesive” group, showing-off, not
sharing (emotionally and musically), being overly needy (especially of attention) and being judgmental. These seemed to be fairly well-mixed throughout musical interactions and dialogue.

4. **Connecting musically** and non-musically involved “feeding-off” each other’s ideas and emotions, being in a “groove,” being cohesive (such as working together) and having “ego in-check”

**Story**

1. **History**- the category of history can refer to history that is either unique to an individual, the history of the group, or the history of a population. It includes memories, telling stories, and includes a person’s knowledge and education.

2. **Metaphor** was primarily found in the music. Music as metaphor correlates to or represents a life event or use of instruments symbolically-for example, drums representing a heartbeat. Also includes parallels between music and “way of being” in the music that mirrors a person’s life, for example “wandering” music.

3. **Shared experiences**- This category includes commonalities, such as struggling, addiction, and issues with self-esteem. It may be different versions of the same story.

**Structure**

1. **Boundaries**- include giving and following direction- musical and non-musical, goals, confidentiality, and practicing music.

2. **Traits** are how the session “flows.” Is it open, flexible, closed, flowing? Traits are general qualities.
3. *Musical*- musical structure was one of the largest of the categories. Words relevant to musical structure included: finding a pattern, making sense out of chaos, freeing, wandering, transitioning, establishing a groove, being jelled, cohesive, chaotic, falling apart, developing from one note, ability for follow-through, repetition, fading, melody, etc.

**Create/Risk**

1. *Making music*- musical creation was represented by the following words and phrases: anew idea, having a need to sing and play, exposing oneself, chaos and groove.

2. *Void*- The void category includes developing from one note, making sense out of chaos, holding back, building, problem solving, and breaking away.

**Health**

1. *Psychological*- These words and phrases are related to psychological well-being: effects of mental health on functioning, addiction, paranoia, recovery, instant gratification, dysfunctional home, needs not being met, rationalization.

2. The *cognitive/physical* category-our health-our minds and bodies-are so interconnected, it was hard to separate these out. For example, the ability to maintain a thought, maintain a musical theme- these require concentration and attention, which are a combination of psychological, cognitive and biological functioning. Healing and relaxation as a direct result of music, how music physically makes one feel, was also included in this category.
Discussion

All these words—“themes,” “categories,” “sub-categories”—have I discovered something new? Maybe, maybe not. But I can articulate some things differently than I could have before, and have developed some new insights.

The themes of relationship, emotional expression and structure were the most represented through dialogue and interpretation of music. Of course, interpretation by me as the clinician/researcher would direct this finding. It could indicate that these are the areas that people who are or have recently been homeless are experiencing the most need. It might also indicate that these are the themes of therapy that are most constant in group music therapy.

Drawing back to the original question, “How does MT add to the recovery experience for homeless/shelter guests?” It would make sense that music therapy adds a needed forum for developing relationships, providing an outlet for emotional expression, and adding much needed structure to an otherwise very unstructured existence.

The next question is, “What does music therapy add that is different from the “choirhouse” music and social experience?” It may be the quality of relationships and insight into relationships, as well as a “non-religious” and therefore, more free form of emotional expression. Music therapy provides a structure that is music-based, like the choirhouse, but uses a variety of different boundaries.
The response to the question, “What is the meaning or significance of music for musically inclined guests in a shelter?” lies in the themes of beauty, spirituality, creativity- I would imagine these are harder to come by when living is compromised. This would also tie into need for normalcy, which music provides when one is faced an a situation that is not “normal” or stable. The need for comfort and security also comes to mind.

The way that music therapy could “provide a voice for a person in recovery and transition from homelessness?” could be found in the story that is exposed through telling of personal and group history, use of metaphor, and shared experiences among members of the music therapy group. The improvisations and songs give a voice to the participants.

The last two questions remain unanswered. One question is if music can supply a “basic need.” I think there can be pockets of this. For some of the AIR members, the basic needs were only marginally being met. They had food, although it may not have been what we would call regular meals. I know there were times when group members came to a session hungry, having missed dinner, but still preferred coming to their music therapy group and getting food after the session. I doubt they would have been willing to attend had they gone days without a meal, or if they didn’t have at least temporary shelter. Finding an answer to the last question, “where does music therapy provide a spiritual connection?” is one that I currently am finding too subjective to answer. It seems like that would make a good starting point for another course of inquiry.
In Conclusion

Although music and its’ influence surfaced in all the themes or categories that emerged, its’ greatest benefit was found in the theme of “structure.” By this I mean, seeing the way that music and structure were so intimately and constantly connected proved a strong way for me to see the reflection of the psychological and personal issues being “played out” in the music. Almost all of the items under the music category in the structure theme were directly in line with issues of men and women in stages of transition from the shelter to the next phase, whether it be independent living or cycling back to homelessness, addiction and/ or prison. Within the musical structure were the sub-categories of: finding a pattern, making sense out of chaos, wandering, transitioning, falling apart, being static, developing from one note- all things that are a strong parallel to lives of the members of AIR.

A last detail to point out. You may have noticed how some of the words and phrases wound up in more that one category or sub-category. The best example is “groove” which can be used to describe connecting and relating, it can be a thing of beauty, an element of structure, even an expression of a state of being, like, “in the groove.” To me, this shows how so much of what we do, and who we are, is interrelated and defies categorizing. This overlapping is in itself a theme.

To end with, I want to add a personal touch by including music that is the conclusion of the improvisation that you heard at the beginning of the video. It was recorded the evening of October 30th 2001, the month following the tragedy at the World Trade Center in New York. The
tragedy had a tremendous impact on me personally. I believe it affected the participants in the AIR program as well, although not much session time was devoted to discussion around the event. I’d like to think that we worked through some of our fears and anxieties in the music. In the improvisation, Mark is playing bass, Terry plays the xylophone, Henry is on the drum set and vocals, and I am playing bongos and singing. As a transplanted New Yorker, I felt an especially strong need for connection, community, and support. I also felt the need to believe in beauty and unity, despite hatred in the world. This improvised song holds a simple and powerful message I would like to share with you at this international conference.

“One... are we together. Under one sky. Under one moon. Under one sun. One.

*As we swim through the ocean. As we fly through the sky. Holding hands together, you and I. One...”*

I feel that we are one, as humanity, as healers and helpers, as “groovers” and as those who know the deep power that musical connection holds. It has been an honor for me to share my work with you and be part of this world-wide community.

References


Introduction

Infant directed singing is an ancient, universal and universally recognized form of care-taking that has survived industrialization and urbanization and is recognized across cultures and music systems. The mutuality during singing between mother and infant may further serve to ensure infant survival. This singing allows for improvisation, thereby enabling expression, emotional release, relaxation and soothing for singer and child.

In addition to the adversity of poverty and new motherhood, pregnant and parenting teens face the additional challenge of adolescence. They want to be good parents yet require help to meet their own basic needs and develop an understanding of their child’s needs and the parenting skills to meet those needs. Some may need to learn how to sing to their children, what to sing to their children, and why. The Lullaby Group was conceived to address this challenge by providing age-appropriate music experiences for infants and young children, promoting parental self-expression, relaxation and self-soothing, facilitating attachment and bonding between parents and children and enhancing parental self-esteem through music interaction with their infants and children.
This writing describes the challenges of teen parenting and characteristics of infant directed song as rationales for developing and piloting the Lullaby Group in an inner city centre for pregnant and parenting teens. The group and its evaluation are described. Implications for future applications are discussed.

**Pregnant and Parenting Teens**

Teen mothers characteristically have histories of poverty, family problems (including jail, suicide, mental illness and substance misuse), and physical and/or sexual abuse. They have increased health risks due to smoking, alcohol and other chronic problems. Their higher scores of persecutory ideas (i.e., feeling victimized by family, friends, educational or welfare systems) are grounded in reality. Forty percent of teen mothers have severe psychological problems. Increased stressors affect them, their babies, and their relationships with their babies. (Osofsky et al, 1993)

Children of teen mothers have greater risk of low birth weight and developing physical, cognitive, social, emotional problems and are less likely to succeed later in school (Fulton & Factor, 1993; Rakic, 1996; McCain & Mustard, 1999; Doherty, 1997). Increased postnatal risk means that babies spend the most critical period of their lives under significantly enhanced risk, physically, medically, emotionally and cognitively. Postpartum adversity lasts many years and is responsible for
enhanced longterm risk to both mother and child (Acheson, 1998; Barker, 1997; Power & Hertzman, 1999).

The development of attachment patterns, affect regulation, language and cognition are described in terms of "windows of opportunity" during the crucial early years after birth. The brain develops according to the quantity and quality of the stimuli it receives. Good nutrition, nurturing and responsive care-giving during these first years of life plus good early child development programs improve the outcomes for children's learning, behaviour, and physical and mental health throughout life (McCain & Mustard, 1999). Dollars spent on early intervention and education are far more effective than dollars spent at any other time in a person's life (Cleveland & Krashinsky, 1997).

The social context is the cause of many problems for these young mothers, who lack the resources and fundamental life skills necessary for the demands they face. Teen mothers also lack a sense of control of their bodies. These feelings of loss of control are exacerbated by the rules for obtaining and maintaining social assistance benefits.

**Infant Directed Song**

The hearing capacity of newborns is acute and well developed (Klaus & Klaus 1998). They have good incentive to listen: The acoustic environment of the infant is musically rich (Trehub, 2002; Trehub, 1999; Trehub, 1996). Speech to infants has been called "motherese" (Fernald, 1991) because of its musical qualities. This infant directed speech from parents, other care-takers and children has a higher pitch, slower rate and
is more melodic as compared to adult directed speech and speech to older children.

For their part, infants are particularly responsive to musical elements. They prefer singing even to sing-song, motherese speech (Trehub, 2002). Recent studies of music perception in infancy demonstrate that their processing of musical or music-like patterns is similar to that of adults (Trehub 2000). Music processing similarities between infants with limited exposure to music and adults with many years of exposure point to biological foundations for this ability. The favourable consequences of singing to infants (e.g., infant's cry reduction, sleep induction, positive affect) contribute to infant wellbeing while promoting the likelihood of continued activity of the singer. This mutuality during music between mother and infant may further serve to ensure infant survival (Trehub, 2001; Dissanayake 2000a).

It is not surprising that "the practice of singing to infants and many details of form and style are rooted in ancient traditions that have survived industrialization and urbanization" (Trehub & Trainor 1998, p.43). Infant directed singing is an important, universal and universally recognizable form of care-taking that is recognized across cultures and music systems (Trehub et al. 1993 a,b,c). This special genre of music for children consists of two song types: lullabies and play songs.

Lullabies are quiet, intimate songs sung to soothe the listener and induce sleep. They are structurally, perceptually and functionally distinct from non-lullabies (Trehub & Trainor 1998; Trehub et al. 1993a,b; Unyk et. al. 1992). Lullabies are characterized by:
• a slow tempo
• restricted set of pitches and narrow pitch range
• simple, repeated pitch contours
• rhythmic character linked to rocking and/or swaying
• repetitive nonsense syllables
• tranquil images, terms of endearment or diminutives
• humming
• considerable improvisation
• indefinite song length

(Trehub & Schellenberg 1995; Trehub & Trainor 1998)

Lullabies have been discussed in terms of function (Hawes 1974). Lullabies function as work song, love song, incantation, emotional release and self-expression (Trehub & Trainor 1998). Infants enjoy lullabies more than adult songs or even play songs (Trehub 2000).

Play songs are songs to arouse and/or amuse infants and children. They are lively and exuberant in contrast to the soothing, quiet of lullabies (Trehub & Trainor 1998). Compared to lullabies, play songs have faster tempo, wider pitch range, greater animation and contain referential gestures. Whereas rhythm in lullabies capture those of swaying and rocking, rhythm in play songs capture the rhythm of the text. The words of play songs are more important than those of the lullaby and often have a didactic component; they are a vehicle for teaching and enculturation. The same play song melody is often used for multiple texts (e.g., "Twinkle, Twinkle," "Baa, Baa Black Sheep" and the "ABC" song, or "This Old Man" and the "Barney" song). Singing play songs begins later
in infancy than lullabies and continues longer, until the child's own song repertoire is in place (Suliteanu in Trehub & Trainor 1998).

With the exception of North America and Europe where play songs dominate, lullabies are the more common song form in infancy. Trehub & Trainor (1998) posit this is because young children sleep with their mothers in most other world cultures. Interviews conducted with Canadian mothers (Trehub 1999) showed they learn songs from recordings and television, which feature mostly play songs.

**Self-Expression, Relaxation and Self-Soothing**

Lullabies allow for improvisation, thereby enabling self-expression and an outlet for emotional release. The deep, regular breathing necessary to sustain vocalization during song increases vital capacity and maximizes oxygenation, relaxation and can also decrease the perception of pain. Singing anything has a soothing effect. Singing lullabies, with their characteristic simplicity, repetition, slow tempo and gentle images further ensures relaxation.

Trehub & Unyk (1991) claim that lullaby singing as a part of care-taking children would not have persisted across centuries and continents without good effects. Recent studies (Trehub, 2001) of infant salivary cortisol as a measure of changes in arousal (i.e., alertness or sleepiness) following their mother's singing provide concrete and measurable evidence of what has been known by lullaby singers throughout the ages. The capacity of lullabies to soothe the singer as well as the listener (Hawes 1974; Trehub
& Trainor 1998) may also have contributed further to the survival of lullaby singing.

**Attachment and Bonding**

Dissanayake (1992) proposes that the arts, as a way to "make things special," serve as enabling mechanisms for other activities more directly related to survival. Singing is mutually enjoyed by singer and listener, fosters communion between the nurturer and the nurtured (Trehub & Trainor 1998), and thereby enhances affiliation and the child's likelihood for sustained care and survival. Dissanayake (2000a) describes mutuality as "a kind of taproot formed in the elemental loam of the mother-infant relationship" (p. 69). Being a baby means wanting such mutuality and to participate in patterned, multi-modal, emotionally communicative improvisations.

Music functions to preserve this mother-infant relationship in the mother's absence. Lullabies and play songs may function as transitional objects in early childhood (Rogers 1990; Garfías 1990). Lullabies and play songs come to evoke a child's feelings for mother, allowing the child to recreate the feeling of being with her even in her absence. Garfías (1990) refers to the lullaby as a "convenient metaphor for all of the earliest communications to the new infant from those already established members of its society" (p. 101); these ideally include associations with comfort, warmth, security and protection.
Infant Directed Song and Parental Self-Esteem

Singing to infants affects arousal by inducing sleep and also eliciting interaction. Infants attend more to mother's singing voice than spoken voice (Trehub 1999). In an experimental setting, infants display more visual regard for their mothers' videotaped singing compared to speaking (Trehub, 2002). I believe this also occurs in natural, real-world settings but has not been explored or documented. If so, this increased looking has the potential to enhance the mother's self-esteem and promote a positive self-concept of herself as a parent.

The Lullaby Group

Rationale

Based on what is known about parenting teens and their children, infant directed song and the musical responsiveness of infants, the "Lullaby Group," was conceived and piloted as a means of addressing the needs of parents, infants and children in an inner city centre. Lullabies and play songs were seen as ways of providing teen parents with skills and empowerment in a non-threatening spirit of belonging and fun.

Goals

1. Provide opportunities for increased self-esteem for parents;
2. Provide a means of self-soothing for parents;
3. Promote and facilitate bonding and interaction between parents and children by modeling music interaction with babies and children;
4. Provide relaxation in support of breast-feeding for parents and infants; and
Description

Live music (voice and classical guitar) was provided in the nursery of an inner city centre for teen parents one afternoon a week from January to June 2000 by an accredited music therapist. The duration of the music varied from 45 minutes to 2 hours. The group was attended by pregnant teens, teen parents (average age, 17) and their infants, toddlers and preschool children (age birth to 5 years).

The focus of the music provided in the nursery was three-fold and not mutually exclusive: the teens, the infants, and the preschooolers. The focus of the music was directed to where the greatest need was perceived to be in any given moment (e.g., crying infants, rambunctious children). The fluidity of live music and its ability to make contact across distance was useful in the large rectangular shape of the nursery. There were times when the music was directed to the preschoolers while the therapist was sitting with the parents and infants; similarly, there were occasions when songs and stories were directed to the parents and/or infants while the therapist was sitting with the children.

Infant songs consisted of lullabies and simple, improvised melodies accompanied by guitar. They were intended to induce sleep, provide quiet and calm and elicit infant vocal play and interaction. Songs directed to the children consisted of play songs, ballads (story songs) and stories intended for fun, learning (e.g., language development, social interaction, fine and gross motor control) and self-expression. Songs for parents were
intended to provide relaxation, enjoyment and interaction, and were also suitable for use with their infants and children.

Books of song lyrics were provided during the group to encourage parents and staff to sing along. The books contained songs that were most familiar and easiest to read and sing. Songs were added to the books as they were requested. A larger lyric collection was brought each week by the music therapist. Teens were welcome to photocopy songs from any of these song collections.

**Evaluation**

**Therapist Observation**

Live music in the nursery provided a calm, soothing presence, playfulness, interaction and a sense of cohesion and belonging. The lullabies served to promote sleep. Improvised melodies accompanied by guitar elicited vocal play with infants. On one occasion, an infant was distracted from her hunger distress by vocal play while her lunch was being prepared and heated. Parents expressed surprise and delight to watch their infants engaged in music.

Parents were encouraged, but not pressured, to sing along. Sometimes they sang with enthusiasm and staff and volunteers joined in. At other times, the music therapist's singing provided a quiet background for conversation. New song material was sometimes introduced during these times.

Live music, while appealing and enjoyable, can also be threatening. The music therapist strove to maintain a very low profile and let the music
establish the relationship. The collection of parent evaluation towards the end of the pilot served to facilitate dialogue and connection with the parents. The songs requested by the end of the group showed a desire by parents to sing for their own self-expression and enjoyment.

Play songs were sung with the older, pre-school children. Sometimes an informal music circle occurred with staff and volunteer support. Parents were less likely to join this activity but always watched and many did sing along. This was very enjoyable for staff, children and the music therapist. Stories were also provided and were particularly enjoyed by one pre-school child. Sometimes there were no older children or these children were engrossed in other activity and chose not to engage in music.
Parent Observations

Figure 68 Evaluation form

What I liked...

What I didn't like...

What I noticed about myself during the music...

What I noticed about the parents and children during the music...

Anything else?? Suggestions??

I am a (check one) Staff ☐ Volunteer ☐ Student ☐

I experienced or observed the Lullaby Group approximately _______ times.

Your name and function (optional):
What Parents Liked: "I like the music when the babies are crying."

Parents generally liked the music. Specifically, they cited liking belonging, inclusion and that the music was relaxing, calming and soothing. One parent liked the variety and that the children liked it.

What Parents Didn't Like: "Sometimes it gets annoying because it's so slow and it puts you to sleep."

Two parents stated they didn't like "some of the songs" but didn't say which ones. One parent wants more songs in the book, one didn't like the time of day the group took place and another didn't like when it is too crowded.

What Parents Noticed about Themselves: "Is that I can sing so beautifully and that my son enjoys when I sing. I love to hear my voice now that I know I can sing."

Many parents noticed feeling quiet, relaxation, enjoyment and calm. One remembered a lot of songs. One parent said, "I caught myself singing along," seemingly in spite of herself.

What Parents Noticed about Their Children: "He enjoys it. He pays more attention to me when I sing. I sing to him all the time now. He is used to it now when he goes to sleep and he won't go to sleep until I sing to him (7 mos.)."

Parents noticed their children's responses to music. These responses ranged from settling and sleeping to increased arousal (e.g., looking, getting excited and perking up). One parent noticed that her baby "watches our mouths and listens to us."
Parents' Comments and Suggestions: "I like to sing to her (2 mos., 7 days). It makes her calm and she doesn't cry. I got to learn more songs I didn't know."

Suggestions were made for familiar songs as well as more song variety, including songs of different ethnic origins (specifically French). One parent said the group should continue. Another said the time of day for the group was good.

**Synthesis of Staff Observations**
"Often the parents appear to be re-living missed experiences from their childhood; Sometimes they are embarrassed to see adults being 'silly' and it's good for them to be encouraged to let go and 'play'."

Staff expressed appreciation of the flexibility of live music to be able to go with the flow of what is happening in the moment, the participatory (versus performance) focus of the music, and the casual "low pressure" atmosphere. Suggestions were made for more variety and that the group wasn't long enough. Staff noticed they felt relaxed and sometimes energetic, and that the room was calmed down after lunch. Comments were made about the parents singing, the children being soothed, and that the music times "help parents to connect with each other." Suggestions were made for current songs and song choices coming from parents.

**Evaluation Summary**
Observations from parents, staff and the music therapist indicate the Lullaby Group appeared to achieve its intended goals. Further to these goals, the presence of live music in the nursery served to facilitate group
cohesion by providing opportunities for all to participate in a shared experience, actively or passively, as they chose. An ambiance of quiet and calm or laughter and fun was generated in response to the needs of the moment. What emerged towards the end of the life of the group was the parents' enthusiasm and expressed desire for song material for themselves, for their own self-expression and emotional release.

Discussion and Implications

Teen mothers need to acquire skills to support the integrity of their intentions. They deserve respect for their decision to become parents. And they require tools to enable them to fulfill their responsibilities as parents. (Jessie's Centre, 1999) Hopefully the Lullaby Group has contributed, in some small measure, to this end. While specific outcomes were not measured, evaluation results do indicate that the Lullaby Group increased the likelihood that the teen parents involved would sing to their children.

The target of intervention for the Lullaby Group pilot was the teens, the infant and/or the older preschool children. Interventions directed specifically to the mother-infant relationship itself might more effectively enhance mental health outcomes. Lenz (1999) describes mother-infant music psychotherapy interventions that rely heavily on musical instruments. Such interventions are effective but not appropriate for the teen mothers described here because they lack the financial resources necessary to acquire musical instruments. It would be unethical to help them learn to soothe their infants with instruments in the clinic setting without providing them with instruments for their own use at
home. For this reason, the Lullaby Group did not use expensive musical instruments or pre-recorded music.

Lojkasek et al (1994) describes four models of mother-infant intervention as supportive, development and relational guidance, psychotherapy and infant-led psychotherapy. Of these four, infant-led psychotherapy, based on the Tavistock "infant observation" method (Muir et al, 1999; Cohen et al, 1999), is well suited to music therapy infant directed song and improvisation for adolescents. Applications of music therapy intervention for infant mental health—i.e., aimed directly at the parent-child relationship—have yet to be explored.

The target of music therapy intervention for early education intervention has been preschool aged children (Standley & Hughes, 1996; Standley & Hughes, 1997; Register, 2001). What might the outcomes be with earlier intervention during infancy? The possibilities for music therapy with infants are rich in potential. Similar to Winslow's (1986) work with women experiencing high-risk pregnancies, music therapy with pregnant women (Allison, 1994; Browning, 2001; Rykov, 2000) takes on unique characteristics when applied to adolescents.

**Summary and Conclusions**

The challenges of teen parenting, the characteristics of infant directed song and the musical responsiveness of infants were discussed as rationales for development of the Lullaby Group in an inner city centre for pregnant and parenting teens. The group and its evaluation were described and implications for future applications were discussed. Future
variations on this theme might entail interventions aimed at the parent-child relationship itself. Education outcomes as a result of early infant music stimulation might also be explored.

End Note: The writer thanks Jessie’s Centre for Teenagers, where the Lullaby Group initially took form, Literature for Life, where it continues to change and grow, and the Canadian Music Therapy Trust Fund, for providing the material support that made the work and this writing possible.

References


Acknowledgement

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Sick mode and dying mode: music therapy in the treatment of cancer treatment

Rykov, Mary

Introduction

This paper discusses a music therapy support group for cancer patients in a community setting. The group is described in terms of goals, content and process. Participant evaluation themes and the therapist's observations and reflections are provided. The "music mode" of music therapy treatment in cancer care is described as palliative care orientation. Music therapy can function in "music mode" to preserve continuity of cancer patients' sense of self throughout the course of their disease.

Description

Background

Music therapy groups are a recent addition to a variety of group programs offered in a community cancer support setting. All programs are available free of charge to participants. Some groups are continuous and function on a drop-in basis. The music therapy group is a closed group that runs for 8 weeks, and is 1.5 hours in length. The goal of the music therapy group is to provide music and related nonverbal media as a means by which participants may express and explore their cancer experiences.

Content and Process

Music therapy groups include combinations of singing, song-writing, vocal toning and improvisation, guided imagery and music,
improvisation, music sharing, psychodrama and/or theatre games, movement, and pastel drawing.

The group process typically unfolds, as follows:

Week 1. Introductions; singing; much talking

Week 2. Introductions, continued; singing; introduction to instrumental improvisation (Murrant et al, 2000)

Week 3. Introduction to improvisation, continued; singing/toning/movement

Week 4. Improvisation as self-expression; psychodrama/singing/movement

Week 5. Guided Imagery and Music (adapted Bonny method); drawing

Week 6. GIM; improvisation; closure discussed

Week 7. Improvisation (vocal and/or instrumental); develop closure

Week 8. Evaluations and closure exercise

The content at any given week is a function of the issues brought forth by the group. By week 4, participants are comfortable enough with the instruments and each other to bring these issues into the music. Often during the life of an 8-week group, one or more participants experience changes in health, for better and worse. These changes are expressed and processed musically, nonverbally (art, movement, psychodrama) and verbally. With permission, sessions are audiotaped and participants receive copies of the audiotape at the last session.
Evaluation

Participant Evaluation

Participants evaluate programs by means of written questionnaires at the conclusion of each 8-week group. Responses to "ways in which you found the program helpful" yielded the following themes:

Uplifting: E.g., "leaving feeling uplifted and good about myself"

Calming: E.g., "created a sense of inner peace"

"relieved anger, rage, stress"

Social: E.g., "The rapport with various individuals, combined with the sounds from the music definitely contributed to a feeling of well-being when the group is over." "Sharing experiences"

Empowering: E.g., "Respectful of our ability to cope with deep issues."

"It allows for better coping with my pain."

Fun, enjoyment: E.g., "Making noise and having fun."

"It brought a smile on many faces."

"It gave me a lot of pleasure."

Music experiences: E.g., "Finding the meaning of beauty in music"

"Reintroduced me to music and its healing qualities."

"Restored and motivated me to return to my music."

"Opened my mind to practice more listening of music."

"Explore a new type of music."
"I could express myself freely using musical instruments."

"Using music and sound in a free form way was extremely liberating"

"Encouraged us to let go into the music."

"Music lifts my spirits."

**Therapist's Observations and Reflections**

Music, as is its nature, functions to open people to themselves and each other. Discussions can be deep and fraught with the existential crises inherent in coping with potentially life-threatening illnesses and their treatments. Joy and sorrow are profoundly expressed through the music, song and discussion. The group dynamic is supportive and intensely caring.

Each group has its distinct characteristics. One group was attended by a majority contingent of participants who sought recreation and escape and had previously attended other programs together. These participants were relatively well, had good prognoses, were at the end of their treatments, or were in remission. They certainly were enjoying themselves, but were not playing (Bruner, 2000) in the full sense of the word. One participant whose health was much poorer was unable to get the support she had experienced during another music therapy group she had attended; her health declined further and she was unable to continue.

The remaining participants continued to seek diversion and I became aware of my boredom. I wondered how this might be experienced by the group. I remembered Lawrence LeShan's (1994) advice that therapists be "aware of their own special orientation, compensate for it, and be as
sensitive to patients as possible (p. 166)," I realized my palliative care orientation and spiritual philosophy influenced the manner and tone of my leadership. This awareness served to diminish my boredom and enabled me to "lighten up" to meet the needs of these participants.

Discussion: Music Mode and the Cancer Treatment Continuum

Dr. Bannerjie is a character in a novel by Irish writer Niall Williams who confronts the boundary between treatment and palliation in the cancer disease trajectory:

"But when he heard in the man's tone the desperate beseeching for life Hadja Bannerje felt the grief rumple him like an illness of the stomach and acknowledged in himself the awfulness of reaching this place at the end of medicine. This, he thought, is beyond the last page of all the books I have studied. This is a place further than prescription. (p. 103)"

This boundary is depicted in the profile of cancer treatment (Expert Working Group, 1988, p. 80), as conceptualized in Figure 1.

Callahan (1993) contends that death should be seen as the necessary and inevitable end point of medical care and not as what happens when medicine fails. This is clearly depicted in Figure 1 where active treatment stops and palliative treatment begins. In Callahan's terms, oncology treatment should extend to the very end-stage of disease, i.e., death. He also recommends that books dealing with potentially fatal diseases should include a chapter dealing with the care of people dying of that disease.
The boundary between active and palliative treatment in the minds of cancer patients is clearly delineated. For example, one music therapy group discussion concluded that they certainly want good symptom control when this becomes necessary; but call "it" (i.e., palliative care) something else, they challenged. The stigma of palliative care is hardy.

In contrast, Figure 69 depicts the profile of AIDS treatment (Expert Working Group, 1988, pg. 81).

**Figure 69 AIDS Care**

This figure depicts the concurrence of active and palliative treatment intent over time. Here, palliative caring begins concurrently with active treatment, and increases over time. Similarly, active treatment continues, and diminishes over time as the disease progresses towards death. This model has developed into the current proposed norm of practice for Hospice Palliative Care shown in Figure 3.
This model suggests permeability between active and palliative caring. It is this palliative model of treatment that I advocate for cancer care. Here, whether in sick mode or dying mode (as per LeShan, 1994), music therapy service delivery has the flexibility to treat cancer patients in "music mode," according to their energy reserves and preferences in any given moment. This music mode of service delivery is not altered by a change in medical prognosis and disease progression. Furthermore, music mode has the capacity to preserve identity and integrity, contain fear and express hope throughout the continuum of cancer treatment.

**Summary and Concluding Challenge**

A music therapy group in a community cancer support centre was described. Participants' evaluation of what they found helpful focused primarily on the positive experience of music-making. Therapist's observations and reflections convey the need for self-awareness and awareness of personal orientation and philosophy. The palliative care model of cancer care treatment, extrapolated from Callahan (1993) and
LeShan (1994), was discussed as "music mode" in terms of its manifestation in music therapy service delivery.  

Music therapy can function in profound ways throughout the continuum of cancer treatment but the challenge of how to do so remains. Currently, boundaries and funding of music therapy in active cancer treatment and palliative care are firmly distinct. Continuation of active treatment until death and the assumption of palliative care at diagnosisæas per the proposed standard for hospice/palliative careæmight serve to redefine these boundaries. Perhaps then the challenge posed by cancer patients to call palliative care "something else" would not be necessary.  

References


INTRODUCTION: PRESENTING THE PROJECT

The relevance of Music Therapy as an indicated treatment in Psychiatry has been well documented in literature (Aldridge, 1996; Cassity y Cassity, 1991; Davis et al., 1992; Heany, 1992; Lindvang & Frederiksen, 1999; Odell-Miller, 1999; Wigram y De Backer, 1999), and schizophrenia has been the subject of different studies in applied music therapy (Pavlicevic & Trevarthen, 1989; Jensen, 1999; Odell-Miller, 1991).

This paper will focus on a Music Therapy research project developed at the Mental Health Service, of the Servicio Andaluz de Salud (Andalucian Health Service-Regional Health Care System), in collaboration with the Area of Psychiatry of the University Hospital of the University of Cádiz, in the year 2000, from January to November. The project obtained Government financial support from the Area of Research of the Junta de Andalucía.

This was the first Music Therapy project developed in the Servicio Andaluz de Salud, and was not easy to convince the Hospital authorities about the quality of music therapy, its relevance as treatment modality in Psychiatry, and the viability of the idea. After several meetings with the hospital's staff, where the theoretical bases of music therapy and treatment modalities with adult psychiatric clients were explained, doctors and therapists involved on the project where asked about what
they wanted to see from the music therapy intervention, and how much they were willing to co-operate on the project. A nurse, called Pilar Lozano, from the Dispositivo de Salud Mental "Hogar Constitución", was very interested on the idea and offered herself to collaborate with me, and we decided to implement the project with the in-patients of this service, sited at the Puerto de Santa María in Cádiz.

Conclusions from meetings with the staff revealed an absence of knowledge about music therapy as treatment modality: music therapy is an unknown discipline, and a lack of interest on exchange and compare clinical information about clients: doctors and therapists only want results without active participation. This information makes me to decide to devise a research design emerged from this reality. The research study was based upon an EVALUATION OF TREATMENT EFFECTIVENESS DESIGN, organised in three main phases (Figure 71).

Research differs from clinical practice in the need for metareflection on the data, goals, roles, beneficiaries, use of knowledge and consumers. While treatment studies focus on clinical interventions and methods, evaluation research is concerned with the outcomes or effects of music therapy (Bruscia, 1995). In order to present outcomes to validate the suitability of music therapy approach in psychiatry, the research project was based upon an EVALUATION OF TREATMENT EFFECTIVENESS DESIGN.
The purpose of the study was to validate music therapy as an important tool working with adults schizophrenics in-patients, in order to include it as part of treatment service.

Participants for this study were 10 adults schizophrenics (5 females and 5 males), ranged in age from 25 to 45 years, hospitalized in an open psychiatric service (Dispositivo de Salud Mental del Servicio Andaluz de Salud "Hogar Constitución", Puerto de Santa María, Cádiz).

Timetable: Participants received Group Music Therapy sessions once a week during four months (March-June, 2000), from 40 to 60 minutes. The length of the sessions depends on client’s responses and motivation to activities.

Documentation: Using observational methods based on recorded data, the focus was on client's responses to group music making. Pilar Lozano, the nurse who works with this in-patients, was involved as participant observer. Data gathering was made through:

1. Video recording of all music therapy sessions
2. Music therapist's clinical notes taken after all music therapy sessions
3. Participant Observer's clinical notes taken after all music therapy sessions

Strategies used in validation of data analysis were put through triangulation and comparative analysis of information obtained from video analysis, clinical notes and bibliographical review. Triangulation allows the researcher to make the following data comparisons:

1. Intraindividual: data comparisons within a single participant, taking several examples of an experience from the same client.
2 Interindividual: data comparison between participants, taking one example of an experience from the several clients.

3 Intraobserver: comparisons within one observer, making several observations of videotapes.

4 Interobserver: comparisons between one observer and another.

PHASE TWO: IMPLEMENTING THE PROJECT (March-July 2000)

Activities with clients: In parallel with the process of the research plan designing, thinking about activities was fundamental to the aims of this project. The main questions was: what type of activities were the most effective to achieve outcomes with this clients in four months, 17 sessions?.

Smeijsters (1996) identifies five modalities for treatment in Psychiatry: 1) recreational music, 2) supportive music psychotherapy and recreational music therapy, 3) music activity therapy, 4) re-educative music psychotherapy, 5) re-constructive music psychotherapy. For the aims of this project therapeutic treatment corresponds to the second one, recreational music therapy and supportive music psychotherapy.

Clients’ participation in group music therapy sessions includes active methods. In this model the therapist uses collective experiences of music as a basis for therapy. As music is related to identity-building, in this project music is used as collective identity, as a tool to empower clients within their own identity and promote emotional involvement of the individual within the group.

Data collection: Clinical notes taken after music therapy sessions includes:
1 the first impression of what I observed in the clients phenomenologically
2 description of interactions between clients themselves
3 description of interactions between clients and music therapist
4 transcription of musical elements
5 critical incidents: detailed descriptions of occurrences observed, related to institution, therapists, nurses or clients

All music therapy sessions were videotaped and analysed adding comments on personal feelings, thoughts and impressions from the two main categories:

1 *quality of participation on music therapy activities* (related to musical expression, creativity, making music with others, participation in a group singing, expression of feelings through music improvisation, use of voice, instruments and body / movement)

2 *expression of musical identity in music performance* (sounds, gestures, movement, body sounds, environmental sounds, family sounds...)

**PHASE THREE: MAKING REPORTS (September-November 2000)**

Communication or make reports is often regarded as the culmination of the research process, and the phase where the knowledge gained is shared with others. This study provided significant findings in two main areas: clients and institution. The information was separated into two different reports that summarises the most important facts about the research project.

• **INDIVIDUAL REPORT OF PARTICIPANTS / CLIENTS**: Detailed account describing the experience of the client in the music therapy process, and making tentative inferences about the factors contributing to her/his development.
Theoretical background: MUSICAL IDENTITY AND MUSIC THERAPY

There is a connection between human, music and social interaction. Music is a universal trait of humankind (Hodges, 1996), it is present in the process of socialization, and helps people to learn about the own culture, and itself. The musical experience integrates body, mind and spirit; it is both personal and corporate, and it is a potent influence on human behaviour (Gastón, 1968).

Each community shapes and is shaped by the individual identities, and music is one of the most important element that binds community together. The way in which people use music, and the kinds of music they listen to, sing and play are result of learning, social interaction and individual characteristics. In this interaction, people also create a relationship with the music. Since the phase of pregnancy, birth and infancy, up to the present moment, sound experiences are present in daily life. There is a connection between music and the way people look at and present themselves. The relationship with the music influences psychological development and contributes on the process of the construction of identity from birth to death.

Influences of music on identity promote development of particular musical characteristics called “musical identity”. To understand the
construction of musical identity it is useful to study the functions of music in society (Merrian, 1964), as they are regarded as the functions and uses of music on personal life. Musical Identity is a result of social interaction, education, sound and musical stimulus received since the phase of pregnancy (table 1).

Table 46 Components of Musical Identity

<table>
<thead>
<tr>
<th>MUSICAL IDENTITY</th>
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<tbody>
<tr>
<td>• Internal Body Sounds: heart beat, joint sounds, stomach sounds...</td>
</tr>
<tr>
<td>• External Body Sounds: walking, breathing, involuntary sounds...</td>
</tr>
<tr>
<td>• Speech Musicality: rhythm and pitch changes, tempo, intensity, timbre...</td>
</tr>
<tr>
<td>• Cultural Music Background: folklore, country music history...</td>
</tr>
<tr>
<td>• Family Music Background: musical training of parents; environmental sounds...</td>
</tr>
<tr>
<td>• Personal Music Preferences: sounds, music styles, uses of music...</td>
</tr>
<tr>
<td>• Personal Musical Skills and Abilities</td>
</tr>
</tbody>
</table>

Related to music therapy, the knowledge of how music helps to construct and individual self-concept may help us as music therapists to empower our clients within their own cultural context, life-history and identity. Understand how music helps to construe a sense of identity is an important tool for perceiving and understanding clinical events (Ruud, 1998).

WORKING WITH CLIENTS: MUSIC AS COLLECTIVE EXPERIENCE

Music experience within a clinical context involves a person, a specific musical process, and a musical product. In music therapy, the main priority
is to address the client's needs and problems through music. Through MUSIC THERAPY TECHNIQUES it is possible to get practical suggestions for encouraging clients within their own identity, as musical activities in a therapeutic situation can provide a possibility for:

1. *self-expression* in sound, music and movement
2. to increase the sense of "own music"
3. the possibility of sharing the "own music" with others
4. to build the "group music collective identity"
5. the development of social and interactive competences
6. to express feelings through music experiences in a group situation

From a THERAPEUTIC PERSPECTIVE, encouraging clients within their own musical identity is a way of:

1. initiating or facilitating the therapy process
2. to rebuild a new sense of belonging
3. to promote emotional involvement of the individual within the group
4. to create memories about significant events
5. to bring the clients together in a group musical experience
6. to feel the power of being in a group making music with others

In this approach, the music therapist has an ACTIVE ROLE, participates in the musical experience improving clients to "feel and make music". The music therapist is the keeper of roots, who connects clients themselves using music, and supports the group with, and through, the music. The music serves as both container for the past, as well as space for the present, providing clients the opportunities to create, recreate and keep them together. The role of, and presence of, the music therapist is essential to make schizophrenic patients refer to music, and the "listening attitude" is
an essential part of treatment (Pedersen, 1997). In building up the first stage of working the therapeutic relationship is considered to be a main instrument of change.

**OBJECTIVES AND GOALS**

Typical problems of psychiatric clients, and the relevance of music therapy with psychotic patients is expressed clearly by Jensen (1999):

- **PROBLEMS WITH CONTACT AND COMMUNICATION:** fear of being together with other people, fear of closeness, autistic withdrawal, paranoia. The experience-oriented and pre-verbal element in music therapy allows possibilities for contact with psychiatric patients, for whom a close contact often can be anxiety provoking. The music therapist can, in a musical way, constantly switch between closeness and distance.

- **PROBLEMS WITH BECOMING AWARE OF AND EXPRESSING FEELINGS:** flat affect of anxiety or aggression that has no outlet. Music therapy gives the opportunity of relieving one's feelings in a safe setting, together with another person who can contain, process and reflect the patient's expression in a modified form.

- **PROBLEMS WITH IDENTITY:** low self-esteem, megalomaniac fantasies.

- Music therapy gives the patients possibilities to rediscover playful and creative sides. In musical interaction, the patient's psychotic symptoms can be contained and transformed. The focus can be on potentials, both for psychotic and non-psychotic origin, instead of a one-sided focus on disease and weakness.

- **PROBLEMS WITH FEELINGS OF DISTORTED REALITY:** hallucinations, feelings of fusion with surroundings. Music has elements of pre-verbal communication. The musical relationship can reflect oceanic experiences. The music therapists can consciously change between uniting and separating elements in the music, change between symbiosis and separation.

According to these symptoms, **MUSIC IS USED:**

1. as a tool to express feelings
2. to empower clients within their own identity through musical experiences
3 to promote personal and psychological growth
4 to stimulate communication (verbal and non-verbal)
5 to create memories
The general CLINICAL GOALS to achieve with these clients are:

• *To improve the sense of identity through music experiences*
  - To help the clients to feel safe and secure in order to express themselves musically
• *To facilitate the client’s self-expression and promote psychological growth*
  - Offering a possibility for expression, and of re-enforcing the sense of self-respect.
• *To stimulate verbal and non-verbal communication*
  - To establish a wide and containing relationship with the client as a human being, to facilitate the client’s self-expression and communication (verbal and non-verbal).
• *To engaged rapport through the clients using music*
  - To develop the feeling of being in a group, making music together and re-inforcing the sense of self-respect.

MUSIC THERAPY SETTING: METHOD AND TECHNIQUES

The orientation in my music therapy approach has grown from years of clinical practice, in the field of psychiatry and in the field of learning disabilities with children, teenagers and adults. My approach is not based on one theoretical framework, and ideas have been taken from the work of different backgrounds: Psychoanalytic and Psychodynamic oriented Music Therapy, Benzenzon Model, and Music Education Methods (Orff-Schulwerk, Jacques Dalcroze, Murray Schafer). Music Psychology has also influenced, particularly the findings concerning to Musical Identity.
In this approach, using SIMPLE GROUP MUSICAL ACTIVITIES the music therapist promotes:

1. a contact of the client with the music,
2. the feeling that he/she is part of the music,
3. and the sense of making music with the others (my music, your music, our music)

Clients’ participation in group music therapy sessions includes ACTIVE METHODS, and IMPROVISATION is the main technique used. GROUP MUSICAL EXPERIENCES are the basis for therapy, and are used to establish rapport with clients, and between clients. Music provides a structure within which there is freedom (Gaston, 1968). While it is a highly structured art form, it accommodates individual interpretation and creativity. While an entire group of people are engaged in a musical activity, no two are expressing themselves in precisely the same way. Thus, it provides a format for learning about one’s own manner of approaching the creative process, expressing one’s self, interacting with others, and organizing and interpreting artistic material.

In this project, from a directive to a non-directive approach, musical activities are focus to promote self-expression, participation and group interaction, and to allow the clients to express themselves with music making (Figure 72).

An intense EXPERIENCE OF "HERE AND NOW" is provided through musical activities, that includes:

- body percussion activities
- improvisation with voice
- improvisation with percussion instruments
• singing songs

Figure 72 Music Therapy Setting

The therapeutic relationship is considered by many authors to be the most influential factor determining success in therapy. The relationship between music therapy and client is enhanced by their relationship to the music. The music therapist uses music to bridge the interpersonal relationship further, adding richness and depth to this shared experience. In building up the first stage of the therapeutic relationship, it is important to support the musical expression and participation of the clients, in order to increase the sense of group identity. The music therapist has an active role, participates in the musical experience improving clients to "feel and make music". 
In this approach the focus is on different musical parameters related to therapeutic aims (figure 3). Musical parameters such as metre, rhythm, tempo, tonality, melody, harmony, sonority, timbre, etc. correspond with the analogous aspects of verbal communication.

- **MOVEMENT**: in order to integrate movement to musical expression when singing and playing. Movement encourage clients to fell in connection with the group (peers).

- **RHYTHM**: connected with movement. Motor activities are central for experiences the rhythm, and the rhythm is originated by the organization of human movement (Fraisse, 1976).

- **VOICE**: connected with the use of the body, breathing and movement facilitates voice contact. The use of voice opens a channel for rhythmic and melodic patterns that facilitate sound communication.

- **MELODY**: connected with the voice, and the expression of emotions.

- **INSTRUMENTS**: encourage active participation, and provides a link between the clients themselves and the music therapist.

- **OSTINATO**: the hypnotic repetition of an ostinato, combined with movement and group music playing create a stable musical environment that facilitates expression and emotional connection.

- **NAME**: singing the (own) family name improve self-steem and identity. Singing the family name inside a music structure offer a background for expression and communication.

- **GROUP LIFE**: the psychological experience of movement and rhythm in a group situation increase the sense of being part of a group, and provides a support structure for expression, communication and integration, feeling the power of being in a group making music with others.

- **emotion**: music is emotional expression making music is a personal experience and a direct manifestation of the person’s unique identity as human being.
SESSION FORMAT

To improve the awareness of identity is an important clinical goal working with schizophrenic clients. Integration of the own music history, experiences, likes and dislikes in music allow the clients to meet themselves and improve their quality of life. Musical activities within a play situation can provide a possibility for self-expression and for the development of social and interactive competencies.

The clients are stand up in a circle. This position brings the opportunity of eye contact, communication and increase the feeling of being part of a group.
WARM UP: CONTACT WITH BODY SOUNDS - BREATHING

Physical warm-up involves movement exercises designed to prepare the client for music making, to contact with her/his body, and to be aware of body position (kinesfera), and the position of the body of the other clients.

Activities are centred on making body sounds and the rhythmic elements of body percussion.

• First step: Free physical warm up and body movement (clap hands, click fingers, slap thighs, slap on legs, slap on the back of a college, etc.).
• Second step: Physical warm up maintainig pulse, (claps in rhythm with a beat structure)
• Third step: Physical warm up maintainig pulse with a binary measure structure (8 tempos): body percussion excersices

Breathing exercises to prepare singing and to concentrate the clients on themselves (body-mind-spirit). Breathing can be combined with voice expression.

IMPROVISATION WITH VOICE

The voice is one of our most personal and direct means of spontaneous communication of expression and relationship. The voice is also a powerful source of connection to oneself. Singing is one effective way to help clients’ access and express feelings while also providing them with an experience that is creative and often pleasurable. According to Austin (1999), the simplicity of the music and the hypnotic repetition of sounds/ostinato, combined with the rocking rhythmic motion and the singing of single syllables (sounds, onomatopoeias, baby talk), can have a profound effect on the client.
Activities are centred on singing simple ostinatos that provides clients with a very safe, containing structure for vocal expression; vocal freedom and improvisation. The aim is to create a consistent and stable musical environment to facilitate spontaneity and emotional connection to self and others through the use of vocal improvisation.

• First step: unisono singing of a SIMPLE OSTINATO in binary measure with babbling sounds or onomatopoeias. Integrate balance movement (binary rhythmic movement) to reinforce the sense of group and the belonging to the group.

• Second step: unisono singing of a simple ostinato adding the family name: SINGING MY NAME accompanied by group music beating. Within the ostinato structure, in a symbolic level, the client feels safe and support. Singing the own name improves the sense of identity in a group situation of accept and supporting.

• Third step: SINGING MY NAME BEATING A DRUM (TAMBOURINE). To improve and to increase the sense of identity.

improvisation with percussion instruments

• First step: Play Orff-instruments freely, exploring sound and timbre.

• Second step: Begin to maintain the beat pulse, in order to feel a musical structure

• Third step: Play in turns round the circle: Plays instrument for others. to listen to the others and to wait for one's own turn (without meter structure). Then plays in turn in mantainig pulse with a binary measure structure (8 tempos). The music therapist supports the improvisation singing with babbly sounds, in order to organize the client improvisation, and promote feelings of safety.

• Fourth step: Instrumental improvisation with a rhythmic structure (ostinato) can be done solo, in duet or in group.

• Fifth step: Play freely in group ensembles, conducting by the music therapist. Instrumental improvisation with a rhythmic structure (ostinato) in two or three group ensembles.
The beat pulse is the background musical structure that links the members among them, and with the music therapist, and promotes the belonging to the group. Represents "the life of the group".

**SINGING A STRUCTURED SONG**

This is the end part of the session. Each client sings a solo song with lyrics in front of the group, with or without percussion accompaniment. When the group participates in a group singing activity, it begins to build its own repertoire of songs as a means of expressing and shaping a new collective identity, enhancing the sense of belonging and community. Singing together is intensified when eye contact is made.

**Assessment and Evaluation of Clients**

Video analysis and clinical notes taken after the sessions are the tools used to assess and evaluate clients as an on-going part of the treatment process. The information allows the music therapist to complete the Individual Descriptive Model of Assessment and Evaluation, as an on-going part of the treatment process. There are not specific assessment sessions. The main Areas of Evaluation are:

- **Quality of Participation on Music Therapy Activities**: listen to others, plays as a group member; plays at appropriate times, makes music with others; eye contact; expresses feelings through music improvisation; development of rhythmic and melodic interaction.

- **Use of Voice**: flexibility and creativity using voice; body movement and vocal sounds to express a particular mood or emotion; participation in a group singing; development of rhythmic and melodic interaction.

- **Use of Percussion Instruments**: maintains the tempo and ostinato pattern; integrate locomotor movement to music when playing as a
reinforcement of music expression; moves in rhythm to music; plays with appropriate dynamics to express a particular mood or emotion; client's instrumental facility; flexibility and creativity with instruments.

- EXPRESSION OF MUSICAL IDENTITY IN MUSIC PERFORMANCE (sounds, gestures, movement, body sounds, environmental sounds, family sounds...)

CONCLUSIONS

The impetus of this study came from my own experience as music therapist and university teacher of music therapy. My position at the University allows me to support and promote the development of music therapy clinical practice in different settings, opening minds, showing results, and the relevance of the application of music therapy.

The major question to be answered when formulating this research project was not, "does music therapy work in the field of psychiatry?", nor either, "what are the benefits or outcomes of music therapy for schizophrenic clients?". The most important question for me was opening a door to a new therapeutic approach. When no music therapy tradition exists it is possible to encourage practitioners to take part, showing them the benefits of music therapy clinical practice.

This study provided significant findings in two areas: clients and institution. From CLIENTS PERSPECTIVE, general results showed significant improvement in their musical interaction, participation and expression through musical activities. Gradually, they began to listen to the others, to played as a group member, to feel safe and secure in order to express himself/herself musically, to maintain eye-contact playing music, and to improve the sense of identity through music experiences.
They accepted the limits of the setting, participated in music therapy sessions without smoking during one hour!

From an INSTITUTIONAL PERSPECTIVE, the Suitability for Music Therapy in Psychiatry was demonstrated through working with clients, and the outcomes reached. Suggestions as how to organise a Music Therapy Department within the Area of Psychiatry of the Servicio Andaluz de Salud in collaboration with the University Hospital of the University of Cádiz were made. Therefore, the necessity of training for implementing music therapy service emerged. Its necessary to educate therapists, nurseries, and doctors in the fundamentals of music therapist in order to developed the profession within the National Health-Care System. In academic year 2000-2001, the first Music Therapy Training Course was organised at the university of Cadiz in collaboration with the Area of Psychiatry of the Faculty of Medicine. Three nurseries from the Mental Health Area of the Servicio Andaluz de Salud participated on it, and at this moment we are discussing terms to include Music Therapy as a treatment modality.

The development of music therapy around the world has been linked with a number of factors unique to each country. At the beginnings of the XXI Century, music therapy is still an unknown discipline in Spain. A door was open in Cadiz for the development of the profession and the discipline of music therapy linking practice, research and teaching. We can and must continue to promote clinical applications of music therapy in different areas and levels of practice, as the process of music therapy still needs to be understood.
References


Address

Patricia L. Sabbatella
Universidad de Cádiz - Facultad de Ciencias de la Educación
Av. República Saharaui s/n. Apartado 34
11519 - Puerto Real - Cádiz - España
Tel: + 34-956-016225 - Fax: + 34-956-016253
email: patricia.sabbatella@uca.es
Subjective Tempos In Music Therapy For Persons With Senile Dementia

Saji̊¹, Nobuko; Sugai², Kuniaki; Ueno², Takashi & Saji³, Ryoya
1) School of Nursing, Miyagi University, 1 Gakuen, Taiwa-cho, Kurokawa-gun, Miyagi, 981-3298 Japan
2) Tohoku University Graduate School of Education, Tohoku University, 980-8576 Japan
3) International Cooperation Center for Engineering Education Development, Toyohashi University of Technology, 441-8580 Japan

Keywords

evaluation, senile dementia, subjective tempo, Electroencephalogram, power spectrum

Abstract

In this paper, we consider spontaneous drum beating and hand clapping of elderly persons with senile dementia to be a form of self-expression. Therefore, when they spontaneously play the drums or clap their hands with a Japanese working song, ‘Saitaro-bushi’, it signifies that interpersonal communication has been formed between the clients and the therapist. From 1988 to 2001, we continuously examined subjective tempos, which were first described by Perilli in 1993, and recorded EEGs of 20 clients with senile dementia (mean age 81.95±6.64 years, mean M.M.S. 9.99±7.75) who were participants in our music therapy sessions and subjects in annual EEG testing. We recorded their EEGs in the following 5 conditions: In a relaxation mode when no music and white noise were played for 5 minutes. In listening to a familiar working song in our area, ‘Saitaro-bushi’ at their respective subjective tempo for 90-116 seconds. In listening to the same song played with a non-subjective (faster) tempo than their subjective tempos for 80 seconds. After listening to ‘Saitaro-bushi’ at their subjective tempos for 3 minutes. After they listened to ‘Saitaro-bushi’ at a non-subjective tempo for 3 minutes. Music was played to subjects in a random order. The first 30 seconds of the EEGs were analyzed by a high cut filter at 60 Hz along with the ratio of relative power spectrum (RRPS). The EEG channels were analyzed by bipolar derivation with linked amplifiers.
The results showed that, firstly, a moderate and slight subjective tempo of the metronome a quarter note equals (M.M. \(\downarrow\) =) approximately 80 was the borderline for distinguishing between severe and non-severe senile dementia. Secondly, significant differences at the frontal, parietal and occipital channels (C3, P3, C4, F4, P4, O2) were confirmed by the two-factor ANOVA for the RRPS of the 2001 EEG tests.

We conclude that the subjective tempo is the key to opening the hearts of clients, particularly those suffering from severe senile dementia. It is suggested that EEGs at the frontal, parietal and occipital channels are useful in evaluating the efficacy of music therapy practice for persons with senile dementia.

**Introduction**

This study aims to evaluate the efficacy of music therapy for people with senile dementia as it relates to the severity of their dementia, subjective tempos and EEG analysis.

We have completed a study of the efficacy of music therapy for people with senile dementia. In a previous paper we described the continuous examination of the subjective tempos of six clients who participated in our video sessions and annual EEG testing from 1998 to 2001. These 6 clients consisted of 2 men and 4 women. In that paper we reported that the development of subjective tempos observed during our clinical sessions and the results of EEG analysis (Saji, Ueno and Saji, 2002 in contribution to JMTA).

In the present study we further examined the subjective tempos of 20 clients during 2001 video sessions and investigated the relationship between subjective tempos and degree of senility in 2001. In this study we adopted two approaches. One was a clinical approach to clients’ response to music therapy. For this we carefully watched their facial expressions and overt behavior during sessions. The other was a
physiological approach to clients’ responses to music, based on an EEG analysis. Our reason for selecting the EEG analysis was because we found that EEGs most effectively and objectively show clients’ responses to music, particularly those suffering from senile dementia.

In clinical practice, a therapist communicates by means of suitable music to develop open channels of communication with clients. *Subjective tempos* were first described by Perilli, G.G. in her 1993 PhD thesis. When we first began working at an elderly home in Japan, we were impressed with the relaxed expressions and movements exhibited by elderly people when they heard familiar music. Next, they began to respond to the music, or moved their mouths. Some clients tapped their hands in time to the music; some clients nodded slowly or began to fall asleep. Some, however, had an opposite reaction and did not remain calm, and were frustrated when the music was not played at their *subjective tempo*. Some clients do not seem to hear the music, even when the same music is played for them. It was considered that in such cases each person’s memory of the music was a little different from the tempo of the given music. Therefore, we observed that *subjective tempos* are the key to opening the hearts of clients, particularly those persons suffering from senile dementia.

In this study we refer to *subjective tempo* as the tempo at which clients smile and play the drums, clap and sing during sessions. These actions signify that interpersonal communication has been formed between clients and the therapist using music.
Methods

1. Selection of music
Familiar and unfamiliar music were selected based on clients' responses during sessions for the three years of our study. We selected a Japanese working song, ‘Saitaro-bushi’, for the present EEG test. This song is sung in delight together by fishermen in Miyagi, when they have drawn their nets ashore and found a large catch. All clients can join in this song with their voices or drums, claps or nods.

2. Tempos
Subjective tempos and non-subjective tempos were set up in the following: Subjective tempos were recorded during individual and group sessions between 1998 and 2001. The non-subjective tempo was set, as the metronome a quarter note equals (M.M. \(\frac{4}{4}\) =) 104, a faster tempo than the CD version (M.M. \(\frac{4}{4}\) = 88) for healthy people.

3. Subjects
The subjects were a total of 20 elderly people participating in our group and individual sessions, and in our annual EEG testing. Among the 20 subjects, 10 each were classified in the severe dementia and non-severe (moderate and slight) dementia group. The mean age was 81.95 ±6.64 and the mean A.D.L. was 74.25±19.42. We classified clients with less than Mini Mental State (M.M.S.) 8 into the severe dementia group and those with M.M.S.: 11 to M.M.S.: 23 into the non-severe dementia
group. Table 1 shows the attributes of the subjects in each group (mean ± standard deviation)

<table>
<thead>
<tr>
<th></th>
<th>Senile dementia</th>
<th>number</th>
<th>Age</th>
<th>M.M.S.</th>
<th>A.D.L.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe group</td>
<td>10</td>
<td>82.9±6.8</td>
<td>3.07±2.7</td>
<td>64.5±21.8</td>
<td></td>
</tr>
<tr>
<td>Non-severe group</td>
<td>10</td>
<td>81.0±6.7</td>
<td>16.9±4.8</td>
<td>84.0±10.5</td>
<td></td>
</tr>
</tbody>
</table>

4. Recording the EEGs

4.1. In accordance with the international 10-20 system, subjects’ EEGs were recorded from 19 regular positions on the scale using an EEG (EEG-4500 made by Nihon-Kohden).

4.2. Individual sessions were conducted while 21 electrodes placed on subjects’ scalps.

4.3. The EEGs were recorded with subjects in a relaxed position on their backs with their eyes closed.

4.4. We recorded subjects’ EEGs in the following conditions:

4.4.1. In a relaxation mode when no music and white noise were played for five minutes.

4.4.2. While subjects listened to ‘Saitaro-bushi’ at the subjective tempo for 90-116 seconds.

4.4.3. While subjects listened to ‘Saitaro-bushi’ at the non-subjective tempo for approximately 80 seconds.

4.4.4. After subjects listened to ‘Saitaro-bushi’ at their subjective tempo for 3 minutes.
4.4.5. After subjects listened to ‘Saitaro-bushi’ at non-subjective tempo for 3 minutes.

4.5. The music (4.4.2-5) was given to subjects in a random order.

5. Recording breathing rates
5.1. An elastic band for measuring subjects’ breathing rates was wrapped around their chests before the EEG test.

5.2. Subjects’ breathing rates were added to the recording of their EEGs.

6. Analysis of the EEGs
6.1. 30 seconds of the EEGs were analyzed by a high cut filter of 60 Hz along with the rate of relative power spectrum (RRPW).

6.2. The EEGs channels were analyzed by bipolar derivation with linked amplifiers.

6.3. The EEGs were divided into frequency ranges of theta, alpha and beta to 2 detailed divisions as follows. The distribution of theta bands was subdivided into two sections, theta 1 band: 4-6 Hz and the theta 2 band: 6-8 Hz, in order to survey the difference between persons with severe senile dementia and those with moderate and slight dementia. For the same purpose we subdivided the distribution of alpha bands into two sections, alpha 1 band: 8-10 Hz and alpha 2 band: 10-13 Hz and the distribution of beta bands to two sections, beta 1 band: 13-20 Hz and beta 2 band: 20-60 Hz.

6.4. The Fp1 and Fp2 and temporal channels had noise in our examination. We therefore conducted our analysis using 6 bipolar
derivations excluding those channels with noise (F3-C3, C3- P3, P3-O1, F4-C4, C4-P4, P4-O2).

**Result**

1. People suffering from severe senile dementia were observed having relaxed facial expression and tapping their hands and beginning to sing the song when they heard familiar music at *subjective tempos*. The Japanese elderly people that were our subjects were at first shy in reacting spontaneously to the music, so we could find few *subjective tempos* in 1998. As our sessions proceeded after 1999, however, the clients came to have relaxed expressions and they began to smile and spontaneously play the drums, clap and sing. We recorded their *subjective tempos* for three years and investigated the yearly development in their *subjective tempos* and facial expressions. We confirmed that relaxed communication was often formed between clients and therapist when *subjective tempos* were found during sessions for elderly people with senile dementia.

2. The *subjective tempos* of persons with severe dementia were under M.M. = 69-76 (Figure 74). The *subjective tempos* of those with non-severe dementia were over M.M. = 80-92 (Figure 75).
Figure 74: Subjective tempos of clients with severe dementia (2001)

Subjective tempos of severe dementia

- M.M. =

Subjects

0 20 40 60 80 100

Mean M.M.S.
Mean Tempo
Figure 75 Subjective tempos of clients with non-severe dementia

3. At the frontal and parietal channels there were the significant differences in the RRPS of the 2001 EEG test. In the tables, the channels in which there were significant differences were shown with thick letters, and the area of significant frequency with white backgrounds (Table 48).

Table 48 Significant channels during and after listening to music

<table>
<thead>
<tr>
<th>While clients with severe and non-severe dementia are listening to music</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>F3C3</td>
<td>F4C4</td>
</tr>
<tr>
<td>C3P3</td>
<td>C4P4 (*theta )</td>
</tr>
<tr>
<td>P3O1</td>
<td>P4O2 (*, **theta )</td>
</tr>
</tbody>
</table>
4. There was a clear difference in breathing rates between the severe dementia and non-severe dementia groups, both during listening to and after listening to music. The breathing rates of the severe dementia group increased 3.2 times more when listening to music with non-subjective tempo than when listening to music with a subjective tempo. On the other hand, the breathing rates in the non-severe dementia group increased 2.7 times more when listening to music with a non-subjective tempo than when listening to music with a subjective tempo. However, after listening to the music with a subjective tempo, the breathing rate in both the severe and non-severe groups increased only 0.5 times. The significant difference was P<0.05 (Figure 76).

**Figure 76** Breathing rates on subjective and non-subjective tempo.
While clients are listening to music with subjective and non-subjective tempos.

While and after clients are listening to music with subjective tempos.
Discussion

1. We have observed that only subjective tempos have a useful effect on elderly persons with severe senile dementia. They can play the drums or clap their hands to their subjective tempos, and sometimes they can even “sing” silently. We also recognized from our experiences that clients’ memory is closely related to their backgrounds.

The following case is an example of background. Subject C is a 102 year-old man. He was hard of hearing. He was born and worked in another prefecture near Miyagi and had recently come to the elderly home, so ‘Saitaro-bushi’ was unfamiliar to him. He was glad to repeatedly sing the first words or shout time just among the short interval of the old working song. He seemed to be delighted playing this song from his childhood with his family. Therefore the song’s tempo would be periodically alive in his brain and his body, even though he could not sing out loud. This was the only song he could join in playing.

2. Despite the distinct increase in slow waves, elderly people with severe dementia could maintain subjective tempos for ‘Saitaro-bushi’ at the M.M. = 72 -76 to a greater degree than at the M.M. = 69-72 in the previous year. From this it is considered that continuously practiced music therapy may be effective for participants.

Indeed the figure of peak frequencies in the relaxation mode in the 2001 EEGs illustrated an increase in clients’ slow waves; particularly, the severe dementia group had all peak frequencies in the theta bands. The non-severe group had a peak frequency of 8.34 (alpha 1 band) only on the P3-O1 channels, while the others were in the theta band (Figure 77).
3. While clients were listening to music, the significant differences appeared on C4-P4, P4-O2. After clients listened to music, the significant differences appeared on P4-O2. Figure 78 is a map of the brain where the locations of significant differences are illustrated with black line. It is suggested from this study that the frontal and central channels tend to be a standard in evaluating the efficacy of music therapy practice. It is also considered that subjective tempos help to revitalize the brain function of those suffering from senile dementia.

**Figure 78 Areas of significant differences**
While clients with severe and non-severe dementia are listening to music

After clients with non-severe dementia are listening to music
However, we must continuously investigate the significant differences in subjective tempos and non-subjective tempos, or in listening to music and after listening to music, in evaluating the efficacy of music therapy for people with senile dementia. We know the channels of significant differences are in the theta 1 and theta 2 bands, and these bands are also the relaxation mode EEGs of people suffering from senile dementia (see Figure 4)

4. It is considered from examining breathing rates during and after clients listen to music that subjective tempos are comfortable and in the relaxation modes of the severe and non-severe dementia groups. Non-subjective tempos are not so suitable for people suffering from severe senile dementia, because clients’ breathing rates suddenly increase and decrease during and after listening to non-subjective tempos.

**Conclusion**

1. The subjective tempo is the key to opening the hearts of clients, particularly persons with senile dementia. The Subjective tempo of M.M. = 80 is a checkpoint for their level of dementia.

2. It is suggested that the EEG analysis are useful in evaluating the efficacy of music therapy practice for those with senile dementia.

3. Presenting familiar music with subjective tempos to elderly people suffering from dementia is very effective in vitalizing their cerebral function.
Acknowledgment

We would like particularly to thank our participants and Dr. Jiro Iizawa, a physician in charge of the Kikan Home for elderly people, Miyagi, Japan.

Reference


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Introduction

I shall begin with a confession. In the past few years I have been experiencing a tension in my palliative care work. I still love the depth, intensity, and meaning of the work, but I often feel a resistance to “getting out there” by the bedside, and I feel guilty if I am not “out there” enough, as are the nurses. I am also aware that I find certain patients harder to approach than previously. I identify more strongly – especially with patients who are mothers of young children (feeling compassion and terror - God forbid it would be me!), and with middle-aged grieving daughters (my empathy is laced with the sadness of my own parents’ deaths 7 and 2 years ago). I am more tired and in the past five years I have developed respiratory problems (asthma, pneumonias). I notice that I am drawn to non-clinical projects in my work; teaching, supervising, lecturing, organizing a symposium, and writing about the work, but all these take me away from the patients and then I feel guilty. I know that when I am able to be present with the patients, I have skill, usually do good work, and feel fulfilled. I am respected in the field. But the resistance persists and the questions linger: Have I sung too many sad songs? Have I absorbed too much sadness over the 17 years I’ve been
doing this work? If I look at my own respiratory symptoms as metaphor, what might I need to get off my chest? I decided to take time off to address these questions and regain my health. When the director of our Palliative Care Service encouraged me to find a research project that would give me a break clinically but keep me involved professionally, I took the opportunity to find out how others doing this work experience their stress and how they cope. This study was part of a sabbatical year of independent study. It explores occupational stress in palliative care music therapists, and related implications for education and training.

**Literature Review**

As the palliative care movement grows, there is increasing interest in professional care-givers’ experiences of working with suffering and death. Humanities professor David Barnard (1995) writes about the promise and fear of intimacy in our work. He maintains that while intimate encounters with dying patients create “psychological and spiritual spaces within which change and growth are possible” they also unleash “the fear of our own undoing in confrontation with chaos and disintegration” (p.26). Psychologist Marie de Hennezel (1998) suggests that it is by daring to accept and fully experience this fear, that caregivers make room for authentic, intimate encounters. Peter Speck (1994), a chaplain working with terminally ill people, elaborates on difficult emotions, such as guilt, fear, and anger, which may be aroused in professional caregivers. He further identifies defenses which health care workers may employ to protect themselves from such feelings. Among these are avoidance, task-centered treatment, and “‘chronic niceness’,
where the individual and the organization collude to split off and deny the negative aspects of caring daily for the dying” (p.97). The Oxford Textbook of Palliative Medicine devotes a chapter to addressing the personal and occupational stress of professional caregivers, how it is manifested and what coping mechanisms are employed (Vachon, 1998).

A study of hospice nurses (Dean, 1998), indicates that nurses find the management of intractable symptoms and communication issues to be more stressful than concerns related to death and dying. Several doctors have also written about stress in caring for the terminally ill. In a 1986 article entitled “Dealing With our Losses”, Dr. Balfour Mount identifies stressors and suggests strategies for minimizing them, including that of “finding one’s personal center”... a process which “probably involves concepts such as accepting, simplifying, emptying, and opening rather than striving, attaining, achieving, and overcoming” (p.1134). Physician Janice Mulder (2000) writes about the importance of personal awareness and reflection in working with the terminally ill:

“I realized that I had often left one emotional death encounter and was forced to suppress my feelings as I immediately attended to another patient’s suffering. The emotional cost was great ... I needed to give myself permission to feel and allow myself to work through my feelings” (p.27).

Larson (1993) comes to a similar conclusion when discussing emotional involvement in caring for those with life-threatening illness. “To meet the challenge of caring, you must find balance...between the demands you face and the resources you have, between giving to others and giving to yourself” (p.57).
To date almost no literature exists examining the stress or coping strategies of the music therapist working in palliative care. Nigel Hartley begins to touch on the topic in his articles; “Music therapists’ personal reflections on working with those who are living with HIV/AIDS” (1999), and “On a personal note: a music therapist’s reflections on those who are living with a terminal illness.” (2001). In the latter article, he poses the question “How is a language found to describe a specific type of musical experience encountered within the confines of music therapy?”, and employs words such as attention, accompaniment, longing, transformation and love when describing his music therapy experiences with patients. Mary Rykov (2001) is the first to write openly about specific difficulties music therapists face when working with dying patients, focusing on the importance of self-awareness and self-care.

As music therapy takes its place in palliative care, issues of the music therapist’s process, well-being, and capacity to give good care in the face of continuous suffering become increasingly relevant. The related topic of training music therapists to do palliative care work remains unexplored. Although supervision issues in music therapy are increasingly being identified and put forth (Forinash, 2001), there is no literature examining the specific challenges of developing excellent music therapists in palliative care.

**Methods / Procedures**

A questionnaire was designed to elicit music therapists’ experiences of working with terminally ill patients. It asked about their original expectations and whether or not they had been met, their sources of
stress, manifestations of stress, coping mechanisms, own uses of music, perceptions of their experiences in comparison to other professionals, and their recommendations for training others.

In the spring of 2002, this English-language questionnaire was sent to music therapists who were identified by their professional associations or colleagues as working with terminally ill patients. Participation was voluntary and anonymous.

Information gathered from the questionnaire was subjected to quantitative and qualitative analysis. Specific responses were organized according to general patterns from which categories of data emerged (Patton, 1990). For some questions, separate analyses were made according to how many years, and how many hours per week the music therapists worked with terminally ill patients. It was hoped that a comparison of the responses of more and less experienced practitioners would increase our understanding of stressors and coping mechanisms as they develop over time. This, in turn, could help identify strategies for training and supporting new palliative care music therapists, as well as nourishing more experienced music therapists as they continue working.

The Sample

294 questionnaires were sent to music therapists in the United States (223), Britain (30), Canada (30), and various other countries (11: Japan, Australia, Germany, Norway, and Switzerland). 78 responses were received, a 27% response rate. This sample is relatively small considering the large geographic area it represents, however the actual
numbers reflect that this group is a small sub-field of each music therapy and palliative care. 10 of the music therapists who responded to the questionnaire worked in geriatrics and dealt with end-of-life issues as part of this work. Although the practice of geriatric music therapy is different in many ways to palliative care, their responses were included in this study.

The responses were divided into six sub-groups according to number of years and hours per week the therapists worked with terminally ill patients (Table 49).

Table 49  Time worked

<table>
<thead>
<tr>
<th>TIME WORKED</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 yrs:</td>
<td>41%</td>
<td>1-11 hrs/wk:</td>
</tr>
<tr>
<td>6-10 yrs:</td>
<td>35%</td>
<td>12-23 hrs/wk:</td>
</tr>
<tr>
<td>10+ yrs:</td>
<td>24%</td>
<td>24+ hrs/wk:</td>
</tr>
</tbody>
</table>

**Results**

As most responses came from the US, the questionnaire is not sensitive to regional differences. A comparison of the British and Canadian samples, which are close in size, indicates that differences in practice do exist (Table 2). For example, 13/14 (93%) British respondents had been working with this population for less than 6 years, compared to 4/13 (31%) in Canada. Almost 2/3 of the British respondents worked less than 12 hours per week, compared to 1/3 of the total sample, while almost 1/3 of the Canadian respondents worked between 12-24 hrs per week. When compared with the total sample, music therapy positions seemed to be less established in Britain, and more established in Canada. The fact that
both music therapy and palliative/hospice care are relatively new fields may explain why many music therapy jobs in palliative care tended to be new and part-time. Another regional difference was that $\frac{1}{3}$ of the British music therapists worked with children, compared to 15% of the overall sample.

Table 50

<table>
<thead>
<tr>
<th>COMPARISONS OF TIME WORKED</th>
<th>BRIT n=14</th>
<th>CAN n=13</th>
<th>MEAN n=78</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 yrs</td>
<td>93%</td>
<td>31%</td>
<td>41%</td>
</tr>
<tr>
<td>6-10 yrs</td>
<td>0%</td>
<td>38%</td>
<td>35%</td>
</tr>
<tr>
<td>10+ yrs</td>
<td>7%</td>
<td>31%</td>
<td>24%</td>
</tr>
<tr>
<td>1-11 hrs</td>
<td>64%</td>
<td>15%</td>
<td>49%</td>
</tr>
<tr>
<td>12-23 hrs</td>
<td>7%</td>
<td>46%</td>
<td>22%</td>
</tr>
<tr>
<td>24+ hrs</td>
<td>29%</td>
<td>38%</td>
<td>29%</td>
</tr>
</tbody>
</table>

**Satisfaction**

The following two questions attempted to look at satisfaction level. What had originally attracted people to this work and had their expectations been met? The following themes (in decreasing frequency) emerged:

Q: What originally attracted you to working with this population?

1. **Opportunity arose**: “…job opening, was part of the job, by chance.”

2. **Depth/intimacy/meaning of work**: “potential for sharing moments of profound intimacy”

3. **Power of music**: “a quiet determination that music had a role to play in a dying person’s life and is transcendent”
4. **Previous experience:** “…personal losses, other professional experience, practicum.”

5. **Wanting to help/feel of value:** “felt I could make a positive impact, do some good, make a difference”

6. **Interest in palliative care:** “working where focus is on quality end-of-life care, challenge of new field.”

Q: Have your original expectations about the work been met? How have they changed over time?

The majority who answered this question stated that their original expectations had been met or surpassed, indicating that satisfaction with the work was high. Expectations about the work had changed in the following ways:

1. **More meaningful than expected:** “Walking with” patients and their families at end of their lives is an extraordinary privilege, I learn so much every day. / Patients teach me about the breadth and depth of music all the time.”

2. **More difficult than expected:** “It is more difficult than I expected in the area of personal boundaries. / I expected the work to be emotionally “easier” / …realizing that music does not always help.”

3. **Required changes in ways of working:** “family took more and more place / I had to encompass a more flexible way of working / more short-term / I used to think I needed to “do music” at all times; now I spend more time listening.”
And…“I never thought I’d fall so deeply in love with the kids and their families, that we’d lose so many kids, that I’d be able to work with dying kids. Working in Pediatrics is far more intense than anything - the joys are deeper, the laughs are harder, the grief lasts longer.”

Sources of Stress

Q: The following have been identified as potential sources of stress for palliative care workers. Please circle whether, for you, they are sources of high (H), medium (M), low (L), or no (N) stress, and elaborate on your experience.

This question was followed by 11 identified stressors. In Table 51 these stressors are listed in order from greatest to least often cited source of stress for the total sample. (For this list, ‘high and ‘medium’ sources of stress were collapsed, as indicated by the middle column in red). The question was also analyzed according to the 6 sub-groups of music therapists who worked varying numbers of years and hours per week.

Table 51 Stressors

<table>
<thead>
<tr>
<th>STRESSORS</th>
<th>%H</th>
<th>%M</th>
<th>%H+M</th>
<th>%L</th>
<th>%N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Exposure to grief/death</td>
<td>27</td>
<td>47</td>
<td>74</td>
<td>23</td>
<td>2</td>
</tr>
<tr>
<td>2. Workload</td>
<td>26</td>
<td>42</td>
<td>68</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>3. Lack of patient stability</td>
<td>13</td>
<td>38</td>
<td>51</td>
<td>34</td>
<td>16</td>
</tr>
<tr>
<td>4. Team issues</td>
<td>16</td>
<td>30</td>
<td>46</td>
<td>36</td>
<td>18</td>
</tr>
<tr>
<td>5. Physical resources</td>
<td>19</td>
<td>23</td>
<td>42</td>
<td>28</td>
<td>31</td>
</tr>
<tr>
<td>6. Status</td>
<td>11</td>
<td>29</td>
<td>40</td>
<td>28</td>
<td>32</td>
</tr>
<tr>
<td>7. Performance anxiety</td>
<td>9</td>
<td>25</td>
<td>34</td>
<td>42</td>
<td>24</td>
</tr>
<tr>
<td>8. Over-identification</td>
<td>5</td>
<td>27</td>
<td>32</td>
<td>46</td>
<td>22</td>
</tr>
<tr>
<td>9. Role ambiguity</td>
<td>8</td>
<td>22</td>
<td>30</td>
<td>40</td>
<td>30</td>
</tr>
</tbody>
</table>
Table 51  Stressors

<table>
<thead>
<tr>
<th>10. Pt/family refusing music therapy</th>
<th>4</th>
<th>21</th>
<th>25</th>
<th>35</th>
<th>40</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Communication with pt/family</td>
<td>0</td>
<td>17</td>
<td>17</td>
<td>53</td>
<td>30</td>
</tr>
</tbody>
</table>

Others: financial, emotional, professional/clinical

1. Continuous exposure to grief and death

Almost half (47%) of all respondents rated this as a ‘medium’ (M) source of stress, within a range of 41% (those working less than 6 years) to 53% (those working over 10 years). Identification of ‘continuous exposure to grief and death’ as a stressor increased with both the number of years and hours per week of working with the population.

Nearly half (48%) of those who worked 24 hrs/wk and more, rated it as a ‘high’ (H) source of stress.

Comments: “Especially when multiple deaths occur in a very short period of time…”

“But with supervision and counseling, this is also the most compelling aspect of the work.”

“I have to deal with my own emotions of grief and loss. It does build up”

“I find I can cope with this at work, but my reserves in my home life are lower so I sometimes cope less well with personal distress.”

2. Amount of workload (too much or too little)

2/3 of all respondents fell into the collapsed H+M range, with 42% rating workload as a ‘medium’ source of stress. Of those who specified the workload stress, most (60%) stated that their workload was “too much”, some (26%) “variable”, and least (14%) “too little”.
Comments: “Too much to do; I can’t keep up.”

“Fluctuation between too much and too little work, you can’t be prepared!”

“Both are stressful; too little leads to anxiety about future employment.”

“6 hours per week is not enough to meet the needs of potential clients and to integrate into the team easily.”

3. Lack of stability or continuity in patient population
Identification of ‘lack of stability’ as a stressor was fairly evenly divided (50/50) between H+M and L+N throughout all groups with 72% falling into the middle ‘medium’ plus ‘low’ (M+L) categories.

Comments: “I never know who will be there in the morning – no plans possible.”

“This is very difficult at times, the constant ‘ebb and flow’ and facing the ‘unexpected’ – however the challenges on constant change drive the work.”

I’ve kind of gotten used to it now, and usually enjoy the challenge. One session can be just as powerful as 20!”

“I do not expect continuity.”

4. Team issues (e.g.: communication, instability, lack of support)
2/3 of the total sample fell into the collapsed middle M+L category when rating stress from team issues. All subgroups followed a similar pattern, with the greatest rating (1/3-1/2) falling into the ‘low’ category. While many therapists enjoyed excellent team support, several part-timers
stated that communication with the team was a problem. This stressor seems to vary according to particular settings.

Comments: “I’m currently working with a great team. / Incredible support!”

“Communication difficulties in being part-time on two sites. / It was not deemed workable to attend team meetings due to my treating patients on different teams.”

“Initially some ambivalence from staff, but now better.”

“Sometimes there are difficulties with staff/volunteers not understanding my work.” “When the team changes, it can be stressful to start training them about music therapy all over.”

5. Inadequate physical resources (e.g.: lack of space, equipment, instruments, etc.)

Physical resources seemed to vary according to setting from “not a problem” to “this is what annoys me most!” with 42% rating this as a H+M source of stress and 59% rating it as L+N. Part-timers frequently reported space problems.

Comments: **Space:** “The room I use is multipurpose, also problematic is instrument storage.”

“My office is a storage room. / No desk to use. / I have no designated space.”

“A lack of privacy at times. / Room not soundproofed.”

**Instruments:** “Always carrying things around. / Limited budget. / I’m completely dependent on what I bring each time.”
“My hospice provided me with a large space and instruments.”

6. Your status in the setting
When rating status as a stressor, 60% of the sample fell into the L+N range, and 40% into H+M. Status seemed to vary according to settings and individuals, but was also less of a source of stress as the number of years working increased. (40% of those working 0-5 years rate their status as a source of ‘medium’ stress, while 42% of those working over 10 years rate it as a ‘low’ stressor.)

Comments: “I am very well accepted by staff, but on a very insecure financial footing.”

“I feel valued by most of the staff. / I am well-respected in my work.”

“The longer I’m in the setting, the more the nurses realize the importance of music therapy. / Most stress with lack of communication from doctors.”

“I constantly struggle to educate and inform about music therapy.”

“I have very low status, but having been there 14 years I do have a place and a voice.”

7. Performance anxiety
Music therapists are continually called upon to play a wide range of music. 2/3 of the total sample found performance anxiety to be a source of ‘low’ or ‘no’ stress. π rated it as a ‘medium’ source of stress. Performance anxiety was more stressful for those working less than 6 years in the job and decreased with time.
Comments: “I do worry about if I’m ‘good enough’, but don’t we all?”

“Especially if clients are musicians/ if staff are listening/ with skeptical clients and family members/ being almost continually ‘exposed’ where others can hear”

“Sometimes, when you don’t know very well the piece asked.”

“I am so aware how precious the time of life is, that I find I can worry whether I am giving them a good enough experience.”

“I remember that I’m NOT PERFORMING, I’m CONNECTING WITH A PERSON.”

“It gets easier with time.”

8. Over-identification with patients and/or family members

This question was problematic because: a) it is not clear that people are always aware of identifying with patients and, b) the term “over-identification” may have been understood differently by different individuals, or perceived as judgmental. Nonetheless, over 2/3 respondents (68%) did not consider this very stressful (L + N), while approx. 1/3 (32%) rated it as a source of M (27%) or H (5%) stress. There were no striking differences noted between sub-groups.

Comments: “Sometimes I identify more with patients of my own age who have children.”

“As I get clearer on my own boundaries, this becomes a non-issue.”

“This hasn’t happened often, but when it has, it’s been very stressful.”

“I do over-identify sometimes, but it feels loving rather than stressful.”
“Can get difficult, especially when my church or co-worker’ families are involved.”

9. Role ambiguity
70% of the sample fell into the L+N range when rating role ambiguity as source of stress. Predictably, role ambiguity was least stressful for those who had worked with the population longest.

Comments: “Most people understand that music therapist doesn’t mean entertainer. / Educating new families plays a large role here. / Many assume I’m a volunteer.”

“Therapist? Support person? Entertainer? Researcher? Member of which team?”

“I have taken pains to make my role clear/ provided in-services and literature.”

“I’ll do anything…we fill in the blanks.”

10. Patients / families refusing your services
This was rated as low or no (L+N) stress for Ω of all respondents. It was least stressful for those who had worked more than 10 years. (89% rated it as L+N) and those who worked 24+ hours per week (86% rated it as L+N).

Comments: “Patients and families have few things to say ‘no’ to. I hope they feel they can.”

“Sometimes this is a relief because it reduces my workload”

“This does not happen often. / My services are requested.”
11. Communication difficulties with patients and/or families

Over $\frac{1}{2}$ (53%) of the sample rated this as a ‘low’ stressor. This increased to 83% when ‘low’ and ‘no’ were combined (L+N). Patterns of response were similar in all sub-groups, and nobody rated communication with patients and/or families as a ‘high’ source of stress! Several mentioned language barriers as a communication difficulty. This stressor came from the medical literature and seems to be more relevant to doctors who must discuss diagnosis, prognosis, and treatment options, than to music therapists.

Comments: “It would be lovely to speak 50 languages!”

“When I experience difficulty, I am not the only one on the team who does.”

“Working with families can sometimes be challenging as there may be guilt or denial of the patient’s condition.”

“Music always seems to bridge potential communication difficulties.”

Manifestations of Stress

Sixteen examples of how stress might be manifested in those working with the terminally ill were cited followed by the question, “How do you experience your stress?” The five most frequently cited manifestations of stress are discussed here.

Table 52 Manifestations Of Stress

<table>
<thead>
<tr>
<th>MANIFESTATIONS OF STRESS</th>
<th>Mean</th>
<th>0-5yrs.</th>
<th>6-10 yrs</th>
<th>10+ yrs</th>
</tr>
</thead>
</table>

1543
Fatigue was the most frequently identified manifestation of stress in the whole sample, and was more prevalent in both those working less than 6 years and more than 10 years. In these two sub-groups, ‘inadequacy’ was the next most frequently cited manifestation of stress, with over ⅔ of the most experienced therapists reporting feelings of inadequacy. Approximately 1/3 of those in the same two sub-groups also reported feeling sadness (compared to 21% of the 6-10 years group). Minor physical ailments increased with the number of years worked with 44% of the most experienced therapists reporting physical symptoms. 44% of this group also reported ‘avoiding patients’.

On 4 out of 5 of these most frequently cited manifestations of stress, the middle group rated lowest. On all 5, the most experienced group rated highest. It is possible that stress is high in the initial years of working in this field, followed by a period of greater mastery, comfort and confidence. After 10 years of work, however, recurrent and cumulative exposure to death and dying may take its toll, leading therapists to feel fatigue and an existential helplessness (inadequacy).

Comments: 1. Fatigue
   “…emotional fatigue, sleeplessness…”

2. Inadequacy
“I feel I can never do enough on some days.”

3. Sadness

“I often grieve in the car, traveling between homes.”
“Deep sadness, depression, uncontrollable tears at times.”
“Collective sadness; emotions build and then something triggers the accumulated grief.”

4. Becoming physically ill

“…sinus or upper respiratory infections, sore throat/unable to sing, pneumonia, colds or flu’s, tension, headache, tight muscles in neck and back, gastro-intestinal/stomach problems, ulcer…”

Coping Strategies

Eight coping strategies were listed, followed by the question: How do you deal with the difficulties and what is most helpful? These coping strategies are listed in Table 4 below in decreasing order of mean usage. Most dramatic is the rate at which spiritual or religious practice/beliefs increased over time, with nearly 3/4 of the most experienced group citing spirituality as helpful.

Table 53 Coping Strategies

<table>
<thead>
<tr>
<th>COPING STRATEGIES</th>
<th>Mean</th>
<th>0-5 yrs</th>
<th>6-10 yrs</th>
<th>10+ yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creative expression</td>
<td>49%</td>
<td>28%</td>
<td>50%</td>
<td>33%</td>
</tr>
<tr>
<td>Spiritual/religious practice</td>
<td>47%</td>
<td>34%</td>
<td>46%</td>
<td>72%</td>
</tr>
<tr>
<td>Exercise</td>
<td>44%</td>
<td>34%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Team/colleague support</td>
<td>38%</td>
<td>38%</td>
<td>43%</td>
<td>33%</td>
</tr>
<tr>
<td>Socializing</td>
<td>29%</td>
<td>22%</td>
<td>32%</td>
<td>39%</td>
</tr>
<tr>
<td>Personal philosophy</td>
<td>26%</td>
<td>22%</td>
<td>25%</td>
<td>33%</td>
</tr>
<tr>
<td>Time off</td>
<td>19%</td>
<td>19%</td>
<td>25%</td>
<td>11%</td>
</tr>
<tr>
<td>Psychotherapy/counseling</td>
<td>14%</td>
<td>6%</td>
<td>14%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Others: family, supervision, memorials
Many other coping strategies were mentioned (from gardening to thrift shopping), however the two most frequently mentioned were family and supervision. The use of supervision decreased with years of experience. Several music therapists also found it helpful to keep a record of patients’ songs or attend memorials.

The means of creative expression most cited was making music. Spiritual or religious practices included involvement in various organized religions or practices, personal faith, prayer and meditation. The three forms of exercise most mentioned were walking, yoga and swimming.

**Use of Music for Self**

**Q: Do you use music for your own self-expression or pleasure? If so, how? If not, why do you think you don’t?**

84% of the sample reported that they do use music for self-expression or pleasure. They play music (73%), listen (27%), sing (22%), compose/write songs (16%), and dance (8%).

Only 16% claimed they don’t use music, use it only occasionally or less than previously. The reasons given were: difficult associations with patients (“My music was so related to my clinical work, it was difficult to use for myself”), time constraints, wanting silence (“…the last thing I wanted was more sound”), and feeling musically fulfilled at work.

**Self-Perception**

**Q: Do you think that music therapists experience working with death and dying differently than other health care professionals? If so, how?**
70% answered “yes” to this question, 18% answered “no” (“this is an individual process, not occupational.”) and 12% of the responses were inconclusive (“yes and no” or “unsure”). Those who felt the music therapist’s experience was different cited the following as the main differences:

1. More emotional/intimate:

“The therapy sessions are often intense, so strong feelings may be evoked, which other professionals may remain more distanced from.”

“Music accesses the core of feelings of people’s experiences; we can easily be flooded with many intense feelings.”

2. Spiritual aspects of the work:

“I think we can relate to a place in a dying person that is still quite intact and whole.”

“I worked with death and dying as a nurse. Music therapy offers the opportunity for something difficult to articulate; profound, deep and full of grace and beauty; the access is more direct, more immediate. Spiritual awareness seems to be more intense at this time and I have come to believe music therapy is primarily spiritual work.”

3. Special means of communication/ nonverbal, creative:

“We are fortunate since we can often tap into the healthy part of patients, hear and respond to their voices; nurses and doctors often get the tough end of the job.”
“It may be easier for music therapists as we are working through the experiences with the patients using a pleasurable medium.”

4. Other health care professionals are treating symptoms:

“Music therapists don’t become involved with the unpleasant, degrading symptoms of dying.

5. Feeling a lack of something in comparison to other health care professionals:

“I was taken to a patient who was actually dead and I didn’t know it, I even said; ‘Excuse me you’re asleep, I’ll come back another time.’ That was stressful.”

**Training Issues**

The following 4 questions were designed to look at training issues. What do music therapists need to do this work and are we training them adequately?

Q: What has been most helpful in preparing you for this work?

Six themes emerged in response to this question. They were:

1. **Life experience/personal losses:** This was the most frequently identified factor. 41% of respondents reported that life experience or personal losses had been most helpful in preparing them for this work.

2. **Musical training/skills:** 19% identified musical skills in response to this question. They mentioned improvisation, practicing, and knowledge of various genres of music.

3. **Personal beliefs/spirituality/faith:** 17% mentioned this.
4. **Music therapy coursework:** Only 14% mentioned their music therapy training, and where they did, most specified practical training; field work, internships, and supervision.

5. **Attending special training:** 9% mentioned learning situations outside of their music therapy programs, e.g.: visiting hospices and assisting the music therapist, attending conferences or workshops on grief or death and dying, and belonging to a palliative care interest group.

6. **Was unprepared/nothing could have prepared me:** Another 9% stated they were unprepared. “There really isn’t any way to prepare for work like this, I never thought I could do this work but am amazed at how much I love it.”

Q: Did your music therapy training address working with the terminally ill? If so, how?

Of those who responded, 43% answered “no”, 40% “a little” and 17% “yes”. This suggests that music therapy training programs are not adequately preparing students for working with terminally ill patients. The question arises whether or not this population should be considered a specialty area requiring additional training outside of regular music therapy training programs.

Q: Do you feel that music therapists need any special skills or training to work with terminally ill patients? If so, what are these?
All 75 people who responded to this question felt that special skills or training were needed. The following 5 areas were identified and elaborated upon as follows:

1. **Counseling skills (43%)**

Bereavement process/stages of grief, verbal processing, communication and listening skills, understanding short-term process, family and group dynamics

2. **Knowledge of death and dying/palliative care (41%)**

General medical and nursing information, physical and emotional changes of dying, knowledge of the literature/research, hospice philosophy and history, sensitivity to the role of spirituality and religious/spiritual practices across cultures, working in a team, how music therapy can be effective in death and dying, and how to deal with one’s own feelings.

3. **Musicianship and music therapy skills (33%)**

**Musicianship:** Excellent vocal and instrumental skills for the ‘best quality of music’, musical flexibility and sensitivity, a wide repertoire, skills in transposition, improvisation, song-writing, ritual drumming, classical baroque music.

**Music therapy:** The ability to shift from activity-oriented music therapy to a depth/process-oriented approach, knowledge of music-assisted relaxation techniques, Guided Imagery in Music or other uses of music and imagery, techniques for pain reduction through music, the ability to assess what is needed emotionally and musically in the moment, the
ability to communicate through music, observation skills to find meaning in the non-verbal.

4. Self-awareness (17%)

A thorough examination of one’s own losses and experiences of death/endings, an awareness of one’s feelings, philosophies and needs and how they are separate from those of clients, understanding what motivates us, a willingness to feel pain and loss, personal therapy, a total commitment to inner growth and learning, trust of one’s instincts, ability to set boundaries, acknowledgement of the importance of self-care.

5. Experience/exposure to the population (15%)

Practicum or internship supervised by a music therapist in the milieu, individual and group supervision, access to others doing the same work.

6. Personal attributes

Many respondents identified personal attributes in response to the above question. Although difficult to ‘teach’, these may be helpful when screening potential music therapists for this field and are therefore listed below:

**Flexibility/adaptability:** ability to work in the moment.

**Resilience/support:** ability to cope with death and grief and to keep going, stay centered, should be emotionally well-grounded, have personal resources and a strong support system, active interests outside work, able to care for self.

**Compassion:** empathy, sensitivity around grief and loss issues.
**Spirituality:** the ability to think about existential issues, a spiritual practice, identification of own spirituality or lack thereof.

**Openness:** acceptance, ‘to really open yourself up to being present for the patients and being open and true to yourself’.

**Comfort in being around dying people:** acceptance of own mortality.

**Others:** creativity, patience, maturity, the ability to simply ‘be’, a sense of humor.

Q: What, in your opinion, would be the best way to train/prepare music therapists to work with this population?

Responses to this question were consistent with the skills and training needs identified above. The following themes emerged:

1. **Clinical experience** (61%)

   Including: practicum with music therapists working in palliative care, internships, observation of related professionals, and volunteering in hospices.

2. **Coursework** (48%)

   The skills/needs listed in #1, 2, and 3 of the above question were reiterated here.

3. **Personal learning** (23%)
Elements of ‘self-awareness’ listed in #4 above were reiterated here. Counseling, self-care strategies and reflective writing were some of the methods suggested.

4. Workshops, seminars (14%)

Intensive short courses related to death and dying or music therapy in palliative care.

5. Supervision (13%)

A mentoring system or peer supervision with music therapists working in palliative care.

6. Selection (11%)

Eight people mentioned that this work should be done by mature students, stable individuals, experienced music therapists, or those drawn to field.

“This work does not compensate for “personal voids” or should not serve as the main focus of one’s life. / Screen for religious agendas.”

7. Post-graduate training (6%)

Only four individuals specified a need for advanced training; “A course, offering specific training for this work and a placement with supervision, should be available for qualified music therapists”. Others suggested Master’s level, or “process-oriented” music therapy training, and more internships.
Discussion and recommendations

This research gives us a detailed snapshot of music therapists working with terminally ill patients in the spring of 2002. Although individual work situations, skills, and coping styles played a large role in how music therapists experienced their work, certain themes and trends were identified.

Many of the respondents spoke of the work being both rewarding, meaningful, and a privilege, and challenging, painful, and difficult. These seemed to go hand in hand as reflected in the following comments: “To bear witness to suffering is intense but also profound and meaningful. My work in a children’s hospice is the most rewarding, exhausting, exciting, challenging and emotionally-draining, and yet tremendously uplifting work. This is the best and the most difficult job!” The challenge for music therapists, and indeed other health care workers in the milieu, may be, as suggested in the literature, to acknowledge and authentically live that tension between the two sides of our experience; the pain and the wonder.

On the whole, most music therapists did not receive much training from their educational programs to work with this population. They all felt that special skills and training were needed in various domains, but there was no clear consensus on how this training might occur. A variety of options, including increased attention to this population in the training programs, seminars and workshops at conferences, more practicum and internships, and perhaps advanced training, might best meet divergent needs within various countries. Although not solicited, several remarks
emerged pertaining to the selection of music therapists for this work. It was felt that these should be mature, flexible, open-minded and emotionally stable people.

Almost 1/2 the total sample worked with terminally ill patients less than 12 hours per week, and many of these therapists experienced stress associated with working part-time; communicating with other members of the treatment team, having the required space and instruments, and being able to effectively meet the needs of the population within a short period of time. On the other hand, those working more than 24 hours per week felt the greatest stress from exposure to grief and death.

Music therapists who worked with the population for less than six years used collegial support and supervision for support more than other groups. There is some indication that doing this work does take its toll over time, as those working more than 10 years in the field seemed to manifest the greatest stress, most characterized by fatigue, feelings of inadequacy, illness and avoiding patients and families. Almost 3/4 of these therapists also identified spirituality as playing an important role in helping them cope, which suggests that this work may promote spiritual development over time. These therapists may benefit from periodic small-group retreats emphasizing physical, emotional and spiritual renewal. Palliative care music therapists should consider forming small working groups for mutual support and ongoing training.

Many music therapists noted the special role that music played in bringing them into a more emotional, intimate and spiritual relationship
with patients. The quality and breadth of music they used was important to them, as was music in their personal lives.

Finally, several music therapists mentioned difficulties around job security and funding. It seems that hospice/palliative care is a new and growing area of music therapy practice, subject to the growing pains of a new discipline. Yet overall, satisfaction was high and the music therapists doing this work seemed to value it tremendously. Hopefully music therapy will continue to become more established and valued in end-of-life care, and funding difficulties will increasingly be resolved.

Limitations of the study and future directions
This study was conducted as an independent project by a seasoned clinician with little research experience. Several limitations exist. The sample of 78 music therapists may have been too small for meaningful quantitative measures, particularly when divided into subgroups. The questionnaire itself contained some problems. For example, some questions had two or more parts and not all respondents answered these questions completely. Responses were organized into categories by the researcher and were not consistently tested for reliability. There was no comparison with music therapists who work with other populations. Further, this questionnaire did not take the variable of age into consideration. Certain findings, for example the increase in the importance of spirituality, as well as in physical illness over years worked, may be influenced by this factor.

Further research might compare the experiences of music therapists to those of other health care professionals working with the terminally ill.
Are our experiences typical or does the music, as many music therapists believe, bring us into a different, more emotionally-based relationship with the patients? If so, how might we best support music therapists in this meaningful and emotionally difficult work? Also, how is palliative care music therapy different from work with other populations, and what are the implications for training? Although this study begins to address such questions, they warrant further investigation.

In attending to the experiences and needs of palliative care practitioners, we may help them maintain a healthier equilibrium, allowing them to be more authentically and effectively present for those terminally ill patients under their care.

**Postlude**

Having begun this paper with a confession, I would like also to end on a personal note. Research should inform practice and this project does have practical implications for me. First of all, it is affirming to know that I am not alone; others music therapists who have worked in palliative care for many years experience similar difficulties. Their coping mechanisms also have personal relevance, supporting the importance I place on family and spiritual development, and suggesting that I incorporate regular exercise into my life. In searching for a healthier balance from which to operate, I might be wise to heed the literature and make self-care and reflection greater priorities. Further, as a long-time practitioner, I understand the importance of mentoring those new to the field, and may have a role to play in helping to create support systems amongst my more experienced colleagues. Perhaps most important, I am more aware of the
importance of authentically living both the richness and the pain of working in palliative care, and in doing so may encourage other team members to do the same. I am enormously grateful for the opportunity to have done this research, and return to work with renewed energy.

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References


I have taught improvisation to music therapists for many years and find it a constantly fascinating experience. But since I teach in a highly intuitive manner, developing a clear picture of just what it is that I am doing and what it is that is being taught is a real challenge. This present talk is another in my ongoing attempts to understand what the process called “teaching improvisation” is all about.

I’d like to start with a few stories and some general thoughts about teaching improvisation, and then focus on one aspect of this teaching—that is, how to deal with the blocks—both the emotional blocks and the musical ones—that prevent students from improvising. So first, two stories:

In an improvisation class that I taught several years ago, I gave the following assignment: “Sit in front of the piano for 5 minutes, doing nothing but being there. Then, after the 5 minutes are up, play something that is right for you to hear at that moment. Give yourself a “musical shower”, play whatever would be most appropriate for this person (you) to have enter his ears and his mind. Then write up what happened.”
I received the following response from a student named Marina:

“I sat down at the piano and began to relax, and suddenly I started thinking about my grandmother. My grandmother died when I was 12 years old, but I have very fond, warm memories of her. I grew up in Russia, and as I showed musical talent at a young age, I was sent to a Conservatory when I was 6, and from then on I became a student in a very strict musical school, where standards were very high, and expectations equally so. I had to practice for hours and hours every day, and had to maintain the levels of excellence that such a school required. It was not easy and it was extremely demanding. My parents loved me, but they too wanted to see me succeed. My grandmother was the only person in my life who seemed to accept me just as I was. She used to call me: “my good little girl.” For her I was always great, always special. In that environment of constant competition and pressure, her presence was as precious as gold. She died when I was 12. I began to cry when I thought about her, and when I put my hands on the keyboard, I played music that I had played then. And I played and cried, remembering that time, and remembering my grandmother. As I was playing, I began to think, that since I was 12, I don’t think I have ever had someone who just loved and accepted me exactly as I am, without demands or expectations—someone who thought I was just fine, all the time. As a girl, I always felt as though I had to live up to my parents’ hopes and plans for me, as well as those of my teachers at the Conservatory. And even now when I am married and have children, I feel that I must always
earn the love and appreciation of my husband and my children, by being the wife and mother they want. And suddenly I felt very alone, and that I missed my grandmother, and the wonderful, unconditional love that she gave me. And how sad it is to not have anyone anymore who can tell me: “you are a good girl.” And then I thought, perhaps I can tell myself that. And I began to play to myself, “you are a good girl.” I improvised music that said to me, “Marina, you are a good, good girl!” And I found that I was able to comfort myself, that I could actually use my music to heal that sad part of me. It was as though one part of me, the mature, adult part, could tenderly care for the lonely child inside, and I experienced a genuine strengthening and healing. It was wonderful.”

Another story:

I had been teaching a course in improvisation for about three months when a student named Dani approached me after a class had ended. “I would like to talk to you about this class,” he said. “Yes?” I responded, sensing that he wasn’t thrilled with something. “I feel that we seem to be staying in the same place, doing the thing over and over with slight variations. We talk about how important it is to listen, then we play, then we talk some more. I’m tired of doing the same thing all the time. I like new things, interesting things. I feel like you’re always saying more or less the same thing, and I understand it. I get the idea—I have to listen, listen to what I hear, listen to myself, and play. I know that. What else? You must have more things to teach us than that, no? I want to learn
different styles, jazz, chords, harmony, all sorts of things. I got the listening part. Couldn’t we learn some new things?”

I began to respond to Dani, but had to cut our conversation short because I had to leave the university right then. I asked him to please give me a call, as this discussion was very important to me and I didn’t want to leave it in mid-air. He took my number and said he would give me a call. A few days later, the phone rang, and it was Dani, who asked in a pleasant voice about when a particular assignment was due, thanked me, and was about to close the phone. I asked him if he would like to continue the conversation we had started after class concerning the content of the course, and he said, no, that that wasn’t necessary anymore. “Why not?” I asked. “It’s all worked out.” he said. “How did that happen?” I asked. And he told me the following story:

“A few days after our short discussion I found myself alone at home. I had some time on my hands, and the truth is I was in a rather emotionally worked-up state. It was quiet at home, and suddenly the idea occurred to me to play the piano, to improvise. So I went over to the piano and started to play. And suddenly everything changed. I started to listen to myself and to what I was playing with more open ears, and the experience was overwhelming. I realized that listening is something that has no limits. I suddenly experienced that listening has no end, that it goes on and on. That is gets deeper and deeper, and that when I’m listening deeply, the experience and the music are both new and
interesting. I realized that listening is not something you do or don’t do, but rather like the edge of a great lake. It’s a door into a whole world, or even to many worlds. I had to have that experience, by myself, at home, in that specific, fraught state. And now I no longer need new subjects and ideas in our class.”

What is teaching improvisation? I’ve been teaching improvisation for years and I still ask myself that question. And I don’t think there’s a simple answer, because teaching improvisation is a complex process. But I think I can say that basically, my role is to expand the music of the students—to expand what music is, can be, can do. To open up the music and enlarge what it does, to make it exciting and vital. There’s a wonderful little word in Hebrew: “stam”, that is very hard to translate. “Stam” means ordinary, run of the mill, unexceptional, boring, superficial. “Stam music” is the kind of music I want to wipe out. Sometimes I feel like I’m trying to reconnect music to life the way that all music in what are called “primitive societies” is vitally connected. There is no such thing in the primitive world as “music” that exists apart from direct involvement in the business of life. Music is work-music, a lullaby, wedding music, part of a religious event or a healing ceremony, a funeral. A morning raga or an evening song. Music is always intimately and deeply connected with life and with people. It’s that connection that I try to develop and strengthen—to return to music, as it were, the power and connectedness that are its rightful context and that are often lost in music’s having become an “art” and a “discipline.” And the way it’s
done is primarily through developing two activities: listening and playing. By listening, I mean developing more concentrated, focused and especially deep listening, one that implies an openness, an embracing, and a vulnerability on the part of the listener. By playing, I mean play in the “child-play” sense of the word—the most free and unhindered exploration that is the basis of creativity. The nurturing of these two, seemingly contradictory functions—one the adult capacity of concentration, of setting limits and working determinedly within them, and the other the most child-like part of our nature, is, I find, the mix that makes improvisation grow.

And what am I trying to get at, by this listening and playing? I am trying to do something that is really quite close to therapy. I want to help students to experience deeper, more honest places inside themselves, and to express that which is inside, in music. It is like therapy because it is really about enlarging self-awareness, and because it requires courage to delve into one’s deeper self. Another teacher of improvisation, Susanne Metzner, writes that

“what other psychotherapists experience and learn solely through self-awareness and personal therapy is covered—at least in part—by improvisation instruction.”

So, teaching improvisation is obviously not just about acquiring certain techniques on your instrument. It’s about expanding your music and expanding your self with it.

And so how does one develop the listening and the playing; the deep connection to self and the ability to pour that connection into music?

“I have never taught anything to anybody. I might occasionally have enabled them to learn.”  

This comment, by Reginald Revans, a well-known British educator and author, says it straight. So does this quote from Ester Elitzur, a Jerusalem psychologist:

“I believe less and less that we [therapists] can work on things [i.e. problems or conflicts of the patient], but what we can do is create the right context in which change [learning and growth] can happen.”

And that’s what I try to do—create the atmosphere, the climate, the circumstances in which self-discovery and “self-playing” in music can happen. When I face a class of students learning improvisation, it’s almost as though I am given a box containing seeds of all kinds of different plants, without knowing which seed makes what plant, and I have to create all types of inviting environments in which this variety of seeds may want to grow. I have to try all kinds of behaviour in order to elicit the blossoming of the hidden beauties of each seed. I have to cajole, comfort, water a lot, water a little, give shade in very different amounts, tickle, yell, sing and carry on in a hundred ways in the hope that at least some of my caring will be appropriate for some of the seeds and they will start to grow and show themselves to the world.


106. Ester Elitzur (1998) taped interview, private archive
When one analyses, and artificially separate out the elements that make up teaching improvisation, one sees that there are many aspects involved. Some of these include:

- Creating an accepting and compassionate atmosphere
- Providing a wide variety of subtexts or pretexts for improvisations
- Making the experience fun
- Orchestrating experiences of flow
- Modeling and teaching improvisational behavior and self-acceptance
- Developing a comportable relationship with Tonality
- Listening and encouraging Listening
- Maintaining proper pedagogic/therapeutic distance
- Allowing the process to happen and
- Working with Blocks

As I said, I would like now to focus on this last element, that of working with the emotional and the musical blocks that prevent students from successful improvising. The reason for this focusing is primarily a question of time—45 minutes is simply not enough time to go through all the aspects in detail. But it is important to bear in mind that one never knows which element of one’s teaching will have an impact, on whom or when.

As I understand the mechanism of improvisation, the capacity to improvise exists in everyone. It needs only to be accessed and nurtured and it will grow and flower. What we are talking about here is “playing.” Everyone would agree that the capacity to play is a given human quality. Everyone know how to play. What happens is, though, that this capacity is applied very differently in different realms of our lives – our ability to
play with our children may have no relation to how we may play in our businesses, our budget or our relationships. The play-ability exists. Its connection and flow to various aspects of our lives depends on how much we are interested in play being part of each endeavour, and then on how open the communication is between our play-capacity and whatever aspect is in question. Developing a capacity to play – to enjoy ourselves, to feel free in our experimenting and at the same time in control, to mold, to make mistakes and discoveries – adding this human capability to any activity can enhance that activity to a great extent. The minute we are playing, we are free, creative, flowing. In a large sense, adding play to our piano playing is what improvisation is about. Teaching improvisation is largely concerned with helping the student to connect her “playing” capacity to her hands on the keys. Since the capacity to play/improvise already exists, a lot of the work of the teacher is helping to remove the blocks that have prevented the student from successful improvisation until now.

First, A few fundamental thoughts about blockages:

1. The blocks must be validated - Whatever the blockage, the student needs to feel that it is okay to have that block. She often needs to hear that many if not most improvisation students have it as well (which is usually true), that it is a perfectly “normal”, acceptable, and understandable aspect of her personality or her piano playing, and that it can be successfully overcome.

2. The blockages must be identified - The student of improvisation often feels overwhelmed by her inability to improvise, and that inability
is therefore experienced as a great fog or mountain. When the individual blocks of each student can be identified, a much easier picture emerges, of a road whose pitfalls are enumerated and clear. In other words, by clarifying the blocks we can often transform the task at hand from something that seems enormous and frightening into a challenge of human proportions that can be conquered and even enjoyed.

3. **Clearing blockages** - The teacher must look for ways to make these defenses and difficulties more flexible, that is, less powerful, and to expel the “demons” that are blocking the student’s path. This requires sensitivity and creativity. While the student experiences the blocks as brick walls, or at least as boulders in the road, the teacher must see them as sub-characters in the personality of the student and therefore as offering directions for work and going forward. “Playing” with the blocks can be an extremely useful way of de-empowering and de-mystifying them.

4. **Lessening fears** - Wherever the teacher senses fear on the part of the student, he needs to try to lessen that fear. One cannot confront fear directly, as unreasonable and silly as the fear may seem. The teacher must accept that the student has that fear and work creatively to overcome it or outsmart it.

5. **Focusing on the here and now** - In general the teacher must find ways of helping the student to discard or circumvent their blockages by concentrating on the task at hand and being as much as possible in the musical here and now.
6. And again, listening - Listening deeply to the student and to her music and encouraging her to listen is perhaps the greatest tool of the teacher in combating the student’s blocks.

What are the emotional blocks commonly found in students?

1. Confronting the self - The student of improvisation is involved in a process of bringing up all kinds of content of which she is unaware. This is generally a difficult and somewhat frightening journey. If I am going to open up and let whatever wants to come out onto the keyboard, I may not like what does come out. It may very well not be pretty or aesthetic, and it’s unnerving enough for me to hear this, but someone else – the teacher – is going to hear it as well. This reluctance to delve into the deeper self can be very insistent. I have even had students who somehow “could not find the time” at home to listen to a recording they had made during a lesson. Playing what is inside us requires courage and support exactly as is required of the client undergoing therapy.

Basically the improvisation teacher needs to realize this and look for all kinds of ways to make the experience easier in order to let the student “enter a new territory without feeling threatened by it”.107 The teacher must be aware of the difficult nature of this activity, respect this difficulty and look for appropriate “cracks” in the armor of the student where the fear will be lessened enough to allow for play.

2. Loss of control - The jazz pianist and psychiatrist Denny Zeitlin writes: “What gets in the way of a lot of players’ abilities to improvise…

is the difficulty in giving up a certain amount of personal control”. This difficulty is related to the previous one. The very openness to listen, to letting inner feelings, directions and images flow out through the fingers, implies that the mechanism for conscious control of the organism is itself inhibited or at least temporarily at rest. Letting go of control describes a scenario where the player becomes more of a *passive witness* to what is happening rather than the director-general. This is a very big change, and to abdicate the control over our feelings that we have all developed as mature, functional people can be difficult. The answer to dealing with this block is to be found in looking for a way to define the activity at hand so that it does not tackle this fear head on.

It is also important to remember that these kind of major fears and blocks do not disappear overnight. They slowly lose their potency over time. A student described the whole experience of learning improvisation as a journey through the layers of her consciousness, now gently touching a place slightly below consciousness, rising up a little, then suddenly finding herself in a very deep experience and quickly rushing back to full self-consciousness. The process keeps going until gradually more and more of her inner space becomes accessible as the fear slowly subsides. Not that we ever “arrive”. The self is an infinite place that is always moving and changing. The greater the improver, the greater the area of inner space he can “swim” in and the more he can express.

**3. Fear of silence** - Many musicians who come to learn improvisation have a fear of silence. Silence is not a comfortable place for them. Evan Eisenberg makes this very interesting comment about silence:

108. *ibid.*
I am afraid to be alone with great music because I am afraid to be alone with my inner self... I cannot find refuge from music in silence. Actually, fear of music and fear of silence are the same.109

I think what he is hinting at is that to really listen deeply to very moving music is to confront what it is inside us that is moved, which is a very unknown place, really. And the ability to be with silence is a corollary to the capacity to know those deep places where music touches us inside. So it is paradoxically necessary to learn about silence in order to learn about music.

We are very used to filling up the silence – with words, actions or music. In order that our music should not be filler against the fear of silence, silence must be mastered. This fear appears as what I call the tendency to “march on.” Many musicians have a tendency to keep on playing no matter what and end up filling the space with unconnected sound. “Marching on” needs to be identified and dealt with.

There are many exercises to develop comfort with and appreciation of silence, like listening intently to the sounds as they die away into silence, or listening to one minute of “silence” and counting all the different sounds that fill up that silence. I also find it useful to teach the student about stopping, that stopping to play is okay and that she should stop:

•  * if she has a question* whenever she feels like it
•  * if she is confused
•  * or if she doesn’t know what to play next.

The habit of stopping to play, of becoming more and more aware of when one is “marching on” on a kind of automatic pilot is important. It is

directly related to establishing a more firm connection with the self when playing.

4. **Fear of success/failure** - A major block to improvisation is the student’s fear that if she just lets go and lets out what comes, it will sound terrible and be a “failure.” That is why it is so much easier to play the notes of a “certified master” – it’s “guaranteed”. It will sound “good.” (This is really not true but it provides a great security net.) But without the courage to fail, how can we ever achieve anything? I once had a dance teacher who, when she’d given the class the combination they were about to do would often say, “okay, who’s going to fall down today?” What she meant was, that by playing it safe and controlled (i.e. by being certain one would not fall), one would never discover the secrets of balance and weight transfer in space. That is, if you’re *worrying* about it, you can’t really be *doing* it. Improvisation is all about putting aside the worry and getting into the doing.

The teacher of improvisation must allow the possibility of “failure” by being totally non-judgmental. If whatever the student plays is “fine”, accepted, okay, the effects of years of fearing mistakes can be slowly undone.

But success can be a blockage just as well as failure. Students are afraid to let go because they might succeed and that wouldn’t fit in with their safe image of themselves as mediocre. I have found also that a successful improvisation – one that surprises the student with its power or originality – can serve to block further growth. It can set up new expectations – “Oh no! Now I have to equal that quality! And I have no
idea how to do it!” What needs to be experienced here is that when one learns to hook into one’s inner self and play more honestly, powerful and original sounds will happen more and more. A veteran acting teacher I know describes the common occurrence of an actor leaving the stage and being greeted by his colleagues’ amazement at the power of the character he just created, and he himself has no idea what he did that was so special. The truth is that he is simply good at his craft. He has developed his connection to his inner self, and this channel is open enough to hook into special waves when they come up. The trick is not to get stuck trying to recreate the next night what he found the previous one, only to be as open as he can every night.

The unconscious is an infinite place and there is “plenty more where that came from.” The teacher can also encourage the student to record what they improvised and that way the really moving moments can be recalled, analyzed and owned. In general I recommend that students often record themselves. Listening to oneself improvise as though it were someone else playing can tell us very interesting and useful things about ourselves and the way we play.

5. Comparisons - Comparisons are not allowed – they deny the basic premise of this work, that the only gauge of success is how well the student can find and express what is inside. What is inside someone else and what he can draw up with what ease is totally irrelevant. What is worse, as soon as the student rates herself unfavorably next to someone else, she is involved in feeling a failure and she can’t be involved in
finding her voice. The best medicine against these feelings of inadequacy is to experience real involvement.

Feeling superior to another player is also a waste of time. That breeds complacency. A student needs instead to listen compassionately to another’s “inferior” improvisation, and to listen to what she feels is behind the player’s music, and how that could perhaps flow out more directly. Listening like that would help her find her own flow as well.

6. Inner voices - There are various types of “noise” – sounds, which disconnect one from the flow and the immersion in the music. There are objective external noises like a plane overhead and the internal noises which are worse. These are inner distractions, voices that can say everything from “what time is dinner?” to paralyzing self-criticism. The optimal situation is when “the internal and the external noise seem to recede way into the background” leaving the player alone with his music110 It is relatively easy to counter the external noise and the “when is dinner?” noise by focusing consciously and deliberately on the music. The self-critical inner voices are another matter. These voices are connected to negative self-images and tendencies in our personalities. These are voices that we have all internalized and adopted to one degree or another and the tendency to be faithful to them as opposed to our true inner selves, the place that is healthy, confident and growth-supportive, is very strong.

Although I am calling both these voices and the deeper self “inner”, they represent very different aspects of the deeper personality. I maintain that the voices are blocks and that the experience of encountering them is one of frustration. Encountering the deeper self is a liberating experience. So I would say that the voices, though they can be quite strong and pervasive, are more superficial in nature, while the inner self is a deep place approaching the true unspoiled core of the person.

Typical messages of these voices are things like:

- “You’re no good.”
- “You’re no good at improvisation.”
- “You can’t do this! You’re not free enough.”
- “You can’t find your inner voice/self.”
- “It’s not nice to play loudly.”
- “This is a waste of time.”
- “I’m staying in control!”
- “This is selfish!/self-indulgent!”

These inner voices must be dealt with in one way or another in order for the student to progress. A student must be able to silence, ignore or to disempower them before she can get to the heart of things. They are obstacles, impediments to flow. There are many ways of dealing with these voices and by listening carefully the teacher can see how best to remove them from the path of the student.

First some general remarks. It is useful to identify the particular voices that seem to be troubling the student. It is always easier to deal with a clear known quantity than a vague “blocked” feeling. The student’s awareness of the particular voice she is hearing at any one time can help
to disempower it. Since the student feels that the voice is part of her, I often suggest playing on the piano that particular voice or message. This action separates the voice from the person and puts it onto the piano, and allows the student to feel distance from the voice and not so bound together with it.

All inner voices/blockages should be respected. The student must be made to feel that having these blocks is normal and understandable. No matter how ludicrous they may seem to the teacher, to relate to them as ludicrous would only add guilt to the student for feeling this way in the first place. Once the voice has been identified I often use humor to lessen its power, joking about it: “Oh, here’s your old friend the judge!” or using fake sarcasm, “Oh, I’ve never encountered a personality trait like that before!” to release tension connected with that voice. I find in general that humour is a great help in this teaching process, and I try to use a lot of it.

Telling therapeutic stories can be another way to help weaken the critical voices and strengthen the healthy resolve of the student. A therapeutic story is just that: the story of someone who managed to put aside the voices that harm, and attach themselves to their own centers. Here is an example: I know a flute player who had through years of classical training developed very strong voices that were always criticizing how she played. They made her feel that music was basically one endless struggle to meet some kind of perfect image of how someone else (her teacher) thought that music was supposed to be. As a mature woman she decided to leave the flute and its neuroses and to study voice. She looked
for and found the correct teacher for her, one who would constantly encourage her own experience, and she fought with herself to only learn to sing those pieces that she really wanted to sing. She utilized the teacher as an aid in her design for her own learning rather than accepting his authority blindly. She checked herself again and again to be sure she wasn’t trying to please him or realize his standard. Slowly but surely she developed as a singer from the inside out, without all the baggage that had come along with the flute. This true story of stubbornness, growth and empowerment can encourage and inspire the student in her own work.

The following are some of the major inner voice blocks I have encountered, together with suggestions for their efficient disposal.

**Some Classic Inner Voices**

1. **Self-criticism**
   - “You’re not good enough!”
   - “You can’t do this!”
   - “This has no validity!”

Many students of improvisation have a very basic difficulty in finding validity in their improvisation. We all feel that just about everything we say has validity regardless of whether or not it is particularly profound. But with regard to what we play, trusting the validity of our spontaneous music often requires some work. The teacher needs to find ways to silence the critical voices so that the students’ self-confidence in their intuition can grow.
“Playing” with these voices can be a good way to lessen their effect. The minute we can laugh about something, its power to affect us is greatly reduced. For example, a student had had horrific experiences in the music academy where she studied, all centered around having to perform and be judged. Every time she had to perform – and this is fairly often in an average academy – she would spend an hour or two in the bathroom, violently ill, beforehand, and arrive at the required room exhausted and petrified of the judgment of her teachers. These internalized critical voices had become so strong that she effectively stopped playing the piano after leaving the academy. When she sat down to play practically anything at all she was deluged by the imagined “jury” listening to her and judging every sound. So I had her “play” with the jury. She described verbally each one – one reading the paper, one listening intently and then shaking his head sadly after one minute, etc. I did this so we could start together to laugh at them and begin to loosen their hold on her. Then I asked her to play now what she would have liked to have played for them then, and she launched into a no-holds-barred barrage of musical anger and fury that was completely honest and uninhibited. She had so much fun that she could hardly stop, and finally yelled out: “I’m ready now!!” In essence, we took the material that was holding her back and played with it in order to utilize that very “blocked” energy to release itself and to allow a very free and enjoyable improvisation to come out.

These voices do not usually disappear in a day, and when they resurface later on I often joke about them – “Thank G-d your critical voice is alive and well!!”, “Oh yes, I forgot, you’re not free enough to really improvise!”
As improvisation does not enjoy a uniformly positive press, especially among classical musicians, many students have inner voices that are largely those of real people, various “adopted” authority figures who strongly disapprove of this activity. Occasionally the possibility presents itself in the course of this work for the student to actually return to someone who has represented this attitude towards improvisation, and with some newly acquired confidence even manage to win their approval. One student recorded herself improvising and later on played it on a tape machine for her mother, herself a piano teacher of the anti-improvisation schoole, to hear it as well. Lo and behold, her mother was very taken with the music and wanted to know what it was. The student held back claiming it was something she had recorded from the radio, until finally she gave in and confessed, much to her mother’s amazement and her delight. This episode was reported back to me with real joy and helped greatly to dull the power of her own inner echo of her mother telling her that what she was doing was worthless.

W.A. Mathieu in his book The Listening Book – Discovering Your Own Music describes another way to tackle these self-defeating voices that can be so prevalent in us all. The voices say things like,

I don’t have the talent to do this. I am too old, I am too dim, too slow, much too slow, plain unmusical, not worth the effort. Whatever made me try this in the first place? Who do I think I am? I am worthless, forget it… The most plaintive of these cries is ‘I just don’t have it’. The way to crack that one is not through the I or the don’t but through the it. Put yourself on the hot seat. Cross examine yourself about the it you are expected to have. When was the it born? Who were its parents? Is it a friend of yours? Are you sure? When did you last see it in person. Is it in the employ of another party?111
Thus, what we can do is explain again and again to our students that there are no expectations, just the constant discovery of what comes next. We can help them to slowly dissolve the harmful voices and to focus on the improvisation experience at hand, so that the voices can fade into the background.

2. “It’s not nice to bang!”
Many improvisation students have a very strong voice that wants to stay in control, keep things quiet and cultured and not let out whatever “monsters” there are inside. Making the flowing out of inner voices a fun experience can help to lessen this voice of “the controller”. Finding the right way for each individual student to enjoy playing improvisationally with force – looking for what would be a legitimate exercise for that person at that time – is one way of avoiding the guard on duty by sneaking in the back door.

3. “This is selfish – self indulgent!”
This is another common voice. At the same time that a student comes to learn improvisation, another part of their personality is belittling the very attempt. One student told me she had to “steal time” for improvisation, working on it at unscheduled “in-between” intervals because it felt illegitimate and self-centered. Here a comparison with acting technique is helpful. The actor needs to be focused completely on the elements he is trying to achieve in each part, in each particular character, and not concerned at all with “how he is doing.” An actor concerned with how he is “acting” is not convincing. In order to arrive at the correct concentration, the actor must practice “throwing away” inappropriate fears and considerations the second they arise and reconcentrating on the

immediate task at hand. The actor may not feel he is involved in a self-serving activity but the “self-observation” that can creep in is the same seed that causes the improviser to judge what he is doing instead of doing it.

The teacher of improvisation must make it abundantly clear that in his opinion this is not a selfish or self-indulgent activity and then help the student to refocus on an improvisation that is appropriate for her at that moment. It is not infrequent for the student to overcome, with the presence and aid of the teacher, these self-indulgent voices and then when they find themselves alone at home the voices all come back and the student has great difficulty “clearing herself” for this work. It is much easier to play music that is already validated – written and printed – than to search for their own. The teacher can suggest ways of organizing the practice time “improvise for exactly ten minutes, no more” or give instructions for extremely specific improvisations.

Sometimes none of these work and the teacher and student must make due with the hour of the lesson once a week as the only time the student improvises. These will generally have a cumulative effect as well. Sooner or later the student who really wants to improvise will break through her voices and get to it. I have noticed that this often occurs in moments of unanticipated free time. I call these times “snow days” – the days when school is called off because of heavy snowfall and all the children get a wonderful surprise holiday. One improvisation student who could not find the time to work on improvising, had a husband who used to do much of the cooking at home. He became quite ill and
together with supervising his care, she had had to do the cooking for several months. Then one day her husband suddenly felt well enough to cook again, and she flew out of the kitchen and headed straight for the piano to improvise. These moments by their nature are serendipitous and cannot be arranged, but they do happen and often give a considerable push to the progress of the student.

4. “I must be boring you.”
Many times improvisation students transfer their feelings of inadequacy onto the teacher and stop playing when they really have more to say, because they feel the teacher must be bored. This is especially true of music therapists whose occupation is involved with being totally tuned in to the “other” – the patient – and his reactions. This makes it even harder to refocus on their own process because along with guilt for boring the teacher, they also feel they are doing something wrong by being so centered on what they are doing. The teacher must remind the student to trust the teacher, and that she will be informed if the music is boring. More often than not when a student stops and claims she was concerned for the state of the listener, it is a sign that something strong may have been about to surface, and the student uses the excuse of boring the teacher to avoid that something. If they can be quietly convinced to continue, that, on the contrary, the teacher is more interested, not less, often the results are surprising and powerful.
Musical Blocks

The Musical superego

Every classical musician has worked long and hard to make the music he plays sound “right” according to clear delineations of what is considered acceptable. Improvisation works without any outside, imposed standards of what is correct. Therefore in the words of a student, “you have to learn to let yourself be where you are without your musical super-ego.” A musical super-ego is a legitimate element that is necessary if one is to play a classical piece, but it must be completely put aside if one is to learn to improvise. This is a new situation for the student who is used to everything being judged by external criteria. In improvisation, the teacher must make it very clear that there are no external criteria. It takes a while for this fact to sink in, but as the student develops more confidence in her own improvisation, the super-ego gets quieter. I am reminded of my fourth grade teacher telling us that when she first began teaching, whenever any other adult would walk into the class she became very nervous and worried thinking that she wasn’t meeting some standard or other. With the confidence that only comes with experience, she told us that today she wouldn’t even care if (then) President Kennedy himself walked in. She would concentrate on what she was doing and listen to how the class was going, be in the moment and go with the flow. Ditto for improvisation.

Since improvisation is such a new world the student often isn’t able to maintain any awareness of what they are doing in a technical sense, and when I comment that they just played thirds, for example, or a waltz, they
may have no idea what I mean. Since this comment may have the effect of causing the student to feel inadequate, I must counter that by, for example, joking, “you mean you didn’t realize you were playing thirds? How could you be so thick?!” In short the teacher must try to prevent any feelings of musical inadequacy.

The myth of inborn improvisational ability
The musical super-ego is concerned with acquired aesthetics and the student is often afraid that their improvisation won’t be “pretty” or “aesthetic” in the traditional sense. But it must be stressed that in improvisation we are after authenticity and not traditional aesthetics. If there is an “aesthetic” of improvisation it is a very different one. The student needs to realize through examples, recorded or live, that the aesthetic in, for example, jazz can be very moving and enjoyable even though it may fly in the face of all the rules of what was considered “beautiful”. If it is authentic, it works.

There seems to be a very widespread belief that the ability to improvise is genetic. Either you have it or you don’t. This myth, if present, needs to be exploded. First of all, I believe it is blatantly untrue. Of course there is such a thing as talent and we are not all created equal. But I believe very strongly that we can all be composers as well as listeners and players, that there is music inside everyone and all that’s needed to get it out is the desire on the part of the student and a sensitive teacher. Secondly, as long as this myth persists unchallenged, the student may believe deep down that she simply doesn’t have this talent and the myth
will “validate” her own self-critical component, thus strengthening the blockage.

What does vary from musician to musician, besides what it is that they have inside, is the level of accessibility of their inner music. Everyone dreams. Everyone has an unconscious. Some people are highly aware of their dreams, while others have no recollection at all. What teaching improvisation is about is enlarging the accessibility of our inner music, but it must be made clear that the teacher believes unconditionally that the student in front of him, or any student, has important and meaningful things to say and can certainly improvise.

“Marching onward”
Since all pianists know “how” to play, that is, their fingers are used to pushing down the keys and getting sounds, they sometimes have a tendency to keep playing regardless of their inner connection to what they are doing. This is probably a result of playing the music of famous composers where one’s strong inner connection to the music can easily be diverted while the hands and memory will continue to “play the piece”. This is what I call “marching on”. The student marches on oblivious to the fact that the music doesn’t feel very important or connected. This tendency must be carefully dealt with. The teacher can gently interrupt the playing of the student if he feels it is too far to the “automatic” side of her playing and not true enough.

This point of decision is unique for each student at each given point in time, and what may be a quite acceptable level of connectedness for one student may be well below the level of authenticity that another generally
achieves. The decision to interrupt any improvisation needs to be carefully weighed and carried out with sensitivity and compassion. There are many ways to try and redirect the improvisation so it will be less automatic – often by setting some sort of limitations on the playing (such as “play everything very softly” or “play three notes at a time” etc.) that can help to reframe the music and move it to another plane with a greater degree of awareness and connectedness.

**Fours and eights**
Similar to the trap of “marching on” is the tendency to play in rhythmic patterns of fours and eights. Since the overwhelming majority of western music is in a meter of four beats, there is a tendency for students to improvise in this meter, and they are often completely unaware that they are doing this, so ingrained is the four-beat structure. In order to develop one’s free expression, however, the language of music must be broadened to allow for all kinds of rhythmic forms, regular as well as irregular. Playing in fours is a bit like speaking in metered rhyme, and it is obvious that most of us would find it quite constrictive and indeed counter-productive to try and learn to emote or express our inner feelings only in this form. The four-meter is not perceived as constrictive, however, because we have all become so used to it. So the teacher needs to find ways of breaking this acquired style. Again, listening deeply is a big key to opening up the rhythm gates. Other suggestions could be to play the rhythm of the student’s thoughts, the rhythm of the words running through their head at that time, her breath, or describing a
physical phenomenon like a rainstorm, or like the way the stars come out one by one at night.

A **standard style**

Sometimes improvisation students feel that they do have an ability to improvise, but that their spontaneous playing always sounds and feels more or less the same, that they have developed a “standard style”. To some extent this is true about everyone, even great improvisers have their usual paths and energies. By creative suggestions the teacher can give new direction and content to the music of the student and help open up new possibilities. This is one of the truly exciting elements in teaching improvisation. One constantly has to search for and discover new ideas, new paths, new ways of looking at what we are doing. Teaching improvisation, the “sound of surprise” always means being surprised as a teacher as well.

To end, I would like to tell you one last story from improvisation class. One of my students, when asked to write what she had learned from the class, wrote me the following:

“This class was one of the “less easy” ones for me. Looking back, this is surprising, as I thought, at the beginning of the year, that improvisation would be the peak experience of my music therapy training, and I approached the classes full of motivation and confidence in myself as an improvisor. I thought that I would feel totally confident in this class, because improvisation is the area of music where I feel most at home.”
But after several lessons, I discovered that I wasn’t having an easy time, and that the lessons were causing me to become more closed and less and less sure about myself. It could be that this feeling was due to my not being a pianist, and a lot of the class was centered around the piano—even though I had often used the piano as a great vehicle for really letting rip. In each class, I tried to understand what was going on inside me, and why I couldn’t express myself in class. Often I projected my lack of self-confidence onto you [the teacher], with all sorts of feelings like: “I don’t feel that you accept me or my music.”

I don’t know when the change happened—but at some point I must have started to listen to myself… I feel as though I’ve gone through an important process that was intimately related to the difficulty I experienced, possibly even because of that difficulty… I understood that the point is first of all to fully accept where I am at musically and emotionally, and to love that place, and only from there to add depth and learning.”

This is the last point, but a very important one. Teaching improvisation is also about teaching people to accept, to embrace, and to love themselves. Because that’s where it all starts.

Appendix

Good Books on Improvisation


This book has lots of great ideas for improvisations and improvisational thinking.

This book has beautifully worked out theoretical explanations of what improvisation is all about.
People with disabilities often deal with issues of visibility and invisibility. With a stroke or muscular sclerosis, for example, one may be “visible” in the sense of being different from others as a result of impaired walking, or speech, or the loss of the use of an arm. The issue of invisibility is manifested in one’s abilities not being assumed, or acknowledged. One’s inner life, culture, or history, may be “invisible” with the more obvious disability taking prominence for the outside world and, in some cases, for the individual.

In our Music Therapy group at the International Center for the Disabled, we have clients from different backgrounds, with different disabilities and different levels of functioning. Some have suffered strokes which have immobilized one arm, but are able to speak clearly, some can barely speak at all, some have musical skills and training, some don’t. On one’s first visual and audible impressions of these people, it might seem that they can not do much.

Four years ago, at the suggestion of Eddie, a client with a strong musical background, our group started giving yearly performances for a small audience of invited staff, relatives and friends. Most of the presentation at the congress was a video of one of these performances. “Showing that we can do something” to an audience and to the members
themselves, became an important, self-affirming goal for people whose sense of self had been profoundly damaged.

Much of the material that we ended up deciding to perform grew out of our group process. Material and themes that evolved were selected and then rehearsed when the time for the performance was nearing. A good deal of the group is improvisation based, and I felt it was important to retain this aspect even in a performance situation. I will give some details about the clients in the order of their appearance in the show.

Eileen suffered from a seizure disorder and appeared depressed, overweight, constricted in speech and flat in affect, making for a leaden overall self-presentation. In one group we were discussing people’s backgrounds and she mentioned Irish background. Somehow the discussion got onto the subject of her Irish dancing. We then suggested she show us, not really expecting to see much, or that she’d even try it, given her past participation. Another client, Marian also having an Irish background, took out her harmonica and started to play “The Irish Washer Woman”. Amazingly Eileen, this previously slow-motioned woman, started skipping around, executing the steps that she remembered from childhood. She then taught the staff and those clients who were ambulatory the basic steps. The group was enthused, enjoying either doing the steps or seeing one of their own doing them and teaching them.

During the previous year Eileen had refused to be a performing member of our group when we performed, and had some emotional, contradictory reactions about this after the performance. This year she
felt confident and involved enough to be an active participant, leading off the show, and dancing with efficiency and energy. She was sensitively introduced and accompanied by Marian.

Rijo, a gentleman from Cuba was brought into, and shared his cultural context by singing the song “Dos Gardenias”, an old standard repopularized by the “Buena Vista Social Club”. At his intake, Cathy Appel, head of the Creative Arts Department and a dance therapist who also takes part in our group, played “Dos Gardenias” for Rijo since he’d said he liked Cuban music. He broke into uncontrollable tears, causing some doubt in Cathy’s mind about his ability to handle the music therapy group. There was never a problem with this issue. Participating in live music with others simultaneously contained and released his emotions.

One of my interns, Tanja auf der Hyde, was familiar with the song and engaged in a duet with him. This further enhanced his portrayal of a courtly gentleman in the song’s performance, replete with hand and head gestures. He said that it was important to let the people know “What we can do” and became teary after successfully performing the song in front of the audience, which included his brother, who gave a bit of his history.

Eugene had been an organist before his four strokes. Although he has made improvements in memory and speech, it is still difficult for him to put together sentences and to enunciate them clearly. He was able to remember and suggest a choral, which we identified as “Eine Feste Burg”. With a simple arrangement and help from Tanja, he could sing a good deal of the words and vocalize the rest. He also was able to briefly
describe his relationship to the song, in front of the audience, with no trace of embarrassment despite his awareness of his verbal limitations.

When two of the less verbal clients were able to make their preferences for R&B known, we selected “Stand by Me”. This is a well-known song with a relevant message and a chorus that is easy to sing along with. Larry, who was a recent addition to the group and is a fine visual artist, as well as a musician, suffers from seizures, depression and drug abuse. He was able to employ his left-handed guitar skills and step in to play quite well in the performance. He wrote a fine introduction to the song, saying that “The lyric is one asking for help in times of trouble. The song is a statement of the singer’s strength and determination to overcome obstacles if some one will stand by him. It’s a song we all grew up with.”

In the video of the performance you can see Joan, who as a result of her strokes is nearly aphasic. Even with this disability, she loves music and can sing. She gradually became more engaged with the audience, encouraging them to sing the chorus with her as she smiled with enjoyment and pride. At the end of the show, when the cast introduces themselves, she says her name clearly, with great concentration. John, who has severe limitations in speech, movement and coordination, still played the gato drum with energetic enthusiasm.

Judeth was intent on telling the story of her stroke. An elegant native of Haiti, she continued to hone her skills in rehearsal, sometimes adding emotional details, and also struggling with memory and speech. It takes a lot of courage to speak in front of an audience. When one struggles with
speech and is talking in one’s second language, it is all the more remarkable. Eddie came up with the idea of adding the drum, responding to the location and rhythms of the story. You could feel Judeth’s great motivation, when she said adamantly that she could do anything with one arm, “ANYTHING!” She also demanded that we give the lyrics to the group-composed calypso to the audience to read, understand and sing.

Eddie, though not particularly featured in this performance, is a skilled musician who plays bass, piano, composes. He has worked in the music industry, theater and has taught children. As a result of his strokes he battles with poor memory and eyesight, as well as the emotions that go along with his awareness of not being “who he was”.

Initially when he joined the group could be alternately domineering and encouraging. Our process was to help him use his qualities awhile accepting his limitations, improve his interpersonal skills, while still supporting his leadership skills and musical contributions. He does a lovely improvisation with Tanja to start the show. I include here the lyrics for a song he wrote that we performed in the previous years’ shows. This poignant song gives insight into his feelings about his situation:

“I REMEMBER WHEN”

I REMEMBER WHEN MY LIFE WAS CLEAR,
I KNEW EXACTLY WHERE I’D GO
BUT IT SEEMS I’VE MISSED A STEP
I’M STILL HERE

STARTED OUT SURE I’D REACH THE TOP SOMEDAY
YES I’D HAVE IT ALL BECAUSE I PAID MY DUES
NEVER THOUGHT THAT I COULD LOSE
I COULDN’T LOSE

BUT NOW I’M NOT SURE OF THINGS ANYMORE
MAYBE IT’S NOT MEANT TO BE
ALL MY STRENGTHS WALKED OUT AND LOCKED ALL THE DOORS

I REMEMBER WHEN MY LIFE WAS CLEAR
KNEW EXACTLY WHERE I’D GO
BUT IT SEEMS I’VE MISSED A STEP
I’M STILL HERE

The show’s final song was a group composition, initiated by Marlene’s desire to have her cultural roots represented by calypso. She suffers from MS, and her speech was often difficult to understand. She had a background in dance and had been involved in the New York cultural scene before her illness. Using Marlene’s idea of a calypso song as a kind of “newsbulletin” about current events, we went around the group asking each person what they wanted to communicate to the audience in our upcoming performance. I took their statements and put them into a musical form with a calypso cadence and style. The group was enthusiastic about this and wanted to perform the song. Even some
members of a dance therapy group wanted to dance to it when they saw us play it.

“ICD CALYPSO”
(ICDISTHEINTERNATIONALCENTERFORTHEDISABLED)

BECOMING AWARE OF THE DISABLED,
WE CAN TELL WHAT IS WHAT
BEING DISABLED IS NOT EASY
WE HAVE TO COPE WITH A LOT
IT’S MY LIFE I’M LEARNING TO
ACCEPT IT GRACEFULLY
IF THEN YOU CAN ACCEPT ME,
THEN WE CAN KEEP COMPANY

(CHORUS)

THIS IS THE BALLAD OF ICD
WHERE I COME FOR MY DISABILITY
WHERE I NEED TO BE ME TO BE
ACCEPT ME AND LET ME BE ME

WITH A STROKE TO FIX IT
THINKING ONLY GOD COULD
BUT WAITING AROUND EXPECTING HIM TO FIX IT
JUST DOESN’T DO ANY GOOD
LOOK AT ME LOVE EVERYBODY ELSE
WITH LOVE YOU CAN HELP
LOOK AT ME LOVE EVERYBODY ELSE
GOD WILL HELP WHEN WE HELP OURSELVES

GOD CAN CLEARLY SEE MY KIDS
TELL THE PEOPLE WHO WE ARE
BECOMING AWARE OF THE DISABLED
WE ALL CAN GO FAR

(CHORUS)
THIS IS THE BALLAD OF ICD
WHERE I COME FOR MY DISABILITY
WHERE I NEED TO BE ME TO BE
ACCEPT ME AND LET ME BE ME

In the performance and the processes that led up to I saw people overcoming some of their own limitations, both physical and emotional. They also overcame audience preconceptions about what they could do and, perhaps most importantly, their own preconceptions.

Some questions that I ask and hope to stimulate in others through this work are: What does it take and what does it mean to go in front of a group of people, knowing you look different, sound different, can’t do what you used to do,- then to perform something you may not have much expertise in, either because you never did, or because you’ve lost the ability? Additionally, what does it mean to represent aspects of your culture that are not the mainstream culture that you are in, as an immigrant or children of immigrants. And what does it mean to do this in the form of music?
Benefits: self-esteem, feeling of belonging, of being special in a positive way, when you may be usually be perceived as special in a negative way.

Showing yourself as well as others your ability to communicate your story, your emotions, abilities, to see your peers do so and support them,

To participate in an art from which you love, without necessarily having many skills,

Interestingly, looking at the etymology of two words that are prominent in this presentation may give insight into the issues and struggles at hand. Perhaps what we are trying to do is indeed to help give shape and beauty to the visible (and audible) aspect of these brave people.

PERFORM: To carry out or do/

PER: Through, thoroughly, completely

Form: n- shape, beauty, a visible aspect of a thing, that which makes matter a determinate kind of thing

v-give form to, be the components of, draw up or dispose in order

DISABILITY: The condition of being unable to perform a task or function because of a physical or mental impairment

Oxford dictionary of English Etymology
ÆD CT ONIONS
Articulating the Dynamics of Music Therapy Group Improvisations

McFerran-Skewes, Katrina
PhD, RMT
(see her Powerpoint Presentation in the Oxford Powerpoints Folder)

The research project that forms the basis of this paper was an exploration of the experience of group music therapy for six bereaved adolescents (Skewes, 2001). It occurred in two stages, focusing first on the participants’ experiences and then on the musical material they created. The reason for the dual levels of the investigation rests primarily with its emerging design. Initially, the verbal testaments of the participants identified a number of essential features of taking part in music therapy, including the benefits that emerged through the fun and creative experiences that formed the basis of the group; experiences that were controlled by the teenagers themselves and often associated with emotional and personal expression. It also identified that the participants struggled to articulate the creative and non-verbal aspects of the group, although they considered them to be critical. During the in-depth interviews, the researcher encouraged participants to explore their thoughts on the improvisations, resulting in some feedback about the beat providing a level of containment, however these contributions were limited. It is not surprising that they were often unable to respond, after all, is this not also the music therapist’s dilemma (Ansdell, 1995).

Thus, from its beginning as an exploration of the participants’ individual experiences and an awareness of the commonalities of that, the research
grew into an investigation of the therapeutic significance of the music they made together. The emphasis on rhythm was drawn from the participants themselves and this was expanded by the researcher’s additional questions and desire to facilitate group improvisations more knowingly. Interestingly, the research took place in a global context that has an increasing emphasis on the development of indigenous understandings in music therapy, as first titled by Aigen (1991). Some years later, Aigen asks “Why is it that music awareness cannot be considered a type of psychological thinking rather than something opposed to it” (p.78, 1999). This provocative question resonated with the researcher’s experience of the music therapy group improvisations contained in the data collected. It led to a series of questions that helped refine the emerging focus of the second half of the study. Is it necessary to rely solely on words to understand processes that are clearly creative and musical? Is interviewing participants the only way to seek a deeper understanding of an experience they described as useful because of its non-verbal properties? Because we do not always have the potential to interview clients in order to understand the underlying processes that have occurred, does that necessarily imply that we should work purely through independent interpretation or speculation? If a greater understanding of the musical material were possible, would that have altered the way the group was facilitated? Why is there a scarcity of literature that addresses the musical material of group improvisations?

In order to explore these questions, phenomenology was selected as the research paradigm that underpinned not only the exploration of the participants’ experience but also the group’s musical testament. Whilst
recognising that describing musical dynamics is a distanced attempt at representing the experience of making music, the researcher believed that it was important to articulate the creative process in order to increase understanding of it and to offer further clarity to our clients and colleagues. Spinelli (1994), a Gestalt Therapist and Phenomenological Psychologist, acknowledges that whilst phenomenology seeks to shed the interpretational layers usually attributed to an experience, its ability is limited. First, it is impossible to explain a phenomenon whilst it is being experienced, thus it is already distanced from the act and must be a reflection on an experience. Second, experience itself is timeless and ineffable and difficult to explain in words, which also happens to be an apt description for music. Therefore, this research attempted to “arrive at a more adequate, if still approximate and incomplete, knowledge of the things themselves” (Spinelli, p.16).

A number of significant music therapy researchers have already contributed a great deal to the development of such indigenous understandings. Amir (1992), Ansdell (1995), Bruscia (1987), Bunt (1994), Grocke (1999), Lee (1992) and Pavlicevic (1995) have worked consistently and publicly to increase awareness through their own research. On a smaller scale, Arnason (1998), Marr (2000) and Streeter (1995) have also supplied noteworthy insights into the actual music made in music therapy. Many of these music therapy researchers suggest that it is time to abandon allegiance to the various schools of music therapy and to explore what we have in common – the music. As Pavlicevic (1995) states, “The information is right there, within the improvisation. We need the sensitivity to ‘read’ this information accurately” (p.173).
Before developing an original model of musical analysis for application in this research, a thorough review of the literature was conducted in order to identify if a pre-existing model could be utilised. Bruscia’s IAPS, Ansdell’s Assessment Map, Nordoff & Robbin’s Evaluation Scales, Pavlicevic’s Dynamic Form, Langenberg’s Graphic Notation and Lee’s Pure Musical Analysis all represent previous attempts at capturing the dynamics of the musical interaction in therapy. Each has merit, but was not considered appropriate for the exploration of the group improvisations generated by six adolescents who did not have a disability or psychiatric disorder. Nonetheless, aspects of each influenced the development of yet another indigenous music therapy model that was applied in the research. Ansdell’s emphasis on describing the musical material before interpreting it was essential in the development of a model that clearly separated these two aspects of the analysis. This premise seemed to also underlie the various models that created a visual representation of the music, either as a score or a graphic, in an attempt to view the material in another way. Additionally, both Bruscia and Pavlicevic emphasised the importance of the musical dynamics, with the IAPs displaying immense potential for developing musical listening and for discerning the nature of relationships within a group music therapy interaction.

Due to the lack of specific literature addressing the musical material of therapy group improvisations, a final stage of review was also incorporated into the research – a review of current practice (McFerran-Skewes & Wigram, 2002). Interviews were conducted with nine music therapists identified as being highly skilled in the facilitation of music
therapy group improvisations, these were: Barbara Hesser, Kenneth Bruscia, Gary Ansdell, Gillian Stephens-Langdon, Alan Turry, Noah Shapiro, Michelle Ritholz, Joseph Fidelibus and David Marcus. The most compelling understanding identified by these group facilitators was the importance of musical listening. These specialists suggested that experienced group leaders listen musically to their clients, responding intuitively and creatively to what is heard. Their ability to create a musical environment that participants can metaphorically ‘step into’ is regarded as crucial for commencing the therapeutic relationship, but once created, the therapists listen as trained musicians to the qualities of the clients playing, as well as the most salient aspects of their musical material. They juggle their listening between the group and the individuals within it, noticing changes and variation in their musical material as well as using other non-verbal cues. The specialists suggested that they listen for indigenous achievements in the group, such as the ability of the participants to play spontaneously, to listen to the music of others, to play in a communicative way and to be flexible in their playing. Only after listening to these indigenous facets of the music therapy group’s work, do music therapists apply external models of understanding that may help interpret these musical achievements into psychological, cognitive, emotional or other group outcomes. This information was critical in the decision to incorporate narrative description into the model of musical analysis developed, as this was considered to be a direct representation of music therapy listening. It also consolidated the need for a two-stage exploration, first to listen and
describe what was being heard and second, to interpret this information for meaning in the context of developing group dynamics over time.

With the reviews completed, each of the identified ingredients was then considered in context of the increasing use of phenomenological methods of musical exploration identified in the music therapy literature. Arnason (1998), Grocke (1999) and the most recent work of Lee (2000) have drawn on the foundational work of Ferrara (1984; 1991) to develop indigenous models that identify the aspects of phenomenological musical exploration most relevant to the music therapy experience. Each utilises an eclectic approach in “an attempt to understand better the dynamic interaction between the various levels of musical significance and to devise a system through which one can report systematically those levels individually and in their interaction with each other” (p.i, Ferrara, 1991). In the case of Arnason, this involved listening to the music from six different levels including the emotional resonance (Langenberg, 1993), the metaphorical associations and the musical sounds and elements. In later work (in press), Arnason has proposed a further two levels of investigation. Lee is even more comprehensive, utilising nine levels that include transcription into notation and in-depth musical analysis, but also incorporates the reactions of the therapist, the client and various consultants. In applying phenomenological models, these researchers have acknowledged the multiple perspectives that can exist in any attempt to understand experience, musical or otherwise. Decisions are made regarding which levels to explore and how many are feasible. It is important to recall one of the arguments initially proposed for the divergence into qualitative research – that of relevance to clinical
practice (Aigen, 1995). The focus on qualitative research was born from the emerging gap between these two fields (Gfeller, 1995) and it is important that qualitative research studies do not similarly evolve to a point of non-applicability because of their complexity. This is an ongoing challenge for music therapy researchers and it is significant that even with this in mind, the musical analysis model used in this research did consist of four levels of listening and a final stage of merging these perspectives together. Resultantly, the data generated was extremely comprehensive.

The original Music Therapy Group Improvisation (MTGI) Listening Model (Skewes, 2001) reflects a focus on the interactive musical dynamics of the group, the musical material of the group and the musical strategies of the group leader. It does not focus on emotions or metaphorical responses because it aims to move closer to the music itself, not to other symbolic meanings inherent in it. It does not utilise a Schenkerian analysis technique, instead incorporating narrative descriptions of the musical properties that can be heard. It does not focus on the individual expression contained within the improvisations, instead exploring the group’s sound and the development of the musical interactions over time, utilising Bruscia’s IAPs. And instead of gathering consultants’ perspectives of the music as yet another layer of the model, it includes these perspectives post-application, in order to verify and add trustworthiness to the results.

This strategy resulted in the most exciting outcome of the research, verification that the narrative descriptions were able to capture and
convey relevant features of the group improvisations in context of the music therapy experience. Two independent listeners were asked to compare the final narrative descriptions of each improvisation to an audio listening of the musical material. Each listener was selected due to their high level of skills in musical discernment and each undertook a rigorous process of listening, reading the narratives, listening again and then selecting their level of agreement regarding the adequacy of the match between the music and the words. Although the philosophical premise of qualitative research supports the existence of multiple, rather than singular meanings, the descriptive focus of this part of the research could be verified because it did not aim to discover meaning. The listeners were not asked to interpret, or agree with any interpretations; they were asked to measure accuracy. Ultimately, there was a high level of agreement between the two verifiers, with both reaching the same opinion on six of the ten improvisations. In addition, both felt that all descriptions were either ‘absolutely’ or ‘pretty well’ accurate and none were 'reasonably' or 'inadequate'. These are important results because they show that it is possible to write recognisable and pertinent descriptions of the musical material in group improvisations using a multi-levelled narrative approach. Previous researchers have commented on the distance they perceived as existing between the results of their analyses and the actual experience of therapy (Lee, 1992; Odell-Miller, 1995). This obstacle was not encountered during this research study, demonstrating potential for grounding our interpretations in the musical evidence, as advanced by Ansdell (1995), as well as revealing a potentially indigenous language, as promoted by Amir (1999).
Within this study, the use of independent listeners was not the only mechanism used for enhancing the trustworthiness of the results. The transparency of description makes it possible for the reader to determine for themself the value of the results, a basic principal of qualitative verification. The terminology used in generating the descriptions was carefully guided by the premise of construct validity. Most importantly, the phenomenological technique of bracketing was also utilised and incorporated into the development of the listening model itself. As described above, this model was multi-levelled and involved setting aside all other perceptions available to the researcher at each stage, whilst focussing only on the one aspect being heard during that stage of listening. This bracketing strategy can be illustrated by an explanation of the model (Table 54). The first four levels encourage the listener to investigate a range of possible descriptions of the material and the final level of distillation explores the complete data until a consistent understanding emerges from the material itself.

Table 54  MTGI Listening Model

<table>
<thead>
<tr>
<th>Level</th>
<th>Listening Process</th>
<th>Description Process</th>
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<tbody>
<tr>
<td>Open</td>
<td>A controlled and focused listening to elicit broad impressions of the music that do not include metaphorical or symbolic meanings.</td>
<td>A narrative is written that describes the personal response of the listener to the musical material using a ‘stream of consciousness’ method.</td>
</tr>
<tr>
<td>Musical</td>
<td>Listening to the selected musical properties within the improvisation and noting their changing or consistent nature throughout the course of the improvisation</td>
<td>A narrative is written that describes the rhythmic grounds, rhythmic patterns, volume, instrumentation, speed, melodic figures, texture, embellishments and verbal interactions within the group’s improvisation.</td>
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</tbody>
</table>
In critiquing the different levels of the model, it should be noted that very little material communicated in the narratives from the Open listening were included in the final description. Although this level assisted the researcher in achieving a state of controlled and focussed listening, these narratives were frequently subjective and even metaphorical in nature, leading to their exclusion. The Musical listening produced the purest narratives, however, it is important to note the difficulties experienced in bracketing out the intramusical implications of the music. Only the reassurance that this information would be addressed in the Dynamic listening made it possible for the researcher to ignore the interactive

| **Dynamic** | Listening is directed by the profiles of Bruscia’s IAPs (1987) and numeric values are attributed to the scales considered relevant by the listener across all profiles. | A narrative is generated by writing sentences about each of the scores within the relevant profiles using keywords from the IAPs. |
| **Group Leader** | Listening is focused on the musical material of the group leader and notes music therapy techniques used (Bruscia, 1987) as well as musical interactions with other instrumental lines. | A narrative is written that describes the musical material of the group leader and the empathic, eliciting, structuring, redirecting and procedural techniques used. |
| **Final** | A final listening that allows the focus to return to the ‘whole’ improvisation and is directed by the material that has been heard in previous listenings. | A distilling process is used that explores the material elicited from the four narrative descriptions generated in the previous levels. The distillation involves: identifying key statements, reorganising the information into structural categories, exploring the structural categories to determine meaning categories, the removal of replication and repetition and the creation of the final description. |
nature of the music. This is bracketing in action and it may be a significant realisation for music therapy researchers in determining the essential elements to be explored in future investigations of the music therapy interaction. The use of Bruscia’s IAPs (1987) to form the basis of the Dynamic Listening resulted in mixed success. The ability of the IAPs to guide listening to the musical properties and their interactions with other aspects of the music was successful, however, the language used in this version of the IAPs contained a degree of interpretation that was counter to the aims of this research, for example controlling/conforming, tense/calm. In contrast, the twenty-four leadership techniques selected from Bruscia’s (1987) compilation, comprehensively assisted the researcher in describing the musical material of the Group Leader. This vocabulary simplified descriptions of her role and once distilled with the other levels of listening, provided valuable information that articulated the group leader’s decisions in the moments of music making. Thus, a significant understanding from this research is that only in combining and distilling all the levels of listening did the descriptions become truly relevant to the music therapy group experience. In other words, music therapists need to be aware of both musical and dynamic interactions in examining our work more closely. It is not a matter or one being superior to the other.

The separation of description from interpretation is useful and potentially offers a myriad of information about the experience of group music therapy improvisations. Although many possible interpretations could be made from the descriptive data, this research focussed on the changing group dynamics over time. In developing this study, the researcher
attempted to predict musical milestones that may be present at various
developmental stages in the group’s work together, based on a review of
the literature. A table was compiled that detailed what features of the
music may be prominent at particular moments in the therapeutic
process. The stages were then contextualised within a Symphonic Form,
comprising an Introduction, Exposition, Development, Recapitulation
and Coda. The researcher focussed particularly on the musical properties
associated with the beat, as noted by the participants and even proposed
that playing together in time may represent group cohesion. In support of
this attempt to predict musical features, Nachmanovitch (1990) has
suggested that there are ‘guideposts’ to assist in understanding
improvisations, rather than rules per se. He recommends that
“knowledge of the creative process cannot substitute for creativity, but it
can save us from giving up on creativity when the challenges seem
intimidating” (p.12). Despite this optimistic attempt to predict the
musical development of clients in group therapy, the results were not
conclusive. A further two independent verifiers were asked to sort the
unmarked descriptions of one improvisation from each session into the
order in which they occurred. They were given a copy of the Symphonic
Development Table to assist them in identifying key features. Little
resemblance to the actual order of the improvisations was suggested. As
noted by the interviewed specialists, it was not possible to predict
meaning or attach preconceived meanings to particular musical
properties. Nonetheless, on reflection there did appear to be a sequence
to the musical material of the group that could be broadly anticipated as
fitting within a developmental sequence. For example, the descriptions
made it possible to clearly identify the group members’ increasing ability to express themselves musically and to work together in a more cohesive way, although this was not seen necessarily as playing together in time. Rather, in the working stages of the group, the highly individualised playing of group members reflected their level of comfort and ability to express themselves authentically. In the affiliative and concluding stages of the group, playing together in time did lend a sense of togetherness to the shared playing. This research provides empirical support to the suggestions made by the interviewed specialists and highlights the inherent knowledge existing in music therapy that is not yet detailed in the literature.

However, the developmental sequence anticipated in the improvisations was clearly seen in the analysis of the group leader’s musical material. It was possible to reflect on the musical material of the group leader and to identify her changing role and responsive use of leadership techniques, although once again, it was not possible to predict it. The narrative descriptions identified that the group leader played a musically dominant role in the initial sessions with the group, modelling improvisation skills and providing a rhythmic ground for playing. Once cohesion was established, the group leader began to challenge the group to move beyond simple pulse playing and modelled more musically expressive playing. As the group reached the final sessions, the leader receded musically and focussed on forming musical relationships with other participants in the group and expressing herself authentically. These changes of strategy were apparent in her musical material, particularly assisted by the use of the indigenous terminology provided by Bruscia.
(1987) and used in the Group Leader listening stage of the analysis. The group leader’s techniques offered a very close reflection of the perceived group dynamics as they occurred over time. Additionally, there was a high level of agreement between the therapist’s anticipated role in each stage and the evidence available in the descriptions of her musical playing. Although the decisions made by the group leader were subjective and intuitive, this research provides evidence that it is not simply creative guesswork. Given the greater level of accuracy in the results describing the group leader’s development over time than the material of the group, it is feasible to suggest that music therapists have greater insight into their own role than into the nature of the musical material created in sessions.

The musical material created in music therapy group improvisations is obviously more than a reflection of the group’s dynamics, as suggested previously by Stephens (1984). It is also the creative and highly individual expression of the group members at a moment in time. Nonetheless, the musical analysis conducted revealed a number of significant insights into the underlying dynamics of the experience, with dynamics being defined as the nature of the relationships within both the music therapy group improvisations and the group experience. The insights were related both to generating deeper understandings of the musical material created in therapy and to the role of the therapist in facilitating the group’s work. In the case of this work with adolescents, it is significant that the benefits fostered by participation in the group were not uttered by the participants within the group itself, but only in the privacy and safety of the in-depth interviews. This emphasises the
importance of indigenous understandings and the ability of music therapists to have a superior level of insight into the musical dynamics involved in group work. This research provides empirical support that the dynamics of musical interactions in group music therapy can be articulated and described in a relevant and useful way. There is no need to distance ourselves from the musical material via graphs or scores, or to assume superiority by jumping immediately to interpretation of the material into the language of our colleagues. We have an indigenous language and it is a direct reflection of, arguably, the greatest gift we give our clients - what we hear when we listen.

References


On Becoming a Music Therapist: the Usefulness of Infant Observation in Training

Hughes, M. Heal & Sobey, K.

Introduction

The undertaking of a mother-infant observation has served as a cornerstone of the music therapy postgraduate programme at University of Surrey Roehampton. This paper shows how this particular form of observation (as described by Esther Bick, 1964) provides unique opportunities to learn from experience some of the basic therapeutic skills valuable to a music therapist. By drawing on actual examples of students’ observations, and linking these to therapeutic concepts and to the literature, it becomes clear how this experience is central to the predominantly psychodynamic approach of this training course.

In presenting this paper at the 10th World Congress of Music Therapy recordings both of a mother and baby and of music therapist and client were used to bring alive the ideas discussed in the paper. The first video gave three snapshots from an ordinary afternoon in the still early stages of the relationship of three-month old Toby and his mother. We showed the cosy satisfaction of feeding whilst being closely cuddled, then a brief unsatisfactory attempt to engage Toby in what might be described as “proto-conversation.”. This was followed by the delight of both when renewed efforts resulted in something more mutually rewarding. For the last three months, they had worked hard at “getting to know each other” There had been a complex series of negotiations between Toby and his
mum: their actual experience, their expectations of each other, all held in the real world within which they live.

If preverbal communicative behaviour were all music therapists needed to know about early relationships we could confine our studies to recordings such as these. Here we hope to show how much more there is to be learnt by regular observations in the family setting and will be tracing its usefulness through the observations and seminar discussions to the heart of the programme, the relevance it has for students’ clinical work.

There is something about infantile states of mind which is communicated by an emotional impact making it virtually impossible to ignore. The pull on us as witnesses is to do something: whether it be escape, provide consolation or distract the infant or ourselves from such distress. For mothers a response to the baby is a must, but as we shall see, for student observers the task is different. They are being asked to become aware of their own responses and learn to hold on to painful and difficult feelings without recourse to doing something that will make them feel better. Nothing is adequate substitute for actually being there to witness the development of this earliest of all relationship with those complex negotiations we have already talked about. We believe all this has relevance to the struggle we have as music therapists when we begin our work with new clients and that it will assist us in exploring ways of “being with” and “getting to know” them.
Mother-infant observation

Mother-infant observation has been at the heart of many psychotherapy trainings since the pioneering work of Esther Bick in the 1940s. She described some of the reasons for its importance in 1964 (p.240) saying that it helped trainee analysts

- to conceive vividly the infantile experience of their (child) patient
- to gain understanding of his non verbal behaviour and play as well as the behaviour of the (child) who neither speaks nor plays..
- to find out for himself how relations emerge and develop
- to compare and contrast his observations with those of his fellow students.

From its inception in 1980 the music therapy training at Roehampton was designed to include a modified, or at least reduced, form of this important learning experience. Our observation involves students observing a young infant within the family over a three month period. They are asked to establish a regular pattern of once weekly visits for one hour with the brief to just “be present”, absorbing and noticing as much as they can, whilst taking no notes and assuming no active role. The student has to find a way of fitting into the family as a non-participating observer, non-active yet intensely involved in the unfolding drama. At the same time they are encouraged to notice what role the family assigns to them: how are they seen and how does this change over the sequence of observations? As Bick(1964) puts it ... the observer should feel himself sufficiently inside the family to experience the emotional impact but not committed to act out any roles thrust on him (p.243) For example a student reported that the mother had asked her whether particular baby
behaviours were “normal” and later whether she thought the baby should be taken to the doctor when he had a sore ear. Helping the student group think about how the observer had come to seen as an “expert” was a good opportunity to learn experientially about “projections “ and “transference” - therapeutic concepts which we would be hoping students would have some understanding of by the time they begin their own clinical work.

Subsequently sessions are written up with students endeavouring to remember and record the sequence of events in the room. The skill we are seeking to develop is that of carrying out “a naturalistic literal observation where judgement and attribution of meaning are kept separate” (Rustin 2000)- the stance we wish to encourage is that of optimal open-mindedness. Gradually they become able to remember more and more significant detail and to find the words, which most vividly capture the events they have witnessed. They are reminded that the emphasis is on what is seen and felt as Reid (1997) puts it “see what there is to be seen and not to look for what they think should be there.” (p.1) This is self evidently a practical preparation for music therapists who need to develop the skill of writing up clinical sessions and later case studies.

Students attention will be drawn to the fact that, as with clinical music therapy notes, the greater the understanding that the observer has of the family, or the therapist has of the client, the smoother is the recounting and the clearer the writing. The better we understand our subject, the easier it is to write up. This clarity comes and goes throughout each
individual mother-infant observation and from one observation to another. Students begin to see that it is not about getting everything right or perfect but that the notes can serve a diagnostic function. This thinking can then carry over into their clinical supervision groups where it may be enlightening for students to become aware of how the pathology of their client “has got into” their way of talking or writing about session events, just as it may have affected their music in the session. Thus there is another opportunity for becoming familiar with the concept of countertransference.

The student group is provided with weekly seminars in which they take turns to present one observation so it can be thought about and discussed. The observer strives to detail the goings-on in the room, and the emotional impact that the experience has had on them. They listen to one another’s presentations, monitoring their own reactions, which may well differ strikingly. The seminar is a space not only for appreciating the actual observation but also (Reid 1997) to support the free associations, ruminations, and speculations of the observer and seminar members to see what other dimensions remain to be discovered. (p.4) They begin to understand how meaning lies behind behaviour and acquire the ability to “wonder” without knowing, to explore possible meanings or understandings in an open and creative way. At the same time they are helped to make links to relevant theory. Again the frame of mind engendered is one we hope to see them develop further when bringing their work to supervision during clinical placements.
Already we can see that various aspects of the task link to practical skills, theoretical concepts and a particular stance, all of which we would feel helpful to a budding music therapist.

What further skills and attributes does the observation experience aim to promote?

The observations allow the student to experience first hand the weekly rhythm of being together and then apart from the family. They are able to observe both the impact on themselves and the family. How does this change when it is near the end, rather than in the middle or beginning of the series of observations? What is the difference in feeling between the beginning and end of each observation? What is the impact of a change of observation time? At first students may not have picked up on the significance of setting up this “weekly rhythm” with attention to regularity and reliability in maintaining the time and duration of their visits. A student observer remarked that the mother had suggested moving the visit “because the baby was always asleep at the original time”. She added that she had concurred, and commented that how she was able to observe a feed. By the time she wrote up the observations in a final paper, she had identified feeding and nurturing as an important issue for this particular mother who felt unsure of herself in her role as provider. It was then possible to ponder on the suggested time change and hypothesise as to whether the mother had been motivated by an unconscious need to reassure herself by demonstrating to the observer her competence in the area of feeding. The first time a student meets such a suggestion (i.e. that a change in arrangements might have meaning in
terms of someone’s “internal world”) they often strongly protest - giving all sorts of rational explanations for forgotten arrangements, observations missed after unavoidable breaks and so on. Gradually they become more comfortable with this way of wondering about everyday happenings and realise that attributing meaning to them is not a denial of reality but can be enlightening, helping them to think about what might lie behind actions and what this might signify. This helps the training therapist to make internal, active sense of what we mean by “boundaries” a word which occurs so frequently. Again they learn from experience and struggle with these ideas within the observation rather than waiting to discover them in their work with clients where lack of consideration of boundaries could restrict their understanding of the dynamics of the relationship and potentially diminish the value of the therapy.

Unlike many other observation models, there is no attempt to focus on developmental changes in the infant - any such changes are understood in terms of the resulting emotional/social impact within the family or mother-infant pair. The lack of a cognitive task renders the student more vulnerable to awareness of their feeling responses to what they are witnessing. Reid (1997) reminds us that our …competencies protect us from being taken unawares (p.1) If a student’s focus is only on developmental achievements, this may be thought about as defensive, a masking or avoidance of some other emotional or relational issue which they need to think about. For example, what joy and power does a baby feel for the first time when he or she experiences the mastery of sitting up. And how does this link to the response of the mother? While many
mothers feel joy, pride and a sense of relief at normal development, others feel dread that a dangerous independence has begun.

There are many challenges to this exercise: as we have heard earlier, infantile states of mind are communicated by emotional impact with a force that may take us by surprise. This is particularly so as the events students witness resonate ever-more powerfully with their own earliest experiences of infancy, or more recent ones of motherhood. We are asking them to become aware of their own responses and learn to stay with the resultant discomfort and anxiety without recourse to doing something that will make them feel better. In therapeutic terms the doing something might well be ‘acting out’, or action to avoid feelings. As therapists we need to develop a state of mind, a condition of “not-knowing”, where there is no recourse to instant solutions or immediate understanding. Bion (1962b) uses Keats term “negative capability” to describe what he calls “living in the question”- an attribute we consider essential to develop in music therapy. Here we are relating experience to the vital component in therapy - his concept of “containment”. We have to learn to respect the emotional experience of our clients: not to feel impelled to move them away from their distress, but to share their experience of it and make it safe, less frightening. Waddell (1998) describes containment as the state of mind in which it is possible....unconsciously to be in touch with the baby’s communications of pain and of his expressions of pleasure.....be able to engage with them if calm and loving or modulate them if distressed and hating and to hand them back in recognisable and now tolerable form ( p.43) When a mother is struggling to bear her infants distress, when she feels herself
unable to be in touch emotionally with her baby, the observer is sure to be affected. They may go blind to the situation, they may find themselves thinking harshly of the mother, or they may be flooded by the desperation of the situation. The possibilities are endless.

**Case example:**

A student presented an observation of a woman whom I will call Katherine, and her baby Max. She began with a short history. Max was an unplanned pregnancy. The parents, both in their early 20’s, had been together for only three months when Katherine had become pregnant. They had moved in together in the last three months of the pregnancy, and the father had found shift work in a packaging company. The observer never met him. Katherine had no family nearby and found herself exhausted and lonely, trying to cope with a baby who had arrived four weeks early, with colic and who slept for only short periods of time. The observations spanned from the baby’s second month to his fourth.

The mother truly struggled to appreciate having a baby at all. When the baby was three months, she found solace in apart-time job that took her out of the house for most of the day. She left the baby with a neighbour who minded several children. The baby she returned to was tired and needy, constantly distressed and often howling. Katherine complained loudly about what a demanding and selfish being he was, totally inconsiderate of others. There was no humour in her tone and most worryingly no love.
The group of students experienced the written and presented observation in a variety of ways. The music therapy student who presented the above material seemed unable to see or feel the struggles of this young mother. She seemed blind to the situation – everything was fine: “Oh well that’s just how some mothers are”. Many in the seminar were horrified as they felt or identified with the desperation of the baby. Sympathy for this mother was in short supply. Someone shouted out, “No one asks to be born!” A minority, some of the students who were mothers themselves, felt great empathy for this needy young Mum. In short, the emotional experience of the different group members were as split and varied as the members of this fledgling family. The feeling of no containment was rife. Just as the family needed some help and holding, so did the seminar group. How could this be done?

There needed to be established a non-judgmental, thinking state of mind where all the different experiences of this family could be held and thought about. The group could then think imaginatively about what was happening. What was this mother struggling with that made it hard for her to feel the needs of this baby, rather than experience the infant as a spoilt, demanding and unrelenting needy creature? What was getting in the way of their spontaneous intimacy, their joy in each other’s company? And more to the point, what a rough time this young mother has had!

Once this reflective, non-judgmental attitude was established, the observer found herself enabled to remember and recount more details of her observation. There were many examples of this mother being unable
to manage or hold on to her own distress and a need in her to pass it on. “Ready for a feed? You can just wait while I get my cup of tea.” By the time the cup of tea was had, the baby was past feeding and beyond consolation. It seemed that this mother could not hold and contain her baby’s distress until her world around her could provide her some support or containment.

Martha Harris (1964 p.268) discusses how frequently student observers tend to find fault with the mothers, to ...criticise rather than empathise. In seminars it may be possible to alert students to this tendency in terms of how this may then have led them into over identification or idealisation of either mother or baby. The whole notion of defence against psychic pain is at the root of the unconscious processes we are helping students to learn about. An understanding of it comes about partly by students recognising their own defensive reactions. However it can also be useful to think about infant behaviours which they actually observe and then reflect subsequently on how such behaviours may be laying the foundations for habitual ways of coping or defensive patterns that may persist in later life.

**A further case example:**

A student is visiting a family with two children, Sarah just two years old and baby Jonathan now four months. It seems a secure happy family with a much wanted baby and traditional parenting roles - father at work and mum staying contentedly at home with the children. Mum has just left the room to go and get cups of tea from the kitchen. Jonathan is lying under a baby gym enjoying the rhythm of a rocking clown. He seems to
the observer to be punctuating its moves with excited movements of his arms and legs. His big sister is aware of the observer’s interest in the baby and is struggling for her attention. She doesn’t seem to be getting any at all and so drops the drum she has been banging, crawls over to Jonathan and begins to kiss him all over his face. Is this affection or aggression? Perhaps both, but how do we know?

The observer feels uncomfortable, and even responsible for Jonathan’s predicament. She feels that she needs to intervene, to move Sarah away from Jonathan. She feels that Sarah is being a jealous and aggressive big sister. However, she manages not to act but to stay sitting and wait for the return of Mum. This was important, as it allowed her to witness how Jonathan defended himself from his sister. Her intervening would not have changed the jealousy of the sister or greatly altered Jonathan’s experience, it only would have meant that she didn’t have to see or, more importantly, feel the jealousy of Sarah or the discomfort of Jonathan.

Let us continue with the observation. Jonathan froze slightly and then turned his head away from Sarah. The discomfort the observer picked up on resulted from a perceived threat to Jonathan’s peace of mind. This led him to demonstrate an early defence. Alvarez (1997) (p.124) has written of the work of Papousek and Papousek (1975) who looked at the response of infants placed in frustrating situations that they were unable to influence. Before two months the infants responded with a state passive unresponsiveness, they begin to ‘play possum’. After three months, they use active avoidance. Alvarez linked these two responses to the development of defences: the student had observed active
avoidance in face of an anxiety-provoking situation. This helpful example was then shared with the seminar group through her presentation. Waddell (2000) makes the same point saying such behaviours \ldots resorted to too often may become built-in aspects of character rather than functioning as temporary respites. This persistence is often exemplified in the behaviour of our adult patients and such links were discussed in an earlier paper (Heal Hughes, 1995) “A Comparison of Mother-infant Interactions and the Client-therapist Relationship in Music Therapy”.

It can be deeply disturbing for a trainee therapist to be faced with a client who is unable, unwilling and apparently unmoved by the musical opportunities on offer - remaining silent and inactive for much of the therapy. It is arguable that the sense of rejection and uselessness they feel in response to apathy and intractable passivity is even more acute than that experienced when a client throws away instruments, runs out of the room or “actively avoids” to the extent of refusing to come to sessions at all. Understanding these behaviours as being probably rooted in early infantile experience allows us to think in a more helpful and meaningful way about our clients. Even the most boring, repetitive behaviour presented to us may have such significance and this not only helps us deal with our own feelings of inadequacy but keeps us curious, interested and optimally attentive. Attention in itself can be an important therapeutic factor. Reid (1997) points out \ldots we are always aware when someone is really attending to us. She writes that the observation situation allows us to \ldots discover how much an infant responds positively
to the experience of having our close attention on them and students may find it encouraging to bear this in mind during their clinical work.

The group experiences described above illustrate three points in particular. First, the introduction of one of the main functions of their group supervision: providing a ‘containing’ (Bion 1962b) environment that enables them to bear the emotional communications and disturbances of their clients. This support is crucial for the therapists during and after training.

Secondly, we have looked at the tendency for observers to jump to passing judgement and the way this might be seen as defence against the discomfort of some painful feelings that surface in response to events witnessed or described. This closely parallels a concurrent experience within the training - that of weekly seminars in which students share their individual experiences of a series of visits to potential work settings. Difficult situations often arise on these visits and both clients and staff impact strongly on the observing student. This can lead to descriptions which imply criticism of staff attitudes or overtly blame them for the painful conditions of the clients. It is important that students have a framework for examining their own judgement of others and what this actually reflects. For instance, helplessness and a fear of their own ignorance. It is vital that before embarking on their own casework, students become of their own habitual responses as well as the dynamics and unconscious assumptions which occur in all groups from families to institutions.
The third point is linked to this. The seminar group gives the student an active experience of splitting which often happens when there are case discussions in the real working world: different members of the professional team link into different parts of the family (or aspects the client) and at times each person believes that they have the ‘right’ understanding of what is happening. It is hoped that students come to see the importance of all opinions being taken into account as reflecting different facets of the client’s or family’s life.

**Conclusion:**

In planning this paper we hoped not only to show how multi-faceted and rich undertaking infant observation can be, but also to draw parallels with clinical music therapy material. Time and space did not allow for specific music therapy casework to be described but links have been made with various aspects of the programme and the skills and attributes we would like students to acquire. We concluded our presentation by showing video of therapist and client making music together to remind ourselves how these ideas do feed into real-life musical relationships. Ideally we would have liked these to be taken from work with adults to emphasise that infant observation is not just a preparation for work with children. Such material was not available for public viewing for ethical reasons. However the examples were chosen with the feeling that the music itself was not being particularly specific to either an age-group or diagnosis. First there was an excerpt connected fairly obviously with the mother baby interaction shown and described at the start of the paper. The three year old multiply handicapped child lay next to dangling
chimes. She looked at them and with difficulty grabbed and rang them; then she paused and met the eyes of the therapist who responded with a similarly shaped phrase on the viola. The two engaged in an animated turn-taking dialogue. The second example showed a different kind of togetherness: one where child and therapist at the piano combined their sounds in a less organised but more intimate way. Stern(1985) commented that research showed the closest moments of contact between mother and infant came not in the to and fro of turn-taking but rather when they vocalised in synchrony which he called communing. This word sums up those special moments in a relationship which are particularly well enacted in shared music making and for which all our studies are just a preparation.

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Prologue

(1) It is June 2001. My son is 5 days old and I can but marvel at the determination he shows for greeting the strange new world he finds himself in. I imagine it a place of bright new intensities: new colours, new sounds, new aroma, new warmth. I try to picture the slow definition of light and shadow, the sudden clarity of sound and silence, the brand-newness of air on skin. How can it be to leave the sequestered safety of your watery universe for the light and heat of day? I reflect on bridges between these worlds: the muffled yet recognisable voices, the daily patterns of activity and rest, the absorbed rhythm of his mother’s living.

It is indeed a world of wonders and terrors. He is in my arms. Terror has suddenly taken hold. I walk with him, rock him, try to soothe him. It seems we cannot get into step; we are out of rhythm with each other. An African song enters my mind and I play it to him:

This music does something. It restores our soothing mind-body rhythm. We step together once again and life’s continuity returns for a while. It has been the first of many moments when music has given us both a way of putting my son’s world back together again. I wonder about the music, the way it suggested itself to me; its powers of transformation. I feel its
pulse, how it wants to lift and rock you; I hear its steady emotional intensity and harmonic structure – rich and sonorous, voices set closely and moving together – and how they cradle and hold you.

(2) It is September of the previous year. I am on a working visit to Cape Town, South Africa, and have agreed to go to a church service in one of the Townships. Immediately I am struck by the extent to which music is woven into the whole pattern of the ceremony. It often comes unexpectedly as someone spontaneously begins a song with which the others soon join. Here is music to dance to, to stomp with, music that is sung standing still, music to sit quietly with: a richly elaborate yet spontaneous use of sound and movement.

It is time for the sermon and three young people get up in turn. They walk around the church, talking in an impassioned and rhythmically stylised way in the Xhosa language. Later I discover they were speaking about drugs and gang violence and HIV in the community. The second speaker becomes visibly distressed soon after she begins. Members of the congregation articulate a soothing ‘ahh’ and she begins to speak once more. She becomes distressed again and the soothing utterance urges her on a second time. It is not enough. She begins to weep. Suddenly a song starts up, quietly to begin with and then building in harmonic intensity. Soon we are all singing and continue for some moments. The music stops. It has done its work, for the young woman begins to speak again with renewed clarity and fluency.

I am left with a sense of having encountered something new. I come away with fresh thoughts about music; about music therapy (I feel I was
witness to a powerful indigenous form of community music therapy); about what you can do with music; about music’s capacity for personal and social transformation.

**Introduction**

These two personal moments incarnate the main themes of this paper. The duality of music will be my main focus: music's capacity for both reflecting and shaping experience; its use in forming and transforming personal and social identity; music as a process of transformation as well as attunement. Views from developmental psychoanalysis and social constructionism will guide the first part of the journey. I will then move to consider what these ideas and understandings allow us to do within the world of music therapy. I will be reflecting on the ways in which people with many different stories – stories of infant deprivation, chronic mental health difficulties, life-limiting illness, community trauma – have been able to use the transformative potential in music to hear themselves in a new way, to evoke and create new personal narratives.

My training at Roehampton Institute London emphasised a broadly psychodynamic view of improvisational music therapy. I have found this a rich resource over the last 12 years, particularly in my work within learning disabilities and severe mental health difficulties (Stewart, 1996a; 1996b; 2002; Walsh-Stewart and Stewart, 2002). However, as I journey on in therapeutic work, treating an increasing number of people who do not have organic damage or deficit, I find myself less and less
willing to align exclusively with one school of therapy. I am more interested in finding a therapy that works for a particular patient, rather than maintaining allegiance to specific theories or individual personalities. I have found this shift a sometimes challenging yet ultimately creative, vital experience. (The 'therapeutic faith' necessary to beginning this work can so easily become a restricting and overbearing god).

Arguably, the psychodynamic approach to music therapy (in the UK at least) has tended to focus on the idea of music as representation – music as a reflection of the internal world – and the receptive-adaptive role of the therapist. In doing so it has, in my view, neglected the potential for music to generate or transform reality. In favouring music's built-in capacity for interaction and relationship, the psychodynamic approach has tended to minimise the role of music as a phenomenon in itself, as the 'something new' in a therapeutic encounter. I increasingly find a need to redress this situation in my work, a need evoked as much by personal as professional experience. For instance, I see in my new role as father - in particular the way I have used music with my son and have seen his response to it - an instrumental contribution to this shift of emphasis. This currently evolving standpoint is one where inclusion of a transformational perspective of music offers a more optimistic view of music therapy and what it can do. In describing this standpoint I could do no better than Adam Phillips who delightfully declares his vision of psychoanalysis as one ‘more committed to happiness and inspiration (and the miscellaneous) than to self-knowledge, rigorous thinking, or the Depths of Being’ (Phillips 2000, pxv). What, I have found it useful to ask
myself, would a music therapy committed to pleasure and inspiration be or sound like?

I Theory

Christopher Bollas and the ‘Transformational Object’: A Psychoanalytic Perspective

In his book *The Shadow of the Object* psychoanalyst Christopher Bollas (1987) persuasively describes how, in the early days of life, the mother – or parent – primarily acts as a transformer of the infant’s experience. Early on the mother is the infant’s total environment. Through her repertoire of caring, soothing and enlivening behaviours the mother constantly ‘manipulates the environment to make it to correspond to human need’ (p36). In this ordinary everyday way she acts as a ‘forming and transforming idiom’ (p36) for her baby. These transformations are real - often physical - actions on the part of the mother, which serve to alter the infant’s psychosomatic experience of self.

Transformational experience is essentially wordless, an ‘experience of being rather than mind’ (p32). The infant’s experience of transformation precedes his knowledge that it is his mother who is mostly responsible for it; his way of ‘knowing’ in this phase of development is more existential than representational. He does not yet experience the mother as a separate individual, rather as a ‘process that is identified with cumulative internal and external transformations’ (p14).

Bollas sees the preverbal transformational process as an essentially aesthetic experience, stating that ‘the mother’s idiom of care and the
infant’s experience of this handling is one of the first if not the earliest human aesthetic’ (p32). Here is an exciting link then with what we have come to understand about music’s role in early life (Stern, 1977; 1985; Trevarthen, 1986) as mother-and-infants’ first language of experience, their first attempt at inventing and reinventing the self. Like music therapist Adva Frank-Schwebel (2002), I am inspired by this kinship of mother and music as sources of self-transformation, how the ‘maternal aesthetic’ of early life (Bollas, 1987 p.35) is a form of ‘maternal music’ (Frank-Schwebel 2002, p.202).

If Bollas reinforces something interesting for us about music’s impact in early life, he also has something exciting to say to music therapists about its function in later life. Bollas is convinced about the way we continually carry with us a need for transformational objects, how we seek out experiences that evoke the promise of self-transformation: a new house, new job or a holiday. He sees the arts as the great mediators of these early memories of self-transformation. In a beautifully aesthetic turn of phrase he describes the way in which we can experience ourselves as ‘uncannily embraced’ (p4) by an aesthetic encounter. It is precisely this kind of embrace that I have long considered to occur in the everyday listening to music. I am thinking of those moments when a particular piece of music ‘hits the spot’. The ‘rightness’ of the music to that moment seems to me to have something to do with its ability to resonate with a particular aspect of our lived experience but, simultaneously, to transcend or transform it.
Music as Personal Transformation: A Social Constructionist Perspective

A central tenet within this perspective is that we cannot ‘know’ reality in an objective sense. Knowledge of the world comes through observations, perceptions, actions and interactions. Our identity – personal and social - is constructed through the stories we find to tell about our selves. It is also often constrained by the stories purveyed by the familial, social, cultural, political and economic contexts within which we live. For those seeking therapeutic help these are frequently contexts that confine identity within what narrative therapists describe as a ‘problem-saturated story’ (Freeman et al 1997, p.49), stories that inspire the challenge of shaping ‘alternative stories’ (ibid, p50) in therapy.

From a social constructionist viewpoint language – and this includes the ‘language’ of the arts – plays a fundamental role in constructing and reconstructing the narratives of identity. Language becomes a source of creating as well as reflecting reality. It enables us to make meaning, to shape more helpful metaphors for living. Music can have an important part to play in this process. Writing within a social constructionist perspective musicologist Nicholas Cook (1998) comments on how we can understand and use music as a ‘means of personal and social transformation’ (p128). In a vision remarkably congruent with music therapy, Cook sees music as essentially a form of action and interaction. Whether we are listening, performing or composing, it is about what music does to our view of ourselves and others that matters. Music is important as a means of representing or reflecting ‘the way things are’ but it also presents an opportunity for changing and reshaping realities.
It has been enlivening to connect these various views on music and transformation with my current vision of co-improvised music therapy. In one way the worlds of psychoanalysis and social constructionism make for strange companions. The psychoanalyst can seem so sure of his knowledge of ‘reality’ - of the way things are, have been and even should be to some extent - while the social constructionist is opposed to what she sees as the false power in this position, making a plea instead for the co-creation of therapeutic narratives that will help the patient attain their ‘preferred reality’.

Detailed discussion of connections between these perspectives begs another paper. However, it seems worth pointing out the way in which, to my ears at least, these potentially contradictory voices find a sort of harmony in the writing of Bollas. He speaks psychoanalysis with an ear for the ways in which our world is sometimes more constructed – and constructible - than knowable and explainable. Indeed my imagination sometimes runs away with the idea that both writers would be excited - in their own ways - by what can be created in co-improvised music therapy!

II Applications

What follows is a gathering together of many music therapy experiences and strands of meaning over a number of years’ practice. Clinical practice – making and sharing music and meaning – continues to be the driving force for any new understandings I come to about what music therapy might be and what it can do. This is very much the manner in which a transformational perspective of music therapy evolved for me.
I continue to be excited by how this process occurs, the way in which pieces of clinical experience accumulate and lodge themselves in my mind only to grow into larger patterns over time. I enjoy the way these patterns unfold and sometimes find uncanny resonance in my own lived experience, in conversation with friends or colleagues or the (often-accidental) reading of a text. These slowly evolving understandings strike me as a further example of the transformational process. From one standpoint they are simply evidence of my ‘professional development’; from another they point to my encounter with ‘evocatively nourishing objects’ (Bollas 1993, p?) that have helped generate new meanings for me about what it is to be a therapist, which in turn keep me alive to the process of making meaning with my patients.

Example 1: first inklings of a transformational perspective.

It is about three years ago and I am a therapeutic community working with a group of adults with chronic mental illness. A new member – D - has just joined the group. She is a ‘real live wire’ I have been promised! We are beginning the session and individuals are ‘signing-in’ with solo improvisations on their choice of instrument. D has appeared physically agitated and psychologically preoccupied since the start of the group. When it is her turn she chooses a headed tambourine and begins to play. Immediately she is absorbed by her music. Her face opens and her eyes light up as she gives herself totally over to the playing. She begins to shake the tambourine, lifting it high in the air, and then letting it fall with a dramatic sweep. It is as if her previous agitated state had been a form of dance just waiting for this music. Her body, the instrument and her playing seem fused together. I see and hear her in a new way.

This in someways very ordinary moment embedded itself in my mind and continued to intrigue me for sometime. I felt that D was showing me the potential for music to enable new self-experiences. For D it seemed
the music could shape her uncoordinated physical and unfocused psychological state into one of psycho-somatic integration and control. It allowed D to hear and feel herself differently as the music resonated through her mind and body. To the outsider it offered the opportunity to take the ‘dead’ description of a clinical symptom and transform it to the witnessing of an alive act of altered self-experience.

**Example 2: experiences of self- and group transformation**

It is some five months later and I am working with the group of which D is now a part. Each member has a form of chronic mental health difficulty. It is the beginning of the session and the group is sharing their solo improvisations. T is the first to play. He chooses the bongos today and plays for about four minutes. He is intently involved in this characteristically lively and rhythmic music. Some way into the piece he changes his way of playing, dragging the nails of his left hand over one drumhead while continuing with a steady pulse on the other with his right. The rest of the group note this change and look over at him. This playing intrigues me. An image enters my mind of the day-to-day T pacing the floor of the community house; an almost silent T, apparently oblivious to the world outside. I enjoy the contrast it makes with T now - so engrossed in and connected with his music. I wonder about the impact of this difference on T, how it affords him an opportunity to hear himself in a completely different way.

After the whole group has played we have a few moments to talk. I remark about how long each member took to introduce themselves - between 3 and 4 minutes each - and comment on how this contrasts the general silence held by many group members when in the wider community. I look at T and comment on how much I enjoyed his playing. T looks back, smiles and, pointing to the drum, says 'different!' [probably the third word I have heard T say in the course of the group]. I talk about how music can give us a different view of ourselves.
It is later in the session and we are improvising as a group. We are playing in a slow tempo using two bass chime bars, a metallaphone, large Chinese drum, gato drum and tambourine; I am playing the piano. The overall effect is one of rich musical sonority and a steady emotional intensity. At one point T - an otherwise virtually silent group member - initiates a clear crescendo that the others follow. It comes to a peak after which the group allows the music to fall back to its earlier dynamic. The conversation that follows runs like this:

J: 'isn't it surprising?'

Therapist: 'what's surprising B?'

J: That we can play together!

Therapist: 'mmm- Yeah! A good surprise!'

This particular mode of music has played an important part in the group improvisations for the last two months. Characterised by a strong, unified pulse, members frequently mirror each other's subdivisions of the basic beat. I have a keen memory of looking from the piano on many occasions to see arms rise and fall onto instruments with exact precision.

The group improvises a strongly cohesive music in which members are fused together musically and emotionally. T's opening solo is full of this connection too, a strong subjective affinity with both the instrument and the music he is creating. To my ears this is the music of self- and group-transformation, evoking a resonance with an earlier, preverbal mode of living. I hear it as a sounding of Bolas' (1987) 'aesthetic moment' (p16), an experience distinguished by a 'deep subjective rapport' and 'uncanny fusion' with an object (ibid, p16). As one group member frequently remarked, it is music 'where we are all harmonising'. It is absorbing this harmonious fusion of sound that provides a form of self- and group-transformation from which a more solid sense of self can grow.

Not that I always heard it this way! When this form of playing first emerged I wondered - from a more traditional psychodynamic viewpoint
whether it was more an 'avoidance' of loss than a developmentally useful experience of togetherness. As the group persisted though I began to hear an implicit appeal to alter my understanding. I found myself thinking of Alvarez (1992) and how finding an object and delighting in it - 'harmonising' with it - can be a developmental achievement for some deprived or disturbed patients. In reading Bollas I encountered a further resonance between the group's music and a search for a transformational object that is 'associated with ego transformation and repair' (Bollas 1987, p18).

Here then was a process of transformation for me, as well as the group. Like J, I found a way to be 'surprised' by the music and what it could do. This experience nurtured an important new meaning for me as therapist. It did more than that though for, in doing so, it enabled us all to further enjoy the music and meaning-making process. By staying close to the group and being open to its surprises, we were all able to create a more valuable narrative about what music was and could do for us.

**Example 3: The therapist as a transformational object**

At times, of course, it is the therapist who acts as a transformational object for the patient (Walsh-Stewart and Stewart 2002).

A colleague has been working with a very deprived adopted Romanian girl, C, for 10 weeks. C is eight years old and has a learning disability; she does not speak. While C plays some of the instruments and shows positive feelings about coming to music therapy, she can also become aggressive and will lash out at the therapist and the instruments. Something about the nurturing offered by the therapy seems at times to evoke an unbearable contrast with her earliest orphanage experiences. For the last four weeks the therapist has been taking the girl out of the room if she attempts to physically attack her or the instruments.
It is halfway through the 11th session and C hits the therapist hard in the face with a large gong beater. She is asked to wait outside with her adoptive parents for a moment. While outside the therapist thinks and acts intuitively. Taking a yellow blanket she places it in the middle of the room and then arranges the girl's favourite instruments around it in a circle. The therapist fetches C back into the room and leads her into the circle. C spontaneously takes off her socks and shoes; it is as if she has 'come home'. The therapist wants to welcome her and so plays a quiet note on three instruments in succession: metallophone, gong and xylophone. C. imitates exactly. The therapist repeats her gesture and C responds as before. C then moves to another instrument; she plays and then pauses; the therapist replies in the pause. C plays once more and waits in anticipation of the therapist's reply.

Here is the therapist-as-transformer acting intuitively, engaging with her maternal aesthetic. She creates a circle and invites C into it; she welcomes her home. The circle - an ancient image of wholeness – and the ‘music of welcome’ transform C's view of the world and her place in it. They help put the pieces back together again. This is a key mutative experience and one that proves a turning point in the therapy. After this session C is not asked to leave the room again.

**Example 4: Self-transformation and life-limiting illness**

This example illustrates how music can be a source of transformation in the context of life-limiting illness. K is 35 years old and has participated in weekly individual music therapy for four years. He has a chronic muscle-wasting condition known as Friedreich's Ataxia.

K's music is driven by opposition: the crashing blow of a cymbal, the poignant line of an African flute, the faltering melody of a metallophone. This music wails, cries out, rages. It is existential music that both screams at the illness attacking K’s body and conveys a vulnerability to
its impact. It is expression and transformation, a statement of ‘the way things are’ and a shift in the way things are. The music medium itself essentially provides this shift. As K literally absorbs the impact of the music he receives powerful somatic feedback, a bodily resonance that he has created. Music can help him feel more physically and psychologically alive. Here is an integrative force to put against the experience of bodily fragmentation. Here is music as psycho-somatic transformation and integration.

There is another dimension to K’s experience of music therapy however. He uses the time available after playing to create verbal meaning for the music. Together we play with words, create a verbal aesthetic for our wordless music. K talks about the music as his ‘lifeline’. He refers to the ‘battle’ between the instruments he plays but also how they ‘must learn to play together’. In the metaphorical vision we create the cymbal – the instrument that affords him the most powerful body resonance - becomes his illness. But not just that, for each cymbal crash also turns into a form of hitting out at illness and its impact. Life and aliveness are in this music too then, and find a voice in other instruments such as the metallaphone, bells and African flute.

Here K and I are moving into the ‘second human aesthetic, the finding of the word to speak the self’ (Bollas 1987, p35). Nicholas Cook (1998) would say we were enlisting words to give ‘specific expression’ (p125) to the music, adding that

‘music is pregnant with meaning; it does not just reflect verbal meaning. But words function, so to speak, as music’s midwife. Words
transform latent meaning into actual meaning; they form the link between work and world’ (ibid, p125).

Here, then, is music and words coming together to make emotional and verbal meaning of an experience of extreme physical and psychological stress. Here is words and music challenging helplessness and reinstating personal agency, making the unbearable more bearable and liveable. Reflecting and transforming.

**Example 5: Music in response to community conflict**

This last example focuses on a group of community volunteers in N. Ireland and how they have used music during a period of heightened community tension. The volunteers live and work in an area of high intensity community conflict, tension that builds as the annual summer ‘marching season’ approaches. Community centre staff identified their volunteers as a group that often misses out on support. As a result it was decided to offer them a music therapy input between Easter and summer. This took the form of a ‘MUSIC FOR HEALTH’ group. MUSIC FOR HEALTH is a community music therapy initiative I have been developing as part of my current work for NOVA, a Barnardo’s Northern Ireland project which gives psychotherapeutic support to children, families and communities affected by the Northern Ireland ‘Troubles’.

As my most recent work, this group represents my latest 'research' into how music can be both a reflection of reality and a forum for creating it. This was echoed in the group aims, which focused as much on helping to generate a relaxed body and mind as on offering the opportunity to voice feelings of stress and tension. The group emphasised the pleasure in the
act of playing music together as a challenge to the isolation experienced by some participants. It was a forum for creating verbal metaphors that linked the experience of music-making to everyday life and in ways that emphasised personal agency and problem-solving.

Here was a group that spent time tuning-in to each other’s rhythm each week and, in playing together, found ways to challenge their ‘stress rhythms’. A group where you could be heard and understood as members gave sound to their week in solo improvisations and heard others respond: ‘your week sounded…hectic…lonely…celebratory’. Here improvised group narratives offered a way of gaining insight into life experience. A group where relaxation and visualisation could come together with improvised music-making to soothe mind and body. Here metaphor could be used to help make more sense of life. The ‘dead beat’ of an exhausting week could transform into a ‘lively rhythm’ in the opening music. A carved wooden fish - the focus for a group improvisation - that appeared to have a different facial expression depending on where you sat, evoked a metaphor for how music-making allowed you to look at life stresses from a different viewpoint.

**Conclusion**

This paper is, in some ways, a tribute to the plurality of music, the fact that it cannot be pinned down. It has been about the reality that music can do many things, express many things, mean many things. Music is in its notes, rhythms and harmonies, the patterns that find a resonance in our minds and bodies. This is music as psycho-biological phenomenon. It is also something that we *do*, something that is part of us whether we are
listening or playing or composing. Music is also latent with meaning; it is a medium that engages the emotional and metaphorical mind. We tell stories with and about music. Words and music are not the same and do not render the same experience or meaning, but ‘we use words to say what music cannot say, to say what we mean by music, what music means to us. And in the end, it is largely words that determine what music does mean to us’ (Cook 1998, p vii).

This paper has tried to track my own evolving relationship with music, what it means to me and, therefore, what it can mean to those I work with. I have tried to show what has been possible for me in opening up to a transformational perspective in music therapy; how this can shift the therapeutic vision towards creativity, pleasure, personal agency; how music can both reflect the ‘terrors’ of the world and have a hand in shaping its ‘wonders’. It has tried to illustrate that the experience of therapy is directly related to what we conceive therapy to be, what we think it can do [as opposed to an idea that ‘therapy’ is something fixed, preordained]. Above all, it has been about recognising that what is important is what music allows us to do, to feel, experience, think or be.

Now I am only too aware that, in putting something in, we might be in danger of leaving something out. In our context we run the risk of running away with transformations and forgetting that people need to be heard and understood first and foremost. Narrative therapists Roth and Epston (1996) rightly encourage us to question if our communications with patients leave them ‘feeling that their unique experience in living is being fully, faithfully and poignantly described’ (p152). Whether the
music therapy patient can use words or not, our conversations – our aesthetic play – must surely aim for this. We must embrace the use of music as reflection and expression. But it should not end there. All therapeutic work must also look to the future. We must recognise that, in embracing music - and letting it embrace us – we don the role of artist. We are affording ourselves the opportunity to shape and transform our past, present and future. We are part of a compositional process, creating narratives in a new key. From this vantage point, therapy is - in Adam Phillips’ (1994) comment on Bollas’ work – ‘not so much understanding – finding out what character you are – but … freeing the potentially endless process of mutual invention and reinvention’ (p159).

References


In this paper I am going to explore the role of imitation and reflection in my musical interaction with children with special needs. My music therapy work is currently based in one special needs school in Cambridgeshire which provides for the educational needs of children with severe learning disabilities. We currently have full-time music therapy provision at the school, which is covered by two music therapists, Kathryn Nall and myself. The impetus for this paper came primarily from a fascination about the regularity and consistency of imitative responses that occur in my music therapy sessions. Over the time that I have been practising as a music therapist, I have been struck by the quality and intensity of interaction that can be achieved through engaging in imitative or reflective exchanges with children with special needs. When this is enhanced by a musical framework the results can be extremely rewarding and therapeutically constructive. I shall begin by exploring corresponding psychoanalytic and music therapy literature, and then move on to my own case studies. Within the case studies I would like to examine my responses as a music therapist and consider the impact of these on the client, in terms of both therapeutic objectives for sessions and my relationship with the client. I shall analyse subtle differences in the way that I respond to the client, and the reasons for and implications of these.
My purpose within this paper is not to categorise or clearly define the words “imitation” and “reflection” in my work, but to use this terminology as a basis for exploration of the therapeutic relationship. I would like to elaborate on this within the case work material.

Imitation can be defined as “following the example of, mimicking or making a copy of”, whereas reflection suggests “throwing back, showing an image of, or corresponding in appearance.” Many music therapists have written about the use of imitative and reflective exchange within musical interaction. Juliette Alvin (1966) stated that “Imitation and repetition are two processes through which man learns, develops and creates. They apply to sound when it becomes a verbal or musical language.” Alvin goes on to quote Aristotle “And further when we listen to imitations we all acquire a sympathy with the feelings imitated even apart from actual rhythms and melodies.”

Leslie Bunt (1994) discusses imitation within his work with children and suggests that imitative play can be crucial in the process of establishing contact with a child at the start of music therapy work. Bunt goes on to write about the research of Pawlby - “Early in infancy a mother tends to imitate the child more frequently, with the child imitating the mother as age increases. The kinds of behaviour Pawlby observed being imitated are interesting: vowel-like sounds, bangs and consonant sounds were the three most frequently imitated behaviours in her sample of mother-child pairs.” Bunt (1994) and many other music therapists have drawn parallels in their work to the developmental and analytical perspectives of Stern. Stern (1977) describes early mother-infant interaction and how the
mother constantly imitates the child’s behaviour. The essential element of this, however, is that the imitation develops and evolves into something else, so the child’s interest and focus is retained. “...the dialogue does not remain a stereotypic boring sequence of repeats, back and forth, because the mother is constantly introducing modifying imitations or providing a theme-and-variation format with slight changes in her contribution at each dialogic turn.”

(Stern 1977). Stern elaborates into his theory of “affect attunement” in which the “feeling states” of the infant are monitored and reflected back. Stern differentiates between an obvious mimicking of behaviour and an “attunement” which encapsulates the infant’s emotional state. He claims that the mother demonstrates an understanding of the infant’s emotional or psychological condition through physical and behavioural imitation.

Stern then makes musical parallels within the affect attunement and refers to elements of the exchanges. These consist of levels of intensity, temporal beats, rhythm, duration and shape. These elements are obviously highly relevant to interactive musical exchanges within the music therapy context. Winnicott (1971) debates the significance of the mother’s mirroring role in relation to the child’s changing moods. He considers the potentially detrimental impact of the mother’s inability to reflect back the child’s mood state if she is too preoccupied with her own emotional condition. To Winnicott the mother’s face needs to be the child’s first mirror. Ken Wright (1996) in his chapter on “Looking After the Self”, draws together Stern and Winnicott’s theories of “mirroring” and “attunement” and suggests that “Mirror images are always like this –
they mock because of their sameness – if I move, the image moves too. But nothing is added. There is nothing in the image which says: ‘I recognise you and respond to you’. Only a slavish identity with myself which tells me I am alone.” Hence he reinforces Stern’s statement that mothers subtly attune to their baby’s mood states, rather than directly imitating the behaviour. Hanne Kortegaard (1993) discusses mirroring in relation to music therapy work with schizophrenic patients. He claims that “By mirroring the patient’s music in her own sound language, the music therapist’s integrated self may serve a reverie function in relation to the anxiety which the patient expresses in the music.”

Linnet McMahon (1992), in her book on “Play Therapy” discusses the play therapist Virginia Axline’s technique of “reflective listening”. This involves the recognition of the emotional state of the child through play and discussion, and then reflecting the feelings back. The outcome should be that the child consequently gains insight into his/her behaviour. I would now like to move on to my case work material. An example of my direct vocal imitation of a child within her music therapy session comes from my work with a girl called Elsie. Elsie has a diagnosis of Down’s syndrome and is seven years old. I have worked with her for three years within the school context.

Elsie is very controlling in the way that she relates to other people and prefers to initiate interactive exchanges. She has a tendency to be very emotionally reactive and finds it hard to cope if she does not feel in control of situations. She resists close physical proximity with other people and moves away from me if I approach her or attempt to join her
in shared instrumental playing. Elsie has a great sense of humour and can often be drawn into interactive exchanges that are pleasurable and engaging. Once she is focused on shared playing Elsie is able to explore her voice freely in imitative vocalising with me.

Elsie often brings some sort of transitional object with her to sessions and this is frequently her doll. Elsie uses the doll for projecting both her aggression and loving feelings onto, and generally alternates between hitting Rosie (doll) on the head and then cradling her and saying “Poor Rosie”. She also uses Rosie as an intermediary between her and me, finding communication via the doll less threatening to her sense of control.

Over the time that I have worked with Elsie her capacity to explore vocalisation has developed enormously. She has been encouraged by my vocal imitation and musical support, and has become increasingly adventurous and creative in the use of her voice. Elsie often uses her doll to focus on for security and attracts my attention both through dancing the doll around and vocalising.

I illustrated my conference paper with video extracts which I shall describe for the purposes of this paper:

**Exploration of vocal exchanges/rhythmic piano framework**

Initially Elsie dances her doll around in the air and amuses herself, at the same time as deliberately attracting my attention. She is not facing me and prefers to keep her distance and consequent sense of control. Her main focus is on Rosie the doll, but she is also aware of my rhythmical
piano accompaniment and moves in time to the music. Elsie then gasps to openly attract my attention and increases her vocalisation. I begin to imitate Elsie vocally and this encourages her to develop and extend her vocalisation. She moves closer to me. The rhythmic piano accompaniment appears to soothe Elsie and it provides a secure, predictable framework within which she can explore imitative exchanges.

The accompaniment I use is based around a 12 bar blues structure and is an accompaniment which I find particularly useful in supporting vocal imitation. Blues chord progressions were originally written for “Call and Response” type vocal dialogue and are consequently ideal as musical support for imitative exchanges. The Blues has a relaxed rhythmical feel to it which can contain tension and anticipation without unnecessary pressure and expectation. If a child feels like vocalising in response to the therapist the structure provides support, but if the child does not respond vocally the therapist can continue without a break in the music. The Blues is suitable for using with children and adults of all ages as it is less “childish” in character than some other predictable chord progressions.

Within this musical framework I continue in my vocal exploration with Elsie. We allow moments of silence, sometimes followed by sudden vocal sounds from me which re-engage Elsie in our exchange.

Towards the end of the extract Elsie moves away from me but is vocally more engaged than ever. Her focus and eye contact remain fixed on Rosie, but vocally she explores my capacity to “attune” with her. A range of vocal sounds with varied intensity and pitch are now explored.
Within this interaction a number of factors enable Elsie to take a more relaxed and sustained approach to shared exchange. Elsie needs to retain her sense of personal space but at the same time is testing out my capacity to reflect back and respond to her vocal contributions. My reflection with musical and vocal embellishment leads to a sustained and exciting interchange. I would like to reiterate Stern (1985) at this point, when he describes communicative progression between mother and infant:

“…the dialogue does not remain a stereotypic boring sequence of repeats, back and forth, because the mother is constantly introducing modifying imitations or providing a theme-and-variation format with slight changes in her contribution at each dialogic turn;”

The music therapist has a distinct advantage in having the unique medium of music with which to augment and intensify this interactive process.

I would like to follow this extract by describing two more excerpts from Elsie’s sessions, both of which demonstrate my more reflective (rather than directly imitative) playing. On analysis of the video material, I was trying to define the differences between my direct vocal imitation and a broader reflective instrumental approach. It seemed to me that within a reflective response there was more anticipation involved on the part of the client. In this next extract Elsie is manipulating a reflective response from me on the flute. She is controlling my behaviour through her shaker playing, and this generates a specific reaction from me. I become “her
reflection” both physically and musically and she makes conscious responses to this.

**Reflective musical support**

Elsie explores “shaky” playing on the egg shaker and I respond to this by playing a trill on the flute and copying her physical movements. Eye contact between us at this point is intense and sustained. Elsie then slows down the shaking to observe whether I will “meet” or “attune” with her in this behaviour. The quality and intensity of the playing is extremely variable and she makes it quite difficult for me to follow her. Every time it feels like her rhythmic pulse will settle she dramatically increases or decreases the tempo.

Silences within the playing exchanges allow us to have eye contact and smile at each other. These silent moments create tension and anticipation during the musical dialogue. Elsie begins to thoroughly enjoy her control over me and this establishes enhanced security and balance within our relationship. Humour lightens the intensity of the interaction and makes shared contact more enjoyable and less threatening.

In this excerpt I reproduce both Elsie’s physical and emotional state, which again reiterates Stern’s concept of “attunement”.

Reflective play is also illustrated in the next extract where Elsie and I play the xylophones together. Within the extract Elsie is clearly dictating and predicting my responses to her playing. She requires an accurate reflective reaction from me and the intensity of the dialogue is maintained through this expectation and anticipation of my response.
Elsie seems particularly aware of her need for me to imitate her playing and to attune in this way.

**Imitative support establishes interactive contact**

Elsie and I sit opposite each other with two xylophones between us. She is initially prepared to play the xylophone in a “conventional” way. We both focus on our own musical instrument. Elsie explores glissandi looking up to examine my response and to see if I will copy her, which I do. Elsie quickly becomes bored of conventional playing and wants to embellish her approach to the instrument. Again she is constantly assessing whether I am in tune with her movements. She begins to explore bouncing the beater up and down on the carpet. I attempt to draw her back into the playing but quickly realise that I need to directly reflect back her movements if we are to retain our sense of dialogue.

Elsie explores playing the beater on the floor the wrong way up. It takes me a while to copy this exactly and it is not until I do that she re-engages in playing the xylophone. We then continue with reflective xylophone playing together and I introduce vocalising and singing with which Elsie joins in.

Had I purely mimicked Elsie’s beater investigation on the carpet she might have become fixated with this behaviour. Instead I directly imitate for a brief moment to “meet” her within this investigation, and then move the exploration on to further instrumental playing. In this way there is a forward flow of dialogic ideas, rather than an obsessive or ritualistic pattern of communication.
My role of imitator and reflector in my work with Elsie has been of paramount importance to the development of our relationship and in achievement of therapeutic objectives. This has been primarily due to the fact that Elsie needs to control dialogue with other people. Through allowing her to retain this sense of control, she has been able to engage in shared, co-operative interaction. Elsie does not like to conform socially in the conventional sense, but can be enticed into enjoyable reciprocal exchanges that evolve into Stern’s “theme-and-variation” format of communication. Elsie’s amusement and involvement in this process then allow her to relax and loosen her control over the interplay.

In the next two clinical examples I would like to demonstrate the use of instrumental rhythmical reflection, where the focus for the playing is based around song structures. This case study is of an eight year old girl called Daisy who has a diagnosis of autism. I have worked with Daisy for two years. Daisy is quite severely autistic although fairly naturally sociable. Daisy can be obsessive and repetitive in her communicative patterns, and is demanding and attention-seeking in the class room setting. Daisy is exceptionally motivated by music, and I rarely see the more difficult aspects of her behaviour in the music therapy context as she is generally focused on singing and playing.

Daisy is primarily motivated by singing activities in her music therapy sessions, and for the first year of her music therapy was totally disinterested in the musical instruments. She has gradually begun to explore expressive playing on the complete range of instruments available. The development of her playing over the last two years has
reflected her overall social and emotional development. Whereas initially she could only focus in a very fragmented way on social exchanges, now she can remain more consistently engaged. Her playing is becoming increasingly rhythmical and sustained.

The next two extracts demonstrate Daisy’s ability to connect musically and socially with me whilst involved in song related playing.

In the first extract Daisy has suggested one of her favourite songs, which I play on the piano. I attempt to support rhythmically and follow her somewhat fragmented drumming, at the same time as keeping the basic structure of the song coherent. Daisy joins in with occasional words to the song. This extends and reinforces her ability to use verbal communication.

**Musical support/reflective rhythmical responses**

Daisy has requested her favourite song “The Inchworm”. She launches into a spontaneous drumming accompaniment in reaction to my piano playing. Daisy’s playing begins rhythmically and enthusiastically, but the rhythmic consistency gradually diminishes. I reflect back this evolving rhythmic progression on the piano. Daisy is so fixated with the words and melody of the tune that she finds it hard to keep focused on the drumming. She periodically sings out the last word to each phrase. She glances up at me regularly and is totally engaged in the song and the shared experience of playing and singing.

Daisy appreciates the control she has over me in dictating which song we select and my rhythmical following of her playing. However, she is
extremely flexible in comparison with earlier sessions, where she could not focus on an individual song all the way through before demanding another. In a similar way to the exchanges with Elsie, there are interesting periods of silence which add to the intensity of the interaction. Here a combination of factors enable Daisy to remain focused on co-operative play. The structure of the song provides security and predictability (which is so essential for children with autism). This enables Daisy to take control and lead from the drum, and I can then reflect back her playing in a rhythmical sense from the piano. The excitement and anticipation of singing the words to songs promotes Daisy’s language development.

In a similar way in the next extract Daisy has selected a song for me to play on the flute, which she chooses to accompany on the tambourine. Again I attempt to follow the faltering rhythm that she establishes on the tambourine. Through this rhythmic following Daisy makes intense contact with me, and this provokes her to offer me the tambourine to contribute to the playing on this instrument. Without this rhythmical engagement and extreme musical motivation Daisy would find it hard to share interactively on this level, without some type of obsessive or attention-seeking behaviour taking over.

**Rhythmical reflection leading to structured turn-taking**

Daisy leads both in her instrumental playing on the tambourine and in her choice of song, which I play on the flute (“Never smile at a crocodile!”). I reflect back her rhythmically faltering tambourine playing on the flute.
There is sustained eye contact between Daisy and myself – she is focusing on the tambourine playing but is also very aware of me and predicting my playing.

Daisy spontaneously expresses an interest in more structured turn-taking on the tambourine and holds out the instrument for me to play. She then shouts out “Jo play the tambourine” and shows some confusion in the fact that I am playing the flute. This interest in turn-taking exchanges is something which has developed over time and demonstrates her increased flexibility in relation to communicative exchange.

It would feel inappropriate for me to engage in direct imitative vocalising with Daisy, primarily because of her verbal abilities and focus on actual singing of words to songs. I find that direct vocal imitation is primarily constructive with children who are pre-verbal, and particularly in the initial stages of language development. Obviously this is not age dependent but developmentally related.

Daisy’s interest in structured turn-taking activities is an element of our music therapy sessions that has developed over the last couple of years. Initially Daisy needed to have absolute control over the singing in sessions and could not explore the instruments, either musically or mechanically. She gradually began to explore the percussion instruments and was able to engage in expressive playing within the predictable framework of turn-taking. In the extract Daisy holds out the tambourine because she wants more of a physical and obvious exchange between us, in addition to the musical dialogue.
As with Elsie, my reflective musical responses to Daisy’s singing and playing have enhanced her capacity to connect and relax into communicative play.

I would like to finish with an extract of a nineteen year old boy with a diagnosis of

Down’s syndrome. I have worked with Sam for three years, primarily in a small group, and then individually as I felt that he needed the space to express himself freely in a one-to-one context. Sam is very lively and humorous in his response to social activities but can also be extremely stubborn and controlling. Within the school context he has limited opportunities to express the more boisterous elements of his personality, which are sometimes perceived by staff to be tiresome. He is generally very popular amongst his peers and with staff, but in the further education unit has little time to express himself either vocally or musically. As he has very little verbal communication Sam needs a space for spontaneous and humorous expression that is not perceived as “attention-seeking” or “demanding”.

In the extract I follow Sam’s drumming on the piano and we engage in imitative vocalising. Here there is a combination of rhythmical and harmonic support from the piano, which provides the basis for vocal imitative exchanges. I again use the 12 bar Blues structure to support the interaction.
Vocal and instrumental dialogue based on imitative exchange

Sam begins his playing with a few definite beats on the drum which I reflect back on the piano. He looks up in recognition of the interaction and establishes eye contact. Sam then experiments with a few lighter taps on the drum and grins when I reflect this back musically. Sam’s playing becomes more rhythmically complex and he begins to vocalise. The interaction becomes increasingly communicative.

Sam explores a range of vocal sounds which are contrastingly low and high-pitched, and is delighted by my imitation of these. He incorporates explosive and infectious laughter into our exchange! He begins to develop different rhythmic styles and body movements and seems quite liberated by both the musical and vocal support. The speed and intensity of the drumming builds up and Sam continues to engage in boisterous vocalising.

For Sam the music therapy space allows him to express the lively elements of his personality in a constructive and socially acceptable manner. Sam is extremely motivated by music and sound, and often becomes immersed in what Daniel Stern describes as a “positive feedback spiral”. This occurs in the extract as Sam offers a musical contribution, I respond, he then vocalises, I imitate, and the interactive intensity escalates. Sam’s enjoyment of musical interchange has provided an incentive for him to co-operate with me in sessions and to take an increasingly flexible approach to shared playing. He has also been able to explore both the expressive and communicative elements of vocalising and verbal interaction.
**Conclusion**

Imitative and reflective responses within a musical framework are integral to my work with children with special needs. As a music therapist I am essentially emulating the maternal role by responding in this way, both vocally and musically. This both enhances and nurtures the relationship one has with the child, and facilitates more fluid and connected interactive exchange.

Imitative responses from an adult can enable a child to feel heard, and this reinforces their sense of identity and individuality. When this evolves into reciprocal attunement, a previously isolated child can be drawn into increased social involvement. Additionally, imitative exchanges can enable the child to take control of the dialogue. This can enhance self-esteem and give the child a much-needed sense of control.

Humour as part of this process can be a useful tool. I am often amazed how much fun it can be to engage with a child through imitative exchange, particularly if they have previously been difficult to connect with. Using humour within imitative exchange can subtly diminish social defences and promote more flexible, freer shared interaction. In turn this can lead the child into more extended periods of expressive play.

So what impact does this have on me as a therapist? I have found that this notion of responding imitatively or reflectively frequently tests out my capacity as a therapist. In my work I have to analyse, with the help of the supervisory process, how I am responding within my work. When is it appropriate to directly imitate? Do I wish to reinforce existing behaviour within the client, or am I attempting to promote change?
My concluding suggestion is that the concept of imitation and reflection used within a therapeutic context is a powerful and valuable tool to be used with care and sensitivity, in relation to the needs of the client.

References


Workshop – What is Disturbed Behaviour?

Strange, John

Introduction

This workshop was presented by the Bedfordshire team of music therapists, working for the Education Service:

Liz Clough – team leader

Philippa Derrington

Gillian Hughes

Anna Jacobs

John Strange

The Education Service in Bedfordshire only uses Music Therapy, although a strong case could be made for the provision of other Arts Therapies. Music Therapy has been available to children in Bedfordshire for about 12 years, so it is quite a well-established service. It is based at the Child Development Centre, which is multi-professional and joint-funded by Education and Health Services. The team is peripatetic, travelling to a wide variety of schools, some Special and some Mainstream.

Bedfordshire’s school population is 65,000 and there are therefore many more children with special needs who might benefit from music therapy, in all types of school, than the small team is able to cater for. It is felt, however, that those with social, emotional and behavioural difficulties are least likely to have their needs adequately met by special educational
approaches or the various other services available to them, and so it is of these children that referrals are accepted from school staff and other professionals. Even so, it is only possible to offer one year of therapy to each of the children worked with, although this can be extended in exceptional circumstances.

In order to determine which children meet its criteria for emotional and behavioural disturbance, the team follows its own assessment procedure. Initially, the child is observed in familiar surroundings, such as the classroom or playground. Each case is discussed with other professionals who work with the child and somebody who knows him or her particularly well, such as the class teacher, is asked to fill in a questionnaire on all aspects of the child’s behaviour, school work and relationship with others.

Thus a clear all-round picture of the child is built up – their strengths and achievements, areas of difficulty, their methods of communication and most importantly their emotional state – how they cope with their environment, the situations in which they are comfortable and those which they find more difficult or stressful.

Subsequently, the child has two assessment music therapy sessions. These are video-recorded and viewed by the music therapy team, who together discuss whether the child meets the criteria. During these sessions, which are non-directive, the aim is to evaluate the emotional state of the child through the moods and feelings expressed, responses to sounds and music and use of instruments and voice, and through the interaction between therapist and child.
Rationale for the workshop

Recently the team began to question the effectiveness of the video assessment in establishing the level of emotional and behavioural disturbance. Often neither the disturbed behaviour described by staff nor indeed any behaviour that might be expected from disturbed or traumatised children was evident in the assessment music therapy sessions. Conversely, the team wondered whether some unusual behaviours that were observed might be responses to the novel situation of the non-directive music therapy sessions, such as might also be seen in children who are not emotionally disturbed. The questions the team began to ask were:

- Is it possible to define disturbed behaviour?
- What are we expecting to see?
- Are we expecting too much to be revealed in just two sessions?
- How would non-emotionally disturbed children behave in their first music therapy sessions?
- Are child-led, non-standardised assessment sessions appropriate for the stated purpose?

As the team had found no literature describing music therapy with children without special needs, it was decided to set up and observe a comparison group of such children in order to provide a baseline with which to compare the children referred for emotional and behavioural disturbance.

It was felt that a workshop in which the participants could form an unbiassed view of the behaviour seen in video-recorded music therapy sessions, without the prior knowledge of the children which the team
have when observing sessions, would isolate the information that can be gained from such observations and allow an evaluation of its reliability and usefulness.

**Procedure**

Participants in the workshop were asked to make and record subjective judgments of the behaviour seen in video clips of eight children. They were told that some children had been referred for music therapy assessment, and that the rest had not been so referred but included some with learning disability. None of the children had an autistic spectrum disorder. After viewing each of the eight videos, participants were asked to rate the emotional and behavioural disturbance seen on a four point scale of 0 – 3 (no evidence, possible evidence, clear evidence, compelling evidence of disturbed behaviour) and then to make a simple judgment of whether they considered the child to have been a genuine referral or a member of the comparison group.

**Results**

Participants were invited to give reasons for their ratings, which generated some interesting discussion, as the same features were sometimes judged by one participant as pointing to emotional-behavioural disturbance and by another as being evidence of normality. It was not practicable during the workshop to analyse the ratings on the four point scale, but answers to the simple question of “referred/not referred” were totalled on a flip-chart. The four genuine referrals were recognised by 100%, 80%, 71% and 20% of participants. The last of
these, where the majority view was “non-referred”, could be described as a “false negative”. The four comparison children were recognised by 67%, 62%, 57% and 21% of participants. There was thus less confidence that these children were not genuine referrals, and one “false positive”. There were 60% of correct individual answers overall and 75% of correct majority verdicts.

After the Congress, the ratings on the four point scale were displayed in a tally chart. Although this potentially offered a finer discrimination than the simple dichotomy of “disturbed/not disturbed” it was not legitimate to calculate mean scores, as the scale used was non-parametric. The median and mode of the scores for the four genuine referrals were identical at 1, 1, 2 and 0, and for the comparison children median scores were 1, 1.5, 0.5 and 0 and modes 1, 2, 0.5 and 0. Taking a cut off point of 1.5 as the minimum to qualify as emotionally disturbed, only one genuine referral and three comparison children would have been recognised.

Discussion

The analysis of the scaled ratings unexpectedly gave a less clear result than the simple “referred/not referred” dichotomy. The most likely reason is that the meaning of the four points on the scale had not been defined clearly and the score to be taken as the cut-off between referrals and comparisons had not been stated.

It might be imagined that the somewhat inconclusive results of both analyses cast doubt upon the validity of judgments based on subjective responses to short video clips. In fact the verdicts of the participants
exceeded the expectations of the team, who had embarked upon this workshop with considerable misgivings about the validity of even their own assessment procedure, in which complete sessions are watched and discussed by the whole team. Finding that a “naïve” audience arrived at six out of eight correct verdicts, despite having no prior information about each child such as is available to the team, was therefore quite encouraging.

The team has since decided to retain the video observation component of their assessment procedure. They feel that it often adds force to detailed prior evidence of a child’s emotional disturbance, and may illuminate the character and possible sources of the disturbance. In paradoxical cases such as the referred child whom workshop participants incorrectly but understandably judged, from the evidence before them, not to be emotionally disturbed, the child’s apparently normal reactions in music therapy are highly significant. They may point to strengths in that child which music therapy could reinforce and develop. They may also offer clues as to areas of the child’s home or classroom experience which may elicit the disturbed behaviour reported in those very different environments.
The Italian PLAIM Association is an association of music therapists in the Rome area. About two years ago, we set up a study group to share our various professional experiences and to discuss the difficulties and dynamics of the practice of clinical music therapy. Among the main issues we have examined are:

- definition of the respective roles when therapists work in pair
- how to end a music-therapy process
- and, of course, the subject of this presentation:
- from evaluation to action: protocol for taking charge of a patient

We consider it important to stress that, in Italy, music therapy is still not among the recognised, codified professions. For this reason, one of the main objectives of the study group was to formulate the most specific technical tool possible to evaluate potential patients, in both private and public institutions, and to determine whether or not to take charge of them, thus making the objectives of the intervention more effective and comprehensible to the other professionals involved.

Although at this point the Evaluation Form is strictly in the experimental phase, it can be seen as a fast-working tool to focus the music therapist’s attention on the patient's initial potential, with respect to his or her capacity to produce sound and music and also to build a relationship.

The following parameters are taken into consideration in the Evaluation Form:
• Sound-music capacity
• Rapport with space, instruments and the music therapist and
• General attitude

As you will see, it is a short form that can be filled in quickly.

The form is useful as a complement to the drafting of protocols on the basis of the theory of Rolando Benenzon, which is the main theoretical point of reference for our Association.

We propose using the form at the end of the first and last evaluation sessions (of which there are a total of either 3 or 4 encounters). This allows for the dynamic evolution of the therapist-patient relationship and makes it possible to obtain precise data from which to extrapolate objectives.

In our experience, the form has been extremely useful, especially for:

• Determining whether or not to take charge of the patient;
• Deciding whether the patient would profit best from individual or group treatment; and
• Defining short and long-term objectives.

At this point, we can look at the evaluation form itself.
Where is the ‘music’ in music therapy?

Swingler, Tim

ABSTRACT

The title of this paper does not imply that there is an absence of music in music therapy. The intention is to raise questions about the ‘locus’ of music making in therapy. Are music therapists taking advantage of electronic music technology, or are they locked into a backward-looking tradition which unnecessarily limits clients to a restricted sound repertoire? Isn’t there a duty to use sound in the most accessible and aesthetically powerful ways possible? In the USA and on continental Europe, the use of technology in music therapy is commonplace. In the UK, special education teachers and community musicians are well ahead of music therapists in utilising it. Technology demands new ways of thinking about music; those with a formal musical training can sometimes be most resistant to this. What investigations using technology have revealed is that the ability to think and behave musically can be present in even the most profoundly impaired individuals; by making the a rich palette of sound accessible, the trapped imagination can be unlocked, with profound ramifications in other areas of learning and life. Technology makes it possible for ‘non-musicians’ to become musically proactive in ways which would not have been possible hitherto, facilitating a hugely enriched musical dialogue between therapist and client.

Why is it that technology which makes a enormous range of expressive possibility available, with the affective and intellectual subtlety which until a few years ago could only have been performed by the most accomplished instrumentalists (making possible a hugely enriched musical dialogue between therapist and client) is being largely ignored by music therapists? Is it because of cost, the perceived complexity of the
equipment, or because it results in a significant shift of musical ‘power’ away from the therapist and towards the client?

In the United States and on continental Europe (notably Scandinavia), the use of electronic music technology in music therapy is not unusual. In the UK, however, special education professionals and community musicians are well ahead of music therapists in recognising and utilising its potential.

We might begin by asking a simple question: How is the process of choosing a musical instrument for a learner undertaken? Typically, some fairly basic questions might be asked:

- What does it sound like? What kind of ‘personality’ does the instrument have?
- How big/heavy is it?
- What does it look like; what are its qualities as an aesthetic object?
- How easy or difficult is it to play? How many months or years is it likely to be before the learner becomes motivated by his or her own progress?

In the context of music therapy, how often are these questions posed? Is the development of expressive musical skills something which is usually considered by therapists to be appropriate for (or achievable by) their clients? Or is the musical dimension seen principally as the therapist’s responsibility? Percussion has traditionally been the instrumental resource most widely deployed in the music therapy milieu, but some degree of physical dexterity is required to access even the limited palette of sounds available from drums, shakers, scrapers and so forth.
Debates about ‘new technology’ can be problematic because of the question of definition, and it is perhaps interesting to see some of the broader generalisations sometimes made about music technology in the context of the hostility encountered by Theobald Boehm when he introduced his redesigned fingering system for the flute in the early 1800’s. Somehow we feel that there is something qualitatively different about devices which are driven by electricity, and “I’m hopeless with technology” is not an uncommonly expressed view, but surely the pertinent question is not “am I the kind of therapist who likes this kind of resource?”, but rather “are the things which can be achieved therapeutically by using this technology sufficiently significant to make it worth investing time in learning how it works?”.

It may be helpful to think of new music technology not in terms of trying to define what it is, but rather in the form of a question: *what does it make possible in music which wasn’t possible before?* Four defining criteria can be proposed in answer to this:

- **Designing sound**
  - new technology makes possible the discovery, or invention, of new timbres and acoustic worlds.

- **Articulating sound**
  - it provides players with new means of accessing sound - of *playing* - without the need for specialist skill in fingering, bowing, plucking etc.

- **Organising sound**
  - it allows processes of composition to occur either as an individual or as a collective activity, without the need for traditional notation or theoretical knowledge.

- **Recording sound**
- it allows a high-quality record of the music to be saved either as a finished product or for subsequent modification and improvement.

Good quality music technology makes it possible for the musical imagination to realise a creative idea without the traditional prerequisites of instrumental proficiency or formal training. Intelligently handled, it can make highly sophisticated processes of musical conception, exploration, composition and performance accessible to new groups of creators. Samplers, for example, allow genuinely new and original timbres to be discovered or invented; sequencing programmes and MIDI controllers such as Soundbeam allow these sounds to be articulated and performed in complex and exciting ways; and sound processors, mixers and portastudios allow each contribution to be made into a recording of a quality which would only have been available to the wealthiest artists 30 years ago.

For example, Soundbeam - inspired by the Thereminvox developed in Russia in 1920 - was originally conceived as a tool for dancers - giving them a redefined relationship with music by using movement sensors to translate gesture into electronic sound. However it is proving to have dramatic significance in the field of special education and music therapy (Russell, ‘96, Perry et al. ’97, Hillman, ‘98, Rickson, ‘98). because even with profound levels of impairment the most minimal movements can instigate and shape interesting sound effects, trigger rich and exotic aural textures, or effect soaring improvisations. Individuals especially difficult to stimulate can benefit from what may for them be a first experience of initiation and control. This feeling of agency, and the sense of immersion in what can be a profoundly aesthetically satisfying world, results in
sustained periods of contemplation, learning and joy (Ellis, ‘95,’96,’97,’00).

There is an openness to the idea that music might be *played* in new ways, but there exist deeply held assumptions about how music should sound (or - on an even more basic level - what music 'is'). As Phil Ellis (1995) has noted, this backward looking approach sees music as comprising predictable melodic, rhythmic and harmonic structures, with an emphasis on correctness and repeatability. Music in the ‘looking forward’ category may feature irregular beats or an absence of pulse altogether; concord and discord may not be relevant concepts, and there is a strong emphasis on timbre.

Ellis' model is an attractive one, partly because it seems to allow the intended rendition of virtually any sound or combination of sounds to be validated as 'music'. Is this a convenient justification for technology which is impossible to 'play' in the traditional sense of the accurate and intentional rendering of chosen notes, chords and phrases, or is it a necessary advancement of our understanding of what might be possible in music? One of the most beautiful elements of Ellis’ research into the applications of new technology is its demonstration of the ways in which children described as having profound and multiple learning disabilities are able to compose and perform with it without being anchored to these traditional parameters, and of the crucial importance of *sound* as a creative and educational motivator.

To date research into the use of technology in music therapy has focussed on populations with various types and degrees of cognitive impairment,
for example children with severe learning difficulties and elderly adults with dementia/Alzheimer’s (Gaertner, ’99), though more recent work by Ellis and van Leeuwen investigating the applications of vibroacoustic, sound processing and Soundbeam technology with autistic children and elderly people with depression (Ellis and Van Leeuwen, ’00,) has suggested interesting directions for further investigations in the area of affective dysfunction.

Table 55  John's autism symptoms and their change according to aspects which allow us to observe behavioural change.

<table>
<thead>
<tr>
<th>Aspects of behaviour</th>
<th>Initial symptoms of John's autism</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Movement control</td>
<td>Extremely stiff gait</td>
<td>Episodes of relaxation</td>
</tr>
<tr>
<td></td>
<td>Body movements are stiff and clumsy</td>
<td>Episodes of smoother and more integrated movements</td>
</tr>
<tr>
<td></td>
<td>Patterns of breathing in and out are extremely unbalanced</td>
<td>Periods of balanced breathing</td>
</tr>
<tr>
<td>Attention span &amp; focus</td>
<td>Focus mainly self chosen; Guided focus only incidental and short</td>
<td>20 minutes (sometimes longer) of focused attention in the session</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guided attention</td>
</tr>
</tbody>
</table>
Many of the new machines demand not only a technical understanding of the operation of a particular device but also a new way of thinking about music. Often it is those with a formal musical training who can be most resistant to this, but it is clear from the observations of Ellis and others (Tuppen, ’99, Borges da Souza ‘95) that the ability to think and behave musically can be present in even the most profoundly impaired individuals; by making the sound-medium accessible, the trapped imagination can be unlocked. Music and sound is central to this approach which, successfully applied, can have profound ramifications in other areas of learning and life.

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TIM SWINGLER [BSc (hons), DSA, PGCE] trained in social psychology and as a teacher. He is one of the founding members of the National Community Music Association, and is currently a member of the ISME Commission on Community Music Activity. Having assisted with the establishment of the Soundbeam Project in 1990, he has given papers and workshops on Soundbeam in over twenty countries. He conceived the first Soundability course in 1995. This residential course which combines practical instruction in the application of new technology alongside research presentations and workshops has been repeated twice-yearly since then and now attracts delegates from all over the world. He lives in Bristol with his partner and their five children.

Tim Swingler, The Soundbeam Project, Unit 3, Highbury Villas, Bristol BS2 8BY, United Kingdom

Tel. 00 44 117 974 4142 Fax 00 44 117 970 6241

Email tim@soundbeam.co.uk
A school for children divorced from their family: First introduction of Music Therapy

Szumanski-Bodineau, Anne

Abstract

For the world of children (6 to 12 years old) very deeply wounded by family events in which they were involved, there is a school in Paris. It is adjoining the special home where they live all week long, divorced from their family.

These children are, at this moment of their life, incapable of normal social behaviour and unable to be taught in a conventional education school.

In this context, Music Therapy was introduced one year ago. This paper explains how Music Therapy, as therapeutic potential hypothesis is initiating and favourizing sociability and learning in children who come from breaking a home.

The school where the experiment takes place

The school is located in a working-class district of Paris. It is a little enclave inside a 5 acres site, protected from the street by a wall three metres high ending with a ridge of barbed wire. It has the like the atmosphere of a military enclosure or a prison. One wonders immediately what is being shielded: the outside from the inside or the inside from the outside?

Adjoining the school, a big grey building of three levels in poor condition, engenders sad and dreary feelings. In this building, a social home is housing about sixty children, day and night. This home is
dependant on an educational group for underage children in charge of a state institution: the Local Social Work Department.

An administrative staff, special education teachers and cleaning ladies (36 people at all) are looking after the children. The director lives on site. Only one watchman is present during the night.

The school is a two-storeyed building including four classrooms (2 at each floor), two little offices (one for the director and the other for administration), a room to isolate children who have an hysterics, and an uncovered playground. The school has no connection with the outside: all windows are looking onto the schoolyard. The ground floor windows are covered with wire mesh for protection from the sport balls. The children sometimes say “this playground is like a prison!”

This is an independent catholic school with a simple State agreement. This is an atypical organisation, today in charge of 40 children, that is to say two-thirds of the social home. The remaining children are receiving conventional education in outside schools.

Who are the children?

The children are 5 to 12 years old, boys for the most part. Most of the children, because of their ill-treatment, are under justice or administration protection. These authorities try to reach an agreement with the parents to keep on being the legal guardians of their children. Each child has a reference educator and his development is watched by the Local Social Work Department.
Why use the word “divorced” concerning the children in the title of this paper? In most of the cases, the children are automatically separated from their family and don’t easily accept, or don’t accept at all, being placed in the social home; in all cases they experience difficulty in understanding their placement in the home. So we can talk about break-up with their family even if their parents often continue being their legal guardians. The children know all about this situation. Except for serious cases, the children are allowed to go back to their families during the week-end.

Each child has his own problematic, and bears a heavy history. The children are victims or witnesses of violence from one parent, sexual abuses, nutritional deficiencies for economical reason, educational deficiencies because of missing or imprisoned parents, and so on. Most of them present psychic disorders linked with these familial events and their environment: they must live with the division of their family, of the people in charge of them, of the different pedagogical methods, and sometime also of the places. They are in great mental suffering. They have listening and concentration deficiencies. It is a real problem for them to learn to read and write. Artistic expression, especially with the plastic arts, is often painful; they encounter great difficulties having an active imagination.

**A Music Therapist in this school**

The director, arrived in 1999 in a school without liveliness. She had the will to bring various activities into the school to create a more positive environment. So she decided to develop various artistic activities like painting, music and school trips. Consequently, 4 people came into the
school during the three last years: a Painter, an English teacher, a Journalist and a Music Therapist (myself).

Knowing me and my Music Therapy training, the Director proposed that I participate as a Music Therapist at the beginning of September 2000.

My intervention as a Music Therapist in this kind of school is rather new. This school is atypical because of its organisation and the Diocesan’s management is very much interested in this work, unique in Greater Paris.

This school was set up with the aim of being a kind of springboard toward normal schooling for these children in great scholastic difficulties, most of them displaying behaviour disturbances. The adults in charge of their schooling are conscious of the important efforts the children have to make. They fear, despite their effort, most of the children will not reach conventional education schools and could even finish in prison. Moreover, in addition to the work of this school, France is short of places in specialised reception centres for 12 years old children. It is also important to note that future life of each child greatly depends of his results at school. All children, even the younger, know that and live all year long in the school with this reality.

**Therapeutic indications and goals of this experiment**

**Therapeutic indications:**

There is a gap to fill because only 10 children among the 60 follow a psychotherapy.
Within context of a springboard school for high risk children, it seemed to me that an introduction of Music Therapy would be an interesting therapeutic hypothesis, considering that clinical listening could initiate sociability and learning to children.

**Therapeutic goals :**
They could be listed as works on :

1. communication with the other,
2. listening,
3. security feeling of the child in his environment,
4. emotional aspect and get to the child’s development,
5. creation of an inner shield against outer divisions,
6. perception of the body life and experience,
7. orientation and awareness of the body image.

**Conditions of the experiment**

Aware of my insufficient experience as Music Therapist, I preferred waiting 6 months from beginning of my training until starting in this school. In February 2001, my intervention was limited to one class. The teacher of this class already knew about Music Therapy and welcomed this experiment. In June 2001, the director asked me to start a second class. In September 2001, to my great surprise, all the teachers show me their will to get my intervention in their classrooms.

Then my interventions are of two types : 3 classes with Music Therapy and one class with choral singing as I am specialised in singing. At this step, I encounter an obstacle : the adjoining social home’s direction does not seem to understand my intervention as Music Therapist, considering
this kind of intervention provided for a school. Nevertheless my intervention was confirmed by the school’s director. At the end of the second year, a project of meeting between the school, the home and myself is beginning to take place. The psychologist of the school wishes to be present during my Music Therapy sessions. She agrees to mediate between the school and the social home, particularly with the psychologist working at this home.

I am in the school every Monday all day. The Music Therapy sessions are scheduled for one hour in each classroom. The duration of the playtime is quite never respected. I finally get just 45 minutes for a group of 9 children. They are often disturbed at the beginning of the session and 10 minutes are necessary before they become quiet. Therefore the actual duration of the Music Therapy is only half an hour.

The school has no multipurpose room; thus my intervention takes place inside each classroom. The classrooms are large but I can only use 9 m$^2$ of free space for Music Therapy purposes. In this small space, the corporal expression is very difficult to organise. Classrooms have high ceilings and the sound space can reach high levels.

At the beginning of the session, children sit on the floor making a circle.

**Music Therapy sessions**

I organised Music Therapy sessions in two parts. The first part, around the Darbouka, is up to now a pure experiment and is linked to a work on the affective relation to the Instrument and the relation to the Other and to the Self, taking into account the ethnic origin of most of the children.
The second part is built around improvisation to amplify the work of creativeness, increase the possibilities in sound production and develop the relation to the Other as part of work in a group.

**Around Darbouka**

I begin the session by saying hello to them and by calling them by their first name, while playing my Darbouka. I always try to speak not too fast with a gentle voice. After welcoming them like that, I give them the Darbouka. This is a special moment where they often fight to be the first to play it. I don’t show them how to play it.

The rule is as follows: “I can and I am free to express myself as I want”. Then the right behaviour applying to this rule is: “I take care of the instrument, I am only authorised to speak when I have the Darbouka”.

During the first sessions, listening their own first name to the beat of the Darbouka is quite difficult: some of them get out the circle, hide themselves under the tables. This behaviour continues for about two sessions, especially in the younger children. In the next sessions, they accept and even ask to listen their first name spoken rhythmically.

Playing in front of the others is not very easy. This difficulty is amplified by the Darbouka being a native instrument of the countries from the children which are often originating. The shame of playing wrong is felt quickly. Their first words are often: “I’m going to break it”, certainly because the batter head of the Darbouka is made of a plastic material and breaking and destroying belong to their daily life. I answer them with a
smile inviting them to be free with the Darbouka, and with a wave of my hand to play. Then they begin to play it at once.

**Knowing how to play the Darbouka** : The first term of school year is difficult; most of the children, except particular cases, don’t succeed in playing it or, even, keeping a beat, or having the same rhythm during the two minutes. At this step, two minutes is a long time for them: some of them get angry, some others try to play and immediately stop, some others are crying. I noticed little violence in these moments.

I also noticed they are very persevering in their research work. The fusional relationship to the instrument evolves during the year to become a sharing relationship with the others. As weeks go by, only on the basis of my suggestions, each child finds his own beat and rhythm, at each time increasingly proud to show his improvement to his companions. The relation to the Other can then begin to exist.

The second term is very important because the success of their sound production’s makes them realise how everyone has his own way of playing the instrument. Four children still failed, unable to express a beat and to produce a continuous rhythm. At this level of failure, no relation to the Other is possible. Thus, to guide them in their research, I decided to help them, while paying accurate attention to their sound production, in order to detect the smallest pulsation and encourage it to emerge from them.

**Touching Darbouka** : When a child is really in grave difficulty, I take his hands and help him first to touch the Darbouka. This is an important step in his psychical development towards seeing himself differently. There is
an element of risk as each child may be teased by other children (this fear is less important when the therapist is present). Emilien, 10 years old, needed one and a half year to approach the Darbouka and touch it. In the early beginning he left the circle each session and lay away from it in a foetal position. Later he accepted to stay in the circle by stating: “I never played music. It is not now that I will begin” followed by “I know how to play music but I don’t want to”. One year later, he accepted to touch the Darbouka while laughing. A few months later, he began to play with it, finding a true pleasure in doing so.

Knowing how to play and playing in front of the others, implies: – being listened to, – listening to the other and – being able to stop to give the instrument to another.

**Being listened to**: It is difficult to play during the first sessions. The shame of doing wrong with the fear of being judged often arise and are characterised by a refusal to play. The eyes of the companions are disturbing. A glance or a smile encouraging them is often enough to put their mind at ease. Their fear fades as sessions go by. The play becomes a privileged time where communication with the other can take place.

**Listening to the other**: Waiting their turn requires patience and an effort. I often have to intervene verbally to avert fights but I have noticed a real progress throughout the year. The first sessions are punctuated by much negative criticisms made from one to the others. As the year goes by, listening skills develop and I notice that the effort is giving way to an increasing and shared pleasure.
Being able to stop: It is not easy for them to leave the Darbouka to their neighbour, especially for the ones who enjoy playing it. I am the conductor and they really enjoy seeing me in that role. I start the play and I manage the group. They know that the one who has the Darbouka is the only one authorised to express himself. The conductor is only able to intervene when there is a danger, for instance: he is the guarantor of the rule which protects the group. During the first term I stop the play of each child, but from the second term I rarely intervene: they are gradually able to manage themselves their playtime. However, at the end of the year, they are very disturbed by their school advising: it is more difficult for them to be able to stand each other but the work established at the beginning of the year remains.

Passing the Darbouka to his neighbour: It is agreeing that the other is allowed to play and that he exists with his own sound production and personality. These are important moments where a lot of Personal conflicts are settled.

My Darbouka is an heavy and strong instrument, so suits very well for difficult children. I noticed they take great care of it, much more than the instruments from the school. It is My Darbouka and the children recognise my ownership very well. It is covered in leatherette, a soft material that they like to touch. The batter head is made of a blue transparent plastic which allows much varying sound effects. To sit astride the instrument is their favourite position; sometimes they stop to play and bend to see through it as if they were trying to know where the sounds go.
Their fusional relationship to the instrument implies an important work on self-control and then on the adaptability of the child and finally the Personality growth (Through a re-building of the body-image). All through these sessions, I found the usage of the Darbouka relevant for these children. At the beginning of each session, they wait impatiently the moment they will play with it. After one year nearly all of them know how to play it. So this instrument seems to be a therapeutic object, through which of my constant impulse, children often surprised themselves.

All the three classes have quite the same behaviour in the first part of each session and, so, each class has not be analysed separately. This is not the case at all for improvisation, which comprises the second part of the sessions, and which I will now analyse.

**Around improvisation**

The second part of the session is based on improvisation with instruments, voice or/and self-expression through movement, without words. It is recorded on a cassette tape, then followed by a listening to recording and, at the end, putting this listening into words. My organisation and behaviour are nearly the same as in the first part; I remain the conductor.

The principal instruction is to try to communicate with their companions using sounds. The only inflexible order is to respect the instrument you play.
These moments are the most difficult of Music Therapy sessions for these children. A lot of conflicts and communication with the other problems appear.

In the beginning, the choice of instruments was rather poor. I only had a little box of eight instruments, mainly flutes and some small percussion instruments, a three-octaves electric piano and my Darbouka. Children only wanted to play with my Darbouka or the piano. I had to draw lots for the choice of the instruments but some of the children, feeling unlucky, got out of this improvisation time and/or got angry even became violent. Five months later, at my request, the school’s director ordered new instruments.

The instruments I can now use are: a small Darbouka, two Balafons, six flutes, one harmonica, one octoblock, a set of little bells, a guitar, 2 electric pianos, some small percussion instruments as a tambourine. The children’s favourite instruments are, by decreasing order: my Darbouka, the guitar and the two pianos. But I generally avoid letting the children use my Darbouka during the improvisation, in spite of their insistence, rather keeping its use for the first part of sessions.

The listening to their record sound production, when it is possible, looks like that: the children are handing the closer than can to the tape recorder to identify at best their own sounds. Putting this listening into words at the end of the session always takes place, even if it too short in time and even if I lack time to leave them speak enough. Anyway children can talk and the analysis of their words should give rise to a whole work itself.
During improvisation, children’s behaviour depends on their class and age.

For the class of the younger (6 to 7 years old): The improvisation with instruments is very difficult to manage. It must be shortest as possible, no more than two minutes, because they deteriorate very quickly and get into violence with their companions and can break the instruments.

It is important to understand what happened to them this year. The teacher in charge was only present during the first term. She was not anymore able to bear the children and was shouting at them a lot. Two women only able to stay one week each, then an inexperienced but nice man followed. This last teacher had finished the school year with children. So during the two last terms, the children’s bad-being revealed during Music Therapy sessions: a child has tried to bite me. Unwillingly, I had to divide children in groups. With the director’s consent, I organise for them half an hour sessions for two groups of 4 children.

The first part of sessions is rather calm with the Darbouka. But during improvisation time I have to be very watchful. A learning in the Relation to the Other is more necessary during this time but needs a work about a full year for these children. Anyway This Relation to the Other remained often a fusional relationship during all this year for them, when it has been developed in the other classes.

Onomatopoeia vocal expression is favourite game for some children.
Self-expression has become possible in groups of four children, even if it remains individual. It is very difficult for these age children to go to meet the other.

The children ask me systematically to record their sound production but listening to their record is unbearable for them. I often had to shorten.

**For the class of the 7 to 8 years old children** : Improvisation time is easier to organise, even if the set up is quite long, because the orders were well understood. They like at most the self-expression. To achieve a better group work, for instance I divide the class in two groups : one group improvise on the instruments and the other group get into relation with self-expression.

If playing and communicating together with the instruments is easy to achieve, in return moving together is more difficult. Children actually are organising against the order to express themselves apart from the group, so that each one can show to the others how he is able to move and dance with music. This behaviour can be explained by their inner deconstruction.

**The class of the 9 to 11 years old children** : I consider this third class as the best experimental class because I can be alone in it with children. The therapeutic relationship is not disturbed by a third person who often acts as an authority reacting at once on the children’s behaviour. I must face alone the children’s aggressiveness and then the session progress is slower. But children expressed themselves more freely and they are more smiling.
They dare to express their tastes and desires in sound production more readily. They behave much more freely but, on the contrary of other classes, onomatopoeia vocal expression and self-expression are more difficult. This is certainly because, in his class, children are psychically much more disturbed.

The triangular relationship between children, music and therapist can better take place when the teacher is not present. In this case all things can be expressed without inhibitory and discrediting criticisms or without the fear to be judged.

Conclusions

A first assessment of my intervention was done at the end of June 2002 with all the teachers. On the whole, the Therapy concept does not seem to be fully accepted but my work begins to be better understood and then better welcomed. So teachers now agree that I am conducting the sessions alone with the children.

Results, compared to therapeutic goals, point out a good use of the Darbouka as a therapy object around which the first part of the sessions is built. Second part of sessions is built around improvisation, which is not so easy to manage and is more relevant to the psychical problematic of children. It can not be easily analysed and should be developed in an extended work, including cases studies. This one can take place as a research part into a thesis work.
The school’s director made a positive evaluation on this experiment and her superiors in visit found children delighted with it. So this experiment will be carried on next year where:

- I will be alone with children during sessions
- I will validate the hypothesis of Darbouka as a therapy object, with the use of an instrument of the same origin, as a Djembe.
- A work will be organised with the school’s psychologist. This work will deepen this experiment

and should confirm the relevance of the Music Therapy as a therapeutic indication in this kind of organisation.

**Endnotes**

* Student in the last year of the Music Therapy Training Course at the Schola Cantorum. Thesis in 2003. Lyric artist and Song Teacher. Instruments: piano. guitar for accompaniment purpose and percussion instruments (two obligatory disciplines in the training).

** Founded in 1894 by Charles Bordes, Vincent D’Indy and Alexandre GUILLEMENT, the school set up definitely in 1900, in rue Saint-Jacques in Paris, at the place of an old and exceptional English Benedictine convent dating from 1640. The Schola Cantorum is an independent superior school of music, dance and dramatic art. It holds a role of the first rank and plays an important part in the Parisian, French and International musical life. Today close to 50 disciplines are taught. In this school, Art is considered to be a formative element of the personality. It is the reason why competitive behaviour is not accepted. Open to all ages, the school distinguishes itself by its’ pioneer spirit, its
power of adaptation and, above all, true independence. In 1998 an Art Therapy department was opened to prepare students to a postgraduate degree of Dance Therapy or Music Therapy.
Music therapy with hearing impaired children – A study -

Thoms, Karen

Since 1999 I have been doing research to examine the components of communicative development within the work of music therapy with hearing impaired children and I’m looking forward to presenting to you my work as a music therapist and in particular the results of my research.

• When I talk about music therapy with hearing impaired children it is necessary to characterise the context first of all and to give further particulars about the cochlear implant.
• I shall then describe the approach, objectives and general outline of my study.
• I shall present short video examples from practice to illustrate procedures, evaluation and results of the study.
• In conclusion, I shall summarize the results and the implications for music therapy in practice.

Hearing impairment is a general term to describe all types and degrees of hearing damage for which there is no medical remedy. Nevertheless, deafness and hearing loss are no longer considered to be static phenomena; instead, ways and means to develop hearing abilities are accepted and encouraged. The process of listening is of increasing importance in the treatment of hearing-impaired children.

This changed perspective is mainly due to three aspects:

• The interpretation of listening as a central nervous procedure of processing
• The improvement and expansion of amplification technologies
• Earlier diagnosis (screening of neonates)
In recent years, these changed conditions led to a new education and therapy approach for hearing-impaired children: the so-called auditory-verbal therapy. In 1999, 73 % of all institutions for early stage treatment in Germany already reported that they had integrated this concept.

These trend have implications for music therapy as well: listening plays a major role in my work, too, and I see applied music therapy as a complementary treatment and part of the auditory-verbal therapy.

Concerning the expansion of the “amplification technology”, one new technical device has to be mentioned in particular: the “cochlear implant”. Let me just say something about this hearing aid which is still widely unknown:

The cochlear implant - or CI for short – is an electronic hearing aid to replace the lost functions of the inner ear. Electrodes are surgically inserted into the cochlea and transmit electric stimuli directly to the auditory nerve; thus, even formerly deaf persons may experience some degree of hearing sensibility – but such a hearing aid cannot completely assume all the highly complicated functions of the 30,000 sensory cells in the cochlea. 12, 16 or 24 electrodes can only cover a much-reduced frequency range; consequently, hearing impressions with CI differ from those in persons with unimpaired hearing.

After the operation with a cochlea implant, deaf or rather high grade hearing impaired people gain at least some physiological hearing abilities, and the condition of learning to hear is created. It is important to note here that hearing must be learned as a new process of perception. Rehabilitation of cochlear implanted children in this context means to
accompany and to support their slow growing into and adjustment to the world of sounds and voices. They have to take the same steps in development as children without a hearing loss - just a few years later. Our job is to bear this natural development in mind and to create conditions to help these children to make the essential experiences on their way.

Music therapy as part of the auditory-verbal therapy, music therapy as a component of rehabilitation following CI surgery may provide a wide range of experiences and pursue a variety of objectives – a comprehensive description, however, would be outside the scope of this presentation. Instead, I want to address in some detail the communicative development as part of applied music therapy with hearing-impaired children.

We live in a world where chances to communicate open up, and where we are required to communicate. If our organic or functional hearing abilities are damaged, then in most cases this will impede social-emotional development. Chances to communicate may become less frequent, and efforts to communicate will fail more frequently.

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 his 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.

I want to mention only two of these studies:

• NICHOLAS, GEERS and KOZAK, 1994: Development of Communication Function in Young Hearing-Impaired and Normally Hearing Children.

• LEDERBERG et al, 1998: Communication between Deaf Children and their Hearing Mothers

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 – of no significance for my study!). In my assessment it seems to be important in this context that verbal communication is always based on non-verbal communication. The studies mentioned above also support this fact.

“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, p. 133)

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

Improvised music offers possibilities for extremely varied communication, and personally I think that the most important aim of music therapy with hearing-impaired children is the communicative
aspect - communication that is not linked to normal speech communication and can be orientated to the age and development abilities of each child. This is why my study focusses on the evaluation of possible communicative changes within a music therapy treatment:

**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 with hearing impairments significantly changes over the course of 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, and
    - the alternation, which has a dialogical structure and which is important for the exchange of symbolic information.
  - In improvised music we can find both modes of communication.
- At least the focus on the “initiatives for communication”, which means the varying offerings made by both players in the interactive phases that bring the other partner into communication. Does the number of the initiatives change, and does the relationship between the initiatives of the child and the therapist change?

I have been working with 21 children between the age of 3 and 6 years in kindergärten for hearing-impaired or deaf children.
9 of them have a CI, the others use conventional hearing aids.

The hearing loss of the children is at least 70 dB.

All of them participate in a special program but have never had any previous experience with music therapy.

Children with additional impairments were excluded from my research.

They came once a week for about 30 minutes, and I’ve seen each child 10 times.

Every session was documented with a videocamera to analyse the improvisations in addition.

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

In order to evaluate these episodes, I have first concentrated on those phases where a joint musical activity emerges in the sense of an interaction.

In a subsequent step, I have assessed these phases for their structure and differentiated between the communicative modi “co-activity” and “alternation”.

In addition, I have underlined the initiatives, i.e. the offers of both participants for interaction, which the other partner takes up for interaction.
In order to explain my procedure I would like to present to you Marvin and Keethena and select illustrative examples from their therapies:

Marvin is a four-year-old boy, very friendly and calm, a little dreamer, who likes to keep to 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, he got a CI. Three months later I met 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 is interested in the music instruments in his own way: he touches and examines them, especially the screws, and fiddles 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 is the triangle.

Let’s have a look at the beginning of 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, so there is nearly no room for musical interaction for the moment.
At the beginning of the 10th session, we are 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 respond appropriately. In addition to that he brings his own ideas into the joint play. Such a phase of directed concentration is something special for Marvin at this time.

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

**Figure 79**

![Graph showing Marvin's interaction](image)

This result explicitly proves that during these musical activities Marvin has discovered and enlarged his way of interacting and has made basic experiences concerning his communicative development.
A second result of this evaluation is the structure of his play within the interactive sessions:

The interaction with Marvin is based on the structure of alternation which seems to be plausible considering Marvin’s stage of development and his hearing age.

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

Now I would like to present Keethena; she’s a 5-year-old girl from India, quite shy but friendly. At the age 3 she was diagnosed as extremely hearing-impaired.

Let’s have look at the results for Keethena.
A lengthening of the interactive phases can’t be observed – the tendency is even to the contrary. However, there is a change in Keethena’s communicative behaviour. I would like to illustrate this with two examples from the first and tenth session:

In the first session we are playing drums together, each of us sitting in front of a drum. Keethena is waiting for my musical offers, then she imitates these offers, the dynamics, the number of beats, the tempo, even the mode of play.

The following example is from the last session with Keethena. She has chosen a red recorder, and a lively improvisation starts. Both players bring their ideas into the improvisation, to be taken up by the other player.
respectively. In between, Keethena takes some time out to busy herself with the airstream and then to take up the metre again.

I think it is very obvious that the quality of interaction has changed between the first and the second examples; in addition, Keethena has found an individual way of creation and expression in musical activity. In the first session it was I who determinated the interaction, and the mode of communication was nothing but alternation. In the 10th session we find both modes of interaction, co-activity and alternation.

**Figure 82**

The mode of co-activity makes higher demands on the ability of hearing, especially for children wearing a hearing aid. Keethena has to follow the sounds of two different instruments simultaneously.

In the 10th session we also see that both players give stimuli and react to the impulses of the partner as well. Interaction is not only the imitation of
a special number, of special dynamics or tempo. Interaction has become more and more flexible and free. It is not so static as it was in the beginning.

An equal partnership has developed.

I want to illustrate this development with the help of another graph. Here we can see the number of initiatives, offered by Keethena and by the therapist, that bring the other player into communication:

**Figure 83**

All these results lead me to the assumption that the quality of partnership between Keethena and me has changed over the course of the 10 sessions.

I hope I have been able to give you an idea of what I do and of the methods to analyse musical activities. After more than 2 years of work we get the following results:
I should like to start with evaluations of interactive phases between child and therapist in musical improvisation.

Figure 84

A marked extension of interactive phases was observed with 13 children. With six children, it was not possible to identify changes as to the length of interactive phases; with two children, interactive phases became even shorter.

The results for the group of children with CI are even more significant, where we find an increasing development in the treatment of 7 children. All these children wear their CI between 4 and 13 months and therefore are still at the beginning of the rehabilitation process. The other two children, where we find no change concerning the length of interactive phases, have significantly more hearing experiences – they wear their CI for more than 2;3 years.
In the group of children with conventional hearing aids, I did not detect any obvious connection between the time when the new device was provided and the development of the interactive phase.

I would now like to present the evaluation of structures in musical play during the interactive phases.
On the outset of interactive phases, the alternation mode is dominant.

This result is not surprising, since it is closely related to the condition of listening with hearing aids or CI. The ability to differentiate between interfering and conducive sound as part of the auditive discrimination is clearly obstructed with technical hearing devices. The more information is audible simultaneously, the more difficult to structure and identify these auditory impressions. To quote someone with a CI: “The less instrumentation, and the clearer the arrangement, the better”.

The communicative mode of „alternation” is highly appropriate for this phenomenon, as hearing-impaired children hear only one instrument at a time and thus have less difficulty in perception.
For a majority of children, this dominance disappears over the course of the 10 sessions, and a majority of children then discovers the mode „co-activity“.

As part of the evaluation, I also detected a connection between results and hearing age for the group of children with CI.

Figure 87

The mode „alternation“ is dominant for three children over the entire therapy period – these children have had their CI for less than 14 months. For four children the “alternation” mode is dominant at the beginning, and both modes emerge more or less equally in the end. The hearing age of these children is between 1;3 and 2;8 years.

The third main component of my study is based on an assessment of initiatives. The results in this area are as follows:
At the beginning of the therapy, the children mostly dominate the joint improvisation. At the end of the joint music-making, this dominance gradually disappears, and in the majority of cases we see the emergence of a more balanced partnership. On the way there we often observe three intermediate steps or stages:

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>I hear me</td>
<td>Have you heard me, too?</td>
<td>can hear myself and you, too.</td>
</tr>
</tbody>
</table>

Let us go back to that first example with Marvin: he plays the triangle and starts to discover the sound of this instrument. He does not really perceive my music on the piano at this stage, but he looks to me for confirmation that I can hear his triangle, too. During this phase, Marvin
makes important personal experiences on our way to a joint interaction. Many children observed in this study look for confirmation of their own activities (phase 2) also in my own imitation of their musical offers or impulses – this is reflected in the children’s dominance at the beginning of a therapy. The more confident the step to phase three, the more open will the improvisation become for the partner’s initiatives. After ten music therapy sessions, the relationship between both partners in musical improvisation is balanced in most cases, and we have thus reached phase three.

What are then the implications of the study for music therapy in practice?

- Interaction in music therapy improvisation can be initiated and extended.
- As music therapists we should always be aware of the problems involved in simultaneous stimuli. In first encounters in particular, the therapist should make a straightforward and clear approach, in dialogue and alternation with the child’s activities. On this basis it will always be possible to change and expand the musical offer in collaboration with the children.
- A change in structures within the interactive phases in favour of co-activity illustrates that simultaneous listening to two instruments is possible, but it requires a certain experience.
- The encounter in music therapy offers an opportunity to build up and develop a balanced partnership. A “healthy” interaction requires that there is a sense of action and reaction from all participants involved. For children with high-grade hearing impairments, interaction on a verbal level is a laborious struggle – but it is easier to connect and find an appropriate level of communication via music as a medium. Children experience active parts of interaction; they feel what it means to react and to lead. They make the experience of autonomy in an interaction.
- Provision with hearing aids, individual hearing age, but also a child’s personality are factors which require differentiation as to points of focus and objectives in music therapy treatment.
Thinking of the results of the research study and thinking of all experience gained from my work with children, I know for sure that music therapy can be a highly useful therapeutic element to complement treatment programs for hearing-impaired 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 communication and verbal interaction.

To conclude: I wish to express my thanks to the Foundation Andreas-Tobias-Kind and also to Witten-Herdecke University for supporting me in this study.

**Literature**


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INTRODUCTION

This paper presents extracts of work with Thora, a 70 year old woman with Pick’s disease, one of the less common dementing illnesses. For her, the sense of ordinary reciprocity with others, verbally and non-verbally, had been all but lost. In her condition she was radically estranged from the world of shared communicative self-expression that is the cherished living essence of Personhood.

And yet, in music, and in Musicking together, something of what she had lost was restored: We found together a sharable space and sensibility wherein meeting was possible and the joy of that meeting was tangible.

The interest of the presentation is twofold:

• First, to show Thora’s movement from musical isolation towards musical interactivity that was both inter-musical and inter-personal.
• And second, to comment on the approach used and its relevance to the broader context of dementia care.

THERAPY IN MUSICKING

It is only in the last 10 years that clinical improvisation has begun to be systematically explored, as a music-therapeutic response to the care needs of infirm and dementing elders. The hallmark of this approach is the development of an interactive relationship-in-music as the primary
therapeutic agent. It dawns as both players begin to hear themselves being heard in the others playing and respond to that spontaneously.

The pioneering work of Aldridge & Aldridge (1992) and Odell – Miller (1995) showed how clinically directed improvisation could create genuinely interactive music making with persons with the cognitive impairments of severe dementia. The therapeutic benefits reported included improvements in motivation, some aspects of cognitive function but overall a strengthening of well-being.

But what of this special relationship to be found in just simply ‘making music’ together, that has the potential to bridge the existential isolation engendered by pathology? The neologism ‘musick-ing’ seems to me to resonate with all the subtlety and potential of this relationship.

Clive Robbins (1999) observed that Music should properly be thought of as a continuum of the creative act of Musicking: from the primal musicking of the infant’s voice, gestures and body movements to communicate self-in-the-world, through to the conscious, inspired creation of musical form.

Musicking as therapy, having the attributes of both play and work, becomes the intermingling of the primal and the intentional acts of music making. It becomes a way of creating, sounding together-ness with the possibility of communicating, one to the other, the quality of that togetherness in all the modalities of musicking. The authenticity that may be sought after and realised together in this musical – personal interface is the heart of the music-therapeutic relationship.
This has immediate relevance to contemporary theory of dementia care.

**MUSIC THERAPY AND DEMENTIA CARE**

The model of dementia care developed and implemented by the Bradford Dementia Research group of the U.K., and in particular through the writing of Tom Kitwood and associates, places paramount importance on the quality of relationship between carer and dementia sufferer. This theory frames the understanding of dementia, and the care of dementia sufferers, in the conceptual language of a person centred social psychology. Kitwood put the position thus:

> We need a social psychology which reveals dementia care as a true process of meeting between persons; which shows what that meeting consists of, how it comes about, and what might prevent it from occurring. (1993, p. 51)

The model aims to provide a theoretical standpoint or basis for care giving that insightfully supports the wellbeing of a person with severe cognitive impairment. And this is through the quality of interaction between the person with dementia and care giver.

In this model, severe dementia, if unsupported, can be understood as a state of ‘shattered’ or fragmented personal being, in radical dislocation from the world of inter-subjective relationships. And secondary emotional disturbances may be better understood as arising from the existential isolation and anxiety of that predicament. A central task of dementia care, according to Kitwood, is that of the carer ‘keeping the sufferer’s personhood in being’ (Kitwood and Bredin, 1992, p. 269); ‘(Their personhood) needs to be continually replenished, (and) their selfhood continually evoked and reassured’ (p. 285).
Two key helping concepts Kitwood identifies as ‘facilitation’ and ‘holding’, providing for the possibility of inter-subjectivity wherein successful acts of communication can happen. An everyday occurrence in care settings provides an example: a dementia sufferer makes an utterance or gesture towards someone. The carer’s role can involve a number of crucial therapeutic skills:

- To recognise the utterance and honour it with an appropriate response.
- To have some empathic understanding of the other’s shattered state.
- To fill out the definition of the situation with the other, and not ‘correct’ it according to institutional norms.
- To help convert the other’s utterance or movement into a possible intention or expression of need.
- To respond sensitively to changes in the other’s initial definition of the situation and go with that.
- To use interaction to hold and sustain the other’s action so that it becomes a completed act in the world of inter-subjective meanings.

Kitwood (1993) compares these skills to that of the tennis coach who can keep the other’s ball, however misplaced, in play.

And so, in such an interpersonal environment, it is possible for communication to be carried through successfully and agency to be confirmed. A dementia sufferer can move faltering towards the world and feel recognised as a person. Moreover, well being as self-esteem and trust is possible despite the isolation otherwise engendered by severe cognitive impairment.

Which brings us back to Musicking and the purpose of this paper, which is to demonstrate the musical equivalent of ‘facilitation’ and ‘holding’ as integral to the process of Musicking as therapy.
THE THEME

• To show the change in quality of Thora’s responsiveness from the mostly uncommunicative, reflexive, repetitive nature of her vocalisations, to the musically grounded acts of participation that were shared and recognised by us both.

• To show the musical processes corresponding to Kitwood’s working concepts of ‘Holding’ and ‘Facilitation’ by –
  • Responding to her utterances in a way that supported and extended them into a coherent musical flow together, and
  • Responding in a way that was and inviting without being overpowering or robbing her of initiative.

THE CLIENT

Before her diagnosis of Pick’s disease dementia in 1994, Thora had lived a full and active social life. She was married to a Shearer and was a mother of 4 children. As well as being active in the local community, she was a skilled seamstress and had a number of creative hobbies. Her illness first became apparent through disturbing and uncharacteristic changes of behaviour, principally stealing and a failing ability to express herself. She would hold her head in her hands and say “my mind, my mind, there’s something wrong with my mind”. Gradually words gave way to incoherent gestures and vocalisations to convey meanings and emotional states. She was admitted to care in 1999.

Pick’s disease is a progressive dementia characteristically affecting frontal and temporal lobes. Its appearance is usually diagnosed if three of following five characteristics are present early in the disease:

• Presenile onset
• Initial personality change
• Hyperorality
• Disinhibition, and
• Roaming behaviour
When I first met Thora in her facility, she constantly wandered, slightly stooped, and intermittently uttered harsh bleating-like vocalisations, which had a number of variations sounding like a laugh. They were not obviously directed at anyone. She could give fleeting but poignant eye contact and despite her manifest helplessness, showed a sense of her own will. Her constant vocalisations would frequently aggravate other residents in her facility and she would express fearful or alarmed states by a variety of dynamic changes in her vocalisations.

THE SESSIONS
I saw Thora over a period of 9 months and our sessions, which were approximately once a week, were conducted in a small meeting room for relatives in her ward.

During the initial sessions, Thora’s anxiety and insistence on leaving the room was such that the sessions were brief, between 5 to 10 minutes. However by session 5 (the first extract) I had made the decision in consultation with the nursing staff to extend the session time in the hope that Thora would become less anxious and more involved in the musical interactivity that was being offered her. This strategy was soon vindicated as Thora began to direct her attention towards me rather than the door.

EXTRACT ONE
Session 5, 15th minute (1:20)

I am seated with my chair against the door.

Thora is distressed; her vocalisations approximate those she daily makes in the living area. The harsh quasi-laugh sound is recognisable as her sound of emotional excitation, frustration, fear.

Accompaniment has clinical intention of:

1. providing tonal stability while staying with the emotional tension in the room,
2. supporting and extending Thora’s tonal leaps and leaving her space in which to vocalize.

At one point her vocalisation becomes sustained tonally and there is a fleeting sense of contact.

EXTRACT TWO

Session 5, end of session (1:07)

Thora trying to open the door - slamming sound.

Music reflects but offers form and containment of her vocal & physical energy.

Thora’s vocalisations momentarily move into the tonality of the accompaniment.

EXTRACT THREE

Session 8, 6th minute (1:24)
Thora restless and little edgy, but not trying to leave the room - walks around and sits down.

Difference in quality of Thora’s vocalisations:

1. They are more sustained and tonally shaped: They seem to be less purely reflexive and more intentional.
2. They come more into the tonality of accompaniment.

Again, the accompaniment tries to support and extend her vocalisations by

1. shaping them into melodic statements, and
2. giving her a sense of having been heard and responded to.

**EXTRACT FOUR**

Session 9, 17th minute (1: 55)

Thora more relaxed in sessions, sits and stands by me, puts her face up close and smiles.

Shaping Thora’s tonal-like vocalisations into a coherent musical phrase. She responds with a vocalisation more like a laugh.

Accompaniment invites her to respond, and tries to develop it when it comes.

Thora’s entrance is musically cued, sense of reciprocity developing.

**EXTRACT FIVE**

Session 14, 4th minute, (4: 12)
Thora standing beside me, walking around the room.

Her vocalisations move between a min 3rd.

Accompaniment tries to connect together and extend her vocalisations by

1 reflecting her tones and
2 giving them musical significance by putting them in different harmonic settings.

Thora’s vocalisations become more tonal, extended and song-like. Again, intentionality seems to be more evident in this.

As our joint vocalisation becomes interwoven, there is a moment of recognition between us. Thora and I acknowledge this moment.

EXTRACT SIX

Session 14, 14th minute (0: 57)

Accompaniment: a little more forceful, exactly matching the length and dynamics of Thora’s vocalisations.

The sense of inter-responsiveness - making music together - starts to develop between us. Thora is smiling and evidently enjoying this.

Thora’s vocalisations become stronger, a sense of her Will in her voice.

Precipitates another extended passage of Thora freely vocalizing and of us making music together.

EXTRACT SEVEN
Session 15, 23rd minute (2:16)

Thora twice begins to clearly sing/vocalise on a single tone in the tonality of the accompaniment. Qualitatively different to her vocalisations to date.

She responds to a musical invitation which develops into an antiphonal give-and-take. She is smiling.

EXTRACT EIGHT

Session 30, 12th minute (4:41)

Thora is standing beside me.

Her vocalising is more like singing, sustained tones in the tonality of the accompaniment.

The 5/4 accompaniment creates a mood for extended singing on one tone.

A sense of shared exhilaration at the first shared ending, Thora is smiling. She moves up with me at the cadence of the first ‘finale’.

Again, on the second and third ‘finales’, she moves up to and holds a sustained ending tone.

EXTRACT NINE

Session 30, 25th minute (1:29)

Thora smiling and enjoying the interaction.
Thora’s vocalising clearly like a sung tone, extended and strong.

Working with the new found strength of her responses, the accompaniment has clinical intention of helping her to move between a semitone interval which she initiated by returning to a phrase which ends on an upward semi-tone resolution. Thora seems to respond to this.

CONCLUSION

Back in the daily life of the facility, Thora still vocalised and roamed as before. But in the intimacy of our sessions the quality of her musical and interpersonal interactions changed considerably: As Thora’s vocalisations became musically grounded, they also started to develop an expressive responsive quality, not as her usual isolated, habitual utterances. In the context of our musicking together, She was in the responses in a way that became vital and meaningful for her and we both spontaneously recognised these moments when they came. Her physical expression of these moments was to approach and hug me, something her daughter later said her mother had ceased to do since the onset of her illness.

Thora’s therapy ended when I moved interstate.

REFERENCES


Creating A Bridge - A Single Case Study Of An Infant In The Light Of The Attachment Theory

Tuomi, Kirsi
Finland

Abstract:

This presentation will describe a qualitative single case study on a music therapy process with a twelve-month-old boy living temporarily in children’s home. The boy has a wide developmental delay, which cannot have been explained medically. The purpose of the therapy was mainly to support the interactional development of the boy, and the process lasted for 23 times. The paradigm of the therapy was Daniel Stern´s theory of parent-infant interaction. To a great extent, the therapy can be classified as a communication centered music therapy. The presentation will be illustrated with clinical videomaterial.

The purpose of this study is to evaluate how the attachment theory of John Bowlby would have applied to this music therapy process. The question whether the attachment theory would have been a suitable paradigm in this kind of music therapy is reflected upon. There will also be comparison between the approaches of Stern and Bowlby.

The presentation is aimed at therapists who are interested in early interaction. The attachment theory can provide new perspectives when working with children who have interactional problems or whose parents are not available.

Keywords:
Attachment Theory, Early Interaction, CARE-Index, Child Welfare, Evaluation of Attachment

1. INTRODUCTION

The purpose of this paper is to view the music therapy process of a twelve-month old boy in the light of the attachment theory. In this paper I will present the central concepts of the attachment theory and compare
them briefly with the theories of early interactions by Donald W. Winnicott and Daniel Stern. The main purpose, however, is to study the possibilities of single music therapy to give an infant experiences of the attachment that the child has been missing.

I got interested in the attachment theory developed by John Bowlby when I started working as a music therapist in a children’s home. The theory seemed to support the theories of Winnicott and Stern. The attachment theory has turned out to be particularly useful when observing children who have grown up in insecure and dangerous circumstances or whose attachment relations have been breaking for other reasons. (Sinkkonen et al, 2001, p. 9).

At the moment attachment theory and its applications are studied a lot worldwide. Little research has been done into attachment theory and music therapy jointly. This paper is a kind of an attempt to create a bridge between these two fields.

2. ATTACHMENT THEORY

British psychiatrist John Bowlby (1907 – 1990) thought that the attachment theory he had created was some variation of psychoanalysis. Bowlby was a psychoanalyst, but he had many different ideas compared to most analysts. He emphasized the early interaction and the hindrance caused by long and repeated separations. (Sinkkonen et al, 2001, p. 7.)

Attachment theory is partly based on the observations made of how a mother takes care of the security and survival of her young ones in nature. Animal babies become attached to their mother and try to be close
to her. It is about protecting oneself from danger and about survival, the point of which is the distance. (Kalland et al., 1999, pp. 13 - 15). A human child has the same kind of behavioral system the purpose of which is to keep the distance to the care giver as short as possible. (Sinkkonen et al, 2001, p. 7; Goldberg et al, 2000/1995; Goldberg, 2000, p. 8; Bowlby, 1997/1969).

2.1 Secure Base
The attachment is based on the idea that a parent’s task is to protect the child and provide him with a secure base from which a child can go and explore the outside world and to which he can return when missing security or protection. (Bowlby, 1988, p.11). The concept of a secure base was brought into the attachment theory by Mary Ainsworth who was a longterm colleague of Bowlby and the creator of many practical applications of the attachment theory.

The concept of a secure base resembles the concept of a potential space by Winnicot (1993/1971). Both concepts enable the child’s playing and little autonomous journeys of explorations to the outside world. (Winnicot, 1993, p. 41.)

2.2 Internal Working Model
The child’s first relationship influences the way he forms internal working models of how other people treat him (Kalland et al, 1999, p. 13). The interactional scenes between the mother and infant leave memory traces and when they repeat similarly enough, representations develop. These representations merge into larger entities and form a
script for the interactional scene. On the following more abstract level representations have merged into internal working models. (Sinkkonen 2001, pp. 154-155.)

Daniel Stern has been called a post-Bowlbyan theorist. Stern, as well as Bowlby, emphasizes the significance of early interaction (Stern, 1985, p. 25). The concepts of RIG (Representations of Interactions that have been Generalized) and evoked companions by Stern and the concept of internal working model by Bowlby are similar in many ways. The RIG can be seen, according to Stern, as a building block from which working models are created. Both RIG and internal working models represent the accumulated past history of a certain type of interaction. (Stern, 1985, pp. 114-115.)

2.3 Internal Representational Model
Bowlby describes the internalizing of the childhood experiences with the help of internal representational models which are called attachment models. These interpersonal and attachment related schemes are models of oneself and of others formed by interactional experiences. Thus attachment models are formed on the basis of internal working models. (Nyman et al, 2000, p. 28.)

2.4 Becoming Attached
The nature of child’s attachment varies and a child can become attached either securely or insecurely (Kalland et al, 1999, p. 13). Mary Ainsworth created a method of Infant Strange Situation with her team in order to study individual differences appearing among the attachment between an
infant and his mother. By means of this method it is possible to observe and analyze the way a child uses his mother as a secure base while his stress is increased step by step. (Hautamäki, 2001, p. 35; Goldberg 2000, p. 19.)

Ainsworth describes three strategies with the help of which an infant tries to maintain and ensure the availability of his attachment figure (Hautamäki, 2001, pp. 36-37, Goldberg 2000, p. 22):

1 Secure attachment (Type B)
2 Insecure attachment – avoidant children (Type A)
3 Insecure attachment – ambivalent-resistant children (Type C)

2.5 Disorders of Attachment in Childhood
An addition to the attachment categories of secure attachment and avoidant-resistant attachment is disorganized attachment which has appeared on the basis of research on different kinds of risk groups. This type of attachment may be connected with later psychic pathology. The actual disorders of attachment in childhood, which appear as behavioural and developmental problems of the child, are secure base distortions and the disorders of non-attachment. (Tamminen, 2001, p. 245; Goldberg, 2000, p. 25.)

3. MATTHEW, 12 MONTHS

Background information
Matthew (the name has been changed) had just turned 12 months when he was placed in children’s home. He was the youngest of eight children and had been in children’s home for a short time once before. Matthew

When arriving in children’s home Matthew had a wide developmental delay. He was hardly able hold his head and turn around. He did not use his voice except when he was crying. He did not smile and avoided eye-contact. When examined by a doctor no medical reason for the developmental delay was found.

Music therapy process started as soon as Matthew’s parents had given their permission. I met Matthew 23 times 1-2 times a week. Each session took about 30 minutes depending on Matthew’s alertness. The purpose of the therapy was mainly to support the interactional development of the boy. Matthew was also given physiotherapy at the same time as music therapy.

The paradigm of the therapy was Daniel Stern’s and Donald W. Winnicot’s theories of the interaction between the parent and child. To a great extent, the therapy can be classified as a communication centered music therapy because the main purpose in this process was to create a contact and attune to the same interactional level with the help of music (Ahonen-Eerikäinen, 1999).

I wanted to study Matthew’s music therapy process from two viewpoints by means of attachment theory. First, I wanted to find out if it is possible, in music therapy, to use the indicators of the attachment theory which measure the interaction between the parent and child when the primary care giver, in most cases the mother, is not available. Second, I wanted to
learn if music therapy can provide attachment experiences the child has been missing.

3.2 Evaluating the development of the attachment
The viewpoint of the development of the attachment was new to me. Advised by experts I chose the items assessing attachment from CARE-Index created by Patricia Crittenden. CARE-Index is the simplest and most versatile of the attachment measures. It assesses mother-infant interaction from birth to about two years of age. It is based on a 3-5 minutes long videotaped material. The scales are highly correlated with the Infant Strange Situation assessment patterns of attachment. (Crittenden, 2002a.)

Differently from CARE-Index I chose two samples from the videotape to be observed. That was because I wanted to find out the significance of the process to Matthew’s attachment behavior. Video clips have been taken from the beginning and the end of the process.

The items of interaction that are observed in CARE-Index are the facial expression, vocal expression, position and body contact, expression of affection, turn-taking, control and the choice of activity (Crittenden, 2002b). These items work as a basis of video analysis. Differently from CARE-Index I only evaluated Matthew, not my own activity or reactions.

3.3 Development of attachment in this case
I have divided the evaluation of video samples into non-musical and musical interaction. I wanted to do so because in my opinion it is
important to find out what the role music is in the development of attachment.

I asked Finnish CARE-Index expert psychologist Sinikka Maliniemi-Piispanen, who is the head of Care and Research Centre of Early Interaction the ALMA Clinic, to assess the same video clips. This way I have tried to increase the validity of my evaluation and support my observations as in peer debriefing. Please pay attention to the items of interaction mentioned above (the facial expression, vocal expression, position and body contact, expression of affection, turn-taking, control and the choice of activity) and assess the attachment of Matthew with the help of them. First we are going to look at Matthew at the beginning of our process. Video sample 1.

**Matthew in relation to me**

According to my observations Matthew’s facial expressions seemed rather unchanged. It was striking that Matthew did not use his voice at all. The only vocal expression was a whining cry, which, however, seemed aimless. The appearance of Matthew was constantly unsteady. He was not satisfied in my arms pushing himself back and when being touched on the face he felt uneasy. Mathew seemed to have difficulties in adjusting the distance between us. The distance when he was sitting or standing in front of me seemed the most suitable. When he looked at me, there was no eye-contact (I checked this in my diary). Matthew seemed to have a dawning idea that he should be standing although he had not apparently done that much. He expressed affection only a little. It seems to me that our interaction did not include turn-taking but I was the one
who directed it. He, however, stretched out his hands towards me, which is one the first signs of becoming attached. Matthew had no ability to control things. He did not seem to have any experiences of influencing the incidents and he did not have any wishes to me. He could not choose what he did. The activities seemed to take place by pure chance and were not goal-oriented. All in all Matthew’s activities seemed very passive, non-orientated and absent.

Matthew in relation to music and instruments
Matthew showed interest in me playing an egg-shaped maraca and looked at it. He reached with his hand towards it and even managed to get hold of even. Matthew noticed and looked up when I first started to sing. When I sang high and lift the maraca up, Matthew also looked a bit upwards.

Next we are going to look at the video clip of our 21st session. At the beginning of the session Matthew cried in a very loud voice next to the door implying that he wanted to get away. This video clip starts after three minutes from the beginning of the session from the moment when Matthew had calmed down. I do not start the video sample from the beginning as it should be done in CARE-Index because I wanted to include more of Matthew’s relation to music. Please again pay attention to Matthew’s behavior and assess it by means of the items of interaction. Video sample 2.

Matthew in relation to me
Matthew’s expressions in this sample were unchanged and he appeared satisfied through the whole sample. Seemingly, Matthew wanted to say
something when vocalizing. Most of the time Matthew did not face me and his direction was away from me. He did not seek physical contact and did not touch me intentionally. There were no significant expressions of emotions during this sample but the boy had a neutral little smile all the time. There was no actual turn-taking. Adjusting the distance was still difficult although Matthew’s motor coordination had developed. I still had to call Matthew by name in order to keep the interaction alive. In my opinion Matthew did not have any intentions to control my activities. He seemed to choose his activities himself and know what he wanted to do.

Matthew in relation to music and instruments
Matthew remembered where the instruments had been and walked purposefully towards them. At the end of the sample Matthew even remembered that the drum had earlier been in a different place. In relation to the instruments Matthew was in a direct contact and towards them. He seemed to want to have a holistic contact with the guitar – he wanted to touch it with his whole body, listen to, look at and taste it. He paid attention to me only when I was playing the guitar. Then, in my opinion, Matthew adjusted the distance more in relation to the guitar than to me – he wanted to approach the guitar and the sound it made. According to Sinikka Maliniemi-Piispanen the guitar seemed to represent even some kind of symbolic mother’s care, ”the guitar as a lost mother”.
4. SUMMARY

The main question here was if there were any changes in Matthew’s attachment behavior during this music therapy process. And if there were, what were the changes like?

It is natural that Matthew developed in many ways during the 6-month-long process. The most striking thing was certainly the significant increase in his motoric skills and in exploration of the outside world. Surely, the care given in children’s home and in physiotherapy has also affected his development.

In relation to me there had been some changes in Matthew’s behavior. Matthew had started to vocalize and clearly wanted to say something, which can also be revealed by the differences in the volume and intensity. Matthew had learned to choose his activities and seemed more goal-orientated than earlier. Adjusting the distance was still difficult and maintaining the interaction was my job. Eye-contact did not appear and the expressions of affection did not increase in the samples. The facial expressions were unchanged – a little smile remained as a basic expression.

In relation to music and instruments I see that Matthew’s behavior changed significantly. The placement of the instruments mattered, he recognized them and showed interest in playing them. Matthew’s relation to the instruments had become holistic and amodal. Particularly meaningful was, of course, the role of the guitar. The guitar seemed to have become “a mother” to Matthew. Just like a little child explores the environment and returns to his mother making sure her availability,
Matthew seemed to occasionally return to the guitar making sure it was there and it vibrated. He did this by touching, tasting, watching and listening to the guitar.

Such being the case, could it be said that Matthew’s attachment developed particularly in relation to music and instruments? Partly the answer is, in my opinion, yes. The increased attachment towards music and instruments was much more significant than his behavior in relation to me. On the other hand, it must be recognized that this relation to music would not be there at all unless I had not been there making music with him and drawing his attention to the instruments. I think that the instruments and the music worked more as tools developing the attachment. But, in my opinion, our tool can work as a component provoking, developing and supporting the attachment behavior.

5. CONCLUSIONS

What is the significance of attachment theory from the viewpoint of music therapy? What can it give to other theories about interaction? In my opinion, the attachment theory includes vocabulary needed when describing interaction. It offers concrete theory and names things that define a human’s basic need, the intimacy. With the help of attachment theory we can better understand what kind of difficulties a long distance between a parent and child causes.

The most significant practical problem when assessing the attachment of infants is, however, the concentrating on the interaction between the mother and child. In my own work with child welfare meeting the parents
and child together is often impossible. When the parents are not there, I should be able to get the information about the attachment from the relation between the therapist and child. However, there is no research on this kind of approach – as we know it is said that an infant does not exist without his primary care giver.

From the viewpoint of child welfare music therapy can offer something unique for the attachment because its tool can be transferred. In child wellfare the problem is often how the information can be transferred from the children’s home to the home of the child or for example to a new family. Matthew learned to recognize some of the songs and music functioned as a cornerstone of our relationship. In an ideal case this music could have been transferred back home with Matthew through videotapes, the lyrics of the songs and the sessions where the whole family would have been present. In Matthew’s case this was not unfortunately possible but the latest experiments in the field of this kind of activities have been very encouraging and will be surely continued and expanded.

As a music therapist I should find out what the tools are by means of which I try to consolidate the different dimensions of the development of attachment, in other words how I try to adjust predictability, regularity and intimacy. In Matthew’s case I noticed I had acted in a right way by instinct, probably on the basis of the experiences of being a mother. As a professional I should, however, be aware of what I am doing in order to, for instance, be able to convey information with the right vocabulary.
We have been creating a bridge between attachment theory and music theory. At times I have felt that even the foundations have been shaking. Perhaps this bridge could be rather described as a couple of planks crossing a river. The material for building a bridge is, however, there and it can be constantly increased. What we need now is knowledge, skills, will and courage to create a real bridge.

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Establishing Developmental Indications for Music Therapy with very young Children

Voigt, Melanie

Introduction

Working in a center for social pediatrics in Germany automatically means that one is involved in early intervention. The fundamental goal of social pediatrics is the earliest possible diagnosis and therapy of developmental delays, disabilities and handicapping conditions. The second goal in this area of pediatrics is the integration of these children in the family, in kindergarten, in school and in society. Parents are involved in the diagnostic and therapeutic processes. The patients range in age from infancy to 18 years. However, as a result of the emphasis on early diagnostics and therapy there is a very large number of patients who are three years of age and younger.

Over a period of years, more and more children in this age group have been referred to music therapy by doctors and psychologists. Working with very young children who show evidence of developmental problems and with their parents has become an area of specialty in the music therapy department of the Kinderzentrum München in Munich, Germany.

Music therapy and developmental disabilities

At the Kinderzentrum München, Orff Music Therapy forms the basis for the music therapists working there. This approach to music therapy is
developmental. The child and his personal development determine the course of therapy. This means that we need to understand the complex interplay between different areas of development, for example how one impaired area of development such as motor development can affect other areas of development, including emotional development and personality development. We also need to consider the family or caregiving situation, since developmental delays and disabilities influence and are influenced by family interaction and relationships. Only then can we plan and carry out the therapy in a way that meets the child’s needs (Voigt, 1998; 1999; 2001).

Music therapy as a means of treatment for children with a wide variety of developmental problems, delays and disabilities has been described in the literature. Examples of patient groups are autistic children, children with cerebral palsy, children with hearing impairments, children who have received a cochlear implant, blind children, children with behavior problems and children with multiple handicaps (Orff, 1980; Oldfield, 1995, 2001; Bean, 1995; Voigt, 1999; Haus, 2002). All authors considered problems that the patients were having within the framework of their diagnosed disability. An important emphasis in all cases was placed on social communication and interaction within the music therapy situation.

Music therapy has been shown to have positive effects on the preverbal development of children with multiple handicaps (Plahl, 2000). Music therapy has also been used to aid in assessing the child’s development in the area of social interaction and communication by describing musical
and nonmusical behaviors within the music therapy setting (Wigram, 1995; 1999; 2000; Elefant, 2001).

The sources from the literature cited above have all described social communication and interaction as an important area of music therapy work. The area of social communication and interaction also forms a major point of emphasis in music therapy with children between infancy and three years of age whose development is not progressing as expected. Social communication and interaction are influenced by a multitude of developmental factors and, in turn, influence other developmental factors such as cognitive development. Problems in this area are not limited to one particular diagnosis such as autism. We therefore find it helpful to establish indications for music therapy for each child based on a description of developmental processes instead of on the global diagnosis of the child’s developmental problems.

Establishing indications for music therapy

„And he loves music!” We have often heard these words from parents and caregivers of children between infancy and 3 years of age whose development does not progress as expected. They have noticed that the child seems attentive, smiles or moves spontaneously when he hears music. It seems to them that this observation could provide a reason for considering using music therapy as a means of treatment with the child. Indeed, it may indicate that music could provide a possibility for establishing contact and developing interaction with the child, but is it really the reason why music therapy should be suggested as a method of treatment for the child? In order to determine indications for music
therapy with children between infancy and three years of age we need information about the types of problems that are inhibiting the development of the child.

Parents, doctors, psychologists and others very often become aware of the fact that a child’s development is not progressing as expected when developmental milestones are delayed or absent. In the very early assessment and rehabilitation of children with developmental disabilities it can be difficult to determine exactly what diagnosis is appropriate for the child. Even if a definitive diagnosis is possible, the cause is not always known. Making a prognosis for the child’s development is also very difficult at this early age (Straßburg et al, 1997).

We know that problems in development rarely affect only one isolated area of development, for example motor abilities or cognitive abilities. Rather, problems in one area usually affect other areas of development as well, with the result that almost all disabilities can be classified as multiple disabilities (Straßburg et al, 1997).

Let us consider some effects of impaired motor development on different developmental processes. Motor impairments can influence the child’s initiative and his ability to explore his environment, to experiment, to play, to make himself understood. The child may have great difficulty in moving at all, which can lead to an inability or a lack of incentive to explore his surroundings. This prevents him from experiencing his own ability to influence his environment. (Voigt, 1999; 2000). Motor problems can also make it difficult for the child to show facial expression, to use gestures or syllables, or to make eye-contact with
persons or objects in order to make his wishes known (Sarimski, 1993). Not being able to take influence upon situations or not being able to make oneself understood can lead over time to emotional problems.

Cognitive delays can also influence other areas of development. These children also tend to be more passive, to show less interest for objects in their environment or to be less interested in social play, interaction or communication than children who are developing normally. A child with a cognitive delay may not be able to focus his attention on a particular object, person or activity. He may have trouble understanding cause and effect and in understanding social communicative signals (Sarimski, 1993; 2001). Social and emotional problems can develop when the child repeatedly has the experience that he cannot understand or is not understood.

Medical and psychological diagnostics give us very important information about the child’s development so that we can understand what factors are influencing and/or inhibiting it. Part of this information can be in the form of a diagnosis. Equally important is the description of strengths and weaknesses of the child, a sort of developmental profile, which helps us better understand the child’s course of development.

Describing the interactive competencies of the child complements more objective test possibilities and enables us to understand the individual child’s development better. Examples of questions that can be answered follow. Can the child focus and maintain his attention to stimuli? Does he try to cause an effect to happen consciously, for example to use an object or instrument to produce sounds? Does he try to make his wishes known
by adapting his behavior until he is understood by his partner, perhaps by pointing and vocalizing or by leading the adult by the hand to a certain object? Can the child pre-plan actions within the context of a particular situation, for example by choosing the appropriate objects for a specific idea for play or use single words to make his wishes known? Can the child interact symbolically, for example in that he talks about things that he did yesterday or will do tomorrow or uses substitute objects such as a block for a piece of bread in play? (Dunst & McWilliam, 1988; Sarimski, 1993; 2001). The development of these competencies is dependent upon interest in and interaction with objects and persons in the environment.

The diagnosis „cerebral palsy” or „mental retardation” serves as an important point of orientation for our work in music therapy. These diagnoses give us information about the general bodily or mental condition of the child and help us to understand in general what problems he may have. However, one child is not exactly like the other--two children with cerebral palsy may have very different courses of development although they have the same diagnosis. Two children with mental retardation may have similar IQ’s but display different developmental characteristics. In order to meet the developmental needs of very young children, we need to formulate the indication for music therapy as precisely as possible, taking into account the developmental profile and the course of development for each child.

I would like to illustrate my ideas about establishing indications for music therapy with two case examples from my work at the
Kinderzentrum München. The names of both children have been changed to protect confidentiality.

**Lukas**

Lukas was the firstborn of twins. His birth occurred spontaneously in the 24th week of a pregnancy which had been complicated. He is the surviving twin. Lukas weighed 700 grams at birth and had to receive artificial respiration for five weeks following birth. During the postnatal period numerous serious medical problems had to be dealt with and could be overcome. Lukas was released from the hospital in stable condition after 5 months. He adapted quickly to life at home.

Lukas has the following diagnoses: Condition after premature birth in the 24th week of pregnancy with artificial respiration for 5 weeks; Retinopathy with bilateral convergent strabismus, psychomotor delay, microcephalus, subnormal growth, language development delay, paralysis of the left vocal chord. He was introduced at the Kinderzentrum München at the chronological age of 17 months. Lukas showed a delay in motor development and had just begun to creep at this time. There were no signs of a neurological impairment such as cerebral palsy. The motor delay was attributed to a delay in cognitive development. Lukas showed little interest in using his newly acquired motor abilities. For this reason he was referred to music therapy, which was begun when he was 19 months of age.
**Indications and goals for therapy**

The indication, „lack of initiative to use motor abilities” was a very general one. Since the motor delay was not caused by a physical disability, we needed to look at the areas of social communication and interaction and cognitive development more closely in order to determine what precise indications for music therapy could be established.

At the beginning of the first session of therapy, Lukas had trouble adapting to the new situation. He whimpered some, reassured himself that his mother was near. He did not seem to look around the room to see what objects were there. I offered him the opportunity to play the lyre, producing sound on the instrument first at some distance, then again when the instrument had been moved into his immediate vicinity. I repeated playing the lyre. Lukas observed closely, but did not show initiative to try to touch or explore the instrument himself. Although the sound of the instrument held his attention, it took him a very long time to finally make contact with the instrument and to begin to try to produce sounds using it.

The scene described above was typical for Lukas’ behavior at the beginning of therapy. He had to be introduced to activities and objects. He did not explore on his own. One of the indications we established was a *lack of initiative to explore his environment*.

Another was *problems in focusing and maintaining attention*. During the same session we observed that Lukas became more active--he interacted with an object (the drum) and with me. However, between alternating exchanges, he looked away from the drum and from me and looked
instead toward the camera. My playing the drum seemed to help him refocus his attention so that our little interactive game could go on. His facial expression here seemed to communicate enjoyment.

The goals for treatment at this point in time were to develop interactive competencies, in this case the abilities to focus and maintain attention, to explore the environment, to experience and develop the ability to influence events within the therapy setting.

**Strategies for therapy**

Orff Music Therapy uses responsive interaction as the basis for therapeutic procedures. Responsive interaction resembles the natural interaction between parents and their very young child. The child sends out signals, the adult interprets these and responds to them. These behaviors and stimuli cause changes in the child’s behaviors and abilities, which cause adaptations of the adult’s behavior (Sarimski, 1993; Papousek, 1994; Durkin, 1995). In therapy, the therapist changes her way of playing with, communicating with or stimulating the child to match the child’s abilities at his present level of development.

Lukas’ spontaneous play behavior, knocking on objects with his hand or another object and throwing things, was used as the basis from which interactive games using music or musical elements were developed. Additionally, well known children’s songs and situation songs improvised to support the course of play were used. During the first four sessions we continued to observe a short attention span, but musical sounds usually caught his attention and enabled us to continue the activity he had just left. He showed great difficulties in following the
course of a well-known musical infant game. After a period of reservation, Lukas was willing to enter into interaction with persons whom he did not know. In the third and fourth sessions we began to see him change his behavior to make his wishes known—in this case removing someone’s hand from an instrument or moving someone’s hand to the instrument to invite the adult to play.

Adapting indications, goals and strategies to development

Lukas saw the psychologist for the first time after four sessions of therapy. The examination carried out there confirmed our indications and goals for music therapy.

The second psychological examination five months later showed a stagnation in preverbal development. Lukas was showing few attempts to make himself understood by adapting his behavior to a situation. Imitation in dialog was not possible. For this reason, music therapy was to be continued.

These problems in development, the absence of the competence to communicate by adapting behavior and the absence of the ability to imitate in dialog, became the indications for music therapy.

The basic therapeutic procedures described above were used in order develop activities supporting the ability to communicate through changes in behavior and the ability to play and act in dialog. Variations were introduced to well-known activities. Different actions were formed into a chain of events, for example if he wanted to take the bars out of the metallophon, he could do this, then we „baked a cake” in the
compartments of the instrument using a German children’s song, „closed the oven” by putting the instrument back together again and heated it up by playing it. His actions were imitated, actions that he carried out or that appeared in a new context were used to develop new interactions with instruments and in play.

**Course of therapy**

At the end of the year, Lukas was showing a much longer attention span, he explored different objects and instruments. We began to see the beginning of spontaneous imitation in games. He was able to make his wishes understandable in a much clearer way through behaviors such as shaking his head for „no” or inviting me to take part in a game by giving me an object. He inserted his favorite game, „peek-a-boo”, into the chain of events within musical activities. His own musical and play activities were not monotonous but contained small variations. He also initiated activities by showing me which instrument he wanted to play (for example the drum) and what he wanted to do with it (put marbles on it and let them „dance” or roll round the rim) by pointing to the drum, crawling to the marbles, bringing them back to me and letting them fall onto the drum.

We have continued therapy up to the present, adapting indications and goals as Lukas’ development progresses. He has made continuous progress in communication and play. He can change roles in a well-known movement activity, playing the drum while I move through the room.
However, Lukas does not plan actions or activities independently but needs to observe the adult carry out the activity first. He has also begun to have temper tantrums at home when he does not get his way. There are certainly several factors which play a role in this new development. He now has to share attention with his baby sister, but this is certainly not the only reason for his tantrums. Lukas’ problems in understanding new situations and developing strategies for dealing with them certainly plays a role here.

Music therapy has been prescribed again with the indication problems in social interaction (temper tantrums, frustration tolerance, adequate social interaction) and problems in planning actions independently. We will now begin working in these new areas, adapting activities and principles to his developmental level, taking into account how his cognitive problems influence his interactive competence without losing sight of the emotional side of development.

**Paul**

Paul was referred to music therapy at the age of 11 months. He, too, has a dramatic medical history. There were complications in pregnancy from the twenty-fifth week on. He was born by cesarean section in the thirty-first week of pregnancy after the CTG reading was repeatedly pathological. He weighed 1435 grams and had to be intubated and put on the respirator for a total of 9 days. A sonographic examination of the central nervous system in the neonatal period gave reason to suspect a hypoxic encephalopathy. During the next period of time he showed a motor delay, muscular hypertonia especially in the facial area, and he had
problems drinking. He received physiotherapy while still in the hospital. He was released a little over 2 months after birth.

Paul has the following diagnoses: spastic cerebral palsy, mental retardation, eating disorder, stomach tube.

At his first in-patient stay, the psychologist noted that he seemed to look around the room without focusing on any certain object. He did not react when spoken to, but laughed silently when his parents laughed. He could also grasp an object held near his hand.

Paul had a great deal of trouble swallowing because of his motor disability. Feeding took an extraordinary amount of time. He could not cough or sneeze, which made respiratory infections very dangerous. He had just begun to turn from his back onto his side. Interaction between parents and child mostly took place in the form of care for his many bodily needs.

Two global indications were given for the beginning of therapy. The first was the need for assessment--to try to determine if the child would react to stimuli in interaction, the second was the need to promote parent-child interaction. During his first 10-day stay in the clinic with his parents, five sessions in music therapy were held.

Paul is severely disabled. During the first session he was laid on his back on the floor because of his inability to hold himself upright even if supported on his mother’s lap. We have made the observation that these children can be more active if they lie on their backs.
Establishing indications and goals

At the beginning of the first session, Paul made some sounds, and he did make some slight movements with his extremities. He seemed to turn his head as I moved away and came back while speaking with him. However, due to his motor disability, he was very limited in his ability to interact with persons and objects and because of this, very limited in his possibilities for communication. These limitations became our indications for music therapy with Paul.

Parents of children with developmental problems are under a great deal of stress. Health problems that the child has, behaviors that they cannot understand and their own feelings of responsibility for the disability of their children are some of the factors that can influence the way parents interact with their children (Voigt, 2002). Paul’s parents were very caring, but his lack of reaction to stimuli and the enormous amount of time required to feed him had put interaction on the level of caring for bodily needs. The need to promote parent-child interaction was therefore another indication for therapy.

Our goals were to begin to pave the way for interactive competencies by furthering the ability to focus and maintain attention, to enable him to experience the ability to make something happen, for example to produce sounds, and to help him begin to discover ways to communicate wishes and needs by adapting his behavior to the situation. In the area of parent-child interaction, we wanted to support Paul’s parents in discovering their own abilities to play and interact with their child in spite of his very severe disability.
Strategies for therapy

Paul’s very limited abilities to respond required a close observation of his behavior so that I could find possibilities for interacting socially. Using the principles of responsive interaction, I tried to offer Paul opportunities to respond to social stimuli of musical activities by structuring these clearly, by taking up his spontaneous behaviors or expressions and reinforcing these socially, even if they occurred by chance. Activities were repeated often with slight variations. Paul was given the opportunity to produce sound using all extremities.

In the first session I placed bells around his hands since spontaneous movements could then cause sound to occur. Using a well-known German children’s song about a little galloping horse, an interactive game could be developed which then became our theme song during this stay. At first, I moved his hands to the music so that the movement caused sounds to be produced. At the end of the song I asked him where his „horses” were. When his spontaneous movement caused the bells to ring I reinforced this socially, also answering with my bells. Then the song was repeated. This game was repeated several times. After 9 minutes he began to move his arm up and down, causing the bells to ring clearly. From this time on he answered in the dialog part of the game in this way. In the second session a bell fell repeatedly from his hand. I then exclaimed „gone!”, put the bell back on his hand and said, „and back again”. Whereas he did not seem to understand the principle of this game immediately, in the third session he began to reach out his hand to receive the bells, only to „throw” them away again. In this way, variations of the game were developed based on variations in the child’s
behavior. His parents reported seeing him react purposefully for the first time and being amazed at his activity level since they were accustomed to his being very passive (Voigt, 2002).

Paul’s parents were present in all sessions, observing how I attempted to play with Paul using musical activities. They also assisted me when I needed someone to hold him. In the fourth session his mother began to take part actively and to play with Paul using the activities I have described. At first I supported her often. She quickly gained confidence in her ability to play with him using musical activities and began to use clearer signals in interaction (Voigt, 2002). It was a joy to watch his mother playing the game about the little horses with him. The positive quality of the developing parent-child interaction was clearly observable.

At the end of this stay we observed that Paul was indeed capable of taking part in social interactions if they were geared to his level of development. He used his motor abilities consciously to produce sound in musical activities. Paul seemed to recognize when he was able to make something happen by acting--in our case producing sounds for music. He was also beginning to understand very simple structures of play.

Within the music therapy situation we were able to obtain information about Paul’s development in the area of social interaction and communication. This information helped his parents to include playing with Paul as part of their interaction with him. Because we had used Paul’s individual developmental characteristics as a point of departure, we were able to discover that he was not only severely disabled, but that
he had many strong points as well. Music therapy helped to assess some of the qualitative characteristics of his development.

Course of therapy
The family used the musical activities we had developed in playing with Paul at home. They reported that the game with the little horses was the first activity that motivated him to play and interaction after a serious bout with pneumonia.

Eight months later during his third stay at the Kinderzentrum he showed us the ability to initiate and maintain games of social interaction. The next video excerpt will illustrate this point clearly. Paul included both his father and me in the game. After his father intuitively gave him a mallet, he rolled to me, played the drum, rolled to his father, gave him the mallet, took the mallet back, repeating the sequence several times.

Adapting indications, goals and strategies to development
Paul’s motor disability has proven to be very severe. He is now 3 years and 4 months of age. He can only creep with great difficulty and cannot sit without support. His initiative to interact with his environment is strong, but his motor abilities prevent him from doing this without assistance. Therefore, the indications for therapy for Paul are still his limitations in the ability to interact with persons and objects in his environment and his limitations in the ability to communicate.

Our goals have changed. Paul is now able to make his wishes known through varying his behavior--he creeps to different instruments and objects, points to them, plays „chase” with two cymbals that I hold and is
showing the ability for symbolic play. During his last stay he had begun to say „yes” and „no”. His sense of humor is delightful. The goal we have now is promoting Paul’s development of more differentiated and complex interactions with more communicative character and the promotion of his ability for structuring play flexibly and for self-expression through music. To close this case example I would like to describe a sequence which occurred during his last stay at the Kinderzentrum. As we ended the session the previous day, Paul had „baked a cake” and was of the opinion that it wasn’t done yet. I had ended the session saying that we would let the cake set in the oven (which was the Pipedream). He had remembered this. After playing using the cymbals, he tried to make me understand what he wanted, pointing and answering my naming instruments with „no” until I named the Pipedream. Paul took up the activity where we had left off the day before, thoroughly enjoying delaying the cake’s being done, heating up the oven repeatedly by playing the Pipedream.

**Summary**

At the beginning of this paper I stated that in order to establish indications for music therapy it is helpful to base these on a description of developmental processes of the individual child instead of on the global diagnosis of the child’s developmental problem. Problems in one area of development affect development in other areas of development as well. Therefore, it is not possible to consider only one aspect of development, for example social interaction, without taking other areas of development such as cognitive development into account.
What have these two examples from clinical practice shown us about establishing indications for therapy?

Both children have received the diagnosis of mental retardation, both show language delays. Paul also has a severe motor disability. These diagnoses alone do not give us enough information to determine whether or not music therapy should be suggested as a means of treatment for the children, nor do they enable us to set goals which are suited to the developmental needs of each child. Only after we described the qualitative developmental characteristics each child showed through his behavior in interaction was it possible to understand how the disability was affecting development. Lukas could move but lacked the cognitive ability to put this ability into action. Paul could hardly move at all because of a central motor disability. Lukas had problems in focusing attention. Paul was attentive, but it was difficult at first to recognize this. We needed this information about each child’s development to determine how music therapy could be used to support the children in making progress in coming to terms with persons and objects in their environments, in developing interactive competencies for communication and in developing positive relationships with others.

Development is a dynamic process that takes place within reciprocal action between the child and his environment. Social interaction plays a very important role in development and influences its progress by providing a means of coming to terms with persons and situations and in developing a means of communication. However, developmental factors also influence the child’s abilities in the areas of social interaction and
communication. Only if we consider both aspects, interaction and developmental factors, can we establish more precise indications for music therapy which, in turn, enable us to develop strategies and goals suited to the individual child’s developmental needs.

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

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 working. 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 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.
There are already many music therapy reviews, why not use those?
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-
uating 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.
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

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### Table 56

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<th>RANDOMISED CONTROLLED TRIAL</th>
<th>CLINICAL CONTROLLED TRIAL</th>
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<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>
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<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>
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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](http://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 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, unbiased 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](http://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 90  Levels of evidence**

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)

Let us not go back to the past.....

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 end result 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)

**Figure 92 Three levels of EB practice**

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.

**What is Evidence Based Music Therapy? An example.**

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 focussing 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:

**Figure 95**

Step 1: formulating an answerable question

- Do musical concentration exercises (I) improve cognitive skills (O) in schizophrenic patients (P) compared to no musical concentration exercise (C)?

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 Johns 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 focused on the application and standardization 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 Johns 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:
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:
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.

Useful 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)
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

website: www.ebmt.info
Cerebral palsy is a disorder occurring in infancy that affects movement and posture. Children with cerebral palsy typically are unable to make gross movements such as running and skipping. Their fine motor skills (manipulative use of hands) are also affected demonstrating poor fine motor control. Additionally, posture is either hyperextensive or hypopotonic. Children do not stand with symmetrical alignment and need assistance to stand at all.

Two in every 1,000 infants are born with cerebral palsy. It can take several months to several years to diagnose this disorder since pediatricians and neurologists are reluctant to extend this diagnosis to parents at an early age. Early interventionists (including music therapists) are able to treat the child with their presenting issues. Early diagnosis is critical in order for the child to receive therapy and work to achieve all they are capable of.

Infants born with cerebral palsy exhibit a variety of developmental delays. These can include speech and language, sensory deficits, physical challenges, deficits in cognition, and secondary behavioral and social emotional traits as a result of frustration and stemming from an
inability to communicate and be understood. Children with cerebral palsy (will be referred to as CP) with normal or above normal cognitive abilities also become frustrated with their inability to “play and learn like other children”.

In the past 20-30 years, pediatricians felt that the cause of CP occurred during the birth process when the infant experienced a lack of oxygen (anoxia). More current thinking lends itself to the belief that the premature infant or the infant born with low birth weight will more commonly suffer with CP. Simply explained, CP presents itself in 2 types: (1) Athetoid – involuntary and uncontrolled movements, and (2) Spastic – weak and/or stiff limbs.

As the child matures, other problems may present such as learning disabilities. While a bright child with CP cognitively performs within normal limits (WNL) they may experience reading difficulties (forms of dyslexia) or be poor at math. The child with CP requires longer response time in order to function within their capabilities and they need continual assessment to monitor their unique learning style.

The intent of this paper is to focus on communication and language development using Music Therapy with the child with CP. Language is our internal thought process resulting in the spoken word. Given the range of abilities and dysfunction in the CP child, speech development is attained within a gross time range. There are also those children who are cognitively intact yet never achieving the ability to verbalize. The child with CP will babble and vocalize significantly later than the typically developing child for a variety of reasons. Furthermore, the type of
interventions needed to acquire speech with a child with CP are vastly different from those of a typically developing infant.

The child with CP is unable to interact with her environment in a natural, developmental style. All children learn from play, first using their senses. Normal gross motor development follows a pattern; head control develops, rolling over, sitting, attaining quadroped (pre-crawling), crawling, pulling to stand, cruising and walking. The child with CP does not achieve these goals (and sometimes never does) without intervention. Since they are unable to interact with their environment on their own, it is up to the parents and interventionists to present their environment to them in a way that is easily understood and appropriately accessible to the child.

The child with CP develops speech and language skills atypically. Given their poor head, neck and trunk control it is difficult for them to utter sounds. Therefore, they often struggle with severe delays in speech and language milestones. They might exhibit facial grimacing, slow response time, no facial reaction or uncontrolled vocal pitch and dynamics. Initially, these sounds can be reflected by the music therapist to allow the baby to experience feelings of acceptance. Given this baseline, the music therapist working with the child move at the child’s pace and move forward as the child is ready by using adaptive considerations.

These considerations include positioning the child to allow for the most natural breathing patterns and coordinated movements of the body and oral motor mechanisms. It is significant to sing or speak to the child at eye level to maintain good eye contact. It is also important to use long
chains of sounds (speech, singing, babbling) and not to communicate with the child in short utterances. The goal is to hold and/or position the child so as to imitate as normal sitting posture as possible including support for the feet to give the child sensory input. All of this “work” needs to be fun to keep the child engaged, motivated, comfortable and secure. The child’s vocal responses should not be corrected but matched and reflected since change occurs over time. The emotionality of these moments are significant to the therapist and child since this baby requires the same communicative input as a typically developing child.

The foundation for speech develops in infancy. Stimulation from the environment and a nurturing relationship creates positive responses in infancy and helps to mold a happy and responsive infant. Healthy relationships foster speech and language development. A secure, loved child will respond to a responsive mother, caregiver and therapist. The mother with a CP infant may be sad or depressed and may not think that her child understands or is rejecting of her interactions thus her responses to the infant may be dulled and inconsistent. This baby is not the baby she hoped and dreamed for during her pregnancy and the mother as well as the infant needs time and space to adjust to this monumental life change. When the baby does respond it might be in a shrill or unpleasant tone that does not lend itself to the mother to seek further initial bonding. The baby might be tight and not be able to mold herself towards the mother’s body or easily achieve eye contact. Often these babies are unable to nurse and this is a disappointment to the mother. The mother needs to be taught new and different ways to enjoy and bond with her new baby. Observing the music therapist’s interactions can demonstrate
to the mother ways in which she can share more meaningful moments with her baby.

Music therapy can assist relationship building and help the mother in bonding with her baby. Relationship is an interactive process that needs to develop first and then work towards encouraging the development of speech and language through music therapy interventions. Music therapy creates an avenue within which to work with the child to develop communication skills and language. Reciprocity and security needs to be established in relationships with the atypically developing child. The CP child often is given limited experiences to develop a meaningful and emotionally satisfying relationship. Music therapy can help establish a bond, sense of safety, and feelings of reciprocity with the infant with CP.

The typically developing child achieves the primitive stages of speech and language development without professional intervention. The mother rocks the baby holding her close while talking and singing and the baby responds by turning in towards the source of sound (mother) and gazing into the mother’s eyes. The CP infant may be difficult to hold; either being tight or low toned. It will be difficult to achieve eye gaze while singing or talking to the infant and this will lead to a moment of tension rather than a satisfying experience. However, this baby is able to still integrate the soothing rocking motion and is still hearing the sounds such as cooing, singing and talking and is still receiving the offerings of the therapist. While it is a more complicated relationship, the baby is being stimulated tactily, feeling the rocking motion, experiencing closeness and learning to recognize loving familiar sounds/songs.
Relationship is being established and primitive reciprocal communicative skills are developing at the pace of this baby.

The actual music, singing and sounds that are the most pleasurable and will optimally involve the infant at this time needs to be soft, gentle and diatonic sung to the child in short phrases. Babies appear to react more positively and for a longer duration of time to moderate tempos and uncomplicated rhythms. These musical moments need to be coordinated with gentle rocking which is synchronized with the rhythm of the music while the baby is held firmly and securely. The baby needs to be held so that eye contact is achieved.

As the baby matures and bonding deepens, the music therapist discovers which music the baby responds to more positively and the baby’s eye gaze increases in duration. As motor skills develop the baby begins to manipulate the environment by averting eye gaze. At this point the music therapist can choose to stop singing until the baby turns to seek out the therapist or “more singing”. This mutuality allows the baby to have some internal control of her environment as well as creating a playful game with the therapist. In turn, the therapist could stop rocking or singing and wait until the baby becomes agitated or cries and resume singing and rocking. In this interaction the baby learns that their response causes something to happen in their environment. This is a very powerful discovery for an infant who is disabled. Cause and effect relationship has been established in this very early and primary interaction. Bonding has taken another step and early developmental speech and communication skills have mutually developed. Small,
pleasant sounding instruments can be slowly introduced at this time. The music therapist might strum an autoharp openly tuned to the diatonic to accompany her. A wrist bell could be placed on the baby’s hands or feet so the sound will occur at the baby’s involuntary movements. Physical prompts need to be given to the baby in order to establish for the child that there is an “instrument” on this body part. Soft drumming in the rhythmic pulse of the rocking adds to the sensory experience for the baby.

Adding, soft, pleasing instruments gives more richness and depth to the experience and holds the baby’s attentions and reactions more deeply.

Music can match speech development; we can move towards silly sounds, cooing, turn-taking and smiling. Dialoging has been established in a healthy pattern and pre-verbal conversation has begun. A primitive and rhythmic dyad exists between mother/therapist and baby.

It is a dramatic life change when a baby with cerebral palsy is born into a family. For the music therapist it is important to view the baby not only with their disabilities but also with their abilities and potential. The client is the family structure. Working with the baby to achieve speech and language milestones and also helping the mother discover how to enjoy and share loving and productive moments with her baby is the work for the music therapist. We become the model for relationship and skill building to help this baby and family move towards becoming a healthy and loving family.
Dialogue in Music Therapy; making the most of our opportunities to communicate.

Watson, Tessa

The Oxford World Congress has the title dialogue and debate, and this paper is about dialogue. When the World Congress information flopped onto my door mat last year, and I read it through, I was inspired by the topic of dialogue and debate. The word ‘dialogue’ draws together aspects of my recent clinical work, and my own thoughts and dialogues about this. When we speak about our work we are saying something about an idea that seems important, that has become clear to us, and that needs conveying. I have remained inspired by the concept of dialogue in Music Therapy and it is this that is at the heart of my paper.

I have been working with learning disabled clients, amongst other client groups, since I qualified in 1990, and inevitably my thoughts and approaches have changed and developed over this time. Some of these thoughts concern my role as therapist and my position in the client’s world. I want to talk today about our position as therapists in learning disability work, and to explore the ways in which we can make the most of our opportunities to communicate. This is not a theoretical paper, but my work continues to be influenced by psychoanalytic theories and approaches.

My current clinical work is with adults with learning disabilities. I am employed by Ealing Primary Care Trust to work in the Ealing Community Team for People with Learning Disabilities. I work closely
with other professionals in this team; with nurses, doctors, social
workers, psychologists, and of course other therapists (physiotherapists,
speech and language therapists and other arts therapists). We work as a
team to help clients overcome difficulties in their lives, and aim to enable
optimum independence for our clients (Ealing CTPLD 2001).

What do I mean by dialogue? I think of the musical and perhaps verbal
interactions that take place within the therapy session. I think of internal
and external dialogues. I think of the dialogue that the client has with
their world, outside the therapy session. I think of the dialogue that the
therapist has with others outside the therapy session, for her clients. I
think often of my role as therapist and my position in each client’s world –
and sometimes I feel clear about what I am doing, and sometimes I feel
unsure; I’m sure this is an experience shared by others. I want to talk
today about some of these different connections in learning disability
work, and to explore the ways in which we can make the most of our
opportunities to communicate.

Learning disability services in the UK are often described as Cinderella
services, in terms of profile, staffing and resources. I’m also aware that
of the many presentations at this conference, few are focused on adult
learning disability work. However, last year the British government
published a White Paper on learning disabilities which has both
challenged, and given direction to those of us working in the field (DOH,
2001). The main principles of the White Paper are laudable; rights,
independence, choice and inclusion. The Government wishes to ‘enable
people with learning disabilities to lead full and purposeful lives within
their community and to develop a range of friendships, activities and relationships’ (p26). In the White Paper there is also much mention of community. The idea of community is important to this presentation and to us as therapists, and I will explore this idea in more depth later in this paper.

The White Paper also emphasises the need for workers to develop partnership between all agencies working with clients, and to develop an advocacy and teaching role. Do these roles sit comfortably with that of therapist? Where are our role boundaries?

Clients with learning disabilities are often struggling to establish or maintain an interaction or dialogue with the world. Sometimes they are attempting dialogue; sometimes this attempt turns inwards. Often our work with learning disabled clients starts from a point of building or establishing a dialogue, using music. And this is at the heart of my presentation; where does dialogue start and stop – does it begin and end at the door of the therapy room, or does it continue into the client’s wider life? How much do we need to engage in dialogue with those in the client’s community as well as engaging in dialogue with the client in order to make our work most effective? I want to explore these thoughts further by presenting two very different case studies and exploring the dialogues that were built in the therapy.

**Case study 1**

When clients come for therapy they often communicate something to us about difficult dialogues. Perhaps this difficult dialogue is an internal
one (I remember a client who self injured to a distressing extent). Perhaps the difficult dialogue is with past or present family groups (a man who taken on all the grief for his family when his father died, and who couldn’t express to his family how he felt). Perhaps the dialogue is with the wider community (I’m thinking of a client who didn’t want to have the diagnosis of learning disability and aspergers syndrome because she was too aware of what this meant for her in the community).

I’m always struck by the differences in the interactions that we have with our clients, and the way in which they are able to show us where they need to work in therapy.

The first client I want to introduce to you is a lady in her 40s, who I will call Heather. She has profound and multiple learning disabilities and has been cared for all her life, initially and briefly by her family, then in a long stay hospital, and more recently in a group home. My first contact with this client, and thus the first dialogue that was established in the therapy, was through Heather’s keyworker (see figure 1 for illustration of dialogues). Her keyworker was worried about her lack of involvement in her environment, her lack of interest in objects and people and her lack of motivation to do anything. Heather did very little, wouldn’t use objects and had severe problems interacting with others.

I met Heather at home. She was sitting in a chair, appearing to show no interest in her surroundings. I noticed that Heather had established a dialogue with herself (tapping her fingers together, moving her head). Her carers were finding it painful and extremely difficult to be with her; and indeed I found my contact with her in therapy difficult, and a
struggle to think about (and I’m aware that when I write about or present this work, I can quickly feel disabled, and as though my words are ineffective and can have no impact. I remember Sinason’s quotation ‘The struggle to stay with something painful, however small, is hard for the worker’ (p147)). Heather and I embarked on an individual assessment.

My S&LT colleague also knew and worked with Heather, and we liaised closely once I began regular therapy. She became very interested in the way in which Heather could use the Music Therapy setting in a very different way.

Following our individual Music Therapy assessment Heather continued in long term therapy. We engaged in a long struggle to establish contact; the therapy was hard work but exciting as tiny developments occurred. All the contact in the sessions took place within our musical and physical/gestural interactions. We began to develop sustained interactions, and Heather developed an interest in someone else (the therapist), in objects (the maracas, bells, drum and piano), and in the environment around her (as she began to explore the therapy room). Her dialogue with her world had grown significantly.

An essential part of this work was my engagement with my own internal dialogue.

“…therapists need to acquire their own capacity for spontaneous reflection with the session, alongside the internalised supervisor. They can thus learn to watch themselves as well as the patient…” (Casement, p33).
How hard it was to stay with Heather’s passivity. I was acutely aware of my feelings of inadequacy; a sense that ‘nothing happens’; how important and significant tiny changes or differences are. I acknowledged and valued my thoughts of ‘giving up’ – should I carry on with individual therapy for so long? Acknowledging and considering my own feelings and observations through this ‘emotional storm’ helped me to bear the difficulty of the work and to learn more about Heather. Shipton says that ‘to learn from experience we must allow ourselves to have an experience, to become aware of it and then to think reflectively about it’ (Shipton p25) My dialogue with supervision was also important. It was important to think with someone else about the effect on me of Heather’s use of the session. Shipton states that thinking in supervision ‘is free-associative rather than directed, allowing thought to germinate and develop in the mind and in the discourse between participants.’ (p24); and that ‘the most effective role of a supervisor is to facilitate communication between therapist and patient’ p47

After a year in therapy, an opportunity arose for Heather to join a group. All those involved considered that this would be useful as it would give Heather an opportunity to use her newly found interest in others, in a group setting that still provided a rich and encouraging musical environment. Now Heather began to engage in a much more active dialogue with objects and with others. She engaged with objects more actively and with an emotional quality (for example often reaching out for an object and shaking or playing it and then flinging it away, bringing a lively energy to the session which pleased her and the group).
Heather’s keyworker has continued to be very interested in this work, and in order to respond to this interest and their requests for information, some staff training for a small group of staff from Heather’s house has been arranged. This will be delivered with the Speech and Language Therapist and will use some video from the therapy and some strategies to help staff develop ways of being with Heather. This training is develops the partnerships between community team staff and care staff, but more importantly helps staff to work with Heather so that she can continue to develop.

**Figure 99**

I consider that this development of the therapist’s role is particularly important when working with clients who can’t speak about their experiences in therapy. When working with clients in psychiatric
services, or with clients with learning disability who are verbal, I have been able to have a verbal dialogue or negotiation about what it is ok to share. These clients might also choose to share something about their therapy with important people (much in the same way that we might choose to talk to important people about our own therapy experiences, in order to explain something about ourselves, or to tell them something we have learned about ourselves and the world). There are, however, sensitive issues of confidentiality to be explored when a client is non-verbal and cannot choose to share information herself.

My position is that dialogue about work undertaken in therapy needs to cast a wider net, firstly if we are to make the most of change in therapy, and secondly in order that we do not isolate the learning that has taken place in therapy.

But we must also be careful to keep the focus on Heather, and her work in therapy, whilst we engage in other developments that might help her further.

**Case study 2**

My second case example is of group work that I ran with an Art Therapy colleague. We ran a series of groups together with a different focus for each group. The group that I will discuss was for people who were socially isolated, or who were on the edges of services. There were 6 clients in the group (one of whom did not ever sustain a regular contact with the group). The group members had different challenges to face in their lives at that time. One was on the verge of being excluded from a
day centre placement due to his anxieties which were leading to aggressive verbal attacks. Two other group members were living on their own and both were experiencing difficulties; one was becoming depressed and was extremely isolated because of a lack of ability to make links with others around him, the other was reacting to difficult neighbours in a wild and aggressive way. Another client had just left college and was struggling to structure and manage his time; he was often distressed.

The groups ran for 6 months. The first 12 weeks were one hour sessions of Music Therapy, where the Music Therapist ran the session and the Art Therapist was co-therapist. See figure 2 for illustration of dialogues. Then the group went on a trip together to the Tate Gallery in London. Following the trip, the group resumed therapy together, this time with 12 one hour sessions of Art Therapy. During the Art Therapy sessions, we often listened to the tapes that we had made in the Music Therapy sessions.
I want to explore the ideas around the Tate Gallery trip, as this opens up the most dramatic idea of dialogue; a dialogue between the group and the community, whilst the group is together and with the therapists. The idea for a gallery trip was suggested by the Art Therapist, who had previously visited a gallery with some clients with mental health problems. The visit aimed to help clients to begin to realise their potential for self-directed art work, and to identify themselves as artists with a valuable voice in the community. We considered how to make the most of this possibility, and in order to contain the experience and enable clients to work with the challenges and delights that it would bring, we decided to construct a ‘sandwich’ of therapy, gallery, therapy. The Tate Gallery trip was arranged in conjunction with the Education Department at the
gallery, who work often with people with learning disabilities. We were shown around by one of the staff, and we moved around the gallery as a small group, carrying our own stools and sitting down together to hear something about the artworks and to discuss our opinions. We viewed 7 or 8 previously chosen pieces of art work which linked in with our group theme. We also had time to have lunch together and visit the gallery shop before we left to come home.

So, in these groups, there were many different dialogues occurring. Not only the dialogue in the therapy setting, but the dialogue with the larger community. The knowledge of our trip to the Tate meant that anxieties and issues to do with being in the community; the reasons why clients might either stay at home or might be excluded from a day centre, and very the reasons for their referral to the group, were brought into the sessions at a very early stage. Our trip to the Tate did raise anxieties; on a couple of occasions there were difficult situations to negotiate. All these happenings were brought back into the therapy when the group met again to resume Art Therapy. These gallery visits helped the group to bring their difficulties right into the group, and to focus on these very difficult issues.

On one visit, Oliver, a man who lives alone and is sometimes agoraphobic, is drawn to a painting entitled ‘The Lonely City’. Our guide notices his interest in this picture and listens to his responses. She tells him about the artist, who felt lonely and frightened. Oliver remembers this image and reflects upon it in subsequent Art Therapy sessions. For Oliver, the most important part of the gallery trip was to
find that feelings that he had were shared. Shared by an artist who had communicated and expressed his feelings in a most beautiful but also haunting picture. Oliver was very struck by this, and remembered the image clearly. Back in the Art Therapy sessions, he talked about the image and about the artist who had felt so lonely. He identified strongly with the artist, and importantly, valued the picture as an expression of their feeling. He was helped to engage in a process of valuing and expressing his own feelings. This experience rekindled some hope for Oliver.

Jade, an angry woman who had extreme difficulty in valuing her own contributions to the group and to her wider life, questions the value of each piece of art work. In one gallery, there are samples of canvas and brushes that show the materials used. Jade says that they must be worth a lot of money, and, unaware that she is observed, slips one piece into her pocket. She seems to be trying to hold onto something of value. The discreet intervention of the Art Therapist enables the material to be returned, and some of the meaning to be understood. Later, in Art Therapy, Jade struggles to keep any of her artwork, scribbling over most pieces by the end of the session. With support from the co-therapist she is able to paint a messy and frightening picture and leave this valuable image in the studio. In her therapy, Jade shared with us her search for objects of value. She sees value in the gallery, and is awed by it. Perhaps in order to internalise or to obtain some of this value for herself, Jade takes a piece of the material on display. In her everyday life, Jade is not able to value herself or her contributions. She has shown us how hard it is for her to value her music, or art work, or the music or art work created.
by the group, of which she is a part. The incident at the gallery Jade enabled the issue of ‘value’ to be more directly addressed in the group, partly by the group giving feedback to Jade that she was valuable to the group. Jade was encouraged to think about where she could find value, and to find value in her own work. She began to work with the co-therapist, and was able to keep some of her work, and to start value this as an expression of her very difficult experiences. Later, when the therapy had finished, Jade requested a meeting with the therapists in the Art Therapy room, saying that she had left objects of value in the Art Therapy room. Her folder was reviewed, and she chose to leave her art work safely in the therapy room, rather than destroy it, which she had thought of doing.

**Conclusion**

These are two very different case studies which explore some of the same issues. The dialogue that has begun in the therapy room, where we learn so much, has been extended further. In order to know the value of these extended dialogues, it is important to reflect upon what has been achieved:

Heather

- Care staff have seen how Heather can be different when offered an special environment that is useful to her (the Music Therapy setting), and have therefore widened their perception of Heather and her abilities and personality.
- Care staff have developed more satisfying and appropriate ways to be with, and work with Heather.
- Care staff have extended their skills (which will be of benefit to Heather and to other clients).
• Professionals have developed their understanding of each other’s roles (and will therefore be able to work more closely together in future, benefiting clients).

• The therapist has gained valuable support, feedback and connection with others (essential in managing this difficult work).

Group

• Using both Music and Art Therapy offered clients a richer environment, and appeared to enable clients to engage in a deeper process through the therapy.

• The two modalities appeared to offer different opportunities, and provide different roles for the clients (the experience of Music Therapy formed the group, and later, helped the group to remember some of their early experiences in therapy by listening to the tapes in the Art Therapy sessions; Art Therapy provided a more reflective role, once issues could be more obviously represented).

• The visit to the Tate Gallery represented a bridge between Music Therapy and Art Therapy, during which the group had a real experience together in the community.

• Clients were able to show the therapists what it was like for them to be in the community.

• Clients were able to see the value of artistic expression and begin to value their own artistic expression (many people come to the gallery to see these art works, some of which were painted in response to feelings).

• Difficult experiences could be contained and brought back to the Art Therapy sessions, enabling them to be considered and worked on with support.

• Clients appeared to be more able to support each other and notice each other’s strengths through the process of having been in the community together.

I have discussed two pieces of work and the dialogues that were developed in the work. My position as therapist was different in each piece of work, and the dialogues were constructed differently. I have then explored the ways in which these extended dialogues have ‘made the most of opportunities to communicate’.
References


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This presentation at the World Congress of Music Therapy served as an opportunity to share the work that had taken place in the Symposium on Experiential Learning in Music Therapy, held on July 23, 2002, immediately preceding the opening of the Congress. Attendance at the Symposium was by invitation, and the program included presentations on various aspects of experiential learning in music therapy as well as discussion of the presentation material and issues. Abstracts from the presentations are included at the end of this report.

Participants in the Symposium were: Barbara Wheeler, chair, Lia Rejane Barcellos, Rachel Darnley-Smith, Cheryl Dileo, Denise Grocke, Nigel Hartley, Connie Isenberg-Grzedo, Mechtild Jahn-Langenberg, Kathy Murphy, Inge Nygaard Pedersen, Benedikte Scheiby, Chava Sekeles, Elaine Streeter, Dorit Amir, Diane Austin, Joy Berger, Jos de Backer, Lars Ole Bonde, Alison Davies, Janice Dvorkin, Johannes Eschen, Michele Forinash, Adva Frank-Schwebel, Sarah Hoskyns, Terese Leite, Charlotte Lindvarg, Louise Montello, Monika Noecker-Ribaupierre, Helen Odell-Miller, Kana Okazaki, Eleanor Richards, Almut Seidel, Helen Patey Tyler, Jan Van Camp, Marcos Vidret, Gabriela Wagner, Tony Wigram, and Thomas Wosch. Diego Schapira was unable to attend but submitted an abstract for the paper that he had been invited to present.
The presentation during the Congress was intended to be primarily a dialogue and debate about issues surrounding experiential learning in music therapy. It was recognized that many people who would have been interested in attending the Symposium and would have made a very positive contribution had not been included among those who were invited, and the presentation time was seen opportunity to expand the discussion of these issues to those people.

Before the discussion began, though, a summary of some of the issues that had been discussed during the Symposium was presented. Four main points that had come out of the Symposium were made in this summary:

1. It was agreed by the attendees at the Symposium that people should have experiential learning.
   - It is felt to be the best, if not the only, way to understand the music therapy process.
   - The personal and cognitive growth necessary to be a music therapist is best achieved through experiencing a music therapy process.
   - The ethical problems of not having experiential training outweigh the ethical problems inherent in it.

2. There are many complexities of experiential learning.
   - Where it is done – in or out of the training program; whether it is part of the program or separate from it.
   - Who does it – separate staff or the staff of the training program.
• How it is done – music therapist as therapist; students as therapists; individual or group; graded or not graded.

3. The ideal may not always be what is realistic. It is not always possible to have the ideal experiential learning, but this does not mean that it should not be done.

4. Every cultural and institutional context requires its own model or adaptation – so experiential learning can be organized in many ways and follow many models.

Additional points that were made during the discussion as part of the presentation at the Congress are summarized below:

1. Levels of training should be related to educational level
2. Some felt that all training should occur at the master’s level, however, it isn’t the reality
3. Cultural issues:
   a. In Japan most university faculty are self-taught and do not have experience in experiential learning
   b. Asian cultures—students do what teachers tell them
   c. Attitudes towards experiential training differ within regions of countries
4. A suggestion was made that educational programs without experiential training could offer experiential training workshops
5. Experiential learning shouldn’t be done prematurely
6. Educators who have not had experiential learning as part of their training may be reluctant to try experiential methods in their classrooms
7. Even if experiential learning is not intended to be therapy, it may have therapeutic effects
8. In England, one program experiential training in form of personal therapy looks at student’s relationship with music, it can be a
corrective experience for those who come in with a bad experience with music

9. Ethical Issues:
   a. If at university, run by someone not affiliated with university
   b. Have to safeguard and protect the student
      i. Choices with regard to level of participation
      ii. Can’t be graded on content of experience
   c. Informed consent
   d. Employ additional faculty
   e. Power relationship and dual roles

10. Those who ran training groups felt that if students had private therapy outside of the group, they found the training group to be more beneficial

11. How do we integrate self-experience within training and education?

ABSTRACTS FROM THE SYMPOSIUM

Welcome, Introductions, and Overview
Barbara L. Wheeler -- USA

This presentation, which opens the Symposium on Experiential Learning in Music Therapy, includes introductions of the participants, information on the history of the Symposium and how this topic was chosen, and a discussion of what will be included in the Symposium.

This is the second symposium that has been sponsored by the WFMT Commission on Education, Training, and Accreditation. The first Education Symposium, in 1999, led to the development of WFMT Guidelines for Music Therapy Education and Training, which are now part of the WFMT documents and published on the WFMT website (http://www.musictherapyworld.de/modules/wfmt/w_index1.htm).
Symposium was chaired by Denise Grocke, outgoing Chair of the Commission on Education and Training, and attended by 15 people. The proceedings of that symposium are published on the WFMT website.

The issue that received the most spirited discussion at that symposium was experiential learning. As a result of the obvious interest in this area, and the importance of experiential learning in the training of music therapists world-wide, the topic for the current symposium was chosen.

The words “experiential learning” have been chosen for the content of this symposium, but “experiential training” could also have been used. “Self-experience in music therapy” is also used to refer to much of what will be discussed, although this term has a more specific use than does “experiential learning.” Experiential training is defined by Kenneth Bruscia as a teaching method for music therapy in which “students experience the process of music therapy or healing: 1) authentically, 2) as clients, 3) through a planned sequence of experiences over an extended period of time, 4) as an integral part of an education or training program, and 5) for both educational and personal growth purposes. These experiences may be led by professors, supervisors, other student, or outside music therapists….this practice does not include practicum or internship experiences where the student takes the role of a therapist with real clients” (Bruscia, K., *Defining Music Therapy*, Ed. 2, Gilsum, NH: Barcelona, 1998). The term experiential learning will be used broadly in this symposium, including various approaches and models, but will not include role playing, which could also be included under this area.

Barbara L. Wheeler, PhD, MT-BC
Chair, WFMT Commission on Education, Training, and Accreditation
Self Experiencing of the Music Therapy Student Roundtable: Committee Training and Education

The 5th European Music Therapy Congress
Naples, Italy 20-24 April 2001
Report presented at the Oxford Seminar on Training & Education

Chava Sekeles – Israel

In April 2000 Israel had the honor to host the EMTC seminar which prepared the 5th European Music Therapy Congress (April 2001) in Naples. In this seminar, a decision was made by the committee Training and Education to deal in depth during the coming congress with one subject: Self-experiencing of the MT student.

I took the responsibility to prepare a short introduction on the subject after which the participants were invited to express their own ideas and share their personal experiences. The introduction was based on letters EMTC members sent me, on a questionnaire distributed to 25 ex-students and 15 present students, on professional literature and on my own experience.

In regard to self-experiencing, it is very important to stress the fact that self therapy is not the only subject involved, though it is mostly taken as a main issue. In the following report I shall present the rational behind
integrated studies in music therapy, its contribution to our subject and the need to work on musicality as well as to have individual and/or group treatment, in order to develop a therapeutic identity.

The following list was presented to the participants after which two subjects (no. 1 and no. 6) were discussed in details:

1. Individual and/or group therapy
2. Formal and non-formal music studies
3. Peer activities outside the official program
4. Studies of specific MT models
5. Individual and group observations settings
6. Supervised internship
7. Non-frontal seminars
8. Workshops
9. Visits to therapeutic settings
10. Giving concerts in therapeutic settings

Author
Chava Sekeles (Ph.D; R MTI; OTR;) Dir. MT program The David Yellin College: Institute of Art Therapies. P.O.Box 3578, Beith Hakerem, Jerusalem 91035 Israel. Fax: 02-6521548

Private address: Nataf 51, D.N. Harei Yehuda 90804, Israel. Telefax: 02-5340612 E-mail: sekeles@netvision.net.il
Experiential Learning: Temple University’s Approach To The Education Of Music Therapy Students

Kathy Murphy – USA

This presentation provided an overview of the spectrum of experiential learning methods used across all Music Therapy programs at Temple University. All three members of Temple’s Music Therapy faculty were interviewed to gain a better understanding of how they incorporate experiential learning into their courses. All interviews were then analyzed according to the following research questions:

How does the Music Therapy faculty conceptualize experiential learning;

How is experiential learning implemented within the class room;

How is experiential learning evaluated;

How are the boundaries perceived and/or maintained.

This analysis revealed four methods of experiential learning:

1) Demonstration;

2) Laboratory Experiences;

3) Experiential Exercises; and,

4) Group Models (in and out of class).

The level of participation on the part of the students and the role of the educator within each method was described. Variables affecting the depth of students’ personal involvement and boundary issues were identified. Challenges to experiential learning in an academic setting and topics for further research were also presented.
Experiential Training in Analytical Music Therapy (AMT)

Benedikte Scheiby – USA

A short description of the self-experiential training elements in the AMT model that is offered as a graduate/postgraduate training done within an academic program and outside a program for the music therapist. This training is self-experiential in the offered: 1) individual music therapy sessions, 2) Group music therapy sessions, 3) Intertherapy sessions.

Because I have experience with practicing AMT undergraduate training as a part of an academic program and experience with AMT training in a postgraduate program outside an academic facility I have chosen to share important material from video taped as well as written self evaluations from music therapists that have been doing one or the other. This material will highlight aspects of following questions: What are the goals of the training and what seems to have been accomplished seen from the music therapy students point of view?

The goals of the training are meant to be an integrative way to develop/teach 4 areas of music therapy competency:

1. **Personal** competency – ability to be therapeutically relevant (*being*)
2. **Technical** competency – ability to act therapeutically relevant (*doing*)
3 Artistic competency – ability to create therapeutically relevant (creating)

4 Theoretical competency – ability to think therapeutically relevant (thinking)

Based upon insights gained from my 22 years of clinical experience with AMT training and supervising music therapists that have had the self-experiential training and music therapy students that have not, I will end with a summarization of the risks that are taken by not receiving self-experiential music therapy training.

Benedikte B. Scheiby,
Affiliation: Beth Abraham Family of Health Services and New York University
Titel at BA: Assistant Director of Music Therapy. Titel at NYU: Adjunct Faculty member
Credentials: MA, MEd, DPMT, CMT.
Email: bscheiby@bethabe.org

Experiential Learning in the Bonny Method of GIM Training

Denise Grocke -- Australia

Experiential learning has always been part of the Bonny Method of GIM. Even when Helen Bonny was developing her method at the Baltimore Psychiatric Centre in the 1970s, each staff member was required to undergo an experiential session each year, in order for the staff to be aware of the experience the patients were having.

As training in GIM began to be formalised, the idea of personal sessions in GIM within the 2-year advanced level training became a central part of the learning experience. The Association for Music and Imagery (AMI), which governs the requirements for GIM training, stipulates a minimum 15 personal sessions throughout level 3 (advanced level) training.
sessions must be done with a Fellow of GIM, who is not involved in other aspects of training (e.g. lecturing, supervising etc.)

The Graduate Diploma in Guided Imagery and Music at the University of Melbourne requires 20 personal sessions, and we explain that the training in GIM is an integrated model; and each component interacts with the others. For the GIM trainees to develop effective skills in guiding a client confidently into and out of an expanded consciousness, the trainees must have experienced it for themselves. And having had a series of at least 15 personal GIM sessions, the trainee develops a greater inner confidence, and a depth of understanding and knowledge which equips them to effectively guide clients in a similar expanded state of consciousness. This is particularly true of images that might involve challenging imagery. The trainee can only feel confident in guiding a client through these experiences if the trainee has had something similar in their own sessions.

Denise Grocke, PhD, RMT, MT-BC, FAMI
Associate Professor, & Co-ordinator, Music Therapy, University of Melbourne, Australia.
President, World Federation of Music Therapy
(term as WFMT President ended at the end of the World Congress, she is now Past President)
E-Mail: d.grocke@unimelb.edu.au

Psychoanalytically Informed Group Music Therapy for Music Therapy Trainees

Rachel Darnley-Smith – UK
This paper will describe, with illustrations from clinical case material, the
• rationale and procedures for psychoanalytically informed experiential group
Improvisational music therapy, as taught in the UK, involves a transformative and dynamic process of musical relating between therapist and client. In order for the student therapist to learn about this process and its efficacy they need an opportunity to experience the process for themselves through active personal engagement. Group sessions take place weekly, are not assessed, and their contents kept separate and confidential from other parts of the student training. Through the music making of the group and group therapist, together with verbal reflection, students experience at their own pace a process of change in their music and themselves. At times they may experience intense feelings within the sessions, often arising directly from the 'here and now' experience of training. Such feelings frequently include rivalry between themselves and the group leader, low self-esteem, anxiety, a reluctance to take part, and ambivalence about music therapy. Psychoanalytic thinking on the part of the therapist including concepts of transference, counter-transference, and projection enables some linking together and understanding of the different forms of self expression and interaction which may take place musically and non-musically in a group.

This paper will include the author's perception that in many cases through student's personal experience of group music therapy, a core aim of training is often achieved. That individual's music making can become gradually more authentic in terms of themselves and their relationships to
others, and less focused upon improvisation as a shared artefact. Not only does this experience enable personal psychological growth, but also increases understanding of what professional practice in music therapy can aim to achieve.

Rachel Darnley-Smith
Head Music Therapist
Barnet, Enfield and Haringey Mental NHS Trust, London, UK.
Clinical Tutor, Music Therapy Department Guildhall School of Music Drama,
London, UK.
E-mail:Rachel.Darnley-Smith@haringey.nhs.uk

Experiential Training in the Plurimodal Method in Music Therapy

Diego Schapira -- Argentina

In Argentina, students go through tutorships and supervised clinical practice while they are studying, but they don’t have any experiential training as it is not part of the structure of University courses. Also, it is not a requirement for the students to graduate, to go through their own music therapy process as clients. So, I felt it was necessary to create some kind of experiential training structure for graduate Music therapists and advanced students, outside the Universities.

SEVERAL years ago I started working in, what I call today “Experiential Training in the Plurimodal Method in Music Therapy”, which has 2 basic streams: The Theoretical Models study group and the Experiential Music Therapy group (GEMT). I developed this structure within a Music Therapy institution, in Argentina and Uruguay (where, they don’t have a
Music Therapy career by now). This method is also being used in Colombia and Chile.

First, the participants study the theoretical production of outstanding colleagues from different parts of the world. The aim is to make critical readings, and to work in the construction and revision of the Plurimodal method’s theoretical basis.

The same participants work in the GEMT, building a bridge between theory and practice. The basic idea is to go through the experience of working with all the different techniques and methods they have been studying and resonate with, and also with those resources conceived in our clinical practice or during the experiential work.

Diego Schapira
Music Therapy professor at the Universidad del Salvador, in Buenos Aires, Argentina.
MEMBER OF THE ADVISORY COUNCIL OF THE MUSIC THERAPY CAREER. UNIVERSITY OF BUENOS AIRES, ARGENTINA.
Coordinator of the ADIM PROGRAMME (Assistance, Development and Research in Music Therapy) in Argentina and Uruguay.
E-mail: adim@datamarkets.com.ar

“At Ease with Music” - The Case for Mandatory Individual Music Therapy for Music Therapy Students

Nigel Alan Hartley -- UK

Summary
Working with music therapy students within the context of Music Therapy is not well documented; perhaps this is due to the fact that Music Therapy is rarely mandatory within the context of their training, and such cases are minimal. Over the years, I have worked as a music
therapist with music therapy students, particularly training on Nordoff-Robbins postgraduate music therapy training programmes. This has been as part of the training programme at the Nordoff-Robbins London Centre, but also, in a different way, at the University of Witten/Herdecke. Working with musicians, and particularly music therapy students, within the context of music therapy has raised a number of questions and challenges for myself as a Music Therapist.

**Description**

It is my experience that many music therapy students come into training with a damaged relationship to music and the focus of individual music therapy becomes a healing process - particularly in relationship to their past experiences as musicians.

1. When working with music therapy students within the context of music therapy:

2. How is the music therapist's role as a musician challenged by the student?

3. Does the student come with any experience of music therapy, either from his or her own training as a musician or from having read current literature, and how can this affect the therapy?

4. What can the unique way of 'listening' in improvisation within the context of music therapy offer the student towards their own practice as music therapists?

5. How is the student’s role as a musician in the outside world affected and influenced by improvising music within the context of music therapy?

6. How does the music therapy affect the student’s role as music therapy clinician?

This presentation will explore the above questions with reference to clinical work, educational work and research in music therapy.
Should individual music therapy become mandatory for all music therapy students?

Nigel Alan Hartley - United Kingdom Nordoff-Robbins Music Therapy Centre,
Music Therapist2 Lissenden Gardens
Sir Michael Sobell House Palliative Care Unit, LONDON NW5 1PP
Churchill Hospital
Old Road Fax: 0171 267 4496
Headington
OXFORD OX3 7LJ
Tel: 01865 225371
Fax: 01865 225770
Email: nigel@sobellhouse.demon.co.uk

The Value of the Music Therapy Training Group - a Research Project

Elaine Streeter -- UK

Having worked as a facilitator with numerous experiential training groups between 1982 and 1999 I felt it important to try to discover what impact such personal explorations may have on the learning process of a music therapist. This paper discusses the outcome of a small, somewhat basic, research project undertaken in the U.K involving 265 respondents.

My paper attempts to describe how music therapy training group participants evaluate their group music therapy whilst it is ongoing. Which aspects of a music therapy training group do participants value more highly at the beginning as opposed to the end of their group?

The research also attempted to address whether the degree to which music therapists value their training group whilst participating differs in comparison with how they value it, retrospectively, during professional practise.
My paper will focus on the outcome of this research and pose some further questions which it may be useful for us to discuss in small groups. It is not intended to promote discussion on research methodology as such but to stimulate a sharing of experiences between experiential trainers.

Elaine Streeter
Graduate of the Guildhall School of Music and Drama (piano and composition)
Dip.M.Th. (Nordoff Robbins)
P.G.C.E. (primary and special education) Leeds Polytechnic
M.A.Mus.University of York
Adv.Dip.Psychodynamic Counselling (WPF/University of Surrey)
Now lectures at Anglia Polytechnic University, Cambridge, and at the Guildhall School of Music and Drama in London, where has been clinical tutor for some years and currently teaches clinical improvisation.
email: kbl50@dial.pipex.com

Students’ Experiences of Experiential Music Therapy – A Qualitative Research Study

Lia Rejane Mendes Barcellos -- Brazil
This presentation aims to highlight a qualitative research study about ‘Students’ Experience of Experiential Music Therapy’ which has been carried out since 1989, in the fourth year of the undergraduate Music Therapy Program at the Conservatorio Brasileiro de Musica – Rio de Janeiro. Although this kind of experience is done in many Music Therapy Programs around the world – with different denominations, goals and formats - we had no information about research in this subject.

The experience which was the object of this research was realized during the year of 2000 and although the main goal is educational – in order that the students could play the Music Therapist role – it is important to point out that this kind of experience can have therapeutic effects.
The data are being evaluated according to Giorgi’s methodology, adapted to this research and the results are being analyzed in two stages:

• from the students’/music therapists’ point of view – from their written reports of their own experiences, and
• from the researchers’ point of view – analyzing the videotaped ‘sessions’ of the experience.

At this moment we have just evaluated the data gathered from the students’ reports and from this material we created categories/subcategories and unified, re-shaped and organized them.

The students felt that the main contributions of the experience are related to:

• the experience as a whole and
• the different steps of the practice, such as planning and practicing.

The comments about the experience as a whole illuminate its importance in order to:

• make it possible for the students to live a new experience and
• make it possible for the students to play the role of a music therapist in a “assisted clinical experience.”

Although we know that these music therapy experiences are very important for the future music therapists, this research had the aim of ratifying this assumption or not, and, if so, why is it an invaluable and essential component of the music therapy training.

Lia Rejane Mendes Barcellos
Clinical Music Therapist, Graduate in Piano, Master in Musicology, and a GIM student in the USA. Coordinator of the Post-grade Music Therapy Training at the Conservatorio Brasileiro de Musica (CBM) in Rio de Janeiro, Music Therapy professor at the CBM and as invited teacher in other universities of Brazil. Member of the Director Council of Brazilian
Ethical Issues in Experiential Training and Experiential Training in Ethics

Cheryl Dileo - USA

This presentation will consist of 2 parts. The first part will consider the ethical issues involved in experiential training in music therapy education. Types of music therapy experiential training will be delineated, and ethical risks inherent in using these various methods will be identified, e.g., creating dual relationships with students, misuses of power, safety for students, etc. Suggestions for minimizing these ethical risks will be considered. Furthermore, the use of student consent forms will be discussed.

The second part of the presentation will deal with the use of experiential training in ethics. The content of experiential training necessary for developing skills in "ethical thinking" will be discussed. An emphasis will be placed on those interpersonal and self-awareness skills that impact on ethical decision-making, including: common ethical traps, issues concerning spirituality, issues concerning cultural bias, clinical and professional boundaries, propensity for dual relationships, etc.

Lastly, methods for experiential training in ethics will be presented, including self-awareness exercises, problem-solving experiences, and personal exploration tasks.

Cheryl Dileo, PhD, MT-BC
Evaluation of Intertherap

Inge Nygaard Pedersen -- Denmark

Intertherap is the last discipline in the progression of disciplines in the area of Self Experience for music therapy students at the five year music therapy programme at Aalborg University. DK. This evaluation is placed at the end of the fourth year. Due to general rules for university programmes, Intertherap has to be internally evaluated during 'passed' or 'not passed'.

I have developed a form for this evaluation which has turned out to be a real useful tool for the students in their reflection on developing an identity as a music therapist from the area of self experience.

The students have to present a series of 3 to 5 video excerpts with musical examples from the intertherap process and they have to present the intertherap case from a given schedule, where the main focus is to verbalise the process of developing a music therapist identity. The model and idea of the intertherap discipline and the evaluation schedule and form will be presented and exemplified.

Ass. Prof. Inge Nygaard Pedersen
MA Music Science. University of Copenhagen 81
Diplomed Music Therapist. Herdecke, Germany 84
Boundary Issues in Experiential Music Therapy: On the Necessity of Boundaries in Music Therapy Teaching

Mechtild Jahn-Langenberg -- Germany

The security of the setting for a therapeutic experience is a central basis for the success of processes of change. The trustful framework of the working alliance guarantees protection for the encounter with mental/emotional reality, the creation of a working relationship in which one's own biographical material becomes the object of experiential music therapy.

The problems of these experiential situations are clearly alluded to in the name, which points to a teaching performance which takes place for the purpose of professional education and allows oneself to be treated by means of the procedure which is to be learned. From the beginning, the practise of a central therapeutic posture, the observation of oneself, is required. In the further course of one's own development process, this leads to a necessary therapeutic ego-splitting. If the forming of the setting according to psychological standards takes place outside the teaching environment of the university, the candidates experience a secure therapy framework, in which the development of the transference relationship...
can take place free of the accompanying creation of role conflicts. Dependencies, which can be re-experienced in phases through regressive processes, can thus be dared without the danger of abuse. However, problems frequently arise due to the incompatibility of the value systems of all the teachers, teaching music therapists, supervisors, and students who participate in the educational process. Experience shows that despite the good preparation of candidates and the optimal choice of educator, such conflicts often either cannot be avoided or lead again and again to the hammering out of a common basis of values. Examples of conflict situations should make this clearer.

Toward this, the problem of the appropriate choice of teaching music therapists and the connected standard discussion of Music Therapy as a profession, as well as the problem of the research into one's own therapy material (the boundaries of data privacy) will be presented.

Prof. Dr. Mechtilde Jahn-Langenberg, Dipl.-Musiktherapeutin
Hochschule der Künste FK 3
Seminar Musiktherapie
Mierendorffstr. 30
10589 Berlin
Tel. 030/3185-2552
Fax 030/3185-2680
e-mail: langenmu@hdk-berlin.de

“Self-Experience” as a Metaprocess in the Training of Music Therapy Students

Connie Isenberg-Grzedat – Canada

Whereas the focus in a traditional undergraduate academic programme is on knowledge acquisition and skill development, the very nature of music therapy as a discipline leads us, as music therapy educators, to
focus on the “person of the student”, as well. Having all experienced the student who masters the theoretical information, excels musically but fails to connect therapeutically with patients, many of us cannot help but wonder about the most effective and appropriate ways to encourage the personal development of our students. At the graduate level, it has become more common to integrate a form of experiential training into the academic program so as to allow students to have a personal experience in music therapy. This is less common at the undergraduate level. An examination of the components of an undergraduate music therapy training programme reveals, however, that a myriad of opportunities to learn about the “self” exists, even when there is no explicit intention on the part of the faculty to provide a “self-experience”, per se. We will look at examples of these opportunities for self-experience which emerge out of the experiential nature of the work and which may be viewed as a metaprocess inherent to music therapy training. Issues related to the role of the educator will be addressed.

Connie Isenberg-Grzeda, M.M., MT-BC, MTA, FAMI
Doctoral candidate, clinical psychology (Concordia University, Montreal)
Founding professor and coordinator, Music Therapy
Université du Québec à Montréal
Case postale 8888, succursale Centre-Ville
Montréal, Québec
Canada H3C 3P8
e-mail: isenberg-grzeda.connie@uqam.ca
Musical Relatedness in Infancy as a Resource in Understanding Children with Disabilities

Wheeler, Barbara L.¹ & Stultz, Sylvia²
1 PhD, MT-BC; University of Louisville, Louisville, KY, USA
2 PhD; Private Practice, Washington, DC, USA

This presentation addresses the ways in which developmental observations of normal babies can inform music therapy with children with disabilities. The research project examines normal infant development, with special attention to musical relatedness and communication. Videotapes of music therapy sessions of children with multiple severe disabilities and tapes of play sessions with normal infants are examined in light of developmental milestones and implications for treatment strategy.

This study is part of ongoing research based on video recordings of work with children. Videotapes of therapy with children with multiple, severe disabilities were drawn from earlier music therapy sessions. In addition, taping of infants without known developmental problems began 2 years ago. These sessions took place in the infants’ homes and involved musical interaction and play with parents as well as structured and unstructured musical interactions with one of the researchers. The observations occurred approximately monthly for the first year of each child’s life, and are continuing at slightly longer intervals. For the older child, these tapings have now been done for almost 2 years; for the younger, they have been done for slightly over 1 year. Both sets of tapes were analyzed in terms of developmental issues, conceptual frameworks,
and relationships between normal development and developmental issues of children with disabilities.

Greenspan’s model of psychosocial development (Greenspan & Wieder, 1998) was used as a basis for analyzing observations. Like other developmental models, the system is helpful because it provides guidance in understanding how early progress leads to later skills. The Greenspan model was chosen because it is especially rich in its attention to very early stages of development and to issues related to relationships and communication.

Greenspan’s developmental stages include:

- Regulation and interest in the world (normally achieved by approximately 3 months)
- Forming relationships (attachments) (by 5 months)
- Intentional two-way communication (by 9 months)
- Complex sense of self I: Behavioral organization (by 13 months)
- Complex sense of self II: Behavioral elaboration (by 18 months)
- Emotional ideas I: Representational capacity (by 24 months)
- Emotional ideas II: Representational elaboration (by 30 months)
- Emotional thinking I (by 36 months)
- Emotional thinking II (by 42-48 months)

(Greenspan & Wieder, 2000, April)

The present study focuses on the first three of Greenspan’s stages of development, covering approximately the first year of life.
Stage I. Regulation and Interest in the World (by 3 months)

The human infant is born vulnerable not only to physical dangers of life outside the womb, but to the vast array of stimulating sights, sounds and bodily sensations. A new baby is likely to react to stimulation with extreme states of arousal, by being either extremely agitated or by withdrawing. Moments when the child can achieve a balance between being alert enough and calm enough to notice the environment are fleeting and fragile. Gradually, with maturation and support from parents, the infant develops the capacity to regulate these states and notice and enjoy the world. The parent helps the child in this process by soothing and containing the agitated child and by enticing the withdrawn child. In addition, the parent is available as an object of attention for the child.

Our studies of normally-developing infants shed light on the role of music in promoting the child’s ability to regulate and attend. Adults rely heavily on vocal variety, song, rhythm, and movement in promoting the child’s ability to attain a state of homeostasis and attention.

The importance of addressing Stage I issues in therapy, including music therapy, is highlighted in our analysis of clinical material. In order to make contact with the child, the therapist must assess and, if necessary, assist the child in achieving self-regulation and interest in the world, both as a prerequisite for other activities and as a long-term treatment goal. The therapist must assess and reduce physical distress (pain, hunger, fatigue, etc.) and optimize the level of auditory and visual stimulation. The therapist supports moderate arousal, by soothing and containing the
agitated child and enticing the withdrawn child, and is able to invite the child’s attention to the environment, especially the social environment.

**Stage II. Forming Relationships (by 5 months)**

As the child matures in a safe and supporting environment, he/she forms specific attachments. The infant associates the parent with comfort, pleasure, and safety. The child becomes highly focused on the parents, and both child and parent “fall in love.” This relationship drives development in all areas. The child uses vision, hearing, and movement to seek the parent and the focus on the parent promotes attention to sights and sounds, making discriminations and associations. Gradually, the child becomes able to extend his or her focus.

At this stage, healthy parenting involves reliable availability and warm and pleasurable interactions. The parent allows the child to have an impact on the relationship. The parent joins in the child’s rhythms and integrates objects and toys into interactions.

Our studies of normal infants document the ways in which infants evolve during this stage. The relationship becomes the focus of anticipation and pleasure and, within this context, musical communication moves from being an organizing force, as in Stage I, to being an embodiment of the growing intimacy between the baby and the parents.

In music therapy, we can use these insights in fostering the development of children who have not mastered this stage. Analysis of videotaped sessions illustrates the importance of conducting treatment based on the foundation of the relationship and fostering a vigorous attachment.
between child and therapist. The therapist uses the power of the relationship to energize development. The therapist attempts to maximize pleasure associated with the relationship and to follow the child’s lead, allowing child to have impact on interactions. The therapist joins in the child’s rhythms regarding affect, sights, sounds, and movements. The interactions put emphasis on learning that is meaningful to the relationship, including shared pleasure, predictable routines, and human media (voice and face).

III. Intentional Two-Way Communication (by 9 months)

As the relationship between parent and child deepens, communication abilities become more complex and reciprocal. The child realizes he/she can have an impact on the parent. The child expands in his/her ability to express needs with expectation of outcome. Communication volleys, or “opening and closing of circles,” develop. The baby becomes a “person of volition,” aware of the ability to have an impact on the parent. This leads to awareness of impact in other realms and to exploration and curiosity.

Healthy parenting at this stage requires alertness to the child’s desires and responsiveness to the child’s communication and initiative. The parent promotes the child’s ability to have an impact and participates with the child in extended volleys of communication. In our observations of infants, we see rich communication at this stage. Music is a medium which supports extended volleys, in which both adult and child contribute to evolving exchanges.
Music therapy which addresses Stage III issues builds on the child’s interests and energy. The therapist maintains focus on the child’s desires and supports actions initiated by the child. The therapist promotes opportunities for the child to make the connection between wanting something, taking action, and achieving a goal. The therapist is vigilant for opportunities to support extended volleys of communication. In our clinical samples, music therapy provides the context in which the children are supported in their ability to engage in dialogue in which they have an impact on the interaction and are able to extend their ability to participate in communication volleys.

The current study addresses the ways in which music therapists can use a developmental framework to help children progress in their abilities to self-regulate and focus on the environment, to enjoy closeness with attachment figures, and to engage in two-way communication. Future work will extend to more mature stages of development in the areas of feeling, communication, and thinking.

References


Listening and Being Heard - Music Therapy with a Group of Young Adolescents

Wetherick, Donald
SRAsT,
Nordoff-Robbins Music Therapy Centre,
2 Lissenden Gardens,
London NW5 1PP

Abstract

This presentation shows improvisational group music therapy as a way of meeting the needs of adolescents with special educational needs. Group members were referred for reasons including low self-esteem, emotional difficulties and problems in peer relationships. Some were recent immigrants or refugees, for whom English was a new or second language.

Using a combination of structured listening exercises and group improvisations, music became a medium through which they could hear and acknowledge each other, and learn to listen and appreciate each other in a new way. This focus on listening and being heard helped to bring about increased self-confidence, reduced social isolation and the opportunity for relationship building and creative self-expression.

Introduction

In this talk I want to present and reflect on some group music therapy work which my colleague Jane Gibson (JG) and I (DW) have done at the Nordoff-Robbins Music Therapy Centre in London. I am going to share material from one group of three adolescent boys which we facilitated over the school year 2001-2002, focussing on the use of free group improvisations and the way our interventions as music therapists changed over the course of therapy.

Behind our work lies the conviction that music therapy offers a special way in which we can both listen to others and be heard by them. We see
our task as music therapists as being to enable our clients to listen to others, and to be heard by them, in new ways through improvising music together.

This work was not undertaken as a research project, nor is it presented as a new way of doing group music therapy. However, it was a new departure for JG and myself. It has grown out of our working relationship both with each other and with the clients we have worked with over the past three years. It has also been an important part of our personal development as music therapists. At the end of the paper I will reflect briefly on how our approach compares with other group music therapy work.

**Background to the work**

Our work together has been shaped by several factors:

1. Our training (we both trained in the Nordoff-Robbins approach)
2. The needs and ages of the clients we worked with (adolescents with emotional/behavioural problems and/or moderate learning disabilities)
3. Our wish to explore a non-directive approach to group music therapy based on free group improvisation, with a minimum of pre-planned interventions or verbalisation from the therapists.

First, our training in the Nordoff-Robbins approach has led us to value listening, both to and within improvisation, as an essential part of music therapy, and to see this as the starting point for therapeutic intervention. In line with this view, we wanted to focus on the music of the group and on the role of musical interventions, and to avoid any unnecessary discussion of the music or other issues during the sessions.
Secondly, the age and needs of our clients suggested to us that they would benefit from a non-directive approach, giving them the autonomy to discover how to play together as a group, with all the difficulties that presents. All three were young adolescents beginning to grapple with the ordinary challenges of adult social responsibilities. They were also identified as having special difficulties in peer relationships and self-confidence. At least one did not speak English fluently and for this reason, combined with own wish to focus on the musical experience of the group, we decided that we would use the minimum of verbal interventions.

Thirdly, our choice to work for free-improvised sessions contrasted with the approach we were familiar with from other music therapy groups with children (c.f. Nordoff and Robbins 1971). There, free group improvisation was only one of several modes of music making we would use, and usually not the most frequent. These would include songs (e.g. Hallo and Goodbye songs), arrangements, and semi-structured or free improvisations with one or more group members, usually with one therapist at the piano. The choice of activities might be made in advance, or in response to events in the session, and would normally be implemented without negotiation with the clients. To base a whole session, or a large part of a course of therapy, on free group improvisation was a new development for us both which we were keen to explore.

We hoped that this approach to group music therapy might enable our clients to develop a more mature confidence in themselves and in their
capacity to relate to others. We felt justified in taking this approach as these were also the principal common factors mentioned in their referral to group music therapy. Nevertheless, we anticipated that some structured input would be needed at first to establish how music could be used in our sessions. This would shape the beginning of the group’s music therapy experience, setting the group off in a direction which they could continue to explore in their own way.

The Group
The setting for our work was a specialist music therapy clinic run by a charity. Our clients came from a local special needs school for a half-hour session once a week during term time over one school year from September 2001 to June 2002 (a closed time-limited group). The sessions took place in a large therapy room with a grand piano and a good range of large and small percussion instruments, and including a strungback (an open piano frame with strings).

The group consisted of three adolescent boys Ricky, Colin and Baraq, and two music therapists, JG and myself. The boys were aged between 12 and 14 at the start of therapy.

Ryan was a quiet, solitary boy who at first often sat a little apart from the others, usually at a side drum. When he spoke, it was often to settle disagreements between the others, or to refocus the group on the ‘task’, though at times he looked resigned rather than confident in this role.

Colin had an open and cheerful manner. He was the only one of the three to have a recognised learning disability. He would often chatter at first,
and was easily distracted. However, when he addressed the group the others would often defer to him.

Baraq was a recent immigrant from Turkey where he had witnessed, and possibly experienced, ill treatment on racial grounds. His English was very basic at first, but became more fluent over the year. He was the most immediately musical of the three, showing sensitivity and creativity in his music.

**An overview of the work**

Based on our experience of similar groups we had run over the previous two years, we already had in mind how we would facilitate the group. Our approach fell broadly into three phases of work (see Table 1).

Table 57 Three phases of the work

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Therapist led</th>
<th>Activities planned in advance</th>
<th>Focus on group musical exercises</th>
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<tr>
<td>Phase 3</td>
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<td>Minimal therapist intervention, mainly musical</td>
<td>Emerging individuality and group cohesion</td>
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<td>Sessions c.16-24</td>
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</table>

**Phase 1 - Sessions 1-4**

In the first four sessions we used group musical exercises to focus the group’s listening skills and to give them an experience of basic musical elements (e.g. tempi and dynamics). These activities were planned and presented by JG and myself and we would demonstrate some activities, (for example playing back a rhythm performed by the other) before inviting the group to do the same. We also included improvisations
between one therapist and one client, and group improvisation with one therapist at the piano. These activities allowed us to assess each client’s musical perceptive and expressive abilities individually, and also provided a way to introduce them to musical improvisation in a simple way.

**Phase 2 - Sessions 5-c.15**

In the next stage of our work, we handed over initiative in the sessions to the clients themselves. Apart from a circle of chairs in the centre of the room we aimed to avoid influencing the shape of the session, within the boundaries of space and time available to us. We then invited the group members to choose how they would use the session.

In this phase of our work we were often challenged to find ways to help the group as they began to explore the possibilities and difficulties of playing together without directions from ourselves. We were pleased to note, however, that the group members were generally eager to use the instruments and even when resistive or bored, did not ridicule the sessions or the music they made.

**Phase 3 - Sessions c.16-22**

The move to the third phase of our work was not a result of conscious decision on our part, but rather an awareness that our role in the group was changing. In this phase of the work (sessions 16 onward) it became common for the session to consist of one long group improvisation. We found ourselves wondering not so much how we should intervene to help the group, but rather whether we needed to intervene. When we did we
were able to do so through our own musical contributions, rather than verbally. It was also common for us (therapists) to spend some time in the sessions listening to the group without playing at all.

**Video Extracts - Phase 1**
I will now present the story of the group through video extracts, focussing on improvisations where the whole group is playing. Whole group improvisation accounted for most of all the sessions we had, and it was rare for any group member to be musically silent for long. The first two extracts come from Phase 1.

*Extract 1 - Follow the leader (S.1)*

In this extract from session 1, JG is leading an experiential exercise in which the group has been instructed to follow JG’s music in playing on their own instrument. JG leads the group through a range of dynamics and tempi to help the group become aware of basic musical elements.

*Extract 2 - The first group improvisation (S.1)*

This extract shows part of the first group improvisation, at the end of session 1. The group members have chosen their own instruments, and are clearly excited. Nevertheless, their music is still tentative and only grows as JG (at the piano) enlarges her supporting music. There is a strong feeling that the group is looking to JG at the piano to lead the music and give permission to explore louder or more energetic music.

*Summary of Phase 1*

All four sessions in the first phase followed the same pattern: experiential exercises, one-to-one improvisations with a therapist and a group improvisation with one therapist at the piano. By the fourth session we felt the group had shown sufficient awareness of the possibilities of music and improvisation for us to move on to the next stage.
Extract 3 - The first free group improvisation (S.5)

The first group improvisation in this new phase, when we had given the group members the responsibility of shaping the session, was similar to those in the first phase. While not so tentative, the group members showed care in listening to each other and did not take strong initiatives individually. They were also able to explore changes in dynamics (soft and loud) co-operatively. We felt they were still influenced by the structured approach we had taken in the first four sessions, which they had partly internalised.

Extract 3 - The microphone game (S.6)

In this phase we deliberately did not structure the beginning or end of sessions. One way the group created its own structure was by using a toy microphone we had set out. It was passed around, and gave the person holding it the authority to address, or instruct, the rest of the group. While the group was clearly keen to play straight away, most sessions at this time began with ‘the microphone game’.

Extract 4 - Ryan counts us in (S.7)

The microphone was also used in beginning improvisations. In this extract, Ryan counts us in ‘three, two, one…’. The music itself has periods when we are ‘all together’ (in tempo, or dynamic for example), but for much of the time each member is going his own musical way, or engages in brief dialogues with one other player (usually a therapist). The ending is ragged, with various people intervening verbally to control the music.

Extract 5 - Colin says ‘Stop! (S.11)

In this extract too, one of the group (Colin) verbally starts and ends the improvisation. The texture of the music becomes very dense, as everyone is playing loudly. By the end of the improvisation (7 minutes in all) it is
impossible to hear what each person is contributing, and Colin intervenes to end the music, shouting and gesturing for everyone to stop. The extract shows the beginning of the improvisation, and then fades into the ending.

This session, in retrospect, marked a turning point for the group, a point of maximum musical confusion, and minimum opportunity for listening to each other or being heard. Following this improvisation, and Colin’s verbal intervention, we talked about the importance of endings and ‘being heard’, and I made the comment that ‘perhaps it was important that someone said “Stop!”’.

In the following term, there was a change in the group’s music and for the first time we experienced a shared musical ending without the need for a verbal or gestural signal. This was partly enabled by a strong musical intervention by JG. This extract shows the end of this improvisation. Colin is the last to stop, and looks up briefly in recognition before characteristically continuing to play. Note Jane’s strong, slow pulse at the beginning of the extract and her strong ‘final’ note near the end, which Colin then finds on the piano.

**Summary of Phase 2**

This phase was a time of many different form of intervention on our part, and from the group members. The issue of how to begin and end improvisations, or the session, dominated the therapy. We were interested to see how the group itself found ways to address these issues, and felt that Colin’s ‘Stop!’ had represented a cry from all the group members that they needed space to hear each other, and be heard, which they then began to find.
**Video Extracts - Phase 3**

Now the group had found they could end an improvisation without words, they also often began playing without speaking. Sessions often started with a ‘tuning in’ time, as each member chose an instrument, and began to play. After a short time, it would become clear that we had ‘started’. This was a challenge for JG and myself, as we realised we too had become pre-occupied with definite beginnings and endings, and needed to learn to hear every sound as potentially part of the group’s music.

**Extract 7 - Ryan’s solo**  
*(S.15)*

This new level of listening awareness was shown by the appearance of ‘solo’ passages in improvisations, where one member’s music was the focus for the whole group for a time. In this extract, Ryan is playing a xylophone set to a blues scale. I begin to accompany his rhythmic improvisation in a 12 bar blues form, and Baraq (playing a drum) comments appreciatively to JG about Ryan’s playing. He then begins to support Ryan, playing the underlying pulse on his drum.

**Extract 8 - The group blues**  
*(S.15)*

Later in the same session, I moved to the piano, and continued to offer a 12 bar blues harmonic structure. All three group members, and JG, were able to join their music to this with each person’s voice remaining audible and individual, while united in the same music.

**Extract 9 - Quieter moments**  
*(S.20)*

This session, just before our Easter break, had marked the point of greatest musical cohesion in the group’s improvisations. This may have been because of the support we as therapists could offer from the piano, but it was also significant that we felt able to use the piano again now, without it being experienced as an intrusion on the group. Even when
playing other instruments, we were able to make musical interventions to extend the group’s awareness of their own musical potential. In this extract, by picking up on Colin’s quiet drum pulse from the metallophone, I am able to extend an improvisation beyond its imminent ‘ending’, and so enable the group to experience a shared period of quieter, less pulsed music.

Extract 10 - Group cohesion (S.22)

The last extract I am going to show comes from session 22 in May 2002. It shows the group’s music as it was near the end of our work together. Ryan and Baraq had both begun to explore their own musical ideas, often at the piano. Here, Ryan is exploring melodic phrases in parallel fourths and thirds. After a time, Baraq joins in at the bass of the piano, while Colin, sitting a little apart, adds his own line on a swanee whistle. I am just audible, playing the metallophone.

Evaluation

Because of absences and other school activities, we did not see the group in the last three weeks of term. This was an unsatisfactory end to our work, but one to which we are vulnerable since we depend on schools to bring clients to their sessions.

Nevertheless, we felt that all three group members had developed in their ways of relating over the course of therapy. Baraq, always musically confident and now much more fluent in English, had demonstrated a new appreciation of other’s music and the ability to share musical initiatives with them. Ryan had moved from remaining behind one instrument for most of the session to exploring a number of instruments, including
sharing the piano with Baraq, and was able to make some original musical contributions. Colin, initially quite distractible and prone to chat while others played, showed he could find a place for himself within the music, and was much less distracted. His simple and direct interventions (e.g. ‘Stop!’) had also been an important contribution to the whole group. The school were satisfied that Ryan and Baraq had benefited from the sessions and no longer needed to attend for music therapy. While they felt Colin needed continuing support, this was possibly because of his learning disability, which put him academically, though not necessarily socially, behind his peers.

**Reflecting on the work**

Reflecting on our own approach in facilitating the group, what was most distinctive was the abrupt change in our mode of intervention after the fourth session. We changed from a directive role in which we presented a structured series of activities (including improvisation), to a non-directive role where we allowed the session to unfold more or less freely, intervening as we felt was appropriate. Conversely, the group members had to adapt to the change from following directions (including directions to improvise) to finding their own ways of working musically. This second phase was a time of struggle for both the group members and ourselves as therapists. Despite our intention to minimise verbal interventions, we often found ourselves talking with the group, especially around the matter of beginnings and endings. Sometimes we would make a verbal statement at the beginning of the session summarising something
we had observed in the previous session. On another occasion we planned an ‘intervention session’ where we as therapists took back the initiative in a planned way for one session only, in order to demonstrate the possibilities of playing in smaller groups or pairs, as well as all together.

Musically we often found ourselves supporting one or other member of the group who was in some way ‘outside’ the prevailing music. In this way we were able to support members of the group during times when they could not be heard in the context of the whole group’s music. While the piano could have been a powerful instrument for holding together different musical strands, we use it very little at this stage. We were cautious about being too musically dominant (thus returning to a more directive role), and we had noticed that the group were all keen to explore the piano for themselves.

Our abrupt change in leadership style might be seen at one level as abandoning the group by suddenly withdrawing the support of a structured session. On the other hand, this was a deliberate and planned change in an otherwise secure group, and we remained present and active as therapists, both musically and in other ways (e.g. keeping boundaries of time and safety).

By the third phase of our work there was less feeling of struggle. Fewer words were spoken, either by us or by group members. We were able to use our own musical interventions as the primary therapeutic way to support the group. There were now longer periods where each person’s
music could be heard in the context of a whole group improvisation. We had found a way to work musically as a group.

A summary of the modes of intervention and interaction is given in Table 58.

### Table 58 Modes of Intervention and Interaction

<table>
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<tr>
<th>Phase 1 Sessions 1-4</th>
<th>Therapists plan in advance</th>
<th>Experiential musical exercises</th>
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<td>Musically Verbally Structurally</td>
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<td>Phase 3 Sessions c.16-24</td>
<td>Therapists less active verbally</td>
<td>Mainly musical intervention</td>
<td>Clients less verbal, more musically aware</td>
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### Conclusion

In reflecting on this work and presenting it in this way, it seems appropriate to try and place our work in the context of other ways of doing music therapy with groups. I consider principally the UK literature.

Among examples from Nordoff-Robbins trained practitioners, Aigen (1997) describes work with a group of autistic adolescents in which group-psychotherapy principles are combined with group improvisation, often using improvised songs as a way to bring group-dynamic issues into the sessions. Ansdell (1995) describes work with adults in which the therapist’s role at the piano is central in weaving together the music of each group member, and where verbal comments from clients are acknowledged without being followed up or interpreted.
Music therapists working from a more group-analytic approach have tended to write about work with adults (Davies and Richards 1998, Towse 1997). This work is often less directive and contains more verbal interventions.

Katrina Skewes’ qualitative comparison of approaches to group improvisation (Skewes 2002) touches on many of the issues raised in the current paper. However, she does not differentiate between levels of structuring in group improvisation, nor between different age groups.

The examples most similar to our own approach are those of Tyler (2002) in the use of semi-structured improvisation exercises, and from an APMT publication on music therapy in schools (APMT 1992) which is based on non-directive group improvisation.

Our own approach combined the structured improvisational approach typical of Nordoff-Robbins practitioners with the non-directive approach of more analytic practitioners, but focussing on musical rather than verbal interventions. It is an approach we hope to continue to develop in our work together with adolescents.

References


Journeys in Hot Air Balloons; Psychodynamic Group Music Therapy with adults in Psychiatry

Whyte, Carol
Music Therapy Department
Dykebar Hospital
Grahamston Road
Paisley
PA2 7DE

Introduction

In this presentation, I would like to outline what I discovered were the benefits of short term group music therapy with adults in a forensic unit in a psychiatric hospital.

I’ll give some details of how the sessions were set up, then focus on two improvisations which highlighted some of the issues which were relevant for the group. I will then discuss how the group was evaluated and consider implications for short term music therapy groupwork.

Setting up the sessions

The sessions were initiated by an occupational therapist who contacted me at the psychiatric hospital where I work.

She worked in a forensic unit in another psychiatric hospital and wanted to set up a music therapy pilot project there.

Her reason for initiating this was that she felt there was a gap in the service that occupational therapy had to offer there. They offered groupwork, for example art groups, photography and gardening groups
but did not offer groupwork which dealt more specifically with emotional issues in patients’ lives.

The money which was available to fund this pilot project determined how long it would be. It would be a ten session project and money was available to purchase some percussion instruments. After this conversation, I visited the forensic unit.

The occupational therapist was based in a sixteen bedded ward for male patients. This ward housed chronic, long-term patients.

All the men were in this forensic unit because at some point in their lives, they had committed a crime. Because of their mental state at the time, they were deemed unable to think through the consequences of their actions and had been placed in this secure, forensic unit.

I talked to the nursing and occupational therapy staff about the criteria for referral. People suitable for this group would be patients who might benefit from a non-verbal means of self-expression or who were difficult to motivate to participate in other groups on the ward.

Four patients with chronic mental health problems were suggested to me as people who might benefit from an alternative means of self-expression.

Those patients were given details about the nature of the group and were then free to choose whether they wanted to attend or not. The four patients seemed open to the idea of being involved in the group and agreed to attend. This was a closed group and members were to remain the same from week to week.
Brief details of the four patients in the group are on the overhead. This information came from the occupational therapist and medical notes.

**Paul** was 34 years old and had been in hospital for ten years. He had been in this forensic unit for a year and a half. Although he could experience dreadful delusions, he was stable at this point in time.

**Jamie** was 47 years old. He had a long history of psychotic illness. He was described as being very self-contained, uncommunicative with staff, had been violent towards females, had a ‘prison mentality’ and there was a significant risk of him absconding. He had been in this unit for one year.

**Andrew** was 42. He had been admitted to this unit ten years ago. When he was 10 years old, he suffered a head injury but he was not admitted to hospital until he was in his teens when his behaviour deteriorated. He was psychotic, had a heavy paresis which was right sided, was dyspraxic, his speech and language was impaired, he had a stammer and a delay in producing speech.

**Callum** was 27 years old. He had been in a secure unit in England and was transferred to this unit in Scotland five months previously. He had a history of schizophrenia since the age of 17. His psychosis was not well controlled on medication. He could be very florid and elated.

Although the details of patients are brief, in this presentation I do not intend to clinically discuss each patient in terms of past relationships and histories. This paper is focused on what happened in the actual music therapy group and while it is important that some information about each
patient is known, it does not feel necessary to include detailed case histories.

During my visit to the unit, I had felt downhearted when I saw the locked doors and alarm systems. Staff carried a multitude of keys and a panic alert device for safety.

The men slept in bedrooms for four and the dayroom was small and overcrowded.

Although the nursing and occupational therapy staff were supportive and interested in this project, I went in with two questions, the first one being - what could I do in only ten sessions with this group of patients? and the second question being how could anything creative possibly happen in such a stifled environment?

**Initial impressions**

I met the patients in the ward shortly before the first session was due to start. The sessions were to take place in a room away from the ward and were to last for forty five minutes.

A member of the occupational therapy team was to be the co-therapist for the music therapy group. Although he knew the men who were to participate, he was based in another ward in the unit and had not much previous contact with these patients.

The co-therapist was to assist in the running of the group and to count the instruments and beaters at the start and end of every session to ensure that
nothing which could be used as a potential weapon was taken from the room back into the ward.

The first two music therapy sessions were very structured. This was both to help the patients feel safe in the group and to help me feel safe with the patients. I felt I needed to be in control of this group and was anxious about letting grip of the tight reign with which I was holding them. I had not worked with patients in a forensic unit before and felt some anxiety about being out of my depth.

Initially, the group responded well to the structured activities during these first two sessions. However, when I introduced a short period of free improvisation towards the end of the sessions, it felt more chaotic. The music was extremely loud and Callum’s playing on the metallophone was particularly frantic. This improvised part of the sessions felt much more unsafe.

Before the third session, Jamie refused to come to the group. He was upset because an afternoon trip had been cancelled due to staff shortages. When I spoke to him, he said that all he wanted to do was to get away from this place for a couple of hours. Jamie’s refusal to come to the group seemed to be part of the protest he was making about not being allowed out.

His absence in the group was particularly felt by Paul with whom he spent the most time on the ward. Before I had started the third session, I had decided that although I wanted to allow the group the freedom to improvise, I felt the actual improvisation needed some structure. Rather
than dictate this structure, I asked if anyone could think of a title for an improvisation.

Paul suggested the evocative title of ‘A journey in a hot air balloon’. This suggestion seemed very much related to Jamie’s wish and possibly all of their wish to get out of the unit.

I would like to play an extract from this ‘Journey in a hot air balloon’ improvisation.

I am going to frame this extract with the following points and will discuss my thoughts on what I thought was happening in more detail at the end of the extract.

The extract begins 7 minutes into the improvisation. During that time, the group had been mainly using the ocean drum, bells, metallophone and tambourine which resulted in a floating, drifting sound. Callum yawned just before this extract begins, as if he, too, was drifting away from us.

At the beginning of this extract,

**Callum** - bells,
**Paul** - tambourine
**Andrew** - cimbala
**Jamie** - absent from group
**co-therapist** - metallophone,
**therapist** - cabasa

I’ll leave the overhead for you to follow through the framework of the improvisation.

This extract lasts for 5 minutes.

I would like to think about this improvisation in relation to its title, ‘A journey in a hot air balloon’. I felt that Paul’s introduction of the strong 6/
8 motif was a reaction to the floating but aimless quality of the group’s music, as if there was a fear of the balloon going too high or becoming out of control. The 6/8 rhythm had an earthy, grounded feel to it and felt like a defence against travelling too far away.

Callum made himself heard by talking as well as playing.

When Callum said to the co-therapist that *he*, the co-therapist, had the right idea, he may have been trying to identify with the co-therapist who he felt knew what he was doing in order to rid himself of the feeling that he had got the wrong idea.

When he stated ‘I’m doing okay’ to the co-therapist it felt more like a question, ‘Am I doing okay?’ Am I okay or am I going to get lost?’ And a feeling of, if I stay next to you, Scott I’ll hopefully be all right.

Again, when Callum played the tambourine, he created a very visual picture of an arc, the shape of a balloon, which seemed to suggest a need for a boundary, so that *he* felt safer and did not fly away, out of control.

When Callum asked at the end ‘Are we finished?’ it felt like he was saying, ‘Can we stop now please because there’s something I don’t like about this.’ He may have felt uneasy and by saying this, he effectively ended the group improvisation although it was actually Andrew who played the last notes on the cimbala.

It felt as if this group had ‘got together’ during this improvisation, but had got together because of their anxieties about the group, wondering how safe the group was and having a need for it not to go too far - thinking about Callum asking, ‘is that us finished?’
There was a need for something solid and Paul provided that with his rhythmic 6/8 motif.

The improvisation on the theme of the hot air balloon journey seemed to be about the music therapy journey which would be made over the ten sessions and the anxieties surrounding that. After the improvisation, we listened back to an excerpt of the audio tape. Paul commented that he liked listening to the audio tape because the group had made up the music together and it would probably sound different the next time we played and that the thing about the music was that it had happened in the ‘here and now’.

I was interested in Paul’s comment about the here and nowness of the music.


This focuses on the ‘living’ data which emerges from observation of a patient’s immediate behaviour in the here-and-now of the group. The patient does not need to tell the group about his detailed past history. Instead the ‘living’ data informs the therapist about the problems of the patient.

The music that the group had played and the comments that Callum had made during the improvisation provided living data that suggested there was a fear in the group of losing control. Given the backgrounds and mental health problems of these patients, the possibility of getting out of
control could have felt very frightening. And although there was a wish to escape from the unit, perhaps it felt safer to be inside.

Jamie, of course, had been absent because he was protesting about not getting out of the unit.

When I spoke to him the following week, he said he now couldn’t be bothered coming to the music therapy group and could I take someone else instead.

My immediate reaction was one of disappointment, because I thought I was losing a member of the group.

But later I wondered if Jamie was unconsciously getting rid of feelings he could not bear within himself into me.

Melanie Klein (1946) describes projective identification as a process which involves actively getting rid of something belonging to the self into someone else.

*Jamie* had felt disappointed and left when his trip had been cancelled the week before and now he was dropping out and was leaving *me* with feelings of disappointment.

Jamie was letting me know how he felt by dropping me.

At the time, I replied to him that whether he decided to come or not, I would not take anyone else because it was his space in the group. After I said this, he immediately said he would come.

Later I wondered if a phantasy for Jamie had been that the week before when he had not been taken out, the staff had taken someone else instead
of him as if he felt he was not worthy of the space. However, when I said ‘No-one else can come to the music therapy group, it’s your space’, he felt reaffirmed and was able to come.

I began the group that morning by asking each patient to play individually on an instrument to express something about the way they were feeling that day. After Jamie had played he said he felt happy about being here but hadn’t wanted to come because of what was going on in the ward. Then when I asked if anyone could think of a theme for the improvisation, Jamie suggested a ‘Battle’ theme. I felt that Jamie’s cancelled trip was being brought into the group that morning.

An outline of the battle improvisation can be seen on the overhead

The extract begins 6 minutes into the improvisation and during that time, Jamie had led the group into a strong, rhythmic pounding on the bodhran which is still happening when the audiotape begins

So you can follow the outline as I play the audio tape and this extract lasts for 7 minutes.

Immediately after the improvisation, Callum said he wanted to go to the toilet. This involved some fuss, with the co-therapist phoning the ward to get a nurse to take Callum to the toilet. Because I was female, I could not be left with the patients on my own.

While Callum was away, I played back some of the battle improvisation that had been audio taped. This sparked off some conversation. Jamie said that while he was playing, he had been thinking about waking up in the morning and not knowing how the day is going to be.
And how difficult it is going into the day room depending on who is there and how he feels.

I wondered aloud if it was difficult living so closely to other people. He agreed that it was, there wasn’t enough space.

I commented that it sounded like they were brothers in a family, jostling for space.

At this point, Callum returned and asked what he had missed while he had been away. Paul told him he had missed hearing the tape. Paul continued that the music had sounded like they were fighting one another with swords and that Callum’s metallophone playing sounded like a singing sword.

He addressed Jamie and said that he felt they were like a family on the ward, but like any family, they could be difficult to live with.

Callum commented that he thought the music sounded like the Battle of the Boyne which fitted in with the line from the sectarian song he had sung during the improvisation, ‘I heard the battle cry.’

I would like to think about the music that was played during this improvisation.

During the strong rhythmic pounding, it felt that there was a shared aggression in the group. Everyone was getting in on it, sticking with the drumming. But the group were also latching onto the strong drumming as if everyone was feeling vulnerable and needing to cling onto something.
I wondered if this activity was preventing thinking or rather was it allowing something to be expressed which could be thought about later during the talking at the end?

But in expressing this *aggression*, I wondered what feelings were being left out and what was happening to these left out feelings.

When Callum sang, ‘I heard the battle cry’, this seemed to sum up the left out *sad* feelings and *crying* feelings. At that point, was it a way of saying, ‘Yes, we’re angry but we’re also incredibly sad.’

The ‘dance’ section felt more upbeat and melodious, reassuring and comforting after the pounding. Some of the aggression had gone out of it. Maybe the group had to comfort itself after the anger and reference to sadness.

Andrew’s glockenspiel line at the end felt quite moving. It’s solo quality reminded me that although I was working with a group, the group was actually a collection of individual people with something to say. His playing was wobbly and vulnerable as if Andrew was expressing the baby part of himself.

Andrew could communicate musically in a way he could not communicate verbally because of his speech impairment and I was struck by the silence from the rest of the group as he played. They were able to listen to his music, maybe because of the battle music which had gone on earlier. This felt like a sign of hope. There was a sense of this being like a family where people *could* listen to one another.
Despite the earlier aggression which had been represented in the music and the fact that these men had committed crimes, Andrew expressed something for all of the men - the baby vulnerable part and the men identified with it.

The contrast between this ward with its locks and keys and alarms and this tiny voice felt striking.

Callum found it difficult to contain his anxiety and uncomfortableness. This was expressed by him singing a song, dropping a beater and clapping at the end.

Callum’s ‘I heard the battle cry’ was a line from a sectarian song - a song which represents splits between Catholics and Protestants.

Such songs stir up strong feelings and made me think of Callum trying to split up the group or at least cause some disruption.

I wondered if there was a link between Callum’s song and his going to the toilet at the end of the improvisation. Perhaps he went to the toilet because he had been stirred up, anxious to get rid of something.

He had made this controversial statement but then became anxious and needed a nurse called to take him away and keep him safe, as if he was worried about his own destructiveness and what he had done. When he returned, he wanted to know what he had missed as if he was checking if everything was okay or not, had he caused a rift, split the group up?

Also, perhaps he was asking, ‘Have I been missed?’

These two improvisations allowed the patients to play and talk about their wish to escape, their fear of losing control, their feelings of
aggression and the tensions arising from day to day living with one another.

At the time, the occupational therapist had contacted me because there was no expressive work being done in the ward.

I wondered if there had also been a fear in the staff that if you gave the men the opportunity to express how they felt, then something might get out of control.

Initially, I had been very anxious about the group getting out of control and the patients were too.

Certainly the co-therapist felt anxious about allowing the men to explore certain feelings. For example, when one of the men suggested that we improvise on the theme of ‘Love’, the co-therapist said to me later that he had been concerned that Andrew might talk about his sexual abuse of children. and that things would get out of hand.

However, although this group allowed some expression of their feelings at a certain level, this was not about total expression but an opportunity to think and feel.

I felt that Callum carried the anxiety for the group and became fearful, just as the staff can do and just as I did at the beginning of the group, that if these feelings are brought out and expressed, than they won’t be able to be managed.

My anxieties about the group becoming out of control changed over the ten weeks. By session 8, the men were able to freely improvise for up to half an hour without the need of a theme. This did not mean that the
anxieties had gone completely in the group, rather that they were more manageable and more contained.

**Evaluation of the group**

The co-therapist and I allowed forty five minutes at the end of each session to evaluate the group. We based our discussions around an assessment form which had been used in my own workplace by the previous music therapist.

I do not know the source of this assessment but I adapted it for use with this client group.

The assessment was split into five sections; emotional, communication, social, physical, and musical.

Each section was split into different categories.

For example, under the emotional section were emotional expression, affect/expression and attention span and after each session the co-therapist and I discussed each patient in terms of these categories and ticked the appropriate box.

We were therefore able to note if there was a change in, for example, emotional expression from session to session and over the whole ten week period.

This is Callum’s assessment form.

I’ll flick through the following overheads, but this was the same for communication, *(Overhead)* social, physical and musical.
The biggest changes for the patients were in emotional expression and conversation.

We were able to use these assessment forms to report back to nursing and occupational therapy staff about the progress of the group and about what had come up in the group so that they were aware of what had been happening, given that they were working with the men on a much more longer term basis.

This culminated in a final report which was sent to each patient’s consultant psychiatrist.

Patient Evaluation

A music therapy evaluation form was given to the patients by the occupational therapist a week after the sessions had ended. The four men stated that they had enjoyed the sessions and felt that they had benefited from them. Some of the comments given were as follows;

- “I found out ways of communicating my feelings”
- “I enjoyed being able to jam with other people”
- “I learned how to play my own music, to express myself”
- “I liked playing rhythms on instruments and drums”
- “I began to express my emotions through different tunes”

Three men out of the four stated that they would like to be involved in a music therapy group again and one was ‘not sure’.

Co-therapist

The co-therapist was available to participate in every session. Because the group was ‘closed’, it was important that he was able to attend every
session just like the other members of the group. This meant that we could move on as a group rather than have different staff members join us from week to week. It also helped to express the importance of the group for the therapists to the patients.

Before this group began, the co-therapist had little previous contact with these patients. This group offered him a way of getting to know the men in a non-directional setting which helped give the patients an opportunity to reflect on their emotional lives. After the ten sessions, the co-therapist felt that this group had been an ideal way to begin to get to know the men and think about ways he could work with them in the future.

**Conclusion**

To conclude then, before I started this group, my two questions were firstly, what could I do in only ten sessions with this group of patients and secondly, how could anything creative happen in such a stifled environment?

The answers were that these patients absolutely seized the opportunity to make the most of being part of this creative group, possibly because of the oppressive atmosphere on the ward and possibly because there were only ten sessions.

This group initially needed some structure to help both the patients and therapists feel safe but latterly was able to function in a freer form.

‘Talking’ on its own would probably have been difficult with these men, but a music therapy group, which offered a combination of being creative and reflective had been possible.
As a result of this group, the hospital employed me to run another group with a different group of patients and are building up a case for having music therapy in the ward on a more permanent basis.

The experience of running this group gave me fresh momentum in my own psychiatric workplace. I began to run short-term music therapy groups on the acute wards based on a similar model to the one above.

For the last two years, I have worked with a member of the nursing staff in the acute wards as co-therapist and we run the groups in blocks of ten. The ten-session framework firmly holds this open group as patients change from week to week in the acute wards and the music therapy group.

Therefore, the experience of running this group inspired me to take other groups of patients on short-term music therapy journeys because these men demonstrated just how far they could travel in a ten week space of time.

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Conversations about culture: an investigation into the importance of ethnic identity in music therapy

Wintour, Emma

The modern British society arguably contains the most dynamic element of cultural and ethnic diversity in the Western world. The mental health service sector, an integral part of the fabric of a fully functioning society, has had to trace this multicultural dynamic in order to successfully perform its function. It now falls upon the music therapy profession to do the same. This paper is based on MA research completed in 2001 which investigated the affect of culture on music therapy practice. The client's viewpoint provided the platform for the investigation. A qualitative research method was used to collect and analyse data. Seven clients took part in 'guided conversations' with the researcher in which the issue of culture in music therapy was discussed. The data indicates that an awareness and understanding of a client's cultural background is an essential step in establishing therapeutic conditions. Extracts from the transcriptions of the conversations are presented to illustrate points. The implications for music therapy are discussed and fields of further enquiry suggested.

Background

This research is based on my work at an acute mental health unit in Brixton, where I worked for five years with groups of between four and ten clients from a wide range of ethnic backgrounds and cultures.

Theoretical context

I work within a psychodynamic framework exploring meaning rooted in, and generating from, the relationship between music therapist and client. This relationship develops through the medium of co-improvised music which can be seen as an expression of intersubjective experience and reality. A study of clinical musical processes and their relation to the pre-verbal mother-infant relationship is central to psychodynamic music
therapy theory. I respond empathically to the emotional state of the client through the use of instruments, voice, gesture and words. And I see transference and countertransference as essential tools for understanding the internal world of the client.

In groupwork I study and respond to the group dynamic. I believe that each individual can alter the overall shape of the group by his or her varied forms of interaction, both verbal and non-verbal. Conversely, the group can affect the individual. Within this projection and introjection, the improvised music embodies the intersubjective exchanges of the group.

The therapeutic environment
In order to produce a safe therapeutic environment when working with clients with acute mental illness, I’ve found that I need to strike a balance between the traditional psychodynamic emphasis on neutrality and receptivity and more proactive qualities; firstly warmth (that is a willingness to share some of the client’s here and now experiences), secondly strength (which takes the form of resilience in a sometimes hostile environment and reliability within a chaotic ward), thirdly verbal reflection (in order to maintain safe boundaries within the group and to clarify confused issues), and fourthly receptivity (a willingness to learn from the client which may include asking appropriate questions about an unfamiliar aspect of a client’s experience).
Background to the research

Various incidents in my sessions led me to conclude that culture is an issue that requires further study in respect of music therapy. For example, a Pakistani client wanted to exclude my flute from the sessions as it made him anxious. When I looked into Hindustani culture I discovered that the flute is a symbol of divinity. Later on in our sessions, the client explained the feelings this evoked in him, confirming it as the source of his anxiety. A Tibetan client was a member of a group in which the members had been working together for ten sessions. His music was ‘perseverative’ despite changes in the music of other clients. Initially, I felt that a shift away from this repetition might be appropriate. However, he explained that the meditative aspects of his music were healthy for him and he appreciated being allowed to indulge them. I have regularly felt that the chaotic nature of a group does not reflect clients' mental disorder, but illustrates the culturally diverse use of melody, harmony and rhythm within a group and I have often questioned my ability as a Western musician to engage musically within this diversity.

Before undertaking this study I completed an audit of clients' views of music therapy which demonstrated, through the clients’ descriptions of the music they play in the sessions, the presence of a rich and varied ethnic music.

Review of the literature

The literature illustrates that the arts therapies profession worldwide has started to question whether its models of working incorporate the needs of clients from different cultures. I discovered some fascinating
descriptive and theoretical material on this complex and wide-ranging subject and a little bit of research. Pavlicevic (1997) debates the usefulness of universals in music and cultural specificity as concepts for music therapists. She explores the use of cross-cultural music in music therapy practice and music therapy in cross-cultural contexts. Moreno (1995) states his belief that “the role of music in therapy cannot possibly be understood without drawing from an exhaustive ethnographic study of the role of music in traditional healing practices throughout the world”. Ruud’s belief is that any study of meaning should focus on a particular situation within a particular context, culture as the genus for therapeutic communication and improvisation (1998). Case (1999) describes her work as an English art therapist working with children in Scotland and as a white therapist working with black and mixed race groups in London. She emphasises the necessity to be aware of the inner and outer world of therapy when issues of class, race and culture are present. Bright (1993) challenges the idea that music is a universal language on the basis of her studies in Australia. She found that a significant majority of participants described the mood of musical excerpts appropriately only when the idiom was familiar to them.

In researching the role of art therapy in regard to identity formation with adolescents suffering from psychiatric disorders Mauro (1998) found that the researcher needed to educate him or herself in the belief systems, behavioural patterns and values of a particular minority group and to be aware of how cultural differences can effect the therapeutic relationship. Lewis (1997) states that:
“..fundamental inquiries designed to discover the individual’s cultural values including ideas about therapy, art and its expression, are crucial. Additionally, stating one’s own limitations regarding an understanding of the individual’s ethnicity or experience, as well as acknowledging one’s own ethnocentrism can begin to bridge the gap toward surrendering stereotypes on both sides of the therapy relationship and toward a working alliance on behalf of the client..”

Multicultural counselling is an established concept in the USA. Much has been written about counselling specific populations (Sue and Sue 1990) and extensive research has been done on the subject. In Britain a body of literature has been published by the Nafsiyat Centre in relation to its work in developing a specialist psychotherapy service to meet the needs of clients in a multiracial society (Thomas 1995) and in providing details of the use of ‘Intercultural Therapy’ pioneered by a group of specialists in this area, which emphasises the whole person as a social as well as a psychological being (Kareem 1992). Research into the influence of race and culture on the counselling process was recently undertaken by Tucknell (1999). Race and culture were found to permeate the counselling sessions at different levels and at varying times in the interactions the notion of threat became apparent. The counsellors were often inhibited from applying cultural understanding and awareness to their practice. A transcultural workshop which was developed and facilitated for the counsellors emphasised the diversity of the issues and examined the influence of unconscious processes, particularly in relation to black and white interactions. Particular attention is given to the usefulness of psychodynamic concepts in understanding the dynamics of race and culture in counselling interactions.
Cultural aspects of mental health care is a hotly debated subject in Britain. Research has included anthropological fieldwork (Carstairs and Kapur 1976), the nature and outcome of psychotic illness in ethnic groups (Chen et al 1996), the validity of assessment procedures when working with ethnic groups (Abas et al 1998), and the over-representation of ethnic groups in psychiatric provision (Coid et al 2000). The literature discusses theory and practice and discusses the implications of culture for services and treatments (Fernando 1995) as part of a move towards a better understanding of the needs of ethnic minorities.

**Research Questions**

Having reviewed the literature I felt there was a need to research the issue of culture from the music therapy client’s perspective and the following questions needed to be addressed:

Is racial and cultural identity an issue in music therapy groups?

Is acknowledgement of a client's personal musical preferences and cultural influences important in establishing a therapeutic relationship?

Does a working knowledge of ethnomusicology enhance musical communication with clients from different ethnic backgrounds?

Are there certain aspects of the indigenous music of different cultures that may have important implications for clinical improvisation in music therapy?
Method

I decided that a qualitative research method was appropriate, both for collecting and analysing data, in order to take into account the interaction between myself and the participant(s) studied.

The seven clients I chose for the research were representative of my caseload. All have had a substantial amount of exposure to music therapy. Sam is 26 years old, is diagnosed as schizophrenic and is of mixed race. His mother is white British and his father is Afro-Caribbean. Patrick is 52, diagnosed as having bipolar affective disorder and is of Afro-Caribbean origin. He was born in Jamaica, but emigrated to England as a teenager. Eve is 48 years old and is diagnosed as having bipolar affective disorder. She is white Irish and has lived in London for several years. George is 22 and diagnosed as having bipolar affective disorder. He is second generation black African. Sonny is 44 and diagnosed as having bipolar affective disorder. He emigrated from Eritrea twenty years ago. Niles is 38 years old, is diagnosed as having non-organic psychosis and depression. He is white British. Richard is 50 years old, is diagnosed as having a schizoaffective disorder. He was born in Jamaica but he emigrated with his family to England when he was a child.

I decided to use a form of ‘guided conversation’. These conversations allowed themes to emerge naturally around the general subject matter of culture without pushing my preconceived notions of import on to the participants. They took place with clients who were experiencing psychosis or acute depression. The unstructured approach allowed
flexibility and minimised any anxieties or paranoia that a client may have about questioning. As I am also the participants' music therapist, I felt the relationship that I had already established with them was a positive and necessary element of the investigation. However, I maintained a degree of social and intellectual distance, keeping the focus on the participant to permit natural development in the data.

I started with an introduction stating the main themes of the research. The rest of the conversation was left open, but gently guided by me keeping the four research questions in mind, to avoid losing the focus of the interview. Since a major focus of a qualitative approach to research is the “meanings and the experiences of the people who function in the cultural web one studies” (Eisner 1981), the participants were encouraged to talk about their experience of music therapy with the issue of culture in mind. Participants were offered a follow up interview to clarify or expand on issues discussed. One participant, Richard, took advantage of this offer.

Procedures for consent were followed and measures taken to ensure confidentiality. It was made clear that the conversations would take place solely for the purposes of the research and were therefore separate from their routine treatment. A risk assessment in terms of psychological distress was made in liaison with the multidisciplinary team when selecting participants. Although the research was not based on actual music therapy sessions, it was anticipated that issues associated with the therapeutic process might arise for the participants and myself. I was responsible for receiving external monitoring through supervision and
advice on ethical matters throughout the research process. The research design itself was thought to be useful and enlightening, and not harmful to the client.

Social constructionism places the individual in the context of a social, cultural and physical environment. A person's knowledge of the world is thought to be constructed through interactions with other individuals within this context. "Accounts of the world.... are not viewed as the external expression of the speaker's internal processes (such as cognition, intention), but as an expression of relationships among persons” (Gergen and Gergen 1991). Social constructionists acknowledge the intersubjective elements of shared exchanges. My research project was grounded in this philosophy. Conversations took place in the context of the ward and the institution, within a culture of music therapy and the multiracial local environment and investigated the theory that a client's experience of music therapy is influenced by his or her social constructs. The research took the line that the nature or quality of a construction depends upon "the range or sophistication in dealing with that information" and drew from Lincoln and Guba's philosophy that there are multiple, often conflicting constructions, all of which are potentially meaningful. I took a primary research position. In undertaking research into communication I was at the same time participating in the very same process being researched. Within a constructionist's framework, this participation was unavoidable. In the same vein, knowledge gained through the practice of research constituted as much a part of the project as knowledge that represented it. I was directly participating in conversations that generated findings. Adopting a sensitive and open
approach in conversation allowed possibilities to emerge, therefore change in understanding was inevitable.

**Data Analysis**

The primary focus of this investigation was not to study variations in individuals, but to clarify issues, therefore cross-case analysis was used. Each of the four research questions were addressed in this way. The process of analyses was based on the ideas of various qualitative researchers including Patton (1990) and Miles and Hubermann (1994) and adapted to suit this research project.

I read and listened to the material intensely, assimilating as much of the explicit and implicit meaning as possible. I systematically worked through the data assigning categories and identifying meanings within the conversations. Statements were categorised according to their applicability to each research question. Within these categories themes were extracted about which initial interpretations could be made. I analysed the meanings and categories as they developed, systematically trying to find new ways of seeing or understanding the object of enquiry. I made sense of the data from a wider perspective, examining the implications of the findings and finding meaning within the larger context of music therapy practice in this setting. Judgements are made about the adequacy of interpretations.

**Results**

Each of the four research questions provides a useful framework within which the data can be summarised.
Is racial and cultural identity an issue in music therapy groups?

Identity

George clearly states that his objection and inability to relate to certain types of music, is influenced by his cultural and racial identity. He accepts, however, that everyone should respect the differing musical culture of others. While Richard concludes that an individual’s racial identity and culture is important, he stresses that it is equally important to establish a common ground in a group that enables people to relate to each other. Only Eve, despite her minority status as white Irish, categorically states that identity is not an issue in the groups. (It is interesting to note that Eve and myself share the same ethnic status. This may give her a feeling of safety because she can identify with the therapist). Sam states that his culture is an integral part of him and cannot be hidden or ignored:

“At the end of the day I’ve got my culture, I’m having my culture satisfied. Thumbs up to my culture and God bless my culture. At the end of the day I’ve gotta stick to my own, gotta get in where I fit in. I can’t be a comedian because masking don’t change colour. So at the end of the day I’m proud of my music and where I come, because where I come from is where I’m at."

- It is clear that identity is an important issue for clients and needs to be acknowledged.

Connections

- Cultural differences within a group and the resultant divergence of the significance of music in respect of those cultures can cause interpersonal difficulties.

George believes that the diversity of clients’ musical culture make it necessary to, as he puts it, “step on the handle a little bit” in order to
accommodate this diversity. He feels strongly that there is a lack of connection in the music because of the multicultural nature of the group. He certainly feels that other members of the group do not connect with him for this reason:

“You get somebody from Africa who don’t speak any good English, and he’s come in and he’s in hospital and he’s playing on the drums (taps beat). You get one person playing the tambourine from Columbia (taps beat), you get some guy from this country comes in and says ‘I want a bit of garage music – here we go now…’, you get someone from Italy who wants to (claps beat). That’s the cultural differences, and the cultural differences can get in the way of things.”

His statements suggest that the therapist should have an understanding of cultural differences and they argue against the concept of music as universal.

Niles suggests that connections occur in music therapy for different reasons. Music evokes personal responses that can be unpredictable, connections with others occur on both conscious and unconscious levels and that it is difficult at times to identify the cause of the connection.

Sonny suggests that although multiculturalism may be responsible for the lack of structure in the group’s music, he emphasises that this does not necessarily hinder communication between group members. He feels there is an acceptance within groups of individual forms of expression. This is an important observation in the multicultural context of the ward where racial tension can cause difficulties. He states that a client’s personal interpretation of the music he/she plays in sessions (an
interpretation which is inextricably linked to the client’s cultural background) is more important than the subjective interpretation of that music by others in the group. This insightful comment about the importance of self esteem and self knowledge is relevant in the context of culture and identity and the therapist’s understanding of how a client benefits from musical interaction will be increased by an understanding of the cultural background from which it springs.

**Instruments**

- The responses of the clients brought some important aspects of musical culture to my attention that could be addressed relatively easily. The instruments used in therapy being one such example. Richard describes the difficulties clients can sometimes have dealing with the choice of instruments in music therapy because of their musical background. He describes a lack of respect for some of the instruments and suggests that this attitude is influenced by cultural differences. He sees the choice of instruments in music therapy as important because people associate instruments with a particular culture. For example, he associates the violin with a ‘high brow’ culture and it makes him feel uncomfortable.

Patrick suggests that there may be some confusion amongst clients about their culture:

“Well, I think that they’re scared, they’re scared. You put on the reggae music they come and dance on a tape. By seeing the drum, because its mainly Jamaicans, the drums or percussion or the organ or the piano, the xylophone, they think it’s not their culture.”

Later he requests the inclusion of instruments that represent his Jamaican culture.
Clients may have conscious and unconscious associations with music that vary according to their specific culture. Any supposition that these culturally dependent associations will not impact on music therapy should be abandoned. I would suggest that use of a wide variety of ethnic instruments, by way of example, is necessary in order to encompass divergent cultures in a group. Interaction and understanding will be increased if it is made clear they are for everyone. The therapist should be sympathetic to the anxiety a client may feel if his culture is not represented by the choice of instruments on offer.

Age
Richard firmly believes that age is an important factor to consider when dealing with clients in music therapy. He feels that age determines what music they feel comfortable with in the sessions. Musical reminiscence is an important factor in peoples lives and will be different for everyone. He points out that ‘music scores our lives’. He reminds us that it is important for the therapist to look at the whole person when assessing a client:

“A younger person will be immersed in the record shop, they’d go to the concerts, they’d go to the gigs and plus, then, they would be armed with so much information that it is almost a culture in itself…”

Pop Culture
- Another prominent theme is the influence of pop culture.
Sam feels that music therapy cannot embrace pop culture. It is too specialised and complex to be incorporated into music therapy’s philosophy, but he feels that music therapy would benefit from an awareness of modern musical culture. A lot of my clients are influenced
by pop culture. It left an indelible imprint on their identity as they grew up. The results suggest it is fundamental to have some understanding of the influence and meaning of this culture and how it might effect the way clients interact in music therapy.

**Universality**

- Music is seen as a universal language that encourages interrelation between individuals.

George comments that music has no boundaries. He believes everyone can relate to music despite its diversity. The music of Sonny’s culture is very important to him, but he is certain that people can connect through music because it is a universal language. He emphasises its healing quality that each individual can benefit from. Niles shares this view of music’s universality. He quotes Stevie Wonder:

“Music is a world within itself with a language which we all understand.”

Richard suggests that music is so pervasive that a connection between people can always be made, Patrick believes the intangible “flow” of music, irrespective of its type, permits connection between individuals and Eve describes an emotional quality in music that transcends cultural differences.

It is encouraging to hear the clients voice a belief in the power of music to transcend the common boundaries of other forms of communication. Words are an imperfect medium. Nothing stands as a better illustration of the universality of music and its worth as a means of communication than the difficulty one faces when attempting to reduce this intangible
quality into words. The clients feel that where words fail them music can succeed.

Overall this data suggests, that although universal in essence, cultural differences may give rise to subtle nuances in musical and non musical dialogue which a therapist can miss all to easily if he/she is not aware of the impact that divergent cultures may have within a music therapy session.

• Is acknowledgement of a client’s personal musical preferences and cultural influences important in establishing a therapeutic relationship?

Predjudice/Musical preferences/Musical influences/Therapist’s qualities and roles

The clients request an acknowledgement of differences, an awareness of prejudice and the danger of stereotyping and a respect for musical preferences and influences. A non-judgemental and open-minded approach on the therapist’s part will help to achieve this:

“..they seem to be comfortable, more satisfied and settled, you know. To not see a man or a somebody breathing down their neck or telling them what to do. They feel quite free. If they want to sound like a bell they can play a bell, you know. Or if they really want to, say, blow a whistle they make a call, you know.”

Sam states that any negative impact that cultural differences may have on a session can be limited by a frank and open acknowledgement of cultural identity. This openness takes the form of my acknowledging that I am a eurocentric therapist, accepting my ignorance of the client’s culture and demonstrating a willingness to learn new things.

On prejudice George comments:
“I wouldn’t use culture, that causes a lot of problems. Culture’s causing problems all round the world at the moment. Religion, like a Greek Cypriot against a Greek Turk, Africans against African Jamaicans, Irish, the English, Scots, Welsh, obvious differences. You’re an English Rose. People from Scotland might not like you. You go to Glasgow and they say…(Scottish accent) “who do you think you are? You’re an English bitch aren’t you?” “You think you deserve everything. You get everything because you’re pompous.” and illustrates the diversity of the issues in respect of black and white interactions.

Musical ability/interpretations/stereotypes

Richard suggests that the therapist needs to be aware of the potential musical ability of clients. The benefits of musical interaction can be stifled if the client feels he/she is being patronised. As an illustration of how easy it is to make such a mistake, he tells the story of his ex-girlfriend who never played the piano in front of him, despite the fact that they had one at home. She was a classically trained pianist who had lost her confidence. “Won’t participate” and “can’t participate” are not synonymous.

Patrick reminds the therapist that music in different cultures has different meanings and that the therapist should keep an open mind and not make interpretations without a complete understanding of the client’s culture. He describes a music therapy session in which a Tahitian man played the drums with speed and fury and suggests that his culture may have influenced his style of playing.

The issue of stereotyping is complex. Some of my black clients feel that as a white therapist I cannot fully understand black culture. Although it
is conceded that I may never be a part of black culture, there is a dramatic
difference between not being a part of a particular culture and not being
aware of it. In the former case, there is still the possibility of insight and
an understanding of how cultural differences may impact upon the
therapeutic relationship, in the latter, there is none. Somewhat ironically,
a black client’s view that a white therapist will not be able to understand
their culture is to stereotype the therapist.

The statements refer to the process of getting to know a client slowly,
allowing their culture to emerge, and allowing them to show something
of themselves in a safe environment. They support the necessity for
cultural knowledge on the part of the therapist.

The clients stress that these are factors which impact upon the therapeutic
relationship.

• Does a working knowledge of ethnomusicology enhance musical
  communication with clients from different ethnic backgrounds?

Relating to culture

• The therapist needs to try and relate to different musical cultures:

  “You know you just have to question your own background and your
  own past... Try and put yourself in their sort of space and time..”

Versatility/Cultural understanding

• Versatility and cultural understanding will help the therapist achieve
  this.

  George thinks versatility on the therapist’s part is a quality that helps
deal with differences of culture and suggests that a practical knowledge
of the music of different cultures is helpful. Sonny is very proud of his
Eritrean culture. He offers me a viewing of a video which illustrates the
musical culture of his country. Sonny feels that if I understood his culture better I would understand him better.

Pinpointing the precise reasons why a client and a therapist are able to build up a relationship through musical dialogue is not an exact science. I sincerely believe, however, that a versatile and flexible approach in sessions will help establish a more productive cross-cultural musical relationship.

**Modern music culture/Classical music culture/Music and religion**

• The responses suggest that musical genres and their potential for providing connections for clients in music therapy should be considered.

Richard indicates that a knowledge of modern music culture will enable the therapist to find a musical theme that achieves common ground within a group on almost all occasions and he considers classical music to be a genre which has the potential to provide connections across cultures as it is so broadly used. Religious culture can be inextricably linked to a client’s musical culture. Richard believes that a knowledge of religious music coupled with an awareness of the divergent religious cultures in the group, could help the therapist provide a means to interrelation between individuals on a musical and a spiritual level.

• Are there certain aspects of the indigenous music of different cultures that may have important implications for clinical improvisation in music therapy?

**African Culture/Media culture/Rhythm/East and West**

• The clients stress the importance of various aspects of the indigenous music of different cultures, all of which may have implications for clinical improvisation.
African music/Media culture/Rhythm/East and West

- There are some aspects of music which have the potential to make cross-cultural connections.

Patrick believes that music has its roots in African culture and that most types of music are directly influenced by African music. This could be worth considering when thinking about how people connect musically from different cultures. Identifying a cross-cultural musical strain would be helpful in starting interaction. Richard suggests that media culture needs to be considered and could be used in music therapy as a way of sharing experiences and relating to one another in groups. Rhythm plays a big part in music therapy, it is a simple way of making sounds and relating to each other. Richard suggests that the predominance of rhythm in contemporary pop music is relevant to its use in music therapy as it is a musical element young clients will relate to. Niles points out that differences in musical idiom, such as Eastern and Western tonality, may cause difficulties connecting across cultures. These observations are insightful and helpful and from my experience make perfect sense when considering how clients create music together.

Dance and movement

- Other forms of creative expression may be essential elements of a musical culture.

Niles points out that dance is a big part of culture and questions whether or not it can be separated from music. This could have implications for the use of movement in music therapy sessions. I have found that dance can become a spontaneous form of expression in groups, acting as a
focus and release. Indeed some clients illustrate that movement is part of their music.

**Rap/Symbolism/Songs**

- The clients give examples of certain types of music which may have a beneficial role in music therapy.

Sam sees Rap as a useful means of expressing the thoughts and feelings of clients who see it as an integral part of their musical culture. George suggests that the use of symbolism and the expression of freedom in female black pop music has implications for the way some clients use music and what music means to them. This in turn may have implications for the way clients express themselves in music therapy:

> “Music in a way symbolises freedom, it symbolises expression of emotions because without music I don’t know how the whole world would cope.”

He suggests that songs have their place in music therapy for relaxation and enjoyment and points to folk songs as a spontaneous form of expression. The clients emphasise that singing is a powerful means of expression and provides a therapeutic physical release.

**Conclusions**

The contradictory viewpoints in the data evidence the multicultural context in which the research was carried out and help substantiate the view that culture is an issue that needs to be examined more closely within the sphere of music therapy.
Therapeutic Conditions

The research indicates that the music therapist should consider the following if the influence of culture is to be better understood within the context of a therapeutic relationship:

- self-knowledge about one’s own culture, the potential influences it may have on the music therapist’s responses in music therapy and acknowledgement that these influences may be present;
- as well as the possibility of stereotyping, the music therapist needs to be aware of the danger of making culturally inappropriate interpretations;
- it is worth considering the possibility that a client’s expectations of music therapy and the connections that occur therein may vary greatly depending on their cultural influences or attitude towards the culture of the music therapist;
- cultural understanding, including the selection of instruments for a particular session by way of example, will help music therapists to provide a more productive therapeutic environment in which to work;
- it is worth examining the function of the indigenous music of different cultures as a way of making musical connections in sessions.

I would question to what extent the music therapist can fully achieve therapeutic conditions without at least some knowledge and understanding of the cultural background of their clients. I know that I have felt confusion and frustration when a client has presented something of their culture that I do not fully understand. Acknowledgement of this ignorance, openness about the issues, and a willingness to ask questions about the client’s culture is an essential step in reducing this confusion and achieving a mutually healthy therapeutic relationship.
Psychodynamic music therapy and culture
A psychodynamic music therapy approach has the potential to incorporate awareness of culture into its working model as long as the therapist is willing to broaden his or her thinking. It is a non-directive approach, the therapist works with whatever the client brings to the session including culturally diverse communications. Verbal reflection can be used to check out potentially inappropriate interpretations before they are made. An emphasis on working with transference and countertransference will stimulate the psychodynamically orientated music therapist to explore the association of feelings with culture. A psychodynamic model which studies the activity of and interrelation between the various parts of an individual’s personality will incorporate culture as part of this study. As the psychodynamic music therapist works within an early infantile dimension, in which there are no words or culturally defined gestures (McDougall 1989), there is potential for a pre-cultural meeting of therapist and client.

Further enquiry
The results both support and contradict theories on the issue of culture within therapy presented in the literature. They answer some questions about multicultural music therapy and have produced many more for further debate. Despite a history of research in mental health and counselling, there is a lack of formal research on the subject of culture in the arts therapies. The results indicate that working holistically within an artistic medium could provide treatment for clients that is transcultural and profound.
This qualitative study achieved its aim of collecting information from clients to produce a platform for further investigation, it also gave me the opportunity to see beyond the external and obvious into the internal and hidden elements of culture. It has confirmed a huge arena for further enquiry which should include:

- statistical evidence of multicultural music therapy taking place;
- case study material to illustrate individual experiences;
- research with different client groups, in particular with non-verbal clients;
- development of theoretical models;
- the therapeutic use of music in world cultures.

The research process, from clinical anecdotes to formal research, has highlighted many themes which reflect the enormous range and complexity of culture as a phenomenon in music therapy.

**FURTHER READING**

**Arts Therapies**


### Counselling and Psychotherapy


### Mental Health


**Research Methodology**


The Use of Song Lyric Interpretation with Mid-Stage Dementia Residents in a Clinical Setting

Witt, Arlene Manso
MA, CMT

Theoretical Orientation

This study takes an approach to music therapy that is guided by both humanistic and creative-process oriented models. Humanistic in that the therapist unconditionally accepts the patient’s musical expression and ensuing discussions and thereby through an honest and empathetic approach, the resident, opens up and learns to trust the therapist. A creative process model is a process in which the client uses creative expressions such as music, poetry, art, drama, and movement to release themselves from rigid patterns in their environment to discover their own personal meanings.\(^\text{112}\)

The therapeutic activity described in this study is song lyric interpretation. By focusing their thoughts on familiar song lyrics, dementia residents are provided with a meaningful structure for reminiscence and discussing issues such as feelings of loss and confusion. It is suggested that a process and content analysis of the group be written throughout the study in order to understand how group process evolves during activity. The music therapist needs to understand the therapeutic process: “what is it that heals?”\(^\text{113}\)


Overview

There are three important parts of the title of this presentation. Song Lyric interpretation is the therapeutic technique, mid-stage dementia describes the target population and the clinical setting is the site where the therapy is administered. All three are important and will be discussed in detail separately but the most important aspect is the interaction among them. Why is song lyric interpretation effective therapy for dementia patients confined to a typical clinical setting?

Dementia is commonly understood as the loss of memory. That common definition, though useful, does not begin to suggest all the consequences of the condition. The impact on the personality from the loss of memory is difficult to fully comprehend unless observed on a daily basis at close range. Dementia literally means a lack of mental form. 114

This definition is a much better starting point for understanding dementia and what treatment is possibly useful.

Paraphrasing Aldridge, “Memory is the coherence of events in time. When memory fails, the sequence of events loses their coherence. This coherence of events in time is a rudimentary narrative. Our perception of self is dependent upon coherence in time.”115

One of the striking characteristics of many dementia patients is their ability to recall music even after all other memories have been lost. Often the words as well as the tune are still accessible. Because a song is a


simple narrative, each song remembered is an opportunity to briefly replace the lost coherence of events in time, an opportunity to restore a positive self-perception. Since songs remembered from youth are often accompanied by significant emotional reward, this positive self-perception can be reinforced by carefully choosing the song to fit the patient. 116

The typical clinical setting of a dementia unit is a messy social laboratory that magnifies the confusion of the patient. Turning this messy social laboratory into a therapeutic situation where song lyric interpretation can be utilized requires skill, planning and coordination.

**Dementia**

There are three stages of dementia. Early stage dementia is characterized by: mild cognitive impairment which indicates preserved long term memory, occasional immediate and recent memory loss, in matters of minor importance, mild disinhibition i.e., beginning difficulties with impulse control; occasional inappropriate remarks, and beginning difficulties with abstract thinking. Middle stage dementia is characterized by moderate cognitive impairment which indicates fairly intact long term memory, immediate and recent memory loss although a tendency to remember matters of significance; disinhibition, and difficulties in abstract thinking and problem solving abilities. The middle stage of the disease is characterized by further decrease in memory functions associated with an increase in major psychiatric disorders such as hallucinations and an increase in behavioral disorders such as verbal and

physical aggression. The middle stage of the disease is usually longer in duration. The last stage of the disease is described by a further decrease in overall functioning, aphasia, incontinence, inability to recognize family members, and loss of psychomotor skills.\textsuperscript{117}

\section*{Clinical Setting}

This study takes place in a dementia unit of a nursing home and hospital located in Manhattan. This facility provides both long term care and rehabilitation services to 530 patients residing in 16 units.

The unit (FK6) described in this study is a dementia floor with 31 residents. These residents who live together on FK6 are diagnosed with different stages of dementia. Sometimes an early stage dementia resident shares a room with a late stage dementia resident. The residents also have different levels of physical functioning and psychiatric diagnoses.

A dementia unit is staffed by a head nurse, a medication nurse, and four nursing assistants. Other members of the clinical team are a medical doctor, a psychiatrist, a dietitian, a social worker, and a music therapist.

The clinical team meets once a week to discuss the status of the residents. A resident is evaluated once every quarter by the team.

On a typical day, residents in a dementia unit may become agitated and confused during events such as dressing and undressing, bathing and toileting, disruptions in routine, medical appointments off the unit, visits from family members or changes in caregivers.\textsuperscript{118}

\textsuperscript{117} Vink, A. (2000). p. 136
Music therapy and therapeutic recreation activities on the FK6 dementia unit take place in the dining room after dining hours. In this improvised activity room, there is also a loudspeaker, and a call bell that can only be turned off from the nurses’ station. There is no secure door in the dining/activity room and thus privacy is not assured during activity hours. Confused residents wander in and out of the room. During a music therapy session it is normal to have at least 3 or more disruptions. i.e., a blood pressure reading is taken; a patient is taken out of the room for physical therapy; an electrician walks in unannounced to check light bulbs, etc. The call bell rings at least a dozen times, the loudspeaker comes on, and a confused patient wanders in asking for directions to Berlin. One of the residents described it well. Mr. P, after being escorted back to the dementia unit, said, “Well, I am back in the dog house again…”

Clinical Setting of the Inpatient Group: “There are few situations more inhospitable to the therapy group than the psychiatric inpatient setting.”(Yalom)¹¹⁹

It is important to describe the above clinical setting in which a music therapy session takes place. By understanding the setting, one can plan appropriate activities, devise behavioral interventions, and modify one’s group techniques. Some of the challenges of this particular dementia unit are:


1 The therapist often has no control over group composition in activity room.

2 The activity room where the group therapy sessions take place is primarily used as a dining room.

3 Residents see their therapist in different roles throughout the day, i.e. transporting them to off unit activities in auditorium, garden, library; taking them out on trips; providing entertainment at parties; setting up bulletin boards.

4 The group is composed mainly of middle stage dementia patients who have heterogeneity of psychopathology.

5 Privacy of the group therapy setting is not guaranteed.

Creating a therapeutic space

In an inpatient dementia unit, the physical setting and environmental requirements for a therapeutic activity should be a team effort among the music/recreation therapist, housekeeping personnel and nursing staff. Because of lack of space on the dementia unit, the dining room is also assigned as the activity room. There should be rules governing the use of the “activity room”. A sign posted outside the room during activity hours requests for privacy. This request should be respected by other staff.

The Role of Singing in Dementia

Songs consist of both verbal and musical components which stimulate the cognitive, physical and emotional aspects of an individual. As such, they enhance communication and creativity. In order to reach persons with dementia, their musical preferences must be taken into account. Favorite songs are received more favorably because they represent significant events in one’s lifetime which have become ingrained in their memory. 120
Music plays a significant role in facilitating the stories and recollections of persons with dementia. It is through the music that information can be presented and received within the music therapy sessions. Familiar music stimulates memory and improves reminiscence skills in those with poor cognitive function. Research shows that music has the strongest impact in persons with severe dementia when compared with other stimuli such as aromas and familiar photographs.  

The connections of the auditory nerve to key limbic structures in the brain account for emotional responses to familiar music. “The limbic area of the mid-brain has been indicated in long-term memory storage and emotional processing. Because memories persist when they have some personal importance for the individual, and the processing of familiar music seems to bypass higher cortical structures, it is possible to reach the ‘sense of self’ that may still be preserved in persons with dementia through the use of meaningful songs.”

**The benefits of singing**

Singing requires breathing deeply to produce phrases. As a result, it increases oxygenation and physical relaxation while it elevates mood. It serves as a path to comprehension, speech and integration of the body and mind. It has been said that what is lost in memory can be recovered through singing. It is an effective intervention for those who have


cognitive deficits because it requires minimal cognitive processing to enjoy it. 123

For those in the early stages of dementia, singing is a fully engaging activity. It provides an awareness of accomplishment when intellectual activity has become a way of frustration. Individuals with dementia may become readily engaged in singing because inhibitions against singing may become less important. The implementation of daily singing sessions and involvement in community singing are positively indicated in research. Daily singing contributes to decreased muscle tension, feelings of control and well-being. 124

Singing compensates for certain losses since dementia patients can no longer participate meaningfully in those activities that require complex cognitive functions. As a therapeutic activity, it also retains its value throughout the stages of dementia. In middle stages, singing provides a way for patients to take part in normalized activities, where they can function as well as any one else for a time. It also provides a way to belong to a group and to contribute to activities for patients and their caregivers.

For dementia patients, singing provides the longest durations of time where they are focused and engaged in a purposeful, meaningful activity. 125


Song Lyric Interpretation: Recovering a sense of identity through a narrative.

Song lyric interpretation is one of the music activities offered in the dementia unit. It supplements and enhances other activities such as Sing-a-long, Name that tune, Music and poetry trivia, and Reminiscence through music. Songs used for this activity are those that are already in the musical landscape of a patient’s memory and which can stimulate their responses. (A list of songs discussed in the group is appended.) As a group activity it enables persons with dementia to express their feelings in a non threatening way. It also promotes a sense of community within the group and a sense of trust between group and therapist. Discussion of song lyrics encourages creativity by clarifying what the song means for everyone in the group. By focusing their thoughts on familiar song lyrics, residents are provided with a meaningful structure for reminiscence.

Protocol for Song Lyric Interpretation

Purposes of the Activity 126

- To promote socialization via musical and verbal interaction
- To promote confidence to assert individual expression more freely
- To develop musical perception, recognition and memory
- To promote reading skills and concentration
- To promote listening and interpretive skills
- To discover the meaning of song lyrics
- To relate self to chosen song
- To recover a sense of personal history

**- Procedure for activity**

Therapist starts the group by singing with accompaniment a song request by a group member during previous session. Therapist then greets every person in the group. Sheets with song lyrics are distributed to group. One or two persons are asked to read aloud. Therapist invites group to sing the song together. Therapist then facilitates discussion of song lyrics. Every person is encouraged to participate and to ask questions. Song is sung again at the end of discussion. Therapist asks for song suggestions for next session.

**-Abilities required for activity**

- Affective
  - the ability to relate to others as well as to oneself
  - the ability to relate one’s feelings
- Cognitive
  - auditory perception and interpretation, imagination,
  - to ability to recall, insight and reason
- Sensory-motor – the ability to communicate

**-Physical setting**

A quiet room. Group (wheelchair patients and ambulatory patients) seated in semi-circle and therapist seated in the middle facing the group.

**Required equipment**

- A piano or a guitar.
- Song lyric sheets typed with large face.

**Guidelines for song selection**

- Is the song appropriate to the cognitive level of group?
• Is the song suitable for achieving specific predetermined objectives and goals of sessions?
• Is the song familiar to the group members?
• Does the music have appeal for the person/group?

To illustrate some concepts of song selection, consider the two songs ‘Yes we have no bananas’ and ‘I wonder what’s become of Sally.’ ‘Yes, we have no bananas’ is an example of a good sing-a-long choice but is not ideal for discussion because the lyrics do not suggest or lead to a short narrative. Neither do they suggest a range of emotions. On the other hand, ‘I wonder what’s become of Sally’ is simple and direct, yet tells a short narrative. A good song for lyric interpretation expresses feelings such as longing, tenderness, and jealousy, among others. A closer look at the songs discussed during lyric interpretation sessions (see appendix) shows the universal themes of love, sadness, courage, patriotism, family.

**Music therapy strategies and techniques applied to activity:**

• use of song that is familiar to or has meaning for the person or group.
• exact repetition of music for emotional security.
• lining-out singing (i.e., filling in isolated words, last word, or words of musical phrases, etc.).
• articulation of words of song to facilitate or stimulate speech: stressing and accenting words and syllables to stimulate natural inflections and cadences in speech. ¹²⁸

**Role of therapist**

• To reinforce positive validation
• To promote a sense of cohesion in group


• To reduce isolation through group building
• To promote a sense of community
• To work through issues of confusion, loss, anger
• To promote a culture of singing

The therapist’s style of communication greatly contributes to the amount of structure in the group. The therapist must speak clearly, slowly, and be encouraging. The first few minutes may also be spent identifying the purpose of the activity. A coherent, consistent group procedure must be provided without compromising creative discussion. Structure provides reassurance to the confused patient. Explicit preparation for the group (song lyrics prepared beforehand) reduces the patients’ confusion and makes it possible for them to participate in the group more fully. Knowledge of the group members’ medical and psychiatric diagnoses is necessary in order to understand group process. An in-depth knowledge of music of the era is necessary to facilitate this activity.

Practical considerations in seating arrangements should be considered to facilitate discussion and to avoid agitation in group. Rosslyn, diagnosed as delusional and with a prior history of bipolar disorder has a tendency towards grandiosity and verbal abuse when her immediate needs are not met in group. Consequently, Rosslyn is seated next to the therapist and at some distance from the other residents. Behavioral support and interventions, such as verbal re-directions are then more easily given by therapist to maintain cohesion and facilitate creative song lyric discussion in group.
Description of participants
A total of ten residents have participated in song lyric discussions since the activity started about a year and a half ago. Since then, one of the residents has died and another has been discharged. The activity is scheduled once a week. An ideal song lyric discussion group consists of six residents. There are currently eight residents participating in this study: Adolpho, Rosslyn, Rhoda, Olga, Mel, Ruth, Lillian, Ethel. Some of them do not participate every week because of medical issues and other ongoing therapies. Six of these residents are currently diagnosed with middle and moderate stages of dementia. The other two who were diagnosed with the same dementia stages are now in the moderate to severe stages of dementia. Lillian, although diagnosed with dementia (SDAT) in the moderate to severe range requires no behavioral interventions in group. She continues to follow simple verbal and musical cues and expresses her enjoyment in the activity.

Themes of Group Sessions
• 1, Isolation and Death
Ethel’s reaction to the song “The Sidewalks of New York”: “Does anybody live in Manhattan? Where do you live? My family is all gone now. Does anyone live in Manhattan? They’re all gone…dead.” After group session, she approaches therapist again and repeats the question.
• 2, A sense of personal history
Reflecting on the song “Over There”, Adolfo recalls in group that the US troops arrived in Europe only 1 year before World War I was over. He points out that ‘Over There’ is not historically accurate because ‘the Frogs and the Brits’ had already been fighting for ‘some years’ before the Americans arrived. Another resident, Rhoda points out that it sounds like a very optimistic song but what happened during the war in fact was very tragic.
3. A sense of pride in past achievements
US Marines’ Hymn ‘From the Halls of Montezuma’ is a favorite song. Adolfo and Mel were in the US Marines during World War II. Mel is teary eyed as he sings this song. He points out that he was stationed in Europe. Adolfo points out that he was stationed in the Pacific and that as an engineer he invented a type of radar which was used by the US Marines.

4. Homesickness
“Guantanamera”. Olga is originally from Cuba. She yearns for her home. It is difficult for her to adjust to her life in the nursing home. Olga cries and says in Spanish (translated) “Why am I here? I hate this place.” Olga was pushed by a confused resident which caused her to be hospitalized for a hip fracture. Adolfo comforts her by sharing his thoughts of life in Peru as a foreigner.

5. Relating to the other
After group sings ‘Five foot two, eyes of blue’, Rhoda tells therapist, ‘you seemed to like that song.’ I respond, “Yes, it has a catchy tune. It almost describes you, but you are ‘five foot four, eyes of blue, right?’ One group member, Mel, then adds, well then it’s “Five foot four, she’s got more…let’s think about that.”

6. A sense of acceptance
“Wus Geven Es Geven” Ruth summarizes for the group, “this is a Yiddish song which means what has gone, is gone, so you have to accept it. The past is gone. You only have memories left.”

7. Romance
The song “Fascination” has an emotionally charged reaction from Ethel. She reads the song lyrics and becomes misty eyed. “It’s very sad. I would rather not talk about it.” Rosslyn points out, “It’s about sex. That’s all there is to it.” Ruth adds, “It is about love and sex. Not just about sex.” Rhoda says, “It’s about a brief affair that turned into love.” After the session, as the therapist is leaving Ethel says, “That was nice, you know, that song about love…boys and girls talking about love.”

8. Nostalgia
“In the Good Old Summertime” After singing this song Lillian, a former teacher, points outside and says “look at the sunshine. What a marvelous day! The children are outside. I like to wave my arms in the air because it makes me feel like I am a part of the song.” Lillian is diagnosed with
severe dementia. She continues to be socially appropriate in group sessions. She has a positive presence in group. She sings along to the music, her lyrics are not accurate, but she usually sings the melody perfectly. She is legally blind but sees shadows.

- 9. Humor
  “It’s a Grand Old Flag” After the song, Adolfo says to Lillian, “well I don’t know what the date is today but I know that it is the day after yesterday. The song is about the 4th of July so it must be a week later now.” “Oh, you’re a genius!” Lillian replied with a laugh. In spite of her diagnosis of moderate to severe dementia, she continues to retain her sense of humor.

**Conclusion**

Research on the institutionalized elderly has shown that participation in structured activities, especially music, lessens agitation and other behavioral problems. The use of live music as a music therapy intervention has also been shown to be highly effective in decreasing agitation.129

This study recommends song lyric interpretation as a therapeutic activity for middle stage dementia residents. This activity combines the use of live music i.e., group singing with accompaniment followed by group discussion. The choice of song lyrics for discussion is an important consideration. Participants are asked to suggest songs during previous sessions. Each participant is encouraged to contribute to the discussion and to relate the significance of the song to his or her past or present circumstances. Some of the themes discussed are familial love, romantic love, isolation, loneliness, and courage. The disinhibition that characterizes middle stage dementia often allows for more spontaneous

involvement in singing and discussion. Some inappropriate remarks that result from this symptom are redirected by the therapist. Song lyric interpretation involves a procedure of singing, reading and interpretation. This process facilitates a continuum of awareness: “the creative process of using music as a tool of consciousness to awaken, heighten, and expand awareness of self, others and the environment.” 130

This particular dementia unit houses thirty-one residents of different dementia levels and other psychiatric diagnoses. Disruptions occur often during music therapy sessions resulting in agitated behavior. This study shows that some practical considerations, such as creating a therapeutic space, are critical to an inpatient dementia setting. Another practical recommendation is that more effective therapy sessions would be the likely result of more cognitively homogenous therapy groups. Unfortunately, sufficiently accurate measurements of cognitive ability are not available in this and many other clinical settings. Use of a cognitive rating scale (e.g. Reisberg’s BCRS) modified to reflect musical elements in the assessment would be a viable topic for further study.

A participant in one group reflected “What have I done to deserve being in this place?” Dementia residents would like to live a life of dignity. The themes explored in group sessions show us that as human beings, they too feel love, sadness, anger, isolation and pain. Despite their cognitive impairments, they are able to express these feelings by reflecting on songs that help give meaning to their lives. This process contributes to

the creation of a personal narrative in a dementia community that strives to live a life of dignity through singing and reflection.

**Index of Songs Discussed**

- After the Ball
- Ah Sweet Mystery of Life
- Alice Blue Gown
- All of Me
- America the Beautiful
- April Showers
- Are You LonesomeTonight
- Arrivederci Roma
- Autumn Leaves
- Battle Hymn of the Republic
- Bill Bailey
- Bye-Bye Blackbird
- Cielito Lindo
- Daisy Bell
- Danny Boy
- Dark Eyes
- Dream a little Dream of Me
Don’t Fence Me In
Edelweiss
Fascination
Five Foot Two
For Me and my Gal
The Glory of Love
Give my regards to Broadway
Greensleeves
Guantanamera
Hello Dolly
I’ll See You Again
I’m Forever Blowing Bubbles
I’m Looking Over a Four-Leaf Clover
I Wonder What’s Become of Sally
In the Good Old Summertime
It’s A Grand Old Flag
It’s a Sin to Tell a Lie
Let me call you Sweetheart
Love’s Old Sweet Song
The Man I Love
The Marines’ Hymn
My Blue Heaven
My Wild Irish Rose
Night and Day
On the Sunny Side of the Street
Over There
On the Sunny Side of the Street
Pennies from Heaven
Quizas
Side by Side
Sidewalks of New York
Smoke Gets in Your Eyes
South of the Border
Stouthearted Men
Tea For Two
Tennessee Waltz
Three Coins in the Fountain
Till We Meet Again
Too Young
When Johnny comes marching home
When the Red Robin Comes Bobbin’ Along

Winter Wonderland

Wus Geven Es Geven

You are My Sunshine

Younger than Springtime

You Made Me Love You
Introduction

What does it mean when children only want the therapist to imitate them? What is the significance of developments in patterns of interaction?

This paper explores levels of interaction in music therapy, and in particular, how a child’s capacity for interaction can move from patterns of rigid imitation to more flexible, cross modal interactions. This is linked with the emergence of a more developed sense of self. Stern’s writings are particularly helpful in drawing parallels between infants’ developing interactions and the ways that children interact in music therapy. This paper explores the roles of imitation and cross modal interactions in normal development, and the relevance of these to the infant’s developing sense of self and other. Clinical examples from music therapy sessions will be used to illustrate how this same process can also occur in music therapy, and how it can assist the child’s social and emotional development.

Mark was a six-year-old autistic boy, who was referred to music therapy because of his very limited interaction with either peers or adults. During one of our first sessions together, we sat on the floor, facing each other across a large gathering drum, and had the following interaction:

Mark patted the drum with his hand. I patted the drum in response. Mark tickled the drum with one finger. I tickled the drum too. Mark tickled the drum again. I responded by tickling the drum with several fingers. Mark
responded by taking my hand and moving my fingers into the same position as his, so that I should copy him exactly. Each time I tried to vary my response, Mark either moved my hand or he became disengaged altogether.

Our whole interaction seemed to become reduced down to Mark tickling the drum with one finger and then wanting me to do the very same thing. What had initially seemed like the start of an exchange between two people turned out to be something rather rigid. I felt that I was playing no part in the interaction: my mind was excluded; this was a game just for my finger.

This interaction with Mark was reminiscent of work I had done with another child, Joshua, who had engaged in similarly strictly imitative interactions when I had begun working with him two years earlier. Joshua had Fragile X Syndrome, and was four years old when he started music therapy. During the sessions, Joshua would bang the drum with a drumstick and would be desperate for me to do the same, sometimes urging me on to copy him, saying ‘do it, do it’. We could engage in long interactions if I imitated him exactly, including playing the same instrument as him, but if I responded more freely or on a different instrument, Joshua could not engage. It seemed as if without an exact imitation he was unable to interact at all, and our connection would seem to fall apart. The boundary between what Joshua felt was him and what was me seemed at times to be similarly fragile. For example, sometimes Joshua would appear to issue instructions, such as pointing to an instrument, but it was unclear whether he was telling me what to do or
asking me whether he could do something himself. This seemed to be linked to how he tended to get our names mixed up when we sang hello and goodbye to each other, how he often confused the pronouns ‘I’ and ‘you’. He sometimes pointed to himself and said ‘you’, or pointed to the therapist and said ‘me’.

Both boys interacted in a very limited way by insisting that I should imitate them. They used their music in order to negate differences between us or to make us both the same. This leads to the central questions: what does it mean if a child needs or wants you to imitate them? What can this use of sound tell us about that child’s stage of development or state of mind? Can the way that they interact in sounds and music serve as an indicator to their state of mind or developmental stage? What would it mean if a child started to develop away from strict imitation?

Over a period of several months, Joshua started to be able to engage in interactions where I did not copy him so strictly. When interacting with him, I would begin by imitating him closely, and then gradually introduce variations, for example by responding on a different instrument or using a slightly different rhythm. Having experienced the extreme control and sameness of purely imitative interactions, Joshua was gradually able to allow us to become more independent of each other. For example, if Joshua played a single strong beat on the drum, I might respond with 2 beats on the drum, or one beat on a xylophone.

When Joshua began to engage in these more flexible interactions it felt like a very important shift. It seemed to be the beginning of a creative,
enlivened way of relating in music. Again, this leads to the question ‘why?’ What does it matter if a child can do turn taking on a drum, and if this can become more flexible? A child begins to allow the therapist to introduce musical variations, but ‘so what?’ When writing reports about the children for their annual reviews, it is interesting to be able to point to a musical development, such as a move from strict imitation to freer interaction, but what does it mean? What does the musical shift indicate in terms of the child’s broader development?

It seems that in the case of a child, like Joshua, who moves from strict imitation to more flexible interaction, there are clear parallels with early infant development, and the development of a sense of self as described by Daniel Stern (1985). At different stages of ‘normal development’, an infant and his/her mother engage in distinctly different types of interaction, related to the child’s developing sense of self. This process can be reflected in the music therapy process. For the sake of clarity, I will refer to the infant as ‘he’ and will speak about his interactions with his mother.

Table 59  The Development of a Sense of Self

<table>
<thead>
<tr>
<th>Age</th>
<th>Sense of self</th>
<th>Experiences</th>
<th>Interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0-2 months</strong></td>
<td>Emergent self</td>
<td>Linking experiences e.g. sound, sight and touch</td>
<td>Imitative, Social importance of meeting of physical needs</td>
</tr>
</tbody>
</table>
| **2-9 months** | Core self     | 1) self agency  
2) self coherence  
3) self affectivity  
4) self history | Imitative, within the same modality eg voice, facial expression  
Repetitive: theme and variations |
From Stern (1985)

Table 59 summarises the developing sense of self from birth to 18 months, and relates the sense of self to the type of interactions that the child engages in with his mother. From early interactions where much of mother’s responses to her child are imitative, the child gradually develops into someone who knows that other people have minds, and who is capable of using language.

Each of these stages will be described in more detail, showing how they relate to the music therapy process and the child’s changing use of music and sounds.

**The emergent sense of self**

According to Stern, between birth and about 2 months, the normally developing infant has an emergent sense of self. He is beginning to link experiences together in order to start to make sense of the world around him. For example, he starts to link what he hears with what he feels or sees. The baby engages in social behaviour, and these are often related to his physical needs, such as eating and sleeping.
Core sense of self

By around 2 months, there has been a significant development, and the infant becomes much more socially interactive. He now seems to be more integrated and organised, and actively engaged with the world around him. He has achieved what Stern terms the sense of a ‘core self’ and ‘core other’ (the two are interdependent). For example, the baby is now aware that he has legs, and knows that he can kick them. He can use a smile to engage with other people. At its fundamental level, the baby knows he exists, and knows that other people do too.

Between 2 and 9 months the infant is an intensely social being. Interactions at this stage include much true imitation, and, in general, the adult will respond within the same modality that the child used. For example, if the infant makes a vocal sound, his mother is likely to respond by makes a similar sound back with her voice; mother will generally respond to a facial expression with a facial expression. Games (such as tickling games) tend to be repetitive, but with an element of variety: within a tickling game, each time the mother tickles the baby it will be slightly different to the way she did it a second ago. These variations maintain interest for both partners in the game, but also enable the baby to work out what parts of the interaction are always the same, which are part of the self (such as the feelings aroused) and which are part of mother. For example, during this tickling game, the infant might feel excited, and this remains so even when mother introduces little variations into the game. The infant comes to sense that the excitement is
his own, and the variations are to do with the other person. If mother played the game exactly the same each time, he might not be able to differentiate between what was created by him and what was created by mother. In other words, variation and flexibility are central to an infant developing his core sense of self and other.

What does this then mean for Joshua or Mark, who at first would not permit variations, or who could not tolerate them? What can this tell us about their stage of development or their state of mind? Mark was keen to engage in turn taking with me by tickling the drum, but only if I imitated him exactly, with no variations. In normal development, these variations would be an essential element in the infant’s developing sense of core self and other, but initially Mark would not allow these to happen in his interactions in music therapy. Despite being cognitively more advanced in some respects than a 7-month-old infant (he could count up to 10), socially and emotionally he was keeping our interactions frozen at a stage, which does not occur, in ordinary development. Mark seemed unable to allow there to be 2 separate people engaged in the interaction. His restrictive, unvarying imitation-based interaction prevented the establishment or experiencing of a core sense of self and other. Certainly, when interacting with him, I sometimes felt as if my own mind was hardly there, and that I became merely an extension of him.

The role of music therapy for Mark, and also Joshua, was to begin to expand their social experience through the safe non-verbal medium of music or simply sound. In order to develop socially and emotionally, they both needed to be able to experience interacting with another person.
imitatively but with variation and flexibility, in the way that an infant would do between the ages of 2 and 9 months. By going through this process in music therapy, a child can engage in a process that he has missed, or that has gone wrong at an early stage. Since each stage of the development of self and other (as shown in Figure 1) is the foundation for the next stage, a child will never develop theory of mind or engage in flexible interactions if this earlier way of interacting has been missed or frozen.

After 3 months of music therapy, Mark was beginning to allow some variations in our game. He seemed to be feeling safer with more ‘risky’ interactions, and is started to enjoy them. He began to use eye contact, and there was now a sense that each of us was engaging our mind. The following describes a typical interaction from that period:

Mark and I sat on the floor, facing each other across the gathering drum again. I waited for him to initiate something. After a short pause, Mark tickled the drum as he had done on many previous occasions. At first I copied him almost exactly, hoping to allow Mark to feel established in the interaction before introducing an element of separateness. After a few imitative exchanges I began to extend my ‘answers’, for example by adding a vocal sound when I copied his tickling. Gradually, Mark began to look at me more. Mark then became distracted by the Velcro on his shoe, which was making an interesting sound on the carpeted floor. I sand gently about how he was looking at his shoes. Mark then returned his attention to the drum, and to our interaction, and seemed more engaged than before. Now when he did something on the drum he looked at me expectantly each time, clearly expecting a response. I began to vary my responses more. For example, if Mark tickled the drum I might respond by tapping the drum at the same volume, or for the same duration. Mark was now able to cope with this, and laughed or smiled at my responses.

I think that it is important to re-emphasise that a child’s social and emotional development, and the development of their sense of self is not
necessarily directly related to their cognitive development. Children with learning and communication difficulties can show very patchy developmental profiles. For example, a child might be very socially aware, with a developed sense of self and other but have limited cognitive skills (this is very often the case with children with William’s syndrome). Anyone who has spoken with a verbal autistic adult will know that the reverse can also be true. Thus it is not unexpected that Joshua and Mark should have shown a very limited development of self despite cognitive ability in other areas, including, in Joshua’s case some language skills. Also, we need to consider whether a child is engaging in an early form of interaction because they are not developmentally or cognitively ready for something more sophisticated, or whether it is because they are emotionally not ready. A therapist’s countertransference response can be the key to telling the difference: a child who is resisting (consciously or unconsciously) will probably produce feelings of boredom, frustration, or as if you are only physically and not emotionally or mentally engaged in the interaction. This was initially the case with both Mark and Joshua.

**Sense of subjective self**

In normal development, at around 9 months, something extraordinary happens: the infant begins to discover that other people have minds that are different to their own. This is shown in the new way that they interact with their mothers. During the previous months, true imitations have been a major part of all interactions. At around 9 months, this changes. Instead of imitating her infant, the mother ‘attunes’, or responds cross
modally. For example, the baby might vocalise excitedly, and mother might respond with a wriggle rather than an imitation of his vocalisation. The affect behind the baby’s action is matched, or attuned to, not the action itself. In this way, mother and baby begin to share a thought or feeling behind an action: their internal states match, not their overt behaviour. Interactions that rely on true imitation (such as those that Joshua and Mark initially insisted on) cannot convey the matching of internal states. If baby waves its hand and mother imitates the movement, it simply shows that mother has seen what baby has done. It does not necessarily show that she has sensed the baby’s state of mind, or that she has a mind herself. Stern (1985) writes ‘True imitation does not permit the partners to refer to the internal state…Attunements…recast the event and shift the focus of attention to what is behind the behaviour, to the quality of feeling that is being shared.’

In normal development, the mother shifts her way of interacting quite naturally and unconsciously, sensing that her baby is developing. She probably feels that her baby is now more of a ‘person’ but may not be consciously aware of how this is shown through their emotional attunements. In music therapy, however, the development from imitation to attunement is a conscious process on the part of the therapist. The therapist can encourage the development by gently pushing at the boundaries of what the child can do or can tolerate. Parents, and therapists, respond to ‘the person their child is about to become.’ In other words, working in the ‘zone of proximal development’, or as it is sometimes called in the education system: ‘emergent skills’. Parents attribute thoughts and feelings to their infant’s actions before the child
can do so themselves. Later in development, mother might encourage her child’s development by getting him to try something new: ‘You can open that yourself!’ and the child discovers that he has new skills.

Joshua’s development in music therapy paralleled this progression, and began, tentatively, to allow me to have a mind of my own that was different to his. After 18 months of individual music therapy, Joshua was on the brink between wanting me to imitate him and letting me have a mind of my own and respond to him cross-modally. By encouraging him to experience musical flexibility and independence through gently developing the interactions that we shared, Joshua was able begin to experience himself differently. The following is typical of our interactions at this stage (after 18 months of therapy):

The interaction started with me sitting at the piano and Joshua moving between the instruments. He hit the cymbal with a drumstick and I responded with a beat on a drum. Joshua said ‘What are you doing?’ and commented ‘different’. We talked in very simple terms about how he did one thing and I did another. Joshua then came and sat down by the drum, and played single beats, expecting me to copy. Initially I copied him almost exactly, feeling that he was still a little bit ‘scattered’. We gradually settled into a pattern of slow alternate beats on the drum, which then became joint, simultaneous beating. When this felt settled, I introduced a simple rhythmic bass line of the piano to support our drumming, and then I gradually eased myself away from the drum and just played the piano. Joshua was able to continue his drumming without me playing alongside him, and he even started marching his feet in time with his playing.

Relating Joshua’s behaviour to Stern’s theory of the development of a sense of self and other, what can we say about Joshua as he begins to allow me to attune to him rather than imitate? When Joshua began to allow me to imitate him but on a different instrument, he was beginning
to allow the variations in games which are essential for the development of a core sense of self and other. When he began to allow me to respond more flexibly still (after 18 months), and we started to move further away from true imitations, he was beginning to allow me to have an independent mind, and he was developing a sense of ‘subjective self’. He was discovering that one person can reframe what another person has done, and that the mental states behind actions can match even when the overt behaviour is different: for example a beat on the drum can have the same feeling behind it as a crash on the piano though they are superficially different. Not only was he discovering this, but also he was experiencing this change in a positive and non-threatening way through musical interaction.

At this stage in music therapy, Joshua became very interested in the concept of ‘same and different’ and we would sometimes put this into words, perhaps by talking about what we had just been doing. This generalised outside the sessions. For example, Joshua’s sessions took place in a Porto cabin that had both steps and a ramp up to the entrance. For a long time, Joshua would tell me which way to go, and we would go down the steps or the ramp together. When Joshua began to engage in cross-modal interactions, and to think about ‘same and different’ he would often let me go down the steps, while he went down the ramp. He would tell me ‘different ways’ as we were doing this, with great excitement. Joshua’s teacher observed a parallel development in his behaviour in class, and was able to use it in learning situations. For example, Joshua could be encouraged to try new ways of doing activities if she explained to him that it was different to how he had done it before.
He also became less controlling of staff and other children in class, and was able to allow them to do things differently.

A normally developing child experiences its mother attuning to him, or reframing what he does by matching the affect rather than the overt behaviour. In this way he begins to develop a sense that he and his mother have minds, and that these minds might be different to each other. This is the very beginning of the development of a theory of mind. In his insistence on sameness, Joshua was resisting this development: perhaps he felt that separateness was too threatening, or perhaps he felt that if the person he was interacting with was not the same as him then his fragile sense of self would fall apart. Joshua was able to retrace this development in music therapy. He began to experience himself as a whole person, and thus was able to treat the therapist as a whole person with a mind too. This development was shown by the move away from exact imitations, through varied imitations into attunement. In music therapy, this marks the exciting moment at which there is a feeling that you are on the verge of making music together rather than just making sounds. Just as verbal language emerges in normal development, a musical language begins to develop. The musical shift is an indicator to an internal development: there begins to be a self behind the sounds.

**Sense of verbal self**

Stern’s next stage of development begins at around 18 months: this is the development of a verbal self. Having experienced attunements where 2 different actions can share a meaning, the child has begun to develop the capacity to symbolise: one thing can stand for another, and two things
can be held in mind simultaneously. At this stage in a child’s development, he begins to use his first words. At the same time, he is developing a capacity to think in very simple terms about the past and the future. The child may begin to understand the concept of ‘later’ or may show that they can remember something that happened the previous day. He may also begin to use the pronouns ‘I/me or mine’.

How does this relate to Joshua’s development? When he started coming to music therapy, he used pronouns in a very confused way and wanted me to copy him exactly and have no independent thoughts. After 2½ years, we reached a stage where we were beginning to play music with each other, having worked through the concept of same and different. At the same time, Joshua began to use pronouns much more reliably, pointing to each of us in the goodbye song and using ‘you’ and ‘me’ correctly. He also became very interested in the timeline on the wall, depicting past and future sessions with coloured circles, and he liked to look at this in every session, counting the sessions that were past and those that were still to come. Joshua showed that he was developing an understanding of his past and future. He had achieved the next developmental shift, to the sense of ‘verbal self’.

What was his playing like at this stage? We were starting to play music together rather than just exchanging sounds. After 2½ years, Joshua could play the instruments while I responded on the piano. He no longer needed me to imitate each beat that he played; instead he was beginning to play rhythmical phrases, and these were starting to feel expressive. Sometimes he would play thoughtfully, and sometimes he would play loudly and
firmly in a way which felt cross. Joshua’s music was beginning to be expressive, because now he had a more developed sense of self which he could express through music.

This development is not a purely linear process: it is not simply a question of a child reaching a developmental milestone and then moving on to the next one. The child’s emotional state, or state of mind, affects the level at which they can function. Thus, although Mark developed the capacity to interact with varied imitations, and Joshua was able to interact with cross-modal interactions or even musical ‘conversations’, neither child would do this absolutely consistently from week to week, or even throughout a session. When anxious, tired or uncertain, they would both revert to earlier ways of interacting, and it was my role to support this, until such time as they were ready to interact more fully again. This is, of course, the same in normal development: for example the child who will revert to wearing nappies or using a dummy when baby brother or sister is born.

**Summary**

A child’s way of interacting in music therapy can tell us an enormous amount about their sense of self as described by Stern. There are ‘musical indicators’ that mark the development of a more sophisticated sense of self from an earlier one. When a child needs, or insists on, exact imitations where you feel as if you cannot use your own mind, we might wonder whether their sense of self is not yet established enough to be able to connect with more interactional sophistication, or that they are actively resisting this experience. Then, when a child begins to allow you
to respond cross-modally, he is beginning to experience himself and another person each having a mind, and to feel safe with this. By meeting a child at their level the therapist can establish a relationship of trust. They can then gently extending the interactions, and thereby extend the child’s experience of himself. By engaging in interactions that shadow a natural development (be that cognitively or emotionally) music therapy can help a child to experience a developmental and emotional process that he has missed or resisted. Imitation is often the first building block in this process.

References


Author

**Ann Woodward** is Senior Music Therapist for Hertfordshire Music Service and the Charity Resources for Autism. She currently with children in mainstream and special schools, and is establishing an arts therapies service for children with autism and their families in North London. Ann’s MA dissertation focused on music therapy with autistic children. She is an APMT registered Supervisor, and is currently Deputy Chair of the APMT.
This paper is based on an ongoing research project. It is divided in three parts. The first part deals with questions on emotion in the context of music therapy and music therapy research. In that part I shall also include some results of my latest research. - In the second part some hypotheses on emotion in music therapy and music therapy research are given. - Finally the third explains the research network, which is beginning to investigate these hypotheses.

Part one: This part could be named “answers to questions of Annemiek Vink and her article on music and emotion in the Nordic Journal of Music Therapy half a year ago”. Vink gave a very broad overview on the recent problems and the recent state of research in that very basic field of music therapy research in the article. – By the way: you could also say that music and emotion is one field of basic research in music therapy. Most of music therapy research is applied research and we have only less really basic research in the field of music therapy. - Vink e.g. consults music psychology very often in her article for basic knowledge regarding the field of music and emotion. But at the same time she concluded, that the musical material is more relevant for music psychology than for music therapy. I concluded that we needed to perform basic research ourselves in music therapy research, including the knowledge of related disciplines like music psychology and emotion psychology but in
adaptation and with necessary changes concerning our subjects in music therapy. – But let me now start indeed at the very beginning.

In summary of Vinks article here are formulated four questions which are very important for basic research on music and emotion in music therapy.

**Figure 101 Question on emotion (Vink 2001)**

These four questions are also the “red line” of my first part. - In the very beginning most of all the first question is interesting: What definitions of emotion exist and are they even relevant for music therapy? According to emotion psychology emotion is very strongly determined by cognition, acting and behavior-changes. One of the most important emotion-psychologists, Caroll Izard, gives the following definition: “Emotion is the basic motivation system of a human being which primarily causes its
acting, behavior and thinking.” (Izard, 1994, 19) As in classical psychoanalysis, emotion has a function in the context of other psychological functions such as thinking, behavior etc. It has no value of its own. But especially in the relationship of music psychology and emotion psychology Vink refers to Sloboda (Sloboda, 2001) and underlines that there is a shift in the definition of emotion in music psychology. The use of the term “emotion” shifts to the terms “musical experiences” and “experience of emotions” (Vink, 2001, 145-146). The “experience”, which can be determined very individually, seems to become much more important, than the term “emotion”. There is to add here that we need not go far away from emotion psychology to make that shift. In the ninties in German emotion psychology, Dieter Ulich did these shifts as an emotion psychologist. But it is very interesting that emotion psychology as a whole, was not so interested in that shift until today. For music psychology and music therapy that can be much more important. Ulich defines the kernel of emotion as the experience itself (Ulich, 1992, 56). That means that emotion is most of all the “being touched”-state of a person. That “being touched”-state has no more function than to be experienced by human being. The special kinds of “being-touched” are very different. These differences vary widely from person to person. So finally the function of emotion as a basic cause of psychological functions is lost. Emotion has its own separate value in the psyche-system. The individuality of emotion is much higher than the former functionality of emotion of a means to an end. However, does emotion cause something as a “being-touched”-state in the end if they do not cause acting, behavior and thinking directly? – My first research on
music and emotion could provide one answer. One result of music- and verbal-analysis was that different emotions could be connected with different stages of the individual‘s object-relationship (Wosch, 2002, 253). This object-relationship is not the same as that describes Kernberg (Kernberg, 1988, 340-346) within the context of affect, drives and primary motivation. The object-relationship here is less complex then Kernberg’s definition. Here these are different stages of “being touched” by a person, a thought, by an object etc. So it is the individual, who is “being touched” and who has internal or external individual relationships within the musical experience of emotions. Nevertheless, the first level, the kernel of emotional experience is the “being touched”. – It is like play, without purpose. – Afterwards, emotion could be but isn’t necessarily motivation etc. However, every emotion as a “being touched”-state seems to be caused at the second level by different stages of object-relationship. So in the end I give the following definition of emotion in the context of recent emotion psychology and musical experience.
This definition may give the first answer to the first question on emotion from Figure 101. So next question is, which music is to investigate “emotional” for music therapy? – In her article Vink concludes that in most music psychology research classical music is studied and these studies are generally focused on healthy adults (Vink, 2001, 148 & 154). In music therapy practice we have quite another situation. People of all ages with special needs and disorders are the clients and in most cases active music therapy with very elementary music structures is used. Therefore, there are problems in transferring the knowledge of music psychology directly into the field of music therapy. On the other hand, receptive music therapy, there are some very interesting findings. The American receptive music therapy method Guided Imagery and Music
works on the basis of associational processes. In the studies of music psychology, which Vink consulted, music listening seems especially linked to earlier associations, which are different for every individual. (Vink, 2001, 152) Helen Bonny, who developed GIM, stated (1986 in Vink, 2001, 154), that the personal music preference was not necessary for successful GIM-processes. Despite that, Gerdner (2000) demonstrated that person’s music preference into account reduced agitation in demented elderly more effectively. We have here two different groups of clients in music therapy and two different results in the applications of music experiences concerning the emotional dimension of music preferences for the therapeutic process. However we can see different approaches in the same client group. GIM works on the basis of associational processes and the music experience. The German receptive method Regulative Music Therapy (Schwabe & Röhrborn, 1996) works on the basis of self-perception and music experience. Associational processes are less important in that method. Much more important are descriptions of the experiences of the clients while listening to music (classical symphonic). In different stages, the client perceives more and more of himself and of the music step by step. Within that process the client also perceives “emotion-reactions” to all perceptions, even emotion to emotion in one stage. Later, the client can regulate problematic self-perceptions, and especially in this stage of the therapeutic process an emotional shift takes place. One result of Sloboda’s music psychology research was that music is generally used as a “change agent” to alter mood state (Sloboda 1992, in Vink, 2001, 151). So it may be that GIM and Regulative Music Therapy use these potencies
of music experience in a context of disorders with different therapeutic processes – one of them with the associational process as musical experience- and emotional process, and the other with the self-perception-process as also musical experience- and emotional process. In both methods music preference is not so necessary for a positive therapeutic process. The high hedonic value of music preference, which Berlyne investigated in healthy adults (Berlyne 1971, in Vink, 2002, 146), does not seem to be useful for the clients of GIM and Regulative Music Therapy and their emotional process. Contrary to this client group, music preferences are very important for demented elderly. Also, the shift of a possible object-relationship (see Figure 102) seems to be a much longer process in GIM and Regulative Music Therapy than in the use of music in a much shorter process of a few minutes to reduce agitation in demented elderly.

There are additional studies of music psychology concerning emotional shifts or the “change agent” music, as Sloboda named it (Sloboda, 1992, in Vink, 2002, 151). In these studies one point is very important. Music psychology aproaches try to focus on the musical elements itself. That means, that in-music-elements are studied. One example is Meyer, also mentioned by Vink (Meyer, 1956, in Vink, 2002, 152). In his study listeners experienced thrill when a new or unprepared harmony occured. That means that unexpected moments occured in the process of music and the mood state altered to thrill. Tempo changes, climax of musical theme and harmony-changes are in-music-elements which are studied by music psychologists regarding an emotional shift. But the music, which is studied, in most cases is classical music. There seems to be some
differences between the “emotional” in-music-elements of classical music and of elementary music created in active music therapy. Even more dimensions of music seems to be relevant for the “emotional” in-music-elements.

**Figure 103: ”emotional” in-music –elements -**

In Figure 103 you can see in the white frame below the in-music-elements of the music psychology studies mentioned. Music there is seen as an only one-dimensional time-Gestalt. The change in tempo of the music occurs as a whole and in this way an emotional shift is experienced. But there are also interactions within the music. In music sociology these moments are called “intratextural interaction” (Mäkelä, 1995, 196). It can be studied in symphonic pieces between different instruments or in a piano piece between the right and the left hand etc. It can also be studied in active music therapy improvisation, e.g. between the instrument of the client and that of the therapist. For such a case I investigated a number of improvisations with 40 raters, who evaluated the emotion-process of the improvisations by listening to them. I studied
the “intratextural interaction” with a measurement instrument of music therapy. I used the IAP (Improvisation Assessment Profil) of Kenneth Bruscia (1987) and its modification in the Autonomy-File by Tony Wigram (1999). I made a further modification. I did not assess the improvisation as a whole, as like in the white frame. I assessed the client’s and the therapist’s instrumental play second by second with the IAP. You can see this in figure 3 shown by the different arrows in the yellow frames. Different emotion-parts within every improvisation created by Cluster-analyses were one result of the emotion-rating. These different emotion-parts of one improvisation corresponded to different intratextural-interaction-patterns within music. In that case-study emotion interest was connected with more music follower-patterns, fear with more resister-patterns, anger with music leader-patterns of both players, sadness with leader- and follower-patterns and joy with leader- and partner-patterns. Last but not least partner-patterns also characterized interest. These patterns occur most of all in the specific emotional parts of the improvisations. The different lengths of the arrows show different intratextural-interaction-patterns as different in-music-elements. It was only possible to show this if in the IAP-item melody the sub-elements tonality and harmony were neglected. The music therapy improvisations which were studied were sometimes atonal and sometimes tonal. This was an important additional information. But a lot of German active music therapy is atonally based; that is tonality, as used in Nordoff-Robbins-music therapy does not appear. In atonal improvisation in therapy the music psychology findings regarding tonality and harmony do not seem to be important for emotional shifts. In the second case of
tonal improvisation, e.g. Nordoff-Robbins-music therapy this would be interesting to research whether or not tonality is important for emotional shifts. However the intratextural-music-interaction-patterns could be an object-relationship within (!) music structures. Another question is whether there is a difference between cognitive music specialist’s listening of music and the more affective listening of “untrained listeners”, mentioned by Vink (2001, 153). If harmony is a more cognitive element of music then we need to leave it, if we are to match our position to the emotional experiences of “untrained” clients (in music therapy research). – Further it also would be interesting to research, whether changes in different interpretations of a musical piece could explain different emotional experiences from the point of view of the music, if the intratextural interaction of music differs. This could be very interesting even for the choice of music in receptive music therapy methods like GIM and Regulative Music Therapy. These are a lot of questions, which cannot be answered by a single study. We need research networks in order to deal with that. Another point, to consider is, that the single-emotion-excerpts within one improvisation were very short. They were only between 1 and 2 minutes in length they.

With this short duration of emotion as affect in music-and-emotion-research I’ll come to the last question from figure 1: In which process do emotions develop “in music”? For the last time I’ll refer here to Vink. She concludes that generally, emotion term lists of emotion psychologists “are very difficult to interpret in the context of music” (Vink, 2001, 150). But if emotions are of short durations in music, which one a result of my research mentioned, and these short durations are
charakterized in emotion psychology as affects, then music therapy has to consult affect-systems. Beyond that, music therapy research also needs to distinguish which emotion is an affect and which is more a cognition or behavior etc. In older and newer German emotion psychology one can find a very strong system of affects in the context of psychobiology. It is to see in Figure 104.

**Figure 104: (Wosch 2002, 253) – affects and emotion-process -**

This began with the work of Hans Lungwitz (1970) and it was further developed in newer EEG-emotion-research of Wielant Machleidt (1989, 1994; Gutjahr e.a. 1994; Brüggenwerth e.a. 1994). The five affects, which are written in capitel letters on the figure are Lungwitz‘s five basic affects. Machleidt developed the ideas of Lungwitz further. He offers the only closed process of emotion in all emotion and affect systems of emotion psychology. Mary Priestley gave seven emotions values based on the emotion psychology of the fifties. It is very interesting that these values are similar to the process, which Lungwitz and Machleidt describe
Bunt and Pavlicevic (2001) also studied improvisations concerning five emotions: tenderness, fear, anger, sadness and happiness, but mention no inner process-character. However, their five emotions are also very similar to the names of Lungwitz’s five mentioned basic affects. They seem to be very “musical” emotions. I can confirm that with my study (Wosch, 2002). Machleidt’s “experience process” starts with interest, is followed by anxiety, then anger occurs and afterwards sadness, which is finally followed by joy, the hedonic end of this process. In the manner of the main stream of recent emotion psychology Machleidt describes a special shift in that process, which occurs in the stage of anger, as the “acting threshold” (acting shift, Machleidt, 1994, 353 & 359). But on the other hand he names this process the “experience process” (Machleidt, 1994, 353), so he seems to be very near to the above mentioned “being touched”-definition. In my study of the music- and verbal-analysis within the context of the affect of anger, this stage seems not to be an “acting threshold”. It became an “object-relationship-threshold” (Wosch, 2002, 253). The client follows in the first improvisations the affects or musical structures of the therapist. Within the stage of anger the client separates from the therapist very clearly, also with his own music elements. Afterwards, the client begins a long period of sadness with different developments. During that period of time different affects were evaluated for client and therapist. The individuality of the client and a separation-process to inner object-relationship could start then within the stage of anger. Therefore, interest seems to show a tendency in the direction of the object, anxiety a tendency away from the object, anger the fight for
separation from the object, with elements of moving toward the object and away from the object. After that, sadness continues separation from the object, including separation from the self of the experienced person. Last but not least, joy turns toward the self as the hedonic end stage of the experience “being touched” by something. In these senses it was possible to add 21 further emotions to these five categories. The emotion psychologist Philipp Mayring characterized these further emotions in a very similar way, also as emotions in the sense of “being touched” (Mayring, 1992). – We were able to evaluate short excerpts of music therapy improvisation using these different emotion based on the five basic affects. It was also necessary to understand emotion in music as an on-going process, not as a static experience. It seems that emotion can be studied only as an on-going process of “being touched” and of object-relationship even within short pieces of music of only two or three minutes in music therapy improvisations.

To make a long story short, following theses for music and emotion in music therapy could be concluded:

1 “Being-touched” as the core experience of the individual can be considered the basic element of emotion, in its definition within music therapy. German emotion psychology, which does not follow the main stream of differential emotion psychology, offers this very important perspective on emotion. Also, in music psychology the function of emotion for acting or emotion as a basic motivation system has been studied very little. The musical experience is an experience first of all. Even if music is a “change agent”, the shift of a mood, meaning here of an emotion is the shift of an experience too.

2 Musical material in music therapy, especially the atonal elementary material, has special characteristics which can differ from those pre-structured material such as classical music. In-music-elements of the music therapy material can focus quite different elements. Therefore
tonality and harmony could be more cognitive rather than affective elements if musical interaction within one moment, the so called “intratextural interaction”, characterizes a single emotion. This should be studied further, also with regard to possible cues for single emotions on the side of music within the individual-music-relationship. These “intratextural interactions” differ in pre-structured musical material each time it is interpreted. The elementary elements for music therapy seem to be timbre, dynamics, rythm and melody.

3 Emotions in the musical experience are affects of short duration. They move from one affect to another as a continuous process within a few minutes. Basic affects and related emotions were seen on the last figure. Just as the emotional experience changes, we can also observe a change in object-relationships over time. Musical material, as a material of time, could deepen the consciousness of such processes and is itself always a continuous process.

Based on these theses, an ongoing research has been started with NEoM, a research network on emotion in music therapy.

**Figure 105: Emotion-research-network**

Most of the elements of the network study natural music therapy materials and contexts. In the yellow frames of the figure an entire music therapy process can be seen. It starts with the diagnostics, is followed by
the musical therapeutic process and finally ends with the results or effects of such processes.

The first study on diagnostics is the doctoral dissertation of Ulrike Gauer, who is performing as a study in cooperation between the University of Rostock and the University of Applied Sciences Magdeburg. The diagnostic value of the musical experience of emotion will be investigated in that study. 50 in-patients in child psychiatry will listen to musical excerpts one minute in length using the described music characteristics of three different emotions in their first clinical time of diagnostics. The in-patients will name these emotions and will be interviewed regarding their experiences. The techniques of free respons and questionnaires will be mixed in that study. Also, children who are not in-patients will evaluate the three short musical excerpts, enabling children with and without clinical disorders to be compared. The results of the first interviews with the patients seems to show the tendency, to formulate the experience of the three short musical excerpts as experiences of conflict. In a psychoanalytical context these conflict-experiences could give special information about special object-relationships which are disturbed. The special emotion or emotions could give special information about the stage of that relationship but this should be researched further. (But also non-conflict-experiences are described, which marks successfull object-relationships.)

Another element of the network is a cooperation of the universities in Magdeburg. Maria Sembdner made the first step in that cooperation. I mentioned the measurement of music therapy improvisations in my study
on emotion (Wosch 2002, 2002a). The emotional processes contained in music therapy improvisations were investigated. But these were only five to ten minutes of a music therapy session, a very small micro-process possible in emotion research in music therapy. The sessions took place with adult psychosomatic patients. The client talked before and after the improvisations with the therapist. These conversations are all recorded on audio-tapes. They were analysed and the process of the client before and after the improvisation could be investigated in order to prove that music is a “change agent” in the experience of the client. The patients’ verbal responses were analysed qualitatively before and after the improvisations. These responses differed. Musically, the shift went from “interest” to “anger”. The verbal responses of the client before the improvisation mostly contained references to time. These point more the experiences on an object-level rather than on an individual subject-level. After the improvisation a shift to “rivalry” occurs in the verbal response of the client, which shows an experience on very individual subject level. In that case active musical experience leads to a more “being touched”-state of the client. – She did not name anger as an emotion, but object-relationship “rivalry” emplies an anger-experience. - In the first investigated complete music therapy session the musical experience was the important moment of change of experience. The analyses of the verbal responses regarding the other investigated improvisations could give more details about emotional experience for the whole music therapy process. 

The next elements of the research network are EEG-process-studies and studies on in-music-elements of the University of Medicine at Hannover
and the University of Applied Sciences Magdeburg. In this element of the network, we plan to connect this research with other elements of research in the network. We will “check” emotional content of the three short musical excerpts from Rostock in EEG-studies. These studies are just beginning. Last but not least, I would like to turn to the ongoing effect-study in cooperation between the University of Applied Sciences Magdeburg with the Kliniken Erlabrunn and the head of the psychosomatic unit Helmut Röhrborn. However this research element is connected with other parts of the network. At this time Maren Petereit is studying the therapeutic process of a Regulative Music Therapy in a quantitative single case analysis (Hilliard 1993, 377) at the University Clinic Magdeburg for her Thesis. The course of identifying emotions by the client will be investigated through the use of an Alexithymia-test after each music therapy session. Audio-taping of all sessions offers the opportunity for further research of the experience-process of the client e.g. by content-analysis.

An Alexithymia-test is also the centre of the effect-study of the emotion research network. Alexithymia, which means disorders in identifying and experiencing of emotions by psychosomatic patient is based on the definition of emotion based above. The “being touched” and the object-relationships are lost in Alexithymia. One of the main researchers of Alexithymia, G. J. Taylor, described a “relation blanche” (Taylor 1977) as the loss of any object-relationships in Alexithymia. At the same time this loss is a loss of emotion-experience, which cannot be felt and described by the persons affected. In Kliniken Erlabrunn we started to compare two therapy groups with a pre-, post- and catamnestic
Alexithymia test. Regulative Music Therapy is the central treatment-method for one of these two groups in Kliniken Erlabrunn. Nearly 50 % of all therapies of this group (these are 15.5 hours a week) are music and creative therapies. The central treatment-method of the other psychosomatic group is a special verbal psychotherapy (with 7.5 hours a week). A leading to “being touched” is possible in music therapy, as shown in Sembdner’s study. In Kliniken Erlabrunn we are investigating whether or not there are differences between music therapy stressed and verbal psychotherapy stressed therapies. In Kliniken Erlabrunn we will have a population of approximility 250 in-patients in each group over a time period of two years. We will be able to correlate these effects further with the special disorders of the in-patients using pre-, post- and catamnestic psychodiagnostic (ICD 10) and Symptom-Check-List (SCL 90R). Last but not least we will use a questionnaire for course of therapy controll for Regulative Music Therapy (EBS), which every in-patient fills in after each Regulative Music Therapy session. This study can research special effects of music therapy in comparison with other therapies in the field of psychosomatics with a special emphasis on the phenomena of the experience of emotions in persons with mental illness.

Finally, let me conclude. The presented ongoing research of a research network on emotion in music therapy is based on special knowledge from emotion psychology and music psychology. However music therapy research has special subjects of research, which also differ from emotion psychology and music psychology. Music therapy research has to integrate these results, for instance the focus on musical elements. Music therapy research also has to investigate whether these results are relevant
to music therapy subjects, for instance to the definition of emotion in differential emotion psychology. Music therapy has to consult the related sciences, but for the basic research it needs its own research, for example about the relationship of music and emotion. This research is very complex and can be realized best, by research networks, which I tried to demonstrate through the examples given above. It is also possible to use quantitative elements in basic research on music and emotion. The results of this basic music therapy research can give new knowledge to music psychology and emotion psychology. At the present time music therapy research is sometimes represented in music psychology but not in emotion psychology. However, emotion psychology seems to be a very important science as basis for the music therapy process.

References


Style And Identity: “Being In The World” As A Musical Form. A Clinical Story

Zanchi, Barbara
† Via Rizzoli 4.

Summary:

1) Introduction

2) The clinical story
First phase:
Music as a rescue: I am only my music.

Second phase:
The other, the dialog and the search for different ways of “being in the music”.

Third phase:
Music as a resource for my “being in the world”.

3) Bibliography

INTRODUCTION

In this paper I would like to propose some reflections about the clinical history of an adolescent with the aim of thoroughly analysing and clarifying the main lines of a music therapy model we are developing and currently using in both clinical and educational situations in the working group which I and my colleagues L. Bunt and G. Gaggero set up inside MusicSpace Italy, an association born in 1999. This model, which we partly introduced at the Naples European Conference last year, investigates the processes of musical interpretation, identity, style and their role in the therapeutic relationship.¹³¹
For our team in Bologna the theoretical frame of reference -which can provide the essential coordinates to “read” and understand both the therapeutic relationship and the processes of musical interpretation within an aesthetic and psychological context- emerges from a combination of the phenomenological and hermeneutic approach on one side, and both research and clinical practice inspired by humanistic-existential psychology on the other side.

In our work we have come to define music therapy as a music-based clinical relationship whose purpose is the care of a person’s health. It is just this relationship the main work-instrument through which and in which the musical expression of intentionality is pursued, according to stylistic features which are different for every person.

In this perspective we can define a Musician Therapist as someone who is able to come into contact with his own and his patients’ interpretive dimension and who means music therapy not only as a music-based therapy, but also as an “encounter” in which it is possible to care for the Other’s “music”; by “music” we mean the holistic description of man which is at the same time instrument and object of the therapy.132

In my work, according to this view, the themes of both intra- and interpersonal relation, of both unconscious and conscious intentionality, of the style of interpretation and expression and of identity have therefore a special relevance. Such views have arisen and


developed especially in the clinical work I have been carrying out for some years with a few teen-agers suffering from serious psychological disorders both in institutional facilities and in private practice.

A typical issue of adolescence is the forming of identity, which can be defined as the possibility to recognize oneself and to be recognized. It is actually “(...) an exciting but also painful process (Erikson openly speaks of “crisis”) because the subject involved in it has to choose only one form of development, giving up other ones which he feels equally gratifying.” His quick growth compels the teen-ager to stormily face the problem of the body-mind relationship, which will decide most of his future depending on the acceptance or the refusal of integrating these two dimensions.

According to A. Ferrari the adolescent’s body “has the peculiar feature to grow up and, at the same time, to be, to become object of knowledge.” The delicate task of knowledge therefore includes everything, inviting a boy or a girl to elaborate on his/her past projections and to gradually replace his/her fantasies with concrete acts, by which they put themselves to the test. In an adolescent’s experience to do and to know have to coincide: they are the expression of a sole operation – albeit complicated.

Such a process, which consists in "doing things to know and recognize oneself", seems to find a suitable and fertile ground in music therapy.


“Doing” is not to be meant as “acting” or “hyperactivity”, but rather as a constant commitment to give shape to more and more recognizable and acceptable self-representations.

Every process of representation and expression is characterized by a particular style, by which we mean a synthetic way to communicate what is indispensable for recognizing one’s own identity and what ensures a complete and authentic expression of it in the “here and now”, a synchronic or vertical testimony to the intuition of one’s own wholeness.

The unfolding in time of the stylistic activity gives rise to narration, a horizontal structure that tells the “stories” of the unfolding of intentional activity. Every narration is characterized by a particular style, expressing those personal values which structure and orientate the narration and thanks to which the “facts of life” become “meanings of life”.136

Style always involves the whole person and especially highlights the relationship between his “presence”, or “hereness”, and his intentionality. Style is therefore strictly connected with personal identity.

Besides this, style also defines the kind of listening a person can offer both to himself and to the other, and shows in the subject’s relationship with elements such as time, space, sound, silence, the body and its weight, moves, gestures and eye-contact.

Thus every kind of expression or communication, both the most structured and complicated and the simplest and most basic ones, has a style that testifies to the person’s wholeness. If we can recognize Bach or

136. As regards the concepts of Style and Narration see G. Gaggero, Cura musicale e costruzione del senso, in Anthropos e Iatria, n.2 anno VI
Mozart by only a few notes of one of their pieces we’ve never heard before, it is simply thanks to their style, which reveals a definite intentionality of expression. Even a few notes of a clinical improvisation or of a piece chosen by one of our patients reveal a style-connoted intentionality of expression, which the patient has often either not yet found or has lost the ability recognise as such.

So, every kind of music, created or recreated in a therapeutic process, gives us a testimony to the style and the identity of the person that, in that specific moment and in that unique relation, becomes his “author”.

The search for his own style, a feature of adolescence on many levels, can be seen as a series of inescapable ”identity tests”, which only gradually will lead him to replace his illusions and ideologies, a result of the massive conditioning of his projections, with his personal experiences.

Therefore the proposal of working on stylistic elements seems to me especially pertinent to music therapy. This possibility arises from training and constant practice in recognizing and “inhabiting”, in the “here and now”, different interpretative styles, a practice which any serious “Musician Therapist” has and which greatly enables him to recognize and understand the style, and consequently the identity, of human interactions based on sound and music elements.

**CLINICAL WORK**

For many years my clinical work has been divided into two levels: my job as a music therapist for the Neuropsychiatric State Service in a
Semiresidential House for Adolescents, which puts up teen-agers affected by serious psychopathological disorders, and my work within the Music Space global project, where I take care of children, teen-agers and young people.

The Semiresidential Centre, born in October 1996 as one of the first Day Centres planned and designed to deal with preadolescents and adolescents suffering from serious psychopathological problems, is situated just outside the centre of Bologna and it is open all day long, from Monday to Friday.

The therapeutic staff, coordinated by the child neuropsychiatrist head of the Unit, includes various professionals coming from different areas, such as three psychiatrists, a pedagogist, seven educators and a music therapist. The integration of their different kinds of knowledge takes place with a weekly meeting and monthly supervision, with the participation of all the professionals working in the Centre.

The Semiresidential House, so far one of the very few facilities of this kind as for both the service it offers and the multidisciplinary model it follows, proposes to carry out intensive therapeutic work aimed at improving the adolescent’s clinical condition and at promoting an increase in his comfort, individual abilities and autonomy, a clinical work that is realized through the formulation of a project centred upon the individual, which also takes into consideration his whole global context which he belongs to. The patient’s treatment consists first of a period of observation carried out by all the members of the professional staff, and then of a longer period in which an individual project is worked out
whose starting point are both the abilities and the problems which emerged during the observation period. The project is subjected to regular checks and updating till the patient is discharged.\textsuperscript{137}

For what specifically concerns my work as a music therapist, in these past five years in the Centre I have taken care of 23 teen-agers, through weekly individual sessions, for a year and a half, two years maximum. In three cases, at the staff’s suggestion, the music therapy treatment has gone on even after their discharge from the Centre.

One of these three boys, whom I have chosen to speak about today, is \textbf{Gregorio}: his process has been a long and intense one, full of ever which lasted for three years and is still in progress. During the first period (a year and a half), his clinical process, integrated by other treatments, has been carried out at the Centre, but was subsequently moved to Music Space and became the only one therapeutic intervention.

I decided to illustrate to you these years of work dividing their salient points into three phases, which allowed me to read the therapeutic process in the light of the themes of identity and style.

The \textbf{first phase} includes the first six months of work, with particular emphasis on the beginning and on the first sessions that, as usual in a therapeutic process, often include many of the leading stylistic elements

of the relationship that is likely to develop later. It was a phase in which
the patient made himself known, with all his potential but also all his
suffering, suffering that could be more easily expressed through some
types of music, mostly music “on the edge”, the metaphors of a border or
“self-container” which was about to break up.

The second and central phase developed for about a year and was
characterized by the patient’s willingness to meet both me and music as a
means to explore other possible self-representations.

The third phase, still in progress, corresponds to this last year and a half
of work, in which the patient’s self-testing has led to concrete projects of
life, new tastes and preferences, more in line with some typical and
healthier trends of late adolescence.

Who is Gregorio?

When he first entered the Centre, G. was 17; he had been described as a
patient at risk of falling into schizophrenia, with a diagnosis of “schizoid
personality disorder, denial of the illness and lack of cooperation”. He
had been sent to the Centre because he was absolutely reluctant to accept
any other kind of therapeutic treatment. In fact he had gradually
interrupted all the sessions with the local child neuropsychiatrist,
accepting to meet a psychologist only for a few months and only in the
presence of his sister, but without his parents. He refused both medicines
and any psycho-diagnostic test. The aim of the team who sent him was to
overcome an impasse situation from a clinical point of view and to “help
G., after a gradual phase of observation, acquaintance and integration, to
set up relationships with people of his same age and grown-ups, through therapeutic, educational and social activities”.

In the family relations were difficult and heavy and also G.'s older sister had some problem that brought her to undertake a psychotherapy. G.’s discomfort made its first appearance about one year before his arrival at the centre, when he started to do badly at school and to gradually cut himself off. He had difficulty in studying and concentrating, which gradually increased to the point where he stopped attending school at all, which was very painful for him. So he started spending most of his time at home, playing the guitar, an instrument he had learnt playing by himself and that he played alone, till his fingers bled.

Fits of delirium began showing when G. started saying that he was “the Prophet” and he also had a few disciples (some of his schoolfellows), but he was still looking for other ones.

What was really striking for people who first met him was his composure, which was almost postural stiffness, and his use of language, so correct and proper, which poured out in a flood of words by which he expressed complicated lines of reasoning that seemed to be incoherent and disconnected from their context. It was difficult to follow him, and in fact only few people were able to keep on listening to him for a long time.

By his words G. seemed to give shape to pieces of present time disconnected from the past and the future, keeping still and motionless.
What he wrote in a composition of that period reveals, more clearly than any description, his increasing suffering: “I always live in the present; I do not know the future, I no longer have the past; the first bothers me because in it everything is possible, the second because in it nothing is real”.

First phase MUSIC AS A RESCUE: I AM ONLY MY MUSIC

G.’s presence at the Centre was absolutely atypical if compared with the other boys’ and our perception was that his link with us was extremely weak: in fact he only occasionally participated in the activities we proposed, while he seemed to be more interested in “chatting “ with some operators.

Our work began some months after he had been attending the Centre, in a rather informal way. We met and got to know each other by an informal chat and I was really struck when, a little later, G. started talking to me of his musical tastes, some of which were very specific and surprising, such as A. Schoenberg’s dodecaphony. In a complicated and redondant language he spoke to me both of the dissolution of tonality and form, and of the relationship between consonance and dissonance, which he had read something about. He seemed to be deeply impressed by Schoenberg’s new concept of dissonance, seen as the growing ability of our ears to become used to even the farthest harmonics138; yet he had never listened to anything by this author!.

138. Ansaldi G., (1993), La “lingua degli angeli”. Introduzione all’ascolto della musica; Guerini Studio, Milano, Pag 85-86.
I tried to listen as open-mindedly as possible to all those confused words, and then gave him some suggestions to help him understand better what he had read. This seemed to touch him, and later he said nothing bothered him more than speaking to incompetent people.

Like most teen-agers, he listened to a lot of music, generally rock songs, whose lyrics had to be only in English, because for him only this language fits in well with music. For a short time he and other two boys had set up a group where he sang, played guitar and, with one of the two friends, wrote the music and the lyrics of their songs, of course in English. He was really fascinated by Kurt Cobain, the leader of the famous rock group of Nirvana, whose suicide was felt by him as the inevitable and coherent conclusion of his existential and creative process. Cobain seemed to represent for him something more than an adolescent myth: the “character” and his music such as Schoenberg’s or G.’s own language, were a stylistic expression of his difficult searching for identity of that moment: “Is living—he somewhat seemed to ask—only going beyond the limit, dissolving all what has been before, being against?” At the beginning of our story, however, this was not a question, but actually a statement, repeated in many ways and very frightening for all the people who met him, and probably also for him.

In that period in many of G.’s speeches issues such as death, suicide, break-up and the dissolution of forms, or else the stopping of time or “non-places” very often occurred.

He had been attending the centre for a year or less when, in a very difficult moment for his family, a very problematic one, he told us that he
didn’t want to continue his treatment any more: his words had run out and nobody could do anything for him by then, since his sister (he hoped) could escape from their family only by a divorce, whilst he could do the same only by dying.

In such a difficult moment, which seriously alarmed all the educational staff, music seemed to come to G.’s rescue; it was no more the music you speak about, but the one you listen together with others, which can thus become a shared experience.

His educator in fact, inviting him “not to escape like a thief” and, in a way, to ritualise his leave, suggested him to read at home some pages from *Doctor Faustus* by T. Mann (one of the books G. had asked him to read), which contain a description of the listening of the *Sonata op.111* by Beethoven, sonata where the author takes his leave of this musical form, and come back to listen together to the music and only after to decide whether it was possible to find new motivations to keep on meeting or if it was better to say goodbye forever. Only after the educator had clearly specified it was not a “trick” to force him to draw out his attendance at the centre, did G. accept.

After the weekend, G. came back to the centre to meet his educator, and he immediately spoke of the passage from *Doctor Faustus* that both of them had undertaken to read (G. had never accepted any kind of commitment before). When he was asked whether he wanted to listen to the piece, he answered that he had come for that very reason.

G. and his educator listened to the sonata *op.111* by Beethoven together, in reverent silence, a silence which continued even after the piece had
ended. Then he said the listening had been long and it had been difficult to follow that piece because it had no lyrics. "*Perhaps the score could be useful*- he suggested. The educator reminded him that the music therapist, which he had already met, could help him.

G. accepted the suggestion and we met to listen together the music that he brought; after our first meeting it was he who asked to continue that experience of shared listening, especially with his own songs, for me, his “being-in-music” of that particular moment.

From my meetings with the educator I received the impression, later on confirmed by the staff, that this suggestion had been for G., in a very difficult moment, the indication of a possible way of self-narration. In fact words seemed no more able to say anything that he could recognize as belonging to him, but only fill the time which, perceived as motionless and eternally present, seemed to “freeze”.

In such moments of shared listening, even words seemed to become a way to create and share experiences, and he no longer felt the need to go on astonishing or protecting himself from the others.

So we started a series of meetings “a trois”- G., his educator and I- which marked out the first six months of music therapy treatment with the boy; this trio setting has been very important also because it allowed me to underline the elements of circulation and connection that music can create.

I shall say some words to describe our first session in which, for the first time, G. clearly proposed someone else a musical suggestion containing,"
in embryo”, many stylistic elements, which would characterize our future work. It was a session which provoked a lot of emotions and reflections in me about the themes of identity and style, which testifies to identity and gives a person the possibility to recognize himself and therefore to be able to change.

In the previous days G. had repeatedly asked when the session would take place and, on that day, for the first time he brought with him some of his CD. The first track he proposed was *Tourette’s* by Nirvana: a “grunge”, very fast piece, made of incomprehensible cries and senseless words, which lasts only 1’30”. G. emphasized it was the only track of the LP which had no lyrics and it communicated something between pain, anger and desperation. The track is part of the album *In Utero* with a particular image on the cover that impressed me: its shows a pregnant winged woman with transparent skin, through which it is possible to see the foetus and all the internal organs of the body.

The second track was *Paranoid Android* by Radiohead, which was listened to for the first time with great intensity, for all its duration (six minutes) listening to it again and again, G. said it was a very difficult song, divided in two parts: “the first one is harder -so he said- the second one is more inner and melodic”. He also commented on the booklet of English lyrics we were reading together. I was moved by his remarks, so centred on musical form, his asking for specific technical information, which I tried not to disappoint, also adding some hints about the kind of emotions such music can evoke. Then G. asked to listen to the piece again, and this time he defined the melodic part, that comes out from a
series of descending progressions, as “sad”. This was the first emotion he named.

In spite of the list of songs he had prepared, including now a piece by Beatles, we listened to Exit Music, again by Radiohead. Before listening to the track, which is part of the sound track of Romeo & Juliet, G. asked whether R. & J. was a sad story because “listening to it was a bit too heavy”, so we spoke about the story of that tragedy and G. remarked that the song was very sad for him, but the end seemed more comforting.

Our conversation had now definitely moved to music and the emotions it can evoke, also relating to the form and structure of the pieces. We listened again to some parts and G. repeatedly went back to one of these, characterized by a vocal groan that, combined with the words-G. said again- can evoke a lot of sadness.

This music and our remarks reminded me of some modal progressions, that I tried to propose G. on a little keyboard: we were speaking about modal and tonal structures and I was using the keyboard to give a few short examples, while music was still playing in the background, when at certain point, as if he was afraid but he could not resist a very strong temptation, G. played a series of notes on the keyboard, trying to reproduce the piece in the background. It was a sort of motor uncontrolled reflex, which took me back to the style of the first song we had listened to, and left him wordless, giving place to a long moment of silence and deep eye-contact.

G. started again speaking about modal music and, still in his twisted way, he managed to tell me that it dimly reminded him of music for children.
The session ended with the recalling of some of G.’s memories about this subject, which I took up and emphasized by playing some songs for children in the modal form.

A feeling of comfort seemed to spread over the room; at that moment his words became less rapid and jerky, and, while we were saying goodbye, he told me it would be better to meet again, so that we could finish listening to the pieces we had brought.

When the session was over, G. told his educator that nursery rhymes for children are often suitable even for grown-ups. He added that he would like to write so simply as well and he would no longer try to correct the stories he used to write; after these words we said goodbye and arranged another meeting.

**In the two following sessions** G. proposed other pieces by Nirvana (All Apologies and Love Buzz), listening to which he started again speaking about Kurt Cobain’s “character”, adding this time new elements: now his figure seemed to be less marvellous and his suicide less mythical. G. spoke of the value of life versus death and of “company” as something more desirable than a “tedious loneliness”. He also underlined how difficult it is to rid oneself of the part the others cast you in, because changes always produce some effects on people around you: “The others always expect you to do the same things, so, when you change, they don’t accept it, even though it is a change for the better”. During a long discussion he said, nearly accidentally and fleetingly, that he and the other boys of the music group had won the chance to carry out a recording in a recording studio for three days: they would set up a demo.
with some of their songs, which G. offered to bring me on my return from the summer holidays, so that we could listen to it together.

Then we listened to some songs by Beatles, "Penny Lane" and "Strawberries Field Forever" from Magical Mystery Tour, and, to end the meeting, we listen again to Exit Music by the Radiohead, during which G. observed: “The record is beautiful, but absolutely, excessively and exclusively sad; unfortunately -he added- there is a stereotype according to which, in order to write or do something intelligent, you have to be sad and gloomy, whilst, if you write cheerful things, they are not considered intelligent”. G. concluded the session with a question:” Is it possible for me to create something intelligent and deep, but also cheerful and not so sad as the music I have preferred to listen till now?“

We said goodbye to each other in quite an intense way: it was the last session before the summer holidays .G. seemed to be moved and he probably wanted to draw out that moment; a little joke from the educator lightened the situation and G. went off smiling.

What he had experienced in those few sessions had already allowed him a global rediscovery of his personal involvement in the clinical work at the Centre and also a more specific way to represent his borderline existential experience, just like the forms of the pieces he had chosen, forms that either came at the end of a creative process or recalled its inevitable breaking up by their lyrics, which did not tell anything, but just cried.

Thanks to the musical experience it had been possible to overcome the dichotomy comprehensible-incomprehensible as a key to interpret G.’ s
delirium which, as well as the use of the adjective “megalomaniac”, had often been used to define his way of thinking and narrations. It was by giving shape to what seemed to be incomprehensible and unbearable thoughts that G. was finally able to recognize them and to commit himself to looking for new and different forms.

Going back to the concepts of style, identity and relationship, we can observe that in this phase music was for G. a mainly intra-personal means to preserve his own identity by keeping in touch with his own body, even though his fingers bled, his voice cried and all his body trembled. But it was too difficult to gather and understand all this by himself, or rather in a condition of “tedious loneliness”, while it could be possible to do so in a listening-based relationship, testifying to the dimensions of presence and life versus death. In the situation G. described as “company” music had become thoughts and, more importantly, emotions such as sadness, comfort, and separation mixed with the promise to meet again.


After the summer holidays, our clinical work started again regularly; as he had promised, G. brought the CD with the pieces composed by him and his group and recorded at the end of summer. For about two months our sessions, at which the educator was still present too, centred upon the shared listening of his songs. The feature that marked out this second phase was the presence of the other, no more felt as an indistinct element who, listening to his music and accepting it, could help him to understand
it, but as somebody different from him who was not dangerous, so that he
could open a dialogue with him and discover the curiosity to explore and
experience together different self-representations by music.

The process carried out with G. in this phase can be read in the light of a
series of stylistic-thematic cores emerging from some polarities or pairs
of opposite elements.

The first pair of opposites, which emerged in this period of music therapy
treatment, was that words/music, highlighted by the sounds and lyrics
created by G. himself: the songs of his group. The lyrics written by G.
and by a member of his band were all solely in English, a language felt as
opposite to Italian because it allows you also to express things that are
not so logical; using English, G. seemed to be seriously intentioned to
break the rules of the narrative development of speech, which he
scrupulously respected in Italian, and to follow an associative, sound-
onomatopoeic and evocative “stream of consciousness”, which he could
accept.

G. emphasized very much the reading of lyrics, some of which were
really odd, some really amusing.

Music, instead, showed an essentially “orthodox” conformed to quite
“natural” harmonic rules and rhythmic-melodic progressions, drawing on
pop music and typical of teen-agers’ musical tastes.

His language therefore seemed to prefer analogical processes and to
correspond more to his need to break the rules just where music and its
rules seemed to be more internalised and less feared.
G. was very with the result he had achieved with his CD and his musical band. I helped him understand that the recording compelled him to very hard work- long hours of intense concentration, aimed at reaching a goal, which hadn’t been so easy for him, but eventually he had succeeded, thanks to his care and passion.

It took us many hours to listen to all the pieces; during these sessions, besides sharing his satisfaction for what he had achieved, I tried to lead G. to a more conscious appreciation of all the process of creation and expression he had carried out, made of motivations, emotions, research, working in the band and dialogue with other people, study, concentration, the achieving of the result and, lastly, his sharing it also with me.

Once we had concluded the shared listening of his songs, G. presented me with a copy of his CD. It was a very important moment, that marked the end of a phase of our work which I could define as “meeting” and “collecting”: meeting and collecting all his external experiences, but especially all the pieces, which were so many, scattered and separated inside him. By giving me the CD G. was implicitly asking me to keep all this.

“Listening” had been the dimension we had accepted to “inhabit” together. In such a dimension musical forms, as the metaphors of a difficult existential period, made it possible for G., thanks to the variety and multiplicity of their possible meanings, both to loosen his defence mechanisms more than words could have done, and to accept the coexistence of contradictory thoughts, the emerging of new connections,
repressed and forgotten meanings, new curiosity and intentions in himself.

**Time of words and Time of music**

Meeting and dialogue led G. to approach this possibility also in music, accepting my suggestion that we could try some improvisations. Once we had finished listening to the tracks of his CD, I suggested that he could “explore” the instruments in the room, which, for the first time, he was starting to look at with some interest.

It was only after some sessions that G., not without a certain difficulty, took the guitar in his hands and made me listen to a series of chords of one of his songs. His preparing the instrument was exhausting: it took him a great deal of time to tune it up and he seemed never to be satisfied and ready to pass from the preparation of the instrument to the real performance. He filled up this time with remarks, speaking very quickly, and his words made me feel how intense this experience was and how difficult it was to keep on listening to it.

The intensity of “preparation” is a stylistic feature typical of adolescence, when you always prepare yourself for something that you are often not yet ready for; that is why young people invest so much of themselves in this preparation. I recognized this attitude as one of G.’s main features: in fact it took him a very long time to enter into experiences, time he tried to fill up with a lot of words, which he used more to defend than to express himself.
I felt that in those moments a “company” able to patiently support such a long wait could be useful for him, so I tried to do this paying attention to non-verbal elements such as his posture, breathing and the rhythm of his speech, which were all very quick and contracted.

When G. finally started playing the sequence, I offered him a rhythmic support on the piano, support which at the beginning followed his disjointed and fragmented rhythmic progression, but gradually became structured around a shared pulse, on which G. proposed some harmonic variations. It was the first time we had played together: this experience produced an intense emotional feeling during the performance and, subsequently, a loosening of G.’s muscular tension and a slowing down of his speech, as well as a more appropriate verbal expression of his moods.

It was finally evident for me how important it was to look for a kind of time we could “inhabit” together and to discover the pulse (life) hiding behind the jerky rhythm of his language, and which could emerge only from it.

From then on I always tried to listen to G.’s language from a more strictly musical point of view, by sympathetically tuning in to the non-verbal parameters of such expression. This always produced in G. a slowing down of his rhythm of speech and the beginning of a dialogue in which it was really possible to communicate lived experiences and deep inner contents doing without his usual verbal virtuosity.

In the next improvisations G.’s approach to the instruments, especially to the guitar, was more direct and prompt, and his curiosity to explore
possible variations increased; at the same time, he didn’t feel the need to be “always” listened to as before. So it was also possible to formulate mutual proposals of original and individual musical ideas.

It was in that period that G. wrote, at my suggestion, an article about music for a youth magazine, in which he said: “Sometimes you are on your own, other times you’re with someone, but whichever, listening to music is as if we received a message from somebody unknown, often saying exactly what we would like to hear, or what nobody tells us. If this happens, it seems like a kind of magic, as people, through this important instrument which is music, have since ancient times spoken about their lives, expressing their anger, hope, happiness or discomfort. That’s why, in time, music has become a universal language, which almost makes us think that there really is something which unites and that perhaps we are not so far from one another”.

As for this second phase of my therapeutic work with G., I would like to stress two further stylistic polarities, whose discovery in our improvisations allowed G. to measure himself, as I have already said, with different ways of “being-in-music”, whilst his first statement had been: ”I can only be that kind of music”

The two polarities I am referring to are those of modality/tonality and monophony (or melody)/polyphony.

In the first improvisations G. used to propose harmonic progressions he already knew, starting from which he began a long speech about tonal organization in music. He asked me a lot of things about harmony and it seemed that what mostly interested him was understanding its rules in
order to question them. What attracted his attention were the specific
tonal functions, static or dynamic, of the main chords. In tonal music the
progression of such chords follows specific harmonic rules, which,
according to the canons of musical aesthetics, define what is right or
wrong in the light of the principle of consonance / dissonance. The tonal /
harmonic system is based upon a functional hierarchy, which has to be
known and respected in order to remain within that system. In speaking
of this subject, G. went back to dodecaphony, 12-note music, making long
and surprising speeches in favour of it, even though he had never listened
to anything of that kind. For G. dodecaphonic music was an “idea”,
representing the evolution of the concept of tonality towards atonality,
aimed at breaking up the limitations of a strictly hierarchic formulation of
musical speech. In it in fact dissonances become “remote consonances”
and all the sounds of a given series are equally important, at least from a
theoretical point of view.

We elaborated very much on this concept and on the possible analogies
and metaphors it suggests about the structure of the inner world and of
the relational dynamics.

It was then I thought it right to take up the suggestion that had emerged in
our first session and to propose him, still remaining on the same mental
and theoretical level, the idea of modalità, taken from Greek musical
theory. I explained to G. that modes are quite flexible structures of a
musical speech. There are some fixed sounds of reference, defining the
extremes and the range of an area inside which it is possible to combine
various intervals and melodies, all equally pleasing. Each mode defines a
particular harmony and, according to the Greek musical theorists, the melodies composed on each of these harmonies are marked out by a particular “character” (*ethos*), so that harmony itself produces specific effects on human will and psyche.

G. immediately remembered that most of children’s music follows modal structures and that modal entries are present also in pop and rock music. His curiosity started increasing and he accepted my proposal to improvise something together according to various modes, listening to the effects produced in us by the different harmonies.

Simplifying the frame of reference had made a more direct expression possible and acceptable to him even on an instrument he found very difficult as the piano, he was rather interested in.

In this case my “interpretive” suggestion was a backward process through the history of music, may be a metaphor of his personal history, in order to recover more ancient and flexible forms able both to allow him to accept and use easier ways of expression and to reduce his desperate need of intellectualisation. After I realized that G.’s suffering led him to defend, within the history of music, a future which broke off with the past and took to extremes the theoretical level, that is dodecaphony, while his lived experiences became approachable only through simplification and flexibility whose roots are in the past.

The last of the stylistic elements I would like to take into consideration is the polarity *melody/polyphony*, which emerged during a musical improvisation on the theme of a Christmas song.
G. found it difficult to sing the “main” melody of a song, the one by which we can recognize it. In his group too he always sang the countermelody. It is worthwhile reflecting on the very word “countermelody”: “counter” in fact is synonymous of “against”. Of course melody was not the most natural and favourite way for G., as clearly showed by the following metaphor he used to describe himself: if, in order to reach a place, it was possible to choose between a main road and a path in a wood, he would obviously take the second one, which was far more interesting for him.

But, since everybody tried to convince him to stay on the main road and to leave the path, this one became not another possible way, but the way “against” the main road that it has to be defended.

Well, G. felt the same about music, and that’s why he used to choose, almost as an ideological conviction, to always sing something different from the main melody.

Once again it was the history of music that gave me a starting point for his “exploration”, in proposing the concept of polyphony to him. I played some pieces for him on the piano, so I could make him notice that in music there are two ways to conceive the inner progression of the parts or voices: the monodic and the polyphonic one. Monody stresses one part, which becomes a melody, while the other ones serve as support or accompaniment. In polyphony, however, there are more sounds, voices or parts that proceed simultaneously, each one with both distinct individuality and equal importance towards the other ones. None of them sings or plays “against”, but rather together with the other ones, thus
creating points of contact and connections which comply with the laws of harmony. In this way a pattern develops in which the expansion of the voices makes it possible to find out various possible “meanings” inside the same piece, both for the performer and for the audience. Such meanings are all equally possible and concur to a coherent definition of the piece, which is the result of both the addition of the single parts and the way they intersect, converge, diverge, are in unison or not.

G. was very interested in all this, so I suggested he should listen to some fugues from the *Well Tempered Harpsichord* by J.S. Bach, in different versions and interpretations, in order to recognize and follow, also using the score, the progression of the single voices. I was very touched when at a certain moment, almost with a sense of gratitude and release, G. defined himself as a “polyphonic personality”, and I thought how this metaphor clearly express both the potential and the risks involved in it.

Once again his musical and personal style seemed to meet and comprehension, always a reciprocal process, seemed to replace explanation.

**Third phase - MUSIC AS A RESOURCE FOR MY “BEING-IN-THE-WORLD”**.

In the final part of this paper I would like to propose some reflections about the last year and a half of work, still in progress, started when G., at the age of 20, left the Centre since he had completed his institutional therapeutic program and followed the staff’s suggestion to go on with music therapy.
The different setting, no more an institutional one but the private context of Music Space, which G. had freely chosen, also supported by his family in this choice, soon contributed to give to the work an even more personal connotation. Such connotation concurred with, and perhaps made it easier, to express and face of some typical late adolescence’s polarities, such as individual/group, internal / external acts, ego / world.

G. gradually renewed his contact with many situations of the external world in which, as he said, “there had been a long break”. He also said he felt “on the move again”, even though not yet at maximum speed as he would like to be.

He started speaking about what had happened to him in those years, of the period of “disconnection” he felt he had gone through, of the fear which had always accompanied him and that was still “the main emotion, ….the one you mostly and always feel”.

In these past months our work has concentrated more on the verbal level; his language was still the mirror of his moods: basically minute and complicated, it still needed “musical” listening, but finally it was also able to include, from time to time, long moments of silence.

In our long conversations we have minutely explored his many wishes and fears, as well as the possibility to renew contact with various aspects of his life which are very important for him, such as school and studying.

After a first try, which immediately failed, this year G. has started to attend a private school again, after a three year “gap”, and has taken and
passed an examination which recovers two years of school in one. Next year he will prepare for his school leaving examination, corresponding to British A level.

In his demanding exploration of the world of relationships, he has chosen a stable group of friends, which he regularly goes round with, even though he sometimes finds it difficult to accept the tastes and ways of communicating of some of them. He has even gone on a quite distant journey with them, but he has come back home alone a week before because he had got bored!

In this last year his look has considerably changed, and his taste, in clothes and in the choice of friends and things to do, is far more refined, even though he sometimes borders on a typically adolescent excess of aestheticism.

Emotions and feelings, almost a “taboo” till not long time ago, now can exist and be said in our therapeutic relationship without putting in danger our alliance and understanding.

I could say many other things, but what really matters to me is to go back to the leading theme of our speech: music. Where has it gone?

Music, as G. says, is still a great friend of his, but now in quite a different way compared with the past. His group split up little less than a year ago because of his friends’ various study commitments: it has been a hard blow for him, not so much -I suppose- for his missing the music (he does not play the guitar either any more), but for the comparison with boys of the same age who were choosing and embarking on different ways, with
different interests and new commitments, something which is still very
difficult for him.

Now music is present in his life in the form of listening: in fact he enjoys
preparing some compilations, which reflect the different periods he is
going through, but he seldom brings them to our sessions so that we can
listen to them together. Still oriented towards rock and English music,
now he also listens to Italian music, even if he defines “lighter”. Some
months ago he brought me Thank you, a song by Dido, to listen to
together, saying that both the song and the singer reminded him of a
simple way to face life which it was beautiful to be grateful for.

In a complicated session centred on the themes of appreciation and
contempt we can receive from and feel for others, he accepted my
suggestion to play together and, for the first time, he used a non-
conventional instrument such as the rain-stick, while I played a small
glockenspiel. In that moment I had a strong impression that G. was
saying, first of all to himself, that, just like in the rain-stick, something
had started flowing through him, even though it still needed to be often
controlled and sometimes restrained, exactly as he had done with his
instrument, using a lot of energy, throughout all the short time we
improvised together.

Recently, after we had reflected together about his current relationship
with music, he said that, of the different ways to deal with music he could
choose among, his favourite one at the moment was the role of
“amateur”. 
G. therefore seems to have moved from a relationship of dependence on music, which he could identify with only in extreme and piercing forms, to considering it as company and a resource for his life. This change has been possible by using music as an instrument of discovery and self-knowledge inside our relationship.

For G. music is no longer what makes his body bleed or which shows his personality, but, just because it has been all this too, it has finally become a sound resource for a young man who listens to it in order to “meet” his emotions, to share his passions and to enjoy himself with his friends in the pub.

From the very beginning of our relationship, I tried to offer G., through music, the “thread” which at first he could cling to, while it could support and orientate him to reorganize and simplify his inner world, which could become as well the relational “bridge” from isolation to his own and unique way of “being-in-the-world”.

Recently G. has brought me some lines he had written on one of the main themes of our meetings: "listening". These few lines, better than many words, express the meaning of the story I have told you:

   Living is choosing
   But there is no living together without harmony
   And in every harmony there is dialogue
   Which is possible only if we listen to each other
   Living is choosing to listen.

Gregorio.
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**Author**

Barbara Zanchi,

Musictherapist, musician and psychologist, she is the President of MusicSpace Italy. She is the Co-ordinator for the University of Bristol of the Italian Course of the Post-Graduate Diploma in Music Therapy. As a clinician she works in a Psychiatric Service for Adolescents and in some private institutions for both children and adults.
Therapeutic Choir – A Music Therapist’s Look At The New Millennium Elderly

Zanini, Claudia Regina de Oliveira & Leão, Eliane
Professor Ms. Claudia Regina de Oliveira Zanini
Counsellor: Professor Eliane Leão, Ph.D.

Abstract

This paper is the result of qualitative research involving Music Therapy and Gerontology. It introduces a new concept, hereafter referred to as Therapeutic Choir – a therapeutic activity to be undertaken by music therapists – for the elderly. Data collection was carried out through such instruments as music therapeutic forms, session reports, audio recordings of sessions (later transcribed), footage, final statements (by the majority of participants) and the transcribed and videotaped interviews of ten participants. A written consent was obtained from the group of participants/students for the entire process of data collection. Another object of analysis consisted of a video of the last session/class which was later shown to three professionals pertaining to different areas. Their task was to observe the elements of the phenomenon. Data analysis was based on the phenomenological paradigm and the participants’ profile was quantitatively treated. After the analysis process, three essences emerged from the studied element: “singing” is a means for both self-expression and self-fulfilment; songs reveal the “subjectivity / inner existentiality of the being”; and finally, the “being’s” self-confidence instils in the participants of the Therapeutic Choir expectations towards the future. Final considerations indicate that the concept of Therapeutic Choir may be enlarged and extended to other professional areas. Finally, it was considered that when dealing with the elderly, the music therapist should reflect deeply on themes related to life and death, in addition to rethinking his/her relationship with time’s multiple faces.

Introduction

The practice of a music therapist, - a professional who appeared in the second half of the twentieth century and who has both musical and scientific education and seeks to improve life quality -, inserted in a
certain field of work, should regard as the main focus of their study and research all that is related to praxis. From clinical practice, research into such practice, from drawn conclusions, and mainly from theories and new questionings which are to arise, Music therapy as a profession will be the recipient of more scientific recognition. This will allow new ways to look at, listen to and think about the music therapeutic setting.

The theme proposed for this research came hand in hand with one of the many possibilities for the application of music in our century, a time when the music therapist turns their attention to a specific clientele (the so-called Third Age), initially changing an essentially socio-educational type of work, that of Choir Workshops carried out in a University Open to the Third Age - UNATI, into a therapeutic form of work, an experiment aimed at generating the necessary data required for the observations which were the object of this study. Since the beginning of choir workshops, about seven years ago, such questionings as the following have emerged:

- By carrying out Choir Workshops for the third age, can the music therapist contribute for the prevention of the Mental Health of the elderly?
- When conducted by a music therapist, can Choir Workshops directed towards the Third Age produce therapeutic effects and/or actions?
- Which music therapeutic activities, techniques or methods are best suited for Choir Workshops for the Third Age?

Starting from a therapeutic education in Music Therapy and an existential theoretical humanistic reference, it is inevitable not to regard each individual as someone who is full of possibilities to be developed, discovered or re-discovered. It is believed that the integration of each
participant of the group has indisputable importance and that the very listening to and the valuing of each opinion, be it about the choice of the repertoire, the selection of songs for a presentation or even about the discussion of the outfit to be worn, add to and enrich the execution of Choir Workshops.

Epidemiology regards Aging and Mental Health as one of the most relevant fields of both study and discussion, with organic cerebral syndrome (OCS) and depression being two of the most important disorders observed among a community's Third-aged individuals.

VERAS (1997) draws attention to the fact that these diseases have an impact not only in the field of health, but they also bear important social consequences in a broad sense. They also have an impact on the life of each individual and their family. The author explains: OCS is understood as the compromising of such cortical functions as the memory, the ability to solve everyday problems, motor ability, speech and communication and the control over emotional reactions. There is no consciousness clouding […] Depression includes the nosological categories major depression and dysthemia." (p. 17 - 18)

An increasing need of attention directed towards this age has been observed and actions have been taken aiming at creating conditions for the re-establishment of citizenship. UNATI, one of such initiatives, is a program which has as one of its motto to "privilege the elderly as the subject of the teaching-learning process, placing emphasis on contents that prioritize their interests, motivations, accumulated experiences, life stories and social context". (LACERDA e SILVA, 1997, p. 12)
When this research was proposed, the possibility of answering the questions mentioned earlier, in addition to documenting the literature on Music Therapy was thought of. Such documentation took place through reflections on the therapeutic potential of a choir, an interdisciplinary study involving music therapy, phenomenology, social gerontology, among other areas, all aimed at reading this contemporaneous "musical making" at the beginning of this new millennium.

**Methodology**

The present existential research-action, with a qualitative approach, limited its subject of study – the music therapists’ contribution in carrying out Choir Workshops for the Third Age, changing it into a therapeutic activity, hereafter referred to as “Therapeutic Choir”.

For the proposition of the problem, several pilot studies were carried out via the Choir Workshop of the University Open to the Third Age, having as a starting point a practice which had in its early days, around seven years ago, an essentially socio-educational character. Conducted by a music therapist with therapeutic objectives in his/her *praxis*, this experience allowed data generation, and the phenomena were then considered the object of the study.

A term was established as the period during which fieldwork was to be carried out. The data was collected from the sessions/classes held with a specific group of participants, as described below.

Fieldwork took place at UNATI, an extension program of the Catholic University of Goiás. The studied population consisted of 50-year-old
students or older. The sample was made up of 26 participants with an attending average of 20 students of the subject Choir Workshop. The mean age was 69 years old.

After an initial interview, regarded as the first session/class with the group, all the participants of the Choir Workshop expressed their desire to participate as volunteers in the research. Such decision was adequately documented through a written consent made by the subject in conformity with the laws regulating research with human beings of the National Board of Health - CNS, 1996.

Twelve ninety-minute classes/sessions were held during the second term of 2000. The music therapist/conductor of the Choir Workshop was the author of this existential research-action.

Data collection was carried out through such instruments as music therapeutic forms, session reports, audio tape recordings of sessions (later transcribed), footage, final statements (by the majority of participants) and the transcribed and videotaped interviews of ten participants. A written consent was obtained form the group of participants/students for the entire process of data collection. Another object of analysis consisted of a video of the last session/class which was later shown to three professionals pertaining to different areas. Their task was to observe the elements of the phenomenon.

The following issues were considered as guidelines for the research: whether the participation in the activities proposed by the UNATI’s Choir Workshop would allow the prevention of the Mental Health of the Elderly, who would feel more motivated to join a group, consequently
improving their life quality in the society; and whether a choir workshop conducted by a music therapist would reach therapeutic objectives and lead the participant towards the self-expression of their feelings, through songs requested by the group; to the re-establishment of self-esteem and to foster greater acceptance of the difficulties naturally brought about by the ageing process.

The research was based on the phenomenological paradigm, which turns itself to the description of the other and the world, starting from the principle that it is not possible to understand what the world is without simultaneously understanding what human existence is and understanding the phenomenon in which it is inserted and is part of it. The participant’s profile was the only item defined from the quantification of information collected from music therapeutic forms.

According to FORGHIERI (2001, p. 48), in phenomenology, “reality for a human being is originally founded on his/her understanding of the situation he/she experiences, in which three temporal dimensions of hi/her existence are implicit: how he/she has been (past), how he/she is being (present) and how he/she might be (future).”

Aimed at the transcendence of the phenomenon and in order to reach the understanding of the essences, the subjectivity of the participants/students, all collected data were considered for the analysis. DELABARY (2001) was agreed with, when he claims that this research method leads to the “very movement of life, transcending the phenomenon as appearance. As a dialectical and reflective process, it can change as the phenomenon reveals itself, and the essences are perceived
though intuition and reflection, moving towards the understanding.” (p. 34)

Participants’ profile
The research was undertaken with the group of participants/students of the Choir Workshop mentioned early. Twenty-six participants registered for the course; however, each session/class had an average number of twenty participants.

As observed in the music therapeutic forms, the participants’ average age was sixty-nine years old; the younger one was 58 and the older 91. Of the 26 registered students, only one was a male. As for marital status, the majority, 58%, was widows; 19% was married; 15% was divorced or separated and only 8% was single.

The majority was born in the State of Goiás, but some participants were from such other states as Bahia, Minas Gerais, Rio Grande do Sul, Rio de Janeiro, São Paulo and Tocantins.

Most participants were retired. Among the professions, there dressmakers, fashion stylist, teachers, secretaries, housewives, salesclerks, shop owners and nursing assistants.

The picture below is a table in which all collected data obtained from the participants’ filling out of the music therapeutic forms are shown. The data allow the view of the musical profile of the participants, as they refer to how often they listen to music, engage themselves in musical activities, musical taste and others. For quantification purposes, only the non-discursive questions are part of the board. The percentages were the
result of options chosen, which implied in the possibility of answering one more alternative per question.

**Figure 106: Data from the Music Therapeutic Form**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Do you usually listen to music?</td>
<td>Yes</td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>4</td>
</tr>
<tr>
<td>- How often?</td>
<td>Very often</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>Not often</td>
<td>26</td>
</tr>
<tr>
<td>- How do you usually listen to music?</td>
<td>Radio</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>Tape recorder</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>TV</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>CD</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>LP</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Live</td>
<td>26</td>
</tr>
<tr>
<td>- Do you listen to music?</td>
<td>While doing something else</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>With full attention</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Just listening</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Dancing to it</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Singing along</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Whistling</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Accompanying it an instrument</td>
<td>4</td>
</tr>
<tr>
<td>- Have you ever had music lessons?</td>
<td>Yes</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>61</td>
</tr>
<tr>
<td>- Do you usually go to parties?</td>
<td>Yes</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>22</td>
</tr>
<tr>
<td>- Have you ever been to a concert?</td>
<td>Yes</td>
<td>91</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>9</td>
</tr>
<tr>
<td>- What kind of music do you like to listen to?</td>
<td>Vocal</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>Instrumental</td>
<td>78</td>
</tr>
<tr>
<td>- What kind of music do you prefer?</td>
<td>Classical</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Gospel</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>Foreign</td>
<td>9</td>
</tr>
</tbody>
</table>
Data Analysis

All the steps followed in the methodology were grounded on the phenomenological paradigm and aimed at understanding the reality experienced by the participants/students. Both the experience and the participants were described. The session/classes were analysed. The interviews/statements, the excerpts, the analysis of the excerpts were presented. A video was shown to three professionals not participating in the experiment and their observations were subjected to analysis. Finally, the units of significance were synthesised. Upon this analysis of the existential phenomenon, the apprehension of the essences and phenomenological dimensions was sought.

In order to better comprehend and understand the essences which emerged from the phenomenon, the basic concepts of analysis of the new social psychology will be used, once phenomenon object of this study have implications of the social nature made evident through the observed psychic phenomena. Such new social psychology seeks to capture man in motion and puts forth as basic concepts of analysis – activity, consciousness and identity – which are their essential properties or characteristics.

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It is believed that the social relations which established themselves in the group are relevant aspects for the individual subjectivity of each participant and for his/her inner world and expressions. Man is a social being, and as a “being” of social relations, he is in permanent motion.

According to BOCK, FURTADO and TEIXEIRA (1999), Social Psychology, as a field of knowledge, studies the human mental phenomena, “seeking to understand how the construction of this inner world from social relations experienced by man takes place. The objective world is no longer seen as a factor of influence for the development of subjectivity; rather, a constitutive factor”. (p. 141)

This constitutive factor is related to the first apprehended essence – “Singing” as a means for self-expression and self-fulfilment – which implies “doing”, the activity and man’s realisation. Human activity is the basis of man’s knowledge and thought, that which builds his inner world as he acts upon and changes his outer world.

This first essence stemmed from the phenomenological dimensions that bear close relationship with the “doing”, with action or the “singing act”: “The importance of joint musical making”; “The pleasure and satisfaction which involve the singing act”; “The knowledge of the voice (the speech system) as a musical instrument”; and “The openness to a new means of communication – singing”.

When one of the participants (Irene) says: “I was able to sing. Singing is my pleasure... at home I’m way too reserved, but I fulfil myself here”, pleasure and self-realisation are evidenced.
This knowledge/recognition of oneself and one’s instrument is evidenced in statements by the participants of the Therapeutic Choir: “I think I have learnt a lot, we have experienced a lot of growth, wisdom”; I’ll be in the choir as long as I’m here, because I think that we acquire more knowledge in the choir”. (Mª Aparecida)

In order to exemplify another phenomenological dimension, the act of singing and being a participant in the group may be cited: “I’ve made new friends besides being able to sing in a group”. (Mª de Souza); “I’m always singing at home. I get up in the morning singing”. (Lylia) Being part of a group, where social interaction takes place, has changed, in this case, into a relevant element for the participants. For BRUSCIA (2000), the interaction carries the worry to engage in the outer world, in the sense of a mutual influence.

As for the second essence stemmed from the phenomenon – The songs revealing the “inner subjectivity/existentiality of the being” – is related to consciousness, the human thinking. Consciousness, as a subjective product, takes place through an active process, which has as its foundation the activity over the world, language and social relations; it is how man relates himself to the objective world, how he understands, changes it into ideas and images and establishes relationships between these pieces of information. Consciousness is not limited to logical knowledge; it also includes the knowledge of a man’s feelings and emotions, the knowledge of desire and the knowledge of unconsciousness.
This second essence stemmed from phenomenological dimensions which imply “thinking”. In the Therapeutic Choir, “thinking” became evident in the songs and their contents, which brought feelings, subjectivity and the affective universe of the participants. The phenomenological dimensions were as follows: the choice of the repertoire as the result of a joint effort; the songs carrying feelings and emotions; the affective universe of the songs making people open up and lose inhibition; and the desires and memories expressed in the words of the songs.

In the context of the Therapeutic Choir, it was observed that by bringing songs, the participants’ memories were valued and the re-establishment of the dignity of each and every memory was aimed at.

The subjectivity that came from the choice of songs can be observed in some statements by the participants. To give an example: “I’ve... always wanted to sing, but never had the chance. When I was a little girl, people used to laugh at me singing. That kept on building up. I never thought I would ever had the chance... The Choir Workshop really helped me to develop. (Alcy)

With regards to the third essence stemmed from the phenomenon – Self-confidence of the “being”, participant of the Therapeutic Choir, making them have expectations towards the future – highlights identity, as a basic concept of the new social psychology. BOCK, FURTADO and TEIXEIRA (1999) comment that identity is the personal synthesis of oneself, it is the name given to the representations and feelings an individual builds of him/herself from his experiences. Identity
is not static or finite, but rather an ongoing process of representations of your “being” in the world.

The phenomenological dimensions found in the interviews and statements, which the third essence stemmed from, were the following: the ability to sing being inherent to everyone, at any age; the value placed on oneself which came from the “therapeutic listening”; singing as a means of instilling self confidence and allowing recognition by other people; the group’s meeting the same ideal – to sing, to enchant and to find oneself; the autonomy on the decision about the ways towards the musical presentation; the wish and hope to move ahead, to go on singing; and the improvement of life quality and mental health as a result of the act of singing in a group”. Implicit in these dimensions are self-esteem, self-valuing and self-confidence, some of the elements that reveal the representation and the feeling that each individual has of him/herself from his existentiality. With regards to a group, there will also be a group identity, that is, the view the participants have of it.

BRUSCIA (2000, p. 90) mentions ALDRIDGE (1996), when he refers to a view on modern health: “Individuals are accepting to become healthier, and in some cases, they declare themselves as followers of the activity of well being [...] it is a reflection of a modern trend, through which individuals get hold of the definition of themselves instead of allowing that an identity is imposed on them by others...” In several interviews and statements by participants of the Therapeutic Choir, this “looking at” health was perceived as a life style, in which a set of activities are incorporated into life so as to promote health and prevent diseases. The
“being” that places value on him/herself is seen, someone who is self-confident, someone who trusts his/her group, someone who looks at him/herself with the hope of “being” in the future, for both the identity and the consciousness through activity are always in motion, in a “being”, just like health, which exists along a multidimensional continuum.

The prevention of problems of mental health and the improvement of life quality of the participants constituted one of the hypotheses and were therapeutic objectives of the music therapist / conductor in this research-action. In order to exemplify the reach of these objectives, some considerations by a participant may be cited:

“One feels really well, it is very good for the health, for the mind, for the heart. The choir is something wonderful for the third age, at least in my conception”; “it brings happiness, peace, it makes us extroverted. One feels peaceful, one feels happy”; “After I joined the choir, I fulfilled myself, I improved”. [...] “It was a magnificent experience, we integrate ourselves there”; “… we forget the problems and sadness and pains of our age. It is wonderful and beautiful to sing, it feels as if we transport ourselves to the infinite”. (Amélia)

As for the hypotheses established during the development of the research, it is necessary to undertake some reflection about the phenomenological analysis of this research-action. The former, commented on above, was confirmed as being one of the phenomenological dimensions that caused the third essence to stem from the phenomenon – the improvement of life quality and mental health as the result of the act of singing in a group. The second hypothesis, also
confirmed, regarded the music therapist conducting the Choir Workshop and reaching therapeutic objectives as: 1) leading participants towards self-expression of his/her feelings, through songs requested by the group; 2) re-establishing self-esteem; and, 3) enhancing, throughout the sessions, acceptance of the difficulties brought about by the natural process of ageing.

To exemplify the first therapeutic reach, related to self-expression, the following quote may be used: “you gave us the freedom to go back to past experiences – childhood, youth and middle age – I’m speaking for myself, in my 80s; with songs from the passionate times of those youth days”. [...] “To be lulled by the melody and songs of your class was for us a time of happiness, we didn’t even feel the time go by here.” (Dativa)

On self-esteem, approached in the second therapeutic reach, the following example, a statement given by one of the participants, can be used: “Singing is good for us and it is also therapy, that’s why I enrolled myself in the Choir Workshop of the UNATI of the UCG”; “Singing increases self-esteem, it is good for the mind, body and soul”. [...] “By singing, we pass the love and affection on to the people who listen to us”. (Alcy)

The third therapeutic reach, where the acceptance of the difficulties brought about by the natural ageing process stemmed from, may be exemplified with the following statement: “Going on the 'great journey' is not far from now. So we enjoy ourselves with the choir class. We take advantage of this time to do the things we didn’t have the opportunity to do. Let’s put it this way, we are going to multiply... well, exaggerations
apart, we are going to add some more experience on to our lives, the hope to achieve more ahead, right?” (Mª Rita)

The Therapeutic Choir for the Third Age aimed at offering the participants of the group a sense of fulfilment, motivation to live, satisfaction/pleasure, the prevention of Mental Health; the improvement of life quality; the improvement of intra and interpersonal relationships and social interaction; a stimulus to re-establish memories and value the dignity of each and every memory, the perception of others and their sound universe; and the understanding of subjectivity, of the inner existence of each individual.

Finally, it is worth pointing out the new concept which arose from this process of existential action already finished: A **Therapeutic Choir** consists of a group conducted by a music therapist, with therapeutic goals, in which the voice is used as a resource for communication, expression, satisfaction and social interaction. By singing, the participants express their subjectivity, thus letting out their inner existentiality.

### Final Considerations

In their life, every individual, whether a professional or not, has had, has or will have some kind of contact with the elderly. Therefore, knowledge of this phase in life has to be made available and aimed at preparing for a full and quality life experience with the universe of this age band.

BINSWANGER, quoted by AUGRAS (1994), when commenting on the concept of existential horizon, clearly shows that, in each individual's life
experience, there is no separation between the past and present. The future intertwines itself with past and present experiences. In this order of ideas, the past is not immutable, for the meaning of any event changes itself together with the history of the individual. The future also has its role as hope and fear. In the light of this view, the past is not the factor that determines the present, which in turn, does not determine the future either; rather, it is the sense of the being's route what changes the meaning of the past and the present.

It is believed that it is possible to offer the elderly a feeling that is different from that which states he/she is only a survivor, so that he/she is also an agent who is able to carry out social and emotional actions/relations. Throughout this research, it was observed through the examination of all the collected data that this construction of the being is an ongoing process which takes place in all phases of life. Being aware of this process and its continuity may be a great differential for the quality of life of each and every individual.

In phenomenology, the periods of time - present, past and future - are interconnected. When the past is thought back to, one is bringing it to the present, and when the future is thought of, the present takes place.

The music therapist ought to take all these aspects into consideration, all this subjectivity when he/she establishes his/her therapeutic goals. In the Therapeutic Choir, these aspects are directly connected to make the participants' communication, expression, satisfaction and social interaction available, with the voice being the main resource.
When one has the possibility to bring together the past, present and future, the integration of the being is achieved. Such integration may be brought about and facilitated by music, which adds the view not only of the person that ages, but that of the being he/she is, of his/her essence. When memories are brought into the present, through songs, a reflection of the past is also brought; and when an individual has expectations towards the future, such goals as keeping singing and growing, the thought of the future in the realisation of the present takes place. If the "being" does, he/she is, he/she has expectations towards the future, and such expectations make him/her be today. If he/she lives in the past, he/she is not, he/she was, he/she will not be. If he/she has no expectations towards "coming to be", today he/she is no longer, he/she was!

As to the researched phenomenon, the voice work results of a set of organic-functional and emotional factors; therefore, by offering better life quality, it is possible to offer vocal benefits and satisfaction. MARTINEZ (2000, p. 202) refers to this when he says that "…the entire body is involved in vocal production, and much more than this, the entire life is, too. That the voice alters according to emotional states is clearly perceived […] so, seeking good emotional health brings about vocal benefits.

The **Therapeutic Choir** may be related to the choir's major essence, when it appeared in Ancient Greece. The choir had then the role to symbolize and express the Dionysic feeling of the people who watched the tragedy and felt an emersion of subjectivity in that sound expression. Similarly, the Therapeutic Choir makes it possible for its participants to
express themselves, this self-expression carrying their subjectivity and letting out their inner existentiality.

CHAGAS (2000), when commenting the expectations for the professional of the new millennium, claims that he/she "will be engaged in situations that involve collective health, awareness of creating expression, artistic expression, or even social life through musical symbols. He/She might contribute for the effective analysis and intervention in local communities". According to the author, the music therapist may contribute for the establishment of another aspect in discourse analysis in psychosocial methodologies: the musical discourse analysis.

After this research experience, the **Therapeutic Choir** is believed to allow the engagement of the music therapist in fields mentioned by the author. In addition, it is proposed that the role of this choir, this new concept, be extended to other areas of this professional's performance, motivating new "ways of thinking" that are based on praxis and creating new "ways of looking at" and "ways of listening to" to contribute, together with other professionals, with the search of a greater objective, which is the improvement of the life quality of the "being".

It is believed that the theme studied may serve as contribution for other studies, mainly in the fields of Social Gerontology and Music Therapy. By examining the results of these analyses, new ways of instrument identification are expected to be generated, and they should aim at the grouping and/or identification of elderly people for future programmes and/or assistance projects.
As a partial and concrete victory of this research, the term **Therapeutic Choir** was adopted in substitution of the former Choir Workshops, one of the subjects offered by UNATI, an extension programme of the Catholic University of Goiás in the first semester of 2002. Such gain is definitely evidence of a qualitative change for the area of gerontology, once the practice of the Therapeutic Choir has also become an academic activity and might influence future work carried out in Music Therapy, as well as a contribution with the literature in its domain areas.

Finally, the claim made by COSTA (1992) and quoted by RODRIGUES (1999), p. 17) is agreed with: "...getting involved with the third age stands for or demands from the therapist at least a reassessment of his/her concepts and preconceptions related to ageing and other issues directly related to him/herself and death."

Therefore, in order to deal with all the essences stemmed from the phenomenon, it will be necessary for the music therapist to deeply reflect on themes related to life and death, in addition to re-thinking "his/her" relationship with time's multiple dimensions.

**Bibliography**


de Especialização em Educação Continuada e a Distância.


Before I relate the particulars of the case, I deem necessary to emphasize how my work in music therapy is sustained by the theoretical principles of Humanistic Psychology and by Neuro-Linguistic Programming.

Humanistic Psychology begins by postulating that each person has within themselves all the necessary resources to adapt to the environment in which they live; these same resources, if adequately used, allow individuals to resolve their own internal conflicts (Rogers, 1961). No one is able to help a person in difficulty directly (Freud himself stated that “to cure, educate, and govern” are three impossible tasks).

Yet, it is possible to help individuals realize their own potentials, creating the “opportunity” around the person to draw from their personal resources, the end being the ability to access their problems.

According to such conception, the preferable context for opportunity is constituted by a situation in which an empathic listening activity is present. Carl Rogers, one of the founders of humanistic psychology (along with Maslow and others), sustains in fact that empathic listening, which is not judgmental but accepting, contains within itself a valuable source of help.

In Music Therapy, empathic listening has as protagonists a “facilitated person” and a “facilitator”. According to Rogers, the facilitator is not a person who maintains formerly constituted models and theories, as is true
in psychoanalysis and behaviorism, on the basis of which he or she might diagnose and classify the behavior of the subject. There is neither a theory of pulses on the one hand, nor of apprehension on the other, that might allow them to interpret or label in any way what is happening to the person in front of them. On the contrary, the unconditional positive trust in the inherent potential in every human being causes the facilitator to temporarily consider the cognitive and behavioral strategies of the subject as valid an as the best possible, given the circumstances. The humanistic concept in fact implies total acceptance of the other, no matter how the other presents himself or herself.

This means respecting the individual and their differences, leaving them freedom of choice, and favoring the generation of self esteem and growth in relation to themselves and to others.

These aspects, that beyond the reach of other experiences imply “creativity” and “love”, have often been left aside by psychoanalysts and behaviorists.

The usefulness of the art of music in therapy is confirmed, however, precisely by the Freudian interpretation of the artistic creative process: Freud considered the production of art as sublimation of primordial instinctive impulses, particularly of sexual impulses. From this we can deduct that musical improvisation is in reality an “acceptable form” by which we can express our most wild and uncontrollable sentiments.

We might say that the psychoanalytic perspective is centered mainly around the finished artistic product, seen in a reductive, deterministic understanding, while the humanistic vision gives relevant importance to
the “process in action” in the change process (both the subject and the music therapist are involved as participants in the interactive process of music therapy).

In music therapy, in order to make a relationship effectively “therapeutic,” that is to say capable of facilitating the desired change in the subject, the principles sustained by Rogers (unconditional acceptance, empathy, genuineness and coherence), are to be valued.

Our first objective is thus the formation of an environment of unconditional acceptance for the little girl that we are caring for, empathizing with her by means of various techniques, which we will look at further into our account, and most importantly concentrating on what is happening at the present moment rather than seeking to trace the assumed causes in her past.

I seek to be myself in the relationship with the child, in order to create coherence among that which is perceived on a visceral level, that which is perceived on a conscious level, and that which I communicate to the child.

THE ACCOUNT OF A CLINICAL CASE:

I shall report the case of Letizia, a ten-years-old girl diagnosed as being autistic, which I have been working with for five years using music therapy.

This young girl began with sessions of music therapy at the age of four and a half, after a year of psychomotorial therapy.
Clinical History

First and Last Name: Letizia
Date of Birth: 12/26/1991
Referrer: Dr. N.G. (Psychotherapist, infant neuropsychiatry)
Date of first observation: May, 1996
Became an official patient: September, 1996

Reference Team:

NEUROPSYCHIATRIST: Dr. N. G..
PSYCHOMOTORIST: A. M.
MUSIC THERAPISTS: Ms. M. Zaru (‘96/’02), Ms. A. Cogliandro (‘96/’98)
SCHOLASTIC REFERENCE: helping teacher
OTHER SPECIALISTS

Medical History:
The mother had an automobile accident during her fifth month of pregnancy; there was apparently no organic damage. She recalls experiencing great fear.
The child burnt her right hand at the age of 11 months.

Diagnosis: **Atypical Infant Autism** (diagnosed by the Unita' di Psicopatologia dell'eta' evolutiva - Associazione La Nostra Famiglia [Early years psychopathology unit - la Nostra Famiglia association] - Bosisio Parini (LC))

Excerpt from the report of the infant neuropsychiatrist and the psychologist of the early years psychopathology unit (la Nostra Famiglia association - Bosisio Parini (LC))

"… the child's social withdrawal forms the frame to a series of actions that reinforce Letizia's tendency to remain in an isolated condition."
The **most influenced areas** resulted to be those of **communication**, **social relationships**, **attentive-perceptiveness**, and of **emotional-instinctive reactions**.

With respect to the area of communication, emphasis is placed upon Letizia's **limited usage of verbal communication**. The child often **produces meaningless sounds or incomprehensible words**. Her **non-verbal communication** is poor and redundant.

The area of social-relational abilities is also strongly influenced. **Letizia tends to not interact with the environment, and proves indifferent to stimuli**…

**Eye contact** is **evasive**.

In the area of emotional-instinctive reactions, the following forms of behavior have not been detected: anger and explosions of anger; anxiety in the midst of changes; separation from her mother. These data can be connected to the difficulties the child has in allowing the things that she experiences stimulate her (Letizia **remains often indifferent to the stimuli of her surrounding environment**).

In some instances Letizia has externalized **motor stereotypes** (**waving of the hands, jumping**) as well as **hyperactivity**. She evidences a **great compromise within the relational sphere**. There are moments of **heteroaggressiveness**…”.

The child is being assisted by two music therapists: Monica Zaru (‘96/’02) and Aurora Cogliandro (‘96/’98). The starting point of our involvement is not represented by the medical diagnosis, though it is read with careful attention, but the contingent situation. This, as I explained initially, specifically to avoid "labeling" our little client.

At the outset, Letizia showed to be closed within herself, escaping our eye contact, constantly moving about, and to have a number of stereotypes. It seemed impossible to establish contact with her, even for a few moments. She often pinched violently anyone that tried to get close to her.
Both at home and at school, her hyperkinetic behavior, her lack of attention and of capability to interact with people constituted a source of continuous problems.

She manipulated the materials with apparently senseless gestures.

Her look seemed to be constantly lost in space, and she never concentrated for any period of time on objects or people.

From the first session we tried to begin a relationship with her, in order to gain her trust; in the terminology of Neuro-Linguistic Programming, we tried to establish "RAPPORT:" if we wanted to help the patient towards a change, we would have to convince her to trust us. We had to create a "safe haven" for her, that would allow her to begin again to observe reality and thus enrich her view of the world, which had been impoverished by limiting experiences and convictions.

We sought to create a context of opportunities for Letizia, so that she could regain her deactivated resources and put them in function.

This goal was pursued through the activities of Matching, Pacing, and Leading. Matching and Pacing are the basis for the establishment of the above mentioned RAPPORT. Leading indicates the contribution of novelties that the therapist introduces as a creative person, by the simple means of being present as an empathic listener and as an active interlocutor.

It is fundamental that the music therapist know how to translate the other's world in an sonorous-musical mode just as the therapist perceives it within the empathic relationship.
Since Letizia did not speak, the only elements we had were constituted by the observable behavior. And so I tried to reflect, trace, the expressions and movements of the child by means of musical improvisation on the piano.

The process of reflecting occurred using fine calibration: the child communicated with her whole body: posture, facial expression, tone of voice. Everything was interpreted musically.

In this way Letizia perceived the audible presence of the music therapist and reacted in a positive way, accepting relation.

The establishment of rapport provided us with a great deal of information that aided us in conducting a first evaluation of the capabilities and potentiality of the child. We inserted a little girl in a motivating context, in which she was stimulated to function not according to forced sequences (such a context would falsify the very results of the observation); this allowed us to make more detailed, indirect observations concerning:

1 **Motor skills: posture, prehension, walking, jumping**
   
   The posture and movements were generally rigid. Stereotyped movements were present spinning on her own axis, fluttering, etc.). Her body was often in hypertension.

2 **Prehension and ocular/manual coordination (manipulation of idiophone musical instruments):**
   
   Letizia grabbed objects but did not observe the suggested games or activities; moments of visual avoidance of objects and people were frequent.

3 **Time-space coordination (movement and rhythm)**
The child seemed sufficiently well oriented in terms of space; when she would enter the music therapy office, she would immediately move towards the instruments that interested her;

Concerning temporal coordination, her mother told us Letizia knew exactly when it was time to go to music therapy. This evidenced that the child had a good internal concept of time.

Furthermore, we verified that the child was not capable of waiting until the satisfaction of her needs, the urgency of the pulses caused her great anguish, which translated into an immediate accentuation of her stereotypes.

4 **Breathing:** at times, she was contracted. Letizia often had moments of apnea; her breathing rhythm was irregular.

5 **Vocal qualities:** she did not use her voice in the central register, and often emitted acute head sounds and a sort of "RRRRRRRRRR.

6 **Time periods of attention and listening:** very brief. Letizia was in constant hyper kinetism; she demonstrated the desire to change instruments or activities after just a few minutes.

7 **QUALITATIVE COMPROMISE IN SOCIAL INTERACTION EVIDENT IN THE FOLLOWING ASPECTS:**
   
1 Inability to adequately use: face to face visual contact; facial expression; gestures

2 Inability to develop relationships with peers in terms of common interests, activities, and emotions

3 Lack of social-emotional reciprocity; Lack of or abnormality in responding to other peoples' emotions; Lack of modulation of her behavior in accordance to the social context; Defective integration in social, emotional, and communicative behavior

8 **QUALITATIVE COMPROMISE IN COMMUNICATION**

1 Total lack, initially, of verbal language, which was not compensated by the use of gestures or of mimic as alternative means of communication.

2 Inability to initiate or maintain a conversation in which there should be a reciprocating response to the other person's communication.

3 Repetitious and stereotyped use of language (stereotyped or repetitive language, bizarre language, echolalic language).

9 **LIMITED, STEREOTYPED, AND REPETITIOUS MODELS OF BEHAVIOR, INTERESTS, OR ACTIVITIES**
1 Pervasive concern toward one or more limited and stereotyped interests
2 Apparently compulsive adhesion to specific or dysfunctional practices and rituals
3 Desire to maintain certain activities that remained immutably stereotyped
5 Heteroaggressiveness (pinching, biting)

Observations concerning these points were continuously recorded and integrated with the data from the anamnesis and the diagnosis.

The use of instruments proved to be of great importance. We have various types of materials: flutes, drums, trumpets, wood sticks, recalls, bells, audio games, colored ribbons, etc. It's necessary to have different techniques and materials available, to be used according to the way in which the situation develops.

Each session, the child came in having expectations, needs, moods that differed with respect to the previous session. It was thus necessary to have the capability of continuously adapting, and a great deal of flexibility, always working towards the objectives that we had set as goals to reach.

"Flexibility" thus does not mean "not to know what to do," but rather it means to know how to "interpret" the emotional state of the patient, to have numerous and precise techniques for intervention, and to choose the most adequate and effective of these.

Letizia's body was stiff and locked up, her voice often piercing: by blocking the body's major cavities and impeding their resonance, the
human voice can resonate only within the head's cavities, the smallest, those which allow the shaping of the most acute sounds.

By means of Resonance and Resonant Dialog, we tried to lead the child towards the development of her own harmony, in harmony with the vitality of relation.

**Resonance** is controlled by using the large harmonic case of the grand piano. It provides a frequency gamut which is almost complete (from 27.5 to 4186 Hz).

The child, laying on top of the piano, found in the resonance the warmth of being accepted, understood, cradled by way of the musical-resonant game "improvised" by the music therapist.

**Musical Improvisation**, which must be the expression of the enactment of empathic listening, develops on various levels:

- harmonious: sequence of both major and minor tonal chords
- melodic: use of modal scales, major and minor diatonics, pentatonics, chromatics
- rhythmic: rhythms and accents are used according to different modes
- timbric: a rhythm, a melody can be gradually performed on various instruments; at times, the instrumental improvisations can result in vocal improvisations, as occurs in the footage we will show.

Improvisation can develop also in the form of **Resonant Dialog**: the child's ideas are incorporated and amplified by the music therapist, which introduces some personal variations; this may lead to a second response
on the part of the child, which is again acquired by the therapist. It becomes an actual non-verbal dialog.

In the case of Letizia, the resonant dialog occurred with different instruments, or, at times, with glittering materials that she would move in different ways, always relating to the sounds coming from the piano, to which she was very attracted.

Letizia knew that she was responsible for the changes in my way of playing; her relaxed facial features brought me to think that this might have been making her happy. I had captured her attention.

Through reflecting and resonant dialog, the facial and corporal means of communication also slowly began to change: her glances were focusing more frequently on the eyes of the music therapist; she was searching for her with her eyes and her hands (no longer with her feet), searching for physical contact by hugging her.

The sure foundation was by now set in place. The expressions of attachment became numerous and continuous. Explorative behavior began appearing naturally (exploration of the musical objects). Both the music therapists became very attentive in maintaining contact with the little girl on every level (visual, audible, kinesthetic).

We suggested new games, being at this point accepted by Letizia to a good degree; she cooperated actively and creatively in the shared sonorous game.

The child often sought contact with her feet: she wanted us to grab them with our hands to play, or she would attempt to play the piano with them.
Sometimes I would allow her to do so, as I believed the child was using her feet and the piano itself as a means to relate to us, as a sort of "transitional object."

Any music instrument can become a transitional object in the Winnicotian sense of the term; it can be "used as a bridge between the inside world and the external world of the child, and between the child and the adult." (Leslie Bunt, *Music Therapy*).

The game performed with hands presented itself in the following phase, and appeared to us as a major conquest. The same trail was followed by another older autistic girl, which we treated with music therapy.

Stereotypes were more frequent during those moments in which the child felt a strong emotion, due for example to the realization that she had allowed herself to be too involved, of having in a certain sense "uncovered" herself.

We sought to transform the stereotypes, which were often detectable by strange movements of the hands, into a musical game, into a little song, or something similar (e.g. "Clap your little hands").

We made ample use of **childish folk songs** (which we illustrated on paperboard), which proved to be extremely effective: the singing voice, as opposed to the spoken voice, returns the words to their original nature.

The voice, which is the first musical instrument utilized by man, plays a fundamental role within music therapy: the use of children's folk songs favors games of reflecting ("This is the beautiful eye, this is its brother, 'hi'…"), games with numbers ("This little piggy went to the market…"),
games of movement (ring around the roses, horsey, etc.), learning and respect of rules (who gets to pick first), the apprehension of language itself.

Folk songs also have a very strong symbolic and communication value in the interpersonal relationship between an adult and a child.

Letizia understood the affective value of singing from the start, and we were able to verify that she later came to the comprehension of the significance of most of the sung words.

With the passing of time, the periods of isolation began to diminish greatly. When they did occur, we endeavored to remain calm, open to renewed physical contact, yet without seeking the child in an overbearing way. The message we were thus communicating was "go ahead and distance yourself, put us to the test in all the ways you think necessary in order to verify whether or not you can trust us. We are here and waiting for you, but it must be your own free choice."

The early vocalizations of Letizia were characterized by acute sounds (approximately 1500 Hz), their intensity ranging from weak to medium-strong. We tried to emulate the timbric characteristics produced by the young girl both with our voices and with instruments. Slowly, melodic elements and singsonging began to appear.

Her voice timbre gradually changed, reaching the sonorities of the central register. Letizia improvised a song, and finally sang the words to a little tune.
WHAT CONVICTIONS WITH RESPECT TO THE HANDICAPPED CHILD, OR TO A CHILD WITH PROBLEMS IN GENERAL?

Making reference to the humanistic vision, I consider the handicapped person as one having common needs and necessities, which must be safeguarded with determination. Just as with every child, even he or she is the main character in his or her story; unfortunately, it has to do with a trail that is marked by suffering.

If the experiences lived during the early stages of life have been painful, for any given reason, the child will probably have elaborated a sort of negative script with respect to their own life... but even a handicapped child, just like any other child, possesses certain potential areas that need to be developed. He or she has the potential, just as the other children do, to better his or her own condition and modify his or her personal "script."

The therapist must momentarily take on the child's vision of the world and make the child aware of the freedom of choice that he or she can have. Every change, be it even minimal, can be valued, thus favoring the beginning of a constructive and truly therapeutic relationship, bringing forth a positive alteration with respect to the initial situation.

Letizia was considered firstly as being a child, and then within her pathology. This is possible only when one is able to see beyond what is apparent, recognizing the HEALTHY NUCLEUS of the individual ("appreciation of the healthy nucleus" -).

The concrete results obtained during these years of work in music therapy have confirmed the above described theoretical principles:
heteroaggressive behavior has completely disappeared, stereotypes have been reduced, and a discreet attentive capability has developed. Letizia is capable of being still and participating in a shared action; her eyes follow whoever is speaking to her or interacting with her; she understands the language, and words begin to appear.

Relationships within the home and at school have decisively grown better, as she has also learned to cooperate in small daily tasks. In relation to her state at the beginning of therapy, she has acquired a great deal of autonomy.

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CURRICULUM VITAE

- Diploma in Music Therapy at Bristol University (italian seat) and in Piano (Conservatorio "G. Verdi" Milano)
- Music Therapist at the "Centro Socio-Educativo Ripamonti" (Mi) and at A.P.M.M. Association Pedagogical Music and Music Therapy (Bg)
- Teacher of Piano and Activ Music at the "Civica Scuola di Musica" Corsico (Mi)
- Teacher and Trainer in Pedagogical Music at the “Civica Scuola di Musica” Cesano Boscone (Mi)
- Concert Pianist

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Can Music Help? Music Therapy with Traumatised Refugees and Torture Survivors

Zharinova-Sanderson, Oksana

For over 2 years I have been working at the Treatment Centre for Torture Victims in Berlin as a part of a project organised by the University of Witten-Herdecke and sponsored by the German Nordoff-Robbins Charity. The process of establishing music therapy services and my learning curve as a therapist in this place were very intense. As you see from the title of this talk, I want to talk about the question that I was confronted with throughout my practice, asked by clients, colleagues and myself – can music therapy actually help these clients and if yes, how?

The Treatment Centre for Torture Victims in Berlin is the most well known organisation in Germany that provides medical, legal, social and psychological help for traumatised refugees. It is also one of the only such institutions, where a full time music therapist is engaged. Music therapy was introduced to provide a non-verbal therapy to compliment the verbal therapies that rely on the help of an interpreter and to provide these people with a direct unfiltered way of communication. At the start, most of the therapists in my team felt that the music-centred music therapy that I was practicing missed the “the main” issue of the work – the trauma itself, and thus the effect and relevance of music therapy was extensively questioned by my immediate colleagues.

At the start of my work my understanding of what music therapy could offer these clients was limited as well – since not much written material
about this kind of work was available. Also at first I had little idea about
the musical and cultural worlds of my clients. My gradual discovery of
the extremely insecure circumstances of their lives in exile only added
questions as to how music therapy could benefit them. What does music
therapy offer these clients, first tortured in their countries, then uprooted
by emigration with years of waiting for asylum with fears of deportation
and no chance to work or settle properly in their new country?

Let’s start unravelling this question by looking more precisely at the
clients.

The clients that I see range greatly: in age, culture, nationality, education
and degree of traumatisation. Perhaps surprising as it may seem torture
and traumatic experiences are often not their most urgent concern.
Instead their insecure residential status and unhappy life in exile without
money, freedom of movement or employment, and fear of threat of East
German neo-nazis – these are the most vital issues that are shared by
every client that comes through the door of the centre. Because of their
refugee status there is very little help available for them in the German
health service, so they flood in into our privately run centre for every
help that they can get, mostly for social help and support in the asylum
seeking process.

It is underneath these issues that lie the suffering caused by the trauma
and, resulting from it, the symptoms of posttraumatic stress disorder. The
life of most of our clients is dominated by such symptoms as acute
insomnia, nightmares, extreme psychosomatic pains, phobias and panic
attacks, suicidal thoughts and communication problems. Despite these
symptoms, they often do not seek medical help or simply do not understand what therapy is and what it can offer as in their countries these sort of ideas often do not exist at all, exist only in the big cities, or are understood as something that only “mad psychiatric” people need. This results in the fact that only about a third of people who come to the centre are motivated and open for treatment.

One could speak for hours about the various people that I came across in my work - from a Kurdish political activist to the African woman whose husband and children were murdered, from a Government official of Chechnya to a Kosovo orphan. The human characters and the “Music persons” that live within them differ enormously and come across most distinctly through their use of the music of their ethnic cultures. The abundant use of ethnic songs is one of the most characteristic features of music therapy with this clientele. It is also something that seems increasingly to me to be the focal point of the therapy of many clients – a point at which we often meet for the first time, a point at which the most damaged and depressed clients often come alive and a point at which new meanings are improvised out of their powerful cultural heritage. Today I want us to listen to and think about the meanings that these musical moments carry within them.

I will start with an extract from a session with a 17-year-old Turkish girl. Her family, especially her uncle, were involved in political movement against the government and she was tortured in a Turkish prison. When she was let out, in order to protect her, her family organised her escape into Germany where some of her relatives lived. She was 14 then. The
song that she sings in the next extract was the song that her uncle imprisoned in Turkey used to sing (she fears that he has been tortured to death). In her improvisations she was normally very lost and unfocused, looking for a direction from me. Here, singing the music of her country she is very committed and clear and communicates the power of her inner spirit.

Such structured ethnic songs were often a starting point for mutual musicking between me and the clients and a chance for me to understand better their musical world. While for most of them playing the instruments in the music therapy room was an experience unconnected to them, singing often seemed totally integral to their identity and therefore became my way in to their musical worlds. My relationship to their singing has changed in the time that I have been working. At first I tried to accompany it, to sing with it, but I often felt that I could not match the character and the flavour of their singing. Then I asked myself what was the therapeutic point in this and often felt that my intent listening to their singing was more important than stylistically flawed accompanying. Listening intently helped me to understand their singing quality, which gave me a particular empathy with the spirit of their culture.

I ask the clients about the song texts and try to learn some of them, letting the clients teach me the beauty of their language. That often created lots of humour in our relationship and changed our fixed roles whereby I became the one that did not know and they were the ones that were the experts. Trying to understand the context that they used to sing it in provided me with another opportunity to feel the flavour of their culture.
that was so important to them. Singing often brought out memories, thoughts and ideas from their home that they wanted to share with me. With their limited German, often with the help of signs and drawings, they poured out such images and memories. Their nostalgia for home and their pride for their own culture became shared in this way with me, which created a special bond in our relationship.

As my work developed I could musically meet my clients in their songs better. It was as if I become acculturated as a musician, like a musical ethnographist that goes from village to village and by the end feels that the songs became part of him. I even could sing the words of some famous Bosnian or Kurdish songs because clients would repeat it and I would gradually digest it. I see this process of my acculturation to the clients’ music as important in the therapeutic process as the clients’ adjustment to mine. In the environment of their lives, society rarely moves towards them, trying to understand them – it more often demands the emigrants to forget what they are and to adjust. I believe that it is especially important particularly in the initial sessions to fully accept and celebrate their culture, however different from mine it might be.

The next two extracts come from work with a client where such a process of mutual acculturation took place. He is a Kurdish man from Turkey who used to be a village leader. He was imprisoned many times and was tortured, which included being beaten on his head, feet and back and receiving electroshock to his genitals. After years of living in hiding, he escaped to Germany, whilst his wife and children decided to remain in Turkey. In Berlin he was homeless for a long time and for the last 3 years
he has lived in a refugee hostel in a remote village outside Berlin, being generally very depressed and drinking excessively out of despair. After the initial sessions with me he did not come again and only by chance I found out that he was too embarrassed of being alone with a young woman in a therapy room and would only come back if there was another man there. A Kurdish interpreter, who he trusted, was invited and we tried again. In his presence the client felt freer and sometimes even dared to look at me when we played together, like for example whilst singing the following song. This is a song about the losses of friends, of true commitment and of faithfulness and a wish to regain them. I feel that moments like these were the stepping-stones in his growing trust in me – in which he learned to recognise my musical accompaniment as an integral part of his song. Here you will hear that he has consciously chosen to play guitar, not an instrument from his culture, instead of Saz, an ethnic Kurdish string instrument that he originally played in the sessions. In this indirect way he showed me that he has become aware of and was appreciating the qualities of my participation in his music, explaining that guitar’s scale seems to him to sound more appropriate than the Saz, when accompanied by the piano.

Extract 2

The interpreter that worked with us very quickly abandoned his role as just a verbal mediator between us and became a part of our musical ensemble. This is how our trio came to life. We were asked to perform
for a public event at the centre. The client agreed as he found this an exciting chance to communicate the spirit of his culture to a broader audience. Whilst we were rehearsing one of his songs for this occasion, we started dancing and felt that we needed a fourth person for the symmetry of the dance. The client suggested that it should be a woman and a colleague of mine joined us. Dance and music are often intertwined in the clients’ cultures and thus in their expressive language - one enlivens and reinforces the other. That is why I sometimes see dancing with my clients as important as musicking with them and it often leads into it and comes out of it. In the next extract you will hear the four of us practicing the song, drumming and dancing.

Extract 3

Extreme lack of trust is often a central issue in work with these people, who have experienced such violence in relationships with other human beings. I believe that the development in this client’s therapy lies in him learning to trust and enjoy the relationship between us as it grew through our music making. The separate worlds that we both started from grew into a common musical territory that united us. Sharing our musical unity with a wider community was a symbol of his willingness to open himself and to move towards re-affirming his belief in the worth of the human communication. It was also for me a confirmation of the inherent forces in shared music making, the forces that integrate, forge new communities and create trust.
One feels incredibly privileged to come in touch with so many different expressions of humanity in its geographical and cultural variety. The next example comes from group work with women from Bosnia, Chile, Turkey and Angola. All of them were victims of wars or political regimes and have either been raped, suffered violence or the murder of their close relatives. They did not share a common language, but made effective use of non-verbal ways of communicating like gesture, mimic and movement. The woman who is featured in the next extract comes from Angola, where her husband and one son were murdered in front of her, and her other children disappeared with no trace. She is extremely fragile, weighs about 40 kilograms and often looks more like a ghost than a person. She often does not come to the session because of feeling weak. She understands not a single word of German and often looks absent. Here whilst we are sitting in a circle on the floor singing, she suddenly remembers a song from her home. She grabs my hand and starts swinging it. You will hear her singing one phrase, stopping, trying to remember the phrase till the end, failing to do so and then the group members trying to repeat the previous phrase for her even though they do not know the song and all but one of them do not understand her language. There is a sense of achievement in the group when she remembers the refrain and a strong feeling of support for her. The Portuguese words that she sings can be translated as: “If you love me with all of your heart, then show me your smile, give me your hand, and then you will be my brother”.
Such sharing of each other’s music was a powerful process of creating connections and a new feeling of community in the group. The music therapist and researcher Brunjuf Stige (2002) talking about culture and music says that the meaning of musical expression is always context-dependent. Whilst singing their songs in the group these women were singing them in a new context, away from home, away from people with whom and for whom they had been usually sung. Thus this music not only becomes a symbol and a restatement of the person’s culture outside of its original context, it also creates a new culture encapsulating the new surroundings and new people. The musical piece thus evolves, new voices and accompaniments are added to it and it becomes a medium of transformation for the person who sings it and for the group as a whole.

Alongside some positive developments in my work I continue questioning whether anything changes in the life of these people as a result of musical meeting or am I falsely taking for granted that music making is helpful for them? There is often discontinuity in the process of therapy due to the constant outer insecurities of the clients’ life in exile – threats of deportation, very difficult living conditions, lack of money and difficulties dealing with the every day life as an asylum-seeker in an unwelcoming foreign society. Every session often feels a thing in itself, the experience of “here and now” becomes the only thing that the client and I can grab on to. Here I feel lies one of the strengths and benefits of music therapy – in its focus in the present moment, which they have to
create every time anew if they are to survive the challenge of their uneasy lives. It feels to me that rather than looking for long term aims I have gradually transferred my attention into looking for the music within them, that will help them to remember the life skills, that they learned in their lives before the trauma – that of using their innate creative energies in the now, that can give them strength and hope to fight the darkness inside and around them. The clients themselves have told me that they feel different inside as a result of musicking despite the outside circumstance. To quote the words of one of the clients, “I feel proud again to be me when I play with you, and this gives me the strength to hold on in my struggle for the future and not let the circumstances destroy me”. This statement highlights for me the biggest need that these traumatised, and often lonely and isolated people have – it is simply their need for another person to accept them and value them for what they are. Many of them have lost their loved ones, families and friends. They are hungry for human communication and have forgotten what it feels like to be in a supportive and equal relationship, to work on it, to carry responsibilities, to initiate ideas, to have wishes, hopes and to trust. I feel, that this is where the work and the relationships that were created in the process of our music making were of value and where music therapy was having the biggest impact in their lives.

For the client, whose words I have just quoted, the rediscovery of a sense of pride and faith in himself was indeed a central part of his therapy. A twenty eight-year-old Palestinian man, who passionately fought for the idea of Palestine as an independent country, he was tortured for months by the secret police in a Syrian prison and had been broken into betraying
his Palestinian Secret Organisation’s colleagues. Fearing further confrontations with the secret police he escaped to Germany, leaving everything behind, including his fiancée and hopes for an active involvement in his country’s future. His nostalgia for home, his loneliness, the fact that he had no right to work and his fear to be deported back into the hands of his torturers led him to an attempt at suicide. In the song that you are about to hear, sung in English, there is a feeling of despair that he communicates with power. Such feelings of loss and despair are a recurring theme in the therapy of many traumatised refugees. This song is a romantic ballad, which was for him a statement of the many losses in his life. At the end of the singing he says, “This is what happened with me”.

Extract 5

In my experience such a sense of unreachable loss dominates many of these people’s lives and any therapy (not only music therapy) often fails to reach it. As a result there is a sense of helplessness that accompanies anyone who does this work, one has to accept that certain things cannot be changed. We cannot undo the torture that has been done to their bodies and souls. What we as music therapists can do is to offer them a chance to dive into their own music together with us and go fearlessly with its flow, to discover and celebrate the creative energy in the present moment that despite the trauma still lives within them and to offer
ourselves as creative companions who listen to them - so that they feel heard and accepted.

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