

I

**'SINGING MY LIFE,
PLAYING MY SELF'**

**Investigating the use of familiar pre-composed music
and unfamiliar improvised music in clinical music therapy
with individuals with chronic neurological illness.**

Vol 1

**A thesis submitted by Wendy L. Magee
In order to fulfil the requirements for the degree of
Doctor of Philosophy**

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August 1998

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ii
Table of Contents - Volume I

<u>SECTION</u>	<u>TITLE</u>	<u>PAGE</u>
	<u>Introduction: Title.</u>	i
	Table of Contents - Volume 1.	ii
	Table of Contents - Volume II.	x
	Table of Figures and Tables.	xiii
	Acknowledgements.	xvi
	Publications from this research.	xvii
	Abstract.	xix
<u>Chapter 1:</u>	<u>Music Therapy Practice: The Impact of International Trends and Cultural Differences.</u>	1
1.1:	Introduction.	2
1.2:	Different cultural practices in music therapy.	3
1.2.1:	British trends.	5
1.2.2:	Australian trends.	9
1.2.3:	American and Canadian.	10
1.2.4:	Western European trends.	12
1.2.5:	Other international trends.	14
1.3:	Improvisational models.	14
1.4:	Clinical techniques focusing on the use of familiar pre-composed music: songs and the use of pre-recorded music.	17
1.5:	Personal perspectives.	19

Chapter 2:	<u>The Interactions Between Music, Brain and Meaning:</u>	22
	<u>Theoretical Contextualisations For Therapy.</u>	
2.1:	Introduction.	23
2.2:	An examination of brain functions and the effects of music.	25
2.3:	Music and the brain: what are the implications for music therapy?	30
2.4:	Emotion and meaning within music: the link with music therapy?	33
2.5:	Music Therapy within the field of neuro-disability: a review of practice.	38
2.5.1:	Music Therapy in neuro-rehabilitation.	39
2.5.1.i:	Addressing speech disorders.	40
2.5.1.ii:	Music therapy with motor rehabilitation.	45
2.5.1.iii:	Music therapy to address specific cognitive disorders.	46
2.5.1.iv:	Music therapy in meeting behavioural/emotional needs.	47
2.5.1.v:	Assessment scales.	54
2.5.1.vi:	Summary.	55
2.5.2:	Music Therapy in chronic neurological illness.	57
2.5.2.i:	Music therapy to meet emotional and behavioural needs.	59
2.5.2.ii:	Music therapy in movement programmes.	62
2.5.2.iii:	Music therapy in addressing speech disorders.	65
2.5.2.iv:	Specific cognitive issues.	65
2.5.3:	Music therapy and Multiple Sclerosis.	67
2.5.3.i:	Pre-composed music in the treatment of MS.	67
2.5.3.ii:	Improvised music in the treatment of MS.	69
2.5.3.iii:	Summary of music therapy with MS.	70
2.5.4:	Linking theoretical and practical contexts.	71

<u>Chapter 3: Pilot investigation</u>	74
3.1: Introduction	75
3.2: Outline and rationale of study.	75
3.3: Design.	77
3.3.1: Participants and selection procedures.	78
3.3.2: Measurement instruments: Bipolar form of the Profile of Mood States.	78
3.3.3: Music therapy questionnaire.	80
3.3.4: Consent.	81
3.3.5: Procedure.	81
3.3.6: Equipment.	81
3.3.7: Structure of sessions.	82
3.4: Results.	84
3.4.1: Composed - anxious. mixed	84
3.4.2: Agreeable - hostile.	85
3.4.3: Energetic - tired.	85
3.4.4: Elated - depressed.	86
3.4.5: Further interactions.	86
3.4.6: Additional qualitative data.	88
3.4.7: Summary of results.	88
3.5: Discussion of the results.	89
3.6: Recommendations for developing the research	94
<u>Chapter 4: Developing the Empirical Work: Finding an Appropriate Methodology.</u>	96
4.1: Reflections on the pilot study.	97
4.2: Design considerations.	98
4.3: Design of the current study.	101
4.4: Focus of the current study.	104
4.5: Method of data collection.	104

4.6:	Participants.	108
4.7:	Equipment.	110
4.8:	Procedure.	110
4.8.1:	Session structure.	111
4.8.2:	Welcome activity.	111
4.8.3:	Song techniques.	112
4.8.4:	Improvisation techniques.	113
4.8.5:	Ending the session.	115
4.9:	Data analysis procedure.	115
4.10:	Ensuring Trustworthiness.	122
Chapters 5 - 7: Preliminary analysis and results.		125-210
<u>Chapter 4: Major Category: The Musical Experience.</u>		126
5.1:	Introduction.	127
5.2:	Subcategory: Interaction/relationship.	129
5.2.1:	Interaction/relationship: the concept 'sharing' in songs and improvisation.	129
5.2.2:	Interaction/relationship: the concept 'awareness' in improvisation.	131
5.2.3:	Interaction/relationship: other concepts emerging from improvisation.	132
5.3:	Subcategory: Communication.	134
5.3.1:	Communication: the concept 'talking to each other' in improvisation.	134
5.3.2:	Communication: the concepts 'expressing true self' and 'putting up a front' in songs.	135
5.3.3:	Communication: the concept 'communication to others' in songs.	137
5.4:	Subcategory: Emotion.	138

5.4.1:	Emotion: concepts relating to 'extramusical emotional meaning' in songs.	138
5.4.2:	Emotion: the concept 'emotional expression' in improvisation.	139
5.4.3:	Emotion: the concept 'engagement' in improvisation.	140
5.4.4:	Emotion: the concept 'emotion through instrumental sound' in improvisation.	141
5.4.5:	Emotion: the phenomenon of 'confidence' (related to the concepts 'skill' and 'ability') in songs and improvisation.	142
5.5:	Subcategory: Meaning.	144
5.5.1:	Meaning: the concept 'emotional meaning' (implicit and explicit) in songs.	144
5.5.2:	Meaning: the concept 'familiarity' in songs.	145
5.5.3:	Meaning: the concept 'thematic meaning' in songs.	147
5.5.4:	Meaning: the action of 'purposive selection' and songs.	149
5.5.5:	Meaning: explicit or conscious meaning in songs.	151
5.5.6:	Meaning: variable meaning over time and improvisation.	151
5.5.7:	Meaning: achievement of a goal in improvisation.	152
5.5.8:	Meaning: the concept 'familiarity' to enhance meaning in improvisation.	153
5.5.9:	Meaning: unconscious meaning and improvisation.	156
5.5.10:	Meaning: the concept 'personal association' in improvisation.	157
5.6:	Subcategory: Personal Association.	158
5.6.1:	Personal Association: the concept 'identification' in songs.	158

5.6.2:	Personal Association: the concept 'association with significant others' in songs.	159
5.6.3:	Personal Association: the concept 'emotional association' in songs.	161
5.6.4:	Personal Association: the concept 'association with life events' in songs.	162
5.6.5:	Personal Association: the concept 'association with current issues' in songs.	163
5.6.6:	Personal Association: the concepts 'association with life events' and 'association with significant others' in improvisation.	164
5.6.7:	Personal Association: the concept 'association with pre-illness abilities' in improvisation.	165
5.6.8:	Personal Association: the concept 'association with current issues' in improvisation.	166
5.6.9:	Personal Association: the concept 'association with pre-composed music' in improvisation.	167
5.7:	Subcategory: The Physical Experience.	168
5.7.1:	The Physical Experience: the concept 'control' in improvisation.	168
5.7.2:	The Physical Experience: the concept 'emotion' in improvisation.	169
5.7.3:	The Physical Experience: songs.	170
5.8:	Subcategory: Relationship Over Time.	170
5.8.1:	Relationship Over Time: the concept 'changed meaning over time' in songs.	171
5.8.2:	Relationship Over Time: the concept 'continuing relationship' in songs.	172
5.8.3:	Relationship Over Time: the concepts 'skill developing over time' and 'abilities over time' in improvisation.	174

5.9:	Concepts and emergent themes: the basis for relationships between the categories.	175
<u>Chapter 6: The Illness Experience.</u>		176
6.1:	Introduction.	177
6.2:	Subcategory Illness Monitoring.	177
6.2.1:	Illness Monitoring: the action of 'cognitive monitoring'.	179
6.2.2:	Illness Monitoring: the action of 'physical monitoring'.	180
6.2.3:	Illness Monitoring: the action of 'vocal monitoring'.	181
6.3:	Subcategory: Identity: changes in self concept.	183
6.3.1:	Identity: the concept 'disability' and 'ability'.	183
6.3.2:	Identity: the concepts 'independence' and 'dependence'.	184
6.3.3:	Identity: the relationship between 'control' and self concepts.	185
6.3.4:	Identity: the concepts 'developing skill' and 'deskilled'.	186
6.3.5:	Identity: the concepts 'loss' and 'ownership/creativity'.	186
6.3.6:	Identity: the concepts 'failure' and 'achievement/success'.	188
6.4:	Summary.	190
<u>Chapter 7: Coping With The Emotional.</u>		191
7.1:	Introduction.	192
7.2:	Subcategory: Life review.	192
7.3:	Subcategory: Identifying emotional states and feelings.	194
7.4:	Subcategory: The Coping Front.	195
7.4.1:	The Coping Front: 'stating rules'.	196
7.4.2:	The Coping Front: 'denying'.	197
7.4.3:	The Coping Front: 'projecting'.	199
7.4.4:	The Coping Front: 'dismissing'.	200
7.4.5:	The Coping Front: 'keeping busy'.	201

7.4.6:	The Coping Front: 'distracting'.	202
7.4.7:	The Coping Front: 'putting on a front'.	203
7.5:	Subcategory: Barriers Down.	204
7.5.1:	Barriers Down: 'acknowledging illness'.	205
7.5.2:	Barriers Down: 'owning feelings'.	207
7.6:	Subcategory: Hope and spirituality.	209
7.7:	Summary.	209
7.8:	Moving onto the next stage of analysis.	210
Chapters 8-10: The Case Studies.		211-326
<u>Chapter 8: Individual Case Study: 'Jack'.</u>		212
8.1:	Background summary to participant Jack.	213
8.2:	Analysis and results: Jack's experience of the music.	215
8.3:	Summary of results.	239
8.4:	Discussion.	241
<u>Chapter 9: Individual Case Study: 'Jessie'.</u>		246
9.1:	Background summary.	247
9.2:	Analysis and results: Jessie's experience of the music.	255
9.3:	Summary of results.	270
9.4:	Discussion.	273
<u>Chapter 10: Individual Case Study: 'Guy'.</u>		280
10.1:	Background summary.	281
10.2:	Analysis and results: Guy's experience of the music.	284
10.3:	Summary of results.	315
10.4:	Discussion.	315

<u>Chapter 11: Discussion.</u>	327
11.1: Returning to the initial questions.	328
11.2: Questions of clinical practice in Multiple Sclerosis.	332
11.3: Improvisation and the therapeutic relationship: addressing the 'social'.	338
11.4: The music and its effect on the illness identity.	342
11.5: Living with incurable chronic illness: Coping.	345
11.6: Music as an agent of hope and change: meaning.	348
11.7: Biographical work through songs.	357
11.8: Music therapy: the gestalt experience.	359
11.9: The implications of this study - the wider picture.	361
11.10: Personal perspectives.	364
11.11: Limitations of the current study.	366
11.12: Recommendations for further developments.	367
11.13: Conclusions.	370
<u>References.</u>	371

Table of Contents - Volume II: Appendices.

<u>Introduction:</u>	Table of Contents.	ii
<u>Appendix 1:</u>	<u>Rancho Los Amigos Scale</u>	1
<u>Appendix 2:</u>	<u>A Description of Multiple Sclerosis - Biological, Psychological and Social Implications.</u>	3
2.1:	Biological Factors.	3
2.1.1:	Definition and aetiology.	3
2.1.2:	Demographic features.	3

2.1.3:	Symptoms.	3
2.1.4:	The disease process and its effect on the central nervous system.	4
2.1.5:	Diagnosis and treatment.	6
2.1.6:	Disease course and prognosis.	7
2.2:	Psychosocial factors.	9
2.2.1:	Neuropsychological effects.	9
2.2.2:	Emotional responses and mood disorders.	12
2.2.3:	The social consequences of MS.	14
2.3:	Summary.	17
<u>Appendix 3:</u>	<u>Mental State Questionnaire.</u>	18
<u>Appendix 4:</u>	<u>Criteria for inclusion to the pilot study.</u>	19
<u>Appendix 5:</u>	<u>Music Therapy Questionnaire.</u>	20
<u>Appendix 6:</u>	<u>Post session questions.</u>	22
<u>Appendix 7:</u>	<u>Session evaluation form.</u>	23
<u>Appendix 8:</u>	<u>Background to the research participants.</u>	25
8.1:	Introduction.	25
8.2:	Background to participant 'Francesca'.	25
8.3:	Background to participant 'Tracey'.	26
8.4:	Background to participant 'Elaine'.	27
<u>Appendix 9:</u>	<u>Consent form.</u>	29
<u>Appendix 10:</u>	<u>Words to song 'All cried out'.</u>	31

<u>Appendix 11:</u>	<u>Background information to participant 'Jack'.</u>	32
<u>Appendix 12:</u>	<u>The therapeutic process of participant 'Jack': Musical, behavioural and verbal responses and changes in these over time.</u>	35
<u>Appendix 13:</u>	<u>Guide to reading the analytical diagrams.</u>	45
13.1:	Introduction.	45
13.2:	The phenomenon under investigation and its concepts and properties.	45
13.3:	Intervening conditions.	47
13.4:	Actions and interactional strategies.	48
13.5:	Consequences and outcomes.	48
13.6:	The overall diagram.	48
<u>Appendix 14:</u>	<u>Background information to participant 'Jessie'.</u>	50
<u>Appendix 15:</u>	<u>The therapeutic process of participant 'Jessie': Musical, behavioural and verbal responses and changes in these over time.</u>	53
<u>Appendix 16:</u>	<u>Background information to participant 'Guy'.</u>	64
<u>Appendix 17:</u>	<u>The therapeutic process of participant 'Guy': Musical, behavioural and verbal responses and changes in these over time.</u>	66

Table of Figures and TablesVolume I.

<u>Fig. No.</u>	<u>Figure title.</u>	<u>Page.</u>
Table 1:	Analysis of Variance of All Bipolar Mood States by Treatment and Pre-post Measures.	87
Table 2:	Pre- and Post-session Mean Scores for the Mood Subscales Composed-anxious, Agreeable-hostile and Energetic-tired.	87
Table 3:	Single Factorial Repeated Measures Analysis of Variance Within Each Group for the Mood Subscale Composed-anxious.	87
Figure 1:	Paradigm model for establishing relationships in Grounded Theory.	119
Figure 2:	Methods of triangulation to ensure trustworthiness.	123
Figure 3:	Continuum reflecting the relationship between control and self concepts relating to Identity.	185
Figure 4:	Relationship of ownership and loss to identity, meaning and control.	188
Figure 5:	Bipolar properties pertaining to self concepts in the category 'Identity'.	189
Figure 6:	Bipolar range of emotional states or feelings.	194
Figure 7:	Emerging properties of pre-composed music and the consequences for strategies adopted.	219
Figure 8:	Process stimulated by pre-composed familiar songs to reach state of Barriers Down.	226
Figure 9:	Properties of unfamiliar improvised music with high/low values, leading to effect on illness identity.	227
Figure 10:	Processes stimulated by unfamiliar improvised music.	234

Figure 11: The process of vocal monitoring stimulated by the act of singing.	238
Figure 12: The process of reinforcement of Jessie's disabled identity.	254
Figure 13: Concepts pertaining to Jessie's experience of improvisation with value ranges.	259
Figure 14: Jessie's experience of songs leading to relaxation and no change to disabled identity.	263
Figure 15: Jessie's experience of improvisation leading to a change in mood and to disabled identity.	264
Figure 16: Jessie's experience of songs including the use of cognitive monitoring.	269
Figure 17: Effects on illness identity after each type of activity in Jessie's experience.	272
Figure 18: Developing properties of Guy's experience of pre-composed music with value ranges.	286
Figure 19: Processes stimulated for Guy by familiar songs to maintain 'Coping Front' or reach 'Barriers Down'.	306
Figure 20: Developing properties of Guy's experience of familiar songs with value ranges.	307
Figure 21: Process stimulated for Guy by pre-composed familiar songs.	321
Figure 22: Process of illness monitoring stimulated for Guy by improvisation in the earlier part of his therapy process.	322
Figure 23: Changes within Guy's experience of improvisation.	325
Figure 24: Changes to Guy's 'illness identity' effected by improvisation in the later stages.	326

Figure 1:	Central phenomenon cell with concept property value box.	46
Figure 2:	Diagram depicting the resulting concepts with high or low properties.	47

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Publications from this research.

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Magee, W. (1995) 'A Comparison in the Use of Improvised Music and Familiar Pre-composed Music with a Neurologically Impaired Population'. In: Nygaard Pedesen (Ed.), *Book of Abstracts*, 3rd European Music Therapy Conference, Aalborg, Denmark, 12 - 20 June, 1995, p. 24. Aalborg: Department of Music and Music Therapy, Aalborg University.

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Magee, W. (1998) "'Singing my life, playing my self". Song-based and improvisatory methods of music therapy with individuals with neurological impairments'. In: De Backer, J. & Wigram, T. (Eds.), *Book of Abstracts*, 4th European Music Therapy Congress April, Leuven, Belgium, 16-19, 1988, p. 135.

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Magee, W. 'Music therapy in chronic degenerative illness: Reflecting the dynamic sense of self'. In: Aldridge, D. (Ed.), *Music Therapy in Palliative Care*. London: Jessica Kingsley Publishers. In press.

This thesis explores the use of familiar pre-composed music and unfamiliar improvised music in clinical music therapy with adults with acquired non-traumatic neurological illness. A detailed examination was made of six participants whose individual music therapy sessions spanned approximately six months. Clinical techniques used both songs and improvisation to explore issues pertinent to their lives.

Primary data was collected in the form of focused interviews during and after music therapy sessions. Secondary sources of data included musical, behavioural and verbal material from the clinical sessions. Interview data was analysed using a modified form of Grounded Theory (Strauss and Corbin, 1990) to reveal emergent themes central to the participants' experiences of music therapy. Drawing from a neurobehavioural framework, analyses of the clinical material were made incorporating psychodynamic reflection through clinical supervision. This offered an alternative viewpoint and served as triangulation, in addition to checks with the multidisciplinary team.

Open coding of the data established three major categories pertaining to the experience of the music, the experience of illness, and the emotional strategies to cope with illness. Three detailed case studies explored the relationships between these major categories using axial coding.

The findings demonstrate that individuals living with chronic degenerative neurological illness find emotional meaning through the temporal relationship held with songs throughout their lives. Through songs which hold personal meaning, individuals are able to explore and express a wider range of emotional states than through words. Improvisation, on the other hand, possesses enhanced interactive properties pertaining specifically to the

therapeutic relationship. Through playing and singing, individuals may monitor their physical selves. In this way, the therapist validates the individual's developing sense of 'self' through mutual music making, thereby shifting concepts of 'self' from less able and damaged identities to identities which involved feelings of greater independence and ability.

CHAPTER 1

MUSIC THERAPY PRACTICE: THE IMPACT OF INTERNATIONAL TRENDS AND CULTURAL DIFFERENCES

1.1: Introduction.

Music is a cultural phenomenon through which people identify themselves and their way of being in the world. As such, 'music' is given meaning both constructed and emerging from cultural norms. For instance, within western popular and art culture, music is most often described in terms of 'song' or 'composition'. In more traditional folk cultures, however, music may be more influenced by improvisatory practices. Irish chants and traditional dance music, vocal chants from the sub-Saharan continent and Australian Aboriginal ceremonial music all serve as examples of how traditional forms of music are developed through improvisatory practice.

Music, when used as a medium for therapy, must consider such cultural norms and practices for the client and practitioner alike. This initial chapter will examine wider music therapy practice from cultural, theoretical and practical viewpoints. Following this, consideration will be given to the cognitive processes involved in music, and whether acquired brain damage changes how an individual experiences and processes music. Current music therapy clinical practice in neurology will be reviewed, with adults who have acquired disability through illness or trauma stemming from damage to the brain. This will establish whether practice and research have adapted the use of music to meet the particular needs of a neurological population. A pilot study will then be presented, with recommendations for how a study of music therapy with this group may best proceed. Drawing from design recommendations from the fields of music therapy, music psychology and health sociology, the methodology employed in a research study with a group of neurologically disabled adults will then be presented. The analysis and results of this study will be given at a general level, followed by more detailed case studies. These case studies will develop the simpler concepts and themes which were gained from the group data and explore the relationships

between these themes. In this way, a more complex understanding will be achieved of the many issues affecting someone living with neuro-disability and how these issues shaped the participants' experiences of the music. The final chapter will draw together the results, and referring back to the literature, reflect on the implications for music therapy with adults living with acquired chronic neurological illness.

1.2: Different cultural practices in music therapy.

In different countries, different ways of working in music therapy have emerged. As an introduction to this thesis, international perspectives on working practices will be reviewed in order to explore the disparity between different music therapy 'cultures' and highlight why this issue is so pertinent for a therapist from one culture working within another. Coming from Australia to work in Britain, I felt it was essential to understand why these differences existed and to explore which of these different cultural approaches may be more appropriate to certain clinical areas. Having little knowledge or understanding of psychodynamic principles, I was intrigued about the application of such principles to music therapy practice, if not a little sceptical about the particular use of improvisation with brain damaged clients. Having worked with clients who had acquired brain damage, my knowledge base drew from neuropsychology regarding the application of music for therapeutic purposes. It was difficult to place improvisatory methods within this knowledge base, due to my own perceptions of improvisation at the time. It was also difficult to understand the extent to which it is useful to draw on psychodynamic principles within a medical model setting.

In attempting to clarify working practices, it became clear that working practice is most often based upon a theoretical framework stemming from an individual's training and influenced by a personal belief system. Theoretical

stance then indicates different procedures or approaches employed. Internationally, music therapy practice varies enormously, particularly in how music is actually created within the session, what type of music is created, and how processes or effects are interpreted. These differences will be explored in the review of the literature.

Initial insight into the different cultural working practices can be found by comparing definitions and descriptions of clinical work. Bruscia (1989) wrote a treatise on this subject alone drawing from 41 world-wide definitions. Although it is apparent from this that one exclusive definition of music therapy is impossible, it is immediately clear that definitions used within non-British cultures are less restrictive and more embracing of different practices. In fact, in a review of definitions given by international associations and authors, it is notably only the British ones which define music therapy by the type of music used, that being 'improvised' (Odell-Miller, 1988a; Priestley, 1980, cited in Bruscia, 1989). Definitions which are less exclusive reflect clinical practice which embraces a wider range of techniques, approaches and types of music than the British stance.

Bruscia describes methods used in a variety of clinical settings which employ both improvisatory and pre-composed music, and also both live and recorded music. Bruscia (1989: 29) mostly uses the term 'musical experience' to denote activities used within therapy rather than any specific descriptions. 'Levels' of music therapy are defined, determined by whether music is used as a 'primary' therapy, where it is indispensable in meeting the main therapeutic needs of the client, through to an 'augmentative' level, where music is used to enhance the efforts of other treatment modalities such as within rehabilitation (Bruscia, 1989: 61). This is important when attempting to elucidate why differences may exist within music therapy practice. It also suggests that different client groups may create different 'cultures' as music adopts variable

importance within the therapy for each group. Hence, besides national trends, differences emerge in the requirements of certain patient populations as well.

Bruscia states that:

'the needs of clients must take precedence over theoretical stances or preferences of therapists. Music therapy must be defined in broad, inclusionary terms that embrace diverse practices and philosophies in various settings!' (Bruscia, 1989: 44).

This is a critical point, but does not seem to influence clinicians immersed in one form of clinical practice. Furthermore, Bruscia highlights that it is the client's needs which determine the extent and depth of music in the intervention, and whether music is used as therapy, where the client-music relationship is the primary agent of change, or in therapy, where the client-therapist relationship is primary (Bruscia, 1989: 49).

In the sections which follow, I will examine the literature describing clinical practice and research from around the world, revealing the diversity of clinical practice between and within cultures. A brief review of the literature from Britain, Australia, America and Canada, and Western Europe under the categories of nationality will highlight any national trends which may exist. Particular emphasis is given to searching for improvisatory models and models employing pre-composed music as highlighted within the literature, as these offer very different approaches within music therapy practice.

1.2.1: British trends.

British clinical practice has been strongly influenced by psychodynamic and psychoanalytic theoretical frameworks since its growth as a profession in the 1960's.

Early training set up by Juliette Alvin was principally influenced by Freudian and humanistic models of psychology (Wigram et al., 1993). Improvisation was given prominence to develop the relationship between the client and therapist, using psychodynamic principles to interpret responses. A later training model started to integrate further psychodynamic orientations, particularly mother-child relationships.¹ From this point, psychodynamically informed practice has evidently been widely influential with Britain. Additional models from the fields of education and psychology have been seen to influence music therapy theory, broadening the development of the profession. However, British music therapy practice remains firmly rooted in improvisational practice.

The 'debate' between improvisation and pre-composed music within current British clinical practice has been raised by some British authors (Bunt, 1994: 133). This suggests that it is indeed an issue in clinical practice. Bunt differentiates clinical practice within Britain from other music therapy cultures by pointing to the fact that British therapists use predominantly live music. In published collections of clinical case studies drawing on international perspectives, British work often stands out for greater uniformity in clinical techniques. In one collection (Bruscia, 1991) two British authors, however, beg 'flexibility and variety' from the therapist (Wigram, 1991) and state that 'therapeutic theory and practice must adapt' (Bartram, 1991) in order to meet the client's needs. Despite this, there does tend to be a largely inflexible attitude that pre-composed material holds very much a secondary role to improvisation. For example, working with families in a psychiatric unit, Oldfield (1993) specifies that the familiarity and structure of songs facilitated not only a non-threatening environment, but also helped to provide containment and improve concentration difficulties. This is however balanced out with the additional use of improvisation. In her work with adolescents on a secure unit,

¹ This was the training at the Roehampton Institute in London, by Elaine Streeter.

Flower (1993) used pre-composed material which a client brought to the session only as a 'springboard' for improvisation, an idea described earlier within psychodynamic work with the elderly by Odell-Miller (1988b).

Odell-Miller provides definitions of music therapy which either specify improvised music or stress its primary role in British clinical practice (Odell-Miller, 1988a&b). She also acknowledges that pre-composed music may be used within improvisation, but then adapted to meet the therapeutic process. There is an underlying supposition, however, that a therapist using pre-composed material does not need musical skills. Moreover, she asserts that pre-composed music cannot be used in an interactive way. Her thoughts are disputed within this current study, as much of the music therapy literature will indicate.

So, improvisational music therapy dominates British practice without questioning. However there is considerable debate on the role of words within music therapy (Wardle, 1992; Howat, 1992) and, stemming from this, differences between musicologically oriented models such as the Nordoff-Robbins model, and psychodynamic ones, such as that in which the Roehampton training specialises (Lee, 1992a).

Working as a music therapist with adults with HIV and AIDS challenged Lee (1996) to explore many approaches which were new to him. He found his clients' needs demanded new approaches of him, such as listening with clients to recordings of their preferred music and playing pre-composed music. Thus therapeutic relationships were developed which were verbal as well as musical (Lee, 1996: 6). For Lee, a therapist trained in Nordoff-Robbins² who drew predominantly from musicological models, this was quite clearly an issue which caused him much soul searching. A music therapist

² The Nordoff-Robbins model of music therapy is described later in this chapter in section 1.3.

from a non-British training would not have found these approaches quite so novel. However, Lee's brief description of one client's need to sing love songs in his therapy is given what appears to be a justification for the use of songs in therapy, whilst simultaneously acknowledging the 'need for music therapy to be totally open to the idiosyncratic needs of every person' (Lee, 1996: 6). Despite Lee's suggestions embracing alternative methods of working practice, his acceptance of anything other than improvised music is quite clearly not as broad. Whilst he states that 'improvisation as a therapeutic medium has rarely been mentioned in the (palliative care) literature' (Lee, 1996: 22), he acknowledges quite clearly that this is his own 'main therapeutic modality' (Lee, 1996: 6).

Considering Lee's statements regarding the need for versatility in a therapist, questions are raised as to whether music therapists are working predominantly in improvisation with all client groups due to training, or whether methods are adapted in a versatile way for every individual situation. For example, Lee describes his own working practice as predominantly improvisational, with a background in working with adults and children with learning disabilities. Working with a new client group necessitated a broader practice, as his new clients were articulate and had musical experiences and associations from which they needed to draw. Is it possible that some of the methods employed by Lee in order to work with his articulate group may have been just as appropriate for his previous group of clients? How do we, as music therapists, assess one particular way of working over another with any one client? Are our decisions firmly rooted in our own training philosophies, or do we adapt easily and readily to the ways in which our clients wish to use music? More importantly, do we adapt our methods of working flexibly to meet the specific needs our clients may have?

The British literature reflects a strong working practice within improvisatory models, mostly influenced by psychodynamic principles. There is evidence of a lack of adaptability within clinical situations, and yet in contradiction, there is a simultaneous plea for flexibility in the literature by therapists.

1.2.2: Australian trends.

Although the literature from Australia is not prevalent outside of that continent, it is included here as it reflects this author's original 'culture'. What is reflected in reviewing the literature is a greater amount of work within rehabilitation and medical model settings which, according to clients' needs, seems to demand a greater flexibility in approaches. Bruscia (1991) presents three such contrasting case studies, differing in theoretical background and approaches employed. Shoemark (1991) used Nordoff-Robbins' improvisational model combined with an educational philosophy of 'Gentle Teaching' in developing basic musical skills and interactive behaviour with a blind boy. A completely contrasting use of music is given by Erdonmez (1991). She relates a case study of one man's rehabilitation of piano performance skills after a stroke. As a measure of change, Erdonmez uses improvements in the client's ability to play pre-composed music from written scores of Beethoven and Bach, combined with standardised testing using the Botez-Wertheim tests for amusia. A third equally contrasting case study is presented by Allison (1991), evaluating the effectiveness of the use of tapes of preferred selections of pre-composed music to assist in the labour of a primipara woman and her husband.

Such diversity in approaches and theoretical frameworks is further reflected in the literature published by the Australian Music Therapy Association in the Australian Music Therapy Journal. From a general review of such publications, it is clear that clinical practice differs markedly from European or

British practice, and tends to reflect aspects of Canadian and American clinical practice. Descriptions of treatment programmes which involve instrument playing are often in the context of their use for accompaniment to pre-composed music rather than as part of improvisation (Ely and Scott, 1994; Ely and McMahon, 1990). In the same way, improvisation is often referred to within the context of music which is played for a client, rather than in interaction with the client (Edwards, 1994; Cosgriff, 1988). There is also far more frequent use of recorded music rather than live music (Dye, 1994; Bruinsma, 1995). Although more recent trends towards improvisational models of music therapy exist (Meadows, 1996), these are not psychodynamically oriented. Hence models which are prevalent in the Australian literature can be seen to differ markedly from those in Britain.

1.2.3: American and Canadian.

Bruscia (1991) presents eighteen case studies from the US in his collection of international case studies. Such an anthology serves to reflect differences between therapists' work and also how several techniques are often applied within any one single case. What is indisputable from the outset is the lack of uniformity and enormous flexibility in approach, theoretical framework, and the modes in which music is presented and combined. Techniques employ both pre-composed and improvised music, presented both live by the therapist or using pre-recorded music. In addition to techniques employing primarily either music or verbal reflections, other media are also used, such as storytelling, drawing, musical drama, and poetry.

Improvisatory models are varied, from the use of Nordoff-Robbins/Creative Music Therapy with children and adolescents (Robbins and Robbins, 1991), to Jungian-oriented analytic music therapy using improvisation (Snow Austin, 1991), to more eclectic combinations of improvisational models such as

psychodynamic and Nordoff-Robbins (Clarkson, 1991). Group improvisation techniques with adult psychiatric patients are also described, and these tend to draw from psychodynamic models (Murphy, 1991; Nolan, 1991). Other improvisatory models described include Priestley's, drawing on Freudian principles with a male forensic patient (Boone, 1991), combined with the use of songs.

Pre-composed music is used in different ways. Instructional aspects as part of therapy are evident within two rehabilitation programmes presented (McMaster, 1991; Darrow and Cohen, 1991) both of which use pre-composed music, and one which combines this with improvisation. The technique of Guided Imagery and Music (GIM) is also described within case studies, which uses recordings of pre-composed music.

Clinical work in the case studies from Canada is similarly broad in approaches and techniques. Both improvised music and pre-composed music are used within clinical practice, however there is greater emphasis on techniques employing pre-composed music within Canadian work. Extramusical associations are given prominence within the therapy work. For example, within palliative care, the use of specific song-based techniques relating song themes to personal processes and for the purposes of building a life review are commonly drawn upon (Beggs, 1991; Whittal 1991). The use of song themes and associations are also used with children with burns injuries (Loveszy, 1991), and adolescents with behavioural and substance abuse problems (Lefebvre, 1991). Particular techniques using song themes are explained in more detail later in the current chapter. Helping a pre-school aged child work through the grief process, Burke (1991) describes a combination of methods and media including improvisation with reflection, drawing and song composition. A similar combination of drawing and song composition helped an autistic man improve an obsession with food and

reduce irrational fears (Fischer, 1991). An even more unusual combination is described by Moffitt (1991) in her work with a physically disabled woman dealing with trauma. Here the therapist combined Guided Imagery and Music, musical improvisation and Gestalt verbal therapy to help the client gain an enhanced self-concept.

Beyond Bruscia's collection, a review of the literature appearing in journals from both America and Canada supports the flexibility reflected above. Approaches are responsive to the needs of the client, reflecting versatility in how music is used, be it pre-composed or improvised. Clinical practice draws on a range of music therapy models and models from other health sciences, which are often combined within the one treatment.

Hence, American and Canadian literature depicts diverse approaches with many combinational features from all schools of possible influence. This flexibility may well be due to a well-established professional identity which gains strength from such diversity. Further literature from both the USA and Canada is included later within this chapter in examining specific techniques more thoroughly.

1.2.4: Western European trends.

For the purposes of this study, and because it appears to stand out alone, British clinical practice is treated as a separate entity to Western European in general. Despite the geographical proximity, a survey of the literature demonstrates that different methods exist in working practices. European clinical practice is not only derived from psychoanalytic, psychodynamic and humanistic theories, but also draws from educational and medical models. Techniques and methods include combinational approaches (i.e. dance, movement and art), Orff, Creative Music Therapy, psychodynamically

informed improvisation, and the use of recorded and live pre-composed music (Nygaard Pedersen, 1995). The diversity of clinical practice and theoretical frameworks reflects cultural identities, and seems also to be influenced by not only different training programmes, but also the different standards required for registration between countries. With approaches and techniques contrasting so widely, it is debatable whether grouping the different cultures of music therapy within Western Europe is appropriate. However for the purposes of this study, such grouping serves to emphasise the point that within Western Europe clinical practice is drawn from many different applications of music therapy and theoretical frameworks, often even within the one country.

For example, one description from Italy of music therapy programmes using pre-recorded music within a psychiatric setting is reported as being administered by psychiatrists who used listening techniques and discussion to explore symbols in the music (Berruti et al., 1993). This differs markedly from other Italian work which specifically draws on psychoanalytically informed practice and live music making with a similar client group (di Franco, 1993). Similarly, Dutch clinical practice draws on differing techniques and frameworks. For example, Brandt (1996) specifies the use of pre-composed music which holds particular personal meaning for the purposes of life review for people living with Huntington's Disease and relates the need for simplistic musical structures to meet the cognitive needs of the clients. Within mental health settings, other music therapists draw on listening techniques with pre-composed music in combination with improvisation to facilitate cognitive or emotional aspects of the client's therapy (Berman, 1995). Similarly, Raijmaekers (1993) combines improvisation to observed expression of emotions with activities which involve listening to taped excerpts to examine affective reactions evoked by the music.

In summary, European practice, in parallel with British clinical practice, has a strong basis in improvisation, and can be seen to draw from differing psychoanalytic models. In contrast to British practice, however, European practice more commonly draws on a wider range of methods using receptive and active techniques, live and pre-recorded music, and pre-composed and improvisatory music. In this way, it bears greater resemblance to American or Canadian practice than to British.

1.2.5: Other international trends.

Further review of music therapy within other cultures will not be explored here, as that is not the focus of this study. However in cultures which can be classed as 'non-Western', i.e. African, Chinese, Japanese, South American, there continue to be numerous techniques and practices which are heavily influenced by or drawn from relevant cultural factors (Smeijsters and Mecklenbeck, 1996).

So, within Western practice, it remains that music therapy within Britain stands alone in being so focused on one particular technique, albeit one within varying interpretational frameworks. Having considered international trends, focus now will be given to the musical 'cultural' differences presented in improvisation and pre-composed song.

1.3: Improvisational models.

Elsewhere a thorough review of improvisatory models used within music therapy has been given (Bruscia, 1987). Within Britain, it is not only the ways of making music with clients which have developed, but a review of recent literature reveals the extent to which interpretation of the musical interactions holds importance.

For example, Heal's use of the term 'psychoanalytically informed music therapy' defined music therapy whose practice and conceptualisation lay in psychoanalytic theory (Heal, 1989, cited in John, 1992). John stated his belief that music therapy is a 'derivate of psychoanalysis ... considering music as a bridge between unconscious and conscious processes', using the term 'music psychotherapy' (John, 1992). Towse (1997) presented an interpretative model for group improvisation using Foulkes' psychoanalytic theory. In her article on music therapy and sexual abuse, Rogers gave examples of techniques which draw from family therapy (Rogers, 1992). Stewart (1996) stated that it is specifically 'co-improvised music (which is) the most effective context for developing therapeutic relationship' in 'psychodynamic music therapy' (Stewart, 1996: 21). All of these examples reflect the trend in British music therapy to draw from verbal models of psychotherapy in working practice and analysis, and commonly drawing on terms from psychoanalytical frameworks such as 'transference' and 'countertransference'. Improvisation is always the key tool in such practice.

Currently, the improvisational model which holds greatest international influence and bearing on clinical work and the literature is the Nordoff-Robbins model, more recently developed with adults as 'Creative Music Therapy'. The emphasis in Nordoff-Robbins is very much on the improvisatory experience, although pre-composed material is used (Nordoff and Robbins, 1977). Unlike other forms of music therapy, the Nordoff-Robbins/Creative Music Therapy model interprets the musical interaction without using psychodynamic interpretation. In this way, this model differs from other models used within Britain as the focus is primarily on the musical interaction rather than psychodynamic interpretation of the musical relationship.

The essential belief is that music-making is 'an end in itself' and largely avoids the 'verbal-conceptual dimension' (Ansdell 1995). The place of words

within music therapy is a well-debated issue by Nordoff-Robbins trained therapists in particular (Howat, 1992; Lee, 1992a, 1996; Pavlicevic, 1997), as other improvisational models certainly draw on the use of words in conjunction with improvisation.

There is no doubt that these models are essentially improvisatory. As Ansdell (1995) states, 'the central fact of Creative Music Therapy is of two people sharing intention and meaning in music by improvising together' (Ansdell, 1996: 13). For music therapists who work using either of these models, the intrinsic belief is that the 'real' therapy work is done in the improvising. However it is clear that in practice the use of music is broader than on first appearance. Case studies from several music therapists (Ansdell, 1995) highlight the difficulties faced working with pre-composed music within this model, whilst also offering some observations as to the therapeutic effects of using familiar music. In the case study of 'Herr P.', the therapist identified that her client was able to play with greater continuity and engagement when playing to his preferred familiar pre-composed music, resulting in a 'more genuine dialogue' than when improvising. In the case study of 'Tom', the therapist reflects how her client, when he felt insecure or disorientated in the session, used particular favourite songs symbolically to represent times and subjects of personal importance within his life. The therapist's frustration at his use of his songs as a 'refuge' led her to adapt her techniques to incorporate aspects of her client's songs into improvisatory methods. More importantly, she found that with increased acceptance from each of them in the other's music, their joint music making became closer.

Despite flexibility, however, a fundamental belief of the Nordoff-Robbins/Creative Music Therapy model is that using songs from an individual's past can only trap them in a 'self-contained and safe musical time-capsule, avoiding a creative musical relationship in the present'

(Ansdell, 1996: 141). It is quite apparent that this is an issue which causes concern for the practitioner and theorist alike. The core therapeutic tool remains firmly in improvisation, which is believed to keep the musical relationship alive between therapist and client.

1.4: Clinical techniques focusing on the use of familiar pre-composed music: songs and the use of pre-recorded music.

In American, Canadian, European and Australian literature, there are many references to the use of songs. The use of 'song' may be for many different reasons. It may be structural components which are the important aspect of the music (Bailey, 1984; Gervin, 1991). Alternatively, it may be that pre-morbidly learned material facilitates automatic vocal responses (Cohen, 1992; Magee, 1996) or addresses impaired initiation (O'Callaghan and Brown, 1989; O'Callaghan and Turnbull, 1987 & 1988). Familiarity and emotional associations may be important to increase arousal levels (Boyle, 1995). Similarly it may be the associations held within a song which promotes the therapeutic process (Bailey, 1984; Beggs, 1991). Or it may be the theme behind the lyrics which becomes the main catalyst of the music, to express in music that which cannot be expressed in words (Whittal, 1991; Martin, 1991; Duey, 1991).

The importance of song choice and song themes in the music therapy process was clearly identified by Bailey (1984), whose work has influenced many music therapists working within palliative care in America, Canada and Australia. Bailey suggests that songs used by terminally ill cancer patients usually encompass one or more major themes. These themes also reflect the stages through which individuals work according to their readiness and willingness to progress in therapy.

This song technique has also been applied with clients with chronic degenerative conditions and in mental health settings. Within the stages she outlined, Bailey emphasises the cancer patient's need to use their defences in coping with illness for as long as necessary. By monitoring the patient's song choice and the willingness to reflect on the themes of the chosen songs, she found that the therapist could provide support for the patient which meets them where they are in their own process. The music therapist needs to be aware of the moments when a client may be using music as a defence, but also needs to remain sensitive to the client using such a defence as a necessary coping strategy.

Listening to selected songs using pre-recorded rather than live music is also used in music therapy within the USA and Europe, following the ideas presented by Bailey but adapting the clinical aims to the pathology of the client group. Berman (1995), in his work with psychiatric patients, states that the client's personal choice of music reflects his or her personal history, and that individuals have sometimes formed relationships with their chosen music which can replace their contact with other people. Berman therefore stresses the importance of the client choosing the music themselves, rather than the therapist selecting the music they feel fits the client. Duey (1991) reports the benefits of this technique specifically to encourage sharing personal information in a safe manner within groups.

Relationships with preferred music have been used by other therapists to help clients build 'musical life reviews' (Bright, 1986; Beggs, 1991). Bright describes how life reviews in this form are based on 'musical milestones', pieces of music which have strong associations with crucial life stages and happenings. Developing this technique, O'Callaghan (1984) describes the use of what she terms 'musical profiles' with dying patients. O'Callaghan reports that using significant music in this way in her work helped to facilitate

freer communication between therapist/client and client/family, increased the clients' feelings of self worth, and provided a supportive situation in which maladaptive repressed emotions were evoked and dealt with.

Other techniques using pre-composed music gaining greater prominence include the use of recorded music as a part of Guided Imagery and Music (GIM). This method involves listening to selected recordings of western classical music whilst in a deeply relaxed state. The therapist acts as a guide whilst the client verbalises the images stimulated by the music. These emergent images are then interpreted by the therapist in order to gain understanding of the therapeutic journey. A fundamental difference between the use of song and techniques such as GIM is the absence of personal association with the music, which is the key issue in the varying techniques which employ songs.

1.5: Personal perspectives.

Having trained in Australia, arriving to work within Britain stimulated many questions for the current author concerning clinical practice. Surveying the working practice of others within the field of neuro-disability in Britain was of little help, as in 1990 when I started in my current post, the Royal Hospital for Neuro-disability was the only setting to employ a full-time music therapist with such a client group. A survey in 1994 of the Association of Professional Music Therapists in Britain revealed only approximately 5% of members to have been currently or previously employed to work with people with neuro-disabilities. This situation has changed little within the years since then.

There are, however, many more therapists working with the elderly mentally ill, or with people in palliative care, for whom descriptions of music therapy in the area of neuro-disability are highly relevant, as aspects of the work can be

generalised throughout the populations of clients with differing types of brain damage. Comments such as “It’s not really music therapy, as he/she only wants to play/sing/listen to songs” were frequent during anecdotal discussions with music therapy colleagues who also worked with neurologically impaired clients. This revealed a sense of frustration and questioning of the use of improvised music with this population. Reviewing the wider literature with neurologically disabled populations, it is suggested that should neuropsychological processes be considered with such clients, then the familiarity and structure of pre-composed music may be recognised for its use with brain damaged populations. Questions were stimulated for me about music therapists’ beliefs that improvisation is more appropriate than other forms of music in a given setting. It would seem that it is fundamental to music therapists within Britain to define their work by the type of music that they use in their work. To date, there has been no research into a comparison of the two within this country.

Turning to authoritative definitions of music therapy in Britain, one can possibly view these perceptions in a larger context of professional identity. The prominence improvised music is given in many definitions is exemplified by the following:

‘Music therapy is the use of predominantly improvised music to fulfil therapeutic aims for the client’ (Hoskyns and Odell, 1986, cited in Odell-Miller, 1988b: 14)

‘Music therapy in the UK has consistently emphasised two principles; the use of improvised or extemporised music and the relationship between client and therapist’ (Wigram et al., 1993: 574).

The term ‘pre-composed music’ is not found to be included in definitions used within Britain, and rarely within descriptions of clinical work, reflecting the fact that British music therapists consider improvisation their key tool. The purpose

of this dissertation, however, is not to further define music therapy or offer new definitions. It is intended here to examine two different approaches within one population, and from research, to offer recommendations for clinical practice which can be generalised to similar populations.

The following chapter reviews the literature of music therapy with neurologically impaired populations, which is the client group of this investigation. This reveals that improvised music does not feature heavily in described methods of working. One is left to question whether this is due to differences in training between different cultures (i.e. American, Australian and British), or whether this is a reflection of the clinical methods music therapists have found most beneficial in their work with this specific client group. Considering the types of disabilities commonly found with this population as outlined in chapter 2, one is left asking whether familiar pre-composed music is a more meaningful experience for the person with brain damage than improvised music. Do songs facilitate responses more often and to a greater depth than unfamiliar improvised music? And if so, what is it about the music that causes such differences?

CHAPTER 2

**THE INTERACTIONS BETWEEN
MUSIC, BRAIN AND MEANING:**

**THEORETICAL
CONTEXTUALISATIONS FOR
THERAPY**

2.1: Introduction.

In any clinical context, it is essential to explore the impact of a given pathology. This is particularly relevant with music therapy in neurological work. Research from a wider artistic context suggests that changes in artistic style after brain damage result from pathological changes rather than as an emotional reaction to severe illness (Gardner, 1982). However, the tendency to relate changes in an individual predominantly to emotional reactions is one which is still prevalent within the psychoanalytic world of music therapy, without a wider examination of what effects the pathology may have upon an individual's ability to process material and express musically. For example, when a client delays in responding or shows some 'non-compliance' in responding, he/she may be described as being 'resistive' within a psychoanalytical framework. For the neurologically damaged client, however, delayed or absent responses may indicate an inability to initiate, which is a neurological problem, and not an emotional one. Considering the complex and contradictory nature of findings which occur in the research literature concerning music processing within the brain, it is perhaps understandable why music therapists draw on psychoanalytic and other non-neurologically oriented frameworks. In recent years, however, some therapists have started to establish links between clinical observations made in music therapy and the client's particular pathology.

Therapists who work outside of psychodynamic frameworks stress caution in interpreting musical events. For example, Ansdell (1991) presented a case study of a woman with neurological symptoms of an undiagnosed aetiology. In his interpretation of the clinical assessment,¹ he opposed presenting any assessment information within theoretical constructs such as psychoanalytical or mother-infant interaction. Instead, he asserted that describing the music-

¹ This case study used a creative music therapy approach i.e. improvisatory.

making itself gave a more whole and objective picture of the individual. Aldridge and Brandt (1991) presented a case study of a patient with Alzheimer's Disease.² The authors made direct association between the client's observed residual musical abilities and areas of difficulty in the clinical process and the cognitive disease process by drawing from the literature examining music perception. With a more diverse neurological patient group, Erdonmez³ (1993) related responses observed in clinical sessions to brain processes, with great attention and description of music's ability to overcome abilities affected by the neurological disease process. Pavlicevic (1997) has drawn attention to understanding how a client's perception of the music improvised in sessions may affect the meaning attributed to the musical events. Most recently, Usher (1998) has taken the links between music and neurological events even further by drawing on Greenfield's theory of 'Neuronal Gestalts', and relating such to observations of arousal and stimulation in response to clinical music therapy.⁴

When working with individuals who have neurological problems, it is essential to consider that these are caused by damage to the brain. This damage affects the neural pathways communicating messages to the body or neuro-chemical functioning within brain structures. For this reason, it is necessary first of all to examine what is known about brain function and music. The current chapter will serve to review research findings regarding music and the brain, which is the initial step of the process in examining the application of music with neurologically damaged clients. The application of music therapy to this clinical population will then be explored, examining the clinical practice in neuro-disability to date. Particular emphasis will be given to how this

² The descriptions of the clinical work especially differentiate between pre-composed and improvised music.

³ The case studies involved the use of pre-composed music only.

⁴ This work used improvisatory models only.

relates to existing theories of music and brain function, and to relevant research findings from other disciplines such as music psychology.

2.2: An examination of brain functions and the effects of music.

Specific areas of the brain have been identified as being responsible for or involved in particular abilities or processes of human functioning. This occurs both at hemispheric level, structural level, and at focal points in the brain. In recent history it has been generally assumed that the left hemisphere of the brain is largely responsible for the processing of information which is linear, sequential, logical, analytical, verbal, objective and factual. Information which is non-verbal, expressive, subjective and metaphoric has been attributed to right hemisphere functioning (Erdozmez, 1993). Originating from such theory and demonstrated through the study of brain damaged individuals, the processing of verbal material has been largely recognised as a left hemispheric function. Interest in the particular relationship held between language and music functioning has been historically fuelled by revelations that aphasic patients often present with differing levels of residual musical ability. This has given rise to the consideration of music as a largely right hemispheric function. It is currently more widely accepted that music/brain processes are highly complex, spanning across the hemispheres, thereby being more bilateral or intercerebral in nature (Damasio and Damasio, 1977). Furthermore, differences between musically trained and musically naive subjects have been shown in hemispheric specialisation (Bever and Chiarello, 1974) and in EEG patterns (Besson et al., 1994). These findings add greater complexity to an overall understanding of the relationship between music and the brain.

Research on brain functioning has examined residual abilities in individuals who have sustained brain damage, or had parts of the brain removed or

anaesthetised. Such studies have provided both individual case material and empirical group investigations which have led to developing theories on brain functions. Music and the brain has similarly been researched using such methods. What remains irrefutable is that damage to the brain through any means affects an individual's functioning in many different ways.

Particular weight has been given to the specialisation of brain function in examining the right hemisphere in music and music related tasks (see Zatorre, 1984 for overview), particularly comparing music with speech as right/left brain functions. Gradually, however, more global processes and structures have been understood to be involved in the complex task of processing musical information (Bogen and Gorden, 1971; Gates and Bradshaw, 1977; Prior et al., 1990; Sergent, 1993; Hodges, 1996). Underlying the hemisphere/global debate appear to be fundamental methodological differences between the 'perception' of separate musical elements, i.e. the reductionist approach, and the 'processing' of the musical gestalt. Gardner (1982) contrasted such methodological differences, labelling the former as a 'bottom-up' approach as opposed to the latter 'top-down'. This argument will be explored here in more depth as it reflects and bears relation to how music has been applied in therapy with brain damaged populations. In the following review, an assessment will be made of how music operates in the brain.

There is much to be learnt about the neuropsychology of music processing by studying brain damaged individuals, although methodological problems do remain. The literature examining the neuropsychology of music processing abounds with case studies, predominantly of brain damaged individuals who had been musicians pre-morbidly. In addition, there are a number of group studies using anaesthetic to one hemisphere (the procedure known as the 'intracarotid sodium Amytal injection'). In all of these studies, relationships were discerned between retained skills and areas of the brain not damaged

or anaesthetised, and impaired skills with damaged/anaesthetised areas. Thus, a picture of music's place within hemispheric lateralisation was sketched. However, the generalisability of findings from these studies has been questioned due to methodological problems. For example, the brain's ability to compensate for long standing pathology is widely acknowledged (Gates and Bradshaw, 1977). Indeed, damage and compensatory brain function also suggests differences between brain damaged and normal subjects in information processing which is difficult to control as a variable.

Not only have methodological problems provided complications, but the essence of the the matter in hand is elusive, as musical abilities involve multiple factors. For example, singing has been shown to be affected by anaesthesia to both right and left hemispheres independently (Gorden and Bogen, 1974). Other anaesthetic trials found specifically the right hemisphere to be involved in tonal control but not musical rhythm (Borchgrevink, 1980, cited in Zatorre, 1984). Yet repeated trials produced varying results, supporting findings which suggest singing to be a largely bilateral function (Zatorre, 1984). These studies reflect widely reported criticisms of the research into music mechanisms within the brain: small subject numbers, varying methodologies or tasks presented, which result in contrasting findings. Furthermore, greater insight is consistently gained by the inclusion of additional qualitative data or reports of variability between subjects which reveals individual differences which need to be accounted for if a generalisable theory is to emerge.

Particular lobes of the right hemisphere appear to bear greater importance in music processing. For instance, right temporal lobectomy revealed impaired ability in timbre and tonal memory, and timbre and loudness discrimination (Milner, 1962). Removal of the left temporal lobe, however, made no difference to performance. Zatorre (1984) cites further studies to support the

implication of the right temporal lobe in the processing of musical material, and the involvement of the left hemisphere when the stimuli presented involve familiar tunes. More recently, Zatorre et al. (1994) describe specialised neural mechanisms in the right hemisphere which are involved in pitch comparison and memory, and melodic analysis. However, no conclusive proof of dominance or laterality effect exists for music, as exists with speech and language, despite the large number of individual and small group designs suggesting otherwise (Zatorre, 1984).

Aphasics have provided important research data on brain function. Case studies of brain damaged individuals have often focussed on 'amusia', either in conjunction with aphasia or in the absence of any language impairment. Botez and Wertheim (1959) illustrate the right hemisphere's role in expressive musical functions through a case study of a right handed individual who had sustained right hemispheric damage from a tumour.⁵ Tests identified that although there was no damage receptively in musical skills, certain expressive skills were impaired. These included: rhythmic errors when disassociated from melody; systematically transposing separate notes vocally a 4th above that given (which the authors entitle 'vocal transpositional apraxia'); dynamic and variation of tempi errors in melody production; melodic and rhythmic inaccuracy in reproduction of melodies; and an inability to coordinate certain motoric abilities associated with music production e.g. motor apraxia when whistling and 'bimanual instrumental' apraxia affecting the patient's ability to play instruments with both hands. The breadth of the activities associated as 'musical' skills tested here give an indication as to the complexity and variability of musical tasks. Despite the lack of generalisability due to the individual nature of the case, there is support for the right hemisphere's involvement in expressive music function elsewhere, in addition

⁵ Right handedness suggests left hemisphere dominance. That is, in this case study, the non-dominant i.e. 'musical' hemisphere was damaged.

to attributing receptive functions to the left hemisphere (Damasio and Damasio, 1977; Barbizet cited in Benton, 1977).

Case studies such as the above which compare amusia and aphasia continue to fuel research comparing the neural mechanisms involved in musical and verbal tasks. More recent findings suggest that the substrates involved in musical and verbal tasks are paralleled and yet independent from each other (Sergent et al., 1992).

The literature covered so far shows that aetiology is often unspecified, inexact or slightly variable between subjects. But it is evident that perception, processing, and performance of differing musical stimuli involve different structures in the brain with perhaps greater involvement of the right hemisphere for expressive functions. These considerations certainly have implications for the music therapist who may be considering appropriate techniques for meeting specific needs of brain damaged clients, and how to understand the individual's responses. However, the multidimensional nature of the musical task presented must be considered. For example, familiar songs may involve both hemispheres due to the left hemisphere mediating the verbal components (Zatorre, 1984). Although the right hemisphere may primarily be involved in processing unfamiliar tonal sequences, other aspects such as short term auditory memory may implicate both frontal lobes (Brownell et al., 1982, cited in Zatorre, 1984). It may be initially tempting to hypothesise that the tasks of improvisation and familiar songs can be lateralised to right brain/left brain functions respectively, however, research findings presented later will show this to be an oversimplified response. It is clearly evident that localisation of function may be severely modified through injury. Therefore, when working with neurologically impaired individuals it seems critically important to be aware of types of approach that may be more appropriate to meet individual patient needs than others.

Further considerations to brain function and music emerge, however. Sergent (1993) emphasises an interdependent model of cerebral structures, echoing the earlier conclusions of Gates and Bradshaw (1977). For example, a musical task may recruit various cerebral functions which cannot be separated from other simultaneous thought processes. For example, the act of playing a musical instrument recruits both cognitive processes concerned with musical functions and simultaneously motor cortex functions. More important than the individual functions stimulated, are the relations between these and the organisation of the processes involved. When added to the extramusical associations an individual carries with them and which may be stimulated during involvement with music, the cognitive experience of music can be seen to exist on many different levels and involve many different functions simultaneously. Hence, although brain injury may affect specific functioning, the therapeutic application of music can be hypothesised to work on many different levels within cognition.

Gardner (1982) suggests that neither the reductionalist nor gestalt approaches to examining brain function and the effects of music adequately examines either the specific components or relates the components to the larger whole. Erdonmez (1993) relates the 'top-down' and 'bottom-up' paradigm to music therapy practice, comparing the gestalt experience of improvisation and imagery to music, with the 'bottom-up' experience of singing a specific song or rehabilitation of specific skills within music therapy. Although this suggestion perhaps oversimplifies the categorisation of the two different musical tasks, it is useful as a suggested framework within this study.

2.3: Music and the brain: what are the implications for music therapy?

In recent years, music therapists have begun to interpret the effect of music on human functioning in terms of cognitive systems and structures influenced

within the brain. For example, in reviewing current theories from music psychology and music/brain research, Thaut (1990) emphasises the need to develop not only an understanding of music perception, but also how humans respond to musical stimuli in non-musical behaviour (i.e. behaviour modification using musical stimuli, or physiological responses to musical stimuli). He asserts that only in recognising the behavioural implications of such stimuli can we optimise the possible benefits of music therapy. Although acknowledging that the current theories from which he draws lack substantial verification in research, Thaut explores the links between music perception and subsequent neuro-behavioural responses, particularly arousal and its relationship to emotional responses activated by the different properties contained within musical stimuli. These properties are specifically: the perception of intensity, tempo and timbre; the perception of structural elements such as order, novelty and surprise; and acquired learned associations to musical stimuli.

These ideas are particularly relevant to this study. Thaut suggests that emotional responses to music are stimulated by both the perception of the musical components and structures, as well as extramusical, learned associations. This bears direct comparison to the use of unfamiliar, improvised music, and the use of familiar, pre-composed music as stimuli within therapy and the effects on human emotional behaviour. Thaut stresses that considering affective and behavioural responses to specific musical stimuli should be considered by a music therapist in the clinical setting. For example, drawing on musical structure for its compensatory powers in brain injured clients; drawing on stimulating, activating musical stimuli for clients who are poorly aroused or motivated; and exploiting associative, pre-learned attributes of pre-composed music for affective change or recognition in patients who have mood disorders or suppressed emotional responses.

In considering arousal and behavioural modifications produced by musical stimuli, the influences on an individual's use of pre-composed music in therapy is clearly an issue of importance. In music psychology research, music preference has been defined not only as an interaction between the music and the listening situation, but as an attempt to stabilise arousal levels and achieve a particular situational goal (North and Hargreaves, 1997). Within the clinical setting these findings are relevant in observations of song selection techniques. For example, clients purposely choose music which meets their own particular emotional needs (Bailey, 1984; Whittal, 1991). So, the implications for the use of familiar songs within music therapy become clearer. An individual therapy session is a time when the choice of music and the individual's reactions to the music are the entire focus. Hence, this concentrates the individual on his or her particular choice and emotional reactions. Considering this, it must be acknowledged that choice of music within therapy may be entirely different from other settings. If the individual knows that a particular song will elicit feelings of sadness and tears, but does not feel safe enough to experience that vulnerability at that time, he or she may therefore avoid choosing such a song. Alternatively, if there is a wish to make overt more difficult feelings or issues, song choice not only reflects this, but can help introduce the feeling or mood to the session. In music therapy these are all ideas which are often stated within descriptive case studies, but not founded in research theory such as the research in music psychology.

The notion of music listening being an interactive experience was elegantly theorised by Meyer (1956). In an examination of the meaning of music, he suggested that there exists a triad between 'observer' (listener), 'stimulus' (music), and that to which the stimulus points (events or consequences). Meyer stipulated, however, that for music to possess meaning, there must exist some familiarity.

2.4: Emotion and meaning within music: the link with music therapy?

Recent research in music psychology continues to explore emotion and music, and further supports anecdotal reports of the emotional impact of music within therapy. Sloboda (1991a) found that the emotional experience of music involved music both as an agent of change (i.e. mood) where the individual was able to gain an alternative perspective on their situation through the music, and also promoted the intensification or release of existing emotions (i.e. allows the person to access the experience of emotions already existing, but not fully acknowledged by that person). In one study, Sloboda (1991b) found that subjects could identify a particular mood expressed by a piece of music, and yet not experience this feeling every time they listened to it. Using isolated sections from pieces of music identified by subjects as having produced specified recorded physical reactions, Sloboda attempted to identify musical events which facilitated emotional responses. Analysing the musical attributes of the named sections of music, specific musical structures were identified to produce specific emotional responses. These findings, which used only excerpts of Western classical music, were supported later by the additional analysis of responses to music from a wider range of idiomatic styles, implying that the musical structures themselves elicit the emotional responses rather than any extramusical factors.

As this research tends to focus on musical structures and the specific emotions elicited, it is therefore more intrinsically concerned with psychological processes of a cognitive nature. However, there are also differentiations made between conscious and unconscious expectations and responses to music. Meyer (1956) stipulated that whilst perceiving and responding to music does involve cognitive processes, these need not be conscious, unless reflection takes place. He elaborated, however, adding that:

'if intellectual activity is allowed to remain unconscious, then the mental tensions and the deliberations involved when a tendency is inhibited are experienced as feeling or affect rather than as conscious cognition.' (Meyer, 1956:31)

This topic is hotly debated within the music therapy profession as whether verbal reflection is needed in addition to the music in sessions. Most recently, Pavlicevic has put forward her own theory regarding 'dynamic form' within clinical music therapy, where music and emotion share fundamental features (Pavlicevic, 1997). In essence, this is the process about which Meyer theorises, the unconscious, unexplored mental tensions stimulated by music which are experienced as affect. Pavlicevic believes that verbal interpretation can prevent the client and music therapist from realising the full potential of the musical-therapeutic relationship, and strongly questions any verbal exploration of events within the session. She believes that by focusing solely on musical events, the therapeutic process is experienced as an unconscious process. Whilst with non-verbal clients there may be no option to reflect verbally, when working with verbally articulate clients, it would seem that not offering opportunity for verbal reflection may miss the opportunity to explore whether different musical meanings may be held by the therapist and the client.

Current research, in fact, has produced evidence to support these ideas from the realms of music psychology and music therapy. Using evoked potentials to map the electrical impulses within the auditory cortex, it has been shown that breaking expectation in a musical pattern causes change in the electrical impulses in this area of the brain (Jones, 1998). Although these findings are yet to be linked with affective responses, registering change in the auditory cortex can demonstrate in a measurable way unconscious responses to varying musical stimuli.

The way in which an individual appraises a piece of music is hypothesised to affect one's interaction with the music. In a study which examined implicit and explicit emotional responses to music, Waterman (1996) suggested that an individual's interaction with music may be reliant on internal referents applied by the individual to the music. Waterman built 'appraisal profiles' from qualitative data to examine cognitive representations applied by participants within listening and performance experiences. Of the findings, one major referent was memory based, however this was complex in its relation to the musical stimulus. The internal referents stimulated by music need not be emotional in themselves, but only stimulate further associative responses. That is, an emotion elicited might be a memory of an event which carries emotional salience. For example, a song to which a widow had danced with her husband might elicit vivid feelings of happiness based on memories of that experience.

Of course, Sloboda (1991a) found that particular musical events in themselves provoked strong emotions. For example, tears were most reliably provoked by melodic appoggiaturas, and also by sequences and harmonic movements through the cycle of fifths. Whilst this indicates that emotions may be elicited by musical structures, it is also notable that no generic sound patterns exist in music to communicate mood states as occurs in semantic content of language (Thaut, 1990). Hence it is learned associations which stimulate emotional responses to musical structures. Surprisingly, Sloboda also found that listening to a piece repeatedly did not result in a diminishing of the strong emotion associated with it. In fact, it is suggested that emotional responses can grow during repeated exposure. Both Sloboda and Waterman also noted that a single piece can elicit differing emotional responses at different times.

Besides how one appraises either musical events or associations stimulated, situational factors are also involved, such as existing mood and feelings of threat. Sloboda (1991a) found that an individual's prevailing mood may additionally influence one's appraisal of music, and hence one's emotional responses to it. Individuals were found to experience positively valued emotional responses to music only when feeling relaxed and unthreatened. In the absence of such feelings, an individual's self preservation (for example of personal goals such as safety and self-esteem) overrides appraisal-based emotions as a response to the music involved.

In attempting to present an explanation for the emotional responses stimulated by music, Meyer (1956) proposed that the experience of music is similar to the experience of life itself. Identifying that humans seek clarification and control, in moments when expectancy is broken or uncertainty rules, an individual is faced with a sense of lack of control and an inability to act on existing knowledge. Meyer postulates that this results in apprehensive or fearful feelings: 'in the moment of delay we become aware of the possibility of alternative modes of continuation' (Meyer, 1956: 27). In considering such a hypothesis, the emotional experiences of familiar music and unfamiliar improvised music can be viewed as highly different. With familiar pre-composed music, expectation will not be broken, however, the experience of improvisation could possibly stimulate 'fearful', 'apprehensive' or 'excited' feelings. A new client's hesitancy to try improvising, or inability to engage with it, has been attributed by some therapists to the potential of experiencing these 'risky' emotions. It is also the emotional experience of the unknown which is seen to be the powerful tool within clinical improvisation. Pavlicevic (1997: 18) gives a vivid description of a clinical situation referring to Meyer's theory. In her clinical vignette of the client 'Noel', whose playing consisted of a 'monotonous rhythm', she describes her own emotional responses to the

breaking of Noel's 'habitual stimulus' as the improvisation took a sudden turn due to an unexpected musical event (i.e. interruption of the endless rhythm).

In considering these ideas, it is suggested here that the cognitive appraisal employed in the comprehension and evaluation of music is entirely individual, and is affected by the situation in which, or purpose for which, an individual experiences music. Differences are created by each individual's interactions with music. Sloboda's suggestion that responses to music may be due to the intensification of implicit emotions adds further weight to the individual nature of emotional responses. Despite attempts to develop an explanation for emotional response to music using quantitative analysis, however, an answer remains elusive. The findings of such studies point to the intricacy and depth of emotion and meaning. For this reason, researchers have indicated that within-subject enquiries may be more valid than investigations into group trends.

Emotional responses and meaning in music are built on musical structures, associations, and individual appraisal of musical events. These may be explicit or implicit, although there is a debate that if remaining implicit, the therapeutic value of the musical experience is enhanced. There also seem to be implications from a psychological view for the familiarity and expectancy of the musical structures.

Having now examined music, brain function, and psychological constructs, an examination of the music therapy literature with brain damaged populations will reveal any links between practice and research to date. Firstly, for the client group in question, two particular considerations hold importance. In working with a brain damaged population, there may be implications for abilities in the reception and expression of musical information. Secondly, in working with adults with 'normal' histories, there will also be a lifetime's

associations inherent in the individual's experience of music which will, therefore, affect his or her psychological appraisal of the music.

2.5: Music Therapy within the field of neuro-disability: a review of practice.

In reviewing the extant literature on music therapy in this field,⁶ several themes emerge. Firstly, reflecting the research on music and the brain, a reductionist approach prevails in music therapy research, in which musical variables are largely controlled and manipulated, particularly in the application of pre-composed music. Yet in clinical therapy settings, both reductionist and gestalt approaches are applied in music, reflected by the addition of improvisatory methods. Secondly, restricted areas of human functioning repeatedly emerge as being addressed by music therapy practice and in research. These are movement, speech, cognition and emotional needs. Thirdly, the divide between the use of pre-composed familiar music and the use of unfamiliar improvised music is prominent and appears to follow the cultural trends already identified. Lastly, there is a different emphasis between music therapy practice in rehabilitation programmes and therapy with individuals with chronic, degenerative neurological conditions. The former tends to focus on improvement and gains, with the latter revealing a less goal orientated emphasis.

The recent and largely descriptive clinical reporting style of the literature indicates that the field of neurology is a relatively new area for music therapy to explore, particularly in Britain. In the following sections, different music therapy practices and research in neuro-rehabilitation will be compared, with a following section examining music therapy with chronic neurological illness.

⁶ For the purposes of this dissertation, 'neurological population' is determined as adults who have acquired, complex neuro-disabilities, stemming from damage to the brain and central nervous system, sustained through illness or trauma. This includes acquired brain injury through hypoxia or trauma, cerebral vascular accidents (also called 'stroke'), Huntington's Disease, Parkinson's Disease and Multiple Sclerosis.

The area of human functioning at which clinical intervention is directed will be highlighted (i.e. speech or movement, etc.) examining differences in practice and exploring any links with music/brain research.

2.5.1: Music Therapy in neuro-rehabilitation.

The broad account given by Claeys et al. (1989) of a music therapy service with traumatically brain injured clients is a landmark article serving as an introduction to music therapy in neuro-rehabilitation.⁷ In covering a client group which spans profoundly brain damaged individuals through to those re-entering the community, a progressive picture is given of the application of music therapy within rehabilitation. Using standard behavioural scales such as the Ranchos los Amigos scale (henceforth termed 'Ranchos scale' - see Appendix 1), a clear picture of clients' functional levels is communicated. In using this measure, Claeys et al.'s article is singled out, as music therapy literature rarely draws on standardised scales. Its use provides clarity to the article.

Typical to music therapy in neurology, music is applied in therapy to address movement, speech, cognitive and emotional disorders within rehabilitation. Music therapy in 'exercise routines' is justified by referring to particular musical components such as rhythm, and the emotional motivation which music provides. So, music therapy is used largely to enhance the work of the multidisciplinary team (i.e. with physiotherapy, speech and language therapy, etc.). Pre-composed music is specifically used to draw on the 'familiar' component of the songs in particular.

The description offered by Claeys et al. suggests that music in such settings holds an adjunctive purpose. It may be considered that this article reflects

⁷ The terms 'client' and 'patient' will now be used interchangeably in this review, following the terms used by the authors.

American practice in the emphasis given to the use of pre-composed material. Alternatively, it may be assumed that with pre-composed musical material we can provide no deeper therapeutic intervention such as clinical improvisation may provide. This is certainly the view given by Bruscia (1989), who described physical rehabilitation as one area where music serves an auxiliary purpose only 'in' therapy. Considering neurological problems in the client group concerned, however, it may be that the way in which music is applied in neurological rehabilitation, particular musical components are able to compensate for damaged neurological function.

Taking Claeys et al.'s work as a starting point, the remaining literature examining music therapy in rehabilitation settings will be explored under headings into which 'music as a tool for treatment' tends to be categorised. These are in the treatment of speech disorders, movement disorders, in the compensation for cognitive disorders, and for behavioural/emotional needs.

2.5.1.i: Addressing speech disorders.

Due to the potential for verbal output through singing despite severely impaired spoken language after left sided brain damage, music has been widely used in the treatment of aphasia. Clinical practice specifically aimed towards remediation of speech disorders is directly influenced by the technique described by Sparks et al. (1974) entitled 'melodic intonation therapy' (MIT). This involves retraining aphasic patients to speak by embedding short functional phrases or single words with melodic patterns imitating those of normal speech inflection, and gradually withdrawing the musical framework. Although the music used is not familiar songs, the phrases need to be practised repeatedly so that the speech/singing gradually becomes more automatic. Many anecdotal references exist outside of the music therapy literature about the effects of music in such treatment (Sparks,

Helm and Albert, 1974; Sparks and Holland, 1976; Keith and Aronson, 1975). However this technique is also widely reported within the various articles concerning music therapy in rehabilitation with patients who are aphasic after traumatic brain injury or stroke (Lucia, 1987; Cohen, 1988, 1992; Cohen and Masse, 1993; Cohen and Ford, 1995; de Bruijn, 1996; Magee, 1996).

There is evidence that the application of neuropsychological bases for music were used early on in music therapy with brain damaged clients in Australia. Bright (1980) explored the role of amusia with head injured clients devising a test which used solely well-known familiar songs. The results indicated that clients with damage to the right hemisphere performed better than expected on the musical function test, contradicting the popular theory held at that time of music being a right hemisphere specialisation. The author noted that the findings suggest differences in expressive and receptive musical functions, a view which finds support from the music/brain literature (Botez and Wertheim, 1959; Damasio and Damasio, 1977). This article demonstrates that although in its infancy, Australian music therapy was already emerging as a 'science' rather than as an 'art'. This is a difference which clearly persists, the latter term being associated in British clinical practice.

Lucia (1987) offered valuable clinical observations with patients who had sustained brain damage from road traffic accidents and stroke. She proposed that the familiarity of the music increased the automaticity of the performance, particularly emphasising the use of well-consolidated and overlearned familiar songs in speech and movement programmes. Furthermore, she stated that the use of familiar songs capitalised on preserved right brain functions for singing, which in patients with brain injury often precedes functional speech recovery. In referring to the literature reviewed earlier regarding music and the brain, it may be remembered that sodium amytal studies in fact produced inconclusive results regarding hemispheric,

specialisation in singing tasks. Case studies did suggest, however, greater involvement of the right hemisphere in the production of separate musical components within singing tasks (Botez and Wertheim, 1959). In this way, the early American literature regarding music therapy and speech rehabilitation can be seen to have been influenced by music/brain theory. Lucia based her clinical practice on rehabilitation theory that learning skills are enhanced by associating new material with well-consolidated and overlearned old material i.e. familiar songs.

Using speech variables as a determinant of successful outcome, Cohen (1992) offers findings which contradict those clinical observations made by Lucia (1987). Cohen examined the effect of singing instruction in group therapy with subjects who had expressive speech disorders after brain damage and stroke. This specifically employed a modified form of melodic intonation therapy (MIT - referred to earlier in this section) including singing familiar songs and using lyric substitution to familiar songs. Using a single case study design, differences in pathologies were highlighted. Trends emerged which suggested that song treatment caused an improvement in certain speech variables for subjects with right sided damage i.e. the expressive 'musical' side.

Further and more contradictory evidence looking at songs and rehabilitation is presented in a single case study by the same author. She examined the use of rhythm to decrease the rate of excessively fast speech resulting from right hemispheric injuries and Kluver-Bucy Syndrome (Cohen, 1988). The client's musical abilities appeared unaffected by her brain damage, particularly singing the melodies and words of familiar songs, and her ability to imitate rhythmic patterns with no difficulty. Cohen hypothesised that healthy brain tissue was compensating for damaged tissue in the client, as well as drawing upon rhythmic analytic skills from the left hemisphere. The music therapy

intervention involved singing one pre-composed familiar song. The results showed that intervention decreased the rate of speech by only 11%, whereas the use of a rhythmic variable which did not involve melody decreased the rate of speech by 28%. Amongst other extraneous factors, it was suggested that the additional processing of melody may have involved specific centres of the right hemisphere which had been damaged in this individual. Generalisation of skills by the client was observed, however. Relating these findings back to the music/brain research, it is clear that damaged brain functions appeared to be compensated for by music on a global level as suggested by Gates and Bradshaw (1977). Furthermore, the theory of music as a right brain function could not be supported, although particular aspects of musical functioning were clearly affected by the brain damage (see the findings suggested already by Zatorre, 1984).

Examining specifically unilateral left hemisphere damage, Cohen and Ford (1995) tested the effects of musical cues (melodic and rhythmic) and non-musical cues (verbal only) on non-purposive speech production. An analysis of variance indicated that there were no significant differences between the conditions (i.e. melodic, rhythmic or verbal) in either speech content or types of speech error, however, there was a significant improvement in the subjects' verbal intelligibility with a verbal condition. This would suggest that melodic and rhythmic cues did not improve speech production in any of the variables measured. Severity of apraxia and age were seen to be variables which affected the results. Despite the results failing to support music therapy as an intervention in speech rehabilitation, the authors emphasise qualitative factors in their work, such as providing an environment where the subjects were able to produce some words and feel successful, and providing a means of verbal and non-verbal expression. These additional comments appear to highlight fundamental differences not only between research and clinical work, but also the gap between the intended outcomes and the additional qualitative

findings. The literature from neurology tends to minimise any qualitative outcomes, such as changes in well-being or feelings of self-worth, whilst focussing on changes in the targeted areas. Typically it is song techniques that are associated with more measurable outcomes, such as changes in speech production. Relating songs to measurable outcomes in this way may contribute to the belief that songs are a limited medium for therapy. Cohen and Ford's observations point to the importance of using qualitative data, where small detailed observations can become central to analysis, but are missed, if not recorded as a variable in a quantitative study.

From the European culture, de Bruijn presented clinical work with children and adults with neurological disabilities in rehabilitation (de Bruijn, 1996). Pre-composed songs 'learnt in the past' were used with an aphasic client, and the author deduced that intact right brain melodic functions enabled the client to sing words. Rather than singing function being an end in itself, however, de Bruijn examined the emotional gains of exploring the associative content of the songs and the personal expression afforded.

In summary, pre-composed songs have often been used in the clinical work of music therapists working in rehabilitation. Although this has been standard clinical practice within the US for some years, such techniques have recently been referred to within British music therapy rehabilitation programmes (Purdie, 1997). However there have also been attempts to extend the act of 'singing songs' to greater functional communication within joint music therapy and speech and language therapy rehabilitation programmes (Magee, 1996). This work linked the application of music therapy in this way to measurable outcomes, but received criticism from within the profession as it veered towards 'science' and away from 'art', and did not reflect 'real' music therapy, but a form of speech therapy. The literature reviewed here, however, suggests that the use of pre-composed song may be able to provide form through song

structure, melodic and rhythmic cues, whilst drawing on preserved long-term memory skills to compensate for abilities lost through neurological damage. In this way, the use of pre-composed songs in this clinical area is indeed appropriate and informed by theory.

2.5.1.ii: Music therapy with motor rehabilitation.

Thaut et al. (1993) in their quantitative research shed light on the benefits of music in treatment of movement disorders with patients who have experienced CVA. The researchers studied the effect of auditory rhythm on temporal parameters of stride cycle and electromyographic (EMG) activity in walking gait of stroke patients. Ten hemiparetic subjects with a median post-CVA time of 4 months and mean age of 70.4 years were tested on three occasions over a five week period, initially without any stimulus to gain a baseline of steps per minute (or step 'cadence'), and then with an external rhythmic stimulus paced at the tempo of the individual's baseline walking pace. The rhythmic stimulus used, although an original music composition, was pre-composed, in the style of a renaissance dance, written in 4/4 time, with the first and third beats accentuated and played on a synthesiser. The results indicated that there was a significant improvement not only in weight bearing on the paralysed side, but that stride symmetry also improved using an external rhythmic cue. Hence a strong entrainment effect of auditory rhythmic cues was shown on temporal gait control with these patients. The changes measured were clearly attributable to the rhythmic stimulus and not just to spontaneous recovery, as a baseline measure was taken within each testing. The results also indicated that although there were significant changes in gait within and across trials, there were no such significant findings between trials.

The authors suggest that the data points to 'auditory-motor interactions as a specific coupling process in which motor unit recruitment patterns are effectively modified by sensory cues to improvise temporal muscular control' (Thaut et al., 1993: 15). The implications for such a process are enormous for the justification of using music within motor rehabilitation programmes. This study is supported by earlier research by the same authors with normal subjects aiming to determine the entrainment effect of signal periodicity in auditory rhythm on neuromuscular activity (Thaut et al., 1992). The music used in these experiments was consistent throughout the experimental conditions, manipulating only the tempo of the rhythmic stimulus for each testing.

Research such as that undertaken by Thaut et al. helps to provide a theoretical framework for how particular elements of music perception and performance work in relation to other mental functions. However, questions must be asked about the therapeutic relationship, or rather the lack of any evidence or emphasis given to it. Thaut et al.'s research epitomises the gulf between European, psychodynamically influenced music therapy practice, and the American, behaviourist models using music 'in' rehabilitation therapy. Whilst this research provides 'evidence' of the impact of music on brain functions, it suggests that a metronome could provide this service rather than a music therapist!

2.5.1.iii: Music therapy to address specific cognitive disorders.

Whilst the structural elements of music are referred to anecdotally in literature on music and neurologically impaired populations, there are also more specific investigations into how such elements can compensate for impaired cognitive deficits. Gervin (1991) describes how the repetition, rhythm and melodic prompt inherent in song structure provide a framework for clients with

disorders in initiation, sequencing, motor planning and problem solving. Songs were written by the music therapist with lyrics which gave verbal instructions for dressing, to increase independence in this activity. The client group were traumatically brain injured adolescents and adults who were functioning at levels IV - V on the Ranchos scale for cognition, had minimal to moderate physical deficits, and had difficulty initiating the sequential steps involved in dressing. The accompanying tempo matched the clients' own rate of functional ability, whilst the song's lyrics acted as external cues to address disorders in initiation, sequencing, motor planning and problem solving'. Two successful cases are described, in which duration of dressing was decreased, and independence was increased. The author does not clarify the number of clients with whom this method was unsuccessful, but she does indicate that it was found to be unsuccessful with those who had overriding physical limitations, and those who displayed non-compliant behaviour. In doing so, the application of music as appropriate for the neuropsychological needs specific to this client group is better understood. A full description is given here to illustrate how musical components are isolated and used in a compensatory manner with brain injured clients.

2.5.1.iv: Music therapy in meeting behavioural/emotional needs.

This section will review literature which primarily addresses social and emotional needs within clinical contexts and with client groups not previously mentioned.

Barker and Brunk (1991) explain how song themes were used to facilitate group discussion alongside improvisatory activities with brain injured clients. Activities and techniques were planned according to cognitive and emotional needs. Although both types of music were described as having a role in different activities, it was predominantly pre-composed, well known songs

which were used in the music activities. This article is unusual in the brain injury rehabilitation literature in that it aims to address emotional rehabilitation and yet its approach is clearly linked with neuro-rehabilitation models rather than psychodynamically oriented models. For example, songs progress from those with strong visual images to those with more abstract concepts as clients themselves progress and become higher functioning. The non-verbal improvisatory activities described aimed to develop basic interaction and listening skills, and did not reflect 'clinical' improvisation as is described within the European style of music therapy.

There has been little published on the use of improvisation methods in neuro-rehabilitation settings. One paper described both pre-composed and improvised music in music therapy treatment of clients with stroke to improve self-esteem (Purdie and Baldwin, 1994). The authors claimed that 'improvisation is a key factor in the therapeutic process' as opposed to the 'threat of structured music-making' (Purdie and Baldwin, 1994: 23). However no objective measures of self-esteem were used to support this claim, and there was no evidence given that the music therapy actually did improve self-esteem. Their case studies also detail the use of pre-composed familiar music in singing and piano playing, hence the techniques applied in the 'successful' case studies given conflict with the recommendations made.

Furthermore, the same authors provide a general review of the literature relating to stroke rehabilitation and music therapy (Purdie and Baldwin, 1995). There is discussion of non-English speaking cultures where folk culture and traditions, and in particular nationalistic and traditional folk songs, have potent emotional associations and so offer motivational elements to the clients' therapy (Lehmann and Kirchner, 1986 and Kwolek, 1984, both cited in Purdie and Baldwin, 1995). Such examples pose a strong argument favouring the

use of familiar pre-composed music in cultures where nationalistic symbolism is associated with particular music.

Techniques other than song-based activities or improvisation are described in the literature with brain damaged populations. Goldberg et al. (1988) describe the use of an adapted form of Guided Imagery and Music (GIM) in the programme of a woman who suffered diffuse brain atrophy after anoxic brain damage, with resulting behavioural disturbances, and difficulty in short term memory, construction and learning skills. In GIM, listening to the music, the client describes verbally the images elicited by the music to a therapist who reflects and guides the client through their pertinent issues. In this case, the music described was pre-composed, but was unfamiliar to the client. It is suggested that the form and structure of the music provided structure for the client's images and thoughts, which she was unable to provide independently, and also helped to contain the behavioural outbursts and anxiety with which she commonly presented. It was found that despite the client having impaired insight, concrete thinking and poor concentration, behavioural changes were noted independently of the verbal processing of her images. No stated measures were used, however, apart from the authors' anecdotal observations.

Music therapy with clients who have suffered very profound brain injury most commonly aims to cause behavioural change and achieve consistent responses. The terms used to describe the client who may present in very low awareness states vary ('Persistent Vegetative State' also called 'PVS' (Claeys et al., 1989), prolonged coma (Wilson et al. 1992), or 'low awareness states' (Boyle, 1995),) and appear to be used interchangeably. Due to the severity of impaired functioning in such clients, the application of music is usually in 'gestalt' terms i.e. the use of songs, works of music or receptive improvisations.

Musical stimuli need to be 'as meaningful as possible' with profoundly head injured patients. The music used is stressed as being 'versions of the client's preferred music' (Claeys et al., 1989; Wilson et al., 1992). The priority goal of treatment with clients in low awareness states is described as being to achieve consistent and appropriate responses to stimuli. Clients at this level are often too physically disabled to manipulate instruments, and therefore opportunities for active involvement in instrumental improvisation are severely limited. However, the use of interactive vocal improvisation has been found useful in actively engaging clients in low awareness states (Magee, 1996, de Bruijn et al., 1998).

Claeys et al. (1989) describe work with PVS clients, where music or sounds made on musical instruments are used largely as auditory stimulation. Both familiar pre-composed songs and improvised songs are described within treatment programmes. However, familiar songs of the client's preference are reported as being useful for the purpose of monitoring responses to stimuli which are known to have many emotional associations for the client, therefore drawing on extramusical stimuli.

The structure of song forms and the thematic content of songs are also viewed as being important factors in work with such clients. Glassman (1991) found that familiar songs with original lyrics provided opportunities for emotional expression whilst aiding in the organisation of thought processes. Of particular relevance here is the concept that the given form of a song may provide a structure for a client who has difficulty organising incoming information independently.

Wilson et al. (1992) present a pilot study comparing multi-modal and unimodal stimulation within a 'coma stimulation' programme with clients in prolonged coma. In this study, the immediate effects of stimulation using

music were measured rather than the longer term effects. Four single case studies are presented of patients diagnosed as being in 'PVS'. The effects on behaviour are examined before, during and after the application of music as a unimodal form of stimulation. Taped music was presented through headphones, consisting of familiar songs for which the subjects had a premorbid preference. These preferences had been discovered by consulting the subjects' own tapes and their relatives. Results showed a significant difference between before and during treatment for two subjects (Subject A: $t=2.66$, $d.f.=14$, $p>0.025$; Subject B: $t=2.846$, $d.f.=14$, $p>0.02$), and before and after treatment in one of the subjects (Subject B: $t=3.53$, $d.f.=14$, $p>0.005$), no significant difference between before, during and after music stimulation in the third subject, and a reduced response in behaviour after treatment for the remaining subject. This would imply that the use of familiar songs, with inherent memories and associations, had a positive effect for two of the subjects, and a negative effect for the third. The research reveals few insights applicable within clinical work, other than suggesting further investigations to identify which factors predispose positive responses and whether the application of music stimulation can promote recovery at all. It does serve as an attempt to quantify a behavioural application of music, and through the use of single case study design helps to highlight the personal and individual nature of music as a stimulus.

Further investigations with clients in low awareness states, who were described as 'comatose patients' (Boyle, 1995) examined the use of operant procedures. The aim of this study was to develop an assessment technique to determine which clients would benefit from an operant treatment procedure using music rather than other sensory stimuli. Four differing sensory stimuli were used to assess each client's awareness of the stimuli and the ability to differentiate between the musical stimulus and other sensory stimuli. The clients controlled the stimuli by operating an electronic switch, thereby also

showing preferences for stimuli and associated learning skills. The musical stimuli used were tapes of familiar songs from the clients' adolescent or early adult years, which emphasised the pre-morbid associations to stimulate associative responses. The results showed that several of the clients were able to differentiate between preferred stimuli (tapes of music and video tapes) and other stimuli (a light and a fan). In conducting empirical research with this group, Boyle ascertained that procedures must be systematic and simple, and secondly, that additional anecdotal data, such as physical or behavioural responses in particular, assumed far more importance than was originally anticipated.

From a less behaviourist approach, Durham (1995) describes clinical work which aimed to stimulate consistent responses to auditory stimulation, and similarly to Boyle (1995), describes techniques in which the client 'controls' the music through eye blinks and head movements. The use of instrumental sounds for sensory stimulation is also described, similar to that by Claeys et al. (1989). Durham's work differs significantly from that described by Boyle, however, in that the music presented is played live by the therapist, and largely uses music based on both structured and free improvisations in jazz and rock idioms. Furthermore, there are examples of clients who are actively involved through playing instruments, suggesting much higher level functioning than those described by Boyle. As no functional or behavioural measures are given, it is impossible to ascertain an exact picture of the clients involved.

Differing methods using improvised music with coma clients are described by Aldridge et al. (1990) and Weckel (1996). These accounts describe a technique in which improvised wordless singing is used by the therapist, structuring the tempo, phrase length and repetition of the music on the client's pulse, breathing and random movements. No details of clients' levels of

functioning are given, however, nor any specific details at all about musical stimuli e.g. mode/scale, articulation, which would offer generalisation of such techniques and be of great value to other music therapists.

Furthermore, Weckel (1996) applies 'creative music therapy' (i.e. Nordoff-Robbins improvisation) to clients in 'low awareness states', examining 'intentionality' of responses. The functional responses described, however, indicate that his categorisation of the participating clients as 'minimally responsive' to be incorrect. His projection of developmental psychological principles onto the 'development of the rehabilitation process' stimulates many questions. It is doubtful that after profound brain injury an individual could possibly follow any such 'normal' development as a child who develops with no impairment. Despite his pleas for research to determine exactly what it is about music which is 'working' for the client, he himself fails to give any specific insights into the musical stimuli used.

An interactive interpersonal element which is a fundamental of music therapy theory is not focussed upon by the more 'scientific' application of music therapy in rehabilitation. With other populations, the interpersonal element is seen as being a critical component of music as therapy. The attempts to quantify music in its therapeutic application causes the potentially emotional and interpersonal benefits to be dismissed or not recognised at all. This is clearly apparent from the recommendations which have been published within the US suggesting the use of functional outcome measures and assessment scales to score improvements in music therapy in neuro-rehabilitation in the areas of physical, cognitive, communication, functional and social abilities, whilst failing to make any reference whatsoever to the potential outcomes from music therapy in mood improvement, emotional adjustment or interpersonal interaction (Sandness, 1995).

2.5.1.v: Assessment scales.

Assessment scales, either developed specifically for or used in music therapy in neuro-rehabilitation reflect the primary use of pre-composed material. Erdonmez and Morley (1981) present a case study of one right handed man after he had suffered a left parieto-temporal infarct. The subject was aphasic with a right hemiplegia, and although he was dyslexic, maintained the ability to sight read music to the standard of Bach's two and three part inventions.

Items from the Botez-Wertheim battery, which used solely pre-composed music, were used to assess melodic, harmonic and rhythmic skills. In a later exploration of this case study however, Erdonmez (1982) questioned the length of 'short rhythmic patterns' employed in the rhythm tests, and asked whether it was the duration of notes which was being tested. She suggests the need to involve repetition in order for the fragment to truly represent a rhythm. Due to the precision of the assessment, it can be assumed that improvisatory material for testing as such would have produced too many uncontrolled variables. These articles are further examples of the scientific neuropsychological stance taken by music therapy in Australia.

Thompson, Arnold, and Murray (1990) present a music therapy assessment form reportedly in current use in rehabilitation settings in the USA with stroke patients. The authors claim this assessment to be generalisable to other neurological populations. The assessment procedure outlines cognitive, motor, communication, visual and social items, but fails to address adequately the emotional, interactive or expressive facets which present in people with these disorders. The items included would seem to be discipline specific, and normally adequately assessed by other members of the multidisciplinary team. It is surprising, therefore, to see them included within a music therapy assessment, and suggests an overly conscientious attempt at justifying the

music therapist's role in treatment programmes. There are many items in this scale which refer to instrumental playing under the motor section, but these do not specify the nature of the tasks, i.e. whether in improvisation with the therapist, or as accompaniment to song-based activities. There is reference to the use of song lyrics to assess auditory memory, familiar songs to assess long term memory, and song themes used to assess convergent thinking within the client's ability to reason. One recommendation is made for 'a creative method for treatment', but this is not clarified further (Thompson, Arnold, and Murray, 1990: 23). The assessment aims to be quantifiable and therefore highly suited to a medical model setting. Considering this, one can only assume that this may exclude improvisational activities. Certainly the lack of items addressing interpersonal or emotional adjustment would suggest that psychodynamic models of practice do not influence the clinical work.

2.5.1.vi: Summary.

To summarise, it can be seen that the use of music therapy within brain injury reflects a more scientific, medical/psychological application of music. In this way, music therapy in this setting differs significantly from how it is used with other clinical populations. The more 'scientific' model appears to be practised to a greater extent in the US and Australia, although the research model has also been influential in European practice.

In brain injury rehabilitation, we have seen that in therapeutic application music is often broken down into its component parts in order to compensate for the aspects of human dysfunction reflecting the reductionist approach so prevalent with the music/brain research. The clinical literature also tends to draw on notions of hemispheric specialisation rather than examining more global responses. In this way, there remains little reference to the 'top-down' or gestalt approach that clinical improvisation may have to offer. More recent

work in brain injury discusses the global benefits of the gestalt musical experience of improvisatory music therapy, albeit somewhat more vaguely than the literature which specifies pre-composed material (Weckel, 1996; Purdie, 1997).

Viewing the literature chronologically, it can be deduced that the application of music therapy in the treatment of acquired brain injury has developed rapidly over the last ten years during which it has been documented. Certainly the use of pre-composed familiar music is more widely applied in rehabilitation programmes than unfamiliar improvised music, attempting to link such practice to music/brain function. In adopting such models, it seems that the potential to use music for rehabilitation of social skills or emotional adjustment remains little explored. Where brain injury is more profound, a wider use of music is reflected and principles stemming from behavioural psychology prevail.

It appears that the predominance of familiar pre-composed music is supported by several arguments. In contrast, there is little information regarding the value of improvisatory models with this client group, and that which exists does not reflect a theoretical basis for the recommendations made. Other contributing factors may be that the use of familiar music in song form is one of the only ways of quantifying and controlling conditions in music for empirical research, thereby influencing the choice of music to be used. Certainly, attempts to ascertain what it is about music that 'works' in the literature describing improvisatory models is poorly supported by specific theory or standardisation of the differing human and musical variables. Indeed the literature generally reflects a lack of consensus concerning exactly what area of rehabilitation the music best addresses. For example, the more convincing literature specifies a particular task or ability which intervention can address, whereas the literature which focusses on the gestalt musical experience tends

to reflect a very general mixture of individual benefits. Such benefits span physical, communication, interpersonal and awareness abilities.

It is evident, therefore, that there is a lack of balance between different approaches within brain injury rehabilitation. The reductionist approach, most commonly using pre-composed material, often poorly acknowledges emotional or interactional gains, whilst the gestalt approach, represented by largely improvisational therapy, lacks consistency or standardisation, essential for developing research and theory. Furthermore, improvisatory methods are less frequently discussed with this client group, leaving questions as to either its benefit in comparison with methods which draw on pre-composed music, or the extent to which improvisation is used.

Moving to the literature concerning chronic neurological illness, different trends emerge, however. Whilst cultural influences remain, it would appear that improvisatory methods have been explored more with individuals living with chronic degenerative neurological disorders.

2.5.2: Music Therapy in chronic neurological illness.

The types of chronic neurological illness to be included in this review include Huntington's Disease (HD), Parkinson's Disease (PD) and Multiple Sclerosis (MS). These conditions meet the criteria that damage to the brain and central nervous system causes progressive degeneration for which there is currently no cure. The literature relating to the first of these two conditions will be reviewed together initially, followed by a separate section reviewing Multiple Sclerosis, since Multiple Sclerosis patients will form the focus of the therapy work in this dissertation.

Reflective of music therapy in rehabilitation settings, HD and PD work tends to be on specific programmes to address movement disorders, behaviour

modification and speech disorders. Although some of the published work concentrates on one particular area of human functioning such as speech (Erdonmez, 1976), other work attempts to address the more holistic needs of the individual, such as speech, movement and emotional needs altogether (Hoskyns, 1982). Examples of both improvisatory and familiar pre-composed music are to be found in the programmes described. There is little evidence of psychodynamic therapy approaches, although most of the literature is Australian, and so this may offer some explanation.

Whilst the literature is largely descriptive in nature, there are small studies which include quantitative analysis of changes in targeted responses (Dawes, 1985b; Erdonmez, 1976; Hoskyns, 1982). The techniques and rationales used in 'rehabilitation' are drawn upon, particularly to improve or facilitate speech and to stimulate purposeful movement. The interventions differ from rehabilitation work as there is less emphasis on improvement in abilities, but rather a focus on maintaining existing abilities as well as expression of emotional needs. Much greater emphasis is given to life review processes (Curtis, 1987; Dawes, 1985a; Brandt, 1996). Once more, song-based techniques are prominently used as a catalyst for discussion and emotional expression through song choice and thematic identification (Dawes, 1985a; Curtis, 1987). There is also prominent emphasis given to how music can be used to compensate for changed cognitive abilities (Dawes, 1985a; Curtis, 1987; Magee, 1995a&b). Such assumptions, although widely made, remain unfounded to a large extent in the literature. Techniques include the use of both taped and live music (Hoskyns, 1982), mostly pre-composed, and also passive and active techniques. Some programmes, although facilitated by trained therapists, could be described more accurately as recreational due to the few clinical skills needed (refer Rainey Perry, 1993).

2.5.2.i: Music therapy to meet emotional and behavioural needs.

In the literature, much greater emphasis is given to emotional needs with the chronic neurological population than the rehabilitation population, and there is less evidence of any medical models of practice. For example, Dawes (1985a) and Curtis (1987) both employed a technique entitled 'counselling-oriented music therapy' with HD patients in the early through to advanced stages of the disease. This employed pre-composed material, drawing on song themes to stimulate identification and discussion. The particular focus was on emotional needs such as being accepted, having independence, establishing relationships, promoting self-esteem, and emotional and spiritual well-being and personal growth. In the discussions, the musical structural form of songs is emphasised, accentuating the potentially compensatory properties in the music for cognitive deficits in short term memory, concentration and other frontal lobe impairments. Dawes highlights how such therapy techniques may enable the therapist to continue working with such patients even into the advanced stages of the disease when other media for communication and expression become impossible. The same author (Dawes, 1985b) offers further insight into the use of familiar songs in an evaluation of a music therapy programme to increase one man's expressive use of music and decreasing socially inappropriate behaviour from HD. The client had previously been a rock musician, and was therefore presumably familiar with improvisation, and still capable of playing his instrument. However, clinical improvisation was not used in the treatment programme. Considering the 'expressive' emphasis often placed on clinical improvisation by music therapists, this seems surprising. The quantifiable properties of songs offer one possible reason for this omission, but it would also seem that the therapist's clinical practice failed to provide an appropriate range of techniques for this client. In the clinical setting, therapy which is focused on the client's overall needs and abilities, aims to reflect a range of techniques to

meet these. In this particular case, improvisation would have seemed a more expressive therapeutic approach to address behavioural problems through existing underlying emotional issues, particularly as improvisation is stressed elsewhere as an essential tool with HD clients at this stage of the illness (Magee, 1995a&b).

Song writing is also reported widely in both the Australian literature (Dawes, 1985b; Curtis, 1987) and also the European (Brandt, 1996). This technique serves particularly to offer opportunities to HD clients for reviewing their life stories or relationships, thereby reflecting a 'palliative' model. The techniques described draw heavily on either the familiar musical structures of pre-composed songs with lyric substitution, or on the lyrical content of the words written by the individuals. Brandt (1996) claims that lyric substitution with very familiar songs helps individuals to participate actively.

Hence in music therapy with HD, the use of pre-composed music can be seen to draw heavily on the verbal content and associative properties of the music. There is a lack of reference or use of improvisatory models to meet emotional needs, which cannot be attributed to physical disability preventing the use of instruments.

Very different approaches are recommended for people with PD, however. Selman (1988) emphasised the emotional and expressive responses in one man's individual music therapy intervention. In treatment which used only improvised music, the author's subjective comments served to evaluate the efficacy of intervention. The aims were broad and focussed on emotional expression. Frustration at not being able to 'find the tune' of a pre-composed song is reported as 'discouraging' the client, whereas in improvisatory activities with this same client 'his music-making ... showed no lack of will, no

impoverishment of feeling, motive or attention' (Selman, 1988:7). Although offering novel insight into the use of improvisation with PD clients, this case study reflects Selman's own belief that improvisation is the central tool in music therapy. Rather than making an informed comparison based on previous findings about which components in pre-composed music may be useful in addressing particular needs in PD, she dismisses previously published literature about music therapy programmes with this population as 'adjunctive' to physiotherapy and relaxation therapy.

Sutton and Swallow (1993) specifically differentiate between pre-composed and improvised music with PD clients, stating that the

'holding, stabilising effect of structured (i.e. pre-composed) music have much to offer the person with PD: coordinated movements (such as walking) - when set to music - become fluent and less likely to break down. On another, deeper level, music improvised *for* the person, *with* the person, can directly address the emotional state'. (Sutton and Swallow, 1993: 6).

The authors, therefore, make a qualitative distinction between improvisation and pre-composed music, suggesting that both have very different roles to play in therapy with these clients. In a small study Sutton (1988) reported that for one subject, changes in the client's ability to produce a familiar song resulted in stress and anxiety i.e. negative mood effects. If the use of pre-composed material stimulates these types of feelings, this would suggest that it is not useful if emotional issues are the central goal of intervention. However in the following section of this chapter, it can be seen that pre-composed music is recommended for movement programmes. Once more, it is emerging that different types of music may serve different purposes, and a central aim of therapy is to accurately identify the client's needs and use appropriate therapeutic strategies to meet these. This particularly includes understanding the different roles pre-composed and improvised music may have.

Anecdotal observations regarding the power of musical structures on movement patterns in neurologically damaged people have been widely made. Most notably, Oliver Sacks, in his case studies on post-encephalitic Parkinsonism, described 'frozen' individuals coming to life on hearing a waltz, i.e. familiar, pre-composed music with a strong pulse and well learned movement patterns (Sacks, 1991). Such anecdotes have led to more rigorous testing within this area.

2.5.2.ii: Music therapy in movement programmes.

Groom and Dawes (1985), in the abstract to a practical workshop on a music and movement programme with HD clients, refer to a programme where music was improvised to match the patients' movements or stimulate a particular mood or atmosphere for movement. Although it is stated that music was improvised by the therapists for the clients' movements, no further details were given in the abstract. Hoskyns (1982) refers to aspects of movement in a brief music therapy programme she ran, which included instrumental playing both in improvised duets and to Irish jigs and reels. One of her aims was specifically to reduce choreic movements as a measure of promoting relaxation. Her findings indicated, however, a significant increase in choreic movements after music therapy. Hoskyns attributed this to the physical involvement of playing instruments, and as the subjects indicated this was a pleasurable part of music therapy, increased movements were not interpreted as showing a negative response. She also included qualitative observations that group members were motivated to dance to the music in the sessions, even individuals in more advanced stages of the disease. Clearer and more specific results might have been achieved if 'purposeful' and 'non-purposeful' movements had been differentiated in the measured behaviours.

Cosgriff (1988) describes both improvised and familiar pre-composed music being used as part of a programme for music and movement in which it was observed that both forms of music, 'of an essentially rhythmic type', stimulated movement. This research used self assessment at multiple time points; pre-testing approximately four months pre-treatment, at the start of the programme, and at the end of the programme once more. The use of well-known familiar songs with a chorus and verse structure was found to be helpful in dance and movement exercises. It was observed that internalising the music through the act of singing familiar songs caused movements to become more ordered. Results remained largely observational however, as there was no overall change measured between the initial and final assessments. Erdonmez (1993), in her work with a Parkinson's patient also observed that walking could be initiated when accompanied by a 'well-known song with a strong rhythm', claiming that 'music as an auditory cue activates neural pathways to enable the person to initiate walking'.

There is quantitative research examining the effect of rhythm in PD to support such descriptive accounts. For example, Miller et al. (1996) found that gait parameters in Parkinsonian patients shifted towards those of healthy elderly patients when subjects walked to tapes of metronome pulse sequences embedded into rhythmically accentuated music for 25 minutes a day. This technique, known as 'rhythmic auditory stimulation' (RAS) was also found to affect gait patterns in other neurologically disabled populations (Thaut et al., 1993). Most notably in the Parkinsonian study, the authors found that the beneficial effects of RAS found were not replicated in the healthy elderly population suggesting that the metronomic pulse embedded in music 'helps to improve specific aspects of motor control in deficient gait rather than causes a generic 'musical' walking pattern' (Miller et al., 1996:6). A further empirical study examined the effect of RAS with Parkinson's patients using a control group

who either received no gait training or who used 'internal pacing' rather than external auditory stimulation. The experimental group trained with RAS. Pre-composed familiar music of the subjects' choice was used from the categories of 'folk, classical, jazz or country', with the rhythmic stimuli once more embedded within the music.

The study showed that RAS training significantly improved gait through rhythmic entrainment. Furthermore, there was a carryover effect. Additional anecdotal information gained from several of the subjects suggested self pacing during this post training session by 'singing the music silently'. This supports the earlier idea put forward by Cosgriff (1988) regarding the internalising of songs to promote order of movements. Furthermore, Thaut et al.'s findings offer greater support for hypotheses made in the clinical setting by developing theories concerning music processing and how such processing may stimulate other brain functions, such as providing order for movement patterns. Both empirical research and observational studies indicate that the use of pre-composed familiar music can improve and enhance different facets of movement for people with PD.

Relatively few recommendations have been made for the use of improvisation in movement programmes, although Sutton (1988) focussed upon initiation, co-ordination, rate, and involuntary rhythmic body movement using clinical improvisation. There were specific comparisons between what responses improvised music could provide compared to pre-composed. Anecdotal observations reported that participating in joint improvisation with a music therapist seemed to facilitate control of arm movements in one subject more than pre-composed.

In summary, anecdotal and empirical research indicates that rhythm is a key component in the use of music with neurological disorders. This has largely

been used with pre-composed music, due to the additional associative properties which therapists tend to exploit for motivational reasons.

2.5.2.iii: Music therapy in addressing speech disorders.

Similar to rehabilitation programmes, music therapy has been applied with chronic neurological conditions to address speech disorders caused by the disease process. Erdonmez (1976) examined the effect of music on functional speech in HD patients using pre-composed material. Although the results were largely inconclusive due to methodological problems in the design, anecdotal observations noted that singing popular songs of the patient's choice increased motivation. It is questioned here whether the technique of melodic intonation therapy used was appropriate for the language deficits experienced by HD patients, or whether a 'rehabilitation' approach was most suited to the clients' needs, particularly as the other literature found focussed mostly on emotional and spiritual needs, reflecting a 'palliative' model. Another study examined a combined speech and music therapy approach with a PD group (Crozier and Hamill, 1988). This did not use familiar songs as might be expected, but used mostly chants and speech drills to rhythms. This seems surprising considering the similarities in speech disorders between this group and other neurological groups, and the overwhelming use of song singing in programmes with similar populations. There was no statistically significant improvement seen in subjects' speech intelligibility post treatment.

2.5.2.iv: Specific cognitive issues.

In both empirical and descriptive investigations examined here, assumptions are made regarding the relationship between music and cognitive processes. Much of the time these are merely assumptions, as individual neuropsychological measures are not available and no greater individual

details are given. At other times, cognitive disorders typical of the patient population norm are used to formulate assumptions on a theoretical basis, such as with the movement studies already cited with PD patients. There does appear to be some divide between music therapists who do consider cognitive aspects, and those who ignore them or wrongly interpret them as emotional responses. For example, some of the literature explicitly outlines problems such as immediate, recent or remote memory; the ability to plan, sequence, reason, problem solve, or show flexibility in thought processes; or describes behavioural aspects such as disinhibition,⁸ lability,⁹ and adynamia.¹⁰ Although claims are made by some authors regarding the compensatory power of pre-composed music, this is not always backed up by any detailed behavioural observations or specific individual neuropsychological measures which indicate a need for cognitive compensation.

For example, using a neuropsychological framework to explain behavioural and musical observations made within music therapy intervention, the current author suggested that freer forms of improvised unfamiliar music are appropriate only in the early stages of HD (Magee, 1995a&b). Such recommendations were related to HD dementia, and to the cognitive degeneration which progressively takes place in the illness process. This, in fact, supports and draws from earlier recommendations made by Dawes (1985a) regarding the need for structured familiar music in the later stages of the illness. Although the use of improvisation is described with people in the later stages of HD, the author strongly recommends that the musical material is based on recognisable familiar music in order to maximise attention and

⁸ Disinhibition can be described as poor impulse control, resulting in impulsive behaviour or speech.

⁹ Lability is the inability to moderate or control emotional responses. Responses may be prolonged and exaggerated in comparison to the stimulus. Often there is an oversensitivity to emotional triggers.

¹⁰ Adynamia is apathy or reduced motivation, caused by neuropsychological deficits. This is different to an emotional response.

concentration, particularly as the clients are often unable to participate 'actively' themselves.

In comparison to the literature on HD and music therapy, no reference is made to the changing cognitive needs in a PD population. Once more, this may reflect cultural trends, as the literature pertaining to PD and music therapy is predominantly British. It is clear from a wider review of the music therapy literature that British music therapists do not yet fully consider these types of issues when working with neurological clients.

2.5.3: Music therapy and Multiple Sclerosis.

Of all the areas of music therapy in neuro-disability reviewed, the least information is available regarding its application in work by Multiple Sclerosis (MS) clients. The available literature is dominated with material from the Australian music therapist Clare O'Callaghan, particularly examining the role of song-writing with MS patients. Otherwise, internationally, there is a marked lack of evidence that this client group is treated at all by music therapists, despite the fact that MS is the most common nontraumatic neurological illness affecting young and middle aged adults (Rao, 1986). Furthermore, there has been significant research exploring mood disorders associated specifically with MS, which would indicate music therapy as an appropriate intervention. A detailed background to the biological, psychological and social impact of the illness is given in Appendix 2. Given the demography of MS in the population combined with the lack of evidence and information on MS and music therapy, this thesis will focus on this client group in particular.

2.5.3.i: Pre-composed music in the treatment of MS.

Reflecting previously made assessments of cultural trends in music therapy practices, there exist several reports on joint music therapy and

neuropsychology programmes for severely brain damaged MS patients from Australia. The use of music was described to address specific disorders such as adynamia (i.e. exhibiting problems with initiation) and disinhibition. Different techniques used in individual and group settings are described, including relaxation techniques, songwriting, instrumental and vocal improvisation, and musically supported counselling using pre-composed familiar music (O'Callaghan and Turnbull, 1987 & 1988; O'Callaghan and Brown, 1989). The authors relate activities and the type of music used specifically to neuropsychological deficits and abilities, stressing the need for familiar, pre-composed music in addressing an individual's cognitive needs. By applying a neuropsychological knowledge base it was found that the use of well-learned musical material i.e. familiar songs, particularly choruses and emotionally laden songs, facilitated arousal for adynamic participants, and it was recommended to avoid unfamiliar music to minimise lapses in concentration and maximise active participation. For those with short term memory deficits but relatively well preserved long term memory, familiar songs from the participant's youth were recommended. The authors recommend avoiding 'new and complex material', such as unfamiliar improvised music, which serves to highlight organisational and problem solving deficits.

Although O'Callaghan et al.'s literature was descriptive of clinical work and, therefore, showed no evidence of any sort of analysis other than observation, the recommendations were founded on a multidisciplinary approach and a neuro-behavioural model of practice. Despite practice drawing from a neuropsychological model using songs, emotional needs were not ignored. In this way, a combined neurobehavioural and humanistic model is evident. The recommendations support the suggestion that familiar music may provide a stronger structure for people whose brain damage inhibits the processing of novel, unfamiliar material. This reflects much of the clinical work described in

the literature on music therapy both in rehabilitation and with other degenerative conditions.

Research with MS patients has also been categorised specifically under 'palliative care' (O'Callaghan, 1995, 1996). The author examined the lyrical themes in songs written within individual and group music therapy sessions by palliative care patients, two thirds of whom had advanced MS. Although no formal neuropsychological measurements were available, the author specifies the cognitive impairments of the research participants in categorical and functional terms. These assessments were made on clinical observations and neuropsychological assessment reports 'where available'. Although music was composed for these songs, the techniques described also include lyric substitution to familiar melodies.

The research and clinical case studies by O'Callaghan and her associates are important contributions to the music therapy literature, as they reflect a combined model of practice to meet this population's complex needs. In this way, this work stands as an example of how to consider a client's cognitive functioning and simultaneously not dismiss the 'person', which appears to be a concern within music therapy practice with brain damaged clients. Unlike the literature reviewed which focussed on song techniques, emotional needs were the central focus of intervention.

2.5.3.ii: Improvised music in the treatment of MS.

From a European perspective, music therapy with MS patients is described as a 'special kind of psychotherapeutic treatment' (Lengdabler and Kiessling, 1989) using only 'minimally structured improvisations' within group therapy. A two year study included 225 MS patients as part of a music therapy group in a clinic for MS. Themes which were explored were disability, uncertainty,

anxiety, depression, and loss of self-esteem, and the results showed that music therapy provided psychological support and individual strategies for coping with the disease process. In the descriptions of the music played in the group, analytical interpretations were offered about the musical meaning, using a psychodynamic framework. The authors state that motor disturbances limited some people from participating in instrumental improvisation to some extent, but that anxieties about exploring emotions and expectations of immediate results contributed far more to limiting factors. This work contrasts dramatically to that by O'Callaghan. Not only are the musical structures of intervention entirely different, but so are the other recommendations, such as active instrument playing, the particular focus on group therapy, and the application of a psychotherapeutic framework. There seems to be no consideration for the clients' cognitive functioning abilities. The absence of these types of considerations must be questioned, as many people with MS experience cognitive dysfunction, and recent research indicates that large numbers experience subcortical dementia (Mahler and Benson, 1990). It is unlikely, therefore, that the sample size of this study would have included no patients with some type of cognitive problem.

2.5.3.iii: Summary of music therapy with MS.

The diversity of reported approaches within this area of therapy suggests that further investigation could shed light on how different music therapy approaches are beneficial to MS clients. O'Callaghan's work strongly recommended song-based activities and focused on the clients' emotional needs, but accessed these using a neuropsychological knowledge base. Despite also focussing on emotional needs, the Lengdobler and Kiessling study recommends only improvised music, basing their rationale on a psychodynamic framework.

2.5.4: Linking theoretical and practical contexts.

Increasingly, the music therapy literature is calling for greater consideration and awareness of cognitive functioning when working with brain damaged clients (Erdonmez, 1993; Magee, 1995a&b, 1996; Pavlicevic, 1997; Usher, 1998). The chronology of literature suggests that more recently music therapists may be taking note of such recommendations. Also, trends suggest that certain music therapy 'cultures' may be more influenced than others by fields of theory outside of music therapy, such as neuropsychology and medicine. This is substantiated by the early application of wider models in neurological conditions within the Australian (Bright, 1980), and American literatures (Lucia, 1987; Claeys et al., 1989) and yet only very recent evidence of such application within British models (Magee, 1995a&b, 1996; Pavlicevic, 1997), as opposed to earlier British literature with neurological populations which applies mainly psychodynamic principles (Selman, 1988).

We have seen from the literature that there are many variations in clinical practices with neurological populations, perhaps more so than with any other client population frequently appearing in the clinical and research literature. Differences in philosophies or applied frameworks, such as 'rehabilitation', 'psychodynamic' or 'palliative', are reflected across the broad range of conditions falling under the umbrella of 'neuro-disability'. Ultimately, these different approaches also tend to indicate the type of music used i.e. pre-composed, familiar, premorbidly learnt songs, and unfamiliar, improvised music within clinical improvisations. The former of these is most often applied in what Erdonmez termed the 'bottom-up' approach to therapy, whereas the latter are applied in the 'top-down' or gestalt approach (Erdonmez, 1993). We have also seen that many claims have been made regarding the cognitive functioning of the clients involved, and in some cases what the implications are for the use of music in such conditions. However, to date there has been

no empirical study examining a comparison of pre-composed familiar music and improvised unfamiliar music in the clinical setting in order to examine the appropriateness of either with this client group.

Furthermore, there are other implications of a client's condition or pathology which may influence intervention. For example, brain injury rehabilitation is often goal directed, aiming for observable change during short term intervention. This suggests that the client will experience change in the direction of improvement. However, experiencing progressive illness often means reducing 'identity' goals, aiming for a lower level of achievement and a less preferred identity (Charmaz, 1987). Clinical work with degenerative and long term illness should indeed reflect fundamental differences in approach and the intended aims of intervention. For example, issues of spirituality and hope and the role of music therapy in these have been rarely mentioned in the literature reviewed here, though in 'acute' palliative care these concerns are central to the clients with whom therapists work (Munro, 1984; Aldridge, 1995&1996). This suggests differences between palliative care and chronic neurological illness, and also how clinical practice is affected. Techniques using pre-composed familiar music of personal meaning to the client have been claimed to be beneficial to patients living with chronic or terminal illness, facilitating 'musical life review' (Bright, 1986; Beggs, 1991). Indeed such a technique can be seen to parallel what has been termed 'biographical work', which includes review, maintenance, repair and alteration of one's life. These functions are highly important to the individual living with chronic illness (Corbin and Strauss, 1987; Charmaz, 1987&1991). A wider examination of music therapy in neurological illness is called for, considering the impact of the 'chronic' nature of degenerative illness, in addition to other particular aspects. For example, if brain damage affects an individual's musical ability, what does this mean for the chronically ill brain-damaged client in their music therapy?

Stimulated by the huge gap in the literature and the current author's own clinical experience and approach, a pilot study was undertaken to compare the use of pre-composed and improvisatory music in mood effect in music therapy intervention with neurological patients. This will be presented in the following chapter.

CHAPTER 3

THE PILOT STUDY

3.1: Introduction.

This chapter will describe the research design and the method employed to implement the pilot project. Included are the rationale for the pilot study, the hypothesis, a description of the participants involved and the selection procedure, an explanation of the measurement tools, and the procedure with details of the conditions being compared.

3.2: Outline and rationale of pilot.

The purpose of this study was to explore the use of familiar songs and unfamiliar improvised music within music therapy sessions with a group of people with neurological disabilities, and to examine the effect of these two different activities on mood. Each participant was seen for two individual music therapy sessions. Each session involved either song-based activities, or improvisation activities, so that each participant experienced one session of each type of activity. The sessions occurred one week apart in the music therapy room.

In more detail, the two types of activities were:

A : song-based activities, using familiar, pre-composed music. These activities included singing and/or playing pitched and non-pitched percussion instruments to familiar songs of the participant's choice.

B : improvisation activities, using unfamiliar, improvised music. These activities included exploration of a variety of instruments; turn-taking activities with the therapist on the same or a different instrument; and joint improvisation between the participant and the therapist on different instruments. On occasions, voice was also used as an instrument.

A standardised psychometric measurement system was used to collect data in order to examine the differences in mood immediately before and after the session. The differences between pre and post mood measures for each music therapy condition were compared, aiming to contrast any differences in scores for the two conditions. A self measuring scale was used in an attempt to gain more accurate and personal data as to how the two conditions affected the participants, rather than observer measurements which would record behavioural or more superficial responses.

The initial hypothesis was formulated considering the suggestion that the use of well-learned, pre-composed music in song based activities facilitates participation as a result of the familiarity of musical structure, even for those with severe memory difficulties and poor concentration commonly found in people with brain damage (O'Callaghan and Turnbull, 1987 & 1988; O'Callaghan & Brown, 1989). The authors state that due to increased performance, the participant is able to achieve an enhanced sense of self-esteem and increase in positive mood. Similar suggestions of facilitating a positive mood change however, have been made regarding the use of improvisatory activities with similar and other neurologically impaired populations, by accessing deeper emotional states and allowing for emotional expression (Lengdobler & Kiessling, 1989; Sutton, 1988; Selman, 1988; Purdie & Baldwin, 1994). Although claims of increased self-worth and self-esteem abound in verbal and published anecdotal accounts of music therapy practice, in reality such factors are much more difficult to measure. It was felt to be more realistic in this study to measure immediate changes in mood which could be directly attributable to the session which the client had just experienced.

This study focussed on mood change directly after music therapy intervention as an indication of how the participant was affected by the music therapy

activities, and how they experienced their own performance in the session. By measuring mood immediately before and after music therapy, the change which occurred due to its application could be clearly observed. Should the experience be one which the participant could not comprehend or in which he or she did not feel as able to participate, then it was expected that the mood changes would reflect this accordingly.

Considering the types of cognitive impairments exhibited by the participants in this study, it was felt that the consideration of neuropsychological impairments in the studies by O'Callaghan and Turnbull (1987 & 1988) and O'Callaghan and Brown (1989) gave a stronger theoretical basis for recommending the use of familiar pre-composed music in music therapy sessions to elicit responses and facilitate positive mood change. This was also supported by the many anecdotal descriptions given in the literature about the use of pre-composed music with neurological populations, and also from the researcher's own clinical experience. The initial hypothesis was that song based activities using familiar pre-composed music would produce different results than activities using unfamiliar, improvised music in facilitating mood change in participants with neurological disabilities.

3.3: Design.

A single subject design was employed alternating conditions A and B, using pre-session and post-session measurements of mood. Fourteen participants with neurological disabilities attended two music therapy sessions each, one session involving condition A and the other involving condition B. Seven of the participants were randomly assigned to order AB, and counterbalanced with the remaining participants assigned to order BA.

3.3.1: Participants and selection procedures.

All participants were living on residential wards at a neuro-rehabilitation hospital at the time of the study. Fourteen participants were selected from referrals made by the multidisciplinary team, after a request for subjects for a music therapy research project. Five participants were diagnosed as having Multiple Sclerosis (MS), five were diagnosed as having sustained a brain injury through trauma (TBI) and the remaining four formed a mixed group who had sustained damage to the brain from stroke or anoxia (CVA/An). The sample selected reflected the diversity of neurological disabilities typical at the hospital, as well as the approximate frequency of cases with similar diagnoses resident in the hospital. Participants displayed a variety of physical, cognitive, communication, sensory, and behavioural impairments. A mental state questionnaire was administered to participants to assess receptive skills and give an approximate gauge of memory and orientation, as used by Purdie and Baldwin (1994) in a pilot study of music therapy with a neurologically impaired population (Appendix 3). All participants met pre-specified criteria which are given in Appendix 4.

3.3.2: Measurement instruments: Bipolar form of the Profile of Mood States.

The Bipolar form of the Profile of Mood States (POMS-BI), a classic test used widely in research, was used in this pilot study. One of the principal uses of POMS-BI is 'to assess mood change resulting from such techniques as relaxation therapy, meditative treatment, and brief and long-term psychotherapies' (Lorr & McNair, 1988: 3). It was constructed following experimental studies of mood states and feelings in normals and in psychiatric outpatients, specifically to measure not only negative affects of applied conditions, but also positive affects, which previous unipolar mood scales failed to measure.

It measures six bipolar subjective mood states, each state defined by a subset consisting of 12 adjectives or phrases. The 72 items listed on the questionnaire appear in a cyclical order. Each subset has both a negative and positive pole, as follows: composed - anxious; agreeable - hostile; elated - depressed; confident - unsure; energetic - tired; clearheaded - confused. In completing the questionnaire, participants were asked to categorise how much like each stated mood they were feeling at the moment of completion, in terms of '(3) much like this, (2) slightly like this, (1) slightly unlike this, or (0) much unlike this'.

Due to impaired memory, attention and concentration spans exhibited with the population under investigation, however, it was necessary to reduce the number of items on the POMS-BI scale. This was in order to reduce the combined effects of measurement time and the types of cognitive deficits specified on accuracy of results. Three independent assessors, all experienced music therapists from differing theoretical backgrounds, were asked to select which bipolar mood states of the six they believed to be the most likely to be affected by music therapy intervention, of which four categories were chosen consistently. These were selected for measurement purposes, reducing the number of questions overall from 72 to 48. These mood states were: composed - anxious; agreeable - hostile; elated - depressed; and energetic - tired. Each item is scored 0, 1, 2 or 3 as categorised above, using hand-scoring stencils. The scale score for each subset is the sum of the positive items minus the sum of the negative items, plus a constant of 18 in order to achieve positive scores between 0 - 36 for all possible answers.

Due to varying levels of physical, visual, and cognitive abilities between participants which inhibited self administration of the POMS-BI, it was necessary for the questionnaire to be administered by an independent

person. This took place immediately pre- and post-test. Measurement packs were supplied with written instructions to ensure consistency in administration.

3.3.3: Music therapy questionnaire.

In order to collect additional data to support any findings regarding effect of music therapy activity, a questionnaire was devised asking specific questions about the music in the session (Appendix 5). This questionnaire was developed in conjunction with the independent assessors who were asked to list fundamental aspects they believed to be addressed by music therapy. The questions were formulated around five key aspects suggested: self-esteem, emotional expression, motivation, reminiscence and associations, and providing a supportive relationship/environment. It was to be used only in conjunction with the POMS-BI, and aimed to provide data from which information could be drawn to support any trends apparent in the results.

Thus, in addition to the POMS-BI questionnaire given post session, participants were administered with 10 questions directly related to the music therapy activity they had experienced. The answers to these questions were categorised as for the POMS-BI i.e. 'much like, etc.'. Each answer was scored between 0 - 3, with 0 registering as a negative score for the condition experienced, and 3 being a positive score. Maximum possible score for a condition was 30, with a minimum score of 0, a higher score indicating a more positive result for the condition being evaluated.

All sessions were tape recorded and evaluated by the music therapist on session evaluation forms (Appendix 7) immediately after the sessions, to provide qualitative and anecdotal data which could be used to support or question results from the quantitative data.

3.3.4: Consent.

Informed consent was obtained from the participants themselves. The treatment period and activities involved were fully explained to the participant in front of a witness, and the participant was given a consent form, with the above explained in writing, to sign. If they were unable to sign themselves, the witness signed authorising that the study had been fully explained, understood and consent had been given (Appendix 9).

3.3.5: Procedure.

Participants were seen in music therapy sessions occurring in the music therapy treatment space in the hospital. Participants were brought to this room where the POMS-BI was given verbally by a research assistant, involving 48 questions. The music therapist was not present for this period. Administration of this questionnaire took approximately 7 - 15 minutes, depending on the participant's form of communication and cognitive ability. After the questions had been answered, the research assistant left the room, and the music therapist entered the room to begin the session. Each session lasted approximately 30 minutes. At the end of the music therapy session, the therapist would leave the room for the research assistant to enter and administer exactly the same questionnaire. This procedure was repeated for the second session one week later.

3.3.6: Equipment.

A wide range of instruments were offered within the sessions to participants which required no previous musical expertise to be played. All instruments could be played with one hand, or with limited assistance from the therapist when necessary, such as with the guitar and autoharp. The instruments

included pitched percussion such as alto metallophone, xylophone chime bars, and bass xylophone, and unpitched percussion such as the cymbal, rotary drum, conga drum, windchimes, maracas, bongos, and tambourine. Other unpitched percussion which were particularly popular included a range of ethnic instruments such as an African cabassa, a Nigerian drum, a Mongolian drum, a 'rakatak', Indian ankle bells, an African cane shaker, and a nut rattle. Additional pitched instruments included an electric piano with a range of timbres, guitar and autoharp.

3.3.7: Structure of sessions.

All sessions followed a similar structure, regardless of whether condition A or B was involved. All music presented in sessions was live, and consisted of a welcome activity, the main activity involving either A or B exclusively, and then a goodbye activity. Activities to frame the start and end of a session are widely recognised by music therapists of many different theoretical persuasions to be an important aspect of a music therapy session (Bruscia, 1991; Ansdell, 1995). Not only does a welcome activity help orientate the client and establish active live music making as an integral part of the session, but in association with the farewell activity helps to establish boundaries which are vital to a therapeutic relationship. It is important to acknowledge however, that such activities were part of the gestalt experience of the research sessions within this project, and as such, may have contributed to some extent the effects on mood. It was not considered to affect the participant's attitude towards the main activity, however, which occupied the largest part of the session.

Each session began with presentation of a range of instruments, exploration of these, and selection of one or more to play in the welcome activity. The session then proceeded with a welcome chant using the participant's and therapist's names, which used a repetitive melody, but was improvisatory in nature.

Condition A used pre-composed song material, involving song choice and discussion of song themes, personal associations and reminiscences. In conjunction with the participant, the therapist located songs of the participant's choice or songs which were of particular relevance to the participant. This technique, known as 'song choice' has been described by Bailey (1984), Whittal (1991) and Martin (1991). The chosen songs were played by the therapist on piano or guitar, or by the participant on the autoharp with some assistance. Participants chose which instrument the therapist played the songs on and whether the words were sung. If there was a particular emotional response to the song, this was acknowledged by the therapist, and either opportunity for discussion of this, for the song to be played again, or for another song to be chosen.

Condition B involved presenting to the participant a range of tuned and untuned percussion instruments, small strumming instruments, and an electric piano. Participants were encouraged to explore these instruments on their own, participate in turn-taking activities with the therapist, and participate in improvisations with the therapist. The improvisations were either spontaneous or on a theme suggested by the participant or therapist. Mostly improvisations were purely instrumental, however occasionally they involved both instruments and vocalisations. Themes may either have been based on concrete subjects such as nature or styles of music, or on more abstract themes such as relationships. After the activity the participant was gently encouraged to discuss associations or feelings aroused by the sounds and music being made. Although discussion was encouraged, the wishes of the participant not to discuss the material were respected.

Each session concluded with a goodbye activity, which was a brief improvisation based on the melodic theme of 'Frere Jacques'. Participants

were again encouraged to choose an instrument on which to play, or sing if they so chose.

3.4: Results.

Possible differences in mood state of the participants were examined in an analysis of variance with repeated measures in the following mixed design: 3 (group i.e. MS, TBI and other) by 2 (MT condition i.e. improvisatory and song-based) by 2 (pre/post measures). Analyses were carried out on each of the mood subscales; agreeable - hostile, composed - anxious, energetic - tired and elated - depressed. These examined the main effects of music therapy condition, group, and pre/post measures, in addition to the two way interactions between each of these and the three way interaction overall. The results for each mood state measured will be considered in turn.

3.4.1: Composed - anxious.

There was a significant main effect of pre/post measures for the mood state composed - anxious ($F(1,11) = 9.61; p = 0.01$), however there was no significant effect found for the treatment condition, nor was there an interaction between the treatment condition and pre/post measures (see Table 1). This suggested that participants' composed - anxious mood states differed before and after music therapy intervention, but that this change was not linked to the type of music therapy treatment they had received. An examination of the mean scores pre- and post-session (see Table 2) indicated that this difference was in a positive direction, suggesting that music therapy intervention resulted in feelings which were more towards a 'composed' mood state rather than an 'anxious' mood state.

While there was no significant main effect of group or treatment there was an interaction of the two for this mood state ($F(2,11) = 4.62; p = 0.035$). A single

factorial repeated measures analysis of variance was used to examine the effect within each group for a group/treatment interaction. This, however, did not reveal statistically significant results. Stronger effects were shown for the interaction between condition and group for the MS and CVA/An groups than for the TBI group (see Table 3). These results suggested that the difference between groups was due to the variance between individual means rather than any pattern of interaction across all individuals.

3.4.2: Agreeable - hostile.

Main effects of pre/post measures were found to be significant for participants' agreeable - hostile mood states ($F(1,11) = 13.8$; $p = 0.003$), however again there was no main effect of treatment condition or pre/post mood measures (see Table 1). As with the results already reported, this suggested that participants' agreeable - hostile moods were different before and after music therapy intervention, but that this change was not associated with the type of intervention they had received. A comparison of the pre- and post-session mean scores indicated that the means moved in a positive direction (see Table 2) suggesting that subjects felt more towards an 'agreeable' mood state after music therapy sessions than they had done before music therapy intervention.

3.4.3: Energetic - tired.

A significant main effect was found of pre/post mood measures for the mood states energetic - tired ($F(1,11) = 4.6$; $p = 0.5$), but not for the interaction between music therapy condition and pre/post mood measures (see Table 1). Once more, this suggested a change in participants' energetic - tired mood states before and after music therapy intervention, but that this change in mood states was not dependent upon which type of music therapy activity

participants had experienced. A comparison of the pre- and post-session mean scores indicated that the means moved in a positive direction (see Table 2) suggesting that subjects felt more towards an 'energetic' mood state after music therapy sessions than they had done before music therapy intervention.

3.4.4: Elated - depressed.

There were no significant results found for either main effects or interactions for this mood subscale, in contrast to the other mood states already examined. This suggested that neither of the music therapy interventions, or possibly that music therapy at all, affected elated - depressed mood states significantly for this population.

3.4.5: Further interactions.

There were no statistically significant results found for the interactions between pre/post measures and group, or for the three way interaction between group, condition and pre/post measures. This suggested that no link could be established between mood changes elicited by music therapy intervention and particular deficits experienced from neurological damage, and that there was no link between mood change, group and the type of music therapy intervention received.

SOURCE	SS	DF	MS	F	Slg of F
Composed-anxious					
Treatment	1.25	1	1.25	0.09	0.775
Pre/post	117.79	1	117.79	9.61	0.01
Treatment x pre/post	0.19	1	0.19	0.01	0.92
Agreeable-hostile					
Treatment	10.4	1	10.4	0.8	0.39
Pre/post	75.38	1	75.38	13.8	0.003
Treatment x pre/post	3.02	1	3.02	0.75	0.406
Energetic-tired					
Treatment	7.62	1	7.62	0.11	0.748
Pre/post	102.82	1	102.82	4.6	0.05
Treatment x pre/post	68.55	1	68.55	4.02	0.07
Elated-depressed					
Treatment	32.91	1	32.91	0.43	0.525
Pre/post	95.41	1	95.41	2.35	0.153
Treatment x pre/post	20.22	1	20.22	1.64	0.227

Table 1: Analysis of Variance of All Bipolar Mood States by Treatment and Pre-post Measures.

Mood subscale	Mean scores	
	Pre-session	Post-session
Composed-anxious	28.2	30.5
Agreeable-hostile	28	33.6
Energetic-tired	22.4	25.1

Table 2: Pre- and Post-session Mean Scores for the Mood Subscales Composed-anxious, Agreeable-hostile and Energetic-tired.

SOURCE	SS	DF	MS	F	Slg of F
Composed-anxious					
Group x treatment					
Group 1	3.6	1	3.6	1.24	0.329
Group 2	34.22	1	34.22	3.37	0.14
Group 3	32	1	32	3.46	0.16

Table 3: Single Factorial Repeated Measures Analysis of Variance Within Each Group for the Mood Subscale Composed-anxious.

3.4.6: Additional qualitative data.

Although the mood scale failed to find any differences between the two activities, the music therapy questionnaire did show differences between the two. For the group of 14 participants, there was an average score of 23.6 for improvisation, and an average of 25.6 for song-based activities. This reflected only a small difference in the overall rating between the two activities, with a small preference for song-based activities. Examining these scores in closer detail however, there remained some differences between activities in the ratings given by the separate sub-groups.

Within the MS group, the song-based activities were consistently scored the same or higher with a range of 0 - +6 between the scores of the different activities. Within the CVA/An group, only one participant scored the improvisatory activities higher, with a range of -1 - +7 rated between improvisation and song scores. The differences were not significant for the TBI group, with either the same score rated for each activity, or differences of only 1. Hence, rather than highlighting significant differences between the two activities, the results from this additional data appeared to highlight differences between the activities for one sub-group only.

3.4.7: Summary of results.

Although there was found to be a significant main effect of pre/post mood measures for the mood subscales agreeable - hostile, composed - anxious, and energetic - tired, there was no significant interaction found between music therapy conditions and pre/post measures for any of the mood states. The lack of any statistically significant results then failed to support the hypothesis that song-based activities using familiar pre-composed music will produce different results than unfamiliar, improvised music in facilitating mood change

in participants with neurological disabilities. Looking at this generally, it would suggest that whilst music therapy certainly appeared to significantly change participants' moods, that these changes were not due to a particular type of music therapy intervention, and indeed may have been due to other variables which were not measured. These will be discussed in more detail later.

Trends in the mean scores suggested that some change in mood did occur for both types of music therapy condition in each mood subscale, even though the difference between conditions was not significant. Nearly all scores changed in a positive direction, with the exceptions of composed - anxious scores for the TBI group with song-based activities, and the CVA/An group's scores for energetic - tired and elated - depressed in improvisational activities.

Although no significant interaction was found between pre/post measures and music therapy conditions, group mean scores of pre/post measures for the MS group appear to differ markedly for song-based activities in comparison to improvisational activities within the mood subscales composed - anxious, energetic - tired, and elated - depressed.

The differences between pre/post measures of the two music therapy conditions were not so marked for the other groups. Although this was not reflected statistically in the results, a question remained as to why the MS group's results in particular should appear so different when raw data were examined. It was felt that possibly some difference between the two activities other than mood may have existed for this group which affected the results. This point will be discussed further in the next section.

3.5: Discussion of the results.

The results illustrated that although music therapy was effective in significantly altering participants' composed-anxious, agreeable-hostile and energetic-

tired mood states, that changes in mood states were unrelated to whether the methods employed familiar pre-composed music or unfamiliar improvised music. Of the four mood subscales tested, it is perhaps surprising that the subscale elated-depressed was not found to be significantly different after music therapy. This is so for two reasons. Firstly, it is within the descriptive literature from our own profession that authors make claims to lifting 'depression' or low mood. This raises questions as to generalised misconceptions of which aspects of mood music therapy actually does affect. Secondly, it is often for perhaps misconceived reasons that using music therapy within such rehabilitation programmes is believed by managers or health care administrators to be for enjoyment or 'fun'. Again, in the light of these results, it could be suggested that this aspect of mood is not significantly affected by such input.

Although the results revealed no significant interaction between the type of music used and mood change, the differences in group mean scores for the MS group hint that some differences may exist between the two music therapy conditions. There may be other factors, however, which should be considered. Firstly, by examining mean scores, it was observed that for each of the mood states the mean pre-session mood measures for the song-based sessions were much lower than those for the improvisational sessions. This contributed to the wide difference between mood scores for each of the music therapy conditions. It should be noted, however, that mean post-session mood measures were relatively equal for both conditions in each mood subscale: for only one of the mood subscales did the song-based activities result in a higher post mood measure than the improvisation activities. Furthermore, in examining the raw data, it was observed that the differences found may be due to the differences in individual scores which were then reflected in the group means. These factors considered, it cannot be ignored that there was a stronger effect on mood when using familiar pre-composed music than when

using unfamiliar improvised music. This warrants further exploration because there may be some support for the recommendations made by O'Callaghan & Turnbull (1987 & 1988) and O'Callaghan & Brown (1989), which focus on the use of familiar, well learned songs to compensate for memory, attentional, organisational and planning deficits in MS clients. With no detail of tested neuropsychological functioning of the group examined here, however, it cannot be surmised that it is the structured familiar aspect of the music which caused differences in the results. Similarly, it could also be suggested that the recommendations of Lengdabler & Kiessling (1989) have been supported, particularly in their claims of improvisation having a positive effect on feelings of anxiety, depression and self-esteem. In this study, these feelings were shown to significantly improve after music therapy. However, if the mean scores are considered, the difference is not as dramatic for improvisation as for song-based activities. Despite using empirical data collection, a standardised measurement tool, and statistical analysis, the question under examination remains unanswered.

There are various factors which undoubtedly contributed towards inconclusive results. Looking firstly at the experimental design, only two sessions were involved, and thus did not allow for any development of familiarity with music therapy nor the therapist. As both of these factors are widely recognised to be central to the music therapy process, the design may well have prevented more sensitive differences experienced by the participants within each condition to become evident in the results. However in order to study a statistically viable group it was decided in this study to examine a larger number of participants. Clearly future work would need to look at either much larger numbers or adopt a different design in order to gain significant results.

Although the welcome and goodbye activities followed a standard session format in helping to familiarise the participants with the music therapy setting

and providing boundaries to the session, these activities could not be excluded from affecting mood, and may therefore have acted as variables. As mood scores were taken before and after each of these activities, it cannot be ignored that differences in mood scores were a reflection of the overall music therapy experience, rather than the central activity being examined. Indeed, it was the overall music therapy effect which was clearly reflected in the results.

Using a standardised measurement tool allowed for a general picture to be drawn, however this was too general to give any real insights as to what value the different types of music were to the individuals' therapy. There were other disadvantages identified in using the POMS-BI to measure mood states. The first of these was the scale itself. Certain words used in the scale, such as 'dejected', repeatedly caused some confusion and hesitation with the participants. It is questionable as to whether all participants fully understood all the mood states listed. For truly accurate use of this tool with this population, it would be necessary to test thoroughly the language and auditory comprehension to exclude these factors from possibly affecting the results. Secondly, it was observed that there were interactional effects between the person administering the test and participants in both the pre and post session measurements. The effects of such interactions were not directly reflected in the results, but were felt by both the tester and the researcher to affect participants' observed mood and behaviour. Such possible effects would have been absent had the POMS-BI been self scoring, however this was not possible due to the visual impairment, physical disability or attentional and memory deficits experienced by the participants. It was also difficult to exclude interactional factors with the music therapist, rather than the music therapy intervention itself from any differences in mood scored.

Another aspect of the measurement tool which rendered the scores less accurate was the pre/post nature of measuring change, whereas a

heightening or lowering of mood sensation was observed to be experienced actually during treatment. The results were therefore a reflection of the overall music therapy experience i.e. interaction with therapist, time off the ward, individual attention, experience with music, rather than as a simple result of one type of music therapy method exclusively. Despite the disadvantages for the purpose of this particular study, using a standardised tool did, however, enable the general effect of music therapy on mood to be examined and statistically tested. To date, this has been largely anecdotally reported within the music therapy literature. It also helped to illuminate the fact that there are different facets to 'mood' which can be affected by music therapy and that as a bipolar measure the effects were predominantly in a positive direction. It is important for music therapists to understand these concepts and have some reference point, as claims to have positive effects on 'mood' in general can be seen here to be inadequate.

Qualitative observations, such as verbal statements, individuals' engagement during each music therapy activity, and immediate responses such as changes in body posture or facial gestures and verbal statements, when considered revealed more explicit information as to the differences between the music therapy conditions. For example, one participant spontaneously verbalised 'wonderful' after participating in an improvisation, even though his mood scores were shown to be lower after the session than before. There was no opportunity however for clarifying further the process which had occurred for him within this session, nor for reflecting the comments he had made. Qualitative data from this same participant in the song session alluded to how songs which had been important within his life had taken on a new meaning for him since becoming disabled. His mood scores were higher after the song session, despite being moved to tears by the songs which he had chosen to use in the session. Such additional data may have revealed fascinating insights into what the differences were, and in particular how pre-composed

music could be used as a therapeutic tool for this individual. Several participants asked to finish the improvisation sessions early which contrasted from their responses within the song sessions. One participant requested to withdraw after her initial improvisation session. Combining information from the music therapy questionnaire and observations made within the session evaluation notes suggested that there was some aspect of having to manipulate instruments physically which affected people's ability to maintain engagement with improvisatory activities. These subtleties could not be reflected using a standardised measurement tool. Physical dysfunction has been described as being central to the experience of chronic neurological illness in how the individual integrates aspects of the self and develops concepts of self. These points could possibly strongly influence the individual's experience of music therapy, as Corbin and Strauss stress that 'when illness brings about a failed body ... the foundations of existence are shaken' (Corbin and Strauss, 1987: 250).

3.6: Recommendations for developing the research.

Had the current data included the participants' own words, greater depth would have been achieved and a meaning nearer to the participants' experiences. When combined with the researcher's observations of the participant's verbal, non-verbal and musical behaviour from within the session, information regarding participants' experience of the central music activity could be gained without the inclusion of extraneous factors. In addition, this would provide more sensitive data which could then relate the music used specifically to each individual's personal issues within therapy.

Therefore, this study clarified the need to develop qualitative research tools for music therapy work, and highlighted other methodological issues which needed to be resolved. Firstly, the raw data indicated that the participants with

MS appeared more sensitive to differences in the two music therapy conditions used than the other groups. For this reason, further exploration might be successfully limited to this group. Secondly, data collected should include participants' own words and observations from within the sessions since it appeared to produce more useful data than a standardised tool. Data such as this could be then analysed qualitatively, which would ensure greater depth and sensitivity to any differences experienced by participants between the two conditions. Thirdly, data collection should be over a longer period of time, allowing greater familiarity with both methods, and a more detailed picture to be drawn. This would also illustrate process within music therapy, which may highlight further differences between the two conditions being examined, and how each could be tailored to meet the individual's needs in therapy. This process and the methodology which was developed will be the focus of the next chapter.

CHAPTER 4

DEVELOPING THE EMPIRICAL

WORK:

FINDING AN APPROPRIATE

METHODOLOGY

4.1: Reflections on the pilot study.

From the initial pilot study given in Chapter 3, several personal and professional issues arose. Mirroring the published quantitative studies with neurological patients, the pilot study produced some significant results regarding the effect of music therapy, but it was not sensitive to the underlying causal processes of the therapy. Moreover, although the use of a standardised measurement tool may have ensured reliability in terms of research requirements, it served to be detrimental to individuals' experiences. For example, despite the testing procedure having been explained and consented to, some of the participants became agitated at the seemingly direct questions about their mood and emotional states, feeling that they were being judged or subjected to a test which questioned their mental health. For this reason, some individuals answered the questions in a way they felt would show them as 'the model patient'. Others merely became distressed or dismissive. Therefore, the inclusion of a measure such as this was questioned on ethical grounds and also for its ability to produce reliable results. The use of the mood scale stimulated many questions for the current author about what appeared to be the exploitation of patients in a clinical setting for the purposes of research, and who was likely to gain from the research.¹ The pilot design and measures were geared towards research purposes, and not to the clients' therapy needs. Therefore, a conflict existed which needed to be resolved. Furthermore, if the research was to yield meaningful results, it needed to be conducted in a way that reflected a 'real world' experience of music therapy. This highlighted that the duration of therapy and the role which the therapeutic relationship may have to play in therapy had to be accounted for in order to conduct meaningful research.

¹ Informal discussions with research colleagues in the same clinical setting have revealed this issue of using patients for inclusion as 'research subjects' to be questionable for ethical reasons.

Following a review of the pilot study, several differences needed to be resolved between good research practice and good clinical practice. The research needed to be collaborative to a larger extent, with patients involved as 'participants' rather than as 'subjects'. This is one of the fundamental differences between 'positivist' and 'non-positivist' research principles. The positivist approach most commonly starts with a theory which is tested through experiments to examine a specific outcome. Data is collected and transformed into numerical values, and when collection is complete, analysed through statistical formula. The non-positivist approach differs in that enquiry may focus on an area rather than a hypothesis, data collection and analysis often occur simultaneously, and the data are more usually verbal rather than numerical.² It was realised that the participants' experiences would offer the most valuable data. The method of data collection and analysis needed to combine, therefore, empirical rigour without concessions to the clients' therapeutic needs. Furthermore, any conflicts between the roles of researcher and therapist needed to be minimised, with neither role being compromised. These personal aspects served as a starting point for wider design considerations.

4.2: Design considerations.

The literature review has revealed that attempts at researching music therapy with neurological populations have failed to produce a combination of both appropriate design methodology and findings which are relevant to therapeutic aims of clinical intervention or illustrative of the underlying therapeutic processes. The lack of sensitivity both to the individual's experience and reliable between-subject differences has caused the research to bear little relation to clinical practice.

² Although only design differences have been specified here, positivist research is traditionally seen as more 'scientific', where the researcher is more removed from those on whom the research is being conducted. There is an increasing trend towards collaborative research in non-positivist research practice (see, for example, Lee (1992)b).

Considering the wide variation in clinical techniques in music therapy practice, it is evident that these may function as variables in research conditions, affecting both the process and generalisability of results. Hence, variables, techniques or methods must be qualified. For example, although the research by Thaut and his associates (Miller et al., 1996; Thaut et al., 1992&1993) offers reputable scientific proof of the benefit of metronomic pulse in gait retraining, many music therapists would deny that the technique of rhythmic auditory stimulation in physiotherapy treatment represented 'music therapy', and also question whether gait retraining should even be an aim within music therapy intervention as it excludes any aspect of the interactional therapeutic relationship. The use of pulse in this way can be clearly argued as the adjunctive use of music in rehabilitation therapy.

It must be stressed that examining 'process' within clinical music therapy is as valid as seeking outcomes, particularly at this stage of examining the profession as a researchable 'scientific' practice. There seems little point in reproducing measured results of interventions when the journey towards the point of arrival is still not well understood. This idea is reflected in the tendency and recommendations to draw on anecdotal or raw data in quantitative studies in order to give greater insight into the individual's or group's experience (Boyle, 1995; Cohen and Ford, 1995; Miller et al., 1996). Furthermore, the existing quantitative studies examining music therapy intervention have failed to reflect any outcomes related to emotional changes or client/therapist interaction which many therapists would argue are the essence of music therapy. Arguments to these ends are presented in the research works of Cohen (1988&1992), Cohen and Masse (1993), Cohen and Ford (1995), Thaut et al. (1992&1993), and Miller et al. (1996). This is contrasted by published case studies of clinical work which have not used objective measures to substantiate claims made regarding changes in emotional status or the therapeutic relationship (Curtis, 1987; Dawes, 1985b;

Purdie and Baldwin, 1994; Weckel, 1996). Although lacking clear measurements, clinical case studies such as these focus on the substance of the therapeutic interactions. In essence, this disparity in designed and controlled research and clinical case studies highlights the difficulty of amalgamating research aims which are reflective of and relevant to therapeutic aims and practice.

Design should, therefore, encourage data which include participants' own verbal or musical material as central to the analysis, in addition to observational data from the sessions. Considering the inclusion of these types of data as 'additional information' in the existing empirical studies, it is clear that its inclusion appears to produce more useful results than a standardised measurement tool. Single-case designs have been noted to be particularly useful for creative arts therapies research as they allow for analysis of the therapist-patient interaction and within-participant comparison rather than comparison to group norms (Aldridge, 1994). Hence from a clinical viewpoint, case study design would seem the most appropriate methodology to incorporate a combination of participant data, observational data, and empirical analysis, without losing the emphasis on the individual.

Empirical studies from the research into the psychology of music make methodological evaluations which are relevant for an investigation into music therapy, and support the recommendations already made from a clinical viewpoint. Sloboda (1991a) suggests that when exploring emotional responses to music, designs should be open-ended, employing a strong element of natural history. Such a proposal supports the use of data which are drawn from the participants' perceptions. Furthermore, the interaction between music and the individual has been identified as highly complex and individualistic (Waterman, 1996). So, within subject designs are essential in order to gain valid results. Therefore, in considering psychological aspects of

the music therapy experience, single-case study design is suggested, drawing on participants' own perceptions of music therapy, over an extended period of time.

These design proposals also meet the requirements for researching chronic neurological illness, where the need for process research has been stressed over outcome findings (Brooks and Matson, 1987). Conrad (1987) states that a qualitative approach is 'still probably the most appropriate for examining topics as subjective and fluid as illness experience' (Conrad, 1987:18).

No neurological condition produces a 'homogeneous' subject group. Neither is any individual's illness experience like anyone else's. This reflects the musical and therapeutic experience as well. Hence the design used in this study aimed to examine individual processes, drawing on participants' own verbal evaluations, and using observational data for validation. Using primarily the verbal material collected in interviews, methods of qualitative analysis were used in order to reflect both the depth and complexity of the processes taking place.

4.3: Design of the current study.

So, case study design was adopted as it held many advantageous aspects due to the Multiple Sclerosis client group involved and the nature of the therapy experience. Within-subject differences were sought rather than between-subject differences due to the individual illness trajectory typical of Multiple Sclerosis. Also, within-subject data would allow any personal differences between the two approaches under examination to emerge, if they existed. This design would highlight aspects which to date have not been shown in research with a neurological client group, such as whether the client/music or client/therapist interaction bore greater importance in either

activity. Furthermore, case study design would permit data to be collected over time, thereby revealing how process may affect the experience of the music therapy techniques for the individual. Lastly, it was hoped that this design might foster the emergence of larger issues which have not been considered with a neurological client group to date. Novel information of this nature could then illuminate not only the potential music therapy holds in work with this particular patient population, but also clarify where the focus of clinical intervention should lie, i.e. in the areas of physical, emotional or interpersonal goals.

Further to these considerations, my own dual role as therapist and researcher directed the design adopted. A design was needed which would enhance the therapeutic process rather than jeopardise it. This is a difficult issue, as when the therapist becomes the researcher, the focus of the therapeutic relationship and boundaries can change. When acting as a therapist, the central focus of the therapeutic contact is the client's needs. When acting as a researcher, the therapist has gains to be made from the alliance. As Bruscia (1995a) elucidates:

'... the goals (between research and clinical practice) are different. Research is aimed at increasing or modifying the knowledge base in music therapy; in contrast, clinical practice is aimed at helping clients achieve health.' (Bruscia, 1995a: 22).

However, there were also benefits in having the researcher and therapist as one person. The trust and depth of the therapeutic relationship already established can serve to enhance the interview material collected. Furthermore, acting in this dual role, it is possible to be sensitive to points brought up in the interview data which may refer to or contrast with previous therapeutic material. In this way, much greater complexity can be revealed in each individual's processes.

As a music therapist, acting as the researcher collecting verbal data may blur boundaries in some ways. By focussing on verbal material, the participants lapse more easily into verbal coping strategies, which is not helpful to the therapeutic process. In this way, therapy material has the potential to become more verbal than would normally be encouraged. Furthermore, it could be hypothesised that the intensity of the musical therapeutic process is diminished by making the implicit musical processes become verbally explicit. However, in this process, invaluable and insightful material can be gained which may be lost if the interview takes place outside of the therapy session or with another person acting as data collector. Furthermore, as the client group to be included in this study was verbally articulate, there existed a potential for the revelation of important material from the client's perspective rather than the therapist's interpretation.

Qualitative methodology was specifically chosen for several reasons. It was felt that qualitative analytic techniques would enhance the complex and fluctuating nature of responses typical in the clinical setting. These types of responses have been noted to result in oversimplified outcomes when a quantitative methodology is adopted (Prickett, 1995). Furthermore, this study serves as a preliminary investigation, for which no standard variables have yet been established. It was anticipated that responses would be highly individualistic, and rather than mask these with a quantitative approach, it was intended to create a fuller picture.

The current author's own clinical experience with a Multiple Sclerosis population also helped to formulate both the design and the research questions. It was not only the appropriate clinical technique which was which was being examined, but also exactly how a particular technique could address issues pertinent for the individual. Although it is always necessary to

identify individualised goals due to the variability of the illness, certain trends are evident in the clinical work.

4.4: Focus of the current study.

Particular research foci were central to this study, and shaped the data collection. These foci were formulated by considering the music therapy literature with neurological populations and Multiple Sclerosis patients in particular, as well as additional considerations from the broader Multiple Sclerosis literature, such as studies into the biological, psychological, and psychosocial impact of chronic illness.

The main research questions in the case studies were:

1. What are the differences for each of the participants in the experience of activities using familiar pre-composed music and those using improvised music?
2. Does one activity provide greater access to feelings or associations than another for each individual?
3. Do participants express a preference for one activity, and what may have influenced such preferences?
4. What other factors may have contributed towards participants' experiences?

4.5: Method of data collection.

This study aimed to collect comprehensive data from a variety of viewpoints in order to enhance trustworthiness. Firstly, all sessions were audio taped to aid

in evaluation and in order to keep a record of events. Secondly, thorough session evaluations were made immediately after clinical sessions, documenting the participant's personal details, session format, musical events, mood/behaviour observations, important verbal material and a section for other additional comments such as my own personal reflections and responses. Alongside session evaluations, focused interviews were introduced at approximately session 10 to collect the primary data for analysis. Clinical material, both audio recordings of musical events and my own verbal reflections, were taken to clinical supervision on a regular basis. This material was also used as a source of triangulation.

The primary source of data were the transcripts of the focused interviews. The focused interview technique can be described as:

'an approach which allows people's views and feelings to emerge, but which gives the interviewer some control ... to investigate a particular situation, phenomenon or event' (Robson, 1993: 240).

As researcher, it was my aim to record in the participants' own words their experiences of the two conditions using this technique, and to examine what larger psychological processes may have been taking place. The combination of less structured interview techniques and qualitative analysis have been noted to be particularly useful in examining processes which are complex or personal (Smith, 1995). Due to the fusion of intrapersonal, interpersonal, intermusical and intramusical processes taking place in therapy, it was believed that this technique of data collection could capture the complexity of the individual's experience.

Interviews were introduced at session 10 rather than earlier in order to allow familiarity to grow with both types of activity being used, and also for some development of the therapeutic process and the therapeutic relationship.

Collecting data at a much earlier stage would have produced less reliable or less personal material. However, the point of introduction was flexible. For example, if a participant started to informally discuss the music after a session at an earlier point, the opportunity was taken to expand on this material. In this way, the interviews were introduced in a less formal way.

The research questions provided the focus for the interviews. These foci were the important aspects of the music experienced, the meaning of these for the participant, and the effects on the participant. Although a broad list of questions was initially used from which to draw prompts, cues and more specific questions (see Appendix 6) these needed to be reformulated and developed each week, guided by the previous interview's content and to meet the individual participant's own developmental process in the experience of music therapy. By the final sessions, the interviews had taken on a very loose format, in which the participants were encouraged to discuss generally their experience within the session, and I intervened only when the participants needed to be focused back onto the point, or where a statement could be explored further to give greater depth or clarity to data.

Initially interviews took place after the end of the session. However, this approach needed to be reviewed with each individual for several reasons. For certain participants with severe short term memory deficits, the lapse in time between the music played in the session and the interview after the end of the session caused the data gathered to be unreliable. Sometimes participants could remember very little about the session. In such cases, participants were asked to reflect verbally about the activities immediately after engaging in them. This improved the reliability of the responses gathered. Secondly, the timing of the interview needed to be reviewed when participants felt the post-session situation to be more formalised. This sometimes resulted in significant behavioural changes and evident attempts to give answers the

participants saw to be 'correct'. Responses such as these have been described in the research literature in a variety of ways, such as the 'good interviewee' (Smith, 1995) or the participant displaying 'demand characteristics' (Plummer, 1995). Once more, this problem could be remedied if participants were asked to reflect less formally during the session. Thirdly, the most valuable data were gained from verbal material in the session as this was spontaneous and directly related to the musical experience. It thereby enabled me to capture data relevant to individuals' core issues, giving the data depth and meaning more closely aligned to that which the individual was trying to communicate.

The audio recordings of the interviews were transcribed immediately after the session. This enabled behavioural aspects which accompanied the verbal material to also be documented in the interview. Alongside transcription of the interview, the events within the session were fully documented, including musical and verbal responses, and accompanying behavioural and emotional responses. These events were transcribed from the audio recording of the session using a session evaluation form (see Appendix 7). Rough musical transcriptions were made of key musical interactions in these notes, or developments in the musical material from previous sessions. All transcriptions were made by myself. Certain musical extracts were also chosen at this point to take to clinical supervision, which offered an alternative viewpoint on the clinical material. This part of the process is outlined in more detail in the section 'Trustworthiness' later in this chapter.

Thus, as researcher, I became more deeply involved in the data, and was able to add analytic notes alongside the transcription about the participants' experiences. Through becoming submerged in the data in this way, responses could be monitored for implicit meanings by triangulating the participant's words in the interview, their musical/behavioural/emotional

responses in the session, and the analytic notes being made. Furthermore, the verbal transcripts allowed for easier interpretation of data in order to aid reformulation of questions for the following session. This follows the recommendations made by Charmaz (1995) regarding simultaneous involvement in data collection and analysis shaping the data collection procedures, thereby minimising the risk of collecting large amounts of irrelevant data. It has also been noted to aid engagement in an interpretative relationship with the transcript (Smith, 1995).

4.6: Participants.

Six participants were recruited from fifteen referrals made to the music therapy service at the Royal Hospital for Neuro-disability over a two year period. Relevant background details concerning these individuals are available in Appendix 8. Referrals were both from the multidisciplinary team, and also informal self referrals. Once referred, individuals were considered for the research project under the following general criteria.

1. Had a diagnosis of Multiple Sclerosis and were either a resident at the facility or attended the day hospital there at the time of data collection
2. Music had a significant meaning in the individual's life, either by having had a background in music associated activities, or being an avid listener to music³
3. Were physically able to play the instruments involved in the study as outlined in the section 'Equipment'
4. Were able to communicate effectively using speech or augmentative communication aids

³ This was an important indicator in this particular client group for appropriateness of music therapy. Individuals with a background of music were more likely to engage in this therapy than those for whom music was not such an important part of their lives.

5. Were able to demonstrate cognitive functioning which allowed the individual to reflect on the experience of music therapy. For this reason, individuals with severe cognitive deficits were excluded from this study.
6. Agreed to be included in the study, by giving informed consent recorded on the consent form (Appendix 9).
7. Did not display emotional responses which indicated neurological factors, such as lability or euphoria.

All individuals referred to therapy who met the above criteria were considered for assessment. Assessment involved four individual music therapy sessions following the assessment system outlined in the Music Therapy Department at the Royal Hospital for Neuro-disability. Assessment sessions served as an introduction to the therapist, the room, the instruments, and the music therapy methods to be used in the research project. Sessions followed the format set out in sections 4.8.1 - 4.8.5 in this chapter. This included either activities using unfamiliar improvised music or pre-composed familiar music exclusively in any one session, which alternated on a weekly basis. Assessment in this way differed from regular music therapy assessment which would consider a wider range of methods.

Assessment sessions were audio taped and evaluated in the manner described in the data collection section (4.5). In the fourth session, continuation with the research was discussed with the participant. Not all individuals assessed were included in this study. Some withdrew during the assessment or the project. Some were not appropriate due to being highly verbal with a combination of other cognitive problems.⁴ As the purpose of this

⁴ Due to cognitive impairments, some individuals presented with poor impulse control, highly distractible with very short attention spans, and tangential in their thought processes. The combination of these types of problems meant that it was difficult to engage these clients in musical activities and they were extremely verbal. For the purposes of this research, these clients were excluded. This is not to say that they would not be considered for music therapy intervention outside of this research study.

study was to compare two methods of music therapy rather than to test whether music therapy 'worked', selection was purposeful rather than random.

4.7: Equipment.

The equipment used was the same as that outlined in section 3.1.8 in the previous chapter outlining the pilot study. The therapist used either upright piano, electric piano, flute, or guitar, with voice.

4.8: Procedure.

After selection from the referrals had taken place, consent was gained from the participants using the consent form (Appendix 9) with an independent witness present. Participants continued to come to weekly, individual music therapy sessions held in the Music Therapy Department at the Royal Hospital for Neuro-disability. Regular session times were negotiated with each individual to suit the rest of the weekly activities. Sessions were timetabled to last approximately one hour, fitting with the timetabling tradition at the hospital. Most of the participants were reliant for others to get to the session. Normally I collected and returned the individual from and to the ward. In reality, once the transportation was taken into account, session duration was typically 40 - 45 minutes. Participants were free to ask for the session to end before this time, which did happen on some occasions.

As part of the consent procedure, individuals agreed to come to music therapy for 20 - 24 sessions, which was anticipated to continue over approximately six months. It was not possible to give an exact number of sessions or time span for several reasons. Firstly, it was important that the design remained flexible to suit to the individual's needs. Secondly, as the nature of the enquiry was qualitative, it was believed that flexibility in the number of sessions would

facilitate gaining the optimal data required for the study. Thirdly, participant absences could not be foreseen. There were also unforeseen absences on my part. Therefore, an approximate time span and number of sessions were given.

Participants were offered sessions which alternated between the two methods employed. These were:

A : activities using familiar, pre-composed music. These activities included selecting songs or pieces of music to be included, and singing and/or playing pitched and non-pitched percussion instruments to familiar pre-composed material chosen.

B : improvisational activities, using unfamiliar, improvised music. These activities included exploration of a variety of instruments; turn-taking activities with the therapist on the same or a different instrument; and joint clinical improvisations between the participant and the therapist on different instruments. On occasions, voice was also used as an instrument.

4.8.1: Session structure.

All sessions followed a similar structure which has already been outlined in section 3.1.9 in the previous chapter. Although the sessions followed this structure, this remained flexible dependent on participants' needs which were always prioritised.

4.8.2: Welcome activity.

Each session began with the participant being shown a selection of small, unpitched percussion instruments. She or he was then encouraged to explore

the instruments briefly, and make a selection of one or more to play in the welcome activity. The session then proceeded with a welcome chant using the participant's and therapist's names. This chant used a repetitive melody, but was improvisatory in nature in that the interaction of musical components was improvisatory. The chant used consisted of African words with a strong repetitive rhythm.

4.8.3: Song techniques.

The song-based sessions have already been outlined in section 3.1.9 of the previous chapter, but will be elaborated a little here. Pre-composed material was employed using techniques described by Bailey (1984), Martin (1991) and Whittal (1991). This involved a song or composition choice, with myself and client singing and playing the songs or pieces requested. Discussion of themes, personal associations and reminiscences may have arisen after the music. In the early sessions, song-based sessions involved mostly determining styles or particular songs which were meaningful to the individual. In conjunction with the participant, I located songs of the participant's choice or songs which were of particular relevance to the participant. Previous experience with some of the participants provided me with some knowledge of their musical preferences, and these were drawn upon if the participant was unable to name songs or musical pieces unprompted. For those participants with whose musical tastes I was unfamiliar, suggestions of categories of music were made from which the participant could choose (e.g. Irish/Scottish songs, 60's/70's pop songs, classical themes, specific artists, etc.), and then further choices were offered once the category was chosen (e.g. from the category '60's music', a favourite artist was established, such as 'Elvis Presley', and from this, song choice of 'Love Me Tender' or 'Blue Suede Shoes') following techniques as described by O'Callaghan and Turnbull (1987). I ensured that a range of moods and

themes were also provided in the song choices offered, allowing the participant the opportunity to set the mood or theme of the music. The chosen songs were played by me on piano or guitar, or by the participant on the autoharp with some assistance. The participant was offered pitched and unpitched percussion and strumming instruments to play to accompany the songs. The participant chose whether or not the words were sung by either her or himself and/or by myself. After each song, if not offered spontaneously by the participant, I gently encouraged discussion about the song. This covered thoughts such as why he or she had chosen that song, and any associations or memories he or she may have had around the song. Whilst discussion was prompted, the wishes of the participant not to discuss material were also respected. If there was a particular emotional response to the song, this was acknowledged by myself, and either opportunity for discussion of this, for the song to be played again, or for another song to be chosen. Once I had established a good knowledge of the individual's personal preferences and any particular songs, I was able to draw on these more spontaneously within sessions. In this way, the development and process of the therapeutic relationship was reflected.

4.8.4: Improvisation techniques.

Improvisation sessions involved instrument selection and exploration as already outlined in section 3.1.9 in the previous chapter. The participant was also encouraged to choose which instrument he or she wished me to play. The choice of instrument for myself also needed to consider the musical qualities of the participant's instrument. For instance, the windchimes were a particularly favoured instrument for many of the research participants. As these provided less rhythmic or melodic form to the music, I needed to consider my own instrument to provide potential structure in these particular components.

The improvisations were either spontaneous or on a theme or mood suggested by the participant or myself. If thematically based, styles of music may have been drawn upon, such as 'Spanish', or more abstract themes such as relationships. Within improvisations which were more spontaneous rather than theme related, particular emphasis was given to communicative techniques. These techniques, which have been illustrated by Pavlicevic (1997) included mirroring, matching or reflecting the client's non-verbal utterances in rhythmic, dynamic, pitch, melodic or timbral components. In this way, the client's musical utterances may have been supported, contrasted, structured or developed by my material. Often spontaneous improvisations were shorter in duration, and were less developed musically, acting as non-verbal dialogues. Improvisations on more concrete themes differed in their musical make-up. Particular sounds may have been attributed to specific objects or events by the participant, such as a cymbal strike symbolising a crash of thunder. Alternatively, improvisations on particular moods did not incorporate symbolic representations of this nature. The style of the accompaniment may have been agreed upon with the participant prior to the improvisation. For example, after selecting an instrument, the participant may have selected a musical style such as 'ballad' or 'rock' to match his or her mood, or even named a particular performer whose style they wished to imitate. This selected style thus directed my musical contribution. Within these types of improvisations, the musical communicative techniques outlined earlier would have been incorporated more into the overall musical structure. Often improvisations on moods bore greater resemblance to song structures.

The musical idioms I employed drew from tonal western idioms, such as modes, pentatonic scales, and major or minor harmonies. Spontaneous, exploratory improvisations may have been less musically structured, but still adhered to western harmonic principles due to the use of pitched instruments.

Mostly improvisations were purely instrumental, however, occasionally they involved both instruments and vocalisations. After the activity, time was provided for spontaneous discussion on associations or feelings aroused by the sounds and music being made.

4.8.5: Ending the session.

Sessions concluded with a goodbye activity, which was a brief extemporisation based on a simple melodic theme used each week. Participants were again encouraged to choose an instrument on which to play, or sing if they wished to do so.

Alternating the methods in the early sessions ensured that participants could become familiar with both types of activities. Had personal preference dictated session content, some of the participants would have requested familiar pre-composed music in every session. This predominantly appeared to be because of familiarity with music in song form. However, as the sessions progressed, I used discretion in the session structure. As the participants became more familiar with the instruments and the act of improvising, it emerged that each person developed a particular sense of improvisation and sometimes it was chosen over song-based activities. Therefore, as individuals became more familiar with the sessions and what the two types of activities offered, they were encouraged to direct the format of the session. This flexibility was introduced at approximately session 10 for most participants. Rigidity in session structure would not have been appropriate to client focussed therapy principles.

4.9: Data analysis procedure.

The data analysis drew from a combination of qualitative techniques. These will each be defined and described as appropriate within the process. As

described already in the data collection section, analysis aimed to both thematically group within-participant responses, but also interpret these to some degree. This combination has been defined as 'interpretative phenomenological analysis' (Smith, 1995). However the formal analysis processes outlined in 'grounded theory' were used to shape the analysis of the content.

A grounded theory is one that is:

'inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore, data collection, analysis, and theory stand in reciprocal relationship with each other. 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 and Corbin, 1990: 23).

It was chosen as a form of analysis for several reasons. Firstly, creativity is considered a vital component of the grounded theory method, therefore, it should suit music therapy investigation. It was considered vital in this study that the important aspects of music therapy intervention should emerge from the data. The creative and developing element of grounded theory supports the evolving therapeutic process. One of the earlier criticisms in this thesis of the extant research into music therapy in neurology was that the central phenomenon of music therapy with this particular group remains difficult to grasp despite empirical studies. Such studies have relied on the professional identifying target areas and setting hypotheses to test the impact of music therapy on these areas. Secondly, grounded theory focuses on the participants' experience rather than the researcher's interpretation of musical and non-musical events. Once more, this was considered essential in developing an understanding of the central phenomenon of music therapy as

experienced by someone with a neurological illness. Although it is important to interpret events and results to some degree, relying principally on the professional's interpretation does not acknowledge how the client's experience may help shape and improve our clinical practice.

Participants' interviews were analysed at an individual level using a modified version of grounded theory, to reduce the series of procedural steps. The steps of analysis employed in this study were open and axial coding. In open coding the data are broken down into distinct themes and 'concepts'. Concepts can be defined as 'conceptual labels placed on discrete happenings or events' (Strauss and Corbin, 1990: 61). Concepts and themes which relate to each other or appear to pertain to similar phenomena are classified together in categories. Categories were then analysed for properties which spanned a range of values along a continuum. Particular techniques were used to enhance sensitivity to the emerging concepts and themes. These included;

1. Asking questions of the data such as 'who, when, where, what, how, how much and why'. Asking questions of the concepts or events which emerged from the data ensured that a much more complex picture was achieved, rather than simply a concrete reading of the verbal text.
2. Comparing the analysis of individual words with analyses of phrases, sentences or paragraphs. This ensured a complexity of meaning in that words were isolated but then also contextualised within a larger phrase, sentence or discussion structure. Individual words often indicated concepts or discrete happenings. Examining the context of these often gave larger themes which recurred throughout an individual's data.

3. Comparing opposing value ranges of a property or different phenomena. For example, when a participant used the word 'never', the data was re-examined comparing how the experience would be different if it was 'always' rather than 'never'. Or comparing the phenomena of familiarity and unfamiliarity in the experience of musical styles.
4. 'Waving the red flag' which ensured analyses made were challenged for the researcher's own assumptions or values on the part of, for example, culture, ability, gender or age. This technique involves using questioning (identified above) to reveal conditions to situations which the researcher of which may not be aware in the participant's experience. For example, asking questions about why a participant had refused a session helped to reveal personal issues about control.

Through these techniques, analysis of data became much more detailed and also revealed complexities. For example, in analysing a young black woman's data, the researcher questioned the data for differences had the participant been white, male or older. After each individual participant's data had been analysed at this level, comparison was made across individuals to formulate thematic groupings at a group level. No further group analysis was attempted, however, as this would have masked individual processes.

The second stage of grounded theory involves the process of axial coding. This establishes relationships between the categories through a paradigm involving conditions, contexts, actions/interactional strategies and consequences. Through this paradigm, processes emerge between the music and the individual, whilst also revealing what other factors influence the individual's experience. This offers greater analysis of events than merely thematic groupings of words, whilst remaining based in the participants'

perceptions of their experience. Analysis at this stage was undertaken looking at an individual's data.

The paradigm for axial coding is depicted in Figure 1. A simplified example of the process of axial coding follows. It is useful to refer to Figure 1 at each step in order to develop an understanding of the analytical figures which will appear later in the text.

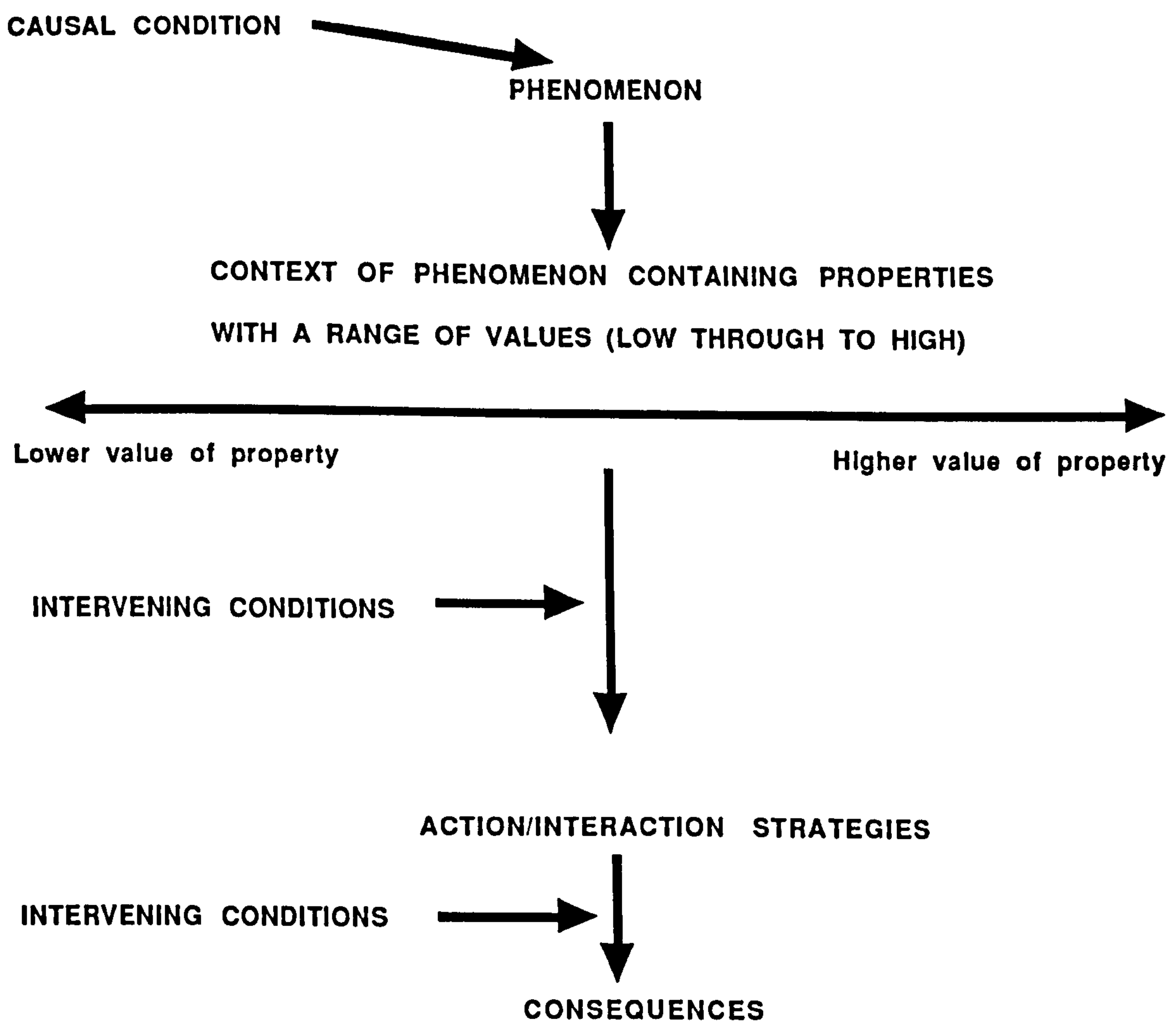


Figure 1: Paradigm model for establishing relationships in Grounded Theory

The initial step of axial coding involves identifying the phenomenon being examined. For example, the phenomenon of 'music'. The second step

involves specifying the 'context' of the phenomenon, for example, 'improvisation'. The third step identifies properties of the phenomenon, which may have a range of value from 'low' through to 'high'. These properties had already been defined in the open coding of individuals' experiences. That is, once a concept emerged, it was analysed using the techniques already described for open coding. So, for example, the concept 'familiarity' was established as a property of music. The value of the property 'familiarity' spanned along a continuum from 'low' through to 'high'. That is, one thing that always pertained to music in sessions was its level of familiarity. It was either unfamiliar (lower value of property 'familiar') or familiar (higher value of property 'familiar').

This experience of the music led the individual to respond by adopting particular actions or strategies. Interactional strategies are purposeful, goal oriented actions in response to or for management of a phenomenon. This step helped to reveal more implicit actions which were not explicitly revealed or acknowledged by the participants themselves, but were readily observable in behaviours and actions. These actions were dependent, however, on the properties of the music. That is, if it was unfamiliar, it may have resulted in different actions or strategies than if it was familiar. That is, the unfamiliar music may have resulted in the individual feeling less confident. In order to manage these feelings, he or she may have adopted certain strategies, such as stopping playing, talking, or adopting a compliant front. This then resulted in certain consequences.

Intervening conditions brought other influences to bear on the overall experience. For example, individual biographical details, such as previous experience with music, mood state, and current issues all bore influence on the music and the individual's ability to respond to it. Considering intervening conditions gives much greater depth to the understanding of the whole

experience for an individual, as well as providing detail for why an individual may respond differently on one occasion than another. Intervening conditions affected an individual's interaction with their environment not simply at one moment only, such as in immediate response to the music, but repeatedly at different points within any one interaction.

These analytical procedures may have been applied to one small area of text, that is one single event, or to a larger process. By analysing different moments through this process, comparisons of different outcomes can be made, taking into consideration the differing variables which may have affected the situation. For example, the intervening condition of increased duration of therapy, reflecting the therapy process. It is also important to acknowledge that this analysis did not consistently move through these steps in the order described above. At times, this paradigm helped to analyse events by tracing backwards from an outcome, and examine what factors had played a part in the individual's responses.

The latter stages of formulating a grounded theory, such as developing a core category and building a conditional matrix, were not pursued within this study. Charmaz (1995) points out that at this point in the development of grounded theory as a model for research analysis, very few studies have actually taken this model to the extent of creating formal theory. Rather, she states that 'most grounded theory researchers have aimed to develop rich conceptual analyses of lived experience and social worlds'. This study stopped at providing detailed analyses of processes occurring in response to two particular phenomena, i.e. familiar pre-composed music and unfamiliar improvised music, rather than creating a theory about these. As the previous research and the results of this study indicate, individualistic enquiry is still the most valid considering the individualistic experience of chronic illness, music and therapy.

4.10: Ensuring Trustworthiness.

Validation and reliability were sought on a number of levels. These were through triangulating sources of data, the clinical material and the analyses of the transcripts. Observations and analyses of clinical material were triangulated with members of the clinical multidisciplinary team. This process is shown in Figure 2. There was prolonged engagement with each of the participants and persistent observation, allowing for collection of data at multiple time points and member checks. I served as researcher, therapist, data collector and analyst. Six years prior experience with this particular client group, experience of working closely with three other music therapists in such settings, and four years familiarity with the institutional setting for this particular enquiry provided reliable clinical and observational skills. Skills in gathering data through the interviews developed over time during this study. An independent auditor familiar with music therapy theory, behaviourist and psychodynamic principles provided triangulation of the transcript analyses.

Although the data source was primarily the verbal transcripts, the session material as documented in session evaluation notes was used as a secondary source of data. This offered triangulation of the interview material. As part of the process described above, this aided in generating deeper meanings than simply the verbal material available in the interviews by questioning the analyses made from the interview transcripts.

In addition to this, ongoing analysis of the musical and verbal material from the sessions was presented on a regular basis to an independent music therapist who was an approved supervisor with the Association of Professional Music Therapists. This supervisor's theoretical framework was psychodynamic, drawing from theories of Klein, Bowlby and Stern. Hence the supervisor triangulated both the clinical musical process within the

improvisations, and also my own interpretations of clinical material from a differing theoretical stance. This was extremely important considering my clinical background which was neither psychodynamic nor based in improvisatory methods. Receiving alternative interpretations of the work both enhanced objectivity and helped to gain greater depth from the data.

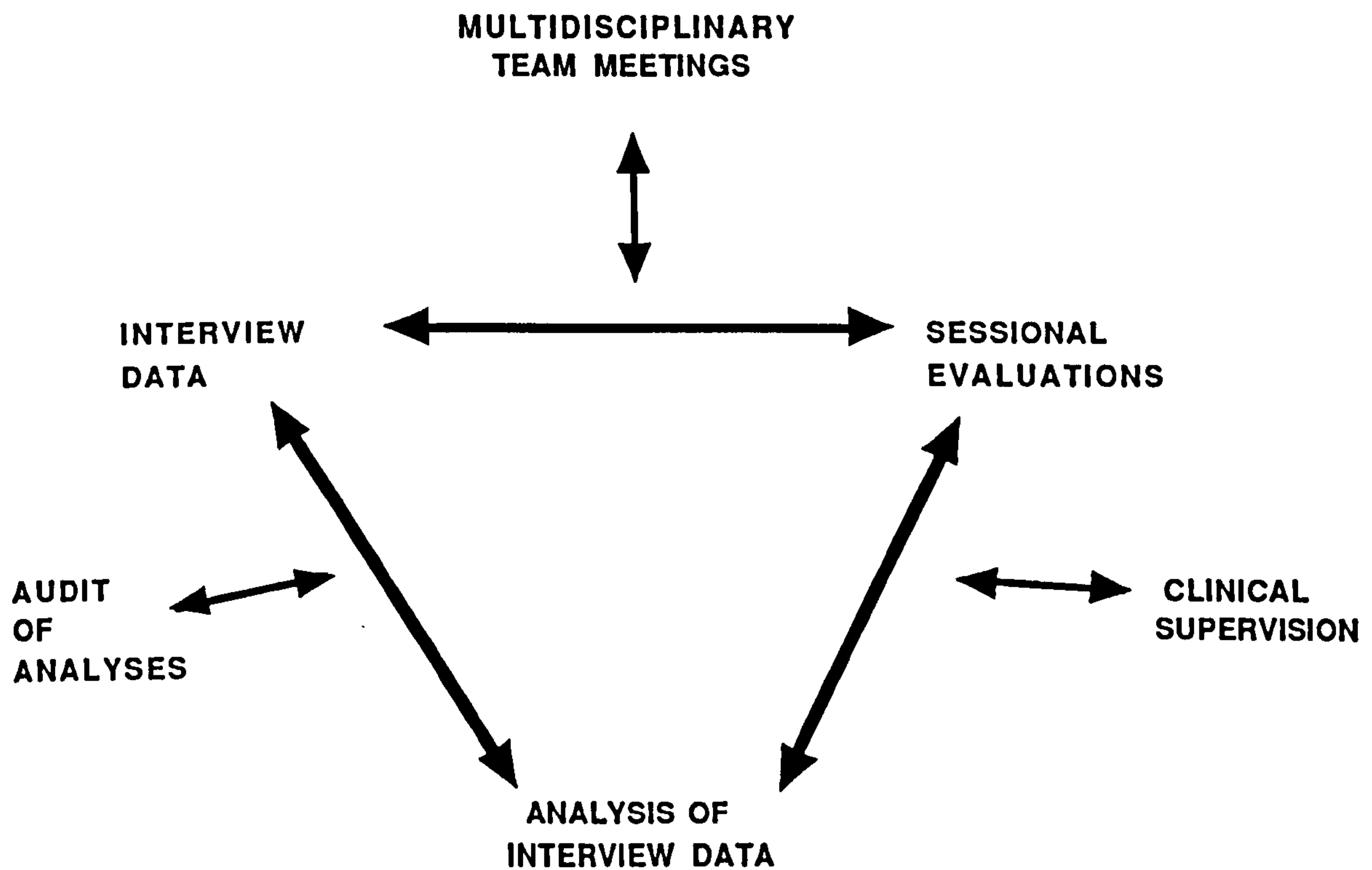


Figure 2: Methods of triangulation to ensure trustworthiness.

Further checks for reliability occurred through:

- Repeated analysis over time, both during the data collection process, and also at a later date well after data collection was completed. This helped to enhance objectivity

- Increased participant reliability as each individual became more relaxed with the interview procedure over time, allowing a greater willingness in revealing their experience in the sessions from a personal perspective and fewer attempts at making statements they thought would “please” the researcher
- Between interview checks by repeatedly questioning individuals' experiences of the phenomena to check consistency in responses. This helped to ensure internal validity.

The following three chapters present the results of the open coding process at a group level. Concepts which emerged across the individuals were grouped together into subcategories, which were then grouped together under three major category headings. These were ‘The Musical Experience’, ‘Coping with the Emotional’, and ‘The Illness Experience’. Each of these major categories will be presented in turn, outlining subcategories and concepts. Examples will be given from the participants' raw data to illustrate concepts or larger themes. The six participants names have been disguised to ensure confidentiality.

CHAPTERS 5 - 7

PRELIMINARY ANALYSIS AND RESULTS

MAJOR CATEGORIES:

THE MUSICAL EXPERIENCE

THE ILLNESS EXPERIENCE

COPING WITH THE EMOTIONAL

CHAPTER 5

MAJOR CATEGORY:

THE MUSICAL EXPERIENCE

5.1: Introduction.

The interview transcripts were analysed firstly between sessions, during data collection and then again after data collection was complete. The first analysis was brief, serving to identify relevant concepts and themes for each individual. A later analysis was repeated several times, and was therefore more thorough. A systematic approach was used, employing open coding techniques already described in Section 4.9 in the previous chapter. In more detail, this involved repeatedly reading through each interview transcript to identify discrete events (labelled as 'concepts') and themes which emerged from the data. This process was assisted considerably by transcribing the audio tapes which involved repeated careful listenings to the interviews. Individual concepts and themes were identified, and then those which appeared to relate to each other or pertain to similar phenomena were grouped together in categories. The techniques outlined in Section 4.9 in the previous chapter were used to identify the properties of each concept in order to gain a deeper analysis.

By analysing the data in this way, concepts emerged which were then grouped into subcategories under the categorical heading of 'The Musical Experience'. This encompassed both the experiences of familiar pre-composed music and unfamiliar improvised music. The properties pertaining to each concept or theme were also identified. Following the identification of properties, it was possible to determine the approximate values of a particular property in the individual's experience of the music. That is, a property (such as emotion) was evidently part the musical experience to a lesser (lower value) or greater (higher value) degree.

Unfamiliar improvised music provided a more dynamic sense of interaction. It was experienced only within the music therapeutic relationship for each of the

participants. That is, none of the participants experienced improvisation in any other setting. Therefore, improvisation possessed a potential which for some of the participants was too intense. Because it was experienced as a form of non-verbal communication, it threatened to override the verbal coping strategies which individuals had in place to survive emotionally with their illness. In addition to the interactive potential with improvised music, the physical elements involved in playing instruments were significant in participants' experiences. This connected the experience of improvisation to 'The Illness Experience'. Participants however had difficulty finding meaning in improvising, sensing it as something at which they were not skilled. This raised feelings about independence and dependence which also related into the major category 'The Illness Experience'.

Because of the associations held between songs and events, people and places throughout an individual's life, songs represented old friends who had seen through good and bad times alike. Songs held particular meanings which were individual to each person. In this way, they could be used to communicate something personal about the individual in a conscious or unconscious way. The words and messages embodied within songs and the emotional qualities of the songs also served to communicate something for or about the individual, either to the therapist, or to a significant other from the past, present or future. This aspect of familiar music also enabled the expression of a deeper 'real' self or alternatively the songs were used to mask feelings which were too difficult for the individual to have openly acknowledged. Although familiar music had some interactive qualities, these were not as subtle or varied as those for improvisation.

Seven subcategories emerged which were given titles to represent the essence of each part of the experience. These are 'Interaction/relationship', 'Communication', 'Emotion', 'Meaning', 'Personal Association', the 'Physical

Experience' and 'Relationship over Time'. These will each be presented with illustrative analytical extracts from the participants' data.

5.2: Subcategory: Interaction/relationship.

The interactive and relationship aspect of the music contained key concepts about how the experiences of songs and improvisation differed.

5.2.1: Interaction/relationship: the concept 'sharing' in songs and improvisation.

Familiar music, and songs in particular, had the potential to be shared with many others. From the participants' interviews it was possible to identify that songs were shared with others on the ward, with the family (past and present), with the choir, and with the music therapist. Not only were songs shared, but they were also sung and played in a range of situations. These varied from being alone, to being with others, and even with favoured celebrities on the radio.

Improvised music was experienced as something that also could be shared, and sharing was significant for all the participants within their descriptions of the experience of improvisation. The properties of sharing, however, differed from pre-composed music, as the experience of improvisation was shared solely with the music therapist. It was, therefore, special to that relationship as the participants perceived no other possibilities for improvising. Hence, the experience of improvisation existed outside other everyday interactions. This in itself intensified the experience of improvisation for certain participants such as Jessie, Guy and Elaine. For Elaine, for example, the shared experience of improvisation brought an awareness of her usual experience of feeling that she did things on her own, and highlighted feelings around the relationship with the music therapist.

Example 1:*Elaine, Session 16*

MT: At the end of the improvisation, you said straight away .. 'I've always been a loner' ...

Elaine: Yes I have.

MT: And I wondered why you said that straight after the improvisation? What was it about the music that caused you to say that or think that?

Elaine: It was the music.

MT: What was it about the music .. can you put that into words?

Elaine: I just thought about how I used to do things on my own. Because we played it together. And I'm used to being a loner.

MT: What was the feeling like of playing that together? Was that a ...?

Elaine: Nice.

For others, such as Jack, however, this experience which was peculiar to the therapist/client relationship caused the intimate nature of the improvising to be threatening, and therefore uncomfortable. Jack identified that it was the shared experience that gave the act of improvising some purpose. However he specified that it was only the 'sounds' which he was sharing, and did not acknowledge anything else he may have been sharing within the improvisation.

Example 2:*Jack, Session 23*

MT: Are you saying it means something when I play?

Jack: Yeah, yeah. And that if I played it myself, to me it would be a negative thing, because, I wouldn't be sharing it. That's what it is, that's what, I wouldn't be sharing it. And um, if you're trying to make a noise, a harmonious sound, you should share it, you got to. Got to share it.

MT: So what is it you see you're sharing when you play? When you improvise with me?

Jack: Sharing a nice sound. Sharing a nice sound.

MT: Besides the sound is there anything else you're sharing at all?

Jack: Well the fact that I can hear you and you can hear me, and it's a two way thing. You can't play it by yourself, because it's got to be two way. At least a two way thing. Um....and it means I'd be doing something positive when I was sharing it, because it had an aim.

5.2.2: Interaction/relationship: the concept 'awareness' in improvisation.

Within the interviews it emerged that improvisation was generally experienced in terms of 'self' and 'other', having a sense of each part in the music. This was further broken down into the property of 'awareness (of other)'. Awareness could be seen to range from being aware only of one's own playing and sounds (low value), to showing an awareness of the therapist's music as well (high value), thereby revealing a heightened awareness of the interactive process. In the following examples, the participants' descriptions highlight how often their own contributions were singled out in contrast to the therapist's. This extended sometimes to an absence of awareness that the therapist had played at all. In the following example, Francesca is so focussed on her own part, that she did not acknowledge that the therapist was playing with her until prompted. This was frequently the case in her improvisatory experiences.

Example 3:

Francesca, Session 10

MT: ... how would you describe what we did in the session?

Francesca: I was trying to play the piano.... I was trying to play the piano by myself.

MT: You said you played by yourself, but were we playing together?

Francesca: Yes we were.

Tracey, although initially separating out her own and the therapist's parts in the music, describes the experience as one of 'intereaction', revealing an awareness nonetheless of the relationship between herself and the therapist in the music.

Example 4:

Tracey, Session 14

Tracey: Well it sounded okay to me. Mainly your playing was okay. The noise I was banging out

MT: What part do we each play in this when we do the music together?

Tracey: Well I think we're sort of mirroring the other one. When you were playing sort of softer I was playing more down here (indicates section of

metallophone). And I was sort of playing up here (taps bass notes of xylophone). And the windchimes as well (plays some sounds on w/chimes).
MT: If you were to describe to someone what we did today, how would you describe the music?

Tracey: Well, I would say we were improvising ... that I was playing and we were sort of mirroring each other, so when you were playing softer, I was trying to play softer, and that when I get loud you got louder on the organ. Yeah .. 'Intereaction'.

Hence the experience of improvisation ranged from not at all interactive through to highly interactive.

5.2.3: Interaction/relationship: other concepts emerging from improvisation.

Further concepts, such as 'following', 'leading', and 'mirroring', also emerged from the data, reflecting a dynamic process, and thus adding a further dimension to the subcategory 'Interaction/relationship'. In the following example, in which Jack describes his musical and communicative experience of the improvised music, his given emphasis lies in how the music was used interactively.

Example 5:

Jack, Session 15

MT: Can you describe to me what you've just done in the music therapy session?

Jack: We've communicated with each other musically.... and then while you're playing, you see, I can (hits drum) I can make a loud sound, and perhaps you will afterwards So I'd say that was a giving and a receiving of nice sound, nice music. Mmm.

Finally, Jessie's description of improvisation was more sophisticated, and she adopted the word 'corresponding' to denote something about the non-verbal interactive aspect of improvising. In her attempts to articulate about the experience, there is also a sense that she felt 'met' in the music by the music therapist.

Example 6:*Jessie, Session 19*

MT: I wonder what's so special about, as you say, "corresponding with each other" in rhythm, I wonder what's so good about that?

Jessie: To get the music together! You know, get the sound almost the same way, like you're playing up there and I'm playing here, we can make one sound together, you know, that we're corresponding.

Example 7:*Jessie, Session 25*

MT: What about what is happening between us, the music between us?

Jessie: I think we are corresponding well. Corresponding well. Yes. That's right! That's why it was coming so good, because we weren't saying anything, just playing and listening to each other, and follow one another and playing what you were playing. Makes it nice.

Briefly summarising the difference between pre-composed music and improvisation in the experience of 'interaction/relationship', improvisation was something which was special to the relationship between the participant and music therapist. This differed in nature to the interactive experience of pre-composed music which was experienced in a far more general way in life. Songs stimulated processes which were more intrapersonal in nature than interpersonal. This granted to improvisation a sense of intimacy and potential intensity not perceived to be part of the experience with songs. This property was both a potential strength, but also prevented some participants from engaging in improvisation, as it had the possibility of being far too revealing. For example, there were very few times when Jack allowed himself to become absorbed in improvisatory activities. Early on in therapy, at the end of one prolonged turn-taking in which he had become very engaged, he was 'lost for words' and completely taken aback. After a pause and an awkward laugh, he made the following comments.

Example 8:*Jack, Session 7*

Jack: (laughs awkwardly) ... Aren't we funny? ... Funny watching me ..funny watching you

Not only did his immediate verbal comments suggest his discomfort, but the following week Jack cancelled his session. The intensity of a non-verbal activity had exposed Jack in a way for which he was not prepared at this early stage of the therapy relationship.¹

Therefore, the interactive experience of improvisation was built upon a greater number of concepts and possessed properties with more variations than in the interactive experience of pre-composed music. Besides the common concept of sharing for both types of music, the additional concepts for improvisation included following, leading, mirroring, interacting, giving and receiving, and corresponding. These gave the interactive experience of improvisation a sense of being a more dynamic process. The differences between songs and improvisation in interpersonal and intrapersonal properties begins to suggest how they may be used for differing therapeutic goals.

5.3: Subcategory: Communication.

Although improvised music was essentially an interactive experience, as a means of communication it was far less successful than familiar pre-composed music which was sensed to communicate more about and for the individual. This was perhaps because it was not clear to what extent improvisation was able to communicate about the individual.

5.3.1: Communication: the concept 'talking to each other' in improvisation.

Alongside the non-verbal interactive nature of improvisation already described, Jack also described it in a more concrete way literally as 'talking'.

¹ The event of Jack cancelling sessions was extremely unusual. This was, in fact, the only time he ever did so. His cancellation was interpreted by the therapist (validated in clinical supervision) as being a response to the intimacy achieved between therapist and client in the non-verbal turn-taking. This was the first time Jack had been engaged in any real way in improvisatory activities, previously only ever engaging in his songs for which he had his song sheets, the familiarity of the music and the words to sing.

In a later elaboration of this idea, he suggested that the language was a musical one.

Example 9:

Jack, Session 15

MT: How would you describe the music that we played?

Jack: I find it's a way of talking. I find that when I'm using those instruments, to me it's like talking to you. That's what I find. No matter what I sound like, I feel it's me talking to you.

Example 10:

Jack, Session 21

Jack: I suppose again it's a language. I was talking to you through making a sound, but to me I was talking to you.

Although improvising may have been perceived by some as 'talking', the nature of the material being communicated was not necessarily personal. For example, there was not a semantic relationship in what was 'communicated', and individuals did not feel to communicate something personal about themselves directly on the instruments.

5.3.2: Communication: the concepts 'expressing true self' and 'putting up a front' in songs.

In direct contrast to improvisation, the individuals in this study used songs of personal meaning to communicate something about themselves. This ranged from hiding the 'self' where the music was used to mask or deny feelings, to the other end of the spectrum where the music was used for expressing one's real feelings and true 'self'. In the following example, the participant Elaine described the 'bombastic confidence' she used as a front most of the time, and expressed that the songs of her choice communicated a different side of her, revealing a more 'real' side of her character.

Example 11:*Elaine, Session 17*

Elaine: I put up a front. I'm so confident, which I am. But deep down, I'm sensitive. It's good you see me when I'm with Elton John.

MT: Is that one of the things you feel these songs do - they show another side of you?

Elaine: I think they do....

MT: And so, in choosing the songs....?

Elaine: I was letting off some sentiments.... I put on a bombastic confident front ...

MT: But ...

Elaine: Inside I'm sentimental.

In an opposite way, the participant Guy used the images he associated with songs to hide his real self, or to give himself a 'front'. The following example is drawn from a session at which Guy had arrived in an agitated and angry state after a difficult morning dealing with his getting up routine. It was documented in the case notes that en route to the session his physical movements were severely ataxic, and he had talked incessantly, cursing the nurses, often in a raised voice. His agitation caused his speech to be more slurred and far more difficult to understand, particularly in the position behind him from where the therapist was pushing his wheelchair. Despite communicating her difficulty in understanding him, Guy did not employ strategies to make himself clearer, such as modifying the speed of his speech or repeating himself. His response was to raise his voice further. On arrival at the session, in an attempt to control his difficult feelings of anger and frustration, Guy requested music which he defined as being 'hippy' or which he associated with the drug culture. He stated that he was 'happy' and wanted music which would reflect his mood.

Example 12:*Guy, Session 11*

MT: If you were to do a song which matched your mood today, what you're feeling ... is there a particular song, or type of song ..?

Guy: Well a hippy type song, Bob Marley or something. Bob Dylan I think.

MT: So what sort of feeling, what's the mood behind the song?

Guy: Woodstock. Nice joint and smoke it happily. Happy.

In the manner thus illustrated, the moods and associations he used to describe songs most often contrasted with the emotional behaviour he displayed in the session. In this way, it was surmised that the verbal representations he offered were a front he wished to adopt in order to mask the emotions with which he was quite evidently having difficulty coping. Hence individuals used songs to communicate something about how they wished to be seen. Such use of song material will later be drawn into material relating to coping strategies, clarifying the role they played in the participants' therapy.

5.3.3: Communication: the concept 'communication to others' in songs.

A further aspect revealed that songs communicated something to others, either from the past or in the present. The following example indicates how in choosing a particular song within her therapy session, Tracey used the words and message central to the song to communicate her feelings to a previous boyfriend (see appendix 10 for the words to this song). Issues about the unresolved nature of the relationship had been the focus of the session prior to her request for the song.

Example 13:

Tracey, Session 19

MT: ...you chose 'All cried out', and I wondered what you could say about that?

Tracey: Well that was probably me singing that to Jimmy - I was all cried out (becomes tearful and voice croaky). And ... 'you took your time to come back this time' ...

MT: So were you thinking about Jimmy when you chose the song?

Tracey: Yeah I think I was. You was saying to me 'what song do you want?', and I think that song is mine to him. (voice still croaky)

In contrast to the above example, Tracey did not get in touch with these more difficult feelings when improvising. However none of these instances existed in a vacuum. The antecedents and consequences of using songs to

communicate something important also aided in understanding the overall experience, particularly how communicative aspects related to emotional processes. These will be examined at a deeper level within the individual case studies.

Songs, therefore, communicated personal facets of the individual through the lyrical content, or a mood or association attributed to that song. In this way, extramusical properties were important in songs. Alternatively, songs were used to mask more difficult feelings which an individual was not prepared to bring into the therapy at that point in time, thereby serving to communicate a 'false' self.

5.4: Subcategory: Emotion.²

The emotional experience of both songs and improvisation ranged between lower values of 'not at all', through a mid-range point of 'a little', to the other extreme of 'very emotional'. Emotions identified at the mid-range were 'lighthearted', and emotions identified at the far end (higher value) were 'anger', 'sad', 'hopeful', 'determining' and 'happy'.

This subcategory demonstrates the influence of extramusical factors on the different experiences of songs and improvisation.

5.4.1: Emotion: concepts relating to 'extramusical emotional meaning' in songs.

Overall, individuals were able to give emotional labels more readily to familiar music than they were to unfamiliar improvised music. Within the group it became evident that songs helped individuals to identify more difficult feelings

² It must be stressed that the titles given to subcategories do not stem from the theoretical literature, but from the themes which emerged from the participants' data.

in themselves, which they otherwise tried to suppress. However, as this data drew from participants' verbal accounts of the overall experience of the music the emotional labels given by individuals were often quite simple.

Pre-composed music expressed a wider range of moods and feelings for the participants than improvisation in both its musical and verbal content. Often extramusical emotional associations were held by each individual to particular songs. Association and personal meaning were properties which combined to enhance the emotional qualities of the songs.

It will be revealed in the case study analyses that a combination of more complex processes were contributing to the phenomenon of emotion in the music. As there are extensive examples to demonstrate this point in the case studies, no further examples will be given here.

5.4.2: Emotion: the concept 'emotional expression' in improvisation.

Because of the absence of association or extramusical meaning in improvisation, the emotional experience of improvisation was reflected in different concepts.

Firstly, it was necessary to establish that improvisation expressed feelings. At the lower end of the range, this was represented by a lack of emotional recognition within the improvisation described by the participants, identified through the participants' actions and thoughts during the improvisation described by them afterwards. At the other end of the range, improvisation was a highly emotional experience which was able to express or stimulate anger, sadness, happiness, hopefulness or determination.

For example, Elaine arrived on one occasion feeling particularly frustrated and angry about a current issue. Although in most sessions she requested a

favourite song which, for her, expressed 'sentimental' feelings, on this occasion, improvised music facilitated her expression of the more difficult emotions she was experiencing.

Example 14:

Elaine, Session 14

MT: I wanted to ask you about the music that we did in the session today. There were two main activities that we did - we did an improvisation on the drum and the piano, and then we did your song... I just wondered if you could talk first about the improvisation ...?

Elaine: I was letting off a bit of the frustration I feel.

MT: A bit of the frustration about some of the things we'd been talking about before that?

Elaine: Yes.

Improvisation was also described in terms of being cathartic and affecting the participant's mood. Jessie articulated this quite clearly, in addition to it being clearly observable through physical and gestural behaviour during the session, and also audible within her music.

Example 15:

Jessie, Session 18

Jessie: Well I always like that (playing) because if I'm feeling a bit upset and I come down here and play some music, I get rid of it. You know ... I don't feel so upset afterwards, I feel a bit....at least I'm with somebody, cheers me up.

MT: If you came down here feeling upset, and you had complete choice over what you wanted to do, would you rather sing through some songs which have been special to you, or would you rather make up our own music, improvise our own music?

Jessie: I'd rather play an instrument.

MT: You'd rather play an instrument.

Jessie: Yes. Get rid of it.

5.4.3: Emotion: the concept 'engagement' in improvisation.

The second emotional experience of improvisation spanned a range of levels of engagement. This varied from 'not at all engaged' through to 'very engaged'. For Guy, the experience of improvisation in his earlier sessions was a highly concrete or cognitive task with which he had difficulty engaging

on an emotional level. The following extract contains verbal material from immediately after an improvisation. This revealed various mechanisms which helped engage him in the experience on other non-emotional levels, one of these being a highly cognitive experience of the improvised music. This was a common response from him to improvising in the earlier sessions (sessions 1-14). The case notes from this session offer additional material, by noting his incessant eye contact with the therapist, qualitatively closer to a 'stare' than interactive eye contact.

Example 16:

Guy, Session 9

Guy: (Immediately after improvisation) What are you playing?.. I was beating 4/4 all the time. I was going 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 ... switched to the windchimes and then the cymbal ..

MT: So were you counting the number of times you hit an instrument as you went round?

Guy: Yeah! It's the only way I can keep the beat. If you're counting 4/4, you've got to count 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

MT: That makes it quite a process .. really using your mind rather than what you're feeling. Is that how you've always played music?

Guy: Yeah, I always count the beat. So you can hear that everyone else is in time with you.

5.4.4: Emotion: the concept 'emotion through instrumental sound' in improvisation.

Thirdly, improvisation was often defined in terms of what instruments were used to play. Because the activity was inherently one which involved playing instruments, it became clear that part of the emotional experience concerned the instruments used, the sounds they made, and the emotions elicited by the sounds for the participants. There were indications that strong emotional attachments were formed with particular instruments, and this also related to the physical experiences of improvisation. Emotional attachment to instruments was dimensionalised, ranging from not at all, to an expressed preference, to the development of a relationship with particular instruments.

Example 17:*Jessie, Session 14***MT:** Would you say that's what you've enjoyed the most this session?**Jessie:** Yes....The autoharp.... I like it because I love the sound. It's beautiful.**Example 18:***Tracey, Session 12***Tracey:** I just feel that the windchimes really relax me. I mean I could sit here and quite easily fall asleep. You know, just moving them quietly, and gently, and then it gets so much louder when it's down this end, and then at this end you've got very sort of tinkly sounds.

The emotions induced by the instrumental sounds and act of playing were not always overt. Guy's repetitive use of the word 'bash' when talking about playing his favourite drum seemed to indicate more than just the physical action of playing. This was validated by the quality of sound he created when playing, a harsh, relentless sound which did not vary in response to changes in the therapist's music.

Example 19:*Guy, Session 9***Guy:** It relieved the feelings a lot doing that. It relieves the feelings to bash drums and that sort of thing a lot.**MT:**What was the feeling for you in playing the drums, in playing the music we've just played?**Guy:** It's just like bashing things to relieve the tension.

The emotional experience of improvisation was therefore seen to involve a direct expression of feelings, have an effect on mood, and be affected by the physical and musical sounds of instruments.

5.4.5: Emotion: the phenomenon of 'confidence' (related to the concepts 'skill' and 'ability') in songs and improvisation.

Lastly, there was a further element which contributed to the overall emotional experience for both songs and improvisation. This was the aspect of

confidence in skill or ability. Improvisation was perceived to be affected by or dependent on musical ability. This ranged from feelings of inability to play, through to feelings of ability to play. In the following example, Jack's lack of confidence in his ability resulted in him feeling less able to express himself when he was playing than when he was singing, an activity at which he felt more skilled.

Example 20:

Jack, Session 19

MT: I wonder what it is about the two things, for you personally, that is different, between singing and playing? What it was that was different?

Jack: (pause) well I suppose if I could play the piano like you, it would be the same as if I was singing. Which would be expressing myself.

However confidence in ability also played a role in the experience of pre-composed music. In terms of the overall musical experience, familiar pre-composed music possessed a 'right' and 'wrong'. When 'wrong', the experience was of being 'out of time' with the therapist, being 'behind' or 'in front' of the therapist, being 'out of tune', and generally expressions of feeling unconfident. The 'right way' experience was one of greater confidence, doing the music at the tempo or in the style which the participant believed was 'right', and when both therapist and participant were in time with each other. This 'right/wrong' was based on expectations governed by the music's familiarity.

Hence part of the emotional experience of both pre-composed music and improvisation was related to confidence in musical skill. Feelings of ability and inability in playing were associated with feelings of increased or decreased independence and are important in the later category of the 'Illness Experience' in understanding the overall process.

5.5: Subcategory: Meaning.

Meaning in music occurred on multiple levels. It was evident that within songs, meaning occurred on both conscious and unconscious levels, either through the verbal content of the song lyrics, or through some type of musical experience, or through extramusical associations with the songs which gave them personal meaning. This meant that within songs, meaning was a complex phenomenon, and often a result of a combination of other phenomena. Improvisation, on the other hand, was described at times as more meaningful, and at other times, as less meaningful. The meaning of improvisation increased over time for each of the participants.

5.5.1: Meaning: the concept 'emotional meaning' (implicit and explicit) in songs.

There are repeated examples where songs were used to acknowledge non-verbally a mood or message which the client was not willing to share overtly with the therapist. In this way, a variety of moods or difficult themes could be explored on an emotional level by the client, without having to explore them verbally. Alternatively, as the relationship with the therapist developed, the client may have been able to explore these difficult feelings more overtly, or perhaps openly associate a song with some personal meaning.

For example, an individual may have requested a song with a 'sadder' or more reflective emotional verbal theme or musical content, whilst verbally stating throughout the session that they were 'happy'. Whilst it is important to accept what the client is saying, it is also important to remain sensitive to underlying meanings which may be too difficult or threatening for the client to acknowledge openly, or to moods of which they are not consciously aware. In doing so, the therapist leaves an 'open door' for the client if they choose to venture through.

It was therefore important to try and develop an understanding of the implicit meanings held in songs, in order for the therapeutic potential of the songs to be drawn on. Examples of evident implicit and explicit meanings in songs will be compared under this subcategory to illustrate the complexity of 'meaning' as a theme.

5.5.2: Meaning: the concept 'familiarity' in songs.

As one of the previous examples clearly demonstrates, songs in particular were identified as having meaning because of the words, messages, themes and stories possessed. The words in songs were either known or unknown. If known, a string of consequences ensued. It facilitated participation in a variety of ways and enabled the song to be sung better whilst reducing the perceived need for props such as words or song sheets. It caused the song to be liked and provided a chance to listen to the message contained.

Example 21:

Jack, Session 20

Jack: I like singing songs that I know how they go, and I expect to not know the words, especially when I haven't got the music. I use the music even though I know the songs, ... I like to have the music in front of me, and it's a big difference singing something I know, cause all the things I know, I like. All the things that I know, I know them or most of the song because I like it. It means something to me, to be able to sing it.

Example 22:

Tracey, Session 17

MT: I wonder if you could tell me why you chose to do the songs today?

Tracey: Well I think mainly because I know the words to the songs, so I feel that I can get involved. You know ... improv is nice ... but I find that when we're doing the songs, the ones that I know I can really get involved with I think it's more psychological (laughs) ... because I know the words to the songs, so I can sing along...

Example 23:

MT: What was it like hearing the songs that you know?

Jessie: Very good, nice to hear all the words. Nice to know that you know the song and the words as well. That you know the words of the song.

MT: When you say it's nice to know, ...when you know the words of a song, ... ?

Jessie: You feel happy. Yes. You sing along better, when you know the words of the song.

Hence, familiarity gave meaning, and feeling an active part by 'getting involved' and singing also increased feelings of skill. This then enhanced the meaning of the experience.

If the words were known, one could then visualise oneself in the words or storyline and fantasise. In Jessie's attempt to articulate the meaning of a requested song, the analogy was all too apparent of escaping from her illness, the hospital and ultimately the life in which she felt completely trapped, all of which were issues she often brought to the sessions. Furthermore, the story of the song she discussed in the following example is literally about being released from earthly life. This, too was a wish Jessie often expressed. Although Jessie never overtly linked the theme of the song and how it related to herself, it is possible that the covert processes were occurring although these were never explored verbally with her.

Example 24:

Jessie: The words of the song, the meaning of the song, just goes through you. It's hard to explain, but.....it's nice.

MT: The words of the song and the meaning of the song just go through you..? What do you mean by that?

Jessie: You know....like 'Swing Low (waves arms from side to side, face highly animated and chants) sweet chariot'...like sitting on the chariot, and singing away and enjoying yourself ... Something like that.

For Francesca, isolation and loneliness were themes that ran throughout her verbal material and reflected in her music. This reality caused her to escape frequently into the ideal world of love songs where everything was 'happy'.

Within sessions she frequently made reference to the storylines and meanings of the songs she requested. In the following example she described the ability to escape through her songs and also their compensatory power for the things for which she longed that were missing in her own life.

Example 25:

Francesca, Session 7

Francesca: They're love songs. You don't know who it's for - you just imagine yourself. You think your dream world.

MT: Do you think listening to these songs it is a chance just to go off into a ..?

Francesca: Dream world. I do.... They're soft .. and nice.... And loving too.

MT: It's sounds like you get something from the songs which ... maybe it's easier getting something from the songs, than ..

Francesca: Than from real life - it is! It is easier.... Then I dream about them.

MT: What is it about them that you dream about - do you think it's the ideal situation..?

Francesca: Yes.

Increased familiarity thus augmented meaning, enhanced feelings of skill and also levels of engagement. The extent to which an individual became engaged in an activity was observed to be less if songs which were not familiar were used for any reason in the session.

5.5.3: Meaning: the concept 'thematic meaning' in songs.

Messages, themes and stories pertaining to pre-composed music gave familiar music a further range of properties in terms of mood and associations. The theme or story may have born no conscious relation to anyone or alternatively, it could be directly related to oneself or a significant other. Both the songs brought up by Tracey in the following examples were not of significance to her before her illness. Her own personal situation however had given the messages contained within the songs a new meaning and intimate relevance, about which she commented directly. In the following examples, Tracey relates the meaning in the words of the songs overtly to herself and her own situation. In this way, the meaning held was on a conscious level.

Example 26:*Tracey, Session 20*

Tracey: Well I know that I'm always pushing to go further, and I know that sometimes I've gotta stop myself and say, 'Whoa, Tracey, hold on! .. You know you've gotta walk before you can run. You've gotta be able to stand up well before you can walk.' And I know that I wanna be up walking You can't demand (hits drum) 'I wanna walk now!' You've got to take it one step at a time sweet Jesus'. That's another song. (Starts to sing words "One step at a time Sweet Jesus - that's all I'm asking from you")

Example 27:*Tracey, Session 13*

MT: (After the song 'The only way is up') The song you chose is a pretty inspiring song.

Tracey: Well I just like the song, because I feel for me it's taken on a new meaning. Cause the way I look at it, the way for me now is up. So songs like that are really important.

Further examination revealed that the theme could pertain to relationships or alternatively relate to beliefs and messages. Themes themselves possessed emotional qualities which gave further depth to the meaning held for the individuals. In the following extract, Guy attributed not only a feeling and mood to the theme of the song, but also demonstrated how the theme of the song supported his own personal belief system.

Example 28:*Guy, Session 14*

MT: Is there a mood you would attach to Eleanor Rigby at all?

Guy: Saying what a futile existence most people have ... very sad song. You can see so many people like that in the world - you come across people who never do anything with their lives ... Some people just stay in London and never ever leave London in their whole lives.

In this example Guy revealed his own values and judgments, which gave the therapist insight into the purpose of his song selection as part of his life review. Again, this extract is taken from the context of an overall process of reviewing his own life achievements, which is reflected in the larger process of 'Life Review', a subcategory included later in the major category 'Coping with the emotional'.

5.5.4: Meaning: the action of 'purposive selection' and songs.

Pre-composed music was identified as holding personal meaning for an individual, or providing a relationship for the individual. This ranged from having no meaning, being unimportant and not being a favourite song, to having personal meaning, being important and being a particular favourite. It was evident that when songs were used, the primary relationship was with the song rather than with the therapist. In this way, songs could be hypothesised to be offering music as therapy. The meaning of a song held by an individual then affected the selection of songs, as it became apparent that the songs selected by the participants were done so purposely. The purpose for selection was related to the meaning the song held for that individual. The range of purposive selection varied from selection with no conscious aim to having a particular conscious aim. Such aims included to relate something personal, to express, to stimulate a memory and to arouse feelings. In addition, the music selected served the purpose to alter mood or to match an existing overt or more covert underlying mood. Because individuals may have had a purpose for choosing a particular song, selection could be classified as 'an action oriented strategy' (see Section 4.9 in the previous chapter).

In the following example, Tracey discusses her purpose in the songs she requested in the session.

Example 29:

Tracey, Session 11

Tracey: Well the songs that I pick are always bringing back good memories. I mean if you played something that brought back a bad memory, I would say "No, I don't like this one!". But the ones that we've picked out from the book have been ones that I really like.

MT: So it's about bringing back good memories, so you're selective about which memories...

Tracey: Oh, yeah! I don't want any of the bad ones back.

In a later session, Tracey talked about the hope which was sustaining her.

She improvised on the theme of 'hope' and requested a favourite song within the session in addition to verbally reminiscing about her life. The following extract highlights how the message in her song choice reflected her feelings of exhaustion and fear underlying her hope, which were too difficult for her to acknowledge verbally. The song however could express these feelings for her.

Example 30:

Tracey, Session 16

MT: You say you're very careful about the songs you choose, and you choose ones which only bring back happy memories -

Tracey: Yeah ..

MT: Do you also choose ones which cause you to feel a bit sad or nostalgic?

Tracey: No. Not really. I choose the good ones from the past.

MT: So we sang a song today, by Alison Moyet ...

Tracey: 'All cried out' ... And that's how I feel ..(eyes fill with tears and reaches for her tissue) ..

The above is an example of an individual choosing a song which superficially brought back 'good memories', but on some deeper level identified with an underlying mood. It is important to refer back to the fact that individuals either initiated their choice of song, or chose from a selection offered, and the suggestion that there is purpose underlying the selection made. It was observed within the sessions that levels of engagement were greater if the mood evoked by the music was one which was sought after by the individual. Referring once more to the above example, Tracey had stated that she carefully selected her songs according to the personal meaning they held. However on this occasion there was also an underlying purpose in her choice, which was that the theme of the song also held some implicit meaning for her at that moment due to her underlying mood, of being 'all cried out'. She was unable to express this explicitly, and it was in contrast to the 'hope' which she was so positively dwelling upon within the session. These examples illustrate how implicit meanings within songs could address unconscious or underlying emotional states, which may or may not have become explicit

during the session. This point will be discussed in much greater detail in the case studies and the discussion section.

5.5.5: Meaning: explicit or conscious meaning in songs.

At other times the meaning held in a song and the emotions thereby evoked by the music were openly acknowledged and identified with by the participant, as seen in earlier examples (refer to examples 26 & 27). On such occasions, it was assessed that the individual consciously sought the meaning attributed to a song. Whether there was a conscious acknowledgement or not of the personal meaning within a song, levels of engagement increased when the individual was able to identify with the song. Similarly, if the message contained within a song held meaning by being consciously related by the individual to him or her self or significant other, the level of engagement increased. Becoming sensitive to this enabled the therapist to support the individual in their emotional state within songs alone without having to acknowledge verbally what the client did not wish to have overtly explored.

The meaning which pre-composed music held for participants emerged to be a major factor contributing to its use in therapy. The property of 'familiarity' was often the key factor in the meaning of this music for the individual due to extramusical properties such as personal association.

5.5.6: Meaning: variable meaning over time and improvisation.

Descriptions of improvisation provide examples of not only meaningful experiences, but also musical experiences which held less meaning. Whereas the meaning of pre-composed music was observed to lie in the words or themes of songs, the familiar nature of the music, and the relationship over time, these aspects were absent in unfamiliar improvised

music. There were many instances where improvisation was described simply as 'noise', suggesting the musical meaning of the experience was little more than this. Such descriptions however did change over time as the participants' experience of and familiarity with improvising increased, when the music was described as a 'song' or generally in more musical terms. Such changes reflected a combination of increasing familiarity with the activity, with music therapy, and also the developing therapeutic process.

5.5.7: Meaning: achievement of a goal in improvisation.

There were times when the meaning of unfamiliar, improvised music lay only in some type of aim or purpose. This often was directed towards musical goals, such as aiming for the best sound, or attempting to get the right note.

Example 31:

Jack, Session 17

MT: There was a time when we were playing, and I noticed that you were looking up at the ceiling and looking around, and I wondered what was going on for you right then in the music?

Jack: Oh I was listening to you ... I was listening to you, and I was listening to the music as well. See I was trying to harmonise my music with you. Not exactly copy, but try and make it melodious - is that the word?

Such musical goals were not always successful in the participants' experience of the music, however, and sometimes left feelings of being unsuccessful as in the following example.

Example 32:

Elaine, Session 13

MT: I wondered if you could talk a little bit about the music that we did in the session, the part where you played metallophone and I played piano. I wondered if you could say something about that?

Elaine: I tried to make it melodious I tried, and I couldn't.

MT: Was there something you were thinking about when we were playing together?

Elaine: 'I wish I could make it melodious!'

MT: So how did you feel when you were playing this?

Elaine : Useless!

There was often reference to providing something which would please others or of which others would approve. Jessie related this aim within improvisation to her professional past.

Example 33:

Jessie, Session 21

Jessie: You have to put a lot in nursing really, the same as in music I suppose, if you want to do it properly, you've got a lot to put in. And I find it's the same with music, if you want it to sound good, to entice people, you've got to put a lot in it. A lot of your own enjoyment, movements.

These examples suggest that individuals had difficulty adapting to the interpersonal aspects of improvising as opposed to the relationships they held with their songs. Because the purpose of improvising remained difficult to grasp, individuals sought to increase meaning by setting musical goals such as those outlined above, rather than interpersonal goals.

5.5.8: Meaning: the concept 'familiarity' to enhance meaning in improvisation.

In order to give meaning to unfamiliar music, reference was made to pre-composed music. Participants often described improvisation in terms of 'song' or stated that the improvisation would have had greater meaning had a song been achieved. In the following example Jessie suggests that the improvisation was like a 'special song' and measured up to the standard of a familiar song.

Example 34:*Jessie, Session 17***MT:** How would you describe the music that we played?**Jessie:** I don't know what I was playing really. Just something going out of my head. It was tasteful, anyway.**MT:** It was tasteful. Do you think it made sense in any way?**Jessie:** (immediately) Yes, I think it was good. Sounds alright ... As if we knew what we were playing. As if we knew a special song or something. As if we knew what we both were playing.

For Elaine, improvisation in the earlier sessions was not meaningful. When asked to suggest what would have been a more meaningful musical experience for her, she clearly refers to familiar pre-composed music and particular performers.

Example 35:*Elaine, Session 5***MT:** How was it actually playing the organ? How do you feel when you are playing it?**Elaine:** (Pause) I wish I could make up a song.**MT:** The music which we played today - how would you describe that in your own words?**Elaine:** Muck up in a dixie.**MT:** ... What does that mean?**Elaine:** (plays a note) it was nothing!**MT:** What would have meant something?**Elaine:** If we could have made a song.**MT:** When you say a song, what do you have in mind when you say a song?**Elaine:** Music by Pavarotti.**MT:** Do you mean something you'd recognise?**Elaine:** Yes.

Not only was the familiarity of a song alluded to in descriptions of how the music could have been more meaningful, but also the structure provided by a song.

Example 36:*Elaine, Session 11***MT:** If I can just start off by asking you, to say how you would describe the music if someone asked you what sort of music we played today, how would you describe the music in your own words?**Elaine:** (Long pause) Not methodical. Is it? It's just bits .. thrown together. I think.

On other occasions, the improvisation had been experienced as a song, albeit an unfamiliar one, suggesting that the music had made greater sense.

Example 37:

Tracey, Session 12

MT: ... Is there anything else you want to say about the music at all?

Tracey: Mm, not really. I mean the music itself, was... I'm presuming it's a piece you know...it's not one that I recognise...

MT: It was actually improvised music, so I didn't know it.

Tracey: Oh was it? I think it sounded pretty good.

It was not only the music itself which caused semantic problems, but also the the physical act involved. Jack so often talked about singing, but when he used his voice to sing within an improvisation, he was lost for words to describe this very familiar act. In the following description of this improvisation, Jack attempted to articulate in words the rather abstract activity of vocal improvisation.

Example 38:

Jack, Session 19

Jack: We um, tried to make a noise, and....We tried to make harmonious sound....We tried to make a nice vibration, and enjoy the sound. We have made an enjoyable sound that I have liked.

MT: But what did we actually do?

Jack: We made sound....We were using my voice, and your brains, and that instrument, to cumulate this sound....I was trying to direct it into a harmonious sound.

MT: Do you mean you were singing Jack?

Jack: Yes, oh yes. ...We done a song, consisting of vibrations from the nose, the throat, and the instrument, and tried to, we put it together to make something nice, nice sound, nice vibration.

All of the above examples highlight how difficult it was for participants to describe verbally the act of improvising. In attempting to do so, familiar constructs were drawn upon, such as referring to the improvising as a 'song', or when the experience was less meaningful, referring to the 'noise' made. The application of these constructs suggests that individuals were cognitively appraising improvisation in the same way that they understood or appraised

songs. Once more, the interpersonal elements of improvising failed to give meaning to the experience. Instead, individuals used constructs such as skill to assess their experience. The construct 'skill' was previously highlighted as being higher when music was familiar.

5.5.9: Meaning: unconscious meaning and improvisation.

If levels of engagement were used to monitor personal meaning in improvisation in a similar way as they were observed during familiar songs, then ultimately it was observed that there were moments within improvisations when unconscious processes were being affected. However such material was not always supported in the interviews, only being recorded in behavioural or musical responses in the session evaluation notes. For example, it was noted that on one occasion within an autoharp and flute improvisation Francesca was able to endure the duration of a brief silence and then initiate novel musical material. These were both aspects of behaviour that were tremendously difficult for her in verbal interactions. Afterwards in the interview however, she was unable to remember the experience of improvising clearly, and was certainly not willing or able to describe it verbally. In a similar way, Jack rarely engaged in the act of improvising music. His engagement was indicated by the spontaneity of his responses in the musical interaction, and also his physical behaviour with an instrument. After such instances, however, his verbal accounts failed to indicate any personal meaning other than 'having a conversation'. Jessie was far more fluent and confident within her musical material than within her verbal material. Therefore the essence of her experience of improvisation was never captured in the interviews in a way which paid full justice to the levels of behavioural and emotional engagement observed within sessions when she was engrossed in the act of improvising. During the middle period of his music therapy, Guy began to engage in improvising in a more emotional way,

indicated through the duration and variation of his playing and the increased interaction he tolerated within the music. His verbal elaborations afterwards, however, in no way reflected this as he used only concrete descriptions of the instruments and seemed unable or unwilling to discuss the music created in any other way.

Hence implicit meanings can be assumed to have occurred with both types of music, but the cognitive constructs were not available to allow individuals to expand on their experience of improvising.

5.5.10: Meaning: the concept 'personal association' in improvisation.

When individuals attributed personal association to an improvisation, its meaning was enhanced for the individual on a conscious level. Individuals' verbal descriptions supported this, as often the most meaningful experiences of improvisation were those that had a theme of some personal significance or association such as current issues, encompassing relationships and feelings about current issues. In this way, discussing improvisations provided an immediate outlet for feelings about important events occurring in the individual's life. For many people there were few opportunities to explore these issues elsewhere. Understanding how individuals related improvisations to their important issues revealed that there were some overlapping concepts between this subcategory and both the subcategories of Emotion and Personal Association. It must be acknowledged that the links made by the participants in this way may have been merely attempts to put his or her feelings about improvising into words. Giving verbal interpretations of non-verbal interactions may be considered to contradict the purpose of improvising. However any links made by a participant between the music and his or her current issues were usually spontaneously offered after improvising,

and therefore should be considered valid as these were clearly the individual's immediate thoughts and feelings.

The meaning of improvisation, therefore, was more difficult to grasp than with pre-composed music and certainly more difficult to describe verbally. Unlike familiar music, the meaning had to lie in the music itself and its ability to be related to emotional states or current issues in the individual's life. However if meaning could not be found in the music itself, then the experience was not necessarily a positive one for the individual involved.

5.6: Subcategory: Personal Association.

This also emerged as a key factor for both types of music in the participants' experiences. Due to the relationship over time held by songs, familiar pre-composed music possessed pre-illness links. Associations facilitated the music to be placed within a personal context. These were diverse and each will be explained separately.

5.6.1: Personal Association; the concept 'identification' in songs.

Associations or identifications with a performer/composer were linked to personal characteristics attributed to that performer or to biographical life events believed to be experienced by that performer/composer. Examples of this included Tracey's knowledge that the singer in a favourite band who had once been a boyfriend of hers had recently been hospitalised with a life threatening neurological condition from which he was making a slow recovery. The identification which this held for Tracey was clearly articulated in her verbal reflections. Other types of identification were about personality traits or characteristics attributed to performers/composers, such as 'strong minded', 'determined', and 'knew what he/she wanted'. These were characteristics which were pertinent in each instance to the individuals' situation and coping style.

Example 39:*Tracey, Session 16*

Tracey: ... and the song, I just liked the song. You know and so I think it makes me really happy when we do a song, because they're usually songs that I like, or my favourites, say a blast from the past! But I think you're right about Alison Moyet, being 'defiant', and I think ... she's a very strong woman. You know, and I like her for that, and I think that comes out in her music.

MT: That's actually something that you've said about the songs before. I know that last week, we did one of (ex boyfriend's) songs - we did 'Lifeline' - and you were talking then about what he's been through, and there being something about that being important for you.

Tracey: Yeah. I think you can relate more to a song when you know that the person that's doing the song has been through a really hard time, and come through it, you know, pretty unscathed. And I think that sort of brings me back to 'hope'.

MT: That's something you referred to last week when you chose one of (ex boyfriend's) songs. Do you think, before you became ill with MS, do you think that issue of liking songs which you related to somebody having been through a hard time and got out ..

Tracey: No. Never.

Example 40:*Tracey, Session 20*

Tracey: ... Cause she was a very powerful lady, Yazz.

MT: Is that something that also attracts you about the song, that it was sung by somebody who was ...

Tracey: Yeah, was very determined, on her own, and wanted to stay on the straight, she didn't want any sort of .. detours, she was ... straight ahead.

MT: Is that a character that you identify with?

Tracey: Oh yeah

MT: That's something you've mentioned before, when you mentioned about Yazz being very strong, and it's something you've mentioned before about Alison Moyet.

Tracey: Yeah. She's another fighter.

MT: Do you think that's something ..

Tracey: I can identify with.

5.6.2: Personal Association: the concept 'association with significant others' in songs.

The previous examples highlight the ability of songs to stimulate associations with significant others. However these were not only current relationships, but also spanned those from the past, the present and even the future. It also included relationships which were unresolved or resolved, and unfulfilled or

fulfilled. This resulted in many more properties for this particular concept, thereby giving it greater complexity and possibilities for relating to other subcategories. The nature of relationships associated by individuals to songs varied widely, but could be grouped into familial, friend, romantic, and mentor.

The following examples highlight a process experienced by Elaine over the period of her therapy. Whereas the therapist was probing to explore if the theme and words held meaning, it emerged that for Elaine a different property of the songs took priority. The associations she held with the song she frequently used in therapy ("Sorry Seems To Be The Hardest Word") were causing her to reflect on a past romantic relationship. Her reflections were pertinent to her current social situation which was one of increasing isolation and dependency. Living at home with an elderly mother she was trying to come to terms with an inevitable future of being hospitalised herself due to her mother's failing health.

Example 41:

Elaine, Session 12

Elaine: Mmm. Sorry does seem to be the hardest word.

MT: Is that something that rings true for you?

Elaine: Yes.

MT: Could you expand a little more on that?

Elaine: There was a .. boyfriend I had. ... (Long pause) He loved me.

Elaine, Session 14

Elaine: I used to have a boyfriend ... and he lived in this caravan.

MT: And hearing that song...?

Elaine: Cause he bought that for me, see?

MT: Was there anything else about the song you were thinking about when it was playing?

Elaine: He would have looked after me. I missed my chance.

MT: Missed your chance for him?

Elaine: Mmm

MT: So when you hear the song you think of him, and are they positive thoughts, or feelings, or are they regretful...?

Elaine:Regretful.

MT: We haven't talked about the theme of that song, have we? The words are actually - 'What have I got to do to make you love me, what have I got to do to make you care, what do I do when I wake up to find that you're not there, what do I do to make you want me, what have I got to do to be heard, what do I say when it's all over, sorry seems to be the hardest word ...

Elaine: Mmm ... very sentimental.

MT: Do you think there's any underlying message there, or anything which clicks with your own feelings, your own sentiments?

Elaine: (Pauses)... It's just a boy friend I had at the time

MT: Do you always think about him when you hear this song?

Elaine: Yes I should have stayed with him.

5.6.3: Personal Association: the concept 'emotional association' in songs.

The associations linking emotional quality with pre-composed music were also connected to the coping process and these will be explored in much greater depth in the case studies. However at a general thematic level, associations made covered a wide spectrum of emotions identified. In the following example Guy tried to put into words the emotional qualities of a song he had demanded on arrival at the therapy session feeling extremely angry and agitated.

Example 42:

Guy, Session 14

MT: If you were thinking about what mood Jumping Jack Flash had with it, how would you describe the mood of it?

Guy: It's more sort of violent, raucous, ... and when they sing it, it's so, so, way over the top in the singing and every thing ..

MT: So way over the top, that's the image you associate with the song, way over the top, and raucous ..?

Guy: Yeah, way way over the top.

MT: Was there anything about the mood of the song that you identified with this morning?

Guy: Well, I'm in a happy mood. I'm always happy when I hear Jumping Jack Flash.

MT: So is it something that no matter how you're feeling, affects your mood?

Guy: It cheers me up totally.

MT: Even though it's raucous, and ...'violent' you said before

Guy: They're trying to impress upon you, get you into the music ..

MT: The song's trying to ...? (Asks for clarification)

Guy: The song is trying to tell you to get with it ..just explode on the music, and do whatever like that.

It can be noted that Guy himself labelled his mood as 'happy', despite having arrived at the session in an agitated state. As was often the situation, his increasing dependence and impaired insight caused him to become irate with the nursing staff during his getting up process, as he believed that he should be got up, washed, dressed and breakfasted before the other patients on the ward. This was exacerbated by his anxiety that he would not be ready for his music therapy. After such a process he usually arrived in an irritable, angry and exhausted state, feeling that he was receiving extremely poor care and that no-one took him seriously. Hence his description of his mood as 'happy' did not match his behaviour and verbal material in the session. This highlights the difficulty in taking explicit verbal descriptions of mood without examining how an individual has used the music. Additional situational contexts and verbal material were needed to support any interpretations made.

5.6.4: Personal Association: the concept 'association with life events' in songs.

Associations with life events stimulated by pre-composed music were a central and common phenomena. Participants themselves repeatedly described a process where a song could be pinpointed to a specific event, time or place, and that in participating in that song the life event could be relived. Such a process often resulted in 'life review' which is explored in more detail in a later category 'Coping with the emotional'.

Example 43:

Jack, Session 14

Jack: 'I'm sure that human beings, no matter what class he's in, when he sings, he must identify himself with some spot in his life. Oh yes. I think every song has something for one stage in your life. It must do, well it does do for me. It does with me.'

Example 44:*Jack, Session 24***MT:** So this is a song which you associate with that time in your life?**Jack:** Yeah, oh yeah.(later) well it's all connected. It's all interwoven. It's all interwoven into your life. These songs are interwoven into *my* life. Into my experiences. They're there.'**Example 45:***Guy, Session 13***MT:** How would you sort of sum up music therapy for yourself?**Guy:** All of my life bends around music. One piece in my head can symbolise somewhere I've been to. With the songs I'm singing parts of my life ... reliving a part of my life.

Greater depth can be achieved by examining the range of the associations. For example, whether a specific event is recalled, or more general events, and whether these existed in the past, the present, or related to future events. This affiliates the associative experience of pre-composed music to the temporal experience.

Example 46:*Guy, Session 11***Guy:** ... but the memories were more specific last time (with songs). There are certain incidences that occurred with that music**MT:** Do you feel a preference yet for one or the other - either improvising or songs?**Guy:** Songs.**MT:** Why is that? You are very definite about that.**Guy:** Well, because a certain song can have a very specific memory to it. So you can play that song and remember what you want to remember.

5.6.5: Personal Association: the concept 'association with current issues' in songs.

The experience of pre-composed music stimulated associations with current issues as well. This may have been due to an emotional quality of the music or the message given by the song. Such an association may have been acknowledged openly by the participant and therefore been made on a conscious level. Alternatively, if not acknowledged openly, but noted by the

therapist to be related in some way to a current issue, it was considered possible that some personal association had been made on an unconscious level.

The following example from Tracey shows how she consciously acknowledged the association between the message in a song and a current issue of great significance to her. She was trying to secure regular visits home on the weekends as a trial to moving back home permanently.

Example 47:

Tracey, Session 18

Tracey: Well, for me, it's because going home is my main aim. And now knowing that the power chair's ready, I just want to get on to practising that, and maybe going home for weekends. So the song was quite relevant to how I feel.

MT: The last song was quite relevant about how you're feeling?

Tracey: Yeah, 'Tie a Yellow Ribbon Around the Old Oak Tree' Well, singing 'I'm going home', I knew the words to that song, so that's what was in my mind, going round....

The associations made with themes, words and stories in pre-composed music, and particularly songs, were of significance within the data. These were related to self awareness as well as to others. Similarly, associations were made with hopes, dreams and ambitions. Once more, temporal dimensions expanded the understanding of these hopes and dreams, covering past, present and future. Further properties also included whether these hopes were unfulfilled or fulfilled, or unrealistic to realistic.

5.6.6: Personal Association: the concepts 'association with life events' and 'association with significant others' in improvisation.

The associative experience of improvisation was not as exhaustive as the pre-composed music experience, however, certain common areas did occur. The activity of improvisation stimulated memories, either about particular events or

of a more general nature. Improvisation also stimulated thoughts, memories and associations about significant others. Elaine and Francesca, after improvising on the piano or electric keyboard, both reminisced about parents who had been accomplished pianists. Jessie reminisced about her extended family and the village life she had left behind when she emigrated. For Guy, improvising stimulated associations with his father with whom he had listened to recordings of classical music. The triggers or processes involved in such reminiscences were not as easily identified however as with pre-composed music where participants could pinpoint specific memories associated with familiar music.

Similarly to familiar pre-composed music, the act of improvising also stimulated associations of unfulfilled ambitions, hopes and dreams. Both Guy and Jessie, who had very positive feelings towards improvising, expressed dreams associated with the creative process involved in improvisation and reflected on what might have been had they taken up music more seriously. This also fed into the experience of life review.

5.6.7: Personal Association: the concept 'association with pre-illness abilities' in improvisation.

For some participants, improvisation had pre-illness links, which associated the activity to the illness process and then led to some form of life review. If associations were made to pre-illness abilities, the active playing of instruments in improvisation stimulated associations about the consequences of the illness and led to reflection on changed abilities. This often led to reflection on changes in physical abilities and the feelings about these changes. Hence the temporal and associative experiences of improvisation existed as one part of a larger dynamic pattern.

5.6.8: Personal Association: the concept 'association with current issues' in improvisation.

All of the above also contain temporal elements. As already noted under the category 'Meaning', however, associations made between current issues and improvised music most often increased the meaning of the improvisation than when no association was made. In the following example, Tracey directly relates the musical feeling of the improvisation to her how her own life was feeling at that present time.

Example 48:

Tracey, Session 20

MT: What about the other things about the music? You were giving a very strong pulse, and I was trying to follow you ...?

Tracey: I think that's what's inside me at the moment. Rushing, rushing, rushing.

MT: Rushing forward. Does it feel hard to sit back?

Tracey: Yeah... Well just that it was light and quite fast .. and that's how my life feels it is at the moment, it's quite light, and it's moving forward quite fast.

Francesca's main current issue for most of her time in music therapy centred around the imminent loss of a favourite carer. She had great difficulty acknowledging how she felt about this situation and although the music therapy session served as a distraction for a brief time, it became evident in her verbal material that her current issues were very much on her mind when improvising, or at least that improvising stimulated associations on some unconscious level for her. In a similar way, it emerged in her next improvisation session that she was also worried about the physical changes happening as a result of the illness.

Example 49:

Francesca, Session 6

MT: If you were to go back to the day hospital or back home and tell someone what we did in the session today, how would you describe it?

Francesca: I was amusing myself.

MT: What did you actually do in here?

Francesca: I played (taps m/metallophone) what do you call this, and this

(touched w/chimes) and this (bass xylo)

MT: And if someone said what sort of music did you actually play, how would you describe that?

Francesca: Don't know. Just played to amuse me, make me feel okay I'm trying to get over Kate leaving me. (touches w/chimes).

Example 50:

Francesca, Session 8

MT: The music that we've played today,...

Francesca: Helps me.

MT: How does it - can you tell me?

Francesca: Yes because I forget all that's going on for me at home. With my body.

5.6.9; Personal Association; the concept 'association with pre-composed music' in improvisation.

Improvised music was associated with familiar pre-composed music. There were occurrences of associations made between the two types of music on some emotional or expressive level. In the following extract, Guy reflects on the emotional content of the improvisation by associating it with pre-composed music with similar emotional expression.

Example 51:

Guy, Session 18

Guy: That was a very good Beethoven improvisation we were doing together. The 1812 bang bang on the tambourine etc. Excellent with the piano doing some Holst planets and that sort of thing.

To summarise, improvisation stimulated associations pertaining to current issues in individuals' lives, particularly around their relationships, hopes and dreams, and ambitions which were unrealised. Associations from the past were also stimulated in the form of life review, as well as to emotional qualities in pre-composed music. Many of these associations were common to those stimulated by pre-composed music as well.

5.7: Subcategory: The physical experience.

As improvising involved actively playing instruments, there was little possibility for an emergent range between 'active versus passive'. Certainly within this study, all improvisation involved some active participation. This meant that the act of improvising was an extremely physical experience, highlighting physical ability and disability. Individuals expressed feelings ranging from disability/inability to feelings of ability. Feelings of disability described how playing instruments demonstrated the way in which changed abilities affected skill and stimulated expression of feelings about these changes. Due to the physical nature of improvising, an emergent theme within this experience was that improvisation is affected by the physical effects of the illness. This ranged between 'not at all' (low), through to 'sometimes', through to 'often' (high). Greater sensitisation of how the illness affected physical playing included comparisons of pre-illness and the present, and other illness factors directly affecting improvising, such as fatigue.

5.7.1: The Physical Experience: the concept 'control' in improvisation.

In the following example, it can be seen that Guy's experience of improvisation was not limited by his musical ability, which was a factor for many others, but that he had not enough physical control to participate in the way he wished to.

Example 52:

Guy, Session 8

Guy: Well because I can play .. play .. bash the drum or something, but I can't really control my hands enough to get a proper rhythm. And that sort of thing.

For Jessie, her physical experience of improvising was affected by her visual loss unlike her participation in the song-based activities.

Example 53:

MT: What was there about the session that you found hardest, or most difficult?

Jessie: Nothing really, wouldn't say anything difficult about it. The thing is, I can't see.

MT: So how does that affect..?

Jessie: Playing the instruments, can't see what I'm doing.

MT: It's difficult to know how to play them when you can't see them?

Jessie: Yes. That's the main thing.

The relationship between the physical act of improvising and the emergent theme of feelings of independence created links with the category 'The Illness Experience'. Such experiences resulted in very powerful outcomes which will be revealed in the case studies. The scope of such a theme ranged from feelings of dependence, particularly where there was an acknowledged loss of independence from changed abilities, through to a sense of increased independence.

5.7.2: The Physical Experience: the concept 'emotion' in improvisation.

Through playing instruments and producing sounds, links emerged between the physical experience of improvisation and the emotional experience of the music. This in turn created a relationship with the illness process. For example, when Tracey described her playing of the windchimes as 'quietly and gently' (see example 18 of this chapter), it was noted that there were few physical activities which she was able to have such a controlled sense of her active movements. It is possible that playing the windchimes in the way she described was the only time she was able to have a physical effect on something in the way she described i.e. 'quietly' and 'gently'. Guy's description of his physical interaction with his most frequently chosen instrument as 'bashing' (see examples 19 and 52) also indicate emotional qualities. The implications for the illness experience when considering the act of improvising are explored in more detail in the later stages of analysis.

5.7.3: The Physical Experience: songs.

The physical experience of pre-composed music involved both active and passive participation. Particularly songs could be experienced passively by just listening, or actively by either singing or playing or both. If singing, then this was a highly physical act which was conducted in certain ways with certain results. Singing could be done 'not well' or 'well'. If affected by a sore throat or feeling physically 'limited', then the singer was unable to sing in a way that was considered 'well'. However if 'not limited' by any physical effects, then this enabled the singer to sing 'well'. These conditions add depth to the experience as they reflect something about how the activity may be affected by the physical effects of the illness. This allowed the experience to be linked to the illness process which will be given more detail in a following case study.

Hence the experience of both types of music within this study was a physical one. The extent to which this affected any one participant's experience however was entirely dependent on their individual illness trajectory such as functional physical state, and how they dealt with this within their life. The physical experience of the music had implications for themes which emerged in one of the other major categories, explored later in 'The Illness Experience'.

5.8: Subcategory: Relationship Over Time.

Pre-composed music and songs in particular were experienced over time and in relation to time. Although this is true of all music through its temporal nature, the individuals in this study referred to time as being across the life span. This is particularly relevant in chronic illness as discussed in the literature review. The way in which songs were experienced over one's life-time gave songs an associative quality which has already been described. The temporal

relationship, however, was different in character to the associative nature of pre-composed music already described, although the two possess overlapping aspects. The important point which emerged was that familiar music held relationship to the past, encompassing people, memories, events, relationships and abilities which existed before the onset of the illness. This attribute empowered the songs to stimulate direct comparisons consciously and unconsciously between the present and the past, particularly in relation to people, relationships and current level of abilities.

5.8.1: Relationship Over Time: the concept 'changed meaning over time' in songs.

For Tracey, the songs which were a 'blast from her past' were central to her experience of therapy. Getting in touch with thoughts, memories and feelings about her songs initially served as a pleasurable experience which passed the time. Later the temporal relationship she had with her songs served deeper purposes as she started to deal with the emotional consequences of her illness and the possibility that she may not be going to get 'better' or find the cure about which she so desperately spoke every week. On several occasions it transpired that her relationship with particular songs, or the meaning they held for her, had changed over time, particularly since the onset of her illness and the changes thus experienced. In the first of the following examples, Tracey's reflections on reminiscing with her songs and the 'warm' feelings she experienced have a relaxed and casual tone. The latter example however, is from a later session. At this stage, Tracey was starting to reveal the purpose behind her requests and the way that songs were taking on new meanings due to her own changing circumstances over time. The examples also reflect the therapy process over time.

Example 54:*Tracey, Session 11.*

Tracey: I mean the ones that we've done before, such as Spandau Ballet and the Alison Moyet ones, they are quite a blast from my past.

MT: So the ones which were a blast from your past, when we do them, what does it feel like, or what happens for you... in the songs which are a blast from your past?

Tracey: Well I must admit I get a very warm and satisfied feeling when I hear them, because some of them, when we first started doing them, they were ones I hadn't heard for ages and ages. I mean doing the Spandau Ballet ones, that was something that made me go home and find my Spandau albums, to bring them back to the ward so that they could all enjoy them.

Example 55:*Tracey, Session 16*

MT: Do you think, before you became ill with MS, do you think that issue of liking songs which you related to somebody having been through a hard time and got out

Tracey: No. Never. (Eyes fill with tears)

MT: So is that something to do with where you are now?

Tracey: Yeah. (More tearful)

5.8.2: Relationship Over Time: the concept 'continuing relationship' in songs.

For others, there had been a changing process in their experience of the music which was personally meaningful for them. The songs had been experienced in different situations over time, and then became a part of life's process which could be internalised and carried with the individual.

Example 56:*Francesca, Session 7*

Francesca: All the things I went to see first of all as plays, and then .. and then as films. Sound of Music, Westside Story, ... and Pygmalion ... My Fair Lady ...

MT: So you saw them first as shows, then as films...

Francesca: Yes. Then I dream about them.

Often as a consequence of the illness, isolation appeared as a common theme which ran through individuals' personal material. Within music therapy, the relationship which some participants described pertaining to their songs

appeared to be one of the only constant ones within their lives. As significant others in their lives died or moved away, and carers moved on, it seemed that the pre-composed familiar music which was important to the individual had remained with them, by their side, in the face of increasing isolation. In the following example, Jack's use of the word 'accompany' suggested that the songs which were of such tremendous personal importance to him, had provided comfort for him through the hard times.

Example 57:

Jack, Session 24

Jack: At every stage of your life, there will be some songs that will accompany you. They will be with you. Forever.

Example 58:

Jack, Session 19

MT: I wonder whether there are many other things that are as important in your life, in the ways you described, as music?

Jack: I think music is the most important thing in your life next to children. You know I think music is very very important. It's always held importance...That's never changed, from the time I've been very young, to the time I am now. It's never changed. Some things in your life don't change.

However the relationship held over time by songs also spanned into the future pertaining to relationships with others. Guy's significant song centred around romantic relationships. Although he openly acknowledged this as a theme and personal association with the song, he did not acknowledge the emotional significance of this theme within his own life. In the following example he discusses the lasting relationship with the song in both the past and future.

Example 59:

Guy, Session 15

Guy: What's in that song for me? ... I don't know I like the music. I've got memories to it as well. And there's probably some ... I like to see what comes in the future with it as well. That music will never die for me.

The temporal experience of pre-composed music emerged as one of its most important properties. This property also distinguished it considerably from the experience of improvisation.

5.8.3: Relationship Over Time: the concepts 'skill developing over time' and 'abilities over time' in improvisation.

Unlike pre-composed music, improvisation itself was not something which had existed over or through time for the participants, although the associations made with improvisation did contain a temporal element. The temporal experiences related tended to be in the short term rather than long term from the past. There were suggestions that improvisation was experienced over time during the process of therapy as a developing skill. This however was linked more with the illness process. Additionally, time was one factor of the experience during any one improvisation.

As improvisation was repeatedly linked to instrumental playing, there was some temporal experience of improvisation which could be related to the illness process. For Guy, who had once been an instrumentalist, the act of playing instruments had temporal reference and associations over time.

Example 60:

Guy, Session 8

Guy: It's a bit annoying when you can't play guitar like I used to.

Jessie also reminisced about improvisations she listened to as a child in her village, hence revealing cultural aspects to improvisation which have not been explored at all within this study. Tracey referred to temporal aspects of improvising spanning the period of music therapy, but only in relation to her own physical improvement.

Hence in reflecting on changes in physical ability, the relationship over time with improvisation tended to refer more to the physical experience, and ultimately the illness experience. Such reflections compared ability before the illness and at the start of the music therapy period, to changes in abilities at the present time. The overall relationship over time for improvising however tended to be in the short term rather than the longer term. Such aspects are revealed in the subcategory of 'Illness monitoring' within the major category 'The Illness Experience', next to be explored in this analysis.

5.9: Concepts and emergent themes: the basis for relationships between the categories.

This chapter has presented that data which, through open coding, revealed concepts and themes relating to participants' experiences of the music within sessions. At a general thematic level, we can see that differences between unfamiliar improvised music and familiar pre-composed music did indeed exist for the individuals. Furthermore, these differences could be grouped at conceptual and thematic levels. To summarise, there were key areas where the experiences of improvisation and pre-composed music differed in music therapy.

More importantly, the relationships with other phenomena started to emerge directly stimulated by the experience of the music. A study of the experience of music standing alone is irrelevant if not related to the larger experience of an individual's life. Such relationships have been alluded to only in this chapter, as the processes were highly individual. These will be explored in the case studies when the analysis is taken further through axial coding.³ The following chapter presents data which emerged and related to the experience of living with chronic degenerative illness.

³ Refer to Chapter 4 Section 4.9 for details of axial coding.

CHAPTER 6

MAJOR CATEGORY:

THE ILLNESS EXPERIENCE

6.1: Introduction.

This category describes how individuals experienced their illness, and the different ways this was expressed not only in their verbal material, but also within their musical and behavioural material. There are two subcategories forming the major category. These are 'Illness Monitoring' and 'Identity: changes in self concept'. It is important to note that the way in which the illness was experienced was very different for each individual. Many factors affected an individual's experience, such as life experience, age, support network, living situation, physical effects of the illness and illness trajectory. Although the experience was a highly individual one, there were similar themes which emerged across all the participants, and were able to be grouped with other related themes.

6.2: Subcategory: Illness Monitoring.

Individuals either overtly or subtly monitored the change in their abilities. This took several different forms. Individuals verbally described their own abilities or changes in relation to before/after or in different situations, such as 'when I'm standing' or 'when I'm in bed'. Alternatively, they described their abilities in comparison with others around them. For all the individuals, comparison with others was possible due to the daily encounters with others around them who also had MS. This was particularly so however for the participants who were resident in the hospital, and lived closely with others with the same illness. Living on a hospital ward involved continually sharing a bedroom, meal times, living space and general recreational time with other people around them. This meant that most of their waking moments were spent watching others' disabilities and changes in their abilities and general health. The others around them may have been people with a less severe form of the illness, or it may have been someone who was profoundly physically, cognitively and

socially impaired by an advanced form of the illness. As a consequence, an individual was often continually assessing many different aspects of their own functioning in relation to those around them. This covered aspects such as physical strength which could be monitored through a variety of activities, but particularly within physiotherapy, and also fatigue, a major problem within MS. Voice production and speech were also monitored, and individuals were guarded in revealing any changes in their vision, another common, degenerative feature of MS. Individuals often referred to their cognitive functioning, particularly with regard to memory, one aspect which was easier to identify and monitor than other more subtle cognitive changes. Certain conditions lessened the illness monitoring. For those individuals who were not resident, there was less evidence of monitoring their own change or comparing themselves to others around them. For Jessie, her blindness prevented her from being able to compare herself to the others around her on the ward, but she was able to recount verbally the changes experienced within herself.

There were three main phenomena which recurred throughout individuals' music therapy. These were physical monitoring, vocal monitoring and cognitive monitoring. Although these differed in emphasis for each individual, there were representations of each across all participants. Individuals monitored the extent of change which had occurred, whether that be of physical, cognitive or vocal functioning and the type of change that had occurred. This indicated that extent was a property, pertaining to the types of changes experienced. Individuals made temporal comparisons of 'now' to 'before' or 'when I was young', hence time was a further property. Those who experienced some type of change monitored it to increase their awareness and self knowledge and so regained some sense of control. Therefore, not only was control a consequence of this strategy, but by increasing self

knowledge, one was better prepared to employ strategies for dealing with the emotional consequences of illness monitoring.

6.2.1: Illness Monitoring: the action of 'cognitive monitoring'.

When individuals described 'knowing' or 'remembering' the words to a song as being something positive for them, it suggested that monitoring their own ability to recall the words was one way of measuring cognitive change or maintaining cognitive abilities. There were also references to keeping hands and arms active through the activity of playing instruments and maintaining strength and function in that way. Individuals mentioned that without such functional and physical activities to exercise their remaining physical ability, such abilities might be lost. These thoughts were not explicitly expressed, but were indicated by such words as 'keeping'.

The following example is taken from an extract when Guy is comparing the activity of singing songs and playing instruments within improvisation. He indicates in this extract that he is working his memory through singing songs which he knows, as they stimulate his mind to remember the words. This phenomenon is identified as 'cognitive monitoring'.

Example 1:

Guy, Session 16

Guy: .. I think when we do the songs on the sheets, I'm getting lots out, memory wise and that sort of thing...

When asked what she found most useful or better in the session, Tracey described how she considered it to be singing songs due to the perceived cognitive stimulation.

Example 2:*Tracey, Session 18*

Tracey: Well, I mean, the song ... was stimulating my mind to remember the words, from what I consider an old song. You know, so that was making me remember things. Remember the words.

This phenomenon was particular to individuals who either had some awareness of cognitive changes occurring, or those who were fearful of experiencing cognitive change as observed in so many people around them.

6.2.2: Illness Monitoring: the action of 'physical monitoring'.

Individuals described their experience of playing instruments in terms of physical reference, as already noted in the themes in the category 'Musical Experience'. This phenomenon was noted in particular concepts such as control of arm movements and types of movements made to play instruments, and also how quickly fatigue affected the ability to play. The therapist needed to remain sensitive to this and ensure provision of instruments which offered a variety of physical movements in playing. For example, reaching out to the side in order to play a large drum or xylophone caused fatigue more quickly than playing instruments which could be placed on the wheelchair tray in the person's midline and close to his or her active hand. Those individuals who monitored their physical change through playing were those who had experienced physical change and were aware of such change. It was also predominantly those who had something to gain by improving their physical ability, such as a possible move back to the community.

Tracey, in particular, related the act of improvisation to changes in her physical abilities. This was noticeably bound up in her continual search for improvement in her physical functioning, as some sign that she was getting 'better'. In every music therapy session she discussed her weekly progress in physiotherapy. In discussion with her physiotherapist and occupational

therapist, it emerged that this was a prominent process in her other therapeutic interventions. Within other sessions she also made temporal comparisons of her abilities between weeks, and comparisons with others around her in groups or the gym. Although such observations would not necessarily indicate a problem, for Tracey it became the whole focus of her experience of improvisation, overriding any emotional connection with the music or the therapist. In the following examples she measured her current functional ability to previous ability. Such instances are described as 'physical monitoring'.

Example 3:

Tracey, Session 16

Tracey: I mean but for me, .. the improvising gives me a good chance to use my right hand, which for so long was just there. You know, I couldn't use it, (plays drum)

Example 4:

Tracey, Session 18

Tracey: Well, I mean I love the windchimes, (plays windchimes) and using my right arm on the Mongolian drum's great as well, because (hits drum) you know I could never have done anything like that even when I first came to your music sessions. My arms ... you know it was a case of get it down and keeping it .. whereas now I feel quite happy with it.

Example 5:

Tracey, Session 20

Tracey: and I just think it's brilliant (playing Mongolian drum all the time) being able to use my right arm in a more controlled way now. Before it would have been all over the place. Because when I first came to the hospital here, I couldn't dream of touching my face (does so) ... not even with bitten fingernails, cause the ataxia was so much worse.

6.2.3: Illness Monitoring: the action of 'vocal monitoring'.

A third type of illness monitoring was observed to be 'vocal monitoring'. This was observed in only one of the participants relating to musical activities, but was similar in its thematic nature to the physical monitoring observed in others when playing instruments. Jack referred every session to his 'sore throat',

'croaky voice', 'cold', 'hay fever' or 'virus' in relation to how he was singing. There was a comparative component in the comments he made between sessions or situations in his voice production, such as 'in this chair' or 'in bed'. He also sought reassurances from the therapist to compare his voice from previous weeks. It was noted that he not only monitored the quality of vocal sound produced, but also the depth of his breathing and the duration of notes he could hold. In the following example it can be seen that Jack did not overtly discuss his vocal monitoring, and in fact gave many reasons as to why his voice may have changed. Such examples occurred on a weekly basis in every session.

Example 6:

Jack, Session 16

Jack: Oh well I know I've got a sore throat. You can hear the way I'm talking....I do know 'What a wonderful world', but with this croaky voice, it's not very good today. But when I haven't got this cold I feel better about it. ..I'm short of breath you see. I'm still doing the breathing exercises ... but I don't seem to be improving much. I suppose I don't know when I'm going to be able to sing right . I can sing in bed much better than that. I can sing much higher ...

In the way described above, activities which involved voice production, which were largely song-based activities, were used to monitor his vocal production. This has implications for someone with MS due to the possibility of losing all voice and vocal means of communication which can occur as a result of muscle weakness. The implications of such for this individual will be examined in greater depth in his case study.

Hence, the Illness Experience manifested itself within musical activities in the forms of phenomena entitled 'Cognitive monitoring', 'Physical monitoring' and 'Vocal monitoring'. Such behaviours served the purpose of aiding an individual in monitoring subtle changes which may have been occurring due to the disease process. It must be highlighted that the act of illness monitoring was an intensely physical one in itself, but may have led to very emotional

experiences. These might have remained implicit and not verbally shared or explored. For individuals who were experiencing increasing disability, coping with such changes was enormously difficult, as will be explored later in 'Coping with the emotional'. Illness monitoring, however, served to increase self knowledge and awareness which in turn gave individuals some sense of control.

6.3: Subcategory: Identity: changes in self concept.

Within this study, individuals' perceptions of the changes in ability which they were experiencing as a consequence of their illness, and the feelings about such changes are grouped together under 'Identity'. Phenomena relating to Identity were again dependent on the individual's experience of their illness and the self concepts which they developed as a consequence of the illness. Those phenomena which emerged from the data differ in very subtle ways, and will be described in turn. The bipolar ranges of each will also be highlighted, as it is important to recognise these in order to understand how the experience of the music therapy may have affected changes within self perceptions. General examples will be given to indicate the types of statements made by individuals from which these phenomena emerged.

6.3.1: Identity: the concepts 'disability' and 'ability'.

Different individuals made comments or reflected upon their disabilities in different ways. For some, it was a simple statement of 'I can't use my hands/walk'. For others, there was a sense of anger or even self-loathing in the comments they made about the changes the illness had caused for them. For example, Jessie often made self-derogatory comments which stemmed from what she thought others thought of her. She made frequent, even weekly, comments about being 'daft' and 'stupid'. Her feelings of self worth

and confidence were so poor as to affect her general behaviour and interactions within the sessions and also outside the sessions in verbal interactions with others. There were occasions when other individuals either openly used aspects of their disability as reasons for not being able to do something, or adopted a 'disabled' behaviour which did not optimise the abilities they had. This phenomenon is labelled 'disability', describing when an individual identified his or her limited capacity or placed him or her self in a limited role. The temporal property of this was in the present, often with references to pre-illness abilities. There also emerged the condition that a high level of disability was associated with a high level of passivity and low level of activity.

The alternative bipolar range of this phenomenon is 'ability'. This was when despite being disabled, the individual was 'able' in his or her identity. Ability referred to physical, mental, musical and vocal abilities, or a general sense of ability. Similarly to 'disability', there were references to pre-illness abilities, which highlighted the temporal aspects of this phenomenon. Further aspects emerged such as quality in ability. It was not enough for an individual to feel that they could be able, but that they were able to do something in a way determined by them. Such an example exists in example 8 of this chapter where Guy states that his ability limits him in achieving something in the way he wants to (a 'proper' rhythm).

6.3.2: Identity: the concepts 'independence' and 'dependence'.

Independence represented feelings of being able to achieve something on one's own and in one's own way. This varied from functional tasks or general mobility, to specific aspects of the music making. Independence therefore was related to tasks, and certain tasks increased feelings of independence. In this way, independence was also related to the amount of ability one felt. Hence the more able someone felt, the greater the sense of independence.

Dependence also emerged from the verbal and musical material within the sessions as an issue for all the participants. The range of dependence affected individuals' everyday lives, from living situations to basic interactions with other people. This often led to the expression of extreme feelings about the consequences of dependency, and these issues or feelings were often the central focus of the individual's therapy.

6.3.3: Identity: the relationship between 'control' and self concepts.

Similar to the relationship between independence and ability, feelings of dependence increased with feelings of increasing inability. The result of greater dependence was decreased control in one's environment, highlighting the role of 'control' as a property. What was noted to be different with this phenomenon however was that by abstaining from all active involvement, individuals in some ways increased their control over the environment. By refusing to be active, choosing to be passive, and claiming inability and dependence without actually optimising one's own ability, it was possible to increase one's control of certain aspects of a situation, as drawn in Figure 3.

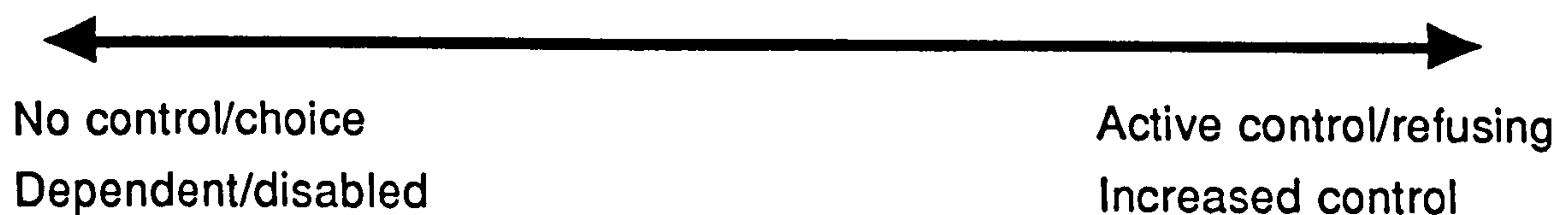


Figure 3: Continuum reflecting the relationship between control and self concepts relating to Identity.

6.3.4: Identity: the concepts 'developing skill' and 'deskilled'.

Skill emerged as a theme which affected the experience. This was particularly related to musical skill, but specifically within the illness experience, it also related to more general physical skill. Individuals felt skilled when they produced something they thought was 'good' musically, or when something about the music met their particular needs. In this way, when the music did meet an individual's needs or goals, the participant perceived their skill to have been greater in the experience. There were also temporal properties to this phenomenon, relating to pre-illness and current situations, such as new skills, lost skills, developing skills and longed-for skills. Physical control and abilities played a role in feelings of being 'unskilled', as those with less physical control also voiced feelings of being less skilled. Skill was also related to the musical product, which individuals classed as either unskilled, such as 'not really music', through to highly skilled, using such words as 'professional'.

6.3.5: Identity: the concepts 'loss' and 'ownership/creativity'.

Loss, in a very general sense, was also a central issue, and encompassed many of the concepts already identified in this section. A sense of loss was expressed by all participants regarding loss of abilities, loss of lifestyle, loss of relationships, and loss of material wealth. Such losses often applied to involvement within music therapy as well. Loss was linked to powerlessness, not having control, not having a say or not being able to protest. The temporal nature of loss was not only in the present in comparison to the past, but also in reference to impending losses in the future. These fears were often unspoken although some individuals spoke openly about impending loss. These themes were more prevalent within the sessional rather than the interview data, in immediate response to the music itself, during moments of reflection when the

mood stimulated by the music was still prevalent. In the interviews, individuals usually did not refer back to such moments, either because the moment was lost or because for emotional reasons they did not wish to. In examples such as this, the session material was drawn on for triangulation. The concepts of 'ownership' and 'creativity' did emerge, however, within the data as significant feelings related to the music therapy experience. Such feelings were expressed emphatically, particularly regarding musical material within the sessions. Ownership concerned gaining things back which one had lost. It possessed an important property of expressing something with which an individual identified. The greater the ownership, the more personally expressive the experience. This also increased the meaning of the experience.

For example, in the following extract, Guy refers to the creative ownership aspect of song-based activities in comparison to improvisation. Having not created the music himself in the songs used in the session, the experience has been one that has had less effect on his illness identity.

Example 7:

Guy, Session 14

MT: It seems you're quite dismissive of your own part when we're doing the songs?

Guy: Well, I know I'm not the progenitor of the music ... I didn't write the music.

Control was a property of loss and ownership which once more related to the conditions of each. With a higher sense of control there existed a greater sense of ownership and lower sense of loss. Alternatively, with a lower sense of control there was a greater sense of loss and lower feeling of ownership. Such properties and conditions can be summarised in the following figure.

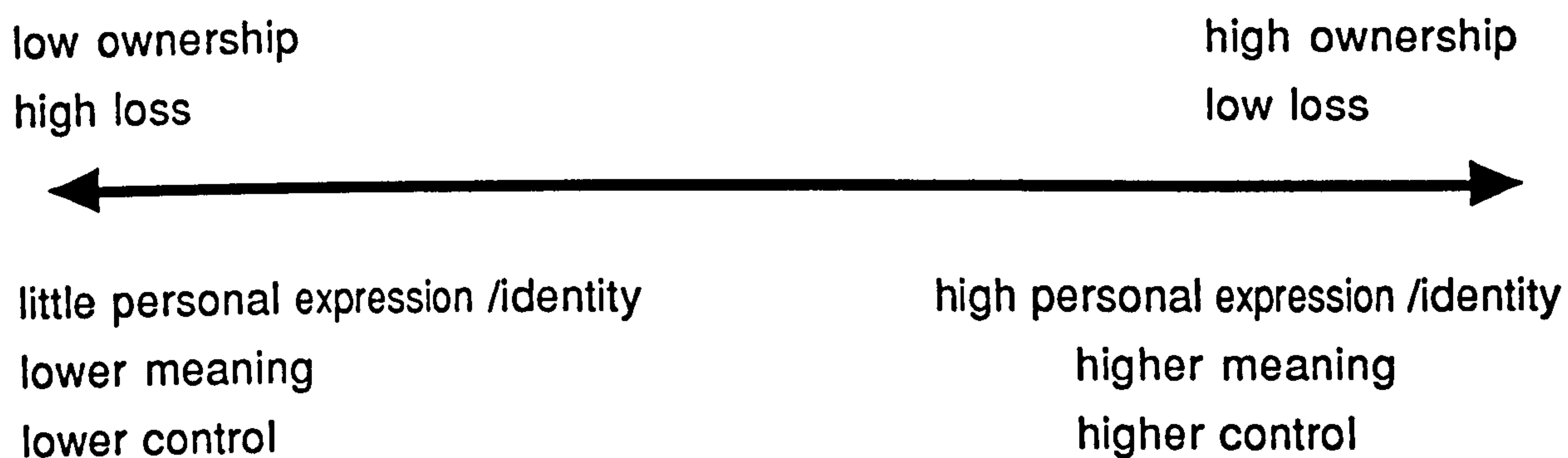


Figure 4: Relationship of ownership and loss to identity, meaning and control.

6.3.6: Identity: the concepts 'failure' and 'achievement/success'.

There were also expressions of feelings of failure. These may have been related to the music therapy experience caused by a factor of the illness, or may have been related to some other issue which the individual raised. A sense of 'failure' was associated with feelings of not being able to do something, being dependent, and having less skill. The opposing experience to this was expressing feelings of achievement or success. Individuals felt a greater sense of success or achievement when they felt skilled, able and independent, and when goals or aims were attained. Control was once more a significant property to emerge. Individuals experienced feelings of success when there was a higher feeling of control. Feeling out of control of voice production, physical movements and the music brought feelings which were more closely associated with failure.

Brief examples of some of the phenomena described above follow. In both examples Guy identifies his physical disability which impairs his control of his hand and arm movements. In the first example he states that his ability impedes the quality of music he wants. Such an example refers to both ability

and skill. In the second example this is extended a little to indicate failure in achieving what he identifies as 'music'. The property of 'control' is low in Guy's experience in each of these examples.

Example 8:

Guy, Session 8

Guy: ... I can't really control my hands enough to get a proper rhythm.

Example 9:

Guy, Session 14

Guy: ...but I can't play ... I shake like that (picks up maraca and shakes with ataxic arm movements). It's not exactly music is it? To do that?

It can be observed that the experience of Identity within the Illness Experience is related to concepts of the self. Individuals experienced shifting concepts of self which could be defined at one end or the other of a bipolar range depicted in Figure 5.

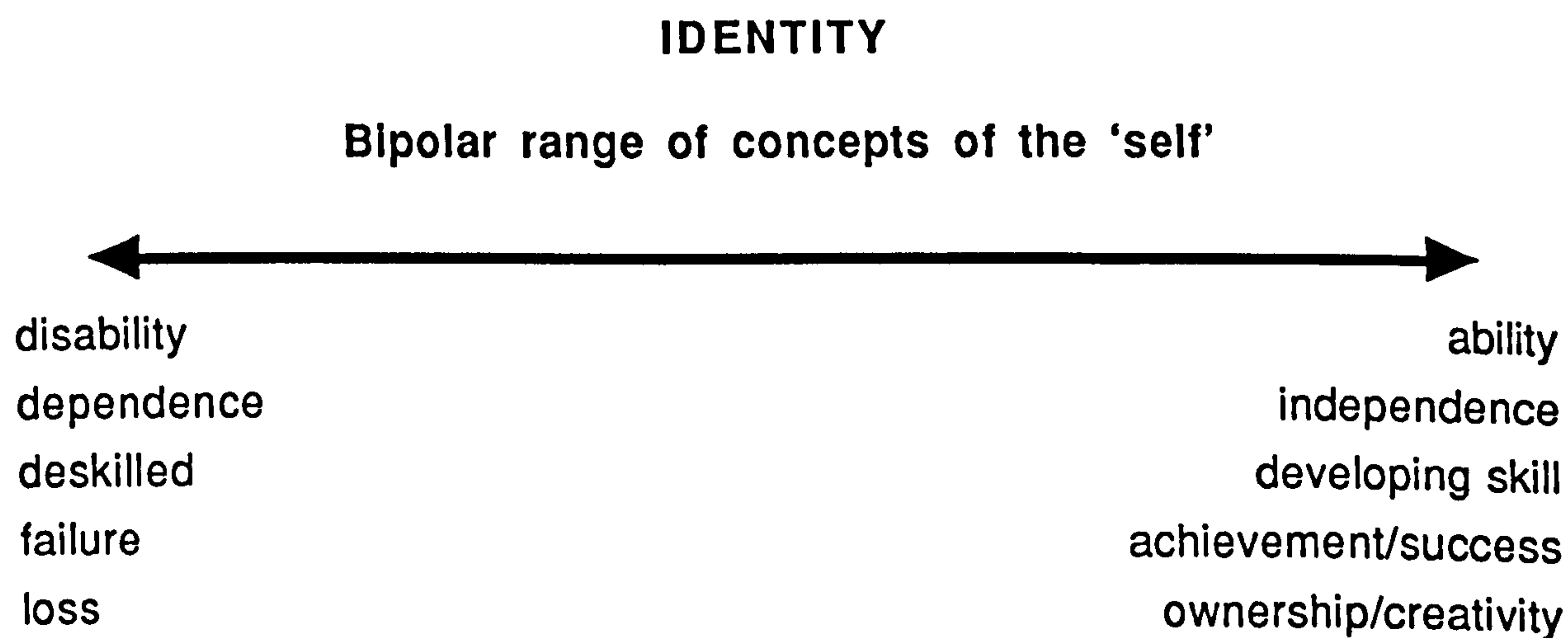


Figure 5: Bipolar properties pertaining to self concepts in the category 'Identity'.

6.4: Summary.

The 'Illness Experience' comprised two main subcategories. The first of these, 'Illness monitoring', carried particular implications for how the music therapy experience related to individual's experiences of their illness. This will be useful when cross examining the different experiences of improvisation and pre-composed music, as it extends our understanding of the impact of particular techniques on an individual's therapy process and any implicit processes which might be taking place.

The experience of illness revealed concepts relating to the 'self' which were grouped under 'Identity'. These included concepts of disability, dependence, loss of skills, failure and a general sense of loss. These phenomena were negatively weighted. In contrast, other aspects of the illness experience also encompassed ability, independence, developing skill, achievement and success, ownership and creativity. These aspects relating to identity were directly related to the musical experience which will be explored further in the detailed individual case studies.

Through illness monitoring, participants gained an increased self awareness and knowledge of how the illness was affecting particular abilities. This then gave them some sense of control over the changes occurring. In a similar way, control and changes in abilities over time were prevalent properties within the phenomena relating to Identity. Additional mechanisms for increasing one's sense of control and coping with changes in Identity will be explored in the next category; 'Coping with the emotional'. Ultimately, however, shifting self concepts can be seen to affect directly an individual's Identity.

CHAPTER 7

MAJOR CATEGORY:

COPING WITH THE EMOTIONAL

7.1: Introduction.

The following themes emerged in the verbal material as the different action-oriented strategies employed by participants, and also reflect how such strategies were manifested behaviourally. The examples given here are purely verbal, but these statements and behaviours were often linked to the use of music within the session. These relationships will be revealed in later stages of analysis. Five subcategories form this category: 'Life review', 'Identifying feelings', 'Coping Front', 'Barriers Down', and 'Hope and Spirituality'.

7.2: Subcategory: Life review.

Life review was one part of the coping process. It existed as a step towards the process of identifying emotions and moods, and often helped to move the individual towards a state of 'Barriers Down'. It may also have been an end in itself serving for non-verbal reflection. It was an important element of individuals' verbal material, and was also strongly influential in the use of pre-composed music. At times it was also related to improvisation. Within the category 'Musical Experience', the subcategory 'Associations' gives many examples of how the music was associated with biographical processes. There were numerous other instances, however, where participants spontaneously started to recount events from their lives within interviews and also within sessions. These were not necessarily related to the musical material, but in some way had been stimulated by the music. Examples of life review were highly individual. It is important, however, to define life review as a phenomenon which bears greater meaning than merely nostalgic recollections. Such reminiscences also occurred, but were brief and often non-referential.

For example, instances where the individual recounted an event, situation, or life episode and gave such an account emotional weight or significance in terms of how it affected other events in their life were considered to be examples of life review. Within these, the individual was able to place an event in a personal historical context, thereby offering an explanatory framework for a current response or event. One such example can be taken from Tracey's response to her favourite songs which she consistently described as 'a blast from the past'. The sudden emotional responses sometimes elicited by the songs took her by surprise. In accounting the place within her life these songs held, however, she was able to start to explore the enormous loss she was experiencing as a consequence of her illness. She communicated explicitly how her life had been 'ever so good' and explored the difficult feelings she infrequently expressed because her current situation denied her the chance to have such life experiences again. This was not just dwelling on 'sad' feelings or happy reminiscences. It was an exploration of where she had come from, where she was at the current time, and how she was going to continue on.

Such a framework existed for every participant, and was often related to current issues in the individual's life. Life review existed so that the individual could draw on previous coping mechanisms or previous emotional experiences in order to take stock of the current situation and to try and prepare for the future. Under the conditions of needing an explanatory framework, with high temporal and associative components, life review served to open the door to exploration, both verbally and non-verbally, of emotional states which varied across a wide spectrum of intensity.

7.3: Subcategory: Identifying emotional states and feelings.

The material within this subcategory actually converges within the following two subcategories. However, in order to improve an understanding of the strategies which follow, it needs some explanation on its own. In adopting coping strategies, participants initially identified feelings or emotional states. Often these were identified through making reference to past experiences through the process of life review. Individuals categorised such feelings covertly as either 'not coping' or 'coping', giving a bipolar sense to emotions. The categorisation of such had implications for the consequences. For example, categorising feelings as 'not coping' largely inhibited participants from continuing with that emotional state or taking it further. The following figure indicates some of the feelings and emotional states identified by participants and the apparent categorisation as such.

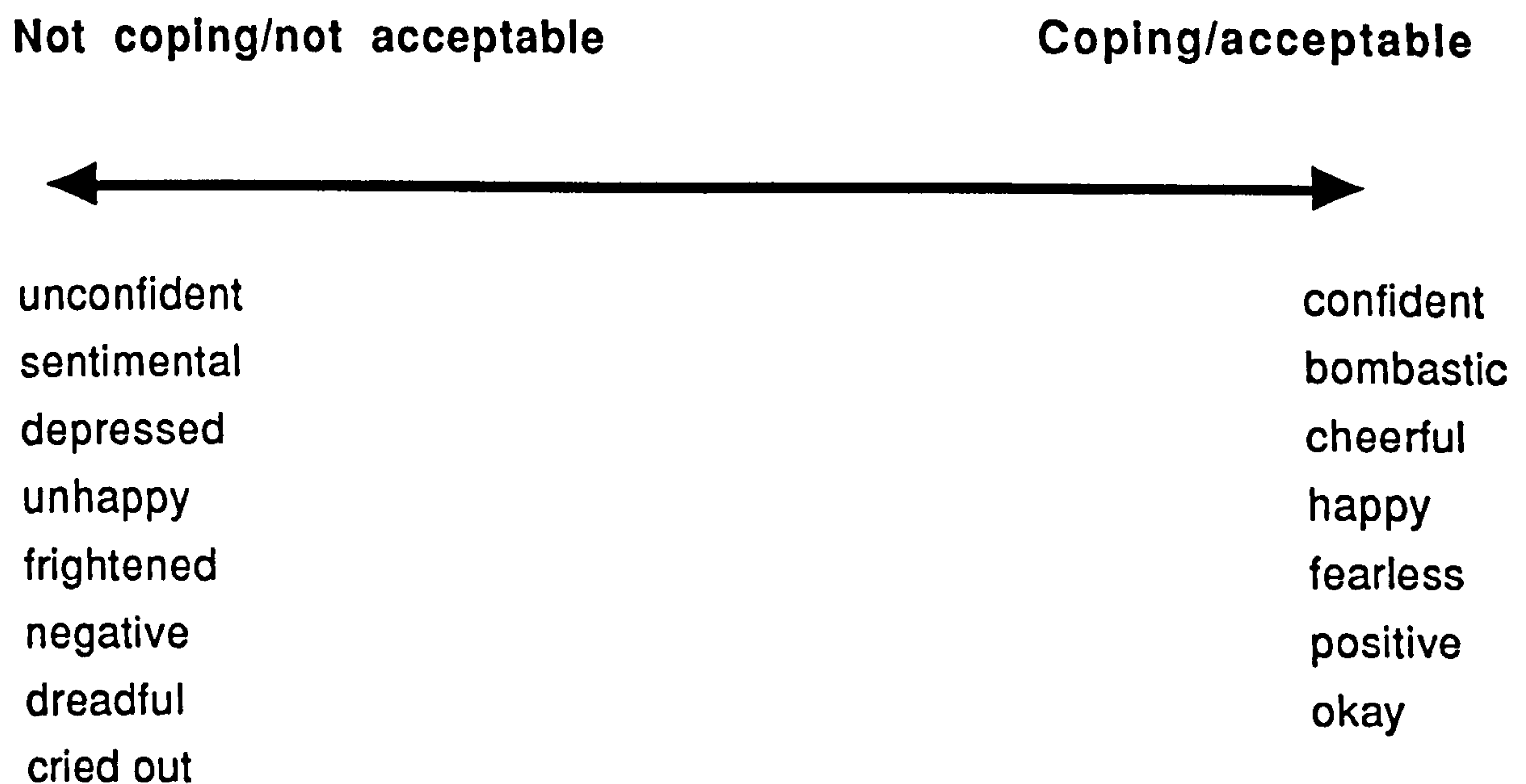


Figure 6: Bipolar range of emotional states or feelings.

Although the opposing of such emotions on a bipolar scale may seem purely speculative in this analysis, the categories which follow contain many examples which support this analysis and reveal underlying processes for the purpose of such division. Further properties of and conditions giving rise to the emotional states will not be explored here, as these are merely concepts within a more complex process, as the following subcategories of 'Coping Front' and 'Barriers Down' will explore.

7.4: Subcategory: The Coping Front.

The subcategory of the 'Coping Front' denotes a particular group of coping strategies. These particular strategies aid the individual in adopting a somewhat superficial front which hides or masks any deeper feelings or responses to a particular event or their illness at large. Participants may have adopted one particular coping strategy more than another, however, generally in any one individual several different types of coping strategies were observed. The strategies observed which fall into this subcategory were also commonly observed in individuals' behaviour outside of the session, particularly on the ward and when an individual was 'in transit' around the hospital at large, interacting with people around the hospital. Such behaviours then are entirely separate from the behaviours and responses categorised in the following section as 'Barriers Down'. It is acknowledged here that such behaviours, rather than being grossly termed as 'denial', are an important part of the illness process, which the therapist must respect and work with. In addition, becoming familiar with an individual's 'coping front' strategies assisted in developing a deeper understanding of the individual and aided the therapy overall. Each of the phenomena categorised under this heading will be described in turn, and the properties and characteristics pertaining to each will also be highlighted in order to draw a fuller picture of this experience.

7.4.1: The Coping Front: 'stating rules'.

The first of the coping strategies to describe is when participants stated rules about expected behaviour. This was entitled 'stating rules'. For Jack in particular this was clearly a strategy which inhibited him from acknowledging his difficult feelings.

Example 1:

Jack, Session 15

Jack: Because I don't want down. I (pause) don't come off the same level in my experiences of happiness. I stay on the same level, because I know how to. So I'm ... I like coming.

Example 2:

Jack, Session 16

Jack: I'm happy.....Yes, I'm happy when I'm singing. I think singing makes you happy. That's why people sing when they're working. They don't realise it, but it's natural to sing, and natural to be happy. It's unnatural to be unhappy. And that's quite true. (Emphatically) *It is unnatural to be unhappy.*

Example 3:

Jack, Session 16

Jack: no matter what you get in life, you've got to chuck it out the window. Say that's... I don't care about it. I'm going to do what I can do, see? And you've got to do as much as you want to.

Already it is clear that the coping front is a strategy employed to deal with mood and the emotional consequences of the illness. It is hinted in the following examples that Jack lived in fear of the depression which had previously been a part of his life. His strategies for ensuring he did not experience this again revealed that even to acknowledge 'sad' feelings was prohibited, and suggest a calculated discipline which allowed only 'cheerfulness' or 'joy'.

Example 4:

Jack, Session 17

Jack: I don't get sad about it, because you mustn't let the negative... depression is a very negative thing, and it will break your heart, and the opposite is joy, and that will lift you up... you've got to be on that side of life all the time, which you can be, so long as you educate your mind to do it.

Further properties can be identified in the previous example, such as a sense of control indicated by such words as 'mustn't let' and 'educate your mind', and a temporal element, indicated by 'all of time'.

Example 5:

Jack, Session 18

Jack: You can either be cheerful, or you can be depressed. If you're depressed, you'll bring all the depressing things around you and you get lower and lower, and depression's the end of the road. You've got to be cheerful, and the only way you can keep cheerful is with music.

Other participants stated rules in a similar manner to Jack, but this was often within the session material rather than within the interview data which is predominant in this analysis. The occurrences of this behaviour were often more implicit within sessions, being revealed by triangulating the interview data with the musical and verbal material documented in session evaluations. This procedure is too complex to show within the stage of open coding being presented here, but will become more apparent in the detailed individual case studies.

Therefore, the conditions under which participants adopted 'stating rules' as a coping front were likely to be when the individual felt a higher sense of threat, felt less in control, and was trying to make sense of the situation. Under such conditions, there was a perceived need for a coping front to be adopted. The coping front was also related to mood, particularly extremes of mood. It was perceived that unless one felt 'happy', there was a high risk of feeling 'depressed'. There was also a temporal element, in that one had to maintain a continuous sense of positive mood.

7.4.2: The Coping Front: 'denying'.

'Denying' one's situation openly was also frequent, particularly within verbal material within the sessions. Instances of denial were not openly challenged

by the therapist, as this was not within the aims of the sessions. Instead, it was important that the therapist supported the individual in their stated belief as it was recognised that such denial was a vital coping strategy in living every day with a chronic degenerative illness. Repeated statements which challenged reality however were labelled as 'Denying', particularly when at other times the individual recognised that a situation was unlikely or impossible.

For example, Guy alternated between overtly acknowledging his illness and the impact that the changes caused by illness had had on his life, and juxtaposing such statements with sudden unrealistic claims and beliefs. Although initially it was thought that perhaps cognitive impairment had damaged his insight into the consequences of his illness, his unguarded comments revealed that he did indeed have an understanding of what was happening to him. It became evident that it was easier for him to immediately contradict any overt acknowledgements of the impact of disability by making statements of denial or unrealistic expectations.

Example 6:

Guy, Session 12

Guy: Oh I miss walking so much! I'd love just to get up and walk like you do, just like that ... never mind - I might one day again (later in interview) ...But anyway, life's coming and going ... I'm sure I will be able to do it one day, I will do it soon I hope .. but it's not possible til I get rid of this bloody wheelchair.

Example 7:

Guy, Session 15

Guy: I'm missing lots of things ... I'm going to go to Hong Kong soon .. I'm going to Hong Kong (louder) next stop Hong Kong! After that, Sydney Australia.

In the above examples, his physical behaviour also helped to determine the underlying emotional causes of his statements. In example 7, the quality and volume of his voice suddenly changed when he announced his travel plans, which altered the mood of the session from intimate, revealing and acknowledging, to a sudden front raised in order to protect himself.

Hence, denial was employed as a coping strategy by individuals who refused to accept their situation and held onto hope as a coping strategy. In this way, hope was seen to be a property of denial, in addition to being a phenomenon on its own independently. Denial occurred at points when the individual felt confronted by something into which they had insight. Even for those with severely impaired cognition which affected insight into certain aspects of their lives, denial was drawn upon in reference to other aspects into which they did have insight, such as immediate emotional states.

7.4.3: The Coping Front: 'projecting'.

For Jack, another form of coping with his illness was by giving it a different name, or attributing the symptoms to other less serious illnesses. This behaviour was entitled 'Projecting'. In particular he referred to his throat and his voice, and the effect the illness was having on his ability to sing. In every session for nearly twelve months he referred at least once to the 'cold' or 'hay fever' which was affecting his voice that day.¹

Example 8:

Jack, Session 16

Jack: And of course, this virus (refers to current cold/virus) It's only a passing phase

MT: What do you think the thing was (in the session) you found the hardest?

Jack: Coping with my cold, with this virus.

Example 9:

Jack, Session 18

MT: So that was the disappointment, that you've not sung as well as you know you can today?

Jack: Mmm yeah. There's a reason for it you see: hay fever, sore throat, so you have to keep going you see.

¹ Although these examples also relate to 'illness monitoring' i.e. the strategy which helped individuals to monitor any physical changes, they are different from simply illness monitoring. By using euphemistic terms, Jack attributed the symptoms which were affecting his singing to an entirely different cause than the respiratory and voice problems he was experiencing as a consequence of his MS.

Hence, projecting was employed by those individuals who continued to hope for cure or a change of some kind, and was employed when individuals were confronted by inability or changed ability. This strategy was also employed when individuals needed an explanatory framework for their experience of illness and inability. Frequency was also a property of this phenomenon in that some individuals never referred to their illness. Temporal elements were contained within statements which referred to the continuation or maintenance of coping, compared to not coping at all in a similar way to that seen in 'stating rules'. Hope was also seen to be a characteristic of this strategy.

7.4.4: The Coping Front: 'dismissing'.

Individuals were often dismissive of their own feelings, even when these were concerning the enormous loss they had encountered. Such material was labelled 'Dismissing'. Overtly dismissing one's own feelings occurred even when earlier in the session or within a previous session the feelings had emerged and been acknowledged or owned by the individual. In the following example Tracey discussed her commonly requested songs in a lighthearted dismissive way, overtly implying that her chosen songs were for 'fun' only. This is despite her use of songs in the previous week's session when she had requested a song which elicited particularly strong emotions for her, openly relating her chosen song to an emotive personal issue (see Example 17). The following example contrasts with any such acknowledgement.

Example 10:

Tracey, Session 17

MT: ..they bring some sort of enjoyment, and I wonder if there are feelings that come up with them at all ...

Tracey: No not really. I don't feel sad at any of the songs I've picked .. you know sometimes, with songs, you go 'woa' (makes an exaggerated face) - a lump in your throat, but none of them do that to me, they're quite fun, you know, and I like them.

'Dismissing', therefore, involved the identification of varying feelings or mood states. Such feelings were either related by the individual to coping or not coping. When the individual was employing the coping strategy of dismissing, those feelings that were related to coping were owned, and those that were related to not coping were dismissed. Individuals dismissed those feelings associated with 'not coping' when they themselves were wanting to cope.

7.4.5: The Coping Front: 'keeping busy'.

Other examples of strategies which kept up a coping front were not as prevalent within the interview data, but are included here as they assist in understanding the extent of the need to keep up the coping front. One such strategy was described by Tracey within an interview, and was certainly clearly evident in every participant's daily behaviour as observed in public around the hospital. This was the coping mechanism of 'keeping Busy'.

Example 11:

Tracey, Session 17

Tracey: You know I do try to keep as busy as I can doing everything, and I find that keeps me on a high. I was the same when I was up working.

In the following example, Jack describes the consequences of such a strategy.

Example 12:

Jack, Session 18

Jack: Whilst you keep your mind busy, you've no problems. I haven't got no problems.

The characteristics of 'Keeping busy' relate to emotional states. Under the conditions of keeping busy, one has no problems and is kept in a positive mood state. Such a strategy is driven by a fear of having problems and becoming negative or low, which would not be perceived as coping.

7.4.6: The Coping Front: 'distracting'.

Individuals often distracted onto unrelated subjects if an issue arose with which they felt uncomfortable or did not want to openly discuss. This strategy was called 'distracting'. It was difficult to discern initially whether this strategy occurred merely because the individual was not able to elaborate verbally about the music. It became apparent though that it was through choice, and one way of controlling the amount of information an individual revealed about themselves to the therapist. The following example is typical from Jack's interviews, where he is unable to talk about the message or personal meaning of the three songs he requested to sing every week, and which meant so much to him. It was felt that discussing songs whose words described being 'tired of living but scared of dying' was too revealing for Jack.

Example 13:

Jack, Session 18

MT: Before, you were talking about 'Wonderful World' and I said 'I think this is a special song for you' and you said 'Yes', and you were explaining why it's a special song.

Jack: Well, it explains the facts, see it is a wonderful world. It is a wonderful world, when you open your eyes, have a look around you. Yes, you only have to go into the garden, and it's fabulous, nature's fabulous.

MT: So when you hear the song being played, or when you were playing to it or singing it today, I wonder what was going through your head?

Jack: Oh, well I do see in the flowers and the trees, and all of nature, how fantastic it all is. It is. I think every day is an adventure, in nature.

By examining the properties of this strategy, it could be discerned that distracting occurred when an individual felt a low level of control within a situation. This may have been when the music or verbal discussion started to touch on issues or feelings which were identified by the individual as pertaining to 'not coping'. Distracting was, therefore, one coping strategy for dealing with such a situation, by which the individual increased their sense of control. Hence control is a major property of distracting. In distracting, the participant also took control of what the subject matter was, or in what way it

was identified. Frequency is another property, referring to how often or regularly the individual employed such a strategy.

7.4.7: The Coping Front: 'putting on a front'.

Another strategy was entitled 'putting on a front' when individuals literally acted superficially within their interactions to hide how they were really feeling. Mostly the mask put up by individuals was observable in behaviours rather than openly acknowledged or identified in fragments of the interview data. However Elaine was open about the front she adopted to interact with others, and identified that she felt quite differently 'inside'.

Example 14:²

Elaine, Session 17

Elaine: I put on a bombastic confident front ...

MT: But ...

Elaine: Inside I'm sentimental (a little later in interview) ..Yes. I manage quite well...

MT: Manage to do ..?

Elaine: To put on this front.

The properties of this strategy pertain to the emotional qualities adopted in order to mask underlying feelings or the 'true' self and can be depicted by the bipolar scale given under 'Identifying feelings' (see Figure 6). Such properties pertain to those feelings which are categorised as 'acceptable' or 'coping' feelings which are then employed to mask underlying feelings which may indicate otherwise.

To summarise, adopting coping strategies served the purpose of presenting a more acceptable side of oneself by owning 'coping' feelings, and by not owning the unacceptable feelings associated with 'not coping'. The characteristics or properties of each type of strategy differed in some ways, but

² The initial part of this example has already been used in a previous category. It is included in this example in order to give context to the strategy which the participant is employing.

common properties for many of the different strategies included elements of control, frequency, and temporal aspects. Although these coping strategies have been presented largely as separate from the music at this point, greater relationship between the two will become apparent later within the more detailed case study analyses.

As the different strategies were observed within each individual, a great deal of thought was given to the repetition of such patterns across individuals. It cannot be stressed enough that the experience of living with an illness for which there is no cure, no known cause, no definite prognosis, and is chronic and degenerative, is seemingly often too much for any individual to bear. This must have been accentuated for those living on wards in the hospital surrounded by other people with Multiple Sclerosis in more advanced stages than themselves. Those individuals lived with a constant reminder of how they could eventually be. It was acknowledged that the coping strategies identified were vital for individuals. Similarly, it was vital to support individuals in their coping strategies in order to build a trusting relationship with them.

7.5: Subcategory: Barriers Down.

This subcategory emerged as individuals verbally acknowledged the difficult feelings they experienced but so often kept under control in the ways exemplified above. Further to identifying such 'non-coping' feelings in a general way, individuals then related such feelings to themselves or 'owned' the feelings. Often this occurred after the feelings were initially associated with the music. The difficult feelings identified and explored may have been associated with their illness, the consequences of the illness, or other personal issues such as relationships in their lives. In this way, this subcategory consisted of the phenomena of acknowledging illness, identifying feelings, and owning feelings. The material contained in this

category was far less frequent than the coping strategies commonly seen which have already been described. Not all the participants reached a state of Barriers Down. Two factors played a role in reaching the depth of material found in this subcategory. For the individual to reveal such a different side of themselves, the relationship with the therapist needed to have developed to a stage where there was a great deal of trust and safety. This was not gained in all the case studies, being affected by factors such as duration of therapy. Secondly, two of the individuals had less difficulty in acknowledging their 'non-coping' feelings earlier in the therapy and tended to adopt the coping strategies already identified to a much lesser extent. For those who had greater difficulty exploring or acknowledging their feelings, the experience of doing so was far more profound, and indicated an immense amount of self exploration. Hence the properties of frequency and the bipolar range of personal feelings identified by participants increased sensitivity to how profound this experience was for any one individual.

7.5.1: Barriers Down: 'acknowledging illness'.

'Acknowledging illness' refers to instances when individuals were able to acknowledge their illness or the situation caused by their illness. This may have been actually naming their illness, or bringing up an issue which acknowledged the situation they found themselves in. For some individuals this was much more difficult than for others. An example follows from Guy, who every session discussed his plans for the future, such as getting married or travelling to Hong Kong. In talking about both of these issues, he was not acknowledging his current situation. Such plans were unlikely to occur for reasons of which he was aware, such as his level of dependence and having no current girlfriend. In several sessions, however, he identified the blows struck by his illness. In doing so, he acknowledged his situation rather than continuing with his usual bravado of 'denial'.

Example 15:

Guy: But I can't get out and do anything - I'm kind of trapped by my MS. Actually, I want to have children, I want to do that sort of thing as well ..

The experience of 'acknowledging illness' varied along a continuum of properties and characteristics which identified instances as less or more profound. When an individual acknowledged their illness, they identified areas of loss, restriction and change. The greater the acknowledgement of these areas, the deeper the individual was delving into the difficulties of their illness. Similarly, the more emotional change identified, the more profound the experience. Identification of only physical change did not facilitate the experience of 'Barriers Down', but rather stayed with physical monitoring. Frequency, temporal factors and extent were all relevant properties pertaining to this phenomenon. Such properties related to how often an individual acknowledged the illness, whether such acknowledgement was momentary or continual, and also whether the effects were related to oneself or to others with the illness. Other intervening conditions which facilitated acknowledgement included a highly trusting relationship with the therapist, and for individuals to have identified in themselves emotions categorised as 'not coping'. One further property emerged, which was that acknowledgement of illness by any one individual was related to greater or lesser degrees of the change they had experienced as a consequence of the illness.

For example, Tracey regularly gave momentary acknowledgement of effects of the illness as it affected others on her ward. In this way, it can be seen that frequency was high, but that the temporal factors and extent were low (i.e. she frequently gave momentary insights into the devastating effects of the illness, but only in how it affected others around her and not herself). It can be noted in example 17 that the extent of acknowledgement in her statement was high in that she relates the situation to herself, and that this acknowledgement was also about emotional change rather than her usual focus on the physical

experience. Frequency and temporal aspects however were low (i.e. momentary and on one occasion only within the session quickly followed by dismissal). Hence even in the situation where she related how she was feeling about her illness to herself, it was not one in which she allowed her barriers down completely to explore her emotional state fully within therapy.

In a similar way already described in the phenomena categorised under the 'Coping Front', individuals had greater difficulty verbally identifying emotions which pertained to the 'not coping' end of the bipolar range of feelings. This did not refer to emotional states or feelings which the participants owned personally, but just emotions in general. In the following example Guy names two difficult feelings which he relates to the world in general rather than he himself specifically, 'feeling of failure' and 'frustration'. Actually being able to name or identify a difficult emotion was the first step in taking this further.

Example 16:

Guy, Session 15

MT: I just wondered whether there was any link between this song and the things you've been talking about at all?

Guy: What, like, feeling of failure in the world because my hands don't work, and stuff like that? ... Frustration ... well that relieves frustration that song ...

7.5.2: Barriers Down: 'owning feelings'.

One step further than this was actually 'owning feelings' or relating them to oneself rather than the music or the world in general. This was not an aim at the outset of the session, but when an individual owned emotions or feelings which were identified in some way within the session, it enabled her or him to explore her or his own personal emotional world. In the following example, Tracey names the song she has requested in the session and then relates the words of the title, which describe a difficult emotional state, to herself.³

³ Example 17 appeared as part of a larger example of emotional meaning in music in a previous category. It has been extracted from that larger example to illustrate a precise action. As an emotional response within music therapy, it relates as a strategy to the emotional meaning that the song has for the participant.

Example 17:*Tracey, Session 16*

Tracey: All cried out ... And that's how I feel ..(eyes fill with tears and reaches for her tissue) ..

In the next example, Guy describes how his illness restricts his freedom and independence in activities which would be normal for someone of his age and personality. Further than just acknowledging his situation however, he identifies how he feels about it.

Example 18:*Guy, Session 12*

Guy: ... you can't just go and just not come back for a night, and that sort of thing. ... Go home and get drunk and that sort of thing. I mean I just can't do it now. There's just no way, can't even pick up a pint of beer and drink it. Need a straw, and drink with a straw... It feels dreadful now.

Similar properties pertained to this phenomenon as with 'Acknowledging illness'. Duration of the session and the therapy period were intervening conditions which related to owning non-coping feelings. It was more usual for individuals to relate difficult feelings to themselves later in the period of therapy, and also later in any one individual session. Such factors did vary however between individuals and depend on the condition of trust already outlined.

Individuals who were able to acknowledge their illness, were able to identify the emotional consequences of such and then furthermore related such emotional states or feelings to themselves, reached a state which has been called 'Barriers Down'. The individuals who reached this state were able to explore the issues and feelings which for the rest of the time remained buried deeply under a superficial coping front.

7.6: Subcategory: Hope and spirituality.

Statements of hope and spirituality also provided coping strategies for individuals and must be considered in addition and separate to those described above. Although hope was a property or characteristic of coping strategies employed within the 'coping front', it was also a phenomenon independent of such strategies. Such material did not emerge as central to understanding music therapy processes in this study, and so will not be explored in great depth here. It does, however, offer additional insight into the overall experience for the individuals involved. The following examples typify instances of this method of coping.

Example 19:

Tracey, Session 14

Tracey: Because I said calling the piece 'hope', that that's what I'm full of .. 'hope' .. you know, and I'm slowly getting to a stage where it is just hope, it's not (parodies self) 'this is going to be the cure' ... you know. I've not been like that lately, and I think that's a lot to do with (my friend with MS) Siobahn sort of bringing me down to earth with a sharp thud sometimes, but I can see she's been through all what was said to be a cure, and it never was... (about the music).. It was quite relaxing. It wasn't fast. It reminded me of being hopeful. And I must admit, I did say a prayer 'Please God this song's for you'.

Example 20:

Tracey, Session 15

Tracey: ... And I think that sort of brings me back to 'hope'. That ... you know ... I mean when I say 'I wish one of the MS patients would be well enough to walk out the door, I mean any MS patient in the hospital ... to give the rest of us the hope.

7.7: Summary.

The category 'Coping with the emotional' encompasses subcategories which represent processes such as 'Life review' and 'Identifying feelings', which then further stimulate strategical actions aimed at controlling and managing the feelings stimulated. These strategies were 'Coping Front', 'Barriers Down', and 'Hope and spirituality'. The musical experience within the session usually

directly led to these strategies. Although the relationship between the music and coping responses has not been explored within this level of analysis of open coding, the way in which music stimulated or broke down coping strategies will be established in the case studies, particularly those of 'Jack' and 'Guy'.

Not all the participants reached the level of 'Barriers Down' within their therapy. The processes of reaching this state reflect the relationship between the categories and will be illustrated by the following case studies. The category of 'Hope and Spirituality' is of less relevance to this particular analysis, but offers a fuller picture of the individual's experience in coping with chronic degenerative illness. The musical experience was closely associated with and influenced by the experience of 'Life review'.

7.8: Moving onto the next stage of analysis.

The following individual case studies offer analyses using axial coding which will expose the complexity of the processes in individuals' experiences. The concepts and categories established through open coding of the groups' material serve as the building blocks for exploring the data in more detail.

Three individuals were chosen from the overall group. These three in particular were chosen due to the differences between their experiences and also biographical details. That is, different ages, genders and cultures are represented by the three chosen. The three were also chosen due to the depth which could be gained from their data in particular. The first case study to be presented is 'Jack', followed by 'Jessie'. The case study of 'Guy' completes the analysis. A brief discussion on individually relevant points will also be given at the end of each case study.

CHAPTERS 8-10

INDIVIDUAL CASE STUDIES

CHAPTER 8

INDIVIDUAL CASE STUDY:

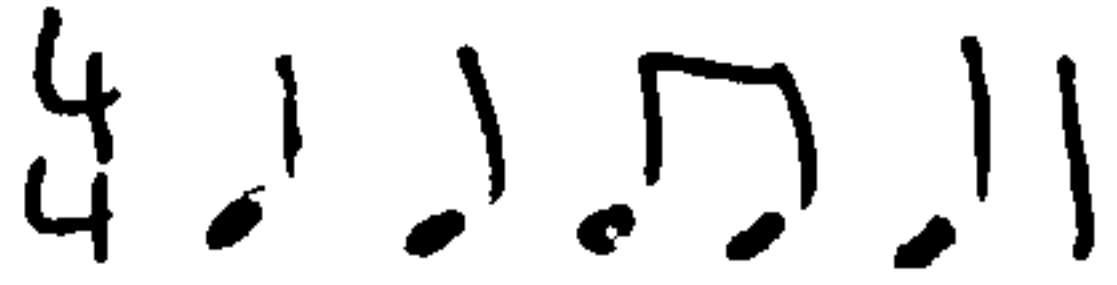


'JACK'

8.1: Background summary to participant Jack.

'Jack' was a Caucasian male in his late 50's who had been hospitalised five years prior to the current investigation. He presented between the relapsing-remitting and chronic progressive classification of the illness. He was dependent on an electric wheelchair, although was independent in his mobility around the confines of the hospital once in his chair. He had functional use of only one hand and arm. More specific details of his background appear in Appendix 11.

Although he appeared busy, socially occupied and somewhat 'jolly' in his social interactions, he was rather isolated from his family and had a medical background of depression and anxiety. Jack self-referred to music therapy, being very eager to find a place where he could sing the songs which were of particular importance to him. This was enormously influential in his approach to music therapy, which he really only saw as a place where he could experiment with his voice to sing 'his' special songs. These particular songs included 'Ol' Man River', 'Some Enchanted Evening' and 'What a Wonderful World'. He was less interested in playing the instruments and improvising, and throughout his therapy rarely engaged in improvisatory activities. A detailed analysis of Jack's music therapy process is given in Appendix 12. Jack rarely lowered his particularly resistant coping front which involved a variety of strategies. His use of songs appeared to perpetuate this somewhat, but his lack of engagement in improvisation also failed to lower this front. Over time, however, as the therapeutic relationship developed, he increasingly identified a wider range of emotions in his particular songs. Gradually, he related the 'non-coping' feelings of the songs to himself, and explored feelings which were more difficult to acknowledge through the act of singing his songs.

The results from neuropsychological testing were available to gain greater insight into Jack's cognitive functioning (see Appendix 11). These results suggested that he had difficulty in learning and retaining novel and unfamiliar auditory information. He also showed some problems with conceptual, abstract thought. In terms of cognitive behavioural responses, this was reflected in his responses to improvised unfamiliar musical material. He displayed typically concrete responses in his exploration of instruments. Within structured turn-taking activities, where instructions were well-defined and the auditory information simple, he responded more enthusiastically.

For example, Audio extract 1 is an excerpt from a structured turn-taking activity in session 7. In the initial section of this extract, Jack's exploration of the rotary drum can be heard. He plays a repetitive rhythmic pattern of  becoming . These rhythms are frequently prevalent in Jack's improvised material. In this excerpt, his exploration of the instrument is heard to be very limited. There is a minimal range of variation in his exploration of dynamic component, tempi, use of pauses, and rhythmic patterns, although he explores the spatial range of the drum skin which can be heard in his sounds. The middle section of this excerpt comprises the therapist's response on the bass xylophone, which initially picks up on Jack's rhythm, but extends this, moving to a freer range of rhythms, style (i.e. glissandi), pitch and dynamics. This response attempts to draw Jack into a more communicative dialogue by demonstrating a wider range of components. In his reply, Jack reverts immediately, however, to his  rhythm, still with a limited dynamic range. He ends his 'turn' by extending his rhythm to prolonged quaver pattern.

Within less structured improvisation where the task was less defined and more abstract, he was usually less engaged, and stated that it had less meaning for him. There were exceptions to this, however, particularly when he

was given a supportive musical structure. Audio extract 2 is taken from later in session 7. Jack had chosen to improvise on the electric piano using the 'Brass' timbre. He requested the therapist to share his instrument, as he had expressed feelings that he 'could not play it on his own'. Jack played in the treble using his right hand, with the therapist giving a grounded tonic/dominant ostinato pulse in the bass. The therapist's ostinato occasionally developed Jack's ideas melodically. Given this supportive musical structure, Jack was more interactive with the therapist's material in his rhythmic fragments and use of articulation. He explored the full treble range of the keyboard. His musical material in this improvisation differed from that in previous and following sessions due to the absence of his rhythmic pattern and the greater variation of sounds and silences. He showed a more heightened awareness of the therapist's music than previously heard. Given greater musical structure, Jack revealed more playful and spontaneous responses.

Through the process of triangulation of the interview analyses, session evaluations and clinical supervision, it became evident that the act of 'singing' bore a meaning for Jack which the improvising did not hold. In his daily life, he was surrounded by people on his ward who had lost all use of their voices, communicating through augmentative communication aids or through eye blinks for 'yes/no'. Some had no means of communication at all. Jack perpetually referred to his voice and throat within sessions. It emerged that, for Jack, music therapy was a physical activity in which he monitored his disease process.

8.2: Analysis and results: Jack's experience of the music.

The outcomes of music therapy intervention for this man were three different levels of responses. It resulted in him employing the **coping strategies** to

deal with emotional states which he had so much difficulty acknowledging, much less sharing with the therapist. It also resulted in him **monitoring his Illness** through registering any changes in breath control, quality in vocal production, range of pitch and dynamic range achieved. On a much deeper level, it supported him through **life review**, acknowledging his illness and his more difficult feelings about his illness, and relating such feelings to himself. In this way, he reached a state of **Barriers Down**.

Overwhelmingly, it was the **relationship over time** and the inherent **associative** properties which were held by pre-composed music which were the key factors to Jack's experience of his songs. When music possessed higher **temporal** and **associative** properties, this made it a more **meaningful** experience for Jack and increased its sense framework i.e. he was able to make greater sense of the music. Hence, familiarity increased **meaning** and resulted in consequences of increased **ability**, increased **Independence**, and also increased **ownership**. The higher **associative** properties also diversified the range of **emotional** qualities associated with the music to include '**non-coping**' emotions as well as ones more normally associated with **coping**. More importantly, through the heightened sensation of each of these attributes, the combinational effect caused an increase in the emotional identification made with the music. This resulted in Jack relating feelings such as 'sadness' to himself. Such feelings were normally strongly suppressed by **coping strategies**. In this way, music which possessed all the above properties enabled him to express a more extensive range of feelings than his usual 'happy'.

The following example breaks down each of these processes into smaller units.¹

¹ The examples in this and the following case studies present the participants' interview data on the left hand side of the page, with the analytical headings under which the data have been grouped on the right side of the page in upper case. Value ranges i.e. 'high' and 'low' have also been given when appropriate to the analytical headings.

Example 1:

(From: Session 24, Songs)

Yes as a matter of fact, life is a programme,
 as I said to you before, of experiences
 it's also, um, a programme of what songs
 go along with you at that particular time.
 At every stage of your life, there will be
 some songs that will accompany you.
 They will be with you. Forever. Forever.
 That's what I've found anyway.
 ..well it's all connected. It's all interwoven.
 It's all interwoven into your life. These
 songs are interwoven into *my* life.
 Into *my* experiences. They're there.
 I'm glad they are.

LIFE REVIEW

"

HIGH ASSOCIATION

HIGH RELATIONSHIP OVER TIME

HIGH ASSOCIATION

HIGH RELATIONSHIP OVER TIME

HIGH ASSOCIATION

HIGH ASSOCIATION

"

"

Therefore under conditions where the music possessed high familiarity, high temporal factors and high associative factors, the process of life review was stimulated by the music, giving it higher meaning. When such an experience was combined with additional factors, other processes developed. For example when the associations made had emotional qualities, this broadened his emotional experience. Within the following example, Jack identified an emotional quality which he related to the songs. This emotion possessed properties with a negatively weighted value, i.e. 'non-coping', which indicated that a different process occurred for him through the songs. Unlike his usual coping front which the therapist had labelled 'perpetually jolly', he identified an emotion which cannot be categorised under the 'coping' heading.

Example 2:

(From: Session 17, Improvisation)

Yes songs are about sad romances. I'm sure that human beings, no matter what class he's in, when he sings, the song he sings, he must identify himself with some spot in his life. Oh yes. I think every song has something for one stage in your life. It must do, well it does do for me. It does with me.

IDENTIFIES NON-COPING
EMOTION
HIGH ASSOCIATION
HIGH ASSOCIATION
LIFE REVIEW

Hence in the above example, under the conditions of high associative and temporal properties which led to life review, the additional property of emotional qualities arises. The property value, however, is towards the non-coping spectrum. Hence the particular set of conditions given by the music gave rise to a strategy, which had the outcome of Jack acknowledging more difficult emotional states. These were attributed to the music only.

The following extract reveals that although at times Jack was able to identify such emotional states, in no way did he relate it to himself. He described his reaction to singing his 'sad' songs which he related so much to his life, but not to any way he might be feeling.

Example 3:

(From: Session 17, Improvisation)

I don't get sad about it, because you mustn't let the negative, depression is a very negative thing, and it will break your heart, and the opposite is joy, and that will lift you up, you've got to be on that side of life all the time, which you can be, so long as you educate your mind to do it.

LOW RELATION TO SELF
STATING RULES
IDENTIFIES & CATEGORISES
NON-COPING EMOTION
IDENTIFIES COPING EMOTION
PERSONAL BELIEFS
STATING RULES
" "
(COPING STRATEGY ADOPTED)

The previous example draws a clear picture of how Jack categorised the emotional states he could and could not deal with. He succinctly described the process of how he adopted coping strategies in order to maintain the coping front and deal with the 'non-coping' emotions which he stated were stimulated by his songs. This process is depicted in Figure 7.

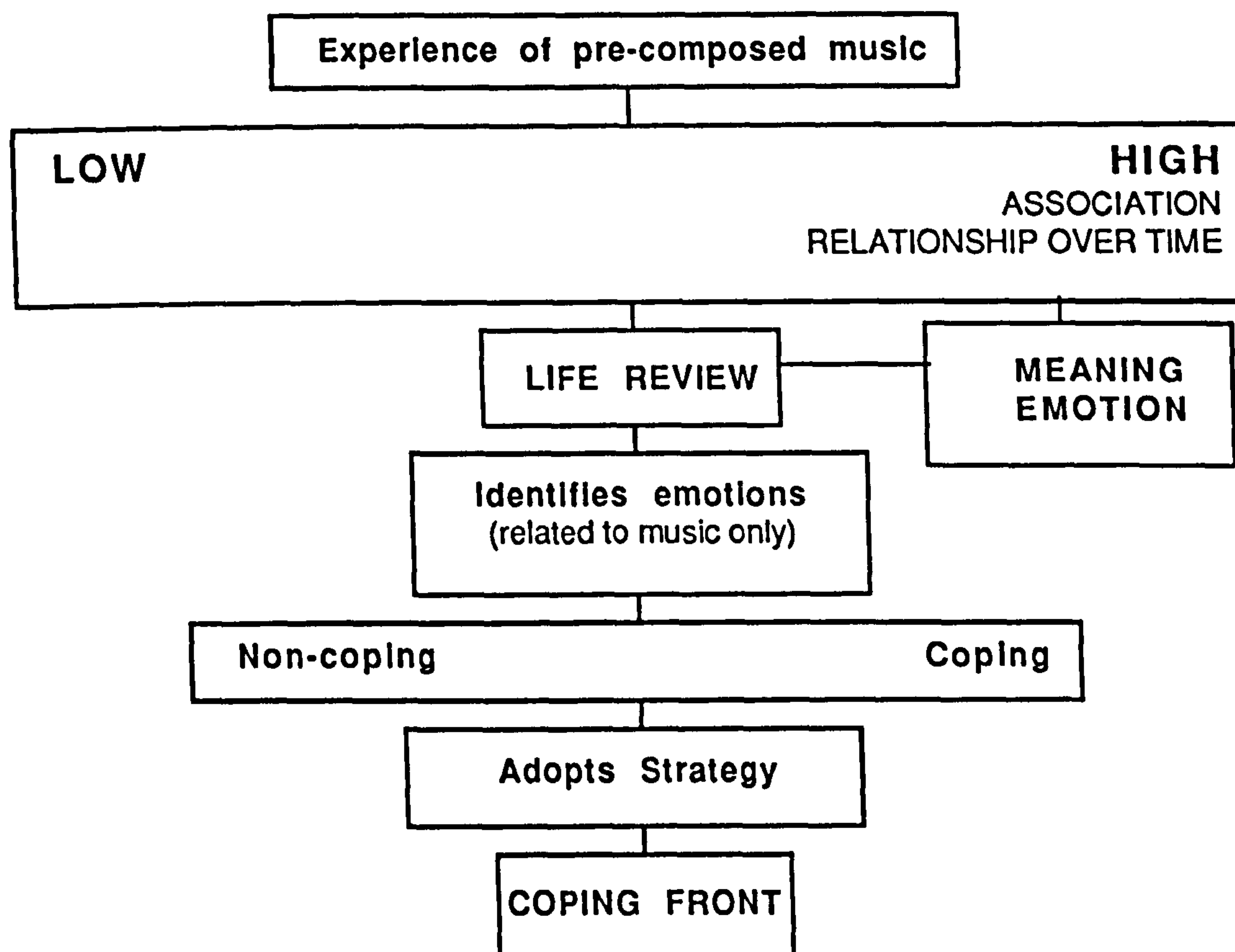


Figure 7:² Emerging properties of pre-composed music and the consequences for strategies adopted.³

² Please refer to Appendix 13 for a guide to reading the analytical diagrams.

³ At this stage, only properties which held a higher value had been identified. Properties measuring in the lower value range had not yet been identified. These emerged at a later stage of analysis. Therefore, at this stage, Figure 7 depicts only the higher value of the emerging properties.

His responses stimulate a question however about the additional contexts and conditions which caused him to adopt the coping strategies outlined. Analysis of data from further into the music therapy period revealed that such strategies were not adopted at a later stage in therapy. This suggests a clear relation between duration of therapy and the strategies Jack adopted.

Example 4:

(From: Session 20, Songs)

I like singing the songs that I know how they go,
and it's a *big* difference singing something I know,
cause all the things I know, I like. All the things
that I know, I know them or most of the song
because I like it. It means something to me, to
be able to sing it.

HIGH FAMILIARITY

HIGH FAMILIARITY

LEADS TO

INCREASED MEANING

HIGH ABILITY

MT: What does it mean to you?

It means, um ... it means harmony in myself, it
means I'm full of feeling, an empty, an empty
spasm ... I'm feeling an empty space ...
I need to sing. There's nothing else that can
fill it. I need to sing.

RELATES EMOTIONAL

STATE TO SELF

In this example, he reiterated that higher familiarity resulted in higher meaning, a relationship that has already been established. However in earlier sessions he was unable to relate emotional states to himself. In example 4 he did not categorise emotional states, but he did start to relate emotions to himself, and identified that he has an 'empty space' and is 'full of feeling'. This indicates a process of moving away from the coping front and moving towards a state of barriers down.

Within this example, he described his experience of music which had high temporal and associative properties, and described the causal relationship between familiarity and meaning. With higher meaning and a greater sense framework he had a greater sense of control. There also existed a higher duration factor within the therapy, which in turn affected the relationship with the therapist. It was substantiated in an earlier section that the condition of being able to start reaching a state of 'Barriers down' depended on trust with the therapist. For Jack, this relied on the condition of a higher duration in therapy.

In the following example, one session later, he not only identified non-coping feelings as being related to the music, but started to relate such feelings to his own life experience.

Example 5:⁴

(From: Session 21, Improvisation)

..they are all sad songs. Autumn leaves	IDENTIFIES NON-COPING EMOTION
is a very sad song. And Stranger In	“ “
Paradise. Almost 75 per cent of the	
songs that I hear on the radio ... are about	
sadness. They're about love affairs,	IDENTIFIES NON-COPING EMOTION
they're all about sadness. And sadness In love.	“ “ “ “
They're all about sadness. ...	“ “ “ “
singing other people's words ...	LOW OWNERSHIP
they've written it to be sad. In that	IDENTIFIES NON-COPING EMOTION
sense they are sad. And you've	
got to feel a bit like that to sing them.	RELATES NON-COPING EMOTION
You've got to feel like that. You've got	TO SELF
to be that way to sing it.	RELATES NON-COPING EMOTION
..cause once you like a song, you	TO SELF
never forget it. And ... cause life is a	HIGH MEANING
series of stop and goes, of experiences,	LIFE REVIEW

⁴ Audio extract 3, which is explored in greater detail later in this analysis, took place in the session before this interview.

and the music that you hear,

brings you nearer ... some music brings

HIGH ASSOCIATION

you to that time and you never forget it,

HIGH RELATIONSHIP OVER TIME

and of course, when you ... when I learnt

the song when I was younger, it

was probably a sad time, so it

IDENTIFIES NON-COPING EMOTION

would mean you reflect on the time

LIFE REVIEW

when you learnt the song, or what you

HIGH ASSOCIATION

head in your life then ... but you get so

many sad occasions as you go through life.

NON-COPING EMOTION / LIFE REVIEW

So many sad occasions, so many sad occasions

and so many experiences. You've got to

LIFE REVIEW

have everything, lots of joy, of sadness,

IDENTIFYING RANGE OF EMOTIONS

you've got to have everything. I suppose

you might think they might have been good, if

LIFE REVIEW & EVALUATION OF LIFE

(as everybody uses these words), 'If only' things

had been different, but things weren't meant

“ “ “

to be different. You were meant to experience

what you've experienced. But I know that

“ “ “

you see, so I know that when I'm singing

the song, that would be sadness for when

NON-COPING EMOTION

I remember it, I know (emphatically) that

HIGH ASSOCIATION

things should be as they were.

Hence due to the condition of increased duration in music therapy, he began to relate more difficult feelings to himself and own such non-coping feelings which he normally never acknowledged in his own life. This is supported by examining the data from an even later session, when he directly owned the difficult feelings he had recently started to identify and explored what had happened to him in his life to cause him to feel that way.

Example 6:

(From: Session 23, Improvisation)

Every song that I sing, is sad,	IDENTIFIES NON-COPING EMOTION
I can't help it. It, uh, ...everything is sad,	“ “
I can't get away from it. It is. I guess there	“ “
isn't any song I don't find sad.	“ “
I don't know why. Like, I s'pose, my life makes it sad.	RELATES NON-COPING EMOTION
(long pause) Yes, I guess all songs get to the	TO SELF
bottom of me. They all do - I don't know. ...	
the reason they all feel sad, is my life I s'pose.	RELATES NON-COPING EMOTION
(laughs with awkwardness) Yeah, it's a lack of	TO SELF
love. (emphatically) I couldn't sing a song that	“ “
wasn't sad. Maybe it's me protesting the lack of love.	“ “
Well, I know it is. You can't change yourself you	
see. You've got to take life as it comes.	LIFE REVIEW
Yeah, that's how when I look back on my life,	RELATIONSHIP OVER TIME
it is all these songs. I don't listen to any	HIGH ASSOCIATION
songs that aren't sad. Every song I hear	NON-COPING EMOTION IN SONG
otherwise it'd never mean nothing you see.	INCREASES MEANING

Before a complete picture can be drawn of his experience of pre-composed music, it is necessary to also examine two further properties which have been mentioned briefly. Aspects of ability were essential in understanding Jack's overall experience. Surprisingly, ownership was only important when combined with other factors. For example, ownership was important in his experience of the songs, in enabling him to express himself in a way he intended, and therefore had a high value. However, as a property, ownership also had a high value in his experience of improvisation. When ownership (high value) was combined with other properties with low values such as relationship over time and association, it bore little impact on his experience of the music. For example, ownership needed to be combined with a higher sense of ability. Jack's self perception of ability not only affected his general experience of an activity, but also triggered or blocked different processes occurring. In the following example, both ability and ownership are high in his experience of singing, as is his sense of independence.

Example 7:

(From: Session 19, Improvisation)

Because I want you to hear how well I can sing.
 I want you to hear the way I want to sing.
 And I want you to hear the feelings I put into
 the song, the way I sing it. And that's
 important to sing. Cause I've got the confidence,
 this has helped me a lot coming down
 here, a lot more confidence in singing.
 I don't worry now so much, how people think I'm singing
 .. I just sing it, cause I'm going let
 them hear *my* voice, and I've gained
 that from coming down here. So my voice
 is alright, I sing that song on my own,
 not fast, not how I think it should be sung,
 and that's my life, that's what I like to do.
 I can do it without relying entirely on
 someone else.

HIGH INTERACTION / ABILITY
 " " / OWNERSHIP
 OWNS EMOTIONAL QUALITIES
 HIGH OWNERSHIP
 ABILITY

 INCREASED ABILITY

 HIGH OWNERSHIP

 INCREASED INDEPENDENCE
 OWNERSHIP
 HIGH MEANING
 INCREASED INDEPENDENCE

Similarly, the following example compares directly the roles which skill, ability and ownership played in his experience of the two types of music. Jack compared how he was able to express himself 'better' because he felt more skilled at singing, and that if he felt greater skill in playing his expression would be better when improvising. In terms of property relationships, this indicated that high ability and high skill increased ownership of emotional qualities in the music. As Jack felt more able and more skilled when singing his songs, this resulted in higher ownership of the emotions he put into his songs. This ownership was higher than that he felt with the music he improvised.

Referring back to example 5, it is worth noting that as the words within songs are written by someone else, they therefore measure a lower rate of ownership. In examining ownership within each of the types of music

however, it is important that Jack recognised that his ownership within improvisation is high, but that this is not an influential factor in the meaning of the experience. The ownership of the expression he is able to put into the music is crucial however, as this helps to him to move towards owning the feelings and into a state of Barriers Down.

From the examples already given the conditional situation for Jack of familiar pre-composed music is outlined in Figure 8.

If associative and temporal properties were key aspects to reach such outcomes, then it is important to examine the process which occurred when these were absent from the musical experience. Although within the initial thematic coding it was substantiated that improvisation stimulated general reminiscences and thoughts about significant others, this did not happen for Jack within his experience of improvisation. Within improvised music, the associative elements and relationship over time were low. This resulted in lower meaning within the music for him. Further intervening conditions in his experience were a low sense of ability and a high sense of ownership as he stressed that he was not 'copying' anyone else's music. Therefore the conditions under which he experienced improvisation were those which are represented in Figure 9.

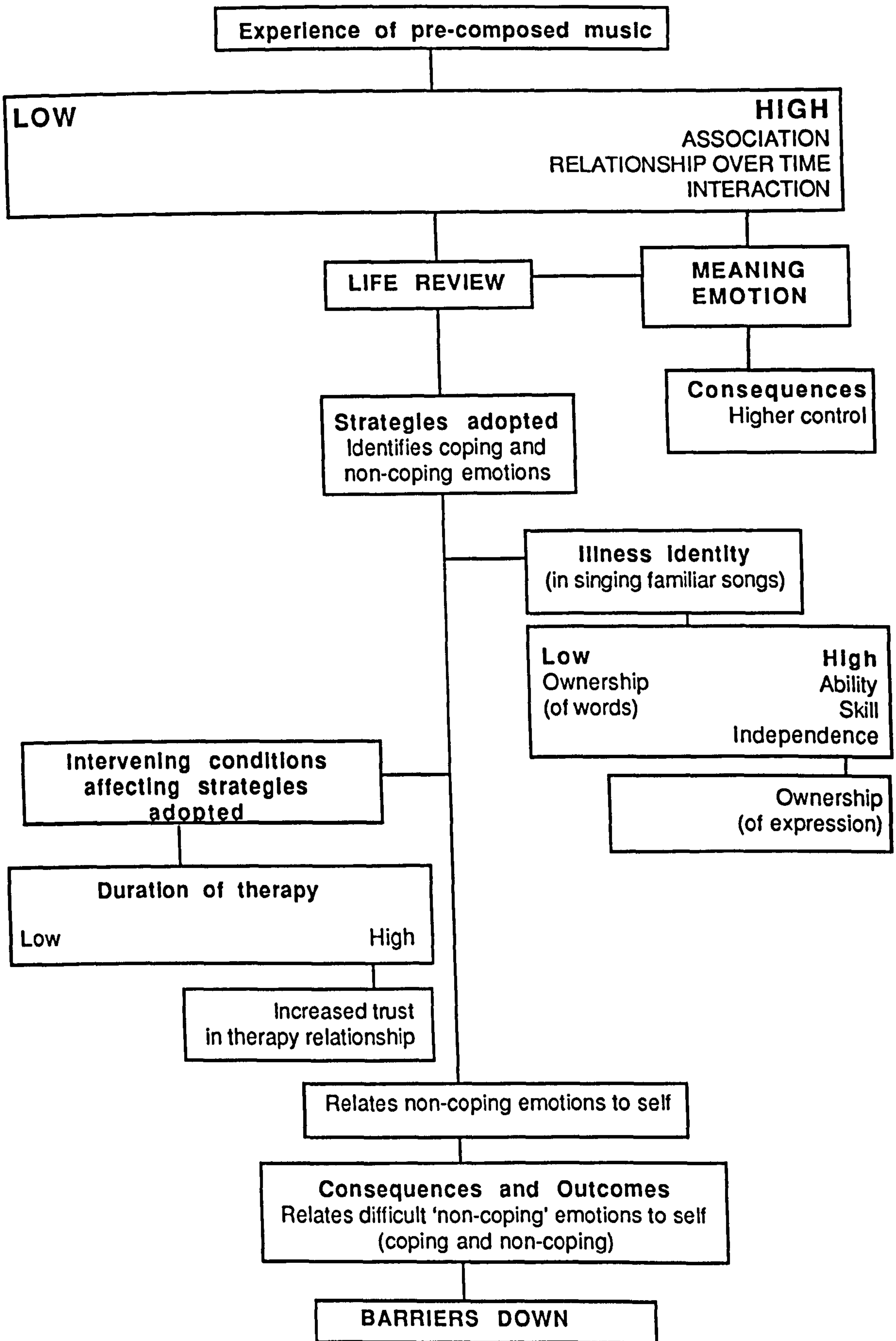


Figure 8: Process stimulated by pre-composed familiar songs to reach state of Barriers Down.

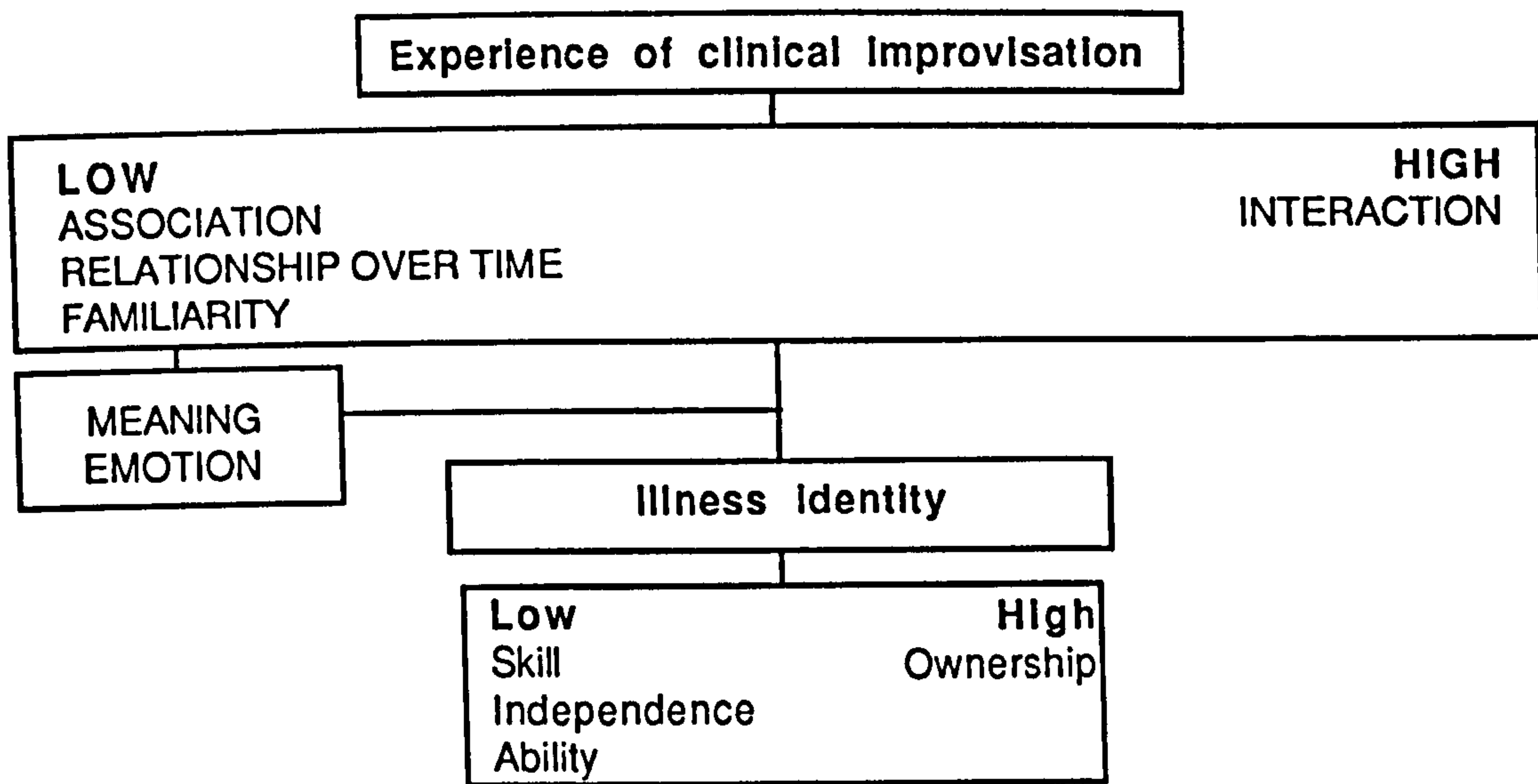


Figure 9: Properties of unfamiliar improvised music with high/low values, leading to effect on illness Identity.

The result of such an experience was a need for sense, a need for some control due to lack of familiarity, and also a heightened sense of threat and confrontation due to the inability experienced. The high element of ownership accounted for little in such a framework. The consequences of such an experience were to adopt the different coping strategies for dealing with such an uncertain experience, in order to increase the sense of control, reduce the sense of threat, reduce the sense of confrontation, provide an explanatory framework, and dismiss any feelings of inability. In such a way, the coping front was maintained. One such example follows.

Example 9:

(From: Session 19, Improvisation)

MT: If you were to describe the session to someone else, and describe it in plain language, what we've been doing, how would you describe it?

I would describe it as um, a time of um, interesting, harmonious, um, worthwhile time spent, and very likable. We um, tried to make a noise, and.. It was trying to get a note from me to express myself. We tried to make harmonious sound. We tried to make a nice vibration, and enjoy the sound. We have made an enjoyable sound that I have liked. We made sound. We were using my voice, and your brains, and that instrument, to cumulate this sound. I was trying to direct it into a harmonious sound.

LOW EMOTION
 POSITIVE COPING
 LOW MEANING
 LOW ABILITY
 LOW MEANING
 “ “
 POSITIVE COPING
 LOW MEANING

MT: Do you mean you were singing Jack?

Yes, oh yes. (Both laugh) I was trying to sing!
 We done a song, consisting of vibrations from the nose, the throat, and the instrument, and tried to, we put it together to make something nice, nice sound, nice vibration.... which was medicine.

MEANING (GIVEN BY MT)
 POSITIVE COPING
 INCREASED MEANING

MT: I notice you don't use the word 'music' at all. I wonder why that is?

Oh, well I used the word vibration, I could have used 'music' just the same.....everything is music, except I never said the word, I know. If I was using the rakatak, I would class that as music, and the buzzing of a bee as music, and when we sing, that is music.

LOW MEANING
 DISTRACTING
 DISTRACTING (LOW CONTROL)

MT: The music that we did today, did we use songs that you'd heard before, or what sort of music was it, describe it quite simply.

That I'd made up. I hadn't heard it before.	HIGH OWNERSHIP
I didn't use anything that I'd heard before.	HIGH OWNERSHIP
I tried to make as many sounds as possible,	LOW MEANING
coming from me, not from any song, not from	HIGH OWNERSHIP
any music I know. You have to find your way	
along, because you've only got your brain to	HIGH OWNERSHIP
guide you to make the sound, and you're not	LOW MEANING
trying to copy another song, so you've got to	HIGH OWNERSHIP
make your brain work to find that sound. So	
you've got to make it up between your brain	HIGH OWNERSHIP
and your voice. You can always pick a song,	
but then you're not making it up, you're copying.	
What we've done today, I didn't copy anything, I just	HIGH OWNERSHIP
went with this croaky voice (sings). See, I'm	LOW ABILITY (Illness monitoring)
not copying, so I had to use my head. No matter	HIGH OWNERSHIP
what it sounded like. I was trying to find a	
way of making a note. Making a sound.	LOW MEANING

Although the benefits of this experience within a therapy context could be described in terms of exploration of novel experiences and developing his sense of interaction with the therapist, this experience was a less meaningful one for Jack, and one which maintained his coping front rather than helping him acknowledge his more difficult feelings through music, then explore and share these.

In the following example, Jack articulates exactly why the improvisations are less meaningful for him. This interview extract follows the improvisation given in Audio extract 3 in which Jack's music differed in quality from previous improvisations. Jack had chosen to play the metallophone and conga, and for the therapist to accompany on the keyboard with 'Electric Piano' timbre. Although initially in this improvisation Jack displayed lower engagement by looking out of the window as he played and playing with less physical intention, he became increasingly engaged during the improvisation.

Although variations of his  rhythm were still prevalent,

there was a greater interaction of rhythmic ideas between Jack and the therapist, and a heightened musical awareness in Jack's use of timbre. His melody was mostly in step movement up and down the metallophone, but was generally 'stiller' in nature, with more pauses and longer time values for individual notes.

Taking this musical material to clinical supervision, the supervisor reflected that Jack was setting a particular mood using his musical sounds, which needed greater shaping, particularly melodically, from the therapist. In the interview after the session, he was initially only able to describe verbally the improvisation with positive feelings which can be categorised as coping feelings. When encouraged, although he identified and related non-coping feelings to the sounds of the instrument, he denied that any link could be made between the music and himself. In this way he was certainly unable to relate his unfamiliar improvised musical utterances to himself or his own feelings on a conscious level.

Example 10:

(From: Session 21, Improvisation)

...well it would be an enjoyable time
making a harmonious sound, and
satisfactory, because it was positive and
meaning something.

POSITIVE COPING
LOW MEANING
POSITIVE COPING
LOW MEANING

MT: What about the actual mood of it?

Yeah, well the mood, the feeling of it
Is that you are making a nice sound (emphatically)

POSITIVE COPING

MT: I was thinking of giving it a feeling, rather than just 'nice'....?

Well ... it would be to me ... um a sad sound.
A sad sound. ...it is a sad tone. I mean, but you

IDENTIFIES NON-COPING EMOTION
RELATED TO INSTRUMENT

could also say that it would be ...

(plays a few notes on metallophone)

you would hear that around Christmas time.

It could also be a pretty sound. A pretty sound.

ASSOCIATION

POSITIVE COPING

MT: How is it different singing somebody else's words, which are sad? How is that different from playing your own music?

it doesn't ... (I've got to be truthful), it

doesn't bring me to any point in life

when I was sad. Well, it doesn't

make me sad, although that tone

(touches metallophone) makes a sad tone.

LOW ASSOCIATION

LOW RELATION OF EMOTION TO SELF

IDENTIFIES NON-COPING EMOTION

RELATED TO INSTRUMENT ONLY

To summarise the above, due to the lack of associative and temporal properties within the improvised music, Jack had difficulty in identifying emotional meaning in the music. He was only able to use positive coping feelings to describe the mood of the music which evidently carried low meaning for him. He was not able to relate the 'sad' feelings identified to himself. Thus in the example given above, the conditions failed to give rise to the outcome of barriers down.

It must be acknowledged here that Jack's inability to express any deeper acknowledgement verbally does not necessarily mean that non-verbally, on an implicit level, there were not deeper emotional processes occurring from the musical meaning and shared interaction of this improvisation. Certainly a psychodynamic interpretative model might have led the therapist to believe this, as the clinical supervisor discussed with me. Without doubt Jack's ability to participate in improvisations had developed, and within such improvisations, he experienced a sense of sharing with the therapist. These points were not dismissed in his therapy, nor are they dismissed in this

analysis. However, what is revealed through the analysis of his verbal interpretation of his experience is the process which is not stimulated for him, due to the missing properties which pre-composed music carried for him.

Not only did relationship over time result in greater meaning, but also related to other subcategories such as the illness experience, particularly in terms of identity and changes experienced due to the illness. When such temporal associations were made, there was a greater incidence of life review. As a coping strategy, this increased Jack's sense framework of why he had experienced the adversity of his illness.

The interactive properties of improvisations were, however, extremely high in Jack's experience. In the following example, as he debates the meaning in the improvisation which has just taken place in the session, he states that it is the interaction within improvisation which increases the meaning of the experience for him. His use of feelings which are 'positive' and 'negative' suggests that he is unable to engage on an emotional level with the experience.

Example 11:

(From: Session 23, Improvisation)

I don't think I'd get any enjoyment out of it on my own. It wouldn't mean nothing. I wouldn't do it cause it wouldn't mean anything to meif I played it myself, to me it would be a negative thing, because I wouldn't be sharing it. That's what it is, that's what, I wouldn't be sharing it. And um, if you're trying to make a noise, a harmonious sound, you should share it, you got to. Got to share it. Sharing a nice sound. Well, the fact that I can hear you and

POSITIVE COPING
 LOW MEANING
 CAUSED BY
 LOW INTERACTION
 NON-COPING
 LOW INTERACTION
 CONDITION TO INCREASE
 MEANING RELIES ON
 HIGH INTERACTION
 “ “

you can hear me, and it's a two way thing.
 You can't play it by yourself, because it's got
 to be two way. At least a two way thing and
 it means I'd be doing something positive
 when I was sharing it, because it had an aim.

HIGH INTERACTION

COPING EMOTION

Similarly, in the following example, low values of 'ability' result in lower meaning, as he specifies that when he sings, meaning is increased, or 'his needs are met'. Again, the properties of interaction and ownership have high values, however, this only results in him identifying a positive coping emotion.

Example 12:⁵

(From: Session 21, Improvisation)

It's good to make a harmonious sound,
 because I can't play an instrument, it
 meets some of my needs. It meets
some of my needs. Singing meets a lot
 of my needs you know. I was trying to do
 what I wanted. I was trying to make a sound
 I thought you might follow. I was talking to you
 through making a sound, but to me I was
 talking to you. When you made a certain
 sound, I made a certain sound. I tried to copy you,
 or lead you, cause it's good to do it.

LOW INABILITY

LOW MEANING

INCREASED MEANING

(THROUGH INCREASED ABILITY)

OWNERSHIP

HIGH INTERACTION

“ “

POSITIVE COPING

Figure 9 depicted the emergent paradigm of Jack's experience of unfamiliar improvised music. This can now be developed to include the consequences of the processes stimulated by his involvement in the music, as shown in Figure 10.

⁵ Refer to Audio extract 3 for the improvisation in this session.

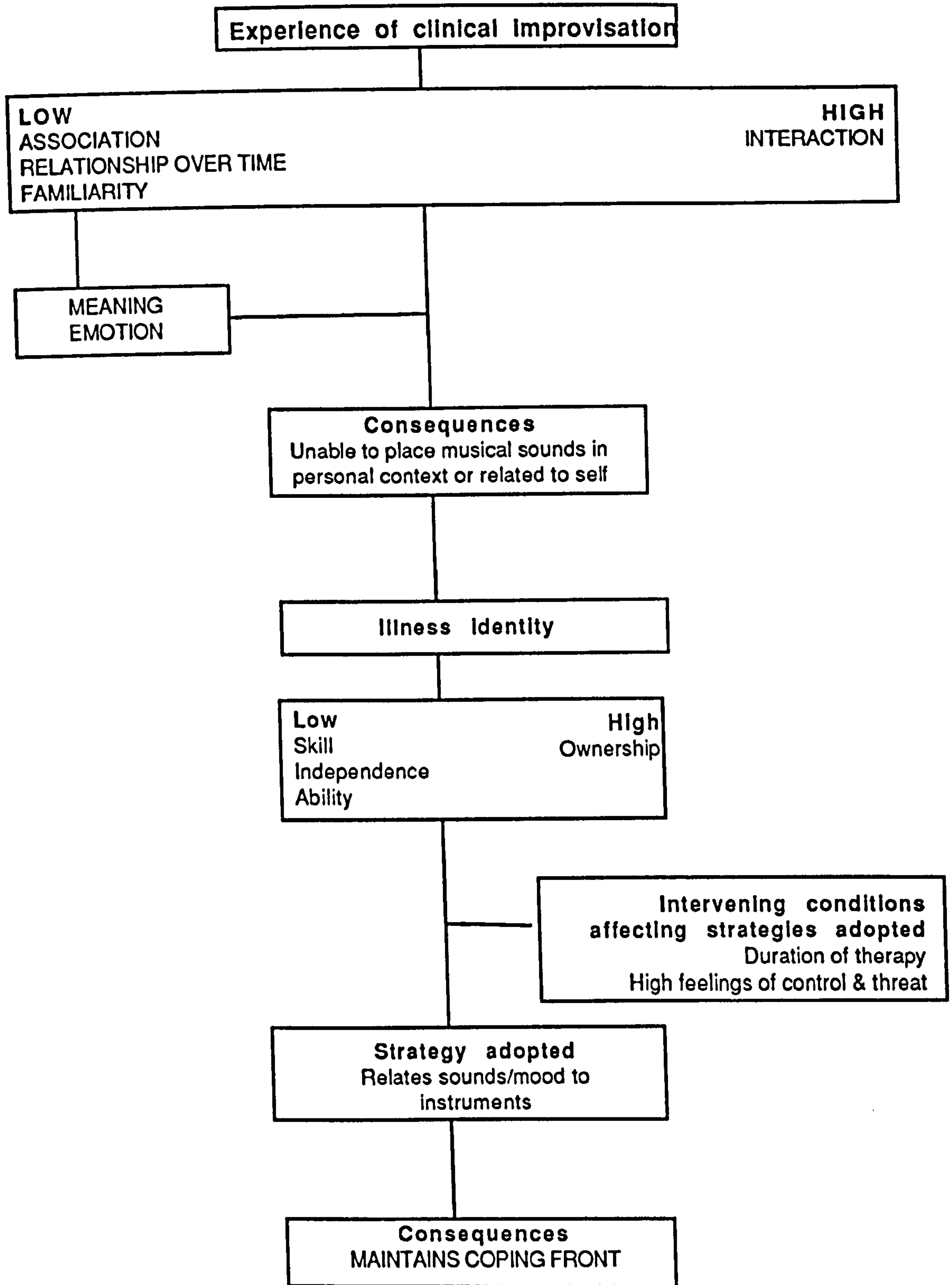


Figure 10: Processes stimulated by unfamiliar improvised music

The physical experience of music was another important aspect which differentiated pre-composed and improvisatory music for Jack, as he monitored the different aspects of his vocal production, particularly through singing his songs. In the following example, he starts to talk about the physical experience of singing. Immediately he starts to compare his voice production in different activities i.e. talking and singing, and the quality of sound produced which he calls 'croaky'. He recognises that any decreased ability in his singing was however caused by not knowing the words rather than his physical experience.

Example 13:

(From: Session 16, Songs)

Oh well I know I've got a sore throat.
 You can hear the way I'm talking. But
 when you're singing any singing is good.
 Even if you're croaky, like I am, it's still okay.
 I couldn't sing cause I don't know all the
 words to that song. I've got to wait for you
 to tell me. I do know 'What a Wonderful World',
 but this croaky voice, it's not very good today,
 but when I haven't got this cold
 I feel better about it. I'm short of breath
 you see. I'm still doing the breathing
 exercises (demonstrates for MT). But I
 don't seem to be improving much.
 I suppose I don't know when I'm going
 to be able to sing right. I can sing in
 bed much better than that, I can sing
 much higher ... But I gotta keep trying.
 I'm not doing any exercise, but I could
 possibly get over it

PHYSICAL
 MONITORING ACTIVITY
 " " (VOCAL)
 MONITORING QUALITY (LOW)
 LOW ABILITY
 HIGH DEPENDENCE
 HIGHER ABILITY
 COMPARISON OVER TIME
 PROJECTION (COPING STRATEGY)
 ILLNESS MONITORING

 ILLNESS MONITORING
 CONDITION OF TIME

 SITUATIONAL COMPARISON
 COPING STRATEGY
 " "

MT: How does it feel if you're not singing in the way you feel you should?

Well it feels limited. You're limited. You shouldn't be limited to sing if you want to sing. And of course this virus ... it's only a passing phase no matter what you get in life, you've got to chuck it out the window. Say that's I don't care about it.

RELATES TO SELF

COPING STRATEGY

“ “
“ “

Illness monitoring occurred for Jack purely through monitoring his voice within the vocal activity within the session. Although this was mostly through his regular involvement with singing his songs, it also occurred when he improvised vocally on one occasion. Although such activity did not pertain to physical manipulation of instruments as with others in the study, it was nonetheless a predominantly physical experience of the music which was the central phenomenon. Although Jack did sometimes engage emotionally with the songs he sang, the occasions when he monitored his vocal production were marked by a lack of emotional engagement with or meaning attributed to the music. When he experienced the music-making as physical, he measured a high degree of change by making temporal comparisons. Under these circumstances Jack was more likely to monitor his voice, particularly when the music had lower association and emotional factors. Other intervening conditions which also affected this were levels of success, ability and skill attributed to the activity. A negative experience of vocal monitoring was associated with lower levels of success and ability and lesser degrees of skill. Under such conditions, there was also a higher level of threat and a lower degree of control. The combination of phenomena under such conditions resulted in Jack using the music therapy activity to monitor his illness, which in his particular case, was the subtle changes in his vocal production. The following example also shows how he used measures of ability and success, which in combination with vocal monitoring and high temporal factors resulted in him adopting coping strategies and maintaining the coping front.

Example 14:

(From: Session 19, Improvisation)

MT: When we finished, the first thing you commented on was your croaky voice. You said " I thought it was awful. I thought it was awful ... I can't really sing", and it seemed you were feeling a bit frustrated with your voice. I wonder if you'd have felt as frustrated if we'd sung one of your favourite songs?

Oh, I think so, as I'd like to sing it properly.

MEASURING ABILITY

Oh, yes, it would have been the same,

cause if you're going to sing a song,

you've got to give your best. It's not so good.

MEASURING ABILITY

When you sing a song....when I sing

a song I give my best to it. No matter how it

sounds, I think that is good, good enough

MEASURING SUCCESS

for me if it's the best I've got. Yes, cause

“ ”

I've got a sore throat, which I shouldn't say,

VOCAL MONITORING

cause I keep mentioning it to you. No,

I couldn't give anything my best today,

COMPARISON OVER TIME

because of my throat. I've got to

PHYSICAL MONITORING

put it on the shelf cause you've got to push on.

COPING STRATEGY

It should be noted that when he was able to engage emotionally with the music, there was less evidence of vocal monitoring taking place. That is, there was a high physical/low emotion and low physical/high emotion correlation. Jack's physical experience of both types of music can be mapped out as in Figure 11.

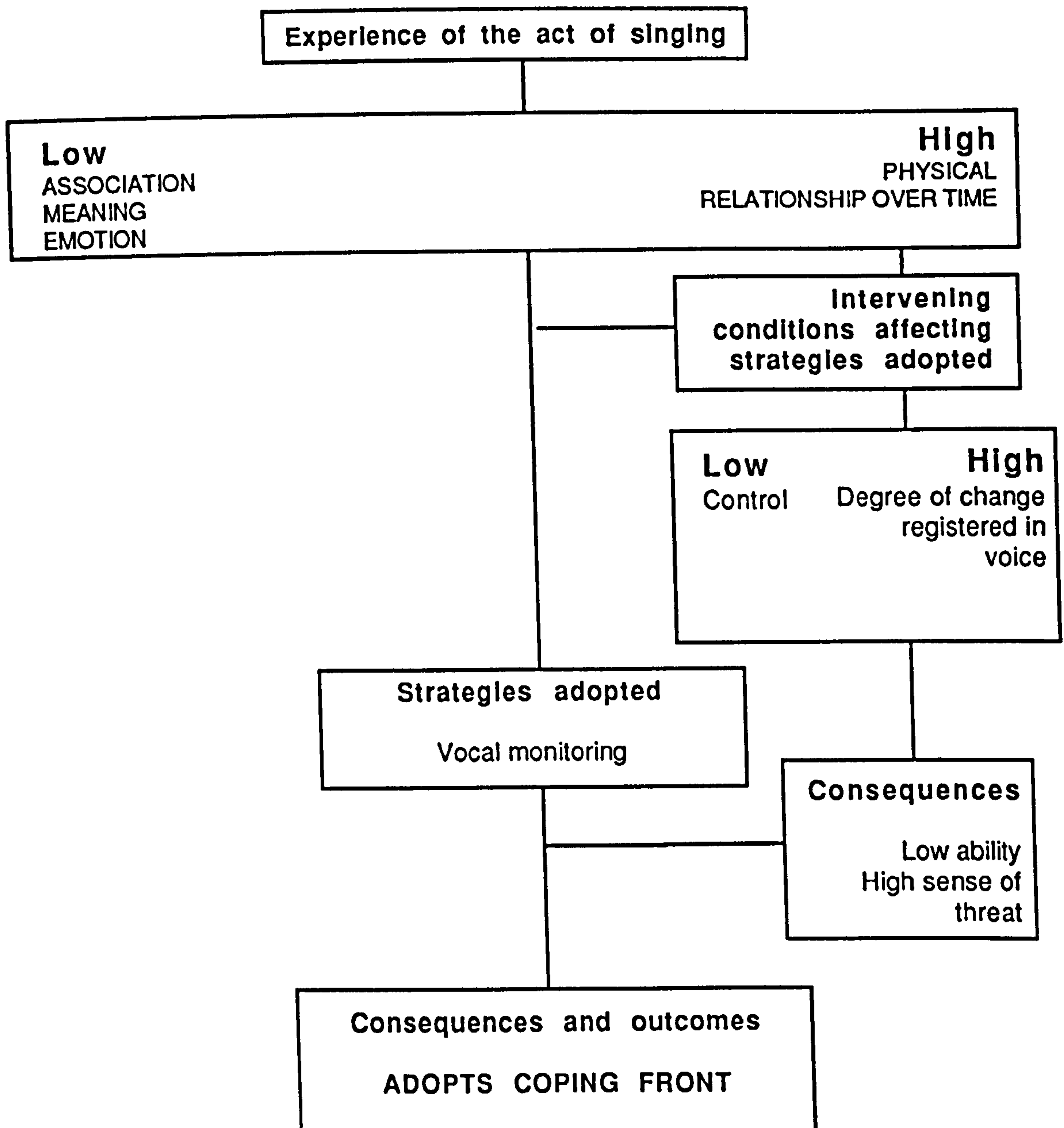


Figure 11: The process of vocal monitoring stimulated by the act of singing.

If we compare Figures 8 and 11, it is evident that the outcomes of adopting a coping front and reaching a state of barriers down were reliant on there being different property ranges in the act of singing. More specifically, when there were higher properties of association and relationship over time, there was a greater emotional and meaningful experience in the act of singing. Under

these conditions, there was less evidence of the experience of singing being a physical act during which he monitored the changes experienced in his vocal production. When the experience of singing did not involve higher associative properties, the act was less meaningful and carried with it less emotional impact. Under such conditions, singing was more likely to be experienced as a physical act. It was established in the chapter 'Coping with the emotional' that a coping front was more likely to be adopted when an individual felt a lower sense of control, a higher sense of threat, and a greater sense of confrontation by their illness, and that this strategy served to mask deeper responses to the illness. It can therefore be assumed that the process of vocal monitoring stimulated emotional responses for Jack which he felt the need to control. As this act was an implicit one within his therapy sessions, these processes were never explored explicitly with him. When he was able to engage more emotionally with the music however, vocal monitoring was less likely to take place. Hence when he improvised using his voice, he was more likely to be monitoring the changes he had experienced which led to a coping front being adopted.

8.3: Summary of results.

The most meaningful experience of music for this man within music therapy occurred under certain conditions and was influenced by certain contextual situations. For Jack, the experience of pre-composed music undoubtedly drew him to an emotional place where he was able to acknowledge his most difficult and fearful feelings and share these within the safety of a therapeutic relationship. The most important properties within the experience of pre-composed music for him were the properties of association and relationship over time, which enhanced the emotional experience and the meaning. Singing either pre-composed or improvised material was a highly physical experience for him, although less so when there was greater association,

meaning and emotion in the music. The importance which his voice held to him certainly influenced his perceptions of what he gained most in therapy. Considering neuropsychological evaluations (refer to Appendix 11), it may also be considered that he had more difficulty with unfamiliar material and activities which were not well defined, both of which are factors of improvisation.

Jack appeared to have difficulty naming or identifying moods of the improvised music independently, or associating how he was feeling with the mood of an improvisation. He was, however, able to label a familiar song in terms of mood due to its familiarity and previous associations. More importantly, he was also able to recognise that he chose sad songs because he identified with the mood of the song, thus acknowledging his own feelings with which he normally had difficulty or which he openly denied. For both types of activity, association with mood appeared to deepen and become less superficial over time, which reflected the therapeutic process.

Having a personal framework in which to place the music appeared crucial to Jack, and provided a strong bias towards the song-based activities. In the absence of such a framework for the improvisation, he repeatedly referred to these activities as being a 'conversation'. Whilst this may have stemmed from the therapist's initial introduction to improvisation and turn taking activities as being a way of conversing non-verbally, the notion of improvisation being a language may also have provided him with a framework in which to place such an abstract activity, as he appeared to hold onto this description throughout the sessions. It may also have provided a coping mechanism, as the idea of a non-verbal activity for a man who rarely stopped talking when in the presence of others may have appeared as a highly threatening activity. As we have seen from the analysis, low control and feelings of threat led to adopting coping strategies.

Although the experience of improvising was a highly interactive one for Jack, this was evidently not where his greatest need lay, or presumably this property would have led to more important outcomes in his therapy. In effect, in singing his songs, he was able to 'express' his difficult feelings to the therapist, therefore heightening the interactive component.

8.4: Discussion.

Although this case study has highlighted the importance which pre-composed songs held for an individual in their therapy, the reasons underlying such importance have not followed those put forward in previous music therapy literature. It was not the messages or themes of songs which were prevalent or fundamental in Jack's use of song as stated by so many therapists who use song techniques. There may have been some implicit meanings held in the verbal material of songs, although this did not emerge in the analysis. Nor was it simply that songs stimulated life review and therefore raised self-esteem for Jack. There was in effect no evidence in any of the analyses that he had a raised sense of self-esteem from musical life review. Therefore the proposition of musical life review affecting self-esteem has not been supported here. The meaning held in the songs by Jack as not merely in the verbal themes. Certainly his private meanings were recognised by the therapist, and in this way it could be seen that he held relationships with his particular songs, as noted by other music therapists working with chronically ill (Berman, 1995). In considering Jack's primary needs, greater understanding of the overall music therapy process can be gained.

For Jack, it was the fundamental need to find some way of expressing all the pent up feelings about his painful life which caused the songs to be so powerful for him. In this way, biographical work, as described by Corbin and Strauss (1987) was facilitated. This was not merely in terms of association

through revisiting and reviewing life events, however, but reviewing and reworking life's emotional experiences. Not only was it the emotional expression held in the songs, but it was that he was able to share such, implicitly within the music, with another who offered him the therapeutic space to do so. This validated his emotional experience. Furthermore, he was able to do so in a way that held great personal importance to him, that is, through singing. Corbin and Strauss (1987) suggest that chronically ill individuals who have experienced bodily changes refamiliarise with their body through testing physical limits and attempting performances, making comparisons in terms of temporal and situational parameters. Certainly Jack was seen to do this with his vocal activities, to achieve greater senses of independence, skill and ability, which helped to shift his sense of identity and achieve performance validation from the therapist. Once more, this was more immediate and personally relevant to Jack through singing songs than through improvisation. It must be acknowledged however that the act of improvising was an interactive one for him, and that implicit emotional processes may have been taking place which were not overt in Jack's material nor the analysis. Certainly within clinical supervision of the musical material, interpretations were given of the instrumental improvisations, in combination with Jack's verbal and behavioural material, which suggested that there were implicit meanings in the music. It would be limiting to consider that deeper processes had not taken place at all for Jack merely because he was unable to articulate them. As Pavlicevic (1997) has pointed out, clients often musically 'know' that something has happened in improvisation even if they are unable to reason this process verbally.

One explanation for Jack's lesser experience of improvisation may be offered in considering his neuropsychological functioning. Testing revealed that despite being able to attend and respond well to auditory tasks, he was repeatedly found to be impaired on tasks requiring him to block distracting

auditory material. In considering the skills required for participating in improvisational activities, this might offer an explanation as to why he was able to attend and became so engaged in turn-taking tasks, which involved simple auditory information, but had greater difficulty with the more complex auditory material presented in a musical improvisation. Jack's foremost preferred way of participating was singing, and therefore, his most meaningful active participation in joint music making was by singing. Furthermore, his concrete thought processes, subtly affected by his pathology, limited an adapted use of this familiar material. Although vocal improvisation of unfamiliar material and vocal extemporisation on familiar songs were attempted, Jack's understanding of singing involved singing the words to his preferred songs and the melody line in a specified format and order.

Further explanation may be drawn by considering Pavlicevic's view on the ability to express interaction and emotion in improvisation for the client who is severely mentally ill (Pavlicevic, 1995). Her postulation that for the client who is damaged in their ability to interact, musical interactions will be further limited by the musically unskilled client's discomfort in using musical instruments. Although Jack was not 'mentally ill' per se, his interactions were notably impeded by his emotional coping strategies and also his apparent institutionalisation. His unease in using the instruments and his specifications about skill which would enable him to 'express himself' are certainly reflective of Pavlicevic's stance. The combination of a lack of skill and his uneasy interactions were audible within his improvised musical interactions, and reflected by improvising failing to shift self concepts of identity. Hence although improvising was interactive, it did not hold as much meaning as singing and playing songs together, and therefore had less emotional impact for Jack.

Some consideration must also be given to the strength of his coping strategies within music therapy. Repeatedly, Jack presented with his 'happy' coping front. It must be questioned whether in addition to the stigma of physical disability there was additional stigma held for him in not being 'happy', particularly considering his past of depression. Although the therapist believed the music therapy session to be a time when such fronts could be dropped and more difficult feelings acknowledged, the only way that Jack could ever do this safely was in his songs. In a client-centred approach, understanding the role that songs served for him in acknowledging these difficult feelings in a controlled way was critical. For Jack, 'control' as a concept was central to his illness management. This has been widely cited in the literature as central to the individual management patterns in chronic illness (Charmaz, 1987; Robinson, 1987; Corbin and Strauss, 1987).

It must be stressed, therefore, that in understanding the effects of music and the therapy process for Jack, it was essential to consider his physical, neuropsychological, emotional and behavioural states. An approach which considered only his 'psychological' or 'social' states would fail to interpret his use of song for illness monitoring. This suggests a biopsychosocial approach which encompasses the client's presenting problems from all angles, including personal history (Engel, 1997). Using this model helps the clinician to develop an understanding of the client's situation from a gestalt viewpoint.

Considering Thaut's postulation that an individual attempts to seek out rewards that maximise changes in alertness, arousal, activation, emotional responses, pleasure, reward and motivation (Thaut, 1990), it is clear within this case study that in his experience of pre-composed music Jack was able to maximise the experiences of emotional responses, pleasure, reward and motivation. Considering these, his motivation for using improvisation were severely reduced. Within the improvisations he engaged little on an emotional

or musical level, although within structured turn-taking there was clearly a heightened sense of arousal, and verbally he stated that he thought such activities were 'great fun'. However they failed to arouse strong pleasurable emotions within him.

Despite his illness process and the difficulty which Jack was experiencing in vocalising, he used the songs within his music therapy as a way to defy his illness process. Jack once stated that 'to sing is to live'. It can only be hypothesised here what singing truly represented to him. Was it actually life's breath running through him? Certainly he gained greater meaning in life through his act of singing songs within a therapeutic relationship.

CHAPTER 9

INDIVIDUAL CASE STUDY:

'JESSIE'

9.1: Background summary.

Jessie was a 53 year old woman of Afro-Caribbean origin. She had started showing symptoms of Multiple Sclerosis 13 years prior to this study, and presented with the chronic form of the illness. In referring to this woman's personal background and details of her therapy material, which are provided in the Appendices 14 and 15, it is clear that she had considerable emotional needs due to the extreme loss she had encountered. In particular was the loss of her sight, which affected all aspects of her life and severely reduced her opportunities for independence, interaction and control over even very small aspects of her life, despite her relative 'ability' which remained in terms of her verbal communication and physical functioning. As detailed in the section covering her therapeutic process (Appendix 15), Jessie was more responsive to clinical improvisation. To gain full appreciation of how involvement with improvising affected Jessie, it is essential to examine her experience of **Identity** and her **Coping strategies** for dealing with the emotional consequences of her illness, particularly the properties pertaining to each of these categories.

Jessie's improvisations were highly rhythmic and syncopated in nature. Audio extract 4 is an excerpt from one improvisation in Session 25. Within this, the rhythmic complexity and sophistication of Jessie's music can be heard. For this improvisation, Jessie had chosen a rotary drum and cymbal, played out to her side, and a pair of bongos on her tray. She therefore had to locate all of these during the improvisation, two of which were outside her normal range of movement. She played all of these with a beater. The therapist played an African shaker and the conga using her hands. Due to Jessie's visual loss, she was not confident to play more than one instrument herself in any one improvisation. It was an ongoing aim of therapy, however, to increase Jessie's exploration of novel experiences, and to develop her feelings of confidence

through improvising. This extract is taken from a longer improvisation. The initial rhythmic patterns are played by the therapist, reflecting patterns already given by Jessie which are typical of her musical material (4/4 ♩ ♩ ♩ ♩ ♩ ♩ ♩ ♩). Jessie can be heard to initiate a development of this rhythm (4/4 ♩ ♩ ♩ ♩ ♩ ♩ ♩ ♩ & 4/4 ♩ ♩ ♩ ♩ ♩ ♩ ♩ ♩). Further variations and developments of these rhythms are alternated between Jessie and therapist, and each take turns in providing a supportive base or developing an idea. Jessie can be heard to move quickly between instruments, starting a pattern on the cymbal and finishing it on the bongos. This rapid alternation between instruments illustrates how she was carried along by the momentum of the music, taking risks which she normally would not have the opportunity to do. Although some therapists may question whether this is true 'clinical improvisation', the principles of communicative music making can be clearly heard through the interactive elements, the anticipation of musical ideas, and the extension and development of musical responses.

Despite the energy and drive typical of Jessie's music, the therapist's clinical supervision emphasised the need to be sensitive to the fine level of emotional expression in her music.¹ Having additional psychodynamic interpretations of the musical material was useful for working with someone very disabled, as it is easy to become desensitised as a way of coping with the loss expressed by the clients in their music.

Jessie only occasionally revealed the coping strategies she employed to deal with her profound emotional state. As will be recalled, examples from the category 'Coping with the emotional', described how individual clients drew on particular coping strategies to deal with emotional responses which were difficult or uncomfortable, particularly when the relationship with the therapist

¹ Given a description of Jessie and her background, the clinical supervisor interpreted the 'strong' rhythms typical of her music as an attempt to hide a more vulnerable self, and the 'weighty nature of the clinical improvisations (thick, unvarying textures, few pauses or silences) as attempts to present a 'strong' self.

was less established and less trusting. As the therapy relationship developed, Jessie increasingly communicated that her emotional responses to her illness were those of loss, distress and suppressed anger. These were indicated through her behavioural, musical and verbal material. She therefore identified feelings which were classified as non-coping and at times openly acknowledged them. For example, nearly every week when she was approached she stated feeling 'fed up' and in the ensuing session expressed a variety of statements such as 'I can't go on much longer like this', or 'What a life!'. Occasionally within sessions she reflected that during the day she was able to 'switch off' from such feelings, and that it was only at night time when she was alone that the 'tears rolled down' her face. She frequently revealed the need to make sense of why she had MS, asking 'What have I done to deserve this?'. She also revealed a sense of having little control over her situation at any time, indicated through many claims of her personal effects having disappeared over the years, and having little control over her personal finances. When questioned a little deeper, it emerged that she believed herself an 'easy target' for thieves and those who would exploit her because she was blind, causing her to have little control over or sense of her environment. Concepts pertaining to **Identity** were therefore key to Jessie's therapy.

With the other participants, a heightened awareness of difficult emotions led to strategies involving adopting a coping front. As the therapy process developed, Jessie gained greater trust in the therapist. The combination of a high degree of loss, low sense of control and increased duration of therapy resulted in her openly acknowledging her emotional responses to her situation. In examining her coping strategies, she continued to hope for a cure ("I wish my eyes would open"), hope for some type of change within her life, and continued to express a need to know why she had been struck with MS. Although within others such responses often led to 'projecting' as with Jack

who called his MS a 'throat virus', Jessie did acknowledge her illness and referred to it by name. Several times within sessions she relayed her own personal illness trajectory, emphasising in particular her loss of eyesight and the series of hospitalisations which impinged on her professional life affecting her sense of professional identity.

It can be noted that most interview extracts presented within this analysis are drawn from the latter part of therapy (sessions 17 - 25). During interviewing in the earlier research sessions (sessions 12 - 16) Jessie adopted a 'disabled' role, lacking confidence to express any opinion or preference. She often responded 'I don't know ...what do you think?' or 'Do you think I'm daft? or 'Maybe I'm talking rubbish?'. The fact that a greater duration of therapy was needed in order to collect data which was more representative of her individual responses rather than those of the 'good interviewee' reflects one aspect of the process of the therapeutic relationship. Particularly within the sessions in the latter half of the research period, Jessie did not dismiss her non-coping feelings, and related such feelings directly to herself. The following example gives some indication of the resources she used to try and continue 'coping' with her never ending situation. She draws on both pre-illness references and also family identity to muster her coping mechanisms. This extract also reflects the interpretations made by the clinical supervisor at an earlier date regarding her use of 'strong' expression within musical components as a coping mechanism.

Example 1:

(From: Session 21, Improvisation)

MT: Is that how you cope now if you're treated in a way you don't like?

Yes, I still cope. I still cope ... I still cope. I
never really can't cope

**TEMPORAL REFERENCE
TO COPING (present &
ongoing)**

MT: It must be hard to cope all the time ...?

It is, but you have to try, try hard. I don't know if
I've got any left now to cope. I cope so much In the past....
I come from a family of very strong women..... strong ...
strong ...strong

STATING RULES
PRE-ILLNESS ABILITY
IDENTITY

MT: You mention 'strong', but I wonder what it would mean to be weak ...?

Given up, can't carry on, can't cope anymore ...
just sit there, don't speak ... I think weakness kills you.
You should try and be strong. There are days when
I feel weak, but then I snap out of it by the next day.

NON-COPING FEELINGS
NOT RELATED TO SELF
STATING RULES =
STRATEGY TO DEAL
WITH NON-COPING

Jessie was unable to 'keep busy' as so many of the other participants did in order to cope. In this way, she had fewer coping strategies from which to draw. Hoping for her 'eyes to open' remained one of her only ways of coping with her devastating losses. The lower frequency of adopting the coping front resulted in an increasing acknowledgement of her illness and reflecting on the the change it had caused in her life. In referring back to the previous section on 'Coping with the emotional', it is clear that she readily moved into the area of **Barriers down**. This was particularly evident as she related to the emotional changes in her life rather than solely the physical ones which the other participants had tended to.

There were occasions when, in a similar way to the other participants, the emotional consequences of her illness were too much to bear. At these times she did focus on the physical experience of improvising rather than any emotional content within the music. In session 15, she became extremely anxious on arriving at the session. Her voice was weak throughout the session, as she started to cry and ask questions about what she had done to 'deserve' her illness. Choosing to play the autoharp, the music she played

was slow, heavy and laboured, affected greatly by her difficulty even to sit upright in her chair, and subsequently affecting both her position and her physical manipulation of the instrument. As she spoke to end the improvisation, she commented 'good exercise for my arm'. By focusing on the physical experience in this way and monitoring the physical performance of her arm, Jessie distracted herself from the emotional experience of the music, and indeed, herself.

The following extract epitomises Jessie's verbal reflections which occurred later on in therapy about the changes to her abilities and how these affected her life. The properties of **change over time, changes to her identity** as a consequence of disability and the resulting **isolation** caused her to seek some sort of framework to make sense of what had happened to her.

Example 2:

(From: Session 23, Songs)

Well, I wish I could write my own letters, I've got lots of letters to write. I miss contact with all my friends. I don't know where they are since I came here. I didn't write to them because when I was blind in the right eye I thought the left eye would come better and I'd see better to write. But it got worse, and I can't see at all to read or write. And I lost contact with a lot of friends...which is a shame really, because I don't know where they are, and they don't know where I am.... I lost touch with all of them. With every one. And that upsets me sometimes. Sometimes at night the tears comes down, and I thought, why is this happening to me, what have I done?

LOW ABILITY & INDEPENDENCE
ISOLATION
LOSS
RELATIONSHIP OVER TIME
CHANGING ABILITIES

DISABILITY INCREASED OVER
TIME

LOSS
ISOLATION
LOSS AND ISOLATION
RELATES NON-COPING TO SELF

SEEKS SENSE FRAMEWORK
(COPING)

It is possible to draw a picture of Jessie's **illness experience and Identity** using the themes identified above. It is essential to examine this at this stage in order to understand the effect music therapy had upon her. A sequence of conditional situations and actions is depicted in the following diagram. It reflects how under the key properties pertaining to **Identity**, Jessie had a very low frequency of experiencing the positive aspects of the property **ability**. It is important to note that there is also a frequent comparison between how her life was before she was ill when she was working to the present time. Jessie derived great esteem from relaying her responsibilities and actions when she had been a nurse, particularly in her ability to help and care for others. Her professional life had clearly given her a sense of achievement. This contrasted starkly with the isolation of her current experience and the role reversal as she found herself dependent on others. It is also important to note her own reaction to the lowered value of the properties **'ability'**, **'independence'**, **'ownership'** and **'skill'**. Jessie withdrew herself further from any opportunities to challenge this experience by actively refusing participation in any event such as sitting in the day room, trying new therapy groups, or even attending weekly concerts held in the hospital. Her repeated refusal of everything resulted in an increase in her passive experience, and reduced opportunities for novel experiences which might have challenged her ongoing sense of **disability, loss, dependence** and offered her a chance to experience **challenge or success** in an activity. In actively refusing any contact with others, Jessie in one sense increased her control over the situation, although the outcomes of such were **isolation** and an **increased sense of her disabled Identity** overall. The essence of this process is illustrated in Figure 12.

It appeared that Jessie had a severely damaged sense of identity due to the devastating effects of her MS. Her loss was experienced on many different levels: materially, emotionally, interpersonally and within her own identity.

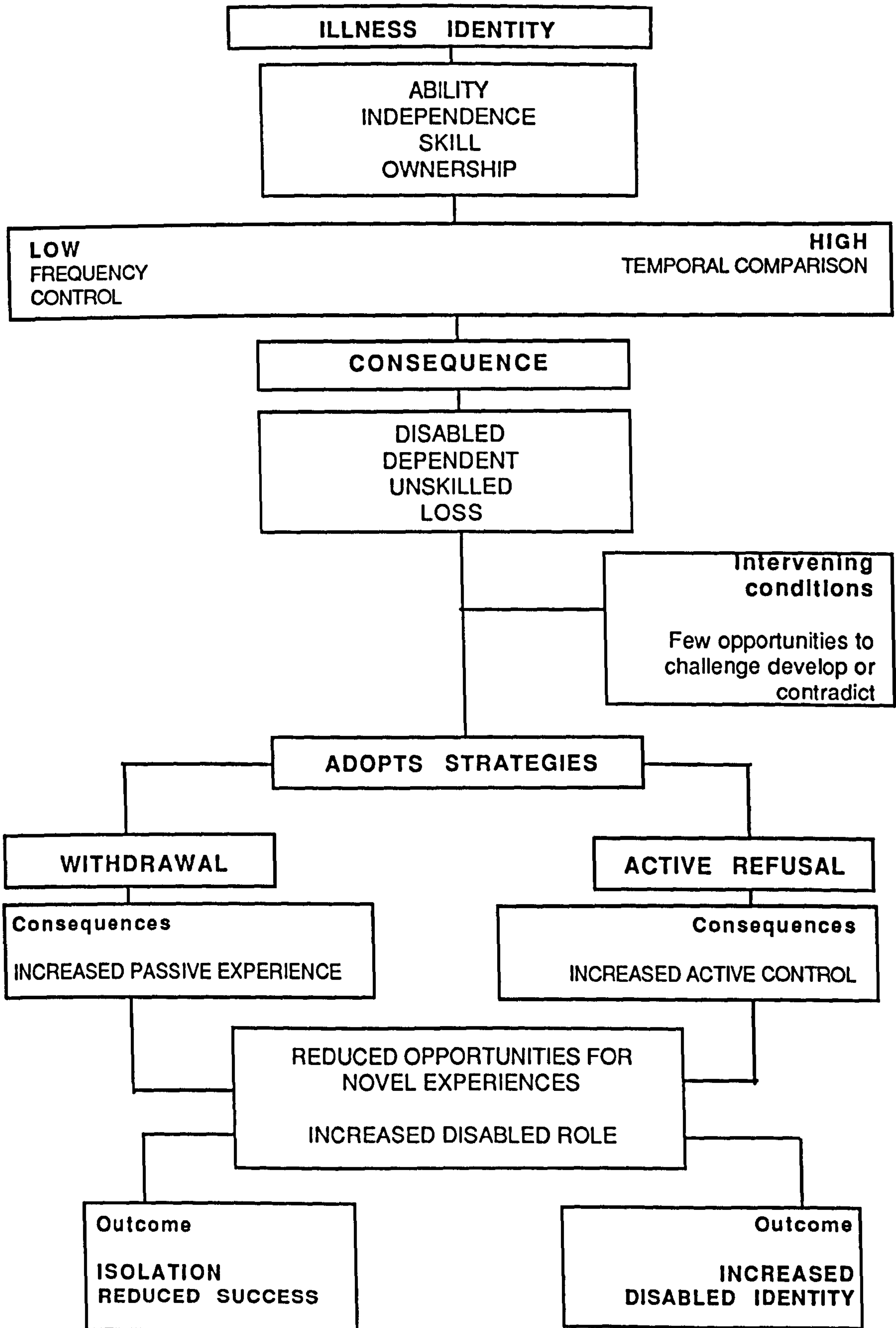


Figure 12: The process of reinforcement of Jessie's disabled identity .

There were few opportunities within her current experience for her to gain a sense of ownership, either materially or creatively. Furthermore she increased her own disabled identity and passive acceptance through the coping strategies she adopted, which essentially prevented any opportunity to challenge her illness identity in a meaningful or non-challenging way. Her life was significantly impoverished as a result of her disabilities and hospitalisation.

It was within Jessie's experience of improvisation, however, that concepts related to identity were challenged directly and repeatedly.

9.2: Analysis and results: Jessie's experience of the music.

In the following extract, Jessie describes an improvisation. What is immediately noticeable is the mood or feeling she uses to describe the music - 'lively'. Such a mood is highly contrasting with the customary non-coping feelings which characterised her descriptions of her life. Such a mood also contrasted with those she used to describe the familiar pre-composed music (see example 6). This mood or emotional state, categorised under more 'positive' coping feelings, continues throughout the extract as she entitled the piece 'joy or happy', and described feeling 'roused' or stimulated by the music. She indicated that such feelings were a consequence of the high levels of ability experienced. She also highlighted further properties of her experience of improvising as she introduced the concept of 'ownership'. Through a combination of ownership and higher levels of ability, she then identified feelings of skill in the word 'professional'. Additionally, as the experience of improvising was a highly interactive one for Jessie, the overall experience was able to be shared with another in a more tangible and meaningful way than spoken words, where her behaviour, sensory and

memory impairment and psychoses distorted her sense of reality. The outcome of the overall experience was one where she had a positive sense of self, which differed so markedly from her usual experience. Furthermore, through identifying the experience as 'professional', parallels could be drawn with the descriptions she gave of herself when she was a 'professional'. It was known from such descriptions that her sense of 'professional' was one with a higher level of ability and independence, who gained so much from helping others who were dependent.

Example 3:

(From: Session 17, Improvisation)

MT: How would you describe the music that we played?

Sounds lively ...

IDENTIFIES POSITIVE MOOD

MT: Was it something you'd heard before?

No, it was just something out of my head.

HIGH OWNERSHIP

I don't know what I was playing really.

UNFAMILIAR

Just something going out of my head.

HIGH OWNERSHIP

It was tasteful, anyway ... I think it was good ...

POSITIVE RE OWN MUSIC

sounded alright .. as if we knew what

" "

we were playing .. as if we knew a

HIGH ABILITY

special song or something. As if we

knew what we both were playing ...

HIGH INTERACTION

it was very corresponding.

" "

MT: If there was a title to the piece, what do you think we would call it?

Um, 'joy', or 'happy'. It sort of roused me.

HIGH EMOTION

Yes. It sounded like a professional

HIGH SKILL

musician playing ... Maybe I was thinking

I knew how to play these instruments.

HIGH SKILL

Wish I knew about them. Knew how

to play them songs I know

sometimes I don't know what I'm playing,
but it sounds alright. Such gorgeous
instruments!

UNFAMILIAR
POSITIVE RE OWN MUSIC

By analysing the above extract in this way, the elements of Jessie's overall experience were broken down to reveal that the changes in mood she described were more than merely 'cheering her up'. As already stressed, it was not the purpose of therapy to change her mood simply, however, through the raised value of identity, combined with heightened interaction, such a result occurred. More importantly, Jessie was able to make positive statements about herself with regard to the experience.

In the following example, she expressed heightened feelings of emotion which were in complete opposition to her more frequently indicated lower mood states. She often repeated similar feelings after improvisations. The only other times she came near to expressing such positive emotional states were when she reminisced about her past and her family. The descriptions within the following example stand out as they are about a situation in which she was presently involved, therefore reflect the 'here and now' situation of reality.

Example 4:

(From: Session 19, Improvisation)

MT: I wonder whether you're able to describe to me in your own words how it feels improvising together?

It feels lovely. It feels rhythmy. We're
playing rhythm together all the time.
We correspond together quite well.

HIGH EMOTION
HIGH INTERACTION
“ “

MT: What's that experience like for you? Coming down here and playing music with me and corresponding in sounds...?

It's a lovely experience Wendy. A beautiful experience. Cheers me up anyway. Feels better afterwards. And as I've told you more than once that I love music.

HIGH EMOTION
MOOD CHANGE
TEMPORAL COMPARISON
(withIn session)

In example 5 she refers to unfulfilled hopes and ambitions as they relate to the music. This indicated that improvising facilitated life review for Jessie as she reminisced verbally about her native culture, significant relationships, and explored hopes and dreams of 'what might have been'.

Example 5:

(From: Session 21, Improvisation)

MT: What was going through your mind when you were playing that?

Nothing really. Just happiness. Or thinking to myself 'wish I could have been a musician'. Yes.... too late now.

EMOTION FACTOR
UNFULFILLED HOPES
" "

The above examples demonstrate that her experience of improvisation widened the range of emotional states experienced by her. **Ownership** and **creativity** within the experience of clinical improvisation were significant for her, and markedly opposed her frequent verbal expressions of **loss**. The themes which began to emerge from her experience of improvisation particularly concerned properties of **Identity**. These can be illustrated in terms of property range values, as shown on the bipolar continuum in Figure 13.

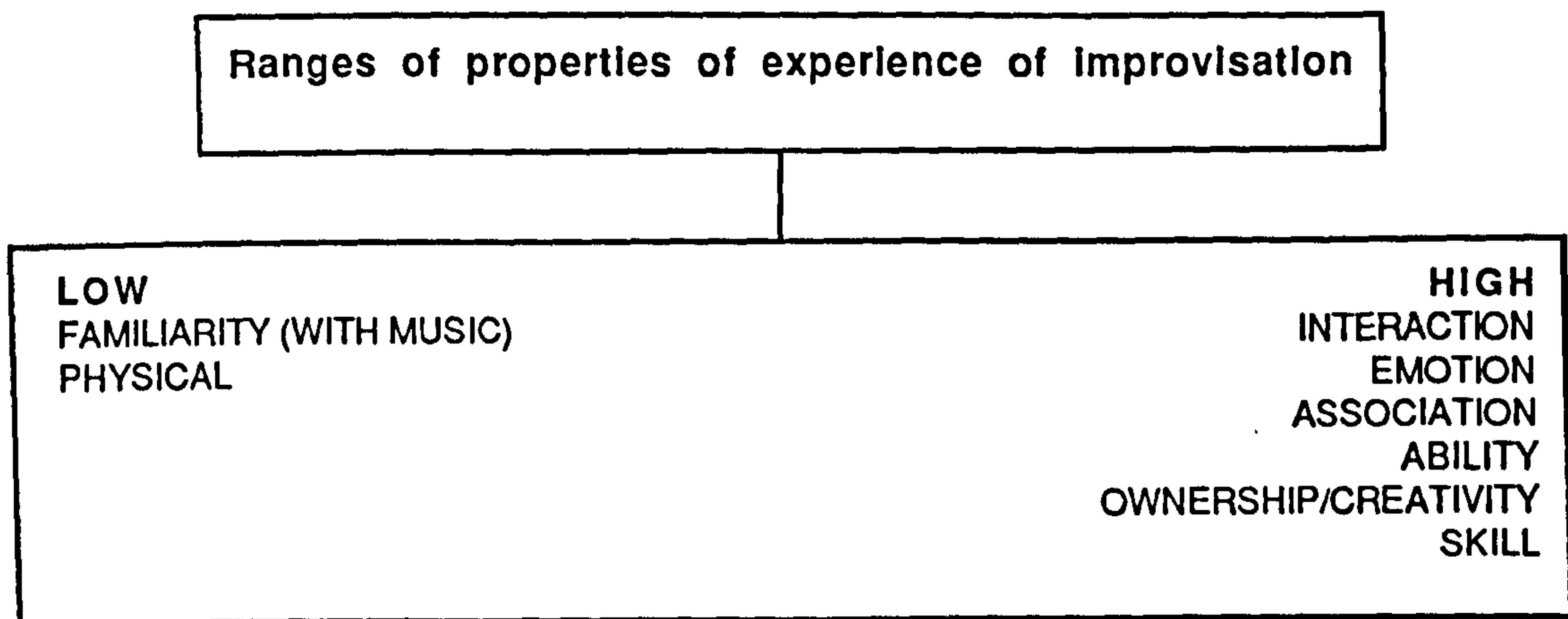


Figure 13: Concepts pertaining to Jessie's experience of improvisation with value ranges.

Already her experience of improvisation can be seen to be causing a shift in key concepts in **identity** (ability, ownership/creativity and skill). Also, she has differentiated the experience of specific concepts within the musical activity. Improvisation can be seen to possess greater interactive and emotional components, and lesser physical components and familiarity.

In the following examples Jessie repeatedly referred not only to the highly interactive nature of the improvising, but linked this with having a heightened sensation of feeling 'challenged' by improvising. This differed from her descriptions of song-based activities, where she felt far less challenged, to the point of even being passive. The familiar properties inherent in songs, in addition to the lower properties of interaction, seem to have contributed to the lower challenge for Jessie. Improvisation, on the other hand, increased both active involvement and interaction and involved structures which were not familiar. Although she was asked about songs on the radio, it is emphasised here that using songs in therapy differs from just passive listening to the radio

where the interactive elements with the therapist are absent. The inherent structures in 'songs', however, i.e. familiarity and words, and the physical activity i.e. 'sing', serve as relevant reference points in her comparison to improvisation.

Example 6:

(From: Session 19, Improvisation)

MT: I wonder when you're playing, what you're thinking, or what it's like for you playing music together?

Ah, very nice. Sometimes I wonder

If I'm following you, If we're on the
same track, but then I think 'oh yes
we are doing the same'.

HIGH INTERACTION

MT: I know that you listen to a lot of music because you have the radio on all the time.

Yes, I do....That's quite different.

MT: I wonder how it's different for you, from listening to music on the radio?

Well, they both have a different sound that I like.

Listen to music on the radio and
there are songs that I know and I
listen to the words and I might sing as
well, but this is quite different,
this is a different type of music. Cause it's
something which I can play, to
make sound, if you don't mind me
saying, and we try to correspond together
with it and get the rhythm right, and
the sound, just to see if we can do something
about it, you know make sounds seem nice
or better.

PASSIVE

HIGH FAMILIARITY

LOW CHALLENGE

HIGH ABILITY

HIGH OWNERSHIP

HIGH INTERACTION

HIGH CHALLENGE

HIGH INTERACTION

HIGH CHALLENGE

MT: I wonder what's so special about, as you say, 'corresponding with each other' in rhythm, I wonder what's so good about that?

To get the music together! You know,
get the sound almost the same way,
like you're playing up there and I'm playing
here, we can make one sound together,
you know, that we're corresponding.

HIGH CHALLENGE

STEMMING FROM

HIGH INTERACTION

“ “

“ “

Within this example and the following, the experience of 'challenge' was a consequence of not only **ability** and **ownership**, but more so of the **interactive** element. Through facing the challenge and meeting it, she expressed feelings of **achievement**, **skill** and increased motivation and arousal as a consequence.

Example 7:

(From: Session 21, Improvisation)

MT: When we are improvising like this together, what do you think is an important thing for you when we're playing together?

Playing.....trying to get the sounds match,
or something like that.. I get a lot, I
get extra energy actually. I don't know
where I get it from. I just seem to play, play,
play, and um, playing something,
It feels *professional*, as if it's something
you're really doing that you learnt to do,
you know I think Improvising takes more
energy. Than singing. I think Improvising I get
more and more interesting, and get more
energy, more and more. Sort of, you know.
It feels as if you're doing something really
professional. You know like knocking that
and that (knocks m/phone) and I think
'My God, Is It professional, I must do it
properly', and you're doing it to sound
good, and you're using a lot of energy
without even thinking.

HIGH INTERACTION

INCREASED MOTIVATION

ACHIEVEMENT

INCREASED SKILL

“ “

INCREASED MOOD / AROUSAL

INCREASED MOOD / AROUSAL

INCREASED SKILL

INCREASED SKILL

HIGH CHALLENGE

INCREASED MOOD / STIMULATION

Such feelings were not stimulated by her experience of songs which had a lower value of challenge and interaction and resulted in being 'relaxing' as shown in Example 8. Whilst the outcome of 'relaxation' is not necessarily a negative one, the increased arousal Jessie experienced as a consequence of improvisation was a far more relevant and contrasting one from her regular experience, and therefore an important aim of the therapy.

Example 8:

(From: Session 21, Improvisation)

.... because singing's just.. relax a bit and sing. I get a lot of energy playing without singing, and get more and more interested in playing, using more energy, cause you feel there's something you're getting out, something you've known and you want to get it right, but with singing, singing is sort of relaxing to me, you know, just sit and sing songs, that you know the words by heart, you know the tune, you're just singing relaxing, sounds really nice, and

LOW CHALLENGE (songs)
INCREASED AROUSAL & MOTIVATION (Improvisation)
 " "
 " "
HIGH CHALLENGE
LOW CHALLENGE
 " "
HIGH FAMILIARITY
LOW CHALLENGE

MT: Are you saying it's not as stimulating when you sing?

It does, but not as much as playing the music I don't think.

LESSER CHALLENGE

In comparing her experience of the song-based activities with the improvisation, the continual reference to 'corresponding' was not made in relation to the song-based activities, although on one occasion Jessie suggested there was something similar in the experience for her. This indicates that her experience of the song-based activities was not highly interactive. Other differences centred around values pertaining to ability. The processes involved in such will be explored in more detail in the discussion of

this section. An immediate comparison of the two, however, is presented in the Figures 14 and 15.

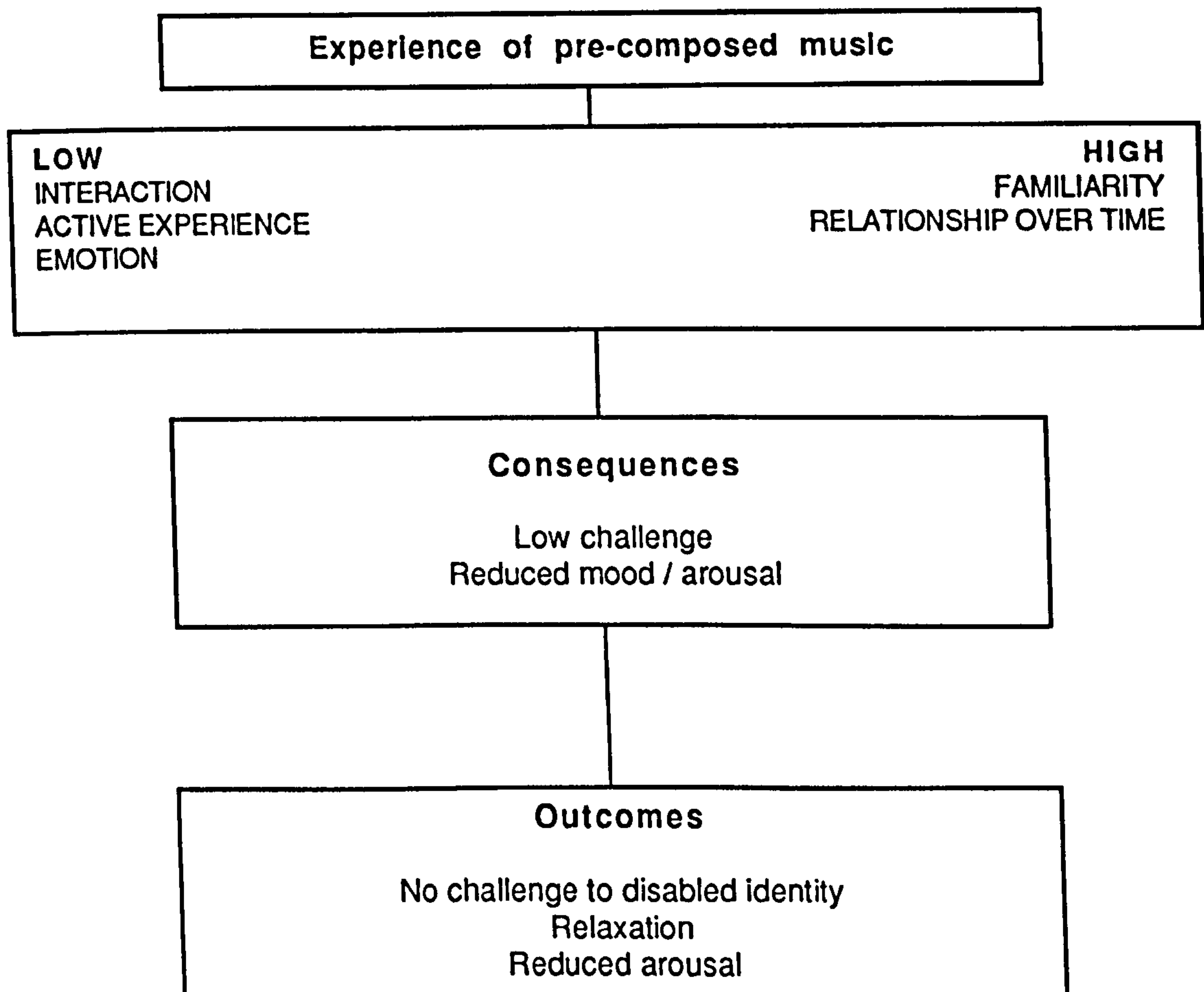


Figure 14: Jessie's experience of songs leading to relaxation and no change to disabled identity

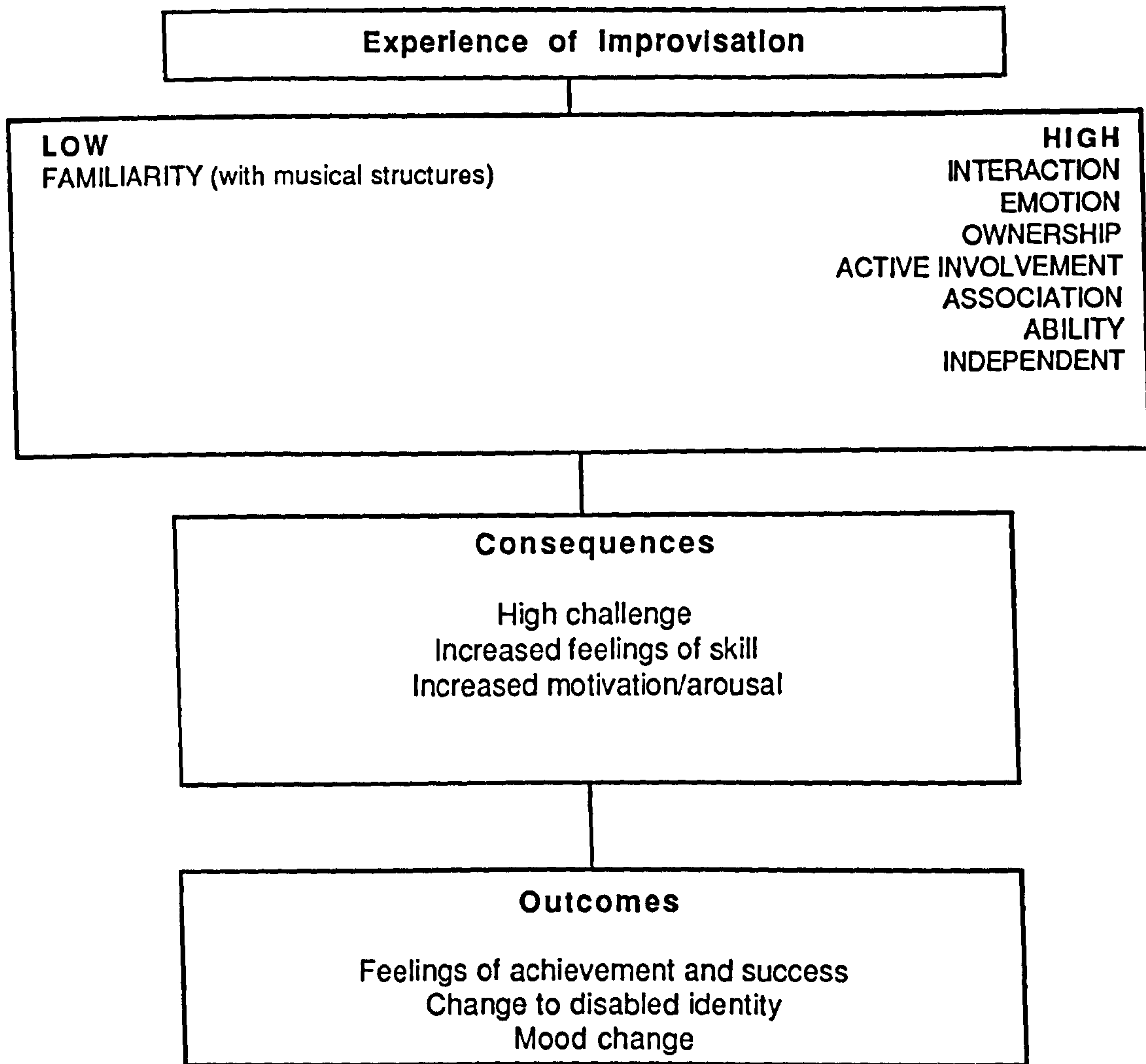


Figure 15: Jessie's experience of improvisation leading to a change in mood and to disabled identity

The following two examples compare further aspects of her experience of the two activities. Jessie highlighted how it was the non-verbal aspects of the interaction which validated her experience, and pinpointed this as being a contributing factor to her feelings of success. Furthermore, she described the **skill** she felt she was developing through the process of improvising. This is really important when considering the lack of opportunities in her life to experience this. Improvising was perceived as a **skill** which developed over time, and for Jessie, increased feelings of motivation.

Example 9:²

(From: Session 25, Improvisation)

MT: What about the music between us?

I think we are corresponding well. Corresponding well.....That's why it was coming so good, because we weren't saying anything, just playing and listening to each other, and follow one another and playing what you were playing. Makes it nice.

HIGH INTERACTION**HIGH SUCCESS****HIGH INTERACTION**

" "

" "

MT: You were saying earlier there's a difference between playing to music that you know, and playing to music that's improvised?

That's right. Different. (Pauses) But also improvising ... suppose you playing something, you sort of learning as you go along. It feels as if you're singing a song, and you're carrying on and on and on with it, and you're singing more and more as you go along, and you're learning what you are singing, or what you are playing. It's like a song itself, like you're singing something and you know, although you're not using any words, but carrying on and it's all there.

DEVELOPING SKILL**INCREASED MOTIVATION**

" "

DEVELOPING SKILL

Within the same interview, however, she described how through the process of cognitive monitoring, singing songs actually reduced feelings of ability as she felt her memory let her down in remembering the words. In this way, it was understood that the song-based activities actually reinforced a disabled identity, as well as failing to stimulate or motivate her.

² Refer to Audio extract 4, the improvisation which preceded this interview.

Example 10:

(From: Session 25, Improvisation)

MT: ... but if we sat down and did a song now, how would it be different?

It's much different really because you're
singing, and with me I can't remember
the words of the song, only sometimes,
and it's just singing.

**LOW ABILITY (through cognitive
monitoring)**
LOW CHALLENGE

Lower feelings of ability combined with lower challenge are repeated in the following example, again monitored by memory. In reality, problems with memory or poor recall of the previous weeks' material were never noted by the therapist. However Jessie monitored any changes in her memory through singing familiar pre-composed music within sessions. Furthermore, she made such a comparison alluding to previous memory capabilities i.e. pre-illness abilities. Within this example, she described the property **success** as a result of high **independence** and high **ownership**, in turn resulting in greater feelings of stimulation.

Example 11:

(From: Session 14, Songs)

Ah, well it's something I'm used to now.
You know, not remembering a lot.
It's not nice, but it's something I've got used to.
I don't remember a lot these days any more...
Maybe to play your own music
is more successful. Cause is something
you're doing for yourself, you know,
you're doing it from your own thinking,
or whatever, ... your own way, or
you feel more, or you want to carry on.

COMPARISON OVER TIME
LOW ABILITY
LOW CHALLENGE
CHANGED ABILITY OVER TIME
HIGH OWNERSHIP
HIGH SUCCESS
HIGH INDEPENDENCE
HIGH OWNERSHIP
HIGH OWNERSHIP
**MOOD CHANGE (INCREASED
AROUSAL)**

In the following example, she repeated her reference to lower ability, and suggested that **ability** within the songs was conditional upon familiarity and being able to recall the words.

Example 12:

(From: Session 24, Songs)

MT: What was the nicest thing about doing the songs?

Everything. Just singing them, knowing the

HIGH FAMILIARITY

words, playing the drum (long pause) ...

wish I'd known more of the words actually.

LOW ABILITY

MT: So is it better when you know more of the words?

Well I can sing better.

**ABILITY DEPENDENT ON
HIGH FAMILIARITY**

However she also expanded upon this to suggest that although familiarity and ability were linked, familiarity also reduced levels of challenge, which was for her an inherent part of the improvising. Challenge was also related once more to skill, as though skill was a product of continuing challenge. Furthermore she suggested that high ownership also resulted in higher levels of challenge, as there was a greater challenge when trying to do something of one's own.

Example 13:

(From: Session 24, Songs)

MT: Can you tell me how it's different doing the songs to when we make up our own music and we improvise?

Oh, doing songs, well we're singing, and

when we improvised, we just playing. I

wouldn't say it's harder, but I think the

instruments are more of a challenge than

INCREASED CHALLENGE

singing I think.... maybe it's a challenge

" "

to do instrumental, and singing... cause you

know the words, and know the tune and that.

HIGH FAMILIARITY / LOW CHALLENGE

MT: Do you like the challenge of playing, or do you prefer the familiarity of knowing the words and the melody?

I think the challenge of playing the instruments, because with the words you know it, you know, and with the challenge of playing, you playing and getting better and better and better, and you know getting in it better and better, and doing your own thing, and you know, sort of ... just playing. And it's getting better all the time ... better all the time you're playing. I mean like the songs, it's something you know already, you know the words that's more challenging, it's something you're trying to make up yourself.

HIGH CHALLENGE
 HIGH FAMILIARITY
 HIGH CHALLENGE
 RESULTING IN
 DEVELOPING SKILL
 HIGH OWNERSHIP
 HIGH ABILITY
 HIGH FAMILIARITY RESULTS
 IN LOW CHALLENGE
 HIGH OWNERSHIP AND LOW
 FAMILIARITY RESULTS IN
 HIGH CHALLENGE

Drawing from the examples above, further causal relationships can be established showing the resulting emotional experience of each activity. When music was familiar and stimulated extramusical associations, it presented Jessie with less of a challenge to aspects of her identity, in terms of perceived ability, independence and feelings of skill. Furthermore, Jessie monitored her memory through her ability to recall the words to songs. In the case of familiar songs, this resulted in reduced feelings of ability. This expands upon Figure 14 in the following way (Figure 16).

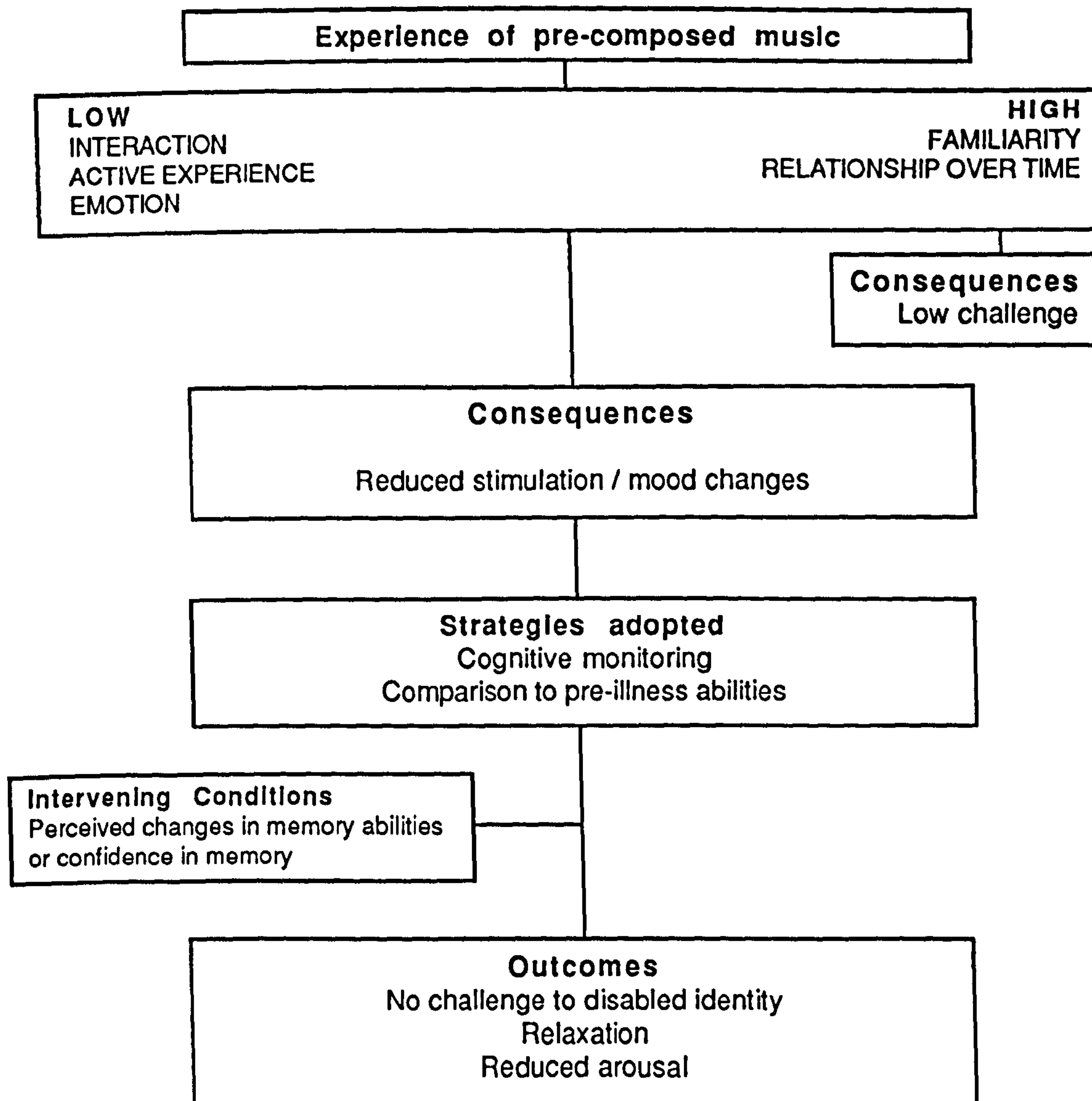


Figure 16: Jessie's experience of songs including the use of cognitive monitoring

Jessie did, however, specify that the songs remained enjoyable and meaningful to her due to the combination of high associative and familiarity factors, as well as the relationship they held over time, which stimulated life review, similar to Jack's experience. Yet the overriding therapeutic experience was the heightened sense of able identity, and that was achieved through the improvising. In the following example she explained her preference based on this experience.

Example 14:

(From: Session 24, Songs)

MT: When we do the songs that you know, what do you enjoy about them?

Songs that I know because I know the words,
 and maybe it's something I learn a
 long time ago ... like from a very young
 age I was singing those songs. I
 hear my mother singing them, or my aunties,
 or it's something you sort of think you grow
 up with ... you hear it so many times, you sing
 it so many times. Just part of life with it ...
 It brings back memories, yes. It brings
 back memories, I must say, yes.

HIGH FAMILIARITY

HIGH RELATIONSHIP OVER TIME

HIGH ASSOCIATION
HIGH RELATIONSHIP OVER TIME
HIGH FAMILIARITY
LIFE REVIEW

MT: And yet you also enjoy the challenge of improvising?

Yes, yes. I prefer that, because it's like it's
 something you're achieving ... on your
 own over time ... you know, you're achieving
 something of your own. Well, I prefer mine
 because with improvising, you're improvising
 all the time, going on and on and on, really
 enjoy what you're doing, you know,
 making your own song, or your words,
 and you're carrying on ... quite nice
 cause you can continue as much as
 you like.... you feel like you're
 doing something. You know
 achieving something.

HIGH ACHIEVEMENT
INCREASED INDEPENDENCE OVER TIME
HIGH OWNERSHIP

POSITIVE EMOTION
HIGH OWNERSHIP

HIGH CONTROL

HIGH ACHIEVEMENT
 “ “

9.3: Summary of results.

In returning to the original research questions, it can be seen that although Jessie did not spontaneously express a preference for either activity, song-based activities were not as effective in stimulating the therapy process of moving towards her core issues. Both types of music stimulated associations

for her, due to her cultural background, but improvisation was a more emotional experience. Despite possessing very familiar musical structures, relationships over time, and stimulating associative properties, songs did not initiate therapeutic change for Jessie, although she expressed enjoying them and finding them relaxing. She remained, however, anxious that she would not be able to participate in the songs due to her impaired memory. In this way, songs reinforced a more disabled identity which she held of herself.

The most influential factor in her experience of music therapy was the disabled identity she held of herself, causing the experience of improvisation to cause the greatest change for her. The fact that songs did not challenge her abilities or skills in a positive way meant that she found them less motivating and they did not increase her arousal levels. Clinical improvisation, on the other hand, presented a challenge to her disabled identity. Jessie gained a different experience of her abilities within improvisation. She felt increased ability through the creative process, and through being challenged in this way, felt 'skilled'. Furthermore, independence and ownership within the improvisation increased her feelings of success. Most importantly, through the interactive experience of clinical improvisation she felt more motivated, stimulated, and validated in her emotional experience.

Although neuropsychological tests indicated that Jessie had difficulty with conceptual thought in her verbal language, this was not reflected in her musical abilities i.e. the 'abstract' task of unfamiliar improvised music. Furthermore, her memory problems were not noted to affect her ability to imitate, extend and develop musical fragments within improvisation. Her confidence in her memory, however, did affect her feelings about how well she participated in activities using familiar pre-composed material within sessions. To summarise, Figure 17 contrasts the different effects each activity had on her identity.

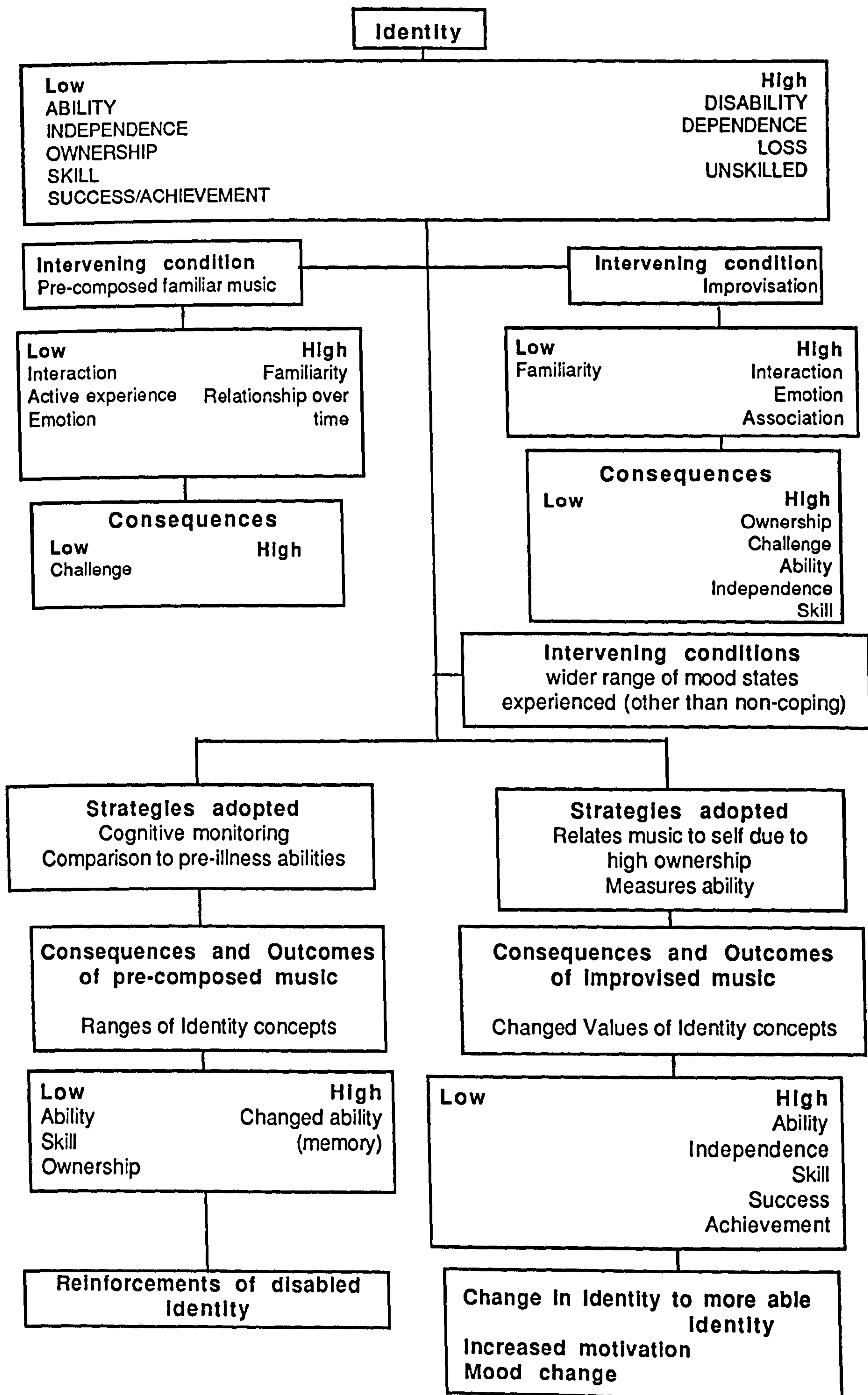


Figure 17: Effects on illness identity after each type of activity in Jessie's experience.

9.4: Discussion.

Jessie's responses to the different types of musical activity differed markedly from those seen in Jack's case study, and indeed in many other ways from the other participants in this study. Unlike Jack, it was the interactive elements of the musical expression within improvisation which were important in Jessie's experience of the music rather than the associative properties of songs, or the relationship they held over time. Jessie's needs, however, which have been described in great detail in this case study, were particularly individual. Referring back to the analysis on a thematic level, two subcategories strongly influenced Jessie's experience of the music.

Firstly, the relationship over time held within songs resulted in a series of properties and consequences for Jessie. The associative properties inherent in the songs were positive and enjoyable for her, as many reminiscences were stimulated of familiar people and things which were now lost to her. However, familiar pre-composed songs also facilitated comparisons over time of feelings of ability, independence, skill and ownership. Hence the relationship between songs and feelings of identity were closely bound, but with a negative effect. The outcome, therefore, did not change her self perception. Again, this differs from the case study of Jack, reflecting differing needs in the two individuals. Jessie had far less difficulty acknowledging and owning her difficult feelings, thereby reaching a state of barriers down more often and with greater ease.

Improvisation on the other hand, did not possess a relationship over time. More than any other property pertaining to the musical experience, the key property of improvisation lay in the interactive elements for Jessie. Although there were associative properties which stimulated reminiscence and life

review, this was not the key focus of her experience. Through the highly interactive elements contained within the improvisations, she experienced a sense of challenge in listening, responding, leading, following and in her own words, 'trying to come together' in the music. Such an interactive experience then heightened her arousal and emotional state, and expanded it from her usual depressed energy levels and motivation. Furthermore, the aspect of skill which she expressed so articulately was bound up in having her needs for interaction met. The developing skill to which she referred must also be considered within the context of relationship over time, particularly the level of skill which existed pre-illness. Playing music, improvising music, was an entirely new experience for Jessie, and thus challenged her illness identity through the creative act of music making for which she had longed and yet never had before.

Identity and feelings about the self are repeatedly identified in the literature as being central to the experience of the individual living with chronic illness (Charmaz, 1987; Corbin & Strauss, 1987; Conrad, 1987; Robinson, 1988; Brooks & Matson, 1987). Challenging identity through music therapy and forming a new aesthetic identity which transcends the physical has also been discussed in the role of music therapy in chronic illness and with the dying (Aldridge, 1995 & 1996). Although issues about physical performance may be central to the chronically ill individual's identity and concept of self, the physical experience was not central for Jessie. Her need for meaningful interaction on an emotional level, in which she was taken seriously as a credible human being, was at the core of her experience in the clinical improvisations. Through her role within the improvisation, the therapist served to validate not only Jessie's emotional experience as expressed through music, but also served as a 'performance validator', essential in redefining concepts of identity (Corbin & Strauss, 1987). Although the role of validation

has been identified as necessary within physical activities, in Jessie's case it can be seen to have taken place as well on an emotional level. This reflects Aldridge's parallel between the activity of mutual music making within music therapy and the 'affirmation of worth' which validates the individual's experience of hope (Aldridge, 1995: 106).

The concept of control and its role in maintaining self esteem for the individual living with chronic illness has also been given prominence (Corbin & Strauss, 1987; Charmaz, 1987; Robinson, 1988). The processes which Jessie used to gain some control over her loss and dependence, as illustrated in Figure 12, are those which Corbin and Strauss entitle 'accommodation' i.e. the actions aimed at achieving a sense of control over life despite the changes brought by illness (1987: 250). After the loss of self and wholeness which chronic illness causes, a new self concept can only be reconstructed with the possibility of discovery of new actions, thereby transcending the body. Jessie's 'accommodation', (outlined in Figure 12) however, increased her control in one sense but also served to reinforce her isolation and disabled identity. Clinical improvisation within a therapeutic relationship provided her with the opportunity to experience control and discovery of new skills through the interactive elements of spontaneous, non-verbal music-making. In this way, she did transcend her physical self. 'Transcendence' of the physical body, and therefore in a spiritual sense, is seen to be central to the experience of clinical improvisation in both this case study and the following. Particularly through the interactive interpersonal aspects of the improvisation experience, Jessie rose above the isolation and despair of her life. Although her sense of identity was so severely damaged, the seeds of the process described as 'identity reconstitution' (Corbin & Strauss, 1987) were evident in Jessie's heightened emotional responses within improvisation, as she moved towards a greater sense of wholeness. Furthermore, the unexpected

introduction of improvisation at this time in her life gave her opportunities to test her own physical limits and interpersonal boundaries within therapy. Such boundary work took place in a more creative way than her existing relationships, such as with those who cared for her daily needs on the ward, and of whom she complained 'do not take me seriously' and 'think me daft'.

Jessie reflects the picture of the chronically ill individual who is 'so immersed in illness that they cannot readily claim other identities in the external world' or 'move on' from their preoccupation with loss (Charmaz, 1987). The external world did not exist for Jessie, either through visual images, physical presence, or access. In fact it existed only through the news items of world disasters which preoccupied the content of her verbal material. Therefore opportunities to claim a more able identity were very limited and immensely difficult for her. Furthermore, her descriptions of her interactions with staff indicated that she felt great hostility and little respect from them. Jessie's feelings reflect the epitome of what Charmaz describes as professionals' responses of anger towards and withdrawal from the individual who is unable to 'move on' from extreme loss. Such responses from staff result in greater social and emotional isolation for the individual at their neediest time (Charmaz, 1987: 316). Brooks and Matson (1987) further describe the process of isolation for the chronically ill individual, stemming from a shift in self perception, strained social relationships and changed relationships with intimates caused by the increasing dependence on others. For Jessie, the interpersonal connections which took place within improvisation provided the support through the musical relationship, and reassurance through the reflection and development of her musical ideas. These were absent in her verbal interactions.

Jessie had little opportunity for change, development or progress in her life due to her disabilities and coping mechanisms. Frequently within sessions

she expressed the wish to die, which she recognised as her only escape from her unbearable present. This aspect, above all others informed the clinical supervision process, particularly on matters such as whether to end therapy at the end of the research project. The abyss which existed with no possibility for hope in Jessie's life meant that the future was arguably filled with the despair of isolation. Her experience of improvisation however did give her hope, and the sense of development. Charmaz (1987) suggests that motivation for the chronically ill individual is a result of developing a personal identity which encompasses future selves, reflecting hopes and aspirations. Dimensions for fostering hope have been allied with the music therapy context, both in improvisation and the use of pre-composed music (Aldridge, 1995&1996). Through her own creative process and the shift in identity she achieved through improvisation, Jessie gained motivation and increased levels of arousal. This was observable in all aspects of her behaviour during and at the end of sessions, contrasting greatly with the lack of affect and reduced energy levels with which she presented every week prior to sessions when collected from the ward.

Discussion so far has emphasised the interpersonal and identity aspects of the therapy rather than the purely musical. Jessie showed different behavioural responses to familiar music than she did to clinical improvisation. The effects of songs were not negative for her, but less stimulating, resulting in her feeling 'relaxed'. It is possible that songs of great personal significance to Jessie were not found, and that this caused 'reduced' emotional responses in comparison to her heightened emotional responses to improvisation. However besides the reduced inter-relational aspects of the song-based activities, other properties of the music must be considered. The emotional responses which Jessie described so vividly in response to improvisations (see examples 7 - 9, 13 & 14) and which were reflected in her behaviour reflect the theoretical suppositions regarding the potential psychophysical

properties within active music making and the immediate reward experience put forward by Thaut (1990). Jessie herself described the stimulation of 'healthy' and 'positive' feelings when she discussed feeling increased energy, motivation and interest during improvisation. In particular, her emphasis on the rhythmic components of the music suggests that in addition to the interactional aspects, the rhythmic components of the music in particular activated such feelings. Thaut describes this as the 'experience of activation', providing a 'rewarding, pleasurable, and reality-based experience of self' (1990: 23). Certainly Jessie's interactions within improvisation were based in the 'here and now' and a greater reality than within her verbal interactions. Furthermore, although the music was unfamiliar and improvised, Jessie elaborated many additional associative properties which were culturally stimulated for her through the instruments and the manipulation of rhythmic patterns in particular within the music. Thaut's hypothesis that music is able to induce changes in arousal levels were reflected in changes which Jessie reported in her alertness, levels of motivation and emotional responses.

Taking into consideration Jessie's particular need for heightened intimate interaction, songs alone did not stimulate such a change in emotional experience nor provide the musical structures to meet such needs. Her essential needs dictated a more interactive experience. In summary, the question must be posed as to whether it was the musical properties or the human interaction which were foremost in Jessie's experience, particularly considering the highly dominant verbal component of the sessions. Within a regular music therapy experience, it would not be necessary to gain such a deep verbal understanding of Jessie's experience of the world, as her use of music was so expressive. For the purposes of research, however, the depth of understanding gained from her verbal material was invaluable. For Jessie it

would have been an unnatural situation not to use words, but it cannot be questioned that her relationships which relied on verbal interactions were impaired. Although undoubtedly the relationship with another was central to her gestalt experience of music therapy, it was the active music-making which was central to the relationship for Jessie, and gave the relationship its strength.

CHAPTER 10

INDIVIDUAL CASE STUDY:

'GUY'

10.1: Background summary.

Guy was a young man aged 31 who was severely physically disabled by MS. The specific details of how MS had impacted on his life are given in Appendix 16. In addition to considerable physical disabilities, Guy was also showing signs of the early stages of subcortical dementia, particularly in short term memory, verbal disinhibition, reasoning, insight, attention, information processing, learning and recall. His behaviour reflected these problems to a certain degree, but predominantly in the way he interacted with others. This was typified by a stream of impulsive statements or questions, for which he did not wait any answer before firing the next question. Guy often relayed various plans and goals which he was intending to achieve in the near future. These included travelling around the world, deep sea diving, studying for a law degree and getting married. Unfortunately due to a complex combination of medical and physical problems caused by his illness, the first of these two plans was not possible. His plans to take a degree and marry exemplify his difficulty in reasoning and insight, as he was not able to reason through the processes involved in each of these commitments, or assess how possible they were considering his current situation. For example, he had no intimate girlfriend and yet believed that he would soon be married. His behaviour was often challenging, as he was immensely frustrated by his level of dependence and disability. He hid his emotional state under a front of 'bravado'. However his behaviour and cognitive problems caused him to be labelled 'difficult' to manage, and he was not popular with staff, nor did he have any significant friendships or relationships apart from his father who lived in another part of Britain. He was, therefore, very isolated.

Guy self-referred to music therapy. A detailed account of his therapeutic process with musical examples is given in Appendix 17, however a brief summary is provided to aid discussion later in the text. He most often arrived

at sessions in a highly emotional state after the frustrating procedure of getting up in the morning, as he was entirely dependent on the nurses. He started music therapy with no bias towards either song-based or improvisatory activities. His responses within improvisations for the first nine sessions, however, revealed that he did not engage on an emotional or even a musical level. For example, after improvisations he reported back that he had been singing various songs to himself during the improvisation, or he counted numbers to himself as he played a pulse which did not vary in dynamics, intensity, tempo or rhythm, regardless of the therapist's music. Audio extract 5 is a brief excerpt from an improvisation in session 3, early on in Guy's therapy. He is playing a bass drum to the side of his wheelchair, with the therapist on the piano. The repetitive pulse prevalent in his drum playing is typical of his musical material for most of his therapy, with little variation in his use of musical components.

Generally in improvisations, he showed a reduced awareness of the interactive elements in the music, although this started to change in session 9 when he tolerated changes in the music away from his unerring pulse. Audio extract 6 is taken from an improvisation in session 9. The musical structure given by the therapist was different in this improvisation, using a 3/4 meter as opposed to 4/4. In this improvisation Guy used a drum placed on his wheelchair tray and a cymbal suspended over his tray. Although he continued playing his regular pulse on the cymbal, the timbral quality of his playing changed significantly with his change of instrument. Furthermore, he tolerated a stiller, 'holding' passage from the therapist on the piano. Previously, changes in the therapist's music such as this had resulted in Guy stopping and speaking. However, in this improvisation he continued to play despite her 'stiller' music, showing a development in the musical therapeutic relationship.

It was immensely difficult to find instruments on which he could sustain playing for any duration without tiring, or which he was able to manipulate, as the movements in his one functional arm were extremely ataxic¹. In addition to this, he was very verbally challenging towards the therapist in the ways described already. Therapy and musical material were taken to clinical supervision regularly, as it was difficult to build a therapeutic relationship with him, particularly in the music.

In session 10, a particular song he had been requesting was played for the first time which elicited very different emotional responses. He became reflective and relayed verbally many associations about the song. He also allowed a more vulnerable side of himself to show, and requested the song to be repeated several times. For the first time he discussed his disabilities and how he responded to these emotionally. He participated by listening, singing and tapping his fingers, using a different rhythm from his regular repetitive pulse. This song, and one other song by the same pop group, became 'his' songs within his therapy. In subsequent song sessions he used a wider range of songs with varying moods and emotional devices in the components to explore a wider range of moods. These varied from moods he described as 'raucous' through to 'very sad'. At times he verbally explored the moods elicited or associations stimulated, but at other times these remained private.

Within the clinical improvisations, both his participation started to change, and also the interactive awareness. He began to associate improvisations with pertinent personal themes, particularly issues around his identity. His exploration of musical components started to widen, although he remained limited in the range of instruments he was able to access physically which in turn affected the music. As the therapy progressed he was able to engage more on an emotional level with improvised music. Furthermore, he started to

¹ Large, uncontrolled, shaking movements on any intentional movements.

direct the use of music in the session, moving between song-based and improvisation for different purposes.

10.2: Analysis and results: Guy's experience of the music.

As already seen in the earlier case study of Jack, Guy's experience of pre-composed music also centred predominantly around two properties. Firstly, the **relationship over time** gave the songs a history for Guy which were interwoven with his own past. Secondly, songs contained an inherent **associative experience**. Through the songs, many memories or other associations from throughout his life were stimulated. At times these were specific memories which the songs pinpointed, and at others the memories were more general or merely associations. Through these properties, a **life review** process was stimulated, which made the songs so meaningful for Guy. He was able to describe this process quite plainly.

Example 1:

(From: Session 13, Improvisation)

MT: How would you sort of sum up music therapy for yourself?

All of my life bends around music.
One piece in my head can symbolise
somewhere I've been to.

**HIGH FACTORS OF ASSOCIATION
& RELATIONSHIP OVER TIME**

MT: Today you were talking about bashing the instruments, but we also do instrument playing to songs. So what is the difference between 'bashing' the drums and things to songs ...?

Ah, well with songs I'm singing
parts of my life ... reliving a part of my life ..

LIFE REVIEW (HIGH MEANING)

The cumulative effect of these two properties enhanced the **meaning** held within songs, and also stimulated the **emotional** experience. Not only were emotions stimulated and acknowledged, but more importantly, Guy more often and more readily identified non-coping emotions through his songs and related these feelings to himself. This process was notably different from the coping strategies evident in his verbal material and general behaviour.

Example 2:

(From: Session 12, Songs)

MT: If you can think as much as possible about the music. You talked a bit in the session about what was going on, but I just wondered whether you can put in your own words, if you had to go back to the ward and tell somebody about what you did today, how would you describe what we did in the session?

I'd say that we were reliving my past.
 Playing songs that mean so much to
 me out of my past. ... it was nice .. to let
 loose the feelings I have about living
 here now .. through the music. Like we
 were talking about how I feel I'd like to
 get out of here and do things like walk and
 that sort of thing. It's great when you can do
 that through music.

LIFE REVIEW
HIGH MEANING
HIGH RELATIONSHIP OVER TIME
HIGH EMOTION RELATED TO SELF

ACKNOWLEDGES ILLNESS

EXPRESSES EMOTIONS THROUGH
SONGS

Furthermore, through the relationship over time belonging to songs, issues related to **illness identity** and changed abilities were stimulated and acknowledged. This then facilitated the process of achieving **Barriers Down**, where he acknowledged difficult feelings normally classified as 'non-coping', and started to relate such to himself.

Example 3:

(From: Session 12, Songs)

(After 'Drive') Well done. (Long pause)

Takes me back in time. ... it's nice
to have good memories when I
could do what I wanted to do. So ...
it's quite nice to be able to think
about something that's all right in my head.

HIGH RELATIONSHIP OVER TIME**PRE-ILLNESS ABILITIES****ACKNOWLEDGES DIFFICULTY****OF CURRENT SITUATION**

It is possible therefore to begin to build a model of his experience of pre-composed music using properties and their values as foundation blocks. Under the conditions where the music had a high value of the properties **relationship over time** and **association**, it resulted in higher **meaning** and higher **emotional** properties for Guy. Early on in therapy, this stimulated Guy to acknowledge his illness and the changes it had caused, identify more difficult feelings, and relate such to himself, albeit only briefly. In this way, he was seen to lower his barriers for short periods during therapy, instead of adopting his usual coping strategies of dismissal and bravado. His experience of pre-composed music can be depicted in the following figure.

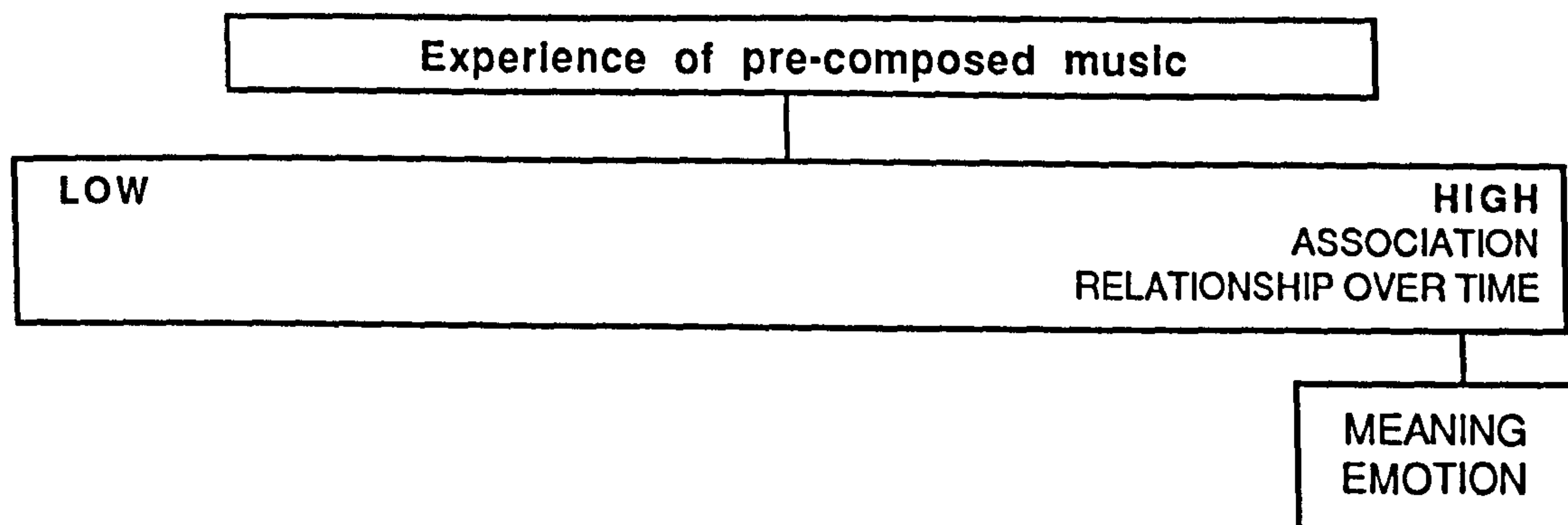


Figure 18: Developing properties of Guy's experience of pre-composed music with value ranges.

This differed markedly from his experience of improvisation. Certainly in the earlier improvisation sessions observations indicated that Guy did not engage on an emotional or even musical level with the improvisation. Analysis of the later interview transcripts indicated several factors which were needed for optimal conditions to deepen the experience of the improvisations. At this stage in his therapy (session 13), however, although he had started to develop a sense of the improvisation, he was unable to place such within words.

Example 4:

(From: Session 13, Improvisation)

MT: So if songs are reliving a part of your life, what's the improvised music?

It's not actually doing anything really.

It's doing something, but I've not got any

idea what it is.

LOW MEANING

This example suggests that there were some implicit benefits of the improvisation taking place. Unlike his experience of the songs, however, Guy had no way of contextualising the unfamiliar improvised music, due the low properties of **relationship over time** and **association**, which enabled him to find **meaning** and **emotion** within the songs. He did state, however, that there were higher levels of **ownership** associated with improvisation, although there were lower values of emotion within the music.

Example 5:

(From: Session 12, Songs)

*MT: I'm aware that the songs have brought back lots of memories, brought up lots of feelings ...
When we do the improvising, you were saying last week, improvising brought up lots of memories as well,
does the improvising bring up as many feelings for you?*

Well .. not really in that sense. I
mean I'm Improvising .. about memories,
but it's more, you know, I like just creating
music and that sort of thing.

LOWER EMOTION
ASSOCIATIVE FACTOR
OWNERSHIP

MT: So when you're improvising, is that?

Definitely, creating music for me, in my head.

IDENTIFIES HIGH OWNERSHIP

However although **ownership** was higher in the improvised music, this did not enhance the experience at this stage. Guy identified other properties related to identity such as **success** and **ability** which had lower values within his experience of the music. Furthermore, he compared songs and improvisation on a level pertaining to **illness monitoring**. His measure of songs helping his memory (**cognitive monitoring**) is weighed against his **physical monitoring** of his control of the instruments. Ultimately, pre-composed music is perceived by him to be the more meaningful of the two.

Example 6:

(From: Session 14, Songs)

MT: So .. when we were doing the songs, you said you were getting something from the music, but not giving much back to it ... so is there any difference when we're improvising and when we're doing songs for you?

No, I think when we do the songs on
the sheets, I'm getting lots out, memory
wise and that sort of thing, but
I can't get anything back, shaking
a maraca. It's not
really doing much with the music.

COGNITIVE MONITORING (songs)
PHYSICAL MONITORING (Improvisation)
LOW SUCCESS (pertains to
Improvisation)
LOW ABILITY

MT: So besides shaking the maraca, what other part are you playing in the music, how else are you participating when we do the songs? ... I just wonder how you feel you're participating? It seems that you're quite dismissive of your own part when we're doing songs.

Well I know I'm not the progenitor
of the music. I didn't write the music.
Adding something to it as I do it anyway.

LOW OWNERSHIP

MT: So then how is it different from improvising, when we're not playing somebody else's music?

Improvising, we're not playing
anybody's music, we're just bashing,
bashing the drums, bashing the cymbals...
I'm bashing the cymbal, bashing the
tambourine, etc.... It's not bad bashing,
it's quite nice bashing. I like doing that,
but it's not the same as listening to a written
piece of music.

HIGH OWNERSHIP

LOW MEANING

HIGH PHYSICAL

LOWER SUCCESS

MT: Do you want to just finish up by saying how it's not the same?

Well it's written music, obviously
written music is musical. Bashing
something with a maraca or a cymbal
(hits cymbal), it's not very musical.

HIGHER MEANING (SONGS)

HIGHER PHYSICAL

LOWER MEANING

Although the following extract is from session 14 which was a song session, Guy discusses improvisation. He indicates that at this stage of therapy, that improvisation was still predominantly a physical activity for him in which he monitors his ability and skill in participating through physical monitoring. He measures his own ability and skill to be very low, largely due to making temporal comparisons of what he was able to do before he was ill. Although the music has few recognisable properties such as association or relationship over time, the act of improvising does possess a high sense of relationship over time as he compares his previous musical skills. The resultant

experience is one of low meaning. This lies in his assessment of his current abilities in comparison to his previous abilities before his illness.

Example 7:²

(From: Session 14, Songs)

Well, I can't play Instruments
very well. But when you're bashing
piano and I'm doing 4 / 4 timing to you ...
Bashing drums and that sort of thing ..

LOW ABILITY

LOW SKILL

LOW SKILL / HIGH PHYSICAL

MT: Is there something about ability to play .. ?

Well I used to play guitar of course.
So I was much much better when I
played bass guitar. I can't play bass
guitar any more.

**TEMPORAL COMPARISON OF
SKILL - NEGATIVE OUTCOME
LOSS OF ABILITY**

MT: But you're playing the other instruments?

Well If you call playing 'bashing'... I'd
like to play better, but I can't play .. I
shake like that (picks up maraca and
shakes with ataxic arm movements).
It's not exactly music Is it? To do that?

**LOW FEELING OF SKILL
LOW ABILITY
PHYSICAL MONITORING
LOW MEANING**

Such an example reflects earlier sessions, where he indicated that his experience of the improvisation was one with low emotional properties. Indeed as a way of coping with the experience of improvisation he stated rules about how one 'must' participate. By stating rules in this way, it can be assumed that this increased his sense framework of the experience. It also served however to maintain lower emotional levels in the music for him, as it gave him a more intellectual or conscious framework during the experience.

² Part of this extract was used to exemplify issues of identity which is a consequence of the strategy of illness monitoring.

Example 8:

(From: Session 9, Improvisation)

Yeah, I always count the beat. So you can hear that everyone else is in time with you. ... If you're playing bass, you've gotta count the beats as you play ..

LOW INTERACTION (OWN PART ONLY)
STATING RULES

MT: What about the feeling behind the music?

No well I like to count and play the windchimes and the cymbal and everything else, as long as you can hear the beat you can hear just about everything. But you can't listen as you're playing it, you don't have to listen, you just keep counting, as long as you keep the beat you can do it at the same time ...

LOW EMOTION
STATING RULES
LOW INTERACTION
" "
STATING RULES

Two sessions later he had arrived at the session again in an extremely agitated and emotional state. After the improvisation, he describe his experience of the music in a similar way to that in example 8. Within this session, he was actually singing a succession of songs in his own head during the improvisation. He states quite plainly that it is the words of the songs of which he was thinking rather than any musical aspects. Considering his experience of improvisation lacking the properties which enhanced the meaning of the music, this strategy aided in increasing the meaning of the music. In drawing on such a coping strategy however, it also served to remove him from any emotional experience that lay within the improvisation and also reduced the interactive components within his experience.

Example 9:

(From: Session 11, Improvisation)

I couldn't find the words of the song
 I was singing in my head. Because
 I was beating that (hits Mongolian drum)
 and looking aimless because I was
 thinking of the wordsthe words
 of the song in my head - Jamaican Holiday.

LOW INTERACTION

LOW ENGAGEMENT

LOW INTERACTION / INCREASED
MEANING

MT: And when you were playing, you just said you were playing aimlessly ..?

Yeah, playing the hippy song and
 then I was playing Elvis Costello. And
 then I played something else as well,
 I can't remember what it was.

LOW EMOTION FACTORS

LOW INTERACTION

" "

A further example from two sessions later continues to show that the meaning of improvisation lay in aspects of identity such as skill and ability, and also of low emotion. Within this session, his experience of the improvisation started to change, and he is not as negative about the outcome of the improvisation. However it still failed to give him feelings of success or achievement, and reinforced his experience of disability.

Example 10:

(From: Session 13, Improvisation)

MT: I wondered how you felt about the music we did today in the session?

I found it interesting doing something
 which was nearly music which we were
 playing..Well the guitar .. when I was doing
 that ..I was nearly getting some proper music
 .. and bashing these instruments as well
 (indicating to cymbal and drum) ..
 making nice noises. Making nice noises
 ... I can't play guitar, I can't do that. I
 can do it, but it's nice for me. Okay .. I

LOW EMOTION

MEANING FACTOR

SUCCESS FACTOR

LOW SKILL

LOW MEANING

LOW ABILITY

can't play the guitar, I can't play the piano, I can't do anything like that ..
 It's nice to know how it works and that sort of thing.. that's why I was asking you about the notes on the piano and that sort of thing ..

LOW ABILITY/SKILL

LOW EMOTION

Therefore, the following conditions can be considered in drawing a picture of his experience of improvisation in the earlier period of music therapy. Under conditions where the music possessed lower values of the properties 'association' and 'relationship over time', it had lower values of meaning and emotional factors. Furthermore, the music was experienced as being low in interaction but high in terms of physical factors and also in ownership of the music. He did draw on the relationship over time when the physical experience was high, which was during improvisation. Guy thus drew on the strategy of 'physical monitoring' to compare his current abilities to how he played instruments before his illness. However, he measured his performance to be poor. The consequence of this were feelings of low skill, low ability, and low success. The outcome of his involvement with improvisation was to have his disabled identity reinforced, as the only meaning he could draw from the music lay in the physical experience. The duration of therapy and current issues acted as an intervening condition which did start to increase the emotional factors within his experience.

From the improvisation in session 15, he started to relate how he felt about his changed abilities. He not only identified a non-coping emotion in response to acknowledging his changed identity, but owned this more difficult feeling. In this way, he moved to a state of 'Barriers Down'. The next example followed a particularly sensitive improvisation in which he used the guitar. This improvisation is given in Audio extract 7. It is important to acknowledge how the improvised music differed in this session from previous sessions. In this

session the meter of his music changed to 6/8 from its regular 4/4, and the mere fact that he had the guitar rather than the usual drum caused the timbral quality of his music to differ entirely in mood, moving away from his relentless 'bashed' pulse. Given that he was using a pitched instrument, the therapist's musical part was simplified considerably using mostly only single notes or sparse chords. This aimed to give structure to Guy's pitched rhythmic patterns. The improvisation was generally sparser and less 'brash' in its volume, textures and timbral qualities. As Guy's musical material was much more varied than he could normally achieve, there was a greater interaction between his music and the therapist's. Furthermore, he requested his special song at the end of the session which extended the mood which had been acknowledged in the improvisation. However, the moment he started to speak about the music the entire mood is changed, as he starts to intellectualise the experience and remove himself from the painful emotions which were stimulated.

Example 11:

(From: Session 15, Mixed)

Well, (completely changing tone of voice) firstly on the guitar programmed to D, the chord it was coming out as,
 It's a shame I can't play the guitar straight out, but it's just me. It's very frustrating not being able to play guitar in the way you're used to.

ACKNOWLEDGES LOW ABILITY

RELATES NON-COPING
FEELING TO SELF CONCERNING
CHANGED ABILITIES =
BARRIERS DOWN

As already shown in example 2, Guy used songs and other pre-composed music as a way of identifying and expressing mood states, particularly extreme emotions. He not only used pre-composed music however to express mood, but also within several sessions to explore a variety of mood states. In

session 16, Guy extended a sensitive mood and theme which had already been stimulated by his improvisation. Following his improvisation, he suddenly requested, with no prompt whatsoever, the song 'Yesterday'. Afterwards, he referred to the song theme, which he identified as being about loss in love. When gently questioned about why he may have chosen this song, he distanced the song from anything personal about himself and stated an association which was highly impersonal and unemotional. He identified that this was a tremendously sad song, but related such to the music only and not to himself. Although within the interview neither the mood nor the theme of the song were related to himself, the theme of loss in love was one which recurred throughout his verbal reminiscences and the themes of the other songs he most often requested. The theme he associated with 'Yesterday' also continued on a theme which he had associated as stimulated by the improvisation. It should be noted that on this occasion he had not arrived at the session in a highly agitated state, but was quieter and more focused in mood.

Example 12: (From: Session 16, Mixed songs and improvisation)

<p>'Yesterday' was one of the ones I associate with a good book I once read. 'Yesterday' is a story, obviously, of somebody who's lost his love, I mean that's the thing. He was terribly terribly In love with a girl, but he said something which just didn't click with her at all. She left him and went to somebody else. It's a very very sad song.</p>	<p>LOW EMOTION IN ASSOCIATION</p> <p>THEME OF LOSS</p> <p>HIGH EMOTION RELATED TO SONG</p> <p>HIGH NON-COPING EMOTION (RELATED TO SONG)</p>
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Following this song, he did not spontaneously request other songs, but selected from several which the therapist offered. He chose ones which were less sensitive and varying in the musical feeling and mood they portrayed. All the songs had high associative properties to his time at university.

Within this session, there were clear differences between how Guy presented and what he acknowledged verbally. It is important to question such overt behaviour adopted when the music he both requested spontaneously and improvised represented such sensitive and vulnerable feelings and issues. Although the use of songs in this way may be considered to have blocked his emotional expression, in effect it gave him greater control of what moods and feelings he expressed, how he expressed them, and how far he acknowledged them. Within this session, the improvisation stimulated emotional qualities for him which although he related not to himself, related to a theme which was reflective of pertinent current issues. He then continued this theme through his song request. By then choosing songs which took him away from this emotional state, he shifted to different emotional level entirely within the musical components of melody, style, and tempo. His use of songs in this way had also been observed in an earlier session.

It could be considered that emotions were stimulated unconsciously within the improvisation that Guy then explored within pre-composed familiar songs. Although he did not explore these openly with the therapist, the similarity between the theme he verbally gave his improvisation and the song he quickly requested cannot be ignored. Because he did not acknowledge this verbally within the interview causes such a link to remain theoretical rather than grounded i.e. based on the therapist's assumption using behavioural and musical material to support this assumption rather than Guy verbally acknowledging such. This highlights one methodological drawback with using techniques which analyse verbal material rather than musical. However it

would be negligent to ignore the musical similarities in the material improvised and the song, the thematic similarities drawn by him between the two, and his following use of songs. In examining the highly variable musical qualities of the requested songs which followed, his journey through a range of feelings, either consciously or unconsciously, could be traced. Although such an exploration may have remained private, it was acknowledged through the songs played.

In the following example which is taken from session 14, Guy had arrived in a highly agitated state. Although offered a selection of songs including his two special songs, he requested 'Jumping Jack Flash'. He associated the extreme emotions of 'violent, raucous' with this song. However when asked if he identified with the song in any way, he did not equate the emotions he had just identified to his own feelings, but instead changed them to the entirely different 'happy', a more benign and 'coping' emotion.

Example 13:

(From: Session 14, Songs)

MT: If you were thinking about what mood Jumping Jack Flash had with it, how would you describe the mood of it?

It's more sort of violent, raucous, ...Yeah,
and when they sing it, it's so, so,
way over the top in the singing and
every thing ... Yeah, way way over the top.

HIGH EMOTION

“ “
“ “

MT: Was there anything about the mood of the song that you identified with this morning?

Well, I'm in a happy mood. I'm always
happy when I hear Jumping Jack Flash....
It cheers me up totally. ... They're
trying to impress upon you, get you
into the music ... The song is trying
to tell you to get with it ..just explode
on the music, and do whatever like that.

COPING EMOTION

RELATED TO SELF/SONG

SONG STIMULATES

MOOD CHANGE

SONG STIMULATES

MOOD CHANGE

He was unable to relate such extremes as 'violent' to himself, but did indicate that he had used the song to effect a change on his mood. Following this, he chose two further songs which varied significantly in mood from this first song. Each of the songs stimulated reminiscences about his mother who had died seven years previously and also his time at university, particularly the loss of a significant romantic relationship at that time. He suggested that the songs possessed very differing mood qualities. As Guy had already stated on many occasions that he experienced emotions through songs, it can be determined that by requesting a succession of songs which differed in mood states, he was exploring these different moods in a non-threatening and non-verbal way through his songs. Although he did not acknowledge this verbally, the following example indicates how he was relating the songs to himself, and the issues they were stimulating.

Example 14:

(From: Session 14, Songs)

MT: Is there a mood you would attach to Eleanor Rigby at all?

Saying what a futile existence most people have.Very sad song. You can see so many people like that in the world - you come across people who never do anything with their lives.

**HIGH NON-COPING EMOTION
(NOT RELATED TO SELF)**

I mean I've been around the world twice, which I consider to be an achievement and that sort of thing. Some people just stay in London and never ever leave London in their whole lives.

**RELATES THEME TO SELF
STIMULATES LIFE REVIEW**

MT: That's quite an important thing to you isn't it - living life fully?

Like the extreme of everything. But I can't get out and do anything - I'm kind of trapped by my MS. Actually, I want to have children, I want to do that sort of thing as well I want to get out and do things ..

**LOW INDEPENDENCE
ACKNOWLEDGES ILLNESS
(BARRIERS DOWN)
HOPES AND DREAMS**

MT: I wondered whether the music you choose, whether the songs that you choose, whether they have anything to say or do with the idea of getting out and doing things?

Mostly they are getting out and doing things, like Jumping Jack Flash, an explosive song - you know, I want to go out and do it..

ABILITY

HIGH EMOTION

He finished this session by moving from the song he identified as 'very sad', to requesting once more the song he identified as 'violent, raucous and explosive'.

The above example develops the model of his use of pre-composed music. Through the relationship over time and associative qualities of the music he was not only able to reach a more emotional part of himself, but also made temporal comparisons in other ways. By examining past achievements and hopes and dreams, he acknowledged that things were not how he would want them, not how he imagined they would be. This was an important step in his process of acknowledging his loss which he found so painful. Indeed, he chose to end the session with the song which he associated with 'getting out and doing things', although briefly he had strayed into the musical exploration of the song he identified as 'futile' and 'very sad'.

He repeatedly used the particularly significant songs with their high association and relationship over time to facilitate an immediate emotional experience of the music. The emotions elicited were not only more vulnerable and non-coping emotional states than those with which he most normally presented, but were also related to himself. Furthermore the memories elicited were related to the change which had occurred as a result of his illness.

Example 15:

(From: Session 10, Songs)

(Immediately at end of song) So many
memories of that song! All good.

All good memories. Such brilliant
memories. Oh, I loved the girl!
Happy memories from Liverpool from
those days.

HIGH ASSOCIATION**HIGH RELATIONSHIP OVER TIME****HIGH EMOTION/CURRENT ISSUES****HIGH ASSOCIATION****HIGH RELATIONSHIP OVER TIME**

MT: So this song brings back memories of those times? What's good about being taken back to those times in your thoughts?

I was so much in love with her then.
I like being in love with somebody... I
also, like ... before I went to university
you see, ... just friends I had back
there and everything. I didn't know
what the hell was going to happen to
my life - I didn't know. I don't know
from here on - I never know what's
going till it comes. I'm planning to do
various things, but I don't know if they'll
work out, so you have to just wait and see.

**HIGH EMOTION RELATED TO
CURRENT ISSUES****CHANGE TO RELATIONSHIPS****LOSS OF PAST HOPES****AND DREAMS****RELATIONSHIP OVER TIME****(FUTURE)****HOPES AND DREAMS**

MT: I wonder whether this song is special because it transports you back to a time when ..

.. when everything was possible and
nothing was wrong with me!They
were damn good times!

CHANGE IN IDENTITY**LIFE REVIEW**

The associations and relationship over time held by the songs helped to acknowledge the enormous loss which he had suffered in many areas of his life as a consequence of his illness. It was immensely difficult for Guy to acknowledge such changes normally, and differed markedly from the usual dismissive behaviour with which he fronted. Whenever he requested his two special songs, however, he immediately engaged with such feelings.

Example 16:

(From: Session 12, Songs)

(Immediately after song) Very good Wendy.

I've got some great memories of that song. Take me back to Liverpool (reflectively).

It was a very good year in Liverpool, yeah. Very very good year. Everybody was there then. Where are they now?

HIGH ASSOCIATIONS

" "

HIGH RELATIONSHIP OVER TIME**LOSS OF RELATIONSHIPS**

MT: Have you lost touch with them Guy?

Well, I have lost touch with all of them.

LOSS

I know where some of them are still.

Recognising the changes to his abilities over time was something that was stimulated by both types of music. However, because of the emotional properties of the songs, Guy not only acknowledged these changes when engaged in song related activities, but more readily related how he felt about such changes. The musical structures contained within this particular song also cannot be ignored. Its slow tempo, lilting rhythm, falling melody lines and passages of non-vocal instrumental parts which allowed for moments of reflection within the musical structure, all gave the song a more meditative, pensive feeling. Although Guy did not explicitly state that this was how the song affected him, he indicated that it was emotional and stimulated thoughts all the same.

Example 17:

(From: Session 10, Songs)

MT: I was interested by the words of the song .. and also the theme behind the words ..I don't know whether you'd ever thought about the words at all?

Well it's about a guy and a girl,
and he's saying that's she's breaking
up .. it's in the song. Her mind's breaking up.
She's screaming and falling apart,
and here's the guy saying, 'You've gotta

**IDENTIFIES NON COPING EMOTIONS
WITHIN SONG THEME (NOT RELATED
TO SELF)**

look at it this way. I've done this for you,
 I've done that, I've done the other ..
 everything's gone wrong between us ..
 I'll always be there for you ..'

**PERTAINS TO CURRENT
 ISSUES**

MT: There seems to be a pretty big theme in it about being on your own, 'who's gonna be there for you?' ..

Well he's telling the girl, he's saying,
 'look I love you'. So many memories with that -
 too much. ...Brought a tear to my eye!
 You've made my day by doing that.
 I didn't go to lectures. It was a free year!
 I was in love!

“ “
**HIGH ASSOCIATIONS
 BARRIERS DOWN - OWNS
 NON-COPING EMOTION
 HIGH ABILITY/INDEPENDENCE
 PRE-ILLNESS**

MT: You've come today and we've played a song from the past ... How do you see that as being useful?

It's nice to conjure up old memories.
 I think about the past, and think about
 the times that are coming. I know
 there are times coming.

**HIGH ASSOCIATIONS
 HIGH RELATIONSHIP OVER TIME
 TEMPORAL RELATIONSHIP TO
 FUTURE**

Although the memories stimulated were emotional for him, the emotional qualities of the music itself cannot be underestimated. This was reinforced when Guy used songs other than the two he most often requested which stimulated such vulnerable and sensitive feelings, as already seen with his use of 'Jumping Jack Flash'.

The relationship over time which songs held also stimulated many comparisons of pre-illness abilities. Such comparisons facilitated Guy acknowledging his illness. This again was markedly different from other times when he made unrealistic statements about his abilities or expressed expectations which were not grounded in acknowledging his changed

abilities. One example of such was when he told the therapist he would go by tube to a shop in central London to buy some music, and did not see his level of disability as any barrier to getting himself there independently. Although acknowledging his disabilities in the way he did in the following examples was no doubt painful, it revealed that part of the bravado with which he fronted was actually a coping mechanism rather than just simply cognitive deficits with insight. Additionally, although he usually quickly dismissed the feelings stimulated about such changes, the emotions elicited by the music helped him stay with such difficult feelings long enough to start to share them within therapy.

Example 18:

(From: Session 12, Songs)

MT: I sense that that year is a year you would like to hold on to very much?

Very much so, yeah. Well I was such a young lad then. Eighteen years old.

Very nice year for me. 18 - 19 was a very good year for me. I could do just as I wanted to do then. ... I just could, I just did everything. A very good year of my life.

**HIGH RELATIONSHIP OVER TIME
PRE-ILLNESS ABILITY AND
INDEPENDENCE
" "**

MT: It strikes me that that's quite different also, in terms of you could do everything you wanted to do in terms of what's going on for you now.

Well I can't go walking anywhere now. I was walking, walking, walking around Liverpool doing that sort of thing. Oh I miss walking so much! I'd love just to get up and walk like you do, just like that ... never mind - I might one day again.

**ACKNOWLEDGES LOSS OF ABILITIES
PRE-ILLNESS ABILITY**

**RELATES EMOTION OF LOSS TO SELF
BARRIERS DOWN**

DISMISSES FEELINGS - COPING

STRATEGY

MT: It also seems to me that when you talk about this year, as you said before it's very much a year when you could do anything you wanted to do ..

I could do anything, anything	PRE-ILLNESS ABILITY
I wanted to do.... Really, if I wasn't so contracted (making fist with hand) I	ACKNOWLEDGES SITUATION
could do what I wanted to do, get a taxi where I want to go, see a film that I want to go and see, just go and do it, go to a restaurant where I want to eat ... you can't just go and just not come back for a night, and that sort of thing. ... Go home and get drunk and that sort of thing. I mean I just can't do it now.	PRE-ILLNESS INDEPENDENCE
There's just no way, can't even pick up a pint of beer and drink it. Need a straw, and drink with a straw. ... It feels dreadful now. But other things in life are all right. I mean I've got a lot more money now than I had ... but I can't, because I just can't go and do it.	LOSS OF INDEPENDENCE CHANGE IN ABILITY LOW ABILITY HIGH DEPENDENCE RELATES NON-COPING EMOTION TO SELF DISMISSES FEELINGS LOW ABILITY & INDEPENDENCE

The developing model can be represented in the following way. Under conditions where the music possessed higher associative properties and a longer relationship over time, it possessed greater emotional properties and higher degree of meaning. That is, songs stimulated increased emotional responses and held greater meaning because they stretched back into Guy's past, before his illness, stimulating many specific memories and general associations as well. However, dependent on intervening situations or conditions, Guy drew on strategies such as relating the theme or emotion within the music to himself, or relating it to the music only. The intervening conditions which affected the strategies employed included the length of time he had been in music therapy, his mood state at the start of the session, the personal meaning he attributed to themes in the songs, and his current issues. If he related the mood of the music to himself, this resulted in him acknowledging his difficulties and identifying more difficult or 'non-coping' emotions which he was experiencing. The length of time he stayed in this

state of 'barriers down' varied. Furthermore, he used songs to extend emotional states or moods which were stimulated through the improvisations. Alternatively, if he attributed mood to the music only, he was able to explore a wide variety of moods and themes without lowering his coping front. In this way, he communicated that the songs he chose affected and altered his mood. Through controlling his song choice, he experienced moods particular to his choice, and in this way had his mood met in the music without having to acknowledge such verbally. These strategies can be added to the paradigm already presented of Guy's experience of the music, as shown in Figure 19.

The model depicted in Figure 19 also serves to highlight the absence of interactive aspects of the music, both in Guy's experience, but also in terms of the relationship with the therapist. This aspect is one of the key differences for Guy in his experience of the two different types of musical experiences. For although he may have been exploring emotions within the songs he chose, such explorations remained private in many respects. As will be seen in later examples, the highly interactive properties of improvisation actually facilitated his emotional expression within improvisation to be more overt. The property values of interaction can therefore also be added to the illustration depicting his experience of familiar pre-composed music, as illustrated in Figure 20.

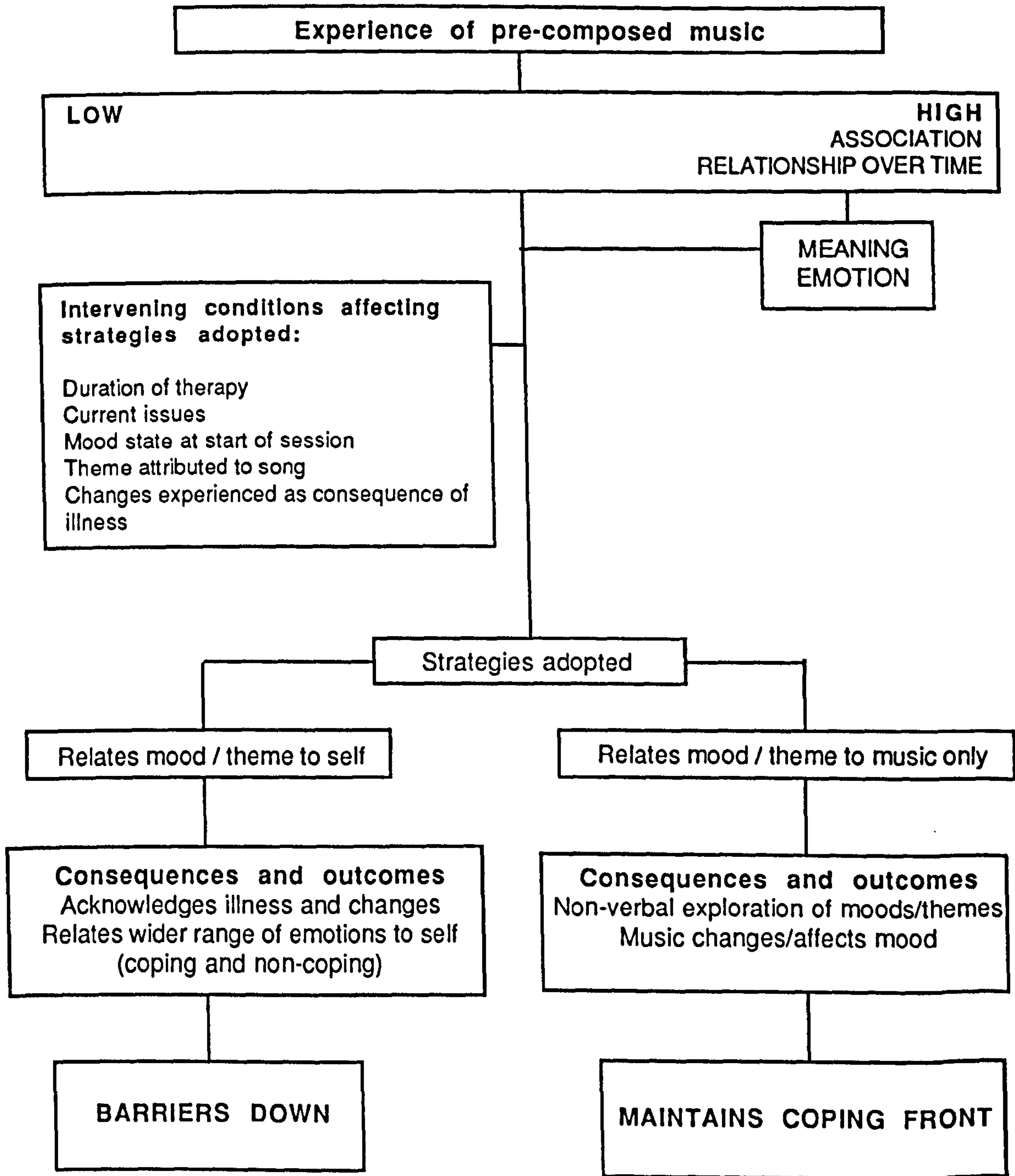


Figure 19: Processes stimulated for Guy by familiar songs to maintain 'Coping Front' or reach 'Barriers Down'.

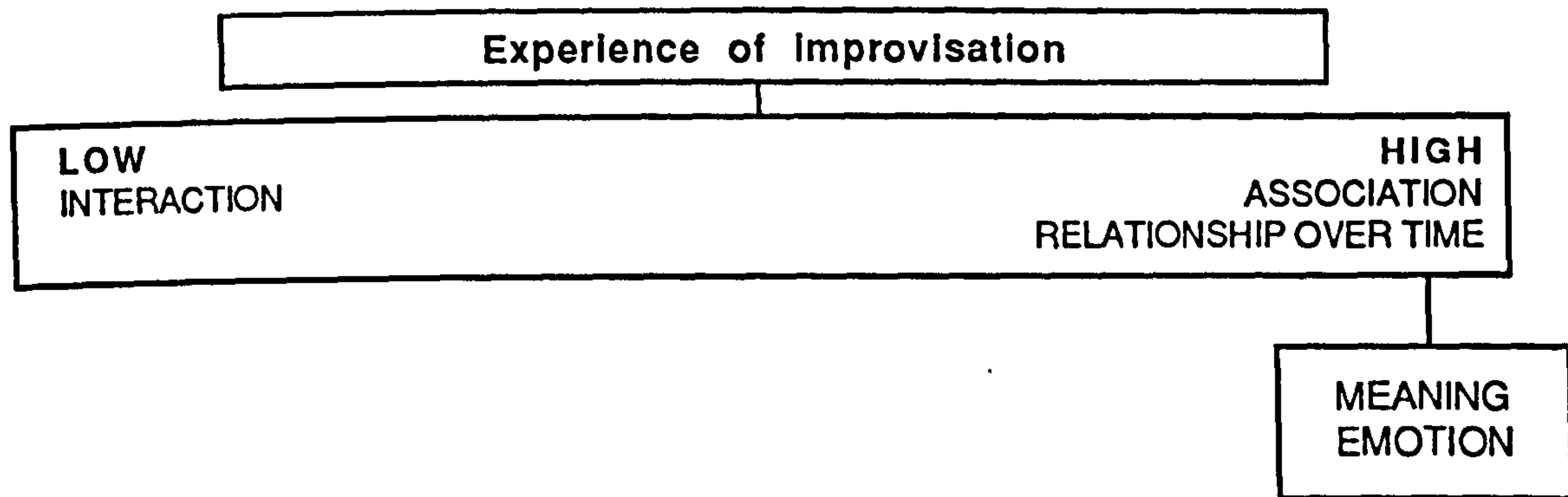


Figure 20: Developing properties of Guy's experience of familiar songs with value ranges.

Thus songs served to stimulate deeper feelings which he was able to relate to himself. It transpired however that improvisation became a vehicle for expressing these emotions. In the following example Guy had already expressed feeling a mixture of frustration and violence about his dependency in this session. In this case, the high physical property in improvising served as a cathartic release of such feelings. Within this example there remains little indication about the interactive elements of the experience.

Example 19:

(From: Session 13, Improvisation)

MT: Was there anything about the music that said anything about you? About how you felt?

I don't know. I'm pretty frustrated by the nurse this morning. Not getting me out of bed in time. I guess I allow my frustrations to wash out of me.

**RELATES NON-COPING EMOTION
TO SELF & CURRENT ISSUES
HIGH EMOTION FACTORS**

MT: How do they wash out of you?

Well I like playing music salves a feeling of frustration. I don't feel so bad now I would say that hitting the drum gets the frustration out..

**HIGH EMOTION FACTORS IN MUSIC
CHANGE OF MOOD THROUGH MUSIC
RELATES PHYSICAL TO EMOTIONAL**

Such sentiments are echoed in the following extract. He continues to associate the physical properties with expressing the emotional aspects, but draws in a higher value of interaction. He also offers a comparison for what type of pre-composed music may have facilitated such emotional expression. Although the improvisation contained interactive factors which helped him express his 'frustration', the pre-composed music he would have chosen would have offered far less an opportunity for interactive properties.

Example 20:

(From: Session 13, Improvisation)

Thinking back, it seems that I was thinking a bit whilst I was doing it.

I was listening to what we were doing
....() .. but I was thinking back to the
frustrating episode of this morning

The music sort of enabled me to get
the frustrations out my head. (Hits drum
very loudly) Bashing that also helps
me get something out.

HIGH INTERACTION
RELATES TO SELF
& CURRENT ISSUES
RELATES MUSIC TO
OWN EMOTIONS
HIGH PHYSICAL
HIGH EMOTION

MT: Was there any other music which could have said better how you were feeling? Does anything come to mind?

Punk rock songs would have done
fine I think violent punk rock would
express my feelings very well. You
know I don't have violence to anybody
else, just go through it in my head, when
I listen to it.

PRE-COMPOSED
HIGH EMOTION

LOW INTERACTION

On rare occasions he managed to overcome the physical aspects of the improvisation and related more to the musical components. Relating a concrete theme to the improvisation gave it greater meaning. This was particularly so if the theme was one which related to personally significant

issues. Thus the improvisation possessed greater meaning than simply representing 'noise' or music being 'bashed out'. Furthermore, by giving the improvisation a theme, Guy started to relate to the improvising emotionally. In session 16 he chose to improvise on the metallophone, the timbral quality and dynamic range of which changed the mood of his improvisation considerably. The physical nature of his playing however also changed, as he achieved more controlled sounds which resonated on the instrument. The therapist used a very simple accompaniment, often of only two notes placed in open fifths and fourths. The overall dynamic was quiet with a stiller meditative section. Guy commented at the end that it sounded Japanese.

Example 21: (From: Session 16, mixed songs and improvisation)

<p>We improvised some willow pattern plate music....Well, the story about the plate as I was saying .. I think it was a very romantic story ... The feeling I got was a story of love and that sort of thing.</p>	<p>THEME INCREASES MEANING</p> <p>THEME RELATED TO CURRENT ISSUES</p> <p>OWNS HIGH EMOTION</p>
---	--

Thus he started to relate to other qualities within the experience of improvisation. Unlike his participation in other improvisations, he did not automatically refer to the physical experience. Instead, he referred primarily to the associative and emotional properties inherent in the music which increased the meaning of the music for him. When questioned about the instruments he used, he alluded to physical aspects and made comparisons on a temporal level to what he was able to do 'pre-illness', but these were not prevalent in his experience. This was surprising considering that the metallophone was a far more difficult instrument for him to manage physically as it involved reaching further outside the boundary of his wheelchair tray.

The interactive properties within improvisations became increasingly important as Guy became more emotionally expressive within his

improvisations in the later sessions. Because the condition of duration of therapy had increased, this also suggests that there was increased trust and familiarity within the therapeutic relationship. Again he made associations between the musical qualities of the music he had improvised and pre-composed music.

Example 22: (From: Session 18, Mixed songs and improvisation)

I liked it when you sort of counterpoint
the music with the piano. I was sort of
trying to get .. like an expression of playing
the bells of .. the Great Bells of Kiev .. or
something like that. It's a lot of bang bang
bang and bells ringing. (Hits drum in pulse).
Sort of the ... when it goes up like that
(compares sound of drum with the bell
he's trying to get) ... Prokofiev - do you
have some Prokofiev? ...1812 overture?

HIGH INTERACTIVE

**ASSOCIATION ON EMOTIONAL
LEVEL WITH PRE-COMPOSED
HIGH EMOTION**

**STIMULATES ASSOCIATION WITH
PRE-COMPOSED MUSIC**

He continued to not only make associations on an emotional level with pre-composed music, but started to indicate that his own feelings of disability had been affected by this improvisation. Guy had arrived at this session once more agitated and highly emotional about the long process of being got up, washed and dressed. Once more, his levels of dependence had severely limited his feelings of control in this process. After the improvisation, however, he indicated that he had experienced higher feelings of success, and he associated the feelings of the improvisation with powerful large scale works of pre-composed music such as the Planets Suite, and those by Beethoven and Prokofiev. This improvisation is given in Audio extract 8. Within this improvisation, he continued with his 'bashed' pulse which initially varied little in rhythm, tempo or intensity. The musical structures given by the therapist, however, reflect the emotional quality of Guy's pulse melodically and

harmonically. Later in the improvisation, Guy's music becomes faster, thereby communicating emotional intention in his music. He is unable, however, to sustain this physically, and he falls back into a pulse half the speed of his faster pulse. After the improvisation, he related the emotional qualities of the music as such to feelings of power, control and aggression. He also emphasised how he felt met in the music in expressing these feelings. The cumulative effect was one of success as opposed to the many expressions of failure he had made in earlier sessions.

Example 23: (From: Session 18, mixed songs and improvisation)

(Imm after improvisation) It sounded good! ...	HIGH SUCCESS
I liked it - It was very good music....	" "
my beating the tambourine,	HIGH INTERACTION
and your counterpoint music, was	" "
very good. A music emblem for that.	HIGH SUCCESS
... Sounded very Beethovenish and	HIGH ASSOCIATION WITH
that sort of thing. It sounded like a	PRE-COMPOSED MUSIC
Beethoven sonata when you were playing it.	

MT: So was there anything about the mood or the feeling of the music at all? .. something about the feeling or the emotion of the music that said anything?

It seemed saturnine. (MT asks him to clarify)	HIGH EMOTIONAL FACTOR
It means somebody in charge of everything.	(PERTINENT TO
Demanding you do things his way. You just	CURRENT ISSUES)
don't do anything he doesn't want you to do.	
Well you were playing the bass bits on	
there - a very very aggressive bass. And	HIGH INTERACTION
me bashing the tambourine as well. That	" "
was aggressive. Aggressive music	HIGH EMOTIONAL FACTOR
was coming out between the two of us.	HIGH INTERACTION

MT: How do you feel about that - that we played aggressive music?

Well, I liked it. It was quite good.

(long pause) It's like the Planet movement -

it's very much (shouts) Do it! Do it now!

I'm In charge, I want to be in charge,

I am In charge today! Don't you try

and counterpoint what I'm saying because

I am In charge (hits drum hard) today.

INCREASED SUCCESS

ASSOCIATES WITH PRE-

COMPOSED MUSIC

HIGH EMOTION RELATED TO

SELF & CURRENT ISSUES

Reflecting on the whole session at the very end, he highlighted other concepts pertaining to his **illness identity**, namely those of **ability, skill and success** which were affected by the improvising. In this extract, it is evident that it was far more than the physical success or temporal comparisons which were the foundation for such expressions. In fact, it was not easy for him to express the sentiments in words, as the emotional expression, for him, had lain in the music. However, by metaphorically linking improvisation with pre-composed music, he was able to convey the power and enormity of the emotions he had experienced. Furthermore, interactive elements are acknowledged as having enhanced and validated the experience.

Example 24: (From: Session 18, Mixed songs and improvisation)

MT: Can you say something about the improvising we did?

... That was a very good Beethoven
improvisation we were doing together.

The 1812 bang bang on the tambourine
etcetera. Excellent with the piano doing
some Holst planets and that sort of thing.

HIGH SUCCESS

HIGH INTERACTION

ASSOCIATES WITH PRE-COMPOSED

HIGH INTERACTION

HIGH EMOTION

MT: So what purpose did that serve for you today?

I don't know - after talking about me not being cared for by the nurses and that sort of thing .. it just proved that I can do it, you know, and we did it - it was pretty good music we did today. Proving I can play pretty good music as well. I wish we could write it up because it was just brilliant music!

RELATES TO SELF AND CURRENT ISSUES(dependency/lack of control)
INCREASED SENSE OF ABILITY & SUCCESS
HIGH SUCCESS/HIGH INTERACTION
HIGH ABILITY & SKILL
HIGH SUCCESS

Hence although the improvisation increased his sense of ability, he continued to communicate that the songs had represented something entirely different (see example 25). The properties pertaining to association and relationship over time inherent in the songs had stimulated memories, particularly around his pre-illness abilities. The high meaning and emotion contained within the pre-composed music facilitated him to allow his barriers down, and acknowledge feelings such as 'dark' and 'sad' which he owned and identified as stemming from the realisation that he could no longer do the things which meant so much to him. Furthermore, he stated that the songs stimulated feelings of hope and determination which helped him cope with the current situation.

Example 25: (From: Session 18, Mixed songs and improvisation)

MT: So it proved that you could do it. So is there something different between the improvising and the song? Is there some different purpose for you?

Well the song, was a memory only for today, whereas the improvisation was just some excellent music we did together. We made good music today Wendy.

HIGH ASSOCIATION
HIGH INTERACTION / HIGH SUCCESS
HIGH OWNERSHIP & SUCCESS

MT: Can you put into words how they said those feelings for you? What went on with the songs, because we played the songs and you talked a lot about how you are feeling. What happened? How did those songs get to those feelings?

Well they made me remember things
I did at University, how I used to go walking
everywhere at the time, I used to walk
right across Liverpool, across Manchester
..it meant nothing to get up and go for a
ten mile walk .. and that evokes memories
of doing things like that and makes me
want to get up and do it again. I'd like
to get up out of this wheelchair and just walk
around a bit ..

STIMULATED REMINISCENCES
**PRE-ILLNESS ABILITIES/
ASSOCIATIVE/TEMPORAL**

STIMULATION OF REMINISCENCES

STIMULATES HOPE

MT: What feelings are you left with after all of that though?

Sort of sad feeling about I can't do it at
the moment, and a determination feeling
- determining myself to go and do it
again. ... Determination I'm going to do it ...
And the memories are driving me to do
it as well. When I think - it doesn't seem
logical I can't walk. I'm not low, just memories
coming back. Happy memories, but it sort
of makes me feel ... dark about my past,
because things which were happening
aren't now. Happy memories but uh
maybe I'll do again one day.

BARRIERS DOWN

**LEADING TO HOPE AS COPING
STRATEGY**

HIGH EMOTION

BARRIERS DOWN

TEMPORAL COMPARISON

ACKNOWLEDGES LOSS

HOPES AND DREAMS

From this example, the difference between the two types of music and their inherent properties are clearly identified. Within the latter sessions he had started to combine improvisation and songs in such a way to either open up his emotions with songs and explore such with improvisation, or to explore his abilities with improvisation and then maintain the emotional state achieved by using his songs.

10.3: Summary of results.

In returning to the original research questions, it has been shown that through pre-composed music Guy accessed memories and emotions more immediately than through improvised unfamiliar music. Over time as therapy progressed, however, clinical improvisation served as a vehicle to express his feelings, and he also gained a more positive and able identity through the feelings of success, achievement and independence stimulated. Although there were times in the song-based activities that the therapeutic relationship seemed less important, by building an understanding of what Guy's songs meant to him the therapist gained a much deeper understanding of his emotional needs. The main factors that affected his perception and experience of the two activities were the highly physical nature of improvising and the increased duration of therapy over time. Other factors involved his sense of identity which had been so damaged by his illness. Although initially he responded to improvisation in a concrete way, he was able to show development both in his music and in his own cognitive and emotional experience of improvising. This would suggest that rather than his cognitive problems with abstract tasks and thinking being the reason for such concrete responses initially, that these may have been equally due to emotional factors and the need to develop greater trust within the therapy relationship. This trust was conditional on an increased duration of therapy.

10.4: Discussion.

For Guy, the essence of music therapy was to reach into himself and acknowledge emotional states through music on an implicit level which he was unable to acknowledge or was not supported in expressing at other times at an explicit level. For a young man with a chronic disabling condition the pressures to maintain a coping front are perhaps greater due to social

expectations of male behaviour and stereotypes of being 'strong'. The combination of Guy's personality, cognitive problems and the way he dealt with increasing disability caused him to become more isolated rather than accepted. In maintaining his continual bravado as a coping front, others found him overbearing, demanding and rude. Whilst he attempted to maintain this front within his music therapy, familiar songs touched a part of him which he began to acknowledge. Through his use of songs, Guy allowed himself to experience the pain he felt as a consequence of loss, but also felt feelings of hope for the future and his own determination.

A combination of factors stimulated such responses for Guy. The association and relationship held over time were certainly dominant in his experience of the songs, and facilitated life review. In this way, songs facilitated 'biographical work', which Corbin and Strauss (1987) have described as necessary to aid in the adaptation to the changes which take place as a result of chronic illness. However, the associative and temporal properties also accessed directly the emotional experience of the music which was the important part in his experience. The findings within this study, therefore, reflect those from other investigations in non-clinical settings of Sloboda (1991a&b) and Waterman (1996) who noted the enormous impact of music on emotions. The hypothetical stance stated by Thaut (1990) regarding the associative properties of music and their relevance within therapy have also been supported. Guy's case particularly reflects the power of implicit associations of music stressed by Waterman (1996) and highlight their relevance for therapeutic application. Furthermore his control in repeatedly requesting these particular songs to release and intensify these emotions also supports Sloboda's (1991b) findings that emotional responses elicited by a piece of music do not diminish, but may in fact grow during repeated listenings. However, the role of identification with the thematic content of the words must be questioned in Guy's case. Although the therapist drew

parallels between the theme of his special song and Guy's evident vulnerability, he identified a different meaning within the words of the song, and identified with a strong character within his song. This suggests that it was his relationship with this song itself, the memories it stimulated, and the inherent musical structures or qualities which were important in his experience. This finding, therefore, questions the assertion within the descriptive literature about the client's identification with the semantic content of songs (Bailey, 1984; Whittal, 1991). It also suggests that therapists need to ensure what it is about a song that the client identifies with, and not to assume the meaning held by themselves is the same for the client. Furthermore, it highlights the point that the associative properties or the musical structures themselves of songs may play a more important role than identification with the lyrics. These issues will be discussed more broadly in the final discussion section.

It must be stressed that Guy was a young man battling to cope emotionally with his chronic and increasing disability in a real world setting and not a laboratory setting. The emotions he accessed through the songs were those he had been keeping at bay and managing for so long. Moreover, the emotions elicited by his special songs were not experienced in isolation, but were shared within a developing therapeutic relationship. Within the music therapy setting, Guy was able to let his barriers down, show a vulnerable self, and do so without losing face.

He not only used songs to access these feelings as and when he wanted to within sessions, but he also used songs as a way of exploring a variety of moods and emotional states, whilst maintaining his coping front within verbal interactions with the therapist. Without having to acknowledge any of his more difficult feelings verbally, he was able to choose songs with differing moods, messages and meanings and listen to or participate with these as he chose.

He was in complete control of how far he wanted to let his barriers down with the therapist. Control has already been cited and identified in the previous case studies and related back to existing literature. The link between control and physical functioning has been given particular weight, however, (Corbin and Strauss, 1987; Charmaz, 1987) and this was highly evident in Guy's case. Hence although he shared the music and his emotions to some extent in this way, ultimately many processes did remain very private within his experience of the songs. Further exploration was entirely under Guy's control. The question remains, however, of whether the songs inhibited the therapeutic relationship. It is asserted here that the songs served the therapist as a way of developing the relationship and facilitating Guy in breaking down the barriers he had built around himself. For him, the songs continued to offer a private emotional place where he could seek refuge from the hostility he encountered as a consequence of having to deal, as a severely disabled man, with the environment and people every day. Perhaps more importantly, this vulnerable, emotional side of himself could be shared with someone else. In triangulating Guy's verbal, behavioural and interactive responses and the musical structures of the songs, it was clear that emotional responses did take place. However, it remains ungrounded as to whether such explorations were conscious or unconscious. Furthermore, the analyses made in session evaluations were triangulated through clinical supervision of the clinical improvisations. Although there was little evidence within the analysis that the interactive part of the experience of songs was so important for him, sharing his songs and emotions within music therapy did offer him validation of his more difficult feelings, particularly vulnerability. Validation in this way has been highlighted as essential for development of feelings of wholeness about identity in chronic illness (Corbin and Strauss, 1987).

Figure 21 conceptualises the process which took place for Guy with familiar pre-composed music within sessions considering the properties contained

within the music and their bipolar ranges. Conditional to certain intervening contexts, different strategies were adopted, which then lead to differing outcomes. Furthermore, these outcomes were not straightforward, as there were further conditional properties such as whether he let his barriers down briefly or for a longer duration. Under either outcome, it is hypothesised here that the experience of pre-composed familiar music was one which enabled him to explore and experience emotional states through both the associative properties and structures in the music. At times, he took this further in his verbal acknowledgements, and at others the experience remained private as he experienced a state of barriers down through the music only.

Improvisation on the other hand did not have the associative factors or a relationship over time, and Guy, therefore, initially had greater difficulty finding a musical meaning in it, or certainly an emotional meaning within the music. His key experiences of improvisation, however, involved several main factors. The physical factors dominated in his experience, and initially this overwhelmed him and prevented him from reaching any further into the emotional experience. As he had a background as a musician, this complicated his experience somewhat, by giving him a biographical temporal reference. The comparisons made between his current physical abilities and his pre-illness abilities were initially negative in his experience of the improvisation. He openly measured his skill and ability in playing, which forced him to acknowledge his loss in physical functioning. The result was initially a sense of failure. The total experience was one which only reinforced his illness identity, or what Charmaz described as 'failure to regain a valued identity' (Charmaz, 1987: 285). Certainly the failure inherent in Guy's description of his own participation would indicate this. These findings reflect the emphasis given to the physical effects of chronic illness by Corbin and Strauss (1987) who identified that individuals conceive of themselves through their bodies, reflecting the whole identity. Furthermore they highlight the fact

that identity through the body's abilities is closely linked with biographical time - past, present and future. Certainly Guy's experience of improvisation reflects the extent to which he used improvising to assess concepts of his 'self' i.e. success and failure, dependence and independence, by making comparisons over biographical time through physical monitoring. This model can be summarised in Figure 22.

However, with the condition of increased duration of therapy, the change in his experience of improvisation became clear. When he had not been to many sessions, the condition 'duration of therapy' was low. Under this condition he was more likely to use strategies such as stating rules and thinking of familiar music in an attempt to increase the meaning of music which had little associative reference or relationship over time. Referring back to the chapter 'Coping with the emotional', the conditions under which individuals employed such strategies were when they felt a higher sense of threat, felt less in control and were trying to increase their sense of the situation. In this way, it is clear that he was adopting coping mechanisms within the situation of improvisation. In doing so, however, the resulting experience was less interactive and less emotional. With increased duration of therapy, however, the therapy relationship developed which increased the elements of trust and familiarity with both the therapist and the overall activity. Under this condition different strategies were adopted which facilitated different outcomes. Figure 23 depicts this, and reflects how as duration increased, he related the improvisations increasingly to himself. In doing so, this increased the emotional experience of the music.

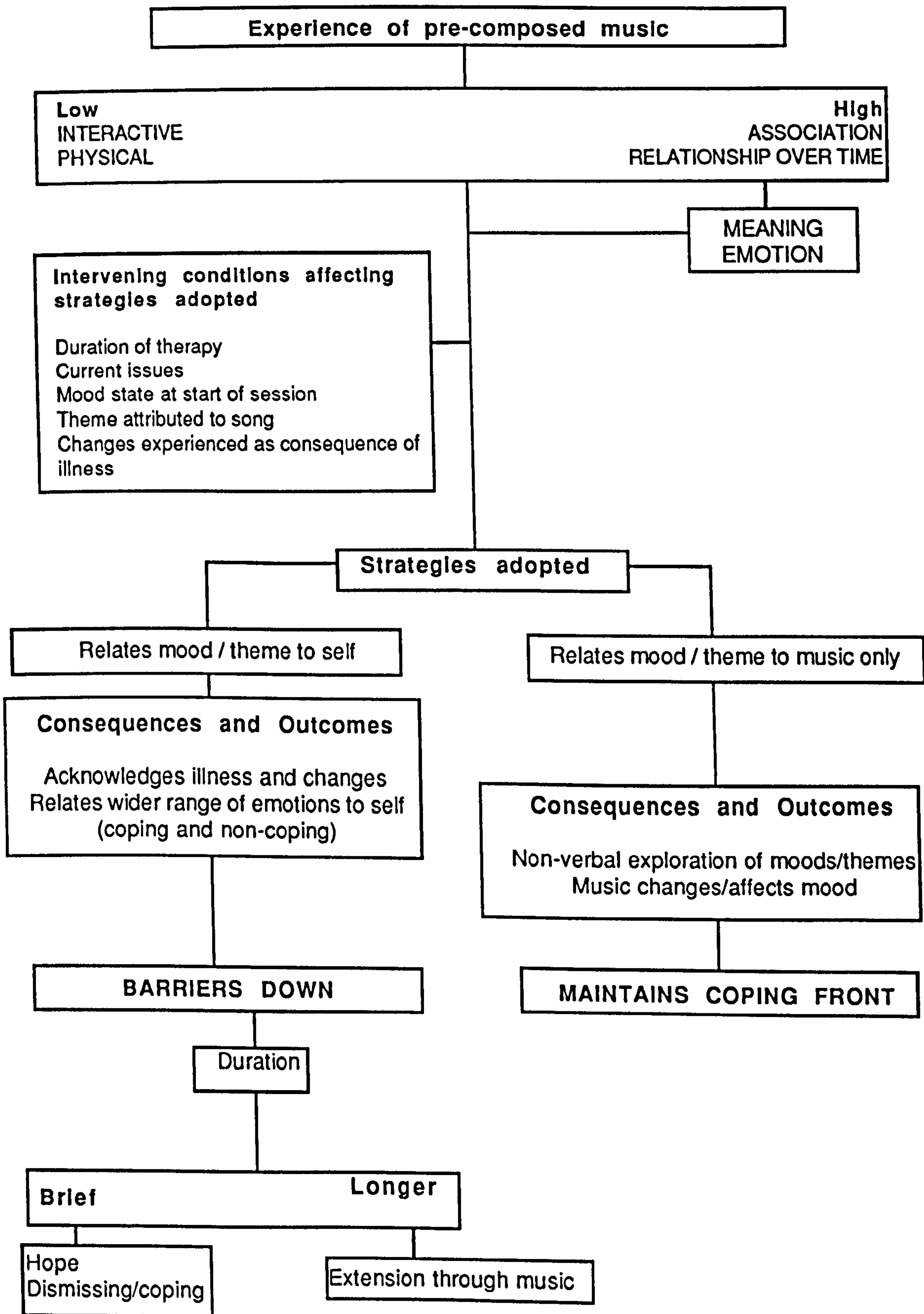


Figure 21: Process stimulated for Guy by pre-composed familiar songs

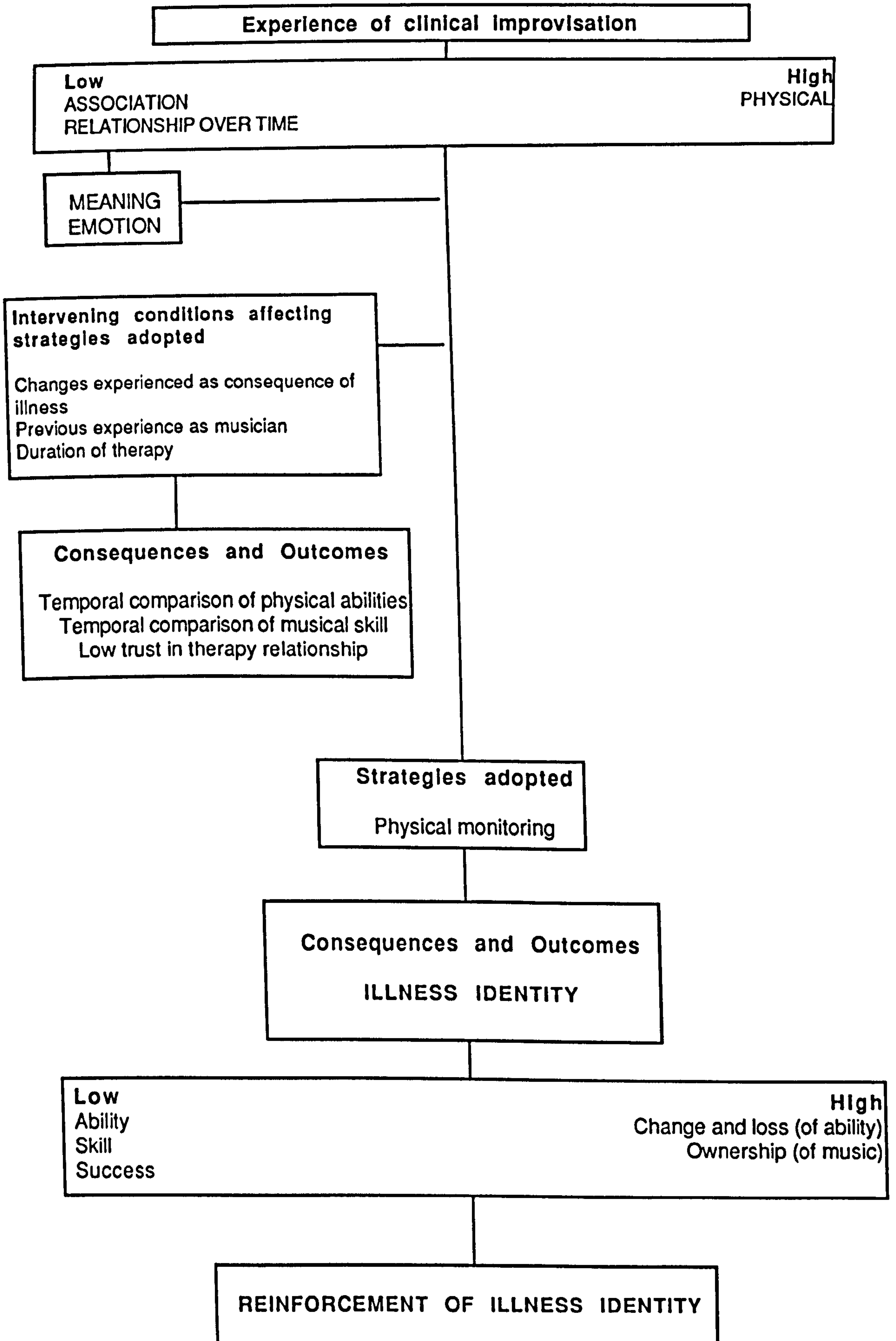


Figure 22: Process of illness monitoring stimulated for Guy by improvisation in the earlier part of his therapy process.

There were further strategies which enhanced the emotional experience within improvisation and in turn bore greater impact on the overall experience. By associating pre-composed music and improvised music in the way that he did (see examples 22 - 24), he increased his emotional experience of the music. These associations were on an emotional level, linked to the musical structures within the improvisation. The interactive element of the improvisations came into play here, as his emotional expression was met and reflected by the therapist, thereby receiving 'validation' for his feelings of successful 'performance' (Corbin & Strauss, 1987). Thus by drawing on his higher emotional experience of pre-composed music, the reference made in this way increased the emotional meaning of the improvisation for him. When combined with the high physical experience and the ensuing strategy of physical monitoring, this served to increase his sense of relationship over time. His mood state on arrival and the events preceding the session served as intervening conditions which strongly affected his experience of the sessions. As improvisation increased in meaning, emotion and interaction, the difficult feelings with which he arrived at most sessions regarding his increasing illness identity came to be expressed within his music. Furthermore, the act of improvising and expressing himself in this way served to disprove his 'disabled' self. Through improvising he was able to experience a successful and more able self. Charmaz has described such a process as 'development of a salvaged self', meaning realising a preferred identity level and salvaging positive self images (Charmaz, 1987). The process within Guy's music therapy is depicted in Figure 24.

The themes within songs were an important part of his experience within the music, and he started to attribute these to the improvisations to increase their meaning and emphasise their emotional quality. However, the musical components of both pre-composed songs and the clinical improvisations must not be overlooked and certainly it has been attempted to describe them here.

The song of greatest significance for him possessed not only highly emotional words, but also an equally emotional melody, rhythm, tempo, form and dynamic range which, in combination, enhanced its expressiveness. These had to be drawn upon by the therapist in order to optimise the emotional experience for Guy. Similarly, however, the musical factors contained within the improvisations cannot be underestimated in their role in stimulating emotional responses. The way in which Guy made associations, however, increased the emotional meaning. In a similar way, although he talked about the cathartic physical release of 'bashing' the drum, it was only when this was responded to and placed within a musical interaction that the experience was truly met emotionally. At the end of the research period, Guy had begun to use both types of music to stimulate emotional responses, express physically through improvisation his feelings about his illness, and then extend his emotional experience once more through his songs. In this way, it can be seen that he combined the musical properties described by Thaut (1990) as the 'collative' i.e. emotional/feeling response that unfolds in the perceptual processing of musical events, and 'ecological' i.e. connotative memories and private images, in a way that personally enhanced the emotional meaning of the music. Guy was perhaps the only one of the three individuals who was able to combine the use of both types of music in this way. His experience of the independent music therapy activities, however, reflects those of both Jack and Jessie already presented. Similarities and differences between the three will be discussed in the following section, with further reference to theory and clinical practice.

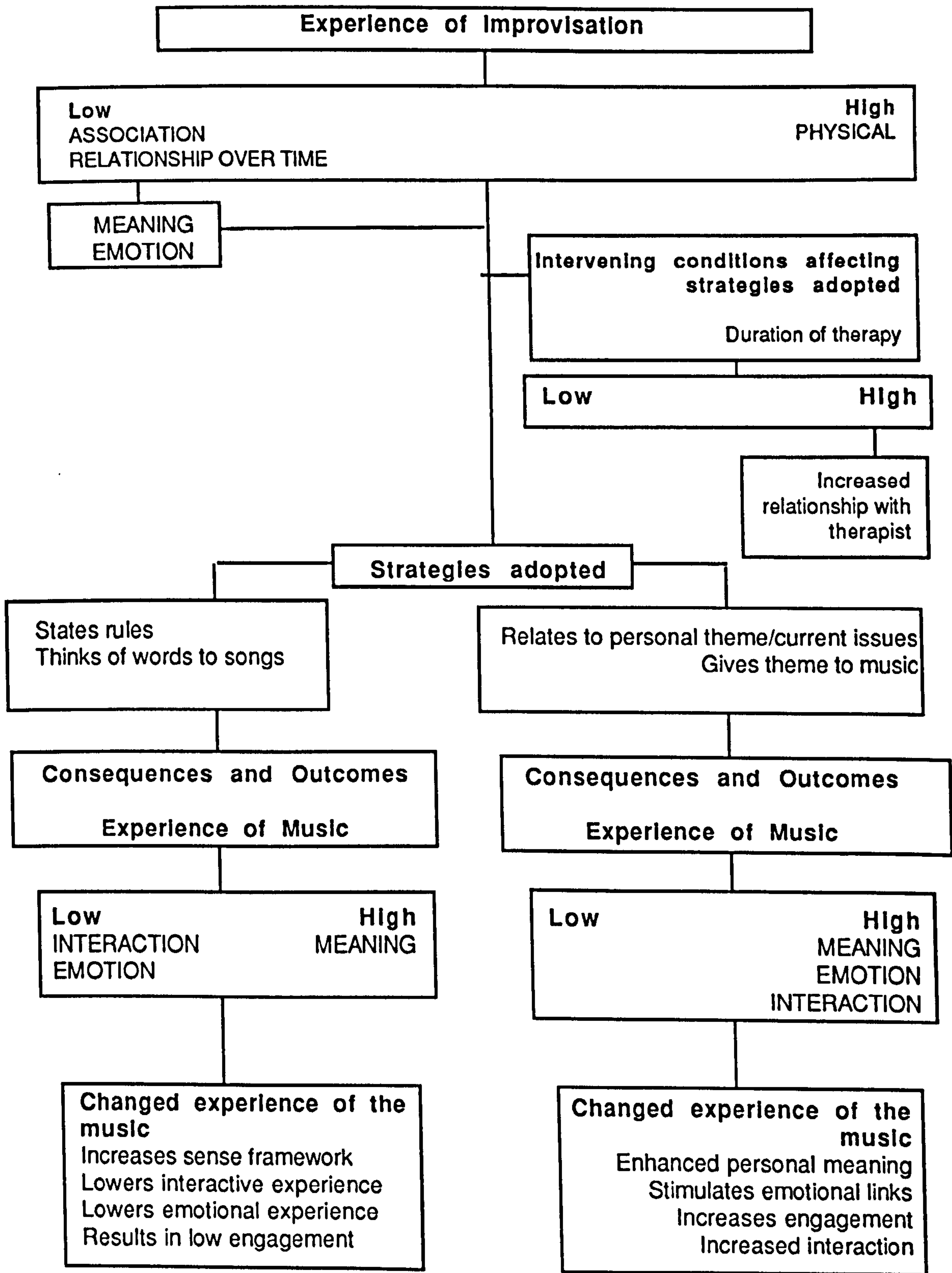


Figure 23: Changes within Guy's experience of improvisation

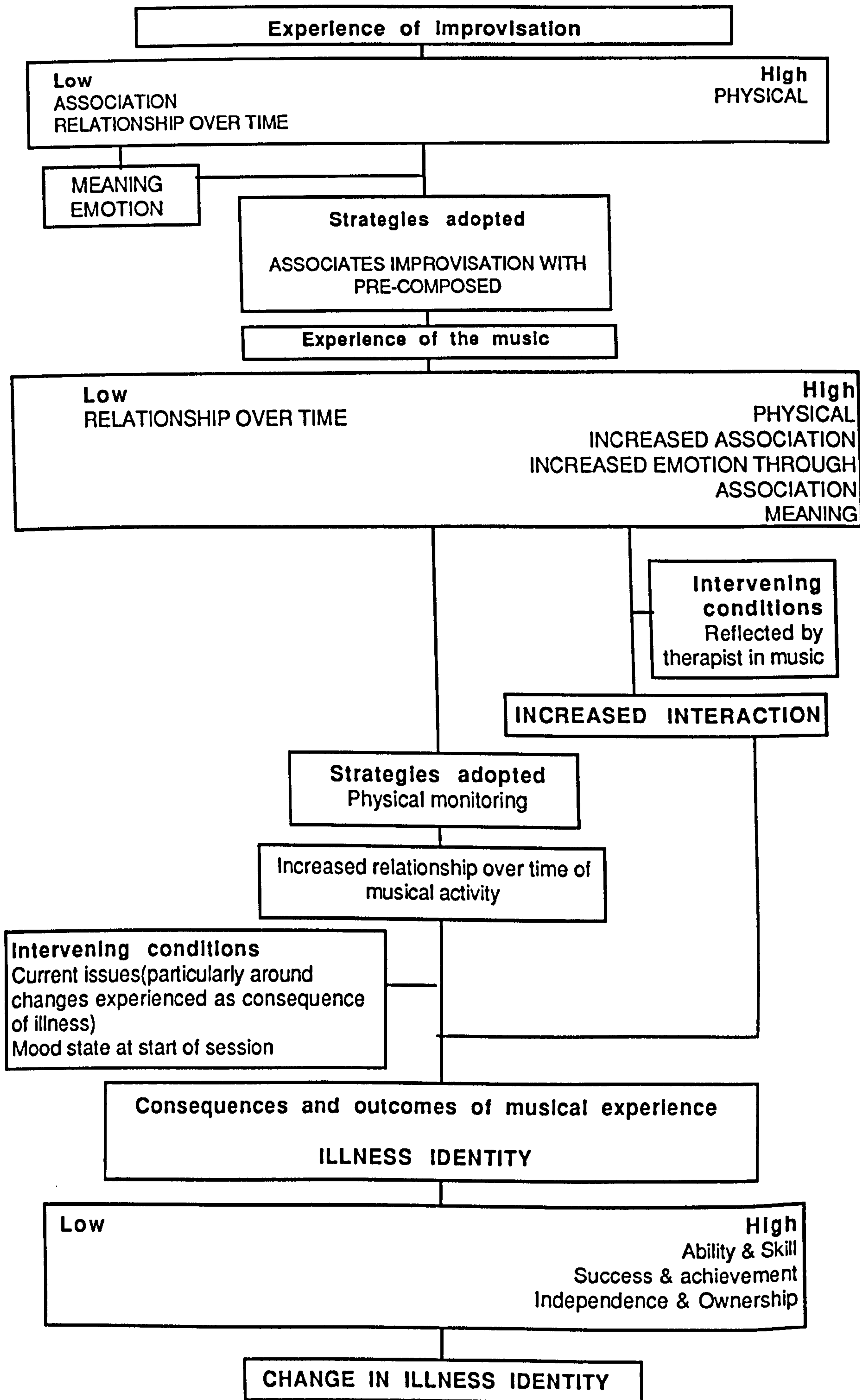


Figure 24: Changes to Guy's 'Illness Identity' effected by improvisation in the later stages

CHAPTER 11

DISCUSSION

11.1: Returning to the initial questions.

In the course of this thesis, moving from the general quantitative pilot study to detailed single case studies, answers have been found to the initial research questions being grounded in the data drawn from the overall group. This chapter will discuss the findings and refer back to the previously reviewed literature to examine how the findings relate to different theories and clinical observations.

As core needs are as individual as human beings themselves, there is no doubt that music as a therapeutic tool, when applied flexibly, is able to meet the broadest spectrum of needs across different client groups. The individuals within this study identified the component parts of the experiences of clinical improvisation and songs as they related to the individuals' needs and lives. What needs to be considered here is whether the analysis provided is relevant only to chronic neurological illness as in this study, or to a wider neuro-disabled group, or to a wider group still. Specifying the 'culture' of any client population has already been shown to affect how music is used within therapy, either at a primary, intensive, augmentative or auxiliary level (Bruscia, 1989). This will be examined further in this discussion under the issue of the prominence of the role which music played *in* or *as* therapy.

Through having identified the component parts of the music experience and the relationship between them, the findings reveal the extent to which the experience of music is a highly individual one. There are commonalities between individuals, however, which allow for generalisation. Songs held **temporal** and **associative** properties which enhanced their **emotional** content and **meaning**. Through these properties, songs helped individuals to implicitly acknowledge their emotional cores and express unbearable feelings which could not be stated in words. Songs therefore helped individuals to

drop verbal coping fronts which may have existed, and move towards a state of **barriers down**. In this way, songs facilitated biographical work as individuals lived with failing health and approaching death. Furthermore, songs could be shared in a therapeutic relationship where the individual would not be judged for expressing difficult sentiments. For example, songs met Jack's core need 'to protest' his 'lack of love'. For Guy, the use of songs allowed his vulnerable self to emerge and initiated the development of the therapeutic relationship.

Improvisation possessed primarily **interactive** properties which validated individuals' **emotional** states, expressed through music. Through the **physical** act of improvising, individuals **monitored their disease progress** and measured change. Although, for some, this resulted in feelings of **failure** and **increased dependence** earlier in the therapy process, as the relationship developed over time, the **interactive** properties served to validate the individual's expression. The combination of **physical** and **interactive** properties caused effects on **self concepts** and shifted individuals' **sense of identity**. For Jessie, the interactive nature of clinical improvisation provided her with validation of her feelings of **success, achievement** and **ability**. This helped her experience new and undiscovered **skills**, develop a **wholeness of self**, thereby shifting her **identity** to reach a preferred sense of self. Although Guy initially had feelings of **dependence** through **illness monitoring** during improvisation, with a longer duration of therapy, the purely **physical** experience of improvisation decreased. At this point, the **interactive** components of improvising validated his **physical** expression of his emotions. This in turn facilitated a shift in his **identity**.

Differences within and between individuals were revealed in responses to the two types of music. For example, songs held a low profile in Jessie's case

study. As she allowed her barriers down more readily, songs did not serve the same purpose for her. Meaningful contact with another determined her central needs. This was met by the interactive experience of improvisation, a non-verbal medium. Additionally, such interactions heightened positive feelings of self, and in turn effected a shift in her identity. Hence individual core needs were seen to be influential factors strongly affecting each individual's perceptions. Jessie's mental health needs were also qualitatively different from the other participants.¹ Within the music therapy literature, particular recommendations have been made regarding clinical improvisation with clients who experience such illness symptoms. Thaut (1990), for example, recommends that the 'here and now' of improvisation meets the needs of schizophrenic patients, whilst Pavlicevic (1997) also singles out the needs of patients experiencing delusions and hallucinations, making claims for non-verbal techniques. Such specifications suggest that the differences in Jessie's responses may have reflected her particular needs.

Ultimately, each person had very individualistic processes for responding to music, as well as individual needs. If it were possible to draw a group of individuals together with similar pathologies, needs, and musical backgrounds, then perhaps more conclusive between individual comparisons would have been possible. It is considered here however that this would be an impossible task, and would not reflect the real world. Even if such similarities could be established, the individual emotional responses to music could not be, despite recommended methodologies offering some way of collecting and categorising such data (Waterman, 1996; Sloboda, 1991a&b). In addition to individual differences, other intervening conditions influence which approach may be particularly beneficial at any one time for an individual. For instance, songs helped individuals with resistant coping strategies in the early part of therapy. For others, verbal strategies played a

¹ Jessie experienced delusions which were attributed to her Multiple Sclerosis disease process.

more prominent role at times. For example, Jessie needed to vent her fears and concerns verbally and know that her verbal expression was taken seriously. To have insisted on only musical intervention would have been dismissive of her distress.

It must be acknowledged here that individuals living with chronic degenerative neurological illness are dealing with not only their emotional existence, but also their physical selves, and possibly with damaged thought processes limiting their understanding of the world. These are the ongoing issues as they also deal with increasing isolation and incurable illness.

The original discussion which revealed that music therapists primarily practice techniques from their particular 'culture' has been shown to be inadequate if attempting to meet the complex needs of the individual living with chronic neurological illness. Certainly, the power of clinical improvisation as a clinical intervention was seen in individual instances, however, it was also seen to fail to engage one of the case study participants in the therapy process or meet his core needs. This is not to say that with a longer duration of therapy that improvisation would not have moved the therapeutic process along. However, as ethical practitioners, we must meet the client where they are. It is fundamentally important to allow the individual to be taken seriously and lead exploration of the 'self' at his or her own pace, particularly for individuals living in hospital and confronted by the issue of a changed identity. That is, if singing songs is important to the client, then this must be the starting point. Some of the clinical literature covered earlier painfully presented examples of practitioners grappling to accommodate the client to clinical theory, rather than the other way around (Ansdell, 1995). Two specific points will direct the following discussion. These are the application of appropriate theoretical models in clinical work with this client group, and indications from the findings for intervention which is focused on the client's particular needs. Personal

perspectives will also be explored, to illuminate the development which took place as a result of this research.

11.2: Questions of clinical practice in Multiple Sclerosis.

The initial hypothetical questions which accompanied this research concerning links between cognitive dysfunction and unfamiliar improvised music could not be supported. In fact, other factors were found to be more influential, such as physical problems. Of the six participants in this study, three had mild cognitive dysfunction, and two others had moderate cognitive dysfunction showing signs of subcortical dementia. There was no correlation found between cognitive dysfunction and the ability to engage in clinical improvisation. The two individuals with moderate cognitive difficulties did show difficulties in responding verbally within the interviews about the experience of improvisation, but this reflected other problems. For example, although not reflected in the interview data, Francesca was observed to actively engage in clinical improvisation for brief moments. This was in spite of being verbally disinhibited, having a short attention span and short term memory deficits. She was, however, unable to translate her experience of improvisation verbally due to language and memory problems. She also repeatedly demonstrated greater emotional enjoyment and longer duration of engagement during her particular songs and a greater ability to verbally discuss these and the feelings they stimulated. Improvisation therefore remained a less meaningful activity for her, but did not fail to engage her nor effect some change in her ability to interact. She also referred to concepts relating to her body immediately after improvising, whereas songs drew her into temporal frameworks relating to the past. Within Guy's case study, a process emerged from his initial concrete descriptions of the improvisations to his latter emotional engagement with such, despite his considerable cognitive problems caused by the early stages of subcortical dementia. Guy's case in

particular demonstrated the power of clinical improvisation once factors which were central to him were overcome. Hence the recommendations made by O'Callaghan and Turnbull (1987 & 1988) and O'Callaghan and Brown (1989) grounded in neuropsychological links between pre-composed familiar music and the cognitive deficits typical of sub-cortical dementia have not been supported in this study. Recommendations for the use of pre-composed familiar music with this type of client group can be made, however, for other reasons which will be discussed.

The results reveal that the focus on the physical aspects of music therapy may initially act as a block for participants in accessing or addressing their emotional states. Throughout the group data and the individual case studies, high property values of a physical experience repeatedly coincided with lower property values of emotional aspects, for example in the process of illness monitoring. In giving closer examination to these values in the participants' descriptions of their physical activity and the manner in which they manipulated the instruments, the relationship between the two can be drawn more accurately.

The marriage between the physical and the emotional aspects of music therapy with neurological client groups as described in the literature is often poor, or tenuous and anecdotal at best. Within the quantitative investigations of music therapy with neurological client groups (Thaut et al., 1993&1996; Miller et al., 1996; Cohen, 1988, 1992; Cohen and Masse, 1993; Cohen and Ford, 1995) the emotional impact or potential of music therapy is constantly ignored or little acknowledged. In their recommendations, O'Callaghan and Turnbull (1987&1988) and O'Callaghan and Brown (1989) largely minimise instrumental tasks due to physical weakness. Lengdobler and Kiessling (1989) focus on the highly emotional responses to MS in their subject group and yet marginalise the physical difficulties involved in instrument playing and

which may have been contributing to the emotional responses. Within the latter study, 'motivation' was identified as being the greatest barrier, but also characterised as being an emotional response rather than a cognitive deficit.

The results from the current study have shown that physical considerations are paramount in the individual's experience of music therapy. For example, the emotional quality contained within Guy's word 'bashing' and the sound he produced by 'bashing' the drum, suggested more than just a physical action. Within clinical supervision, both the musical sound and his verbal concept of the action were triangulated as reflecting an intense underlying emotional quality. Tracey's use of the words 'tinkling', and 'quietly and gently' revealed her desire for more controlled movement in her use of the instruments. In the words she used to describe the sounds of the windchimes, she communicated the introspective experience of her playing as more graceful and gentle than her gross uncontrolled ataxic movements could ever allow. Through her chosen instrument, she was able to elicit a sound which, for her, symbolised something she could no longer achieve. Jack combined the words 'anger' and 'noise' suggesting that although he could never express such an emotion in words, or even through his songs, the act of playing enabled him to 'let a lot out'. It is postulated here that the active involvement in music therapy through playing is a highly physical activity, in which individuals are able to explore their remaining physical capabilities, and use them to cause effect on their environment. Through sustained exploration of their own individual physical change and loss, the physical experience becomes an intensely emotionally charged one relating directly to aspects of the illness identity. Thus, although the original act was one with high physical and low emotional property values, as the therapeutic process developed, heightened emotional responses emerged. Ignoring the physical implications fails to acknowledge what part active music making may really play in contributing towards an individual's experience of interacting with the world and being confronted by their

changed abilities. This indicates that an individual's biological as well as psychological needs must be considered with equal weight if practice is to be client-focused.

In revisiting the literature of music therapy in neurology, we can recall that music therapy with broader neuro-disabled groups has been applied to address four main areas of need: physical, communication, cognitive and emotional. Song-based work was applied particularly focussing on improvement of speech. Despite the common speech problems which present in Multiple Sclerosis, and in particular the group of participants in this study, this was never an aim within this research. At no point did any of the participants demonstrate distress at their speech difficulties, (which were sometimes considerable), nor a wish to work on these through singing. Furthermore, such a reductionist or bottom-up approach to 'rehabilitate' was criticised earlier in the literature reviewed as being inappropriate with people with chronic degenerative illness. The findings presented here do, however, demonstrate that physical and emotional outcomes are strongly linked with a neurologically disabled population. Also, drawing from literature with 'palliative' client groups may indeed be more appropriate.

Although this study does reflect the anecdotal reports by Selman (1988) and Sutton (1988) of clients with neurological deficits feeling greater control in their movement during improvisation, the inconsistency of this process between and within individuals has been revealed. That is, sometimes it was perceived as 'good', and sometimes it was perceived as 'bad'. Relevant variables included the extent to which individuals were limited by the physical changes, the degree of change experienced, and how individuals saw physical changes as affecting their musical expression. Such variables can be appropriately summarised as 'illness trajectory', which is a term commonly used in qualitative research literature from health sociology. Through the

process of physical monitoring, individuals were able to monitor even small changes in their physical functioning. For some participants, the continual search for physical improvements appeared to dominate their experience of the improvising, acting as a barrier to reaching any deeper levels of meaning. This was particularly the case early on in therapy. If there was positive change in the individual's perceived experience, then the experience of playing resulted in heightened feelings of achievement and success. However, often individuals did not experience 'positive' change, and instead 'played how they were'. This resulted at times in a reinforcement of a 'disabled' identity. It is also important to consider that the individual's physical manipulation of the instruments and the resulting music may not have been qualitatively different between occasions. The difference in the individual's experience, therefore, often lay in the music itself, and in how the therapist was able to provide musical structure around the individual's utterances. For example, the musical quality of Guy's 'bashing' did not differ between the sessions earlier on in therapy where he counted numbers during the improvisation, to that when he expressed feeling immense achievement in the power of the improvisation. The musical structures provided, however, did differ.

It was not through the music within clinical improvisation that the links were created between the physical and the emotional experiences. It appeared that the physical act held the greatest personal importance. Feelings of disability or inability were stimulated through both acts of singing and playing, particularly early on in the therapy process. For example, Guy was able to combat the physical difficulties which overwhelmed him at other times, to achieve a heightened feeling of success. Jack, however, never reached such a state within his instrumental improvisations, as his foremost physical task was singing, in which he invested greatest emotional importance. Illness monitoring was, therefore, noted to occur across both activities. For example, Jack monitored any changes in quality, volume or breath control in his

singing. Tracey, Jessie and Guy on the other hand monitored their ability to recall the words to songs. Through the physical nature of singing and playing, individuals tapped into feelings about their illness process, which was always an underlying fundamental, no matter how much it was not acknowledged verbally. This then started to address issues of identity.

Quite clearly, the existing descriptions of music therapy in the treatment of Multiple Sclerosis are lacking in the broader application or exploration of music therapy. Within the findings of their exploratory study, Lengdabler and Kiessling (1989) underplayed the physical role in instrument playing with their Multiple Sclerosis group, whilst giving prominence to the emotional issues which emerged. Furthermore, verbal reflections on feelings about the improvising played a central role in their intervention. Hence although the application of music was seen as a psychotherapeutic medium, it may be assumed that the intervention offered music *in* therapy rather than *as* therapy. Within this current study, dramatic results have been seen to have taken place within the music, albeit with additional verbal exploration (refer to Jessie's and Guy's case studies). Hence the findings presented here offer novel evidence that it is possible to use music as a primary part of the therapy with Multiple Sclerosis patients. Despite the large numbers involved in the Lengdabler and Kiessling study, there are no conclusive findings, only anecdotal reports. Additionally, the design was not optimal, as some individuals included were not able to engage in sustained ongoing therapy, participating in as few as three group sessions over as much as a period of eighteen months. The investigation here indicates that the experience of music therapy, and particularly the physical experience of playing in clinical improvisation, is highly individual. Ultimately, the individual's experience must be given prominence, which the Lengdabler and Kiessling study fails to depict.

If we refer to research concerning chronic illness it should not be surprising that the participants' initial experience of improvising was often a physical one. We can recall that the physical impact of chronic neurological illness is central to the individual's experience, as Corbin and Strauss reflect that 'when illness brings about a failed body ... the foundations of existence are shaken' (Corbin and Strauss, 1987: 252). However other themes were also prominent in the experience of improvisation, particularly that of 'Interaction/relationship'. It was through the interactive phenomenon, heightened within clinical improvisation, that individuals had their attempts to physically interact with the environment supported and reflected by the therapist. This provided the individual with the 'performance validation' which has been described as necessary for reintegrating one's identity into a 'new concept of wholeness' (Corbin and Strauss, 1987). Through the act of mutual music making within clinical improvisation, individuals were able to achieve altered sensations of ability, independence, skill, achievement and success, all of which are components of the subcategory 'Identity'.

11.3: Improvisation and the therapeutic relationship: addressing the 'social'.

The 'social' component must remain a central issue in work with the chronically ill, as prolonged immersion in illness takes its toll upon social relationships and self (Charmaz, 1991). Social isolation translates directly into emotional isolation and loneliness. Taking this as a context for the participants in this study, the impact on the individual's social relationships can be better understood.

Within this study, a process was reflected in descriptions of the experience of improvisation. This developed from the purely physical essence of playing instruments and the barriers to manipulating them, leading to an increased awareness of the therapist's support and role. For instance, improvisation was

initially described by many of the participants as 'noise', although this did change over time. Similarly, improvisation was often initially described in terms of the physical act, the instrumental sounds, or some sort of emotional quality of the physical act e.g. 'bashing', 'hitting'. At a semantic level these descriptions developed into identifying emotional qualities of the music or the playing, and then later, into the association of feelings to the self and one's playing. Following this, participants started discussing interactional qualities in the music - 'sharing', 'corresponding', 'intereaction'. This process from the solo physical experience moving to the emotional/musical duet reflects many aspects of identity reconstitution as described by Corbin and Strauss (1987):

'Through continued self and other validation of each successful performance - however altered, changed, or flawed the performances may be - the ill person begins once more to achieve a sense of identity integration, a feeling of wholeness about identity. Receiving performance validation from others is essential' (Corbin and Strauss, 1987: 275).

The understanding that all tasks are measured as performance by individuals with chronic illness supports the findings here that individuals used music therapy tasks to monitor their illness. Furthermore, the act of improvising was experienced as increasingly interactive over time, as individuals sought and gained feedback for their 'performance' through the therapist's music. This feedback, however, did not exist only in terms of musical performance and components such as volume, intensity and rhythm, but also in the emotional qualities of the musical sounds (refer to Guy's case study). In this way, the act of clinical improvisation served to offer the experience of emotional validation as well.

Within the case studies it has been shown that through the act of improvising individuals gained changed self perceptions, despite also monitoring changes within their abilities as compared to pre-illness abilities. Through the

emotionally expressive medium of music, this found an outlet for expression and reflection. This then validated the individual's emotional experience. It must also be considered that when the experience of improvisation was registered as a purely physical experience, the musical structures provided failed to meet the emotional experience of the individual. It thus emerges that biological, psychological and social aspects must be considered as an integrated whole.

Many questions remain about the little weight and low precedence given by the participants within this study to the 'musical relationship' between therapist and themselves. Other literature with verbally articulate clients emphasises this aspect of their experience and is held above all other aspects of the relationship (Lee, 1996). However it must also be questioned as to why there is so little evidence of music therapy as a clinical intervention with people living with Multiple Sclerosis, despite it being the most common non-traumatic acquired neurological illness in young and middle-aged adults (Rao, 1986).

Although it may be that the findings here are reflective of the therapist's own personal working practice, it is also hypothesised that the way in which the pathology presents in the 'Multiple Sclerosis personality' contraindicates music therapy for treatment. For example, someone presenting with short attention span, tangential thought processes and who is also verbally disinhibited has no difficulty expressing themselves verbally. In fact, it may be too difficult for an individual with these types of deficits to inhibit impulses to talk. O'Callaghan and Turnbull (1987&1988) certainly discuss this aspect of their work with disinhibited Multiple Sclerosis patients, and the importance of ensuring the mix of patients' skills and deficits within the group setting. Working with clients who are verbally disinhibited, it is important to acknowledge their verbal expression, even if only to allow themes of personal

significance to emerge. However, it is also important to distract the client away from verbal material, and into non-verbal tasks, where their material may not be as affected by cognitive deficits. Francesca's exploration through improvisation, which was described earlier, is an example of how non-verbal musical behaviour may release an individual from repetitive, tangential thought processes which dominate verbal behaviour. Verbal expression must be acknowledged, however, to allow the individual to feel that he or she is taken seriously.

In reality, within the screening of referrals for this project, there were individuals who presented with verbal disinhibition. This resulted at times in sessions which were purely verbal. These referrals were rejected for this study due to their inability to inhibit verbal responses to a large degree. Referral to music therapy in the real world work place often excludes verbal individuals, prioritising non-verbal individuals. Furthermore, the physical limitations with which neurologically ill individuals present certainly act as a major challenge for any music therapist wishing to actively involve the client in music therapy. For example, in the advanced stages of the chronic form of the illness, individuals may have control over their eye blinks only.

Within the literature reviewed, theoretical models were seen to vary widely within clinical practice. Generally, clinical practice which applied frameworks stemming from neurobehavioural models failed to reflect in any way the significance of the therapeutic relationship and its role in music therapy. In comparison, practice which drew on psychodynamic interpretations failed to consider the neurological implications of working with this client group. More recently, music therapy literature has begun to acknowledge the need for differing models of interpretation when working with people with neurological pathologies (Pavlicevic, 1997; Usher 1998). The absence of combinational models which address both 'relationship' and neuro-behavioural needs must

be redressed. This will then support music therapists working in neurology to reveal the strengths of clinical practice i.e. be able to meet neuro-behavioural needs, without compromising professional reputation i.e. focusing solely on relationship.

11.4: The music and its effect on the illness identity.

In combining the physical and interpersonal aspects of improvisation, intrapersonal changes were seen to take place. Through the interaction of phenomena pertaining to the musical experience and illness monitoring, individuals experienced shifts in their illness identity. Identity is a construct which is fundamentally affected by incurable chronic illness. Although the concepts which emerged pertaining to 'Identity' were particular to this study and the individuals therein, there is abundant evidence to support generalisation of these concepts outside of this study. The concepts of 'self' and 'identity' occur repeatedly in the literature pertaining to chronic illness. In her many years of research with chronically ill individuals, Charmaz (1991) found that control over defining images of 'self' and over one's life is central to the experience of chronic illness. Furthermore, 'identity' emerges as a complex construct, related to both physical and interpersonal ways of being in the world, with temporal properties, resulting in emotional consequences. Individuals living with chronic illness have been found to gradually scale down their self expectations, resulting in the identity of a 'salvaged self' (Charmaz, 1987). The assertion made by Charmaz that the individual isolated from the external world is unable to claim readily alternative identities has been demonstrated with the individuals who participated in this study, and how they interacted with the world. Brooks and Matson (1987:92) suggest that 'demonstrating that one is dependent on others can strongly contribute to a spoiled identity', underlining the significant interaction between changes in relationships, changes to the body, and how this affects feelings about the

self. In order to address the 'damaged' identity, Conrad (1987) and Corbin and Strauss (1987) state that 'reconstitution of the self' is necessary. This occurs by transcending the body and coming to terms with loss to facilitate the new concept of 'self' around the changes which have taken place.

The phenomenon 'Illness monitoring' which emerged in this study has elsewhere been entitled the 'dialectical self' (Charmaz, 1991). This phenomenon, like illness monitoring, involved taking the body as an object, appraising it, and comparing it with the self in different temporal and situational frameworks. That is, individuals made comparisons between the past, present and future, and also with others. The congruency of the findings presented here with this previous research suggests not only generalisability of the findings presented here, but also offers validation of the analytical methods.

The results of this study have shown that through the active music therapy process isolation is reduced, thereby facilitating the individual to challenge their concept of self. Clinical improvisation incorporates not only unfamiliar improvised music, but also the interactive relationship on an equal basis with the therapist through the physical act of playing. This addresses fundamental issues concerning dependency. Dependency is another crucial issue in forming concepts of self and identity. Individuals with chronic illness express a greater fear of dependence, debility and abandonment than of death itself (Charmaz, 1991). The experience of clinical improvisation stimulated shifts in identity due to the combination of the physical and interactive musical experience with the process of physical monitoring. Clinical improvisation is therefore an effective means of addressing the 'spoiled identity'.

Furthermore, an increased sense of ownership enhanced the meaning of a musical experience. For instance, songs which were chosen by the individual

were in some way owned by them. The ownership of the musical, creative or emotional content of a clinical improvisation was identified by the participants as enhancing the experience for them. 'Ownership' is a critical concept to 'Identity', particularly when related to aspects of the self for individuals who have experienced sustained loss through illness. In terms of material possessions, individuals' lives had been reduced significantly through hospitalisation. In their emotional world, relationships were lost resulting in isolation. Physically, the huge changes caused by illness had shattered each individual's identity and had enormous impact on levels of dependence. Through the exploration offered via improvisation, individuals not only gained a sense of ownership in the creative sense, but also of development through the acquisition of something new. This was referred to in the concepts of 'ability' and 'skill', and was particularly noted when some aspect of the music met an individual's own personal goals.

The emotional consequence of loss is feeling out of control, not knowing what might happen next. As a concept relating to chronic illness, control appears repeatedly, particularly in relation to Multiple Sclerosis due to the unknown aetiology, course and cure. Loss of control in effect raises questions about whether ill people will live, or whether they want to (Charmaz, 1991). The experience of living with Multiple Sclerosis involves any combination of loss of physical, sensory and cognitive abilities. The individuals in this study lived on wards or attended a day centre with others who were at later stages in the illness than themselves. This presented to them 'worse scenarios' of where their illness may be taking them. For example, Jack did not know when or if he was going to lose the use of his voice, Jessie had not known she would lose her sight, and Tracey regularly discussed the progress of others on the ward. None of the participants had control over important and fundamental aspects of their being. Certainly Jessie often verbalised a longing for release through

death. The implications suggest that control is a central property to managing the emotional consequences of the illness. Control emerged as an important concept on different levels; physically, musically through song choice, but most evidently in coping styles.

11.5: Living with incurable chronic illness: Coping.

A critical issue for the music therapist with this population is the way in which music may be used in maintaining impenetrable coping defences, and how to work with these. The therapist must question the purpose of such coping strategies considering that these are in place for emotional survival. Furthermore, by developing an understanding, the therapist may not be so dismissive of an individual's wish to stay with the use of pre-composed material, and instead adapt the use of music accordingly.

As already highlighted in each of the case studies, the concept of control emerged as a property of the strategies individuals used to cope with the emotional responses to his or her illness. 'Control' also appears in the literature pertaining to chronic illness as being one mechanism for maintaining self-esteem. Charmaz (1987) reflects that in chronic illness 'coping' is achieved through controlling one's identity, and in doing so, one feels successful due to the 'front' maintained to the outside world. Health psychology research indicates that social interactions are influential in reinforcing the individual's perception of 'coping' or 'managing' (Brooks and Matson, 1987). It was evident that for the individuals in this study, there were few mechanisms available for coping due to the extent to which chronic illness had resulted in isolation and disability. Songs were seen to be central to the coping processes adopted within the therapeutic relationship in music therapy. Certainly songs were a way for the individual to acknowledge mood states and implicit meanings whilst maintaining a coping front. On many

occasions for each individual in this study, if the therapist attempted to make explicit the implicit moods facilitated by a song before the individual was ready to do so, such attempts resulted in the client verbally dismissing the therapist. It was recognised that such failed attempts on the part of the therapist to bring into the conscious and verbal forum that which had gently been raised by the individual in the musical were ill-judged and untimely. Hence although an individual could sing about mood and emotional states which otherwise would be identified as 'not coping' or intolerable, within the music, such feelings were tolerated. It was only when verbal reflection took individuals too close to the issues at hand that coping strategies would be adopted, such as distracting or contradicting. This is a crucial issue for therapists who may be dismissive of an individual who expresses the wish to stay with the use of songs.

Research indicates that it is the learned associations which translate music into mood states such as, for example, anger or fear, as no generic sound patterns exist in music to communicate such as occurs in semantic content of language (Thaut, 1990). This offers a greater explanation for why individuals who had difficulty accessing their emotional feelings, or allowing their barriers down, were able to access such feelings through their songs. Songs served as the musical vehicle to which particular emotional associations were attached, and could therefore be stimulated. This was not an end in itself, however, and served only as a departure point from which further exploration could take place.

Bailey's suggestion that songs help terminally ill individuals maintain their defences finds general support here (Bailey, 1984). Within this study, however, the use of songs for this purpose was far more subtle. For example, both Tracey and Guy used songs for 'determining' and fighting their respective situations. For Jack, the songs represented the only way he had of

'protesting', and acknowledging his unbearable feelings of loss and loneliness. Coping strategies were employed as the fear of not coping led to insufferable and unbearable situations, usually relating to emotional states. For example, Jack verbally gave extremes of 'cheerful' and 'depressed' as being the only two options of feelings, with no inbetween state. Also, he used a temporal indication of 'all the time', hinting that such a prospect may be an unending state of emotion. Individuals who employed coping strategies were those who recognised and feared such an unending unbearable state, and acted to control this.

Robinson (1987) suggests that the term 'denial' is not helpful in gaining an understanding of the individual's coping mechanisms, due to many varied aspects of change which one is expected to 'accept'. Within this study, denial was seen to be an expression of hope and the refusal to accept the situation as it was. Denial was expressed at different points in the sessions, but particularly when an individual felt a higher sense of threat. Instances of 'barriers down' however suggested low denial. Within the sessions, the use of denial was lowest immediately after songs which held great personal meaning to individuals. In relating to the emotional content of their song, individuals were able to move beyond the emotional state of denial. By personally identifying with the emotion elicited in this way, individuals could start to own the feelings they may have otherwise identified but denied. Also, the personal associations which were held with such songs led to the experience of life review, which in itself drew on a myriad of emotional experiences and states which existed prior to illness, before the need for 'coping fronts' and denial. Through the relationship held over time, songs stimulated temporal review processes which have been observed to exist anyway for the chronically ill individual (Charmaz, 1991). Therefore pre-composed familiar songs which held great meaning to the individual served

an invaluable purpose, particularly for the individual whose coping mechanisms were strongly in place. Coping strategies were not seen to be broken down within clinical improvisations in this way, although without doubt, implicit processes may have taken place.

11.6: Music as an agent of hope and change: meaning.

Although previous literature has emphasised the meaning of songs as residing in the verbal lyrics, meaning was attributed in a diverse number of ways in this study. For example, participants often chose songs which they associated to a performer or a characteristic attributed to the performer. There may have existed some link for them between such a characteristic and a current issue in their own lives. For example, Tracey requested a song associated with 'strong', 'defiant' or 'determined' performers when she felt she needed help to stimulate these feelings in herself. There may also have been some link between the status or image of a song, and some personal theme for the participant. Guy used songs in such a way for two different purposes. He sometimes demanded music with which he associated the 'drug' culture as a way of identifying with an image he perceived as being 'cool'. This appeared to be as a defence within his sessions. At other times he requested heavier rock music. Initially, the therapist believed the latter request to be a form of defence within the music. When explored in more depth however, it emerged that this music was 'determining' music for him, which he associated with motivating himself in his treatment to strive for goals which must have seemed increasingly unrealistic and unreachable. Francesca also chose songs which were pertinent to her current issues. For her, the theme of acceptance was fundamental in her life, due to her sexuality which had caused a painful rift in her relationship with her father. This damaged relationship increased her sense of isolation, particularly since the death of her mother. Francesca chose songs with 'happy' themes and with 'happy'

endings, and then 'dreamt' herself into the story. This offered her some sort of escape from the reality of 'problems with her body' and the increasing isolation she experienced in her home environment. For Elaine, too, the significant themes were both acceptance and anger. The songs to which she related helped her express the anger she felt towards her family for not providing greater support for both herself and her elderly mother who looked after her at home alone. She gained feelings of love and acceptance, two feelings which were central to her life and unresolved relationships, from songs related to a particular performer.

Therefore the experience of pre-composed music can be seen to be complex in its interpersonal, and also intrapersonal processes. Explicit and implicit experiences still need further examination within this study. Revelations for the participants involved took place both implicitly within the musical experiences but also explicitly in verbal reflections about the music.

In his treatise on emotion and meaning in music, Meyer hypothesised that if cognitive deliberations and reflections stimulated by music remained unconscious, then these tensions resulted in emotional responses (Meyer, 1956). Although Meyer's theory relates to mood induced primarily through stimulus patterns i.e. musical structures, rather than associative properties, both have been shown in this study. Certainly Meyer's ideas on unconscious processes could be extended outside of the purely musical experience to include the associative experiences. Although there may be many different emotional and associative responses taking place simultaneously, if the individual does not verbally elaborate on these experiences, the emotional experience may therefore be intensified and increased. This would suggest that by discussing a particular emotional response to music, the process becomes intellectual, thereby bringing it to a conscious level. Here we return to the ideas put forward by Waterman (1996) that emotions aroused by music

become an implicit effect of conscious awareness related to that particular material, and that on repeated future presentations of the material, behaviour is influenced in a similar way. Waterman also highlights the complexity of emotional responses to music, which can include memory responses, emotional precursors and the above implicit responses. These ideas offer strong support for the emotional responses observed within most of the participants to familiar pre-composed music in this study.

For example, Guy was unable to maintain his 'brash' front when his two special songs were played. These songs not only evoked explicit memory responses, but also implicit emotional responses. These emotional reactions were on most occasions conscious, and therefore acknowledged and explored. However there were other occasions when the responses remained implicit, unconscious and unexplored. The sessions where Guy led the music by his requests through a range of emotional moods and thematic messages is a vivid example of using the implicit emotional experience of music. In this way he explored a range of emotional states - both 'coping' and 'non-coping' - in a way that he could not access otherwise. Jack often did not wish to explore the emotional experience or meaning of his songs. In doing so he often reverted to a 'happy' coping front (see example 2, in Chapter 7: 'Coping with the emotional'). In becoming what he termed 'lost in a world of music', it is evident that he was experiencing a realm of implicit emotional responses held within the songs through their associative properties and musical structures. Emotional responses to familiar pre-composed music were far more complex however than simply stimulating 'sad' or 'happy' emotional associations, which reflects what has already been emphasised within the theoretical literature (Thaut, 1990). Such complexity would suggest that alongside theories examining the perception of and responses to musical stimulus properties, an individual's personal psychological constructs play an additional influential part within their responses to music therapy. This must

have particular emphasis with the client group being discussed here - articulate adults who have led 'normal' lives, in which they have had to cope with chronic change and loss stemming from their illness.

There have been other occasions within this research when unconscious processes were assumed to have been taking place touching an emotional level of responsiveness. These have been supported by behavioural observations, the meaning of the song known to be held by the individual, or the emotional quality of the music improvised. Adopting Pavlicevic's stance of 'dynamic form', understanding that music and emotion share fundamental features, may provide a theoretical framework for how the individuals in this study could 'hear the music as dynamic feeling states', but not articulate this (Pavlicevic, 1997). For example, both Guy and Jack used sadder songs, both consciously and unconsciously, to express their feelings when singing, or when wanting to get in touch with a sadder memory. Each, however, verbally denied or masked feeling such difficult emotions, explicitly stating that they felt, for example 'happy', and that this had determined their particular song choice. By using the songs which they related to specific events, points, or stages in their lives, and identified as being 'sad', each chose to stimulate such feelings, was able to express their feelings within the music, and allowed themselves to experience such feelings within the safety and boundaries of a familiar song. As has already been discussed, denial was seen to be an essential coping mechanism for the participants within this study. By using music in this way, the coping front adopted was lowered for a period of time, in a way determined by the individual, controlled by their choice of song.

Although Bailey's (1984) hypothesis that pre-composed music can support coping styles, the role she proposed song themes to play could not be supported. Whilst meaning may have been attributed to themes and categorised by the therapist, it became evident that song themes held

alternative meanings for individuals. It was essential that the individual's meaning was given prominence. Furthermore, in understanding the individual's meaning, the therapist gained greater insight into the individual's psychosocial functioning. The participants in this study were not seen to progress through the stages suggested by Bailey, although the use of songs as a defence mechanism did occur. Ultimately, songs held non-verbal meanings as well, which could not be determined by the therapist.

Sloboda's (1991a) findings that music is most commonly experienced as an 'agent of change' has been confirmed within the thematic material given by all the research participants in this study. It is expanded, however, to offer explanatory mechanisms for how such change is effected. Sloboda attributes the 'change agent' concept 'as offering an alternative perspective on a person's situation, allowing him or her to construe things differently' (Sloboda, 1991a: 34). It emerged from the participants' experiences that, via the temporal and associative properties stimulated, individuals related to emotional selves stemming from the past. This 'temporal' self thus stimulated, revealed to the individual emotional associations which existed before the need for coping fronts. It was in this way that individuals gained alternative perspectives on their self in the present and current situations.

The belief that pre-composed music is able to offer alternative perspectives is commonly used within the range of techniques drawing on familiar pre-composed music, including 'musical life review' (Bright, 1986) and 'musical profiles' (O'Callaghan, 1984). These techniques have claimed to increase feelings of self worth through the process of music stimulating memories of past achievements and life successes. However, the complexity of the processes stimulated by songs has been revealed here, suggesting that the theory underlying such techniques is oversimplified. Individuals living with chronic degenerative illness did not achieve higher levels of self worth

through the process of reminiscence. Memories of life events may have been stimulated or reminisced upon, but these were more likely to stimulate feelings of loss about the changes incurred through the illness, or strayed from more personal feelings to maintain greater superficiality in interactions with the therapist.

Sloboda (1991a) identified that respondents in his study stated that the music promoted 'an *intensification* or *release* of existing emotions rather than creating the emotion (Sloboda, 1991a: 34) supporting the claims made within this study that individuals' choice or use of pre-composed music had purpose within their therapy. This would also support the observations made within sessions that unless the music held particular meaning and unless the individual had specifically requested the song used, they did not engage emotionally with it. For example, it was difficult to find pre-composed songs which Jessie was able to choose without assistance, or with which she engaged. Her emotional responses within pre-composed activities were often reduced. She articulated, however, that she felt more aroused and stimulated by the improvisations. When she was able to initiate some part of the music, for example the tempo and rhythms which prevailed in her improvisations, her emotional expression within the musical components could then be reflected and developed within clinical improvisations. In this way her emotional expression was intensified and released in a way that pre-composed music was unable to harness.

Jessie's case study also raises many questions about the differences in her responses, both in comparison to the other case studies, but also largely from the other group participants. Although the importance of the individual case study is emphasised within the design and results of this study, further explanation must be sought for such variations. Cultural differences cannot be ignored considering her background, and the effects this had on her response

to the instruments and the familiarity with improvised music making. This caused the associative properties of each activity to be more equally weighted for her than for all the other participants. The extent to which the effects of the disease manifested so differently within Jessie than within the others in this study can go, however, some way in offering an explanation. Perhaps more than the others in this study, Jessie had very limited abilities in her interactions. This was not solely due to her blindness, but predominantly through her psychotic episodes and persecutory and delusional beliefs which increased her isolation from everyone around her. Although her interactive 'disabilities' were prevalent in her verbal behaviour, in fact her ability to achieve what Pavlicevic entitles 'interactional synchrony' (1995) was strongly evident within many of her clinical improvisations. Within music making, particularly that of improvising, she was able to achieve a heightened sense of synchrony with another, perhaps more meaningfully and effectively than in any other way available to her. Jessie's need for interpersonal/intermusical experiences was perhaps more than the others in this study.

However greater consideration must be given to what the implicit meaning of the improvisations were for individuals, even when they could not articulate such. Pavlicevic (1997) debates the primacy of 'meaning' versus 'creating'. Within Jessie's and Guy's case studies, descriptions depict 'being' the music. That is, the music sounded as they were, defining their identities, through physical, emotional, and interpersonal ways. The musical meaning remained elusive in their 'non-musician' interpretations. As chronically sick individuals, their interpretations revealed how much the music embodied their concepts of self. This may mirror what Pavlicevic describes as the "portrayal of the client's experience of 'himself-in-the-world' through sound" (Pavlicevic, 1997: 116).

The lower interactive properties contained within songs may be considered to have hampered the development of the therapeutic relationship. This is an

aspect already discussed by Bruscia in his broad and inclusive range of definitions of music therapy (Bruscia, 1989). As already highlighted, he differentiated between the use of music as therapy where the primary therapy process takes place in the music, as opposed to music in therapy, where the client-therapist relationship has greater prominence and may involve additional verbal techniques. In this study, the findings reflect the intensity of individuals' relationships with their songs, and the higher interactive components of the experience of improvisation. It is proposed, however, that the use of songs in this study was not the augmentative use of music as in the extant literature reviewed in chapters 1 and 2 (see for example Dawes, 1985a; Curtis, 1987). Rather, songs were a departure point from which the therapy process grew. Songs often held a very personal meaning which may have remained unacknowledged or unexplored. There was some aspect however to sharing one's special songs within another that enhanced the experience for the individuals. Rather than listening to the songs in the isolation of their bedroom, individuals shared their hopes, fears and feelings with the therapist in a way that was not directly verbal. This aspect of sharing one's personal relationship to songs was seen to influence behaviours outside of the sessions. For example, singing, listening and playing within music therapy to songs which represented so much to Tracey from her past provoked her to hunt out her old records on her following home visit in order to share with the others on the ward. This action gave her some purpose, as she needed to be continually finding ways of helping the others living around her. It was also a way of sharing something highly personal, and seeking others who may have relationships with the same songs. Hence songs did not provide the intensity of relationship with the therapist in the way that improvisation did. The relationship in the music was held with the songs themselves.

Considering that British practice holds the client-therapist relationship most important, this may explain why songs are not a primary treatment modality. However, through sharing the emotional experience of their songs, individuals did share their innermost feelings and thoughts implicitly and explicitly with the therapist, thereby helping to develop the relationship. Jack's example of songs being friends who had 'always been there' indicated the importance songs held for some individuals.

In this way, songs were shown to be used as therapy. The individuals in this study however were able to progress to include the use improvisation as therapy, as a way of sounding or playing their 'selves'. Rather than existing as separate entities (songs in therapy and improvisation as therapy) the two approaches were combined as part of a larger process. This suggests that the application of music in/as therapy need only be so if clinical application dictates such.

However, the private meanings held in songs also inhibited the shared intention of the musical therapeutic process which certain schools attribute to the power of clinical improvisation (Ansdell, 1995). Even within improvisation, however, it became apparent that intention and meaning were not necessarily shared between therapist and participant, as became apparent in their explicit verbal descriptions of the music. Hence, improvisation also relied on implicit personal meanings, albeit in an interactive context.

The unconscious links made by the individual to their songs can help the therapist to gain a picture of that person. It can also offer the individual the chance to test boundaries of safety in terms of how much to share with the therapist. Understanding the individual's schemata of a theme or story of a song was the first step to acknowledgement within the coping process, rather than denial. Acknowledgement in that way on a non-verbal musical level

sometimes led to verbal exploration later. Alternatively, it may not have led to verbal discussion. In that case, there was acknowledgement on some emotional and unconscious level. In this way, songs often initiated movement or change in a way that improvisation was unable to stimulate.

11.7: Biographical work through songs.

The associative and temporal properties of songs give them enormous potential for facilitating the biographical work which has been described as being so important for individuals with chronic illness. Corbin and Strauss (1987) identify three major dimensions to 'biography': conceptions of the self; biographical time incorporating past, present and future; and the body, which exists as the medium through which identity is formed. The chronically ill have been found to engage in multiple reviews through imagery which recaptures the past, examining the present and projecting into the future.

It should be no surprise, therefore, that the temporal properties inherent in songs were a key phenomenon for most of the participants in this study. Songs were repeatedly expressed as having reference and meaning in the past, the present and the future. In this way, they stimulated thought processes, associations, feelings, and responses linked to each of these time references. Most importantly, such responses were spontaneous, whether or not they were explicit and explored, or remained implicit and private and could only be observed in behavioural changes. Songs helped individuals incorporate their illness and the changes experienced into their lives. The emotional expression and temporal references stimulated by songs helped individuals develop frameworks to make sense of the losses and changes experienced, within the boundaries of the music therapeutic relationship. Thus, the types of biographical work which have been identified through grounded theory research were also found to be facilitated by the use of

songs in this study. Individuals were able to contextualise their illness into their biography in the ways already described and gain a sense framework. What is described elsewhere as 'coming to terms' with illness was also experienced by the individuals who moved through individual coping strategies and to a state of barriers down when using their songs. It is significant that the results reflected that this was not a permanent state, nor did it follow a set sequence of steps. Individuals moved in and out of a state of barriers down in response to a combination of variables. Songs which held great personal meaning did, however, facilitate such movement.

The temporal and associative properties within familiar pre-composed music did stimulate life review in the individual, but this in itself did not aid in the therapy process per se. It was these factors more specifically which gave the music greater meaning and greater emotional content on an implicit level as described already. Although the phrase 'musical life review' has been coined (Bright, 1986), it is disputed here that using songs in this way, as an end in itself, results in a therapeutic process. Within this research project, it was only the first step of a deeper process. The findings given here reflect how songs may facilitate freer communication between therapist and patient, supporting the observations made by O'Callaghan (1984) in building musical profiles for patients. However, the participants in this study did not only relay previous experiences to songs. They also related issues central to their current existence to the themes, feelings and memories which gave songs their meaning. Participants related that imagery into the future was stimulated by their songs. This is highly significant for the individual living with degenerative illness, for whom the future is unknown in every aspect of their existence.

The semantic significance of songs did not hold as much importance as the existing literature would suggest. For example, the use of song themes to 'communicate' has been found as central to the use of both pre-composed

songs and song writing with this client group (O'Callaghan, 1995&1996). These findings were reflected in this study to some extent, as it was found within the group data that songs were used to communicate personal messages (see subcategory 'Communication', in chapter 4: 'The Musical Experience'). However the individual analyses revealed that songs for the purpose of communication did not feature significantly in the interactions of larger processes occurring. This low frequency of involvement indicated that the use of songs as a communicative phenomenon did not lead to deeper processes within the therapeutic process. For example, individuals may have related a song's story or message to an individual in their lives, but this did not lead to further processes within the therapy. Often the use of song in this way served as an end in itself within a single session. Furthermore, the exploration of communicating in this way necessitated greater verbal techniques. All use of verbal exploration was closely monitored in this study. Whilst it is recognised that for individuals who are highly verbal it is important to acknowledge their wish to use words, it is also important to examine the underlying reasons for the need to do so, thereby avoiding the use of music. Hence if an individual wished to explore verbally issues around, for example, a particular song, they were encouraged to do so in ways which related to the song or the personal issues stimulated. They were also encouraged however to stay focused on those issues stimulated, or were refocused back onto music again. The use of songs for 'communication' did not play as major a role as expected in this study.

11.8: Music therapy: the gestalt experience.

Within this study, the individual's experience of music therapy has been explored, and found to operate on physical, emotional, interpersonal and cognitive levels. Intrapersonal and interpersonal processes have been demonstrated in both particular techniques explored. The findings suggest

that with this client group, the adult living with chronic disability stemming from neurological illness, a model of practice which incorporates the whole picture of the individual is necessary. The therapeutic relationship must not be ignored, as has been the tendency in the literature pertaining to neuro-disability, as this is central to any meaningful intervention. Similarly, however, theoretical frameworks which focus on the relationship alone fail to meet the complex biopsychosocial needs of the individual with neurological problems. There is a strong need to take on board life experiences from the past, difficulties with living in the present, projecting into the future, and understand the place of music in such. This has been shown to be the use of familiar pre-composed music which holds personal meaning. To address fundamental issues of identity and work towards reconstitution of the damaged physical and emotional self, clinical improvisation has been shown to offer opportunities to shift the individual's concepts of self.

Models of clinical practice have also been examined as they affect our methods of intervention. As a medium, it has been shown here that music is able to affect the biological, psychological and social aspects of the individual with chronic neurological illness. Each of these aspects must be considered and addressed for effective treatment to take place. As a gestalt approach, a biopsychosocial model reflects most closely the gestalt musical experience, operating on conscious, unconscious, physical and emotional levels.

Furthermore, if an individual's needs are to be truly met, there may be times when music is not appropriate, or there is passive involvement only. The individual's needs are paramount at all times. This suggests that when a client expresses the emotional need to journey with a favourite, meaningful song, this must direct the therapy, not what the therapist defines as music therapy.

As clinicians we need to draw on all the different properties which may pertain to music, such as the psychophysical (i.e. intensity, tempo and timbre), the

structural (i.e. order, novelty and surprise) and the associative properties. There will be times, however, when working with clients with degenerative neurological illness when they are no longer able to participate actively. At this stage, there is a need for clinical practice where the client is able to be passive to a larger extent, not simply just a non-participant listener, but participant to the extent that their abilities will allow, with the therapist examining and remaining acutely aware as to what role songs can play in the therapeutic process. The role of the therapist in this case needs to be sensitive to minute physical or behavioural changes taking place, in order to optimise any relation which can be built between the client's responses and their music. The therapist also needs to have a thorough understanding of the relationship which the individual holds with the music used, and how that individual interacts as such in their relationship.

At this stage of the process, songs offer more than just a coping strategy, or a chance to reminisce. For example, despite his illness process and the difficulty which Jack was experiencing in vocalising, he used the songs within his music therapy as a way to defy his illness process. For him, 'to sing' was 'to live'. It can only be contemplated what singing really symbolised for him. Although he did not overtly acknowledge or discuss his difficulty with breathing, it is possible to interpret deeper meanings to his statements. In reality, Jack died of pneumonia and respiratory failure two years after his participation in this study finished. Looking back on this data, it appears that his experience of singing his songs represented life's breath running through him. The continual referral to his breathing, throat and voice, on reflection, indicate a high level of anxiety which he was attempting to conceal.

11.9: The implications of this study - the wider picture.

At this point we return to the initial literature, in which four main areas were the focus for music therapy intervention with a neuro-disabled group. These were

communication, physical, cognitive and emotional needs. The last of these, however, was often either not addressed at all, or not measured in an objective fashion. The literature suggested that often music therapists were hunting for the human behaviour or response upon which music had the greatest impact, and in doing so often claimed to cause dramatic changes in all aspects.

For music therapists working in institutions or hospitals which work within the medical model, there is most frequently greater validation given to those interventions which can show how a patient has improved. This is particularly so for physical interventions. Within the medical model setting, treatment goals as set by a typical multidisciplinary team are usually 'functional', reducing the individual to a list of physical and medical 'problems', which do tend to be the overwhelming ones which present. The social, emotional or interpersonal needs of the client are often seen as being less important than the more visible functional needs, and certainly appear more difficult to measure objectively. This often results in the music therapist feeling less valued in his or her work. Such aspects are clearly reflected in the literature reviewed earlier concerning music therapy and neuro-disability. Within the brain injury rehabilitation literature, greater emphasis was placed on functional gains clients had made in 'music therapy programmes'. This was accentuated in the empirical research examining the role of metronomic pulse in improving Parkinsonian gait. It is strongly questioned here, however, if this is truly music therapy. It must also be questioned as to whether this is not an attempt to 'window dress' music therapy as a curative intervention. There is no doubt that for individuals experiencing an improvement in their gait there may be some impact on issues of identity. However, is this truly the optimum use of a medium such as music therapy for individuals who face immensely bleak and hopeless futures? As practitioners of a medium which may support the difficult emotional consequences of facing mortality and validate the

exploration of physical limits, it is important not to become swept up in trying to show how we can 'make better' those patients for whom there is no cure. Furthermore, incurable illness means facing increasing disability and ill health. It is important that as individuals experience even further loss and degeneration, that we are able to accompany them on this painful and challenging terrain, rather than discharging them, as other therapeutic interventions do because there are no longer any gains to be shown.

Working within the 'medical model' only increases the sense of futility with this client group, both for the 'patient' and the clinician. In this model, not only are aspects of the individual, the personal, the emotional, and the expressive less valued, but such emphasis is placed instead upon improvement, gain, significant results and group norms. In other words, concepts which are unattainable or irrelevant to the individual coping with incurable illness. The implications of this study are therefore much wider reaching than simply comparing two methods of music therapy.

Discussions with colleagues working in similar settings as the one in which this research was carried out, have revealed a sense of 'hopelessness' and 'futility' about working with the incurable as a music therapist. One colleague hypothesised that these desperate feelings were a result of transference from the patients, and spoke of the defences we adopt as a profession against such feelings. As practitioners, we are left with a feeling of 'there is nothing I can do'. Perhaps this offers another explanation as to why so little literature exists about music therapy and Multiple Sclerosis. Individuals living with Multiple Sclerosis are desperate for a cure, and this is central to their day to day existence. As music therapists, we have no cure to offer.

This discussion is seen as centrally important to the work with this client group. This research has revealed powerful outcomes of music therapy

intervention. However it has also established how individual such outcomes are: individual processes and responses from individuals living with personalised illness trajectories. It is stressed here these are individual stories. Additionally, this research reflects my individual working practice and my own personal journey. However, without doubt, 'identity' is a central phenomenon in chronic incurable illness. The wider implications of this research are that as chronically ill individuals become weaker and more disabled, we are able to continue working with them. This research has illuminated how music therapy may be able to address a central concept for every individual living with chronic incurable illness.

11.10: Personal perspectives.

Certainly many personal developments occurred during the process of this research. At the outset of this project, there were many preconceptions which existed in my own beliefs and understandings, particularly of psychodynamically informed practice, and clinical improvisation. At that time, my own belief was that these two approaches existed hand in hand. Through a wider exploration of schools of thought, it is clear that pre-composed songs may be used in a psychodynamic manner, and that clinical improvisation can be interpreted by frameworks which are not psychodynamic. More importantly, my own scepticism of the value of psychodynamic interpretation has been softened not only by the invaluable triangulation offered through supervision, but also through the insights gained by my own emotional reactions to clinical situations. Often, I had extremely strong feelings after sessions which were difficult to understand. These tended to be individual to each person. For example, after several of Guy's sessions, I experienced plummeting feelings of self esteem. It was often indescribably difficult to collect Jessie for sessions, and difficult to listen to her repeated verbal statements which felt very 'pathetic' but on which she would not elaborate. This resulted at times in

feelings of anger in myself. Many examples from each individual could be given representing a range of such responses.

The value of these experiences served to deepen the picture of the emotional experience which the individual may have had. They certainly brought an alternative perspective to how I viewed the individuals. However, the complexity of the analyses given in this thesis reveals that to rely solely on such interpretations would have severely limited understanding many processes at work, and the individual's world from their viewpoint. Indeed, solely psychodynamic interpretations of neurological events in such patients are flawed and invalid, serving to present the profession in a discredited light. Therefore, a balance must be found. As Pavlicevic (1997) highlights, interpreting the client's emotional experience through one's own feelings may lead to misinterpretation or 'complication of the events in sessions', despite being able to offer a much thicker picture and insight into our work.

My own clinical stance has altered however. Through the use of the grounded theory paradigm, the individual's perspective has been revealed with much greater depth and clarity than other interpretive models, allowing for a greater mutuality of understanding. More importantly, an understanding and belief in the use of clinical improvisation has been gained, even with those clients who prior to this study I would have excluded from such an approach. Furthermore, greater specificity has been given to the use of song, and how to use this within the therapeutic relationship. Although the study here has involved people with Multiple Sclerosis, there are many similarities in the emerging concepts for individuals who have also suffered brain trauma. For example, when working with individuals who are undergoing rehabilitation programmes after traumatic injury, the individual's focal goal is most often exclusively around the physical, such as walking or being able to use their arms. This suggests a generalisability of the findings here to other neuro-disabled

populations, and has consequentially influenced my working practice. Developing an understanding of the significance of the physical experience of disability has been invaluable in setting relevant and significant goals within clinical intervention.

11.11: Limitations of the current study.

Although this study has been fruitful in determining all the component parts which make up the larger whole of the client's experience, the reliance on primarily verbal material has presented some drawbacks. Analyses of musical behaviour and carefully documented behavioural responses were crucial in order to provide credible analyses of the verbal material. Without such material for triangulation, the analyses made would have relied too heavily on the researcher's interpretations. That would have counteracted the aim of this study, which was to attempt some distancing from interpretive models. Additionally, the reliance on verbal material is controversial for music therapy research. Certainly, recent music therapy research has attempted to place the musical material central to analysis, influencing the methodologies adopted (Lee, 1992b).

It must be stated that, considering my own theoretical frameworks, the extent to which words have been depended upon has been appropriate. Using methodologies which relied more on musical analyses would not have been as fruitful, as the data thus gained through verbal methods have produced concepts and categories which are grounded and may therefore be used as a starting point for further studies. This is particularly useful considering the limited extant research with verbally articulate clients. However, clients who were too brain damaged to communicate verbally were excluded by the methodology adopted. It is specifically these individuals who may have shown greater observable differences in the application of the two methods.

The original aim of making stronger links between cognitive processes and musical events has not been met in this study. This would be an undertaking requiring enormous resources and experience which were not available within the remit of this study. Indeed, the literature review of music and the brain suggests that it may not even be justified. Although some hypothetical links were made with Jack's neuropsychological status and his use of music, the involvement of emotional responses is likely to have played as important a role, indicated through coping responses. No clearer links have been made in this study for cognition and music and the implications for therapy, although my own personal prejudices about improvised unfamiliar music and cognitively impaired individuals have been broken down.

Furthermore, until adequate theories are gained of how particular neuropsychological impairments affect specific music processing and performance skills, such links will remain hypothetical. It remains for clinicians to make detailed observations of behavioural responses to music and draw analyses from these which consider individuals' abilities to process and respond within music.

11.12: Recommendations for further developments.

Questions regarding clinical techniques have been answered within this study. Furthermore, theoretical frameworks of greater depth and complexity have emerged for the use of familiar, pre-composed material in therapy. There remains, however, a great deal to explore with regard to processes occurring in clinical improvisation and how this relates to music therapy theory.

More importantly, new concepts which are central to the work undertaken with chronically neurologically ill individuals have emerged. These should now be explored with a wider neuro-disabled population to examine generalisability.

The importance of the single case study has been demonstrated here due to the very personal and individual nature of not only the meaning and experience of emotion in music, but also the highly individualistic nature of chronic neurological illness. All of these factors point to not only individual inquiry, but also qualitative enquiry in order to reveal the complexity and depth of processes taking place. Sustained enquiry must also be recommended. This is very clear in the case studies where the duration of therapy was linked to factors of the therapeutic relationship which revealed processes central to the music therapy. For example, there was a suggestion that with two of the case studies that important processes were taking place in the improvisation only in the later sessions. Had the sessions been extended even further, perhaps the improvisation as suited to Jack's particular needs would have been found to combine in some way with his songs. Using participants' self reports was advantageous in that it generated data which was entirely individual to the participants and was not reliant on the researcher's interpretations. However this also relied on the participants being able to communicate verbally and being cognitively proficient in order to provide descriptions of the music. More important was the condition of trust and awareness so as to impart personal processes to the researcher.

Any fruitful inquiry therefore must be geared towards the individual's experience. It is strongly recommended that in order to engage the individual in this process, enquiry must be sustained at regular periods over an optimum period of time for the therapeutic process, both interpersonal and musical, to take place.

Although the grounded theory methodology adopted has presented certain challenges raised already, it provided an invaluable methodology in many ways for this type of study. It not only allowed explicit processes to emerge, but also offered a structure for emergent implicit processes. This suggests that

although it relied heavily on verbal material within this study, it would also provide a useful framework for non-verbal material such as behavioural material. In many ways the grounded theory paradigm reflects how the clinician may approach analysis in the real world setting, looking for antecedents, consequences and additional events which may have influenced outcomes. Furthermore, as the basis of grounded theory is creativity, it supports fundamental aspects of the music therapy process. This methodology will no doubt emerge as a far more important technique in future music therapy research studies.

However future studies would benefit from making stronger links between musical events and responses analysed by incorporating musical events from therapy to a larger extent. In this way, information may be gained to indicate important precursors or intervening strategies - either therapist's or client's - to influence or better understand outcomes.

To summarise, therefore, it is recommended that future studies examine a wider neuro-disabled group using the concepts and categories which emerged from this study. This should adopt study of the individual through sustained enquiry, to examine process by making within-participant comparisons. It would be useful to use grounded theory to analyse verbal or behavioural data, but greater incorporation must be made of important musical events. As the results of this study found physical factors to be a considerable component, a study which involves a multidisciplinary perspective, either through joint intervention or through triangulation, would be invaluable.

11.13: Conclusions.

For the individual living with chronic, progressive, degenerative, neurological illness, there are many factors which specifically affect the music therapy process. As Aldridge (1995) states, 'we sing and play what we are'. In mutual active music making, music therapy can be a highly physical experience for the chronically ill individual, in which they may monitor their own performance and way of being in the world. As therapists, we can validate our clients' performance through mutual music making, thereby facilitating a new concept of wholeness, and aiding in identity reconstitution. In this way, we can provide our clients with opportunities to challenge their illness identity. For those clients who are unable to physically manipulate instruments, or for whom the abstract nature of improvising is less meaningful, familiar songs which hold personal meaning can facilitate biographical work. Through their associative properties and the relationship held over time, songs operate on implicit and explicit emotional levels. Through the sensitive and therapeutic use of song our clients can identify and experience emotional states which coping with their illness does not ordinarily allow.

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