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Music and Psychosis

The transition from sensorial play to musical form
by psychotic patients in a music therapeutic process

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Dissertation submitted for the degree of
Doctor of Philosophy

Supervisor Prof. Dr. T. Wigram

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Abstract

This study examined psychotic patients' music therapeutic process from sensorial play to musical form. Since we know that the psychic space has its origins in the transition from sensorial play to musical form, and that the capacity to make representations is severely affected by psychosis, there is a need to find out by which means this capacity can be re-established. Because of their pathology, they do not make use of a psychic space to reach symbolisation, which means in music-therapeutic terms that they are not able to create a musical form in which they could exist as a subject. Therefore the therapeutic transition from sensorial impression to musical form (i.e. proto-symbolisation) is a basic condition for the treatment of the psychotic.

In chapter 1 there is a discussion of music and psychosis, from where the research question is formulated. The researcher is also a clinical music therapist and this dual role is central to the research. The personal epoché in which the stance of the researcher is clarified and discussed in detail, because this is necessary in order to place the research interpretations in context.

In chapter 2 previous research studies concerning music therapy with psychiatric patients and psychotic patients in particular are covered. It becomes clear that studies examining an active method of work (i.e. focusing on improvised or co-improvised music making) are valuable because they contextualise the way of playing seen in the two clinical cases within this research. These studies clarify and explore what is known about the ways in which psychotic patients play. Regarding the specific pathology of psychosis, the literature review went into further detail about the psychoanalytic literature. It is in this literature that is particularly concerned with the failing of the symbol function, a factor that has a central place in the thesis.

In order to understand the interpretations of the results, the clinical approach as part of the research method was described in chapter 3. Here, my theoretical music therapy framework, which has influences the treatment of the two cases, is covered extensively. There is also further exploration of concepts regarding psychotic functioning from a psychoanalytical 'frame of thought' that are used by the therapeutic team of the ward where the two cases are treated.

In chapter 4 the research method is described in which the single case study design was developed. While departing from the main and sub research questions, this was an essential feature of the methodology. The data collection, as well as the analysis of the music therapeutic material, is covered by this clinically applied research approach.

The results and summaries are presented in chapters 5 and 6. The different categories of *sensorial play*, *moments of synchronicity* and *musical form* clearly emerged. Throughout these chapters, the musical analyses and the specific therapeutic interventions are made more insightful.

The process from sensorial play to musical form is described and discussed in chapter 7. The phenomena sensorial play, moments of synchronicity and musical form are defined and the different characteristics are summarised. The findings are also compared to the material discussed in the literature review. The specificity of the phenomena of silence, timbre and inter-subjectivity, which were essential to the therapeutic process, is discussed. The therapeutic interventions that are of central importance for the clinical music therapist are examined and the limitations and validation of this study is discussed. Finally, the usefulness of the study for the clinical music therapist is made clear.

Acknowledgement

This Ph.D. dissertation was like undertaking a journey, some parts of which are undertaken alone while other parts are accompanied. Certain sections you do by yourself, other sections you are accompanied by someone else. The companions motivate and support you, inspire you, confront you and show you the possible ways which you can take and which ways you should avoid. My companions were necessary for my dissertation to come into being. I, therefore, wish to thank them sincerely.

Prof. Dr. Tony Wigram supervised this research for several years. His trips from London to Aalborg and back were regularly interrupted in Schoten, where he wrestled with my research and gave guidance regarding the structuring of my excessiveness of data and my occasional chaotic thinking. Thanks to him, I was able to develop the necessary scientific skills to undertake and complete the work. He had the ability as no one else to maintain the necessary dynamics, in order for me to successfully complete this research.

Writing a Ph.D. dissertation alongside the other work one does is a heavy burden and the research could only happen through the support and encouragement of supervisors and colleagues.

Prof. Paul Schollaert, director of the College of Science and Art, campus Lemmensinstituut, and Prof. Dr. Jozef Peuskens, medical and general director of the University Centre, Kortenberg, where my work is based, always showed a sincere interest in the development of music therapy and gave me the possibility to further explore my music therapeutic work through this research.

With regard to the psychiatry work, I was very fortunate to work in a ward that is under the supervision of Dr. Ludi Van Bouwel. Her passion for music and her integration of music therapy in the psychiatric and medical world stimulated and inspired me. The two case studies in this dissertation concerned patients from her ward. I also want to thank the other staff members of this ward, and especially the nurses Kristine, Inez and Luc, who cared for the two patients.

I am very grateful to my friend and colleague Jan Van Camp, psychoanalyst on the psychiatric ward which housed the patients studied and professor of the music therapy training course of the “College of Science and Art, campus Lemmensinstituut”. He is a

companion, inspirator and soundboard. He accompanied me throughout the journey of this study. Our weekly conversations and discussions about new theories and about clinical music therapeutic material often stood centrally within the process of my dissertation.

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I was involved with this dissertation day in and day out for six years, while I worked together with colleagues, taught students, treated patients. Each one of these people has influenced my dissertation. Colleague music therapists Ingrid, Erica and Sofie showed their interest and supported me. Through dialogue, the music therapy students gave me the possibility to give form to the therapeutic insights and they were often the soundboard for new possibilities and insights. The patients allowed me to further develop my music therapeutic skills through their musical improvisations. Special thanks go to Marianne and Adrian, because I was allowed to use their personal material. Without them, I would have never obtained the necessary data that enabled me to come to these new insights.

The English version of this Ph.D. is available thanks to my brother Jeroen and his wife Barbara, who arranged the first translation from Dutch to English. Dr. Julie Sutton refined this and gave further additional critique and enriching remarks through her re-reading of the final version. Dr. Niels Hannibal for translating the summary into Danish.

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Notes to the reader

References to the therapist and the clinical approach indicates the author and his theoretical methods of work, with the personal pronoun used. References to patients in the two cases are gender specific, while general references to patients are male.

Translations from Dutch, German and French texts relating to the theoretical approaches involved in the clinical work in this study have been made by the author, and have retained, as much as possible, the authenticity of the original language.

References to the excerpts selected for analysis from the attached CD-ROM appear in the text in chapters 5, 6 and 7.

The excerpts for the first subject can be found on a file called: Case study Marianne listed as excerpts 1-7. The excerpts for the second subject can be found on a file called: Case study Adrian listed as excerpts 1-7.

For purposes of confidentiality, these video-examples are only for the examination of this dissertation. In order to safeguard confidentiality and professional ethics, on conclusion of the examination, the CD-ROM should be returned to the author.

When necessary the raw data of this study (i.e. the research interview; the therapist's personal record; the first descriptions of the sessions and the first categorisation within which the music and the therapeutic material was categorized) can be requested. This raw data is all in Dutch.

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Video Documents (companion CD-ROM)

Case Marianne

Excerpt 1	Session 1
Excerpt 2	Session 1
Excerpt 3	Session 2
Excerpt 4	Session 2
Excerpt 5	Session 3
Excerpt 6	Session 3
Excerpt 7	Session 4

Case Adrian

Excerpt 1	Session 1
Excerpt 2	Session 1
Excerpt 3	Session 3
Excerpt 4	Session 3
Excerpt 5	Session 4
Excerpt 6	Session 8
Excerpt 7	Session 8

Chapter 1

Introduction

Introduction

The focus of this research is the musical and therapeutic process in work with psychotic patients. From the beginning I was interested in the way in which psychotic patients respond to and process music phenomena, both in receptive and in active forms. In thinking about this topic, many questions came up that influenced my way of thinking and the direction of this study, including a consideration of the role of music in the treatment of a psychotic patient, the nature of the interactions between therapist, music and patient, and how this musical engagement changes over time. Other questions related to how the change in the patient's musical production and interaction represent a corresponding change in their perception and insight, and how all these aspects determine the course of the music therapy treatment.

Working in music therapy with psychotic patients, one sometimes encounters characteristic, repetitive and consistently similar musical patterns. Psychotic patients tend to express their experiences and conflicts in musical improvisations, by 'fragmented' play, or constantly repeating rhythms or small melodic sequences. From clinical supervision and a general overview of relevant psychoanalytic and psychotherapeutic literature, looking specifically at Bion (1956, 1957, 1967), Dührsen (1999), Freud (1911, 1925), Ogden (1992, 1994, 1997), Tustin (1981, 1986, 1990), Van Bouwel (1998, 1999a, 1999b, 2003) Van Camp (1999a, 2000, 2001, 2003a) and Winnicott (1960, 1971) it became clear to me that this style of playing (with repetitive rhythms and melodic fragments) could be understood as an expression of a psychotic's 'sensorial play'. As will be shown in the literature review, there were few publications about music therapy and psychosis on this topic. What was written about the effect and value of music therapy for people with psychosis did not provide any relevant or detailed analysis of musical material that could connect interpretation of the behaviour (and changes in behaviour) with specific events in music – either in the patient's solo playing, or in their playing together with the therapist. There was no analysis of differences between playing where the patient was unaware or unrelated to the therapist, and playing where developments in the musical material indicated a shared or connected experience. The need to explore this and

offer some analysis and explanation of the processes that occur then became the motivation for this study, and from this emerged the direction towards which this study was designed. The initial stage in the process involved engaging myself in a new way of thinking – that of a researcher as well as a clinician.

1.1 From clinician to researcher

Starting with research was very new for me. I had to make a long journey to learn what research was and to find my identity as a researcher.

As a music therapist with 20 years of clinical experience (mainly with psychotic patients and children with autism spectrum disorder) I made a conscious choice not to start by pre-determining a research model for this study. The first approach was to look at the material from clinical practice that would form the data for the analysis. The fundamental expectation was to retain an open perspective and then draw on a research method that would best fit the intention of the study and thus address the research questions. This study originates entirely from clinical practice, and therefore should be defined as applied clinical research (Wigram 2001). The authenticity of research of clinical work always has been very important to me. In my research supervisions, at congresses, and especially during half yearly PhD-seminars at the University of Aalborg, I was able to experience quite strongly the field of tension between research and clinical practice. It was not always easy to look at clinical material from a research perspective and I often caught myself looking at the material, and expounding my interpretations more as a clinical music therapist. The entire research process was a quest for balance between my familiar clinical thinking, employing a therapeutic conceptualisation or ‘frame of thought’ and a more resistance loaded attitude as ‘researcher’. Stimulated by the culture for clinically applied research in the Doctoral programme in music therapy at the University of Aalborg, I could slowly develop my research skills through the research process.

My research tries to develop a useful frame of thought for the clinical therapist, and to make more conscious and understandable the problems arising from the psychotic patient’s inability to symbolise. From my clinical practice, I have experienced that research too often stood alone as a discipline and activity, separated from clinical practice. Many research projects stand completely isolated from practice and have almost no relevance for the

practicing music therapists. This is confirmed in the study of Nicholas and Gilbert (1980), in which it seemed that often, scientific research was not applicable or relevant to clinical work. Therefore, I was always alert for the clinical usefulness of this research, so that it could be fully used by music therapists and hopefully contribute towards making clear the music therapy processes and the description of the possibilities in work with psychotic patients.

In this research, the personal meetings with colleagues were very important, not only music therapists and musicians, but also psychiatrists and psychoanalysts. Each discussion gave me new ideas and insights and let me discover new aspects in the research material. My increasing surprise at these new perspectives assured the dynamics of the research, as well as maintaining my curiosity by putting my own music therapy practice into question. The presentation of the provisional findings of the research at congresses and research seminars also encouraged me to select (from an excess of data) the most essential material, and to bring this into discussion with colleagues in a clear and digestible form. The countless discussions with these colleagues have encouraged me to further throw light onto certain aspects, which were necessary both to the research process and also to understand the process from sensorial play to musical form.

The aspect of 'time' played an important role in analysing and processing the data and the provisional findings that came to the fore during the research. Just like a patient needs to gain possibilities of coming to symbolisation, I also took the time to develop a scientific attitude, to work systematically, sceptically and ethically (Robson 2002, p.18).

1.2 The combination of clinical music therapist and researcher

Providing insight into the music therapeutic processes and the music therapeutic interventions lies at the heart of this study. There is an essential importance and relevance of differing therapeutic phenomena such as transference, countertransference, projective identification and reverie, which can be only understandable when these phenomena are experienced. I could only observe, describe and understand them as a researcher after I could experience and feel them as a therapist. It was a conscious choice for me to take the role of the music therapist in this research. Smeijsters (1997) comments: "Because music therapists are most close to the therapeutic context in qualitative research, the roles of music therapist, observer, and researcher

are often filled by one person. If the person who is most committed to the client is most able to “research,” then is it impossible for a non-participating person to understand what is going on? If you need counter-transferential feelings to understand the client’s feelings, are you able to feel these when you are not in the situation yourself?” (Smeijsters1997, p.16) This was not supported by Hannibal (1998), who is very cautious about this issue. He is aware of the fact that the therapist is not a source of reliable information, because he is biased, unconsciously influenced by counter transference, and holding expectations about the therapy that affect his judgement.

Despite this, I am convinced that the ‘truth’ of what is occurring in the patient and the therapeutic process can only be looked for via projective identification, or identification with the patient. Killick and Greenwood (1995) are also convinced of this, arguing that through using himself the researcher can gain insight into all aspects of the patient-therapist relationship. They mentioned Hill (1970, p.614), who writes: “We can only know others (on the inside) by an act of identification, we can only know them (on the outside) by acts of perception.” Killick and Greenwood (1995) see the therapist as a research tool. Thanks to his experiences from training, supervision and personal therapy, he can become aware of how his own process influences his perception. The potential for using oneself as a research tool, while limited by the extent of these experiences, is nonetheless a method that offers valuable insights into and at many levels.

To act as researcher and therapist at the same time underpins the examination of my clinical work in order to acquire further insight. In agreement with Aigen (1995) and Amir (1996), I was motivated to do research precisely to find out more about my clinical practice and theoretical framework. I wanted to take the opportunity to share my understanding of my clinical music therapy work with other colleagues, both within and outside my field, so that I could obtain feedback and learn more about what I am doing therapeutically, and especially to benefit from my research in order to grow professionally and personally.

In terms of the identity of the investigator as reported in this dissertation, the terms therapist and researcher as they apply to my role in both working clinically with the patients, and analysing and interpreting data from the research perspective, are interchangeable. In certain places it is more appropriate that I refer to my role as music therapist, particularly when reporting the case material. In other places in the dissertation were references are made to research decisions, the role of the researcher, analysis of research data and discussion of

findings, I am more likely to refer to myself in the text as researcher. It did not seem appropriate, given this dual role, to exclusively to apply one identity of the whole dissertation.

1.3 Problem formulation

An expected outcome of the research is that music is especially relevant in creating a psychic space¹ in the treatment of psychotic patients. Since we know that the capacity to make representations is seriously affected in psychosis, there is a need to find out by what means this capacity can be re-established. Working with these patients in music therapy we encounter the phenomena of repetition and fragmentation, where patients often repeat the same musical pattern or play in a fragmented way. In their musical improvisations they constantly repeat a specific rhythm or small melodic sequence, which becomes an endless iterative playing, rather like a kind of musical rocking. Van Camp (2000) describes this repetitive or fragmented play as, “the presence of the psychotic 'experience' of the world. Psychotic patients, from their pathology onward, do not dispose of a psychic space to reach symbolisation”. This means, in music therapy terms, that they are not able to create a musical form in which they can exist as a subject. Therefore, the therapeutic transition from sensorial play to musical form (proto-symbolisation) is a basic condition for the treatment of psychotic disorder whatever other treatment intentions may be present. In view of this, a hypothesis for this study is that the development of a psychic space originates from the transformation of sensorial play into some type of form or representation.

Psychosis and Music

To understand the problem formulation for this study, it is necessary to contextualise the ideas that have been articulated so far in this introduction into a relevant theoretical frame, which will underpin the method of the study and the subsequent interpretation of the results. The world of the psychotic patient is unknown and inaccessible. Many years of experience with psychotic patients has convinced me that through music we can not only find a gateway to the amazing world of the psychotic subject, but that we can also develop the means to give a certain shape and termination to the disintegration and timelessness of the psychotic world. It

¹ Psychic space: a mental space in which there can be thought and fantasy and in which inner images can originate. This space is necessary in order to come into a musical play. This psychic space could also be understood in relation to the transitional space. (Winnicott 1971)

is not the first time that it has been proven that music moved on the same level where the central problem of psychosis can be located (De Backer and Van Camp 2003a; Lecourt 1990; Pedersen 1998, 1999, 2002b; Van Camp 2003a).

The psychotic subject lives in a world of presence. He is the defenceless prey of thoughts and ‘sensoriality’, which haunt him continuously. The frontiers between the inside and outside world are so unstable and transparent that it often seems that his psyche finds itself outside rather than inside. The world and the internal movements of drives are not represented in an inner space, but they are characterized by an immediate and brutal presence. Because they can no longer fulfil their representative activity, even words are treated as meaningless things, as pure sound objects.

It is more than a metaphor to assert that the psychotic patient lives in a purely musical world. If we assume that the musical element is what is left of the voice when it is deprived of meaning, one can, in many ways, assimilate our relationship with music to the relationship of the psychotic subject to the world. Neither the voice nor the music can be said to find itself inside or outside the subject. Its presence, which cannot be located, makes it a fusional object. This means that we are related to the music like a baby is initially related to the voice of its mother. Thanks to the fact that her voice has not yet disappeared behind significance, it has an immediate impact on the child. Just like a dancer starts moving immediately and simultaneously as soon as the music sounds, the child responds immediately and simultaneously to the appeal that comes from the voice of the mother (Didier-Weill 1995). Coming into the cadence of the voice of the mother is the first affirmation of a *signifier*², which has not yet acquired meaning at that time. Because of the fundamentally dissonant relationship of the psychotic to the signifier, psychoanalytic theory asserts that the problem of psychosis should be put in terms of this primarily synchronic affirmation of the signifier or, in Freudian terms, of primal repression (“*Urverdrängung*”). As the formation of the very principle of repression or the capacity to repress, the “*Urverdrängung*” is the foundation of the constitution of the unconscious. This concept of the unconscious not only functions as an explanatory principle for symptom formation in neurosis, but it is also found in the more general anthropological category. In this latter context the signifier is responsible for the appearance of human desire. As psychotic phenomena are traditionally attributed to the failure

² The word *signifier* is used by Lacan: it means the carrier of meaning. The signifier is the form which a sign takes. We can speak about a sound image (the psychological imprint of the sound) in terms of the impression it makes on our senses.

of the work of repression, psychotherapy should focus on the very conditions that account for the possibility of repression. Clinical observation of music therapy with psychotic patients shows enormous resistance against musical contact in the first stage of therapy (De Backer and Van Camp 2003b).

It can be stated that music is not only a fusional object, which inspires the body spontaneously and immediately and brings it consentingly into motion. In so far as the specific musical characteristics progress, music also has a linear and narrative form. Musical events do not remain in an endless repetitive play, but they develop themselves via a play of variations and repetitions, to a totality and a synthesis. Within this development the successive musical events lose their independence and they are functionally integrated into a whole. Each sound and each movement refer to what preceded them and to what will follow, although no one knows exactly how this will develop. It is possible to consider the development of the musical form as a fundamental play of loss and the reappearance of these losses in a new shape. It is a constant process of substitutions that takes place within a space, which Winnicott (1971) called the “transitional space”. Winnicott does not describe the play within this space as symbolizing in the full sense of the word, but only as a “transition” to symbolization, because just as in music, the concreteness and the irreparability of the substitutive object remains in the foreground. The transitional object is truly a signifier, but not an “open” signifier. The meaning remains fixed on the object and the latter is not open to other meanings. In that sense, the development of the musical form takes a step further on in the symbolization than the transitional object (Van Camp, 1999b). In spite of the concreteness and the irreparability of the musical event – perhaps also remembering the meaninglessness of the musical event – it is still integrated in the time-bound process, which makes an essentially endless variation possible. Finally, the process of symbolization takes full shape at the moment at which the concrete object has been completely lost in speech.

The unique place of music in the treatment of psychosis therefore lies in the fact that it presents two logical times in the symbolization process, both of which are of crucial significance in the constitution of the psychotic psychopathology and which can be approached much less directly within an exclusive verbal psychotherapy setting. Nevertheless, the “thinking from the music” is – also outside the music therapy room – important for the comprehension and the treatment of psychotic phenomena (De Backer and Van Camp 2003a).

1.4 Selecting the topic

The topic of this study became increasingly clearly focused on the question of what occurs in musical improvisations, and what may or may not happen over time in the musical production of the client. Previous clinical experience had strongly suggested the need to explore and analyse the transfer that occurs from sensorial play to musical form. Therefore, to establish what occurred in that process, it was necessary to first examine and define these two phenomena on a musical, psychic, as well as, on an interpersonal level. From these two phenomena, the process of sensorial play to musical form could be examined. In addition to analyzing the music of patient and therapist together, the study considered the interventions of the therapist, which made possible the therapeutic process. This examination of the combination of the joint music and the musical changes made by the therapist enabled greater understanding of the specific processes involved in the clinical work. Therefore, an integral part of the research involved the identification of the therapist's approach, his methods and interventions and the subsequent outcomes. Connections were then made between these findings and those resulting from the analysis of the patient's music and therapeutic process. This integrated approach enabled a dual focus – both on the individual's responses (the patient's and the therapist's) and the joint music (therapist and patient together), with the overall therapeutic process linking the two.

1.5 Preliminary research questions

As described above, the intentions of this research were based on the need to analyse, interpret and explain some complex and multi-dimensional processes that occur in clinical work. The primary research question for this study was formulated with this specific focus in mind, as follows:

Can one identify the development of a process from sensorial playing into musical form as a central aspect in the music therapy treatment of psychotic patients?

In order to be able to answer this research question it is important to know how the phenomena *sensorial play* and *musical form* can be described and defined. It is essential that a systematic

method is used in order to identify the various musical and therapeutic factors that are vital for the music therapeutic process. It is also important that the different therapeutic interventions of the music therapist are examined, because these are also decisive for the therapeutic process.

The next research issue to address is its relevance to music therapy clinical practice.

1.6 The relevance of research to music therapy clinical practice

It was the aim of this study to explore and analyse the therapeutic process systematically in order to come to a more solid, scientific basis of a method and therapeutic interventions.

1. To explore the methods of intervention in more detail.
2. To explore, in more detail, what happened in the therapeutic process.
3. To inform clinical practice in this area about what expectations we could have.
4. To make case study reports (i.e. clinical reports) where clinical results are connected with analysis from the research.

One of the motivations for this research was that it could be done from clinical practice and that it also makes sense for music therapeutic practice. Nicholas and Gilbert (1980, p. 208) conducted a survey in which 75% of the respondents agreed that, “research studies... were not relevant at their daily functioning as music therapists.” Aigen (1995) also came to the conclusion that there is a lack of relevance of music therapy research to music therapy practice. Much of this research has consisted of quantitative, experimental efforts. Aigen is aware that most music therapists will never have the time and resources to do in-depth research. Those who do should engage in research that has the highest likelihood of producing interesting and useful results for working clinicians, who are in a position to make use of such research. This is an individual perspective, and tends to suggest that research needs to be primarily clinical and qualitative. There is, nevertheless, a need for different types of research, and efficacy or effectiveness studies that provide Evidence Based results to validate clinical practice are equally as important as studies that inform clinical therapy methods. Aigen’s perspective should be tempered by the view that other types of research are equally significant, thus showing that clinical work can be examined in many different ways.

In addition to this was the aim of lifting the therapeutic process to a theoretical level.

5. To create some definitions and theories from the outcome of this research.
6. To lay out these findings as more understandable for other disciplines. To be informed, they need to find out what has happened and why it has happened in music therapy treatment.

Case study research utilises a design that allows some flexibility, while still offering a stable and consistent method for analysing and documenting clinical data. Amongst others, Aldridge has noted the importance of flexible design, commenting: “Such designs have the advantage of being adaptable to the clinical needs of the patient and the particular approach of the therapist” (Aldridge 1996, p.111). From the central research question in which the investigation of individual change in clinical practice plays a central role, the use of a single case research design seemed the most appropriate, a choice that will be further explained and justified in the method section.

1.7 Reporting a qualitative study

This study is a product of a clinician who is simultaneously the researcher. The style of reporting the different aspects of the study, including the literature, method, results and discussion will be explained at the beginning of each section. The dissertation is commonly written in the first person, particularly in the result section, as the researcher is also the therapist.

The combination of reporting two complex cases from both a clinical and a research perspective has involved a substantial amount of clinical interpretation in the case study parts of the results sections, followed by more scientific and objective analysis of the musical and verbal data. Where it is necessary, the researcher will provide explanations and criteria to ensure a clear framework for understanding the concepts explained in this dissertation. Musical terminology will be also defined.

1.8 Personal epoché

Aigen (1995) underlines the necessity to give a personal epoché when the therapist is the primary instrument of data collection, analysis and interpretation. Epoché means the stance of the researcher, by which it is necessary that the reader can understand the individual characteristics and facets of the researcher and their bearing on this particular research. I will use the features as mentioned by Aigen (1995, p.294) in order to describe and present my own epoché.

1.8.1 The researcher's motivation for conducting the study

After having worked for twenty years in clinical therapy with psychotic patients, it was a challenge for me to undertake a more scientific approach to evaluation, and to reflect upon my therapeutic thinking and possibly to further develop it. My therapeutic approach in music therapy, both acting and intervening, originates from an intuitive trust that is based on a theoretical 'frame of thought' that slowly grew throughout my education and practice. However, the question remained concerning what made music so unique and special in the therapeutic process with psychotic or psychiatric patients in general. The daily clinical improvisations in which, time and again, new structures and forms appeared, were sometimes so surprising that I was very curious to know why they appeared only in that form.

At the University Psychiatric Centre where I work, the prevailing culture for scientific research also directed me towards this study. A second stimulus came from the college where I have the function of teacher and head of studies for a five-year masters course in music therapy. In current higher education each field of study is motivated to test and develop its relevance scientifically. Up to now, in there has hardly been any scientific research at this level in Belgium within the work field of music therapy. This research is a first step and I hope that it will also stimulate my younger colleagues to undertake research.

1.8.2 Prior experiences and beliefs which have shaped the area of research and which influence data collection and analysis

My music therapy thinking and acting was formed throughout my education and practice. The basis originated during my study of music education in Leuven (Belgium), with the organ as my main instrument. It was here that I also took my first steps in developing tonal melodic and

harmonic improvising skills, which was a very classical model of that time. During self-experience seminars and courses that formed part of my post-graduate music therapy education in Vienna, improvisational styles became less classical and multi-layered, in order to allow the music to act as an external expression of inner feelings. There, the piano was the main instrument for clinical improvisations, and slowly this became my favourite instrument, besides other instruments such as percussion, guitar, recorder and the voice. To me the piano is the most important instrument for individual music therapy sessions, because it offers possibilities for me to play melodically as well as harmonically, and to accompany and carry the patient musically. I only use the acoustic piano in music therapy, because of the resonance and the dynamic possibilities. In improvising with psychotics I am well aware that I do not use the piano exclusively as a melodic or harmonic instrument, but that I also approach it rhythmically, driven by the therapeutic given or the situation in the moment. The pulsing of the improvisations is sometimes explicitly present, something that appears to be related to a desire to offer stability and structure. I have further developed this style of improvising throughout the many improvisations with patients, students and colleagues.

Of even greater importance is my own psychoanalytic process and my participation in intervision and supervision. Psychoanalysis directed my theoretical and clinical thinking because I could experience and gain insight into different therapeutic phenomena such as transference, countertransference and defence mechanisms. Being able to freely associate and give form to fantasies and inner conflicts positively influenced the way I dealt with music. One can also correlate free association in psychoanalysis with free improvisation in music therapy. Through the experiences and insights offered by my own psychoanalysis, I could make use of my necessary therapeutic intuition and action, knowing that this involves insights that are coloured psychoanalytically.

The participation in intervision and supervision and the fascinating and confronting discussions and conversations with my colleagues and supervisor contributed to making the blind spots in my own therapeutic acting and improvising in the music therapy work with psychotics visible and recognizable.

Through supervisions and listening the recordings of my clinical improvisations I am conscious of the different ways that I can play - neutral, supporting, therapeutically provoking, reflecting, carrying or in a reverie style. Regular improvising, most of the times at the piano, and sometimes after a session in which an emptiness or the digestion of conflicting or painful

therapeutic situations kept resonating, gave me the possibility to experience how I could come to a musical form myself, and could mentalise what had preceded.

Because of my rather classical music education, it took a lot of effort on my part to become conscious of the musical aesthetic prejudices and break free from them. Especially in the beginning of my music therapy career, I was aware that I had a certain diffidence (shyness) to let my free improvisations be heard at lectures or to colleagues or supervisors. Because of my psychoanalysis and my supervisions I could analyse this shyness and cause it to diminish or let go of it altogether. I again became aware of my diffidence through the experience of the invasion of privacy and of the intimacy of the therapeutic relationship that occurred during the sessions with the two patients who formed the study group. However, it was only in the first session of the two cases that I was conscious that the session was being recorded, something that made the therapeutic action probably a little bit more conscious, but this was not a disturbing factor for me.

1.8.3 The researcher's group membership

Several people have been very important for this research project, on a clinical as well as on a scientific level. Especially at a clinical level, twenty years of cooperation with my colleague Prof. Jan Van Camp has very much enriched and influenced my theoretical and clinical thinking on music, music therapy, psychoanalysis and psychosis. Many of the perceptions and interpretations regarding the clinical material in this research have grown through intervision together with him. Prof. Van Camp is a psychoanalyst, with 30 years of experience as a psychotherapist with psychotics, as well as being a talented singer. He is especially interested in the relationship between the arts and pathology. He works in the same ward for young psychotics as me and is also lecturer at the music therapy course at the College for Science and Arts, campus Lemmensinstituut. Besides this, he is a coordinator for the European Consortium for Arts and Education (Ecarte).

Piet Swerts is one of the most famous composers in Belgium. He is a lecturer of composition and analysis at the Lemmensinstituut and, for the past three years has lectured on the analysis of music to the music therapy students. For me, it was reassuring to analyse the scores of the improvisations with him in a systematic way. During the research I noticed that musicians always see structure in improvisations, even though at first sight there is no structure to observe. Taking a look at musical improvisations from two different points of view (namely

the composer's perspective of Swerts and my own therapeutic stance) was often very inspiring and surprising.

1.8.4 Possible biases

During the treatment of the two patients I was aware that material from the sessions was delivered for my research. For me they were not normal or daily patients, and my hope and expectations towards the development of a therapeutic process surely has had its influence on the relationship with them. The reflections upon the sessions and writing down the impressions for this research were delivered more expansively and comprehensively, more profoundly and more consequently than in a normal daily setting. In this way, I was aware that a certain bias was presented, that has had its influence in the countertransference towards the two patients.

1.8.5 The nature of the relationship between the investigator and the research participants

The patients who participated in this research were from a psychiatric ward in which I worked as a permanent team member. I was not a stranger who came exclusively to the ward to work with the two patients who took part in the research. The music therapy treatment was undertaken in a familiar environment for them, the music therapy room.

These patients were informed that everything would be recorded on video. This was not exceptional, because in the centre there was a culture of video or audio-recording for supervision purposes or for research. The patients always had the right to refuse audio or video recording before or during the treatment. During the two cases, video recording was stopped at their request at the moment that a musical form (proto-symbolisation) emerged.

1.8.6 Intuitions and expectations about what the findings may be prior to beginning the study

From my many years of clinical practice it was important for me to discover how the psychotic patient (with an absence of a mental space typical of the pathology because of which they could not come to symbolisation) could come to a musical form. Intuitively, I always experienced in my work that this was at the centre of the music therapy treatment of psychotics. I expected from this research a well-founded scientific foundation for my intuitive actions and theoretical

psychoanalytic ‘frame of thought’. I also expected a meaningful scientific analysis and theoretical reflection upon my therapeutic actions, in my practice with psychotic patients as well as with people with autism spectrum disorder and those with developmental disability.

1.9 Overview of the chapters of the dissertation

Chapter two describes the psychotic personality and psychotic disorders, and the literature about the treatment of psychotic patients will be explored. Descriptions of existing research into uses of music therapy in psychiatry – and especially with psychotic patients – will be presented in a structured way. In this way there occurs a gradation from rather general approaches to studies that are more closely connected to the research question.

The description of the therapeutic ‘frame of thinking’ and the theory in the context of the two cases are described in chapter three. Aspects of the relationship (patient, therapist and music) will also be described because these aspects are important in the therapeutic process with psychotic patients.

The research methodology and the case study design that are used in this research are set out in chapter four. The single case study design research, the music therapy context, the two subjects, the data collection and the structure of the data collection and analysis will be described.

Chapters five and six present the results of the two case examples in this study. The therapeutic process of both cases is first described in the form of case studies, and then selected fragments are analysed phenomenologically and musically in a systematic way.

There will be interpretation and description of the different therapeutic interventions and their characteristics in relation to each separate case, which were the essential features of this process.

The findings from the research material are discussed in chapter 7. The categories and final definitions of the three phenomena *sensorial play*, *moments of synchronicity* and *musical form* will be presented. The music therapy process from sensorial play to musical form will be discussed at a musical level as well as at a psychic one. The findings will be related back to any relevant previous research, and the limitations and clinical implications of this study will be addressed.

The final section of the dissertation contains a comprehensive bibliography, and appendices of material not included in, or referred to in the main body of the text.

Chapter 2

Literature Review

Introduction

This research has emerged from many years of clinical practice and experience with psychotic patients. This clinical practice has a foundation that is not only within the clinical and research literature in music therapy, but also in clinical and research literature in the field of psychiatry and psychoanalysis generally, such as Bion (1956, 1967), Dührsen (1999), Fonagy and Target (2000, 1996), Freud (1911, 1925), Lacan (1981), Ogden (1986, 1992, 1994), Target and Fonagy (1996), Van Bouwel (1998, 1999b, 2003), Van Camp (1999a, 2000, 2001, 2003a), Vermote (1997) and Winnicott (1971).

The music therapy method used in the clinical work from which this study is drawn was originally developed from my music therapy training in Vienna (Schmölz 1983). This training was orientated within humanistic and psychodynamic approaches and further developed and refined through individual psychoanalysis and supervision, and informed by seminars, psychoanalytic literature and specific psychoanalytically orientated music therapy methods (Lecourt 1990, 1991; Pedersen 1998, 2002a; Priestley 1980, 1982, 1994; Streeter 1999a, 1999b; Strobel 1985, 1999; Van Camp 1999b, 2000, 2001; Wigram et al. 2002 and Willms 1975, 1982). My own therapeutic direction and theoretical framework has previously been documented in published case studies and articles (De Backer 1990, 1993, 1996, 1997; De Backer and Van Camp 1996, 1999, 2003a, 2003b).

In many situations clinical music therapy in psychiatry emerged without substantial research evidence to support it, or in some cases with an absence of an underpinning theoretical framework. As mentioned in the introduction, from a randomly selected sample of 150 music therapists Nicholas and Gilbert (1980) reported that in many circumstances clinicians do not express satisfaction with the relevance of published research for their own clinical work. Consequently, it was discovered that when searching for literature to provide a foundation for this study there was a limited amount of material to drawn upon from either the research or the clinical field. After gathering the literature it was possible to come to the conclusion that there are actually a very limited number of studies relating specifically to the use of a psychoanalytic

approach in music therapy with psychotic patients. This does not mean that research is not well founded from the theoretical point of view, only that there is little documented research in this area. In order to support the study the literature review therefore will offer a wider framework that is drawn from other related disciplines.

This study was designed with the intention of connecting experiences together in clinical practice with qualitative analysis data, so that the research results could be closely connected to the therapy process itself.

This literature review is intended to be broad enough to cover a variety of aspects of the study, including an overview of the pathology on which this research is based and for which the results have relevance. First the chapter will offer a definition and description of schizophrenia and psychosis, in order to establish an accepted understanding of the diagnosis in connection with the research. Following that the literature review will look at any significant research with psychiatric patients, in order to present psychoanalytic and other approaches that are currently used in treatment. Finally, there is a focus on music therapy research and clinical work in order to offer a reference point for this author's research. In addition this focus will enable an examination of current thinking about the clinical application of music therapy with psychotic patients, from a range of different theoretical approaches and traditions.

2.1 Description of the patient population

The clinical population that is the target group for this research comes under the general heading: 295.xx Schizophrenia and psychotic disorders (DSM IV¹) or as specified in ICD-10, F20-F29 (ICD-10²). An understanding of the complexity of the disorder and the various diagnostic subtypes under this heading is important in order to be aware of the influence of the music therapy in this the research. Conclusions drawn from this study that are relevant to clinical practice will also be linked to the specific pathologies involved in the research.

This research study is concerned with identifying, analysing, interpreting and understanding the responses of patients with specific diagnosis under the general heading of psychosis, and in particular how psychotic patients develop a psychic space. For any treatment to have the potential of being consistently helpful and effective for patients, a relevant

¹ Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994)

² Classification of Mental and Behavioural Disorders (World Health Organization, 1993)

connection needs to be established between the healthcare needs the patient is demonstrating based on their diagnosis and pathology, and the focus and direction of the treatment. This is especially important in cases with complex disorders like psychosis.

The next section provides an overview of the pathology and diagnostic criteria for the client population under investigation, focussing on schizophrenia, subtypes of schizophrenia and personality disorders. This will also include an explanation of the mental structures of people with psychotic disorders.

2.2 Psychosis

Psychosis indicates a severe psychiatric disturbance in which several aspects of mental functioning are disturbed, such as thinking, feeling, sensing, impulse control, acting, social and other forms of functioning. The disturbance here is mainly where the behaviour, the thoughts, the way of thinking and the patient's perception of their surroundings comes across as strange, unpredictable and incomprehensible. In these cases, directed, adapted and coherent interaction with the outside world has largely become impossible. (De Hert and Peuskens 1996)

2.2.1 Diagnosis

Diagnosis is a construct with important implications for communication, classification, prognosis, and treatment. Both DSM-IV (American Psychiatric Association, 1994) and ICD-10 (World Health Organization, 1993) provide classification systems that give a structured and detailed definition of different pathologies. Generally, DSM-IV requires a half year of mental dysfunction and reduction in social functioning. ICD-10 limited the criteria to symptomatology. The local context within which this research was undertaken uses DSM IV.

DSM-IV Characteristics

A diagnosis of psychotic disturbance is based on the presence and severity symptoms within the following categories according to the DSM IV criteria:

Schizophrenia

A. Two (or more) of the following five symptoms must be identified, each one having been present in the patient's characteristics for at least one month, and for a significant part of the time (or shorter in the case of successful treatment):

- (a) delusions;
- (b) hallucinations;
- (c) marked loosening of associations (e.g. frequent loss of the thread of the conversation or incoherence);
- (d) severely chaotic or catatonic behaviour;
- (e) negative symptoms, i.e. flattened affect, poverty of thought and speech or apathy.

B. Social/professional dysfunctioning

Marked deterioration in functioning after the onset of the disorder for a significant part of the time in one or more domains, such as work, relationships or personal hygiene and grooming, compared with the level which had been achieved before the onset of the disorder.

C. Duration

Continuous signs of the disorder are present for at least 6 months. In this 6-month period there must be symptoms which meet criterion A for at least one month.

D. Exclusion of schizo-affective or mood disorders

A schizo-affective disorder and a mood disorder with psychotic characteristics are ruled out because (a) either no depressive episodes, manic or mixed episodes concurrent with symptoms of the active phase have occurred; or (b) episodes with a mood disorder have occurred during the active phase with a total duration which was short in relation to the duration of the active and rest periods.

E. Exclusion of the use of substances or a somatic disorder

The disorder is not the result of the direct physiological effects of substances (e.g. drugs of abuse or a medicine) or a somatic disorder.

F. Connection with a pervasive developmental defect

If there is a history of autistic disorders or another pervasive developmental defect, the supplementary diagnosis of schizophrenia is made only if there are prominent delusions or hallucinations for at least one month.

Subtypes of schizophrenia:

- Paranoid type (295.30)
- Disorganized type (295.10)
- Catatonic type (295.20)
- Undifferentiated type (295.90)
- Residual type (295.60)

Other Psychotic Disorders:

- Schizophreniform disorder (295.40)
- Schizo-affective disorder (295.70)
- Delusional disorder (297.1)
- Brief psychotic disorder (298.8)
- Shared psychotic disorder (Folie à Deux) (297.3)
- Psychotic disorder due to a general medical condition (293.xx)
- Substance-induced psychotic disorder

2.2.2 The structure of the psychotic personality

The term ‘structure’ refers to a somewhat stable organisation of psychic functioning that comes about in the course of the first phases of life of an individual. In the psychoanalytical structural model one distinguishes three pathological structures (Pierloot 1980, p. 273):

1. In the neurotic structure the ego-functions have come to a satisfactory development.
But, because of unresolved conflicts originating from the id and the superego, the ego

makes use of defence mechanisms in a rigid and exaggerated way.

2. In the borderline structure the distinction of the ego versus the external reality has come into being, although to an insufficient degree.
3. In the psychotic structure the ego has shortcomings in those functions (thinking, reality-testing, sensing of the external reality and of itself) that denote a distinction of the person as a subject with his/her own identity and a lack of connection with the external reality of their environment. Life experiences and current circumstances play a role in the “decompensating” of the psychotic structure, which previously only emerged in the nature of the organisation of relational patterns.

From the various types of psychotic structures we can distinguish the following:

A. The schizophrenic structure: the ego shows deficiencies in different aspects of its functioning. According to De Waelhens (1972, p.22) these deficiencies in the schizophrenic structure manifest themselves with the following characteristics:

- Incoherency and fragmentation of the patient’s perception of their body structure.
- Damage to the symbolic functions of thought, where words are used as if they were things.
- Absence of differentiation between one’s own person compared with others, as a consequence of the lack of differentiation of the patient from their father and mother in the Oedipal triangular relation.
- A consequential lack of sexual identity.
- Confusion between birth and death. Birth is the separation from the mother and is, thus, death. The opposite of this means that death is the re-entering into the womb and thus life.

B. The paranoid structure: in interaction with others a verification and correction of one’s own imaginations and opinions takes place. This adjustment does not happen based on adapting to external reality, but originates from assigning his/her own internal reality into the external reality.

C. The melancholic structure: Under the melancholic structure one understands the structural organisation that predetermines the de-compensation in the form of depressive and/or manic episodes.

2.2.3 Psychotic Disorders

A valuable overview of psychotic disorders to consider in the differential diagnosis of schizophrenia is described by Wyatt (2001).

“Psychotic disorders:

Bipolar 1 disorder:

Bipolar 1 disorder (also known as manic-depressive illness) is characterized by one or more manic or mixed episodes, usually alternating with euthymic and depressive episodes.

Brief psychotic disorder:

Brief psychotic disorder is characterized by the same positive symptoms as the acute form of schizophrenia. Symptoms have a sudden onset and last from one day to one month, followed by a full return to the premorbid level of functioning.

Major depressive disorder with psychosis:

During a psychotic episode it can be difficult to differentiate the psychotic form of major depressive disorder from schizophrenia, but generally an individual having a major depressive disorder with psychosis spends very little time having psychotic symptoms in the absence of depressive symptoms. If psychotic symptoms last longer than 2 weeks and depression is absent, the patient is more likely to have schizophrenia or a schizo-affective disorder. Individuals with major depressive disorders do not have manic or hypomanic episodes.

Schizo-affective disorder:

In individuals with schizo-affective disorder, the symptoms of a mood disorder co-exist

with those of schizophrenia for prolonged periods of time.

Schizophreniform disorders:

The positive symptoms of schizophreniform disorders are the same as those found in brief psychotic disorder and the acute form of schizophrenia. Schizophreniform disorder usually does not have significant negative symptoms, which may or may not be present early in an individual with schizophrenia. The major difference between a brief psychotic disorder, a schizophreniform disorder, and schizophrenia, however, is the length of the prodromal plus the psychotic symptoms. The symptoms of schizophreniform disorder last for at least one month, but less than six months. The time criteria include those of prodrome, active psychosis and residual symptoms.” (Wyatt 2001, p. 8)

2.3 Treatments of psychotic patients

There have been significant developments in treatment over the last seventy years in both pharmacology and in psychotherapy. In view of this, by utilising the existing reviews the author has been able to limit the material while still covering the breadth of research undertaken. This section will look briefly at psychosocial and psychotherapeutic developments, in order to give a general context for current thinking on treatment as it has emerged over the last ten to fifteen years. Firstly, there will be reference to existing meta- analyses in order to contextualise current treatment approaches.

Tak et al. (2000) looked at reports published over a period of 30 years, describing psychosocial interventions for schizophrenic patients. In this review they selected articles from eight journals, which, in 1996, were highly ranked journals on psychiatry (SCI Journal Citation Reports):

- Archives of General Psychiatry
- American Journal of Psychiatry
- Journal of Clinical Psychopharmacology
- Journal of Clinical Psychiatry
- British Journal of Psychiatry

- Schizophrenia Research
- Schizophrenia Bulletin
- Psychological Medicine

The inventory yielded 86 articles that covered 73 different studies. Controlled studies for psychosocial interventions with schizophrenia were only found in 2.9 articles per year in these eight leading psychiatric journals over the last three decades. An important finding from these studies is that external structures by means of prescribed departmental programs can lead to conformist behaviour of patients within a hospital. Taking away this structure seems to have a beneficial effect on the activity of patients, but creates confusion amongst the staff. The overview also makes clear that there is no scientific evidence of a specific effect on symptoms and functioning in individual or group psychotherapy, group discussions, drama therapy and occupational therapy. Nevertheless these interventions can lead to an increase in the patient's well-being.

Some psychosocial interventions do work for people with schizophrenia either as well as, or in place of medication. For example, music therapy (which is the focus of this study) can be used in order to reduce symptoms (in order to reduce negative symptoms) and attention manipulation. Another primary psychotherapeutic intervention used now in many psychiatric situations is cognitive behaviour therapy. In terms of re-admissions and relapses, the effect of treatment is also influenced positively but psycho-education and training in problem-solving for patients and their families. The authors conclude that scientific evidence is necessary for the next basic package in psychosocial care using interventions such as homecare, an ambulant treatment with cognitive behaviour therapy, social skills training for the patient, and psycho-education and training in problem-solving both for the patient and also for his/her social network (Tak, C. et al. 2000).

In recent years psychotherapeutic approaches have obtained a place within the so-called 'revalidation model'. For example, two of such approaches are the models of Lieberman and Murray (2001) and Van den Bosch et al. (1994), both of which involve a therapeutic process close to social skills training. This model does not consider psychotherapy as a treatment for psychosis, but rather as a form of support that can help the patient to deal with environmental stress factors and process emotionally the acquired handicap (Wasylenki 1992). While positive symptoms such as hallucinations, delusions and incoherent thinking in general can be brought

under control with medication, a psychotherapeutic approach is an alternative and valuable method when medication is not satisfactory or is impossible. It can help address negative symptoms such as insensitiveness, slowing down, apathy and autistic behaviour - symptoms that can be increased by hospitalisation (Oswald 1965).

De Haan and Bakker (2000) reviewed studies from 1989-1999 incorporating randomised and controlled designs in individual psychotherapy, and reported that long-term, individual psychotherapy for patients who live together with their family have a clear positive result, and that there is a reduction of the number of psychotic and affective episodes. The installation of an active therapeutic relationship is also the central aim of the treatment. This seems a strong argument against the threatening 'fast-food' or 'hit and run' psychiatry that ignores psychodynamics and 'fosters an impersonal, dehumanizing process' (Jackson 2001, p.38).

The objective of the study undertaken by Thornley and Adams (1998) was to provide a comprehensive survey of the content and quality of intervention studies relevant to the treatment of schizophrenia. Data was extracted from 2000 trials on the Cochrane Schizophrenia Group register. The results of this study showed that hospital-based drug trials undertaken in the United States were dominant in the sample (54%). Generally, studies were short (54% < 6 weeks), poorly reported (64% had a quality score of <-2 and a maximum of 5), and with a small number of patients (65). The study focused on the care of patients with schizophrenia or other non-affective psychosis, with over 95% (n=1954) of the 2000 trials undertaken with people with schizophrenia, serious or chronic mental illness, psychosis, or movement disorders.

Thornley and Adams conclude that "... half a century of studies of limited quality, duration, and clinical utility leave much scope for well-planned, conducted, and reported trials. The drug regulatory authorities should stipulate that the results of both explanatory and pragmatic trials are necessary before a compound is given a licence for everyday use." (Thornley and Adams, 1998, p.1184)

Psychosis and pharmacology

Anti-psychotics is a term that identifies medication used to suppress psychotic symptoms, particularly 'positive' symptoms such as delusions, hallucinations, disorganised behaviour and incoherent speech. Anti-psychotics have a less beneficial effect on the primary negative symptoms such as "speech poverty", emotional waning, anhedony, loss of will and apathy (Louwerens et al., 1999; Peuskens, 1999). Anti-psychotics are classically divided on the basis

of their chemical structure such as phenothiazines, thioxanthenes, butyrophenones, dibenzepines, piperazine and benzamides (Siegfreid et al. 2001).

Since 1960, anti-psychotic or neuroleptic medication has been the cornerstone for the treatment of psychosis. However, the desired therapeutic effectiveness of this earlier generation of anti-psychotic remedies was also accompanied by unwanted neurological and other side effects. More recent developments in medication have succeeded in a maintained and even increased effectiveness, with any side effects reduced to a minimum (Peuskens, 1999).

The maximal limitation of side effects is almost as important an aim as the decrease of psychotic symptoms by the treatment, because the patient's faith in their medication defines the prognosis to an important extent (Louwerens et al.1999). In treatment with classical neuroleptics, locomotory side effects frequently appear. These are very annoying and sometimes dangerous for the patient, and as well as decreasing their faith in therapy for the acute treatment with a delay of adapted therapy as a consequence. There is also a risk of the maintenance of treatment, from which there is therefore an increased risk of psychotic recidivism and re-hospitalisation. Locomotory side effects appear either early at the start of the treatment or after an increase in dosage (e.g. symptoms such as acute Extra Pyramidal Syndromes (EPS): parkinsonism, dystonia, akathisia, rabbit-syndrome and tardive dyskinesia), or later, during the maintenance of treatment (i.e. symptoms including tardive dyskinesia, dystonia and chronic akathisia). Neuroleptic medication also has general side effects, such as decreased blood pressure, weight gain or disturbances in the menstrual cycle of women. Also, one indicates the subjective experiences, which accompany parkinsonian phenomena and, even without the locomotory disturbances, appear: Neuroleptic Induced Deficit Syndrome (NIDS), referring to a cognitive and emotional waning. Patients experience themselves as emotionless, with a loss of will, without thoughts and interests, with difficulties in attention and concentration, and delayed thinking. The patient does not feel interested in the environment or complains about dysphory and depression (Peuskens 1999).

These side effects are significantly less with the new anti-psychotics (i.e. the atypical neuroleptics) and because of this there is a greater belief on the part of the patient in their therapy. Nevertheless, atypical anti-psychotics show side effects such as sedation, orthostatic hypotension and in particular, weight gain (Louwerens et al. 1999).

In spite of the side effects, nobody can deny that anti-psychotics are a true revolution in the treatment of psychosis. Medication is a mainstream treatment for both acute and chronic

psychiatric patients (De Hert and Slooff 2000). However, not everyone is convinced that a sole pharmacological treatment is sufficient, and that when used in isolation medication might serve only to treat symptoms rather than causes. In support of this, Siegfried et al. (2001, p. 87) stated that, “although pharmacological therapy provides the foundation, optimal treatment should also include appropriate psychosocial therapies.” Verhaeghe (2003) is convinced that the use of pharmacology is not irresponsible, and definitely not so during the acute phase of the illness. Despite this, he is sceptical about the pushing forward of the ‘prescription behaviour’ of psychopharmacology. Verhaeghe states that, “regarding treatment, it is important to recognize that the psychotic evolutionary process contains a potential to be cured, in the sense of a subject’s acceptance of what originally was experienced as intrusive. The end result of such a treatment could appear to be insanity, endurable by the patient, and often also for his environment” (Verhaeghe 2003, p. 377). Here, Verhaeghe questions if the exaggerated use of psychopharmacology is a better treatment because of its irreversible extra-pyramidal symptoms. Verhaeghe cites Sacks (1995), who advises strongly against the over-simplified, long-term prescription of pharmacological ‘cocktails’, noting that: “Sacks calls the commitment of patients to life-long suffering from a disease which is the consequence of medication cruel and inappropriate, because it prevents them from further developing their psychosis to a point of natural solution point.”

Peuskens (1998) is convinced that when administered correctly, anti-psychotics not only reduce psychotic symptoms, but can also prevent relapse, which in turn prevents hospitalisation and facilitates psychosocial re-integration. Unfortunately, the type of drug and dosage schedule used is often inappropriate. Anti-psychotic drugs should be prescribed at an early stage, in order to increase the likelihood of a favourable treatment outcome and for long enough to reduce the risk of relapse.

The efficacy of anti-psychotic treatment appears to be directly related to the duration of the untreated psychosis. Peuskens’ (1998) findings are based on clinical studies performed by Wyatt (1991) and Crow et al. (1986), arguing that if treatment starts one year after symptoms commence, the risk of relapse is higher. In Peuskens’ review there is mention of the study undertaken by Loebel et al. (1992), showing that the longer symptoms exist before treatment, the longer recovery takes and the more symptoms persist afterwards. Therefore, the timing of pharmacological intervention is critical for a positive overall prognosis.

In my study, the music therapy treatment was part of multidisciplinary approach, within which music therapy is offered in tandem with other treatments where it increases the potential therapeutic process and benefit for the patient. Therefore, it was not my intention to examine the effects of music therapy in comparison with pharmacological treatment, or even to record and report the influences of any changes in pharmacological treatment as part of the research. The pharmacological influence on the music therapy process and the influence of medication on the musical perception of the therapeutic process would lead us too far beyond the remit of this doctoral study. However, it is important to be aware of medication administered to patients and a description of the pharmacological treatment of the patients involved in the research will be included in the method chapter.

Psychoanalysis and psychosis

The theoretical music therapy framework for this research is psychoanalytically oriented. Over time, there has been a significant development in the application of psychoanalysis with psychotic patients. Throughout the 1930s and 1940s there were psychiatrists in Germany (Simmel 1929), Switzerland and the USA (Fromm-Reichman 1948, Hill 1955) who treated psychoses with a psychoanalytic oriented psychotherapy. Even earlier than this, Federn (1953) applied a modified form of psychoanalysis in 1920. Sechahaye introduced a new technique in the 1950s to facilitate contact with long-standing cases of schizophrenia, namely the symbolic realization (Freeman 2001). One year later, Rosen introduced the direct analysis (in Freeman, 2001). Fromm-Reichman (1948), Rosenfeld (1950), Bion (1957) and Benedetti (1979) developed the theories of Melanie Klein (1946) and published extensively on the use of psychotherapy as a long-standing treatment for schizophrenia. They modified psychoanalysis in order to use psychoanalytic thinking in their work. Searls (1963) was very well known for his work with long-standing cases of schizophrenia. In more recent times Dührsen developed an analytic framework in the ambulant psychotherapy of psychotic patients (Dührsen 1999). In Dührsen's approach, the symbolising process has a particularly important place at the centre of the therapy. The longevity and range of this spread of literature provides compelling evidence for the use of psychoanalytical approaches with psychotic patients.

Within the psychoanalytic stream, an extensive amount of scientific research has been done over the last few years. The Research Committee of the International Psychoanalytic Association collected many studies of the outcome of psychoanalytic treatment within Europe

and the U.S.A. over the past decades and published this in a document “*open door review*” (Fonagy 2002). It includes case study reports (4), naturalistic, pre-post, quasi-experimental studies (15), follow-up studies (13), experimental studies (8), process (frames) studies (17), process-outcome studies (12) and studies of psychotherapy with implications for psychoanalysis (5). Analysing the underlying patterns of intrapsychic changes during a psychoanalytically informed hospitalisation (in-patients and day hospital) is the topic of a study in progress (Vermote et al. 2002), involving a psychoanalytic approach in the treatment of 44 patients with personality disorders. While the results of this study are not yet published, the aspect of mentalisation correlates well to the study documented in this dissertation, and the results show some potentially significant effects of intrapsychic change. These studies show a clear overview of what has already been done and the need to demonstrate the value of psychoanalysis.

The next section will look first at the available research in music therapy with psychotic patients and then at the psychoanalytic approach which relates to the model that is used in this particular research study.

2.4 Music therapy research in psychosis

There follows an examination of specific research undertaken to date in music therapy with patients that have disorders under the heading of ‘psychosis’. In order to organise this material, the different studies have been placed in categories, to clarify what kinds of methods and music therapy aspects or approaches are the focus of this analysis. To start with, it is helpful to see where others have already reviewed literature either in more general overviews of the music therapy journals, or in more specific studies of research literature.

Wigram (1993) undertook a literature review where he analysed articles published between 1987 and 1991 in five journals in music therapy. Only 4% of articles published in the *Journal of Music Therapy* and only 14% in the *Journal of the British Music Therapy* were identified as research studies, while in the other three journals (*Music Therapy*, *Arts in Psychotherapy* and *Music Therapy Perspectives*), there is not even one article identified as research study. Wigram concluded, “We are suffering from a lack of research in the clinical field, and even where some studies have been done, they are in quite selective areas.” (Wigram

1993, p.149) In a more recent analysis of the literature Wigram (2002) analysed and categorized the articles on qualitative and quantitative research study published in three journals of music therapy between 1998 and 2001: the Journal of Music Therapy (JMT) (U.S.A), the British Journal of Music Therapy (BJMT) and the Nordic Journal of Music Therapy (NJMT). He found that there was a different balance between these three journals both in qualitative and quantitative research study, where the JMT documented 34 quantitative research studies, compared with only 10 qualitative studies, while the BJMT and the NJMT had a higher incidence of qualitative research than quantitative. Wigram also found that the JMT to a greater extent, and the other two to a lesser extent published a lot of non-clinical research that was undertaken at universities where subjects were drawn from non-clinical populations of students and staff. In connection to this study, this review showed that there were no studies in the JMT reporting research in psychiatry, and a significant lack of studies published on clinical psychiatry or clinical learning disability in the other two journals. In the British Journal of Music Therapy, only 4.1 % of the articles published between 1998 and 2001 were on clinical work in psychiatry, whereas in the Nordic Journal of Music Therapy it was 10.9 % of published articles (Wigram 2002). This is a surprisingly low figure, considering the number of therapists who work within this setting and my study will directly address this lack of research on clinical material in psychiatry.

A relevant and valuable literature research on musictherapy with psychotic patients was undertaken by Stoffler and Weis (1996). The authors analysed German and English research literature connected to music therapy that was published between 1980 and 1992. Only adult psychiatry was included, with no attention paid to child and youth psychiatry, geriatrics and alcohol and drug abuse. Studies included in this review were searched for in Psychlit, MedLine and Psyn dex and the journals 'Musiktherapeutische Umschau' and 'Musik- Kunst- und Tanztherapie'. The results of the analysis showed that 25 studies were primarily connected to music therapy. Of these 25 studies, 18 were written up as case studies and of these, 39% were case studies on music therapy with schizophrenics, 17% were case studies on psychosis and 44% were case studies of non psychotic patients. Only 28% of the 25 studies identified music therapy as an indicated treatment for the condition, mainly with a 'fireman function' intention of 'extinguishing' the symptom. It was also reported that the indication for music therapy seemed to come from the patient, who had a sympathetic feeling towards the medium of music. Significantly, almost 78% of the 25 studies used the technique of improvisation. The clinical

situations in which patients were treated varied, with 83% of the cases reported as hospital based treatment, and 17% of the studies were based on work in private practice. The duration of the treatments in the studies were between 5 weeks and 4,5 months, and 35% of the studies reported a treatment duration of 1-3 years.

Stoffler and Weiss (1996) reported different ways in which the effects of treatment were measured and validated. In the majority of cases, documentation was by written descriptive or narrative explanation on what happened in therapy. Only 33% of the studies included in this review reported having video or audio material. Of the hypotheses that were generated over all the studies, only 28% were proven. My study will address this area limited methodological effectiveness and ultimately reveal the novel and unique place for the use of video and audio material.

Stoffler and Weis (1996) analysed also seven studies about group music therapy looking at empiric process and research outcome. It should be noted that the information about patients seemed to be incomplete in most of the studies. For instance, the facts regarding the criteria of their illness or disorder, and the socio-demographic background as important criteria to appraise the treatment effects was not present in the published reports. A full and thorough study is not possible without this, and it is also essential for follow-up-studies. The publications reviewed so far shows support for my research proposal, which describes a method of bridging a gap in the available literature. However it should be noted that the work published must be treated with caution, particularly as many studies are incomplete.

In the next section, the literature has been sub-divided into studies based on quantitative (fixed) research methods and those based on qualitative (flexible) research methods. Much has been written regarding the usefulness and validity of different research methods, and it is not the intention to go into the discussion that is still active today regarding whether qualitative methods are more relevant and appropriate than quantitative ones for music therapy research and vice versa (Aldridge 1996; Forinash 1995; Smeijsters 1997; Tüpker 1996; Wigram et al. 2002).

2.4.1 Music Therapy as a diagnostic tool

It is striking how many studies have been undertaken concerning the use of music as a diagnostic tool. In a very early study, Simon et al. (1951) concluded that musical stimuli could be used as a diagnostic screening test. Another early study is the Institute for Personality and

Ability Testing (I.P.A.T.) Music Preference Test, developed by Cattell and Anderson (1953). They discovered the existence of a relationship between musical preferences and personality factors. Different researchers have further validated the I.P.A.T. Music Preference Test. Schultz (1962) showed that the I.P.A.T. Music Preference Test measured stable characteristics of individual personality. Charles (1959) concluded in her evaluation that the test was not capable of discriminating between two groups of 49 college students and 52 inpatients (diagnosed with schizophrenia). A similar study was completed by Mayeske (1962) which agrees with the work of Charles.

Henning (1966) hypothesized that the difference between the normal and abnormal personality lies partially in the intensity, persistency and configuration of sensory perceptions. The only result of this study was that disturbed individuals demonstrated real differences in auditory perception. Healey (1973) investigated the validity and reliability of the factors contained in the Music Preference Test of Personality. From this study emerged the need for further research into the effectiveness of the Music Preference Test as a diagnostic tool. Given the amount of further work undertaken on the tests and the increasing emergence of limitations, it is clear that these findings point the way for more subtle measurements systems or research designs.

Cohen (1986) explored whether analysis of rhythm and tempo in mania could be used for diagnostic purposes. This study compares rhythmicity and subjective tempos between groups of manic patients and groups of other psychotic and non-psychotic patients. The patients were given three tasks: maintaining steady beats; reproducing rhythm patterns; and creating rhythm patterns. Analyses of variance showed that the manic inmates were superior to other psychotic inmates and no different from non-psychotic inmates in rhythmicity and tempo reproduction. Findings suggest that musical-rhythmic tasks could assist in verifying diagnostic distinctions between manic and other psychotic patients. Lund (1985, 1989) also examined the possibility of using music for diagnostic aims with schizophrenics, by trying to describe something that might be called 'schizophrenic music'. Lund concluded that the use of certain musical elements and the absence of others did not provide enough evidence for diagnosing schizophrenia through musical improvisations.

In these research-studies the use of music as a diagnostic instrument is under discussion. I discovered in the studies the wish to transform the subjectiveness of music to a greater

objectiveness in the usage and reception of music. There would appear to be difficulties in correlating the different musical phenomena with pathology.

Most of the time, these studies do not account for the complexity of the phenomena involved at a deep enough level and do not relate to other important non-musical aspects of what occurs in the pathology and in the therapy. In view of this lack of detail and depth, it is essential that musical phenomena that arise in an improvisation should always be considered in relation to the patient-therapist relationship. This was not taken into account with studies such as that of Lund (1989), who also omitted the overall therapy process and the context of free improvisation within this process.

A view of the literature elicited a number of studies about music therapy clinical practice in related areas, such as music therapy with anxiety, music therapy for recreation, or for quietening disturbed patients. The next section will give an overview of some of the related studies, in order to present a general background of research of this particular study. As the review progresses, the studies reported will become more closely and specifically concerned with psychotic patients, and that research which looks at the treatment of these patients through an analytical model of therapy.

2.4.2 Studies on the use of recorded music with psychiatric patients

The receptive use of music is another research category. A very early study was reported by Altshuler and Bessey (1941), which compared the use of music-listening alone, and music listening in conjunction with hydrotherapy for calming down disturbed patients. No differences were found between the groups. Later studies demonstrated the effect of music and music therapy on a patient's emotional state, especially to reduce anxiety (Biller et al. 1974; Fisher and Greenberg 1972; Gross and Swartz 1982; Kneutgen 1970; Peretti 1975; Smith and Morris 1976). The general effects of music as a calming influence (we could categorise music as a mood-alterer) signify the power of the medium – and that this is generally recognised.

Skelly and Haslerud (1952) in the study 'Music and the General Activity of Apathetic Schizophrenics' found that when stimulating music was played, schizophrenics showed a significant increase in activity. Dollins (1965) showed us that background recorded music played during a recreational period increased conversational frequency for a group of chronic schizophrenics who were able to socialize on a limited level. Kneutgen (1970) found out that psychotic patients are able to accurately accompany a rhythm when the attention from this task

is distracted. He concluded that the psychotic's capacity for observation is disturbed when attention is completely focussed on one task, which is in accordance with the assumption that psychotic patients get into difficulties when required to do something that requires the maintenance of an intense conscious direction. In connection to this, Burleson et al. (1989) suggested that when psychotic patients hear background music, it enabled them to sort colour more accurately. In both studies the results suggested that a well-ordered information stream improved the attention and that music was a very effective vehicle for this.

Other studies have examined the nature of the effect of music therapy upon this patient population. Reker (1991) investigated a sample of 30 schizophrenic patients selected for music therapy. From the analysis of a specially developed questionnaire Reker concluded that music therapy has a high level of subjective acceptance among patients. No negative effects were recorded and the positive therapeutic effects quoted were relaxation, activation, reduced anxiety, easier contact-making, and improved opportunities for emotional expression. The duration of the effects was reported to be limited. In a randomised controlled study of 76 schizophrenic patients who received five sessions per week for one month (four sessions of listening to music and 1 session of singing songs), Tang et al. (1994) found an increased ability to converse with others. Negative symptoms such as affective flattening, poor motivation and loss of interest were significantly diminished ($p < .01$), while symptoms such as poverty of speech and attention deficit were attributed a lesser significant effect ($p < .05$). Social isolation was reduced, with those in the treatment group demonstrating increased interest in outside events. The treatment group were also reported to have a significant drop in Chlorpromazine dosages over time ($p = .0002$).

Kahans et al. (1982) undertook a study to determine whether or not music-listening in an audience facilitates an immediate patient attitude change towards therapists. Both recorded music (popular and classical) and live (cello) music were presented and/or performed by the therapist for the patients. A semantic differential was used to measure attitude change in 713 psychiatric patients and 224 control subjects. Significant attitude changes were found when the therapist conveyed a preference for the particular music to the audience. Patients with affective or alcoholic disorders showed significantly larger attitude change than the control group. The study concludes that maximal attitude change occurs when the therapist presents new aspects of behaviour to the patients.

A specific method of receptive music therapy is Guided Imagery and Music (GIM). Grocke (2002) made an overview of qualitative studies in Guided Imagery and Music. The research required methods to resonate with the symbolic search for meaning found in the Bonny Method of Guided Imagery and Music (BMGIM), which suggests that the patient already has the capacity to symbolise. Grocke (2002) gave an example of a case study of an intervention with a client in a hypomanic episode, which revealed a limitation of BMGIM in the work with this pathology. It is useful when researchers report a negative result such as in this case, as it is equally important and necessary to show the boundaries as well as the possibilities of a method. In the literature review of Meadows (2002), it emerged that, when using the BMGIM, some practitioners report the need to adapt the method when treating adult psychiatric patients, who have impaired ego strength (Blake and Bishop 1994; Goldberg 1994; Nolan 1983; Summer 1988). These practitioners provide more of a structure to the music, shorten the musical phrases, and also provide a clear verbal reflection to the imagery so that images can reduce overwhelming and anxious feelings (Goldberg, 1994), and patients can use the music as a 'transitional object' to keep the anxiety at more manageable levels and build ego strength.

Picket and Sonnen (1993) used BMGIM with multiple personality disorders and reported that their imagery tends to be fragmented and discontinuous, which could indicate that the psychic space is not developed. Meadows (2002) concluded in his review that "when patient's ego strength is impaired (especially for inpatient mental health population), the BMGIM is adapted to varying degrees, and goals concentrate more on managing symptomatology, providing insight into current life circumstances, and using positive images to build a healthier sense of self" (p. 210). This implies already that the patient can reflect and can come to images.

Another study from the general field of GIM is from Moe (2000), who undertook a study concerning music psychotherapy based on the Group Music and Imagery method. The model used was based on patients' listening experiences during selected primarily classical music, a model that was specifically designed for an inpatient setting. The patients reported their experiences to the group after the music intervention and this material is used as a part of the therapy process. The music listening was supported by verbal guiding from the therapist, to help the patients to focus. Nine psychiatric patients who were diagnosed as schizophrenic or with schizotypal disorders participated in a therapy group during a six month period, and the

study focused on restititional factors in the therapeutic process and the patients' evaluation of their therapy.

The results shows that these modification of GIM method for group music therapy was useful support for the psychotic patients. Also they found this method helpful, both emotionally and structurally and can be described as a suitable treatment for psychotic patients in long term therapy.

2.4.3 Studies on the effects of active music therapy with psychotic patients

There is only a small selection of studies reported that are concerned with analysing the effects of active music therapy with psychotic patients. Schuttermayer (1983) examined the possibilities of group music therapeutical methods in the treatment of psychotic patients. The study reported that group music therapy led toward modes of communication and behaviour that are more suited to reality. Cassity (1976) undertook a study to determine if participation in a valued group musical activity (i.e. group guitar lessons) enhances interpersonal relationships to a significantly greater degree compared with participation in non musical activities. Oswald (1965) undertook a study with nineteen chronically schizophrenic patients on whom the medication no longer had positive results. He reported positive effects from music therapy after a treatment of mainly active group musictherapy. In a variable timeframe between nine months and two years, significant improvements were reported after psychological test-examinations with thirteen of the nineteen patients. Oswald also reported a better reality orientation over time, and the reduction of secondary personality characteristics of schizophrenic patients that are believed to be caused by hospitalisation and institutionalisation.

Schizophrenic subjects (n=10) in the study of Rogers and Smeyatski (1995) demonstrated a greater ability to process musical information (or a small part of musical information. than verbal information. This study suggested that this client group could be expected to use a musical medium in their expression of emotions and communication more easily than words, thus suggesting that music facilitates patient's participation in a therapeutic relationship in which the therapist seeks to understand, interpret and reflect issues of particular relevance for the patient.

A pilot study undertaken by Clemencic-Jones (1999) researched the impact of group music therapy at an acute psychiatric ward. The results of this study suggest that the cognitive, social and emotional functioning of patients could be enhanced, and that musictherapy

provided a positive environmental stimulus for both patients and staff. Pavlicevic et al. (1994) reported that 41 patients suffering from schizophrenia who attended a series of individual musictherapy sessions improved in their clinical status and in their level of musical interaction with the therapist, which was measured by the Musical Interaction Rating scale (MIR), a tool generated for this study. The results suggest that music therapy can play a role in the rehabilitation of chronic schizophrenics. The length of musical engagements increased significantly for the treatment group, whereas there was no significant increase for the controls. The treatment group also showed a significant drop in their second BPRS (Brief Psychiatric Rating Scale) rating, taken at the end of their 10 musictherapy sessions. Perilli (1994) found similar significant effects on the BPRS and the Nurses Observation Scale for Inpatient Evaluation. Her conclusion is that music therapy can influence the negative symptoms. This research is valuable evidence for the application of music therapy in psychiatry. The reduction of negative symptoms is very difficult to treat with medication, and if psychotic patients experience such symptoms it can dramatically change their mood. As the research showed, music therapy can directly speak to such negative symptoms.

Pfeiffer et al. (1987) used theme-improvisations in which parameters such as “loud-soft”, “weak-hard”, “a wave movement” were central. During the study it emerged that compared to the control group his form of music therapy with psychotics led to significant improvements with aspects such as “contact, concentration, expression of feelings, mood and activation”. Heaney (1992) investigated adult psychiatric patients' evaluation of music therapy and other aspects of their own treatment. Participants were asked to rate music therapy in comparison with other activity therapies, traditional therapies, medication and general aspects of care provided during their hospitalization, through multiple evaluation scales. Results from a one-way analysis of variance showed that music therapy was rated significantly higher than art and recreation therapies on the pleasurable/painful scale, but not on other scales. Taken as one aspect, activity therapies were rates higher than other therapies on several scales, but were not seen to be significantly less important than medication, the highest rated intervention. Heaney suggests that these methods of evaluation could give valuable information to other music therapists, if adapted to the specific program in mind.

de l'Etoile, S. H. (2002) undertook a study to examine the effectiveness of music therapy in short-term group psychotherapy (i.e. music therapy as psychotherapeutic music therapy in group settings) for adults with chronic mental illness (i.e. bi-polar disorder, depressed phase,

schizophrenia, undifferentiated type or paranoid type), with and without a history of substance abuse. The focus was specifically to discover whether music therapy intervention resulted in patients reporting change in psychiatric symptomatology and in their attitude towards seeking professional, psychological help. There were eight participants, who had six weeks of music therapy and six weeks of no music therapy, with one music therapy evaluation test.

The results showed that six of nine symptoms dimensions decreased from the first testing point to the second (prior to the first and fourth therapy sessions) including: obsessive compulsive, interpersonal sensitivity, anxiety, hostility, phobic anxiety, and paranoid ideation. The largest decreases were seen in hostility and paranoid ideation which reached significance.

In Hannibal's single case study research (2001) there is a focus on the transference relationship between patient and therapist. Core conflict relationship themes (CCRT method) showed self-destructiveness and low self-esteem in relation to others. Music therapy enabled the client to express herself in ways not available to her verbally, making it possible for an alliance to be formed and intersubjectivity to emerge. Nielzen et al. (1993) made a study about the perception of complex sound in schizophrenia and mania. They made a comparison between 11 schizophrenic patients, 11 manic patients and 34 dentists. The conclusion was that there was a difference in rating sounds and linking them to emotion between the reference group and the others, but not between the two diagnostic groups. Thaut (1989) measured self-reported changes in states of relaxation, mood/emotion and thought/insight in psychiatric prisoner-patients before and after music therapy. Three scales were used, derived from a survey of 140 prisoner-patients (of which 50 had a primary diagnosis of schizophrenia), concerning the perceived therapeutic benefit of participating in music therapy. The study was conducted over a three-month period with eight groups of patients, each participating in music group therapy, instrumental group improvisation and music and relaxation. Results showed a significant change ($p < .05$) in self-perceived ratings before versus after music therapy. The study demonstrates the efficacy of music therapy in short-term inpatient settings.

Limited research has been done in regard to group music therapy with psychiatric patients, even though in the psychiatry field many publications report group work (Duey 1991; Gindl 2001a; Nolan 1991; Odell-Miller 1991; Wölfle 2001). This lack of research probably has something to do with the fact that music therapy group improvisations and processes are very complex and are difficult to analyze and report. On the other hand, there are many examples of interesting case studies describing individual therapeutic developments in music therapy in

psychiatry (Aldridge 1997, 1998; De Backer and Van Camp 2003a; Duey 1991; Hannibal 2001; 2003; Jahn-Langenberg 2003; Jensen 1999; John 1995; Kenny 1991; Lee 1996; Nolan 1991; Metzner 2003; Pedersen 2002b; Odell-Miller 1991; Perilli 1991), but not many of them attach the exclusive significance of defining the relevance and the coherence of music. These reports do not analyse the music in improvisations in order to explain the function of the musical material in the process of therapy. However, the musical material is described more from the perspective of its background role with the main emphasis on the psychotherapeutic process.

2.4.4 Developing theoretical frameworks for music therapy in psychiatry

An extensive study by Wheeler (1987) involved 148 music therapists in order to look at goals for different levels of therapy in the treatment of psychiatric adult patients (schizophrenic patients, $n = 224$). The outcome of this study supports the proposition that the work of music therapists can be categorized at three levels: music therapy as activity therapy, music therapy as re-educative therapy, and music therapy as reconstructive therapy. In a study with psychiatric patients Metzner (1999a) explored the ‘dynamic triad structure developing’ in psychoanalytically orientated music therapy. She developed a protocol for describing group music therapy improvisations and in a later study illustrated this in a case example where a triadic structure model served as the basis for theoretically reflecting upon a multilateral transference situation within a multidisciplinary treatment team on a psychiatric ward (Metzner 2003). This work showed the multi-layered complexity of a music therapy input in psychiatric settings.

In a research review Risch (1996) noticed that the connection to the modern differential psychotherapy-effectiveness study is essential for the recognition of music therapy (Grawe 1982 in: Risch 1996; Meyer 1991). This research reminds us that it is important to approach the therapeutic process from different individual perspectives – particularly that of patients, therapists and researchers (including the necessity for independent observers to re-establish inter-subjectivity). The study recommends the use of qualitative research methods to examine theory and develop theoretical models. Risch reported that musictherapy will only be able to keep its niche on the basis of its specific medium and that music possesses the power to create an inner world, and an experience of space. The most relevant studies and articles in relation to this current research study address these issues, and most literature underpins this. This

combination of literature supporting the central role and importance of the musical process and the lack of detailed, depth studies of music therapy and psychosis further strengthens the author's research focus.

Storz (2003) investigated the possibility of a short term psychodynamic treatment by psychiatric patients and developed out of her research project a new model called the "Fokale Musiktherapie". She examined the different factors of psychodynamic techniques and interventions of the therapist and the effect of music in short term music therapy. This research showed how important it is to remember that healthcare is increasingly dependent on economic considerations, thus making short term therapy treatments more common, even if this is in opposition to psychodynamic thinking that treatment should be focused on longer-term development within the patient. This in itself demonstrates the vital place of further research studies focusing on therapeutic process and outcome.

2.4.5 Research related to this research project

The final part of this review draws on those few studies that are specifically related to the subject of this study.

Pellizzari (1993) explored the process 'from Monody to Polyphony' by psychotic patients. Her finding was that the constant repetitive play of psychotic patients could be compared with a failure in the symbolization process. A study by Bauer (2000) compared the musical representation, interaction and perception of paranoid-schizophrenic patients to a normal control group. The findings in this study focus on aspects of psychotic patients that are of interest in the current study. Bauer analysed musical parameters in the play of psychotics and compared them with the control group. The psychotic patients tended to play rather loudly and without variety in the dynamics of their musical play compared to the control group and their musical play was rather more rhythmic than melodic - melodically their play was rather flat. Schizophrenic patients recognize emotions, but cannot appropriate them. They show a limited amount of interaction and are rather isolated, which corresponds to some aspects of the sensorial play. Smeijsters (1995) reported the same findings in his literature review about the reflection of schizophrenic patients on their musical behaviour.

Schumacher (1998) developed the Evaluation tool "Einschätzung der Beziehungsqualität" (EBQ) and a theoretical foundation for a developmental psychological oriented music therapy for autistic children. While not focused on work with psychotic adults, Schumacher's

description and analysis of seven stages in the process from ‘no contact’ to ‘inter-affectivity-meeting’ is relevant to this author’s study. The theory is developed from the self development concept of Stern. Questions about video-description of therapy session were discussed. Notations and transcriptions of the improvisations made clear how the relationship quality occurred.

Pavlicevic and Trevarthen (1989) developed the Musical Interaction Rating (MIR) in their study. This is an evaluation model especially developed for chronic schizophrenic patients. Pavlicevic divided the MIR into nine levels, but while the scale can be useful for clinicians in recording a stage in the level of the therapeutic relationship, it is not comprehensive enough to explain what is really happening in the therapeutic process for this research. First, the MIR is only phenomenological on a musical level and Pavlicevic did not describe the psychic state, nor what happened in the patient’s experience. The scale is also mainly concerned with defining a level of interaction, intervention, and communication. Pavlicevic does not investigate one of the central problems of psychosis, namely the fact that psychotic patients have difficulties in coming into symbolisation (Dührsen 1999; Segal 1996; Van Bouwel 2003), and in developing a psychic space in which a musical form can develop. In this sense the MIR scale is not primarily intended for the purpose of obtaining insight in the complex therapeutic process by psychotic patients.

2.5 Sensorial play and musical form

A main aspect of the author’s research is to explore whether music with psychotic patients is especially relevant for them in order to make the transition from the senso-motorical playing (sensorial play) into a musical form (proto-symbolisation). In general terms, one needs a ‘design’ in order for ‘sensoriality’ to grow into something that can be described as an experience. The problem with psychotic patients is that they cannot transform sensorial play into an experience (Van Camp 2001). With this concept in mind, this study will examine whether music can be an effective tool to facilitate this process of symbolisation (musical form).

Plomteux (2003) characterizes the pathology of psychosis as an absence of symbolising. She cites Fink, writing that, “the psychotic patient is characterized by inertia, by the absence of

movement or dialectic in his or her thinking..... The psychotic repeats the same phrases again and again; repetition takes the place of explanation. There is no dialectic of desire...“(Fink 1997 p.101). Following on from this it can be said that the absence of a psychic space makes it impossible to come to an inner image (an impression). Billiet (1996) characterises the psychosis as a ‘passage à l’acte’. This ‘passage à l’acte’ is not an expression of an unconscious imagination, but it is an act - an answer that is not mediated by the imagination. This theory is supported by Schaverien (1997) who characterized psychosis as the absence of symbolic forms and the impossibility for communal understanding. Hengesch (1974) described the musical play of the psychotic as “the patients play with their heads bowed, sunk into themselves, absent and with an indifferent attitude. There is definitely a loss of ‘time feeling’. Improvisations of these psychotic patients were unbearably long and monotone.” (p. 234). Hengesch had the experience that the patients could not conclude or stop their musical play and wrote, “They continued to play and hardened and suffocated in the play.” (p. 234). For him there are two typical aspects in the musical improvisations with psychotics:

1. Stereotypic forms are held by the individuals for a very long time.
2. The volume always remains very close below the highest potential of the instrument.

Hengesh noticed that the musical play seemed to have more to do with the motion than with the production of sounds, noting, “the movements are no longer purely functional, but have their own independent ‘lust drive’” (p.235). From this point Hengesch referred to “Eindrücke” (the impression) and did not do any further scientific research regarding his observations.

This characteristic of repetitive play was also described by Schultz (1987), who researched stereotypical movements in the treatment of the mentally handicapped, a feature which also can be observed in schizophrenic patients. Schultz examined definitions of stereotype behaviour and movements from the literature and explored these phenomena in a case study. In his conclusion he questions stereotypic movements are a form of communication and if the aim of the treatment should be that the patient is taken out of the isolation of his world or stereotypes. Offering possibilities to come to a play is central in the treatment of people with stereotype behaviour.

Van Camp (2001) uses the concept of sensoriality in relationship to psychosis. He defines the repetitive and fragmented play of the psychotic as a ‘sensorial play’ and matches this to the

musical form as a memory, in a sense acting as a varied recapitulation of what happened previously. The repetition as a 'pure repetitiveness' is rather in connection to the passive undergoing of the same, while the recapitulation (or the 'reprise') rather possesses the connotation of actively producing a difference. In the repetitive music - which is by definition endless - the repetition becomes traumatic and provokes a euphoric, fuddle-like or mist effect (where the fuddle is the outstanding sign of pleasure and 'dead drive'). In the fuddle each 'continuation' or remembrance is rejected. Van Camp (2001) compares the repetitive music with the paradigm of the classical sonata form. The phenomena of renewal, recapitulation, variation and reprise find accommodation in the concept of re-exposition (recapitulation), while the endless traumatic repetition can be encompassed in the concept of repetitiveness.

In an article 'Am Anfang war das Chaos' Schirmer (1991) describes the appearance of a melody, coming out of a chaotic play of a psychiatric patient, as proto-symbolisation. Metzner (1999b) defines proto-symbolisation as a symbol in pre-state and she underlines the importance of proto-symbols in the music therapeutic process with psychiatric patients.

Symbolising is only possible if the psychotic possesses a psychic space and the absence of it is almost unbearable for the psychotic. Hence, the development of the mental or psychic space in the pathology of the psychosis is for Van Bouwel a therapeutic necessity in making the immense psychic pain bearable. Van Bouwel wrote, "Within this mental space the psychic pain is being made bearable, thoughts can originate and the patient does not have to be victim of his psychotic experiences any longer"(Van Bouwel 2003, p. 132). Dührsen (1999) described a triangular space, in which the patient can experience himself increasingly as a subject. (Dührsen 1999) Hannibal (2001) recorded that the necessity to create a musical space in the treatment of psychiatric patients and to experience themselves as a subject emerges as a vital component of the work. Killick and Greenwood suggested that the behaviour of psychotic patients was 'pathologically concrete' and that 'abstract' or symbolic behaviour was 'avoided' (Killick and Greenwood 1995, p. 110). Bringing literature and clinical experience together enabled Killick and Greenwood to propose that the concrete elements of image-making within the art therapy setting offered considerable potentials for work with this patient group (psychosis). It is relevant to record the words of Killick and Greenwood in summarising the whole:

"The art process itself offered potentials for a shift in the nature of the regression to a

benign form. This could eventually result in restoration of symbolising functions and accordingly change in the level of ego function for the patient. These potentials of the art process as an area of evolving the capacity to ‘think the unthinkable’ and of the art therapy relationship as one which could foster the capacity to ‘speak the unspeakable’, could be realised if certain principles of approach were followed by the therapist.” (Killick and Greenwood 1995, p. 110)

Only in a few music therapy research studies does one find mention of the specific way of playing of the psychotic on a musical level (that is, a constant repetitive play (Pellizzari 1993), without variety in the dynamic in this musical play and with rather flat melodic features (Bauer 2000)).

Musical form

Several authors have tried to define the term ‘musical form’ but the literature shows that this task is very difficult and complex. Stolnitz (cited in *The New Grove*, vol. 6, p. 709) states: “‘form’ is.... probably the most ambiguous word in the language of art”. Stolnitz is in disagreement with Leichtentritt (cited in *The New Grove*, vol. 6, p. 709) who asserts that: “‘form’ in its general sense cannot be the subject of a systematic study. It is a matter of musical instinct, of taste, and of artistic intuition”. These and other different approaches to a definition show that the meaning of “form” needs to be understood clearly, since it involves the very nature of art (Langer 1953). One possible approach is found in the music dictionary ‘*The New Grove*’ (Stanley 1980) where musical form is defined as: “the constructive or organizing element in music.”(Whittall 1980, p. 709) Expanding upon this, Leichtentritt affirmed that ‘A composition possesses form....’ when it contains ‘...neither a measure too much nor too little, exhibiting the right balance and the right symmetry in all its parts.’ (Leichtentritt, cited in *The New Grove*, vol. 6, p. 709), while for Langer, form ‘is always a perceptible, self-identical whole; like a natural being, it has a character of organic unity, self-sufficiency, individual reality’ (Langer 1953 cited in *The New Grove*, vol. 6, p.92).

If form is hard to define satisfactorily, then the concept of ‘formlessness’ is even more difficult. Logically, the only truly formless work of art is a non-existent work of art. (Whittall, 1980)

Structure and form

The connection between structure and form is sometimes confusing. Rather confusingly, Tenney described structure as a sub-category of form and Stolnitz (cited in *The New Grove*, vol. 6, p. 709) described form as a sub-category of structure! Gieseler (1975) described form as a (sensory) perception which is not only psychic-subjective, but also can be understood as an object of structure. In this sense structure and form are clearly related to each other. Form can be seen as a heard experience of structure.

De Backer and Van Camp 2003a; Frisch 1990; Mahns, 1997; Pedersen 1999; Schirmer 1991 and Wigram 2004 emphasize the importance of structure as a form-giving element in musical improvisation. Frisch (1990, p. 23) is concerned that the structure within music can provide the patient with a safe container for the self-expression that is so crucial to the resolution of the identity crisis and the further development of personality. It can enable the adolescent to channel internal experiences into external expression in safe and growth-producing ways.

According to Mahns (1997, p. 73) acoustic events are only heard as music, when from a tone or a sound a connection with other musical elements is created. Form-giving means that an element, such as a tone, is recapitulated, because without this there can be no recognition, and therefore there is no possibility for a single form to be visible. Thus, an essential aspect of musical form is the recapitulation of musical elements. According to the research of Hoffman (2002), phrasing is also one of the main aspects that is necessary in order to come to a musical form. Bruscia states “Rhythm and melody are related to each other through phrasing. Phrasing places the flow of rhythmic energy together with the shape of the melodic and harmonic feelings” (Bruscia 1987, p. 454). Additionally, Sutton sees phrasing as moments of silence, which are a condition for a “coming into form” (Sutton 1998).

Bruscia (1982) considers musical form as the study of how musical ideas unfold in time. Variations on, and the development of a musical idea belong to a musical form, stating that, “with regard to musical form, the act of creating music requires what the existentialists would call the power, will, and freedom to choose among several options for continuation.” (Bruscia 1982, p. 30). This variation and musical development is also situated in the frame of thought used by Van Camp (2001), who describes musical form as a formative energy rather than as a structure in itself. The music can move the player or listener and, therefore, a feeling can originate that a work possesses a certain logic. This conceptualising follows the philosopher

Kant, who describes musical form as having to be reinvented over and over again. For Van Camp (2001) each concrete musical production is situated in dialectic relationship between repetition and recall, with repetition and reprise (recapitulation, musical form) in relationship with one another as opposite polarities of the negative versus the positive. Repetition has, for Van Camp, “an automatic, mechanical and obsessional character that is a purely quantitative accumulation, which is at the border of the conscious, and is recognized by a certain poverty of sounds.” (Van Camp 2001, p. 7) There is no variation, only a pure repetitiveness. To digress briefly, it is useful to describe repetition as a primary element in sensorial play at this moment. The recapitulation or reprise refers more to the active dimension of the intentional recapitulation, the renewing, the starting over again, the variation, all of which can be a characteristic of musical form. When one brings this into connection with ongoing time, one can mark the repetition within timelessness: it never stops, it is endless. The recapitulation means identifying oneself within that timeframe, bringing oneself into a context of past events. (Van Camp, 2001)

The study of this particular area of the literature led the author to describe the notion of 'symbolisation' or 'symbol' more specifically as 'musical form'. The notion of 'symbol' knows countless specifications, definitions and categorisations. To go into all these specifications would take the reader too far, even in the scope of a doctoral study. However, some of its relevance to the music therapy process will be explained in the next chapter that describes the clinical method. The essence of this research regards the musical and therapeutic process of the sensorial play into a musical form.

2.6 Summary

From this literature review it seems that existing music therapy research in relation to psychosis tends to employ interventions using receptive methods, and is aimed at diagnostic goals, the functional phasing out of fear and tension, or to develop and stimulate cognitive and social skills. These approaches are less relevant to this study, because they do not aim to achieve insight into the therapeutic process and the therapeutic relationship. They focus, rather, on the effect of the perception of music on the patient. Other studies that are mainly related to forms of active music therapy are more typically focussed on effects like the reduction of tension

(Thaut 1989), providing a positive environmental stimulus for patients and staff (Clemencic-Jones (1999), a better reality orientation over time (Oswald 1965), reducing negative symptoms (Perilli 1994), significant improvements in contact, concentration, expression of feelings (Pfeiffer et al. 1987), expression of feelings (Cassity 1976), reducing of psychiatric symptoms (de l'Etoile 2002; Pavlicevic et al. 1994) or the stimulation of inter- or intrapersonal communication (Storz 2003).

None of these studies explores the specificity of music or musical parameters in the therapeutic process and connect musical changes to therapeutic changes. Generally, one can state that in most music therapy studies the research is mainly focussed on the extra-musical instead of the music itself. In a literature research, Risch (1996) describes the danger of music being applied too much as a medium, aid or vehicle (Strobel and Huppmann 1978), thus neglecting the central importance of music in music therapy. There are a small number of research studies entail the musical analyses of improvisation, and connect this with possible therapeutic processes (Aldridge (1998); Hannibal (2001); Hoffmann (2002); Lee (1996, 2000); Schumacher (1998)). The results of these studies are extremely interesting because through the process of musical analysis and of the structures, musical development and interactions it becomes clear that music and musical processes have an influence on the general therapeutic process. Consequently, it is obvious for this research that fragments of the improvisations will be analysed musically.

The author's research examines music in relation to the therapeutic occurrence and, as such, provides insight to specific aspects of the music in a way that will mainly be based on the theoretical positions and foundations of Winnicott (1971), Bion (1956, 1967), Lacan (1981), Van Camp (2001), Van Bouwel (2003), and the art therapists Greenwood (1997), Schaverien (1997), Killick and Greenwood (1995), all of whom emphasize the necessity of the creation of a psychic space for the origination of symbolisation.

The clinical framework of psychoanalytic oriented music therapy in which this clinical research will occur is described extensively in case studies and theoretic papers from Metzner (1999b), Storz (2003), Hannibal (1998, 2003), Jensen (1999), Odell-Miller (1991), Ostertag (1985), Pedersen (2002a, 2002b) and Strobel (1999). While there is literature relevant to my research, these publications tend to either adhere to a particular theoretical framework (i.e. Freud, Bion, Winnicott, Jung), or detail an accepted method of working that is more generally

Chapter 3

Clinical Approach as Part of the Research Method

Introduction

This chapter describes the music therapy method that the music therapist uses, together with his thinking about psychotic functioning. The musical and therapeutic approach used by the music therapist as well as his thinking about, and interpretation of, the personal clinical material of the patient, will ground the results from this study within a specific theoretical context.

Prior to everything else, a few concepts regarding psychotic functioning from a psychoanalytical ‘frame of thought’ will be described; these same concepts are used by the therapeutic team of the ward where the two cases are treated. After that, the theoretical ‘frame of thought’ that influences the clinical work of the music therapist will be described.

3.1 A few concepts of psychotic functioning

The two cases included in this study were treated in the psychiatric hospital ward for psychotic patients. This ward underpins its treatment approach of the population from a psychoanalytic perspective in order to make psychotic functioning more insightful. Dr. Van Bouwel, psychiatrist/psychoanalyst and supervisor of this ward, described this theoretical “frame of thought” in several articles (1998, 1999a, 1999b, 2003). She bases her thinking on the phenomenon of the alpha-function in reverse and the bizarre objects of Bion, the idea of the autistic-contiguous position with ‘auto sensorial forms and –objects’ and the ‘mental skin’, referring to Anzieu (1994), Bick (1967), Ogden (1992) and Tustin (1980, 1984). Van Bouwel also describes the concept of projective identification and the depressive position, with connected ideas such as transitional space, objects and repair. These concepts are important because they give a theoretical framework for the treatment of psychosis, in which the development of mental space and the symbolising process are placed in a central position.

Bion (1962) departs from the statement that a psychotic patient is in a world full of *bizarre objects*, in which it is impossible to think. These because the psychotic patient’s thought processes are disturbed. According to Bion, the normal development of a thought process is initiated in the early mother-child relationship for example, when the anxious or

hungry baby communicates his fear or frustration towards his mother by crying, he also arouses his own fear or frustration in his mother. Bion names the concrete sensed sensations such as hunger, cold, pain and fear, beta-elements, those which the baby puts with the mother. The mother can contain them in her reverie and detoxify and mentalize them into *alpha-elements* (dream thoughts, inner images and forms). In this way the mother gives thoughts to the child through which a thought-process can originate within the child. At a later developmental stage, the child develops its own alpha-function, an individual's power to symbolize, out of which an inner world can be developed. The learning process thus assumes a good relationship between the container (the mother who fulfils the alpha-function) and the contained (the baby who evacuates beta-elements). If this relationship is disturbed (for whatever reason) it is possible that the normal alpha-function does not get developed. If the container is missing or continually fails, the representation of a mental space is impossible. There is no difference any longer between reality and the mental space. The mental space runs becomes as empty as infinity without reference points. This is applicable on the psychopathology of psychosis. The psychotic does not know a mental space in which inner sensations can be experienced psychically and in which there can be a thinking process.

Sometimes a reverse alpha-function originates, for instance if "the offered alpha-elements are not used by the baby, but are destroyed in a cannibalistic way." (Van Bouwel 2003, p. 123) This disturbs the formation of a *contact barrier*, a kind of psychic membrane, which separates conscious and unconscious processes. Instead of this, a *beta-screen* is formed - a screen on which the destroyed alpha-elements are projected in the form of bizarre objects. The psychotic lives in a world full of bizarre objects, a world in which thinking processes are extremely difficult, or even impossible.

The concept of the *autistic-contiguous position*, introduced by Ogden (1992), is based on the work of Bick (1967), Meltzer (1975) and Tustin (1980, 1984). A position can be understood as described by Ogden as "psychological organizations that determine the ways in which meaning is attributed to experience" (Ogden 1994, p.34). Van Bouwel describes the autistic-contiguous position as "a sensorial dominated, pre-symbolic experience area, in which the most primitive form of significance originates on the basis of the organisation of sensorial impressions." (Van Bouwel 2003, p.125) In this way, the autistic-contiguous position can be associated with the most primitive way of giving meaning to sensorial experiences, where psychotics experience a fear of falling apart, a bodily fragmentation or falling to pieces. A grip

on the sensory boundaries on which the experience of a connected self is based is unavailable to them. The fear of loss of boundaries is experienced as falling into an endless and formless space (Rosenfeld 1971). Often, the individual tries to protect himself against this fear by forming a second skin, the so-called “second skin formation.” (Bick 1967)

In the autistic-contiguous position, objects are mainly experienced in the form of relations with sensation objects and sensation shapes (Tustin 1984). However, when these sensations are used exclusively and in a rigid way, they can block any further psychic development. Tustin (1980, 1984) then speaks about *autistic objects* or *autistic forms*. An “autistic form” is a felt form, “a felt shape” (Tustin 1984), existing of idiosyncratic sensorial impressions that the object experiences when touching the skin surface. “Autistic forms” mainly exist of experiences with soft objects and physical substances, primitive experiences which are of a soothing and relaxing nature. These experiences are tactile activities such as patting, rubbing, smearing and rocking and all these activities cause tactile sensorial impressions on the skin. One sometimes sees in music therapy that patients play the conga by continuously patting the instrument with their hands, where they want to experience the tactile contact with the hand as soft and sensory contact. From a very different context, Rauchfleisch (1974) describes how the composer Richard Wagner draped the furniture with silk and patted it while composing.

Relations with “autistic objects” consist of experiences with hard and sharp physical effects that create the sensorial experience of a protecting crust. Van Bouwel describes an anxious schizophrenic patient who constantly wore a cap on his head which was so tightly fitted that there were visible marks on the head when it was removed. Only when wearing the cap could this patient feel safe enough to mingle with other people (Van Bouwel 2003, p. 127). In music therapy there are occasions when patients hold onto a drumstick forcefully, both when they are and when they are not playing. These sensorial objects and forms have, according to Tustin, a projective function, in the sense that the unbearable pain of being physically separated from the mother is tolerable, because of the feeling of being cocooned. Van Bouwel (2003) notices that the sensorial forms and objects do not yet have the status of transitional objects that are described by Winnicott (1971). Transitional objects are less primitive and are more charged symbolically and form the transition between the inner and the outer world.

The *paranoid schizoid position* (Klein 1946) develops a more mature, differentiated way of being than that associated with the autistic-contiguous position. The paranoid schizoid experience dimension is characterized by a form of subjectivity in which the self is experienced

as “the self as object” (Klein 1946). There is a little awareness that one is the creator of its thoughts and feelings. Thoughts and feelings are experienced as forces and physical objects that occupy and attack the self. If the autistic-contiguous position can be viewed as pre-symbolic, then the paranoid schizoid position is characterized by a form of symbolisation, in which there is already the beginning of differentiation between symbols and the symbolised. The “I” between the *self* and the experience is almost not yet present. The individual has only reached the beginning of awareness of himself as an interpreting subject, and is experienced by the other as an object instead of a subject. A small capacity exists for caring about others; one can value objects, but one cannot show the smallest care for the most valuable possessions of the other. In the absence of the power to care, the potential feeling of guilt is nonexistent. There is no mourning about lost objects that in a magical way; within in the mind of the patient. There is a great awareness of the immediateness of the experience. One tries to split the threatening and the threatened aspects of the self and the objects (splitting) using others in order to experience what one finds dangerous for oneself (i.e. projective identification; see below) The use of splitting makes the experience of oneself in relation to other objects inconsistent. A beloved object that is suddenly absent is not experienced as a frightening, unpredictable good object, but as a bad object. This results in a continuous rewriting of history where in every new affective experience with an object, one exposes the other and discovers the truth about who the object is and always was. Born out of anxiety, fear causes threats to and fragmentation of favoured aspects of the self and the object by becoming detested and hated aspects of the self and the object.

Klein (1946) described *projective identification* as means of protection against paranoid fear. Split parts of the self are installed in someone else and are controlled there. There is no clear awareness of an inner psychic space, and painful feelings are split apart instead of processed. Rosenfeld (1971) also described projective identification as a form of affective communication that generally occurs when, as follows:

- the patient starts to project the experiences and feelings that he does not know what to do with;
- unconsciously the patient fantasises about how he can transfer this non-manageable state of feeling to another (for example his mother) in order to get rid of it or in order to get it back in a manageable form;

- the patient puts pressure on the therapist during the interaction, just as when a baby starts crying, with the unconscious aim that the other gets these feelings instead of himself.

If this projective identification succeeds and the patient can reach the other (the therapist), then as he achieves an affective soundboard with the receiver, his feelings will become identical, as a consequence of identification, with the receiver's. We can say that this affective identification originates protectively by the one who projects and introjective by the one whom receives. In this sense the communication is strongly transforming. Vermote (1996) described how a psychotic, who normally does not smoke, smokes a total of fifteen cigarettes in 45 minutes during a session effectively 'smoking out' the therapist. The patient is relaxed and not bored, but the therapist feels angry and suffocated. The patient's feeling of anger and boredom is now put with / held by the therapist.

Bion (1962, 1965, 1975) made a distinction between normal and pathological projective identification. Normal projective identification is the first form of psychic communication between mother and baby, which, as described previously, is important for the development of thought processes.

In the *depressive position* the baby makes steps toward a psychic integration. After a while the child begins to experience that the person he is so angry about is the same person who at other times is needed so much. Guilt and fear for loss cause depressive feelings and the need for symbolic reparation of the other. In this, Segal (1996) sees the psychogenetic origin of symbol formation, creativity and, later on, the arts. The formal qualities of the artwork reflect the artist's need to repair, while the content could appeal to extreme experiences of destruction and loss in any one of us.

The depressive position is the most mature psychological organisation, because in this position there is a much more developed awareness of an interpreting self that is positioned between the self and the experience. In this experience state, thoughts, feelings and observations are not only there, 'like a clap of thunder or a hit' (Winnicott 1960, p.141), but are also experienced as their own psychic creations (that can be transferred) with which one can live, and which do not immediately have to erupt into action, or be warded off in omnipotent fantasies. The individual experiences himself as a subject, and as such he starts to see (through projection and identification) that his objects are also subjects with an inner world

of thoughts, feelings and observations, just like himself. As a result of the growing consciousness of subjectivity of the other, it becomes possible to experience the concerns for the other; one knows that the other can feel pain, which is as real as one's own pain, which cannot be ended or repaired in a magical way. With this development of the power to be concerned, a feeling of guilt also originates, as well as regret and the wish to repair current or fantasised evil that one perpetrated in a non-magical way. In the depressive position the 'trust in the almighty' defence mechanisms are released, a historicity originates. In this paranoid-schizoid position, history is continuously rewritten, whereas in the depressive position one is stuck in the past. Experiences from the past can be remembered and interpreted again, but the past remains unchangeable (Ogden 1994).

In the depressive position *reparation* plays a major role. The fear for continuing objects is gone but instead of this the child is afraid to lose his love object because of his aggressive, sadistic phantasms towards this love object. These phantasms wake up guilt feelings in him. In his phantasm the child therefore starts to repair the external and internal object. It wants to repair or maintain the integrity of the mother body. This happens in the form of different phantasms, as noted as follows by Klein: "protect the mother body for attacks of 'evil' objects, to gather again the dispersed parts, and give life again to what was killed." (Klein 1948, p. 289)

Two important concepts that Winnicott (1971) used are the 'transitional space' and the 'transitional object'. The transitional space is the space which makes the separation between mother and child possible and in which mother as well as child takes part. It is the space of play and fantasy, in which human communication takes place, and where there is separation between the inner and outer world, but also brings them into contact with each other. This space does not seem to be present, or at least very inaccessible in people with a psychotic disturbance. It is as if they are imprisoned in their own world into which nobody is allowed. Music offers possibilities here because it can symbolise the function of a 'transitional space'.

Psychosis and pain

Vermote (1996, 1997) describes psychosis from an interesting viewpoint, that of psychic suffering. According to Vermote (1997) one of the most important functions of our psyche is to deal with painful emotions - with psychic pain. According to Bion (1962) the psyche has two ways of dealing with this: on the one hand psychic pain can be digested, while on the other hand it can be avoided or split. The difference in ways of dealing with psychic pain determines

the distinction between the psychotic and the non-psychotic part of the personality.

Working through unbearable and painful material happens in the non-psychotic part through symbolising, mentalising and mourning. In this sense, something is mentalised to an inner image, or in music therapy to a musical form. By avoiding psychic pain (in the psychotic part of the personality), the observation of the painful reality and additional sensations and phantasms are not allowed. This then leads to fear, where the painful aspects are split off and the mechanism of projective identification is utilised. According to Vermote (1996) the non-allowing of painful emotions can be avoided in different ways, namely by denial, (where a loss of reality can occur), through dissociation (where the traumatic gets frozen together with a part of the personality), through venting (for example, by smashing something into pieces), or by using splitting and projective identification. If one uses these last two phenomena excessively, a psychosis can develop (Bion, 1956).

In a case where the pain becomes too great to digest and the splitting- and projective identification mechanisms are no longer effective, if no (or insufficient) containment can take place the psychic system, through which the painful reality is perceived and mentalized, will be destroyed (Killick 1997). The power to think and the perception system of the psychotic patient are damaged. There is a splitting, a fragmentation of the psyche and inner destructive forces threaten to destroy his psychic world; nothing more than broken pieces, the rubble of the psyche, are left for him to evacuate (Bion 1962). In any case the senses are not used any longer as receptors for the psyche, they become channels through which the psyche can evacuate them. Bion wrote here about the death drive. The drive for life as connecting force is constantly looking for an internal or external object and has an “objectalising” function, while the drive of death, however, has a “de-objectalising” function, because of the disconnection that she causes. The de-objectalising function makes a possible symbolisation impossible and is, as such, the most radical means to resist the mourning or the disconnection of a fusional relation. The destructiveness, which is part of the death drive, profiles itself in the de-investment. The destroyed “I-elements” together with the remains of destroyed sensations are experienced outside the “I”, where everything can be used interchangeably. Each meaning is destroyed and for the psychotic there is only unnameable fear disconnected from each meaning. All of this becomes even more unbearable because the psychotic cannot tolerate situations when the therapist tries to see the connections between these psychic broken pieces. The patient just fragments in order not to feel the pain of mentalising, in order not to suffer and not to process it.

There is only a fearful existence left for him in an endless, empty, but threatening world (Van Bouwel, 1998).

During the research study the theoretical framework of Lacan's thinking of psychosis became relevant to examine the process from sensorial impression to a musical form.

Lacan and psychosis

Lacanian thinking and theory has taken a gradually increasing place within the theoretical frame and approach of the ward where both research subjects were treated. While it is not relevant to fully describe this in order to provide a comprehensive and thorough exposition of Lacan's psychoanalytic theory, it is nevertheless important to briefly highlight Lacan's thinking about psychosis. Some core concepts will be discussed, as well as the relevance of these concepts in understanding the pathology of the subjects included in this study.

Lacan differentiates between the 'real', the 'imaginary' and the 'symbolic' (Billiet 1996). These three concepts are the pillars of Lacanian psychoanalysis. The 'real' stands for the impossible, the unnameable, the inaccessible and the unimaginable reality. It is the order of the body: the immediateness, the affect. At this level one can find the *jouissance*¹, which is defined as a kind of pleasure without any limits. The *real* is by definition never symbolised and assimilated. It cannot take on any form or become an experience. Lacan (1981) states that a child's development of symbolisation is connected with the emergence of language, and it is only via language that a child can start to symbolise and become a human subject.

Becoming a subject

In Lacan's theory concerning the process of becoming-a-subject, the imaginary and the symbolic order play an important part. The occurrence of imaginary identification puts down a first layer of identity, and this symbolic-identification provides a fundamental basis for the acquisition of one's own identity. The mirroring stage, which belongs to the imaginary, can be viewed as the starting point in the process of becoming a subject. The child is in a completely dependent situation with the mother and his experience of the world is defined entirely through

¹ *Jouissance*. Lacan postulates pleasure as a concept which always entails a certain ambiguity, and because of this one can usually only express it with an oxymoron (e.g. 'a youthful grey beard', or 'the use of the usefulness'). *Jouissance* stands apart from each image and is withdrawn from each symbolisation. A characteristic of *jouissance* is that it is idiosyncratic and not divisible.

the presence or absence of the mother, the first Other. They find themselves in an entirely dual, symbiotic relationship. In this relationship the desire of the child equals the desire of the mother. With the child, in a strict sense, there is no articulated desire yet. This direct connection (or joining together) with the body of the mother does not yet allow the child to be disconnected from the environment and as a consequence of this the child cannot experience himself as a subject because of his need to resist reality. On the other hand the mother is the first expression of the Other, but she cannot be recognised as such because her desire coincides completely with the one of her child. Only when the direct link between need and satisfaction is disconnected will the subjective process begin. The articulating of the desire is structurally connected to becoming an individual, with the formation of the *I*. Through the introduction of the father the ‘law’ is introduced, and the dual relationship between mother and child is broken. The child experiences that the desire of the mother is not only directed towards him, but that there is also a desire to the third figure, the father. This is the Lacanian expression of Freud’s Oedipus complex. The father introduces that which is lacking: he takes away the desires that have existed between the mother and the child, initiates a space between desire and satisfaction, and summons the desire of the child for what was naturally present at first “The result of this is that this impossibility moves towards more distance and reflection, and a sense of one’s own identity as well as that of the Other“(Verhaeghe 2002, p. 143). Here the term “*Name of the Father*” is introduced. The child does not identify with the image of the father, but with his function or role. The child receives his own name and can then develop his own desire and identity. Language is introduced and is offered by the Other. Lacan (1981) assigns a central role to language in his psychoanalytic theory, because it requires or calls the human being to respond to the characteristics of his culture. In language he also formulates his desire and expectations. According to Lacan, symbolisation (i.e. the formation of the subject) is connected to the introduction of language, which allows the person to have access to reality and because of this, a psychic reality originates. The *Name of the Father* means the initiation of the capacity to appropriate language, as Verhaeghe (2002, p. 355) noted, “Becoming a subject is always a linguistic becoming”. A triangulation is made possible and the original dual functioning is surpassed. Access to the symbolic order (i.e. the order of the language) is made.

Lacan situates the unconscious in the symbolic order. He states that the structure of the unconscious has similarities to the structure of language (Lacan 1981). As such, metaphors and metonymies are symptoms of the unconscious and are imprisoned in the language. Desire

originates through the feeling of something lacking and while we try to fill up what is missing, neither language nor the Other can fill up the desire.

Psychosis and becoming-a-subject

In psychosis there is a disturbance of these processes. The foundation for becoming a subject is not laid because the imaginary identification either does not happen, or happens inadequately. The desire of the mother is not ‘signified’, or ‘lived’ by the signifier of the Name of the Father. Lacan (1981) connects the psychosis with a failure of the Oedipal event, where, because of the rejection of the Name of the Father, the child cannot distance himself from the triangle and thus the process of becoming an individual identity is disturbed. The basis of the imaginary order is lacking. As a consequence, there is a lack of or only partial development of the *I*. The psychotic remains imprisoned in the ‘real’ and the object wants to be the desire of the mother forever; because of this he will want to compensate for the deficits of others, which makes it impossible to lead his own existence. There is no transition from the imaginary to the symbolic order - the road is blocked. This has been affected by rejection of the Name of the Father, one of the elements on which the symbolic order is built. The psychotic remains stuck in a pattern of dual relationship in which no lack or emptiness may exist and because the conditions for the step towards symbolising are not fulfilled, (namely the joining of oneself in the world of language), one can say that the psychotic personality remains helpless and at the mercy of the real thing. As noted by Mooij (1997, p. 156) “Because of the failure of the ‘*metaphore paternelle*’² the child remains subjected to the desire of the mother, due to which no choice, no identity and no personal desire will be possible”. One remains stuck in the dual reflection with the Other, in a dual-imaginary functioning. The capacity to come to images (i.e. impression) is affected. In turn, one cannot talk of symptoms, but only of images produced from pathological thinking, which are apart from imaginations. The ‘hole’ that is created in reality is filled up by the psychotic with delusion constructions. Everything that is present for the psychotic patient is too intrusive and direct. He does not go into the normal process of repression, the primal-repression (“*Urverdringung*”). The psychotic patient has no experience of images and fantasies that

² The *forclusion* of the *Name of the Father* is a lacking (or absence) in function in the role of the father and not the concrete presence or absence of the father.

protect him against the real thing and hence there is trauma. This confrontation with the real is by definition traumatic, because it does not take on a form or lead to an experience.

3.2 Music therapy framework in work with psychosis

The music therapy method of the therapist with psychotic patients is described here. Here different music therapy aspects are explained, in order to be able to place the treatment, the interpretations and the results in the right context.

3.2.1 Music and word

From the very beginning man has produced sounds. His appearance in the world is announced by a cry and during the first year of life, pleasure and displeasure are vocalised through babble, vocal play and crying. These initial oral utterances are closely connected to the affects. They are sonorous forms in which bodily sensations acquire shapes and because these emotional expressions take place in a world where mother and child are not yet clearly separated from each other (symbiosis), they remain mainly closed to themselves and not primarily directed towards communication (narcissism). Singing and speaking find their origin in this narcissistic phase and each further musical experience remains referable to this original symbiotic and affect bound experience.

It is only after the first year that these sounds gradually develop into speech (i.e. language articulation). Speaking seems to be directed in the first place towards communication, but the expressive vocal aspect (e.g. prosody, the analogue aspect) also remains; it is of an earlier unconscious or pre-conscious level and is of decisive significance. Depending on the extent to which speaking is an exercise in affect control, it bears more or less the traces of early corporeality. This corporeality (hereafter part of individualising) is where the body is experienced as a whole and appears as such for the others and the others recognise the person for everything in the voice. It is not only the thoughts, memories or imagination that makes him what he is, but the voice in which the others recognise him.

3.2.2 Psychosis and music

It can be said that psychotics reside permanently in a symbiotic space, and it is this particular space that has been described as characteristic of music. Psychotics are oriented towards unity and unifying such as the one that exists between mother and child. It seems as they are not able to give up this unity-experience, afraid as they are that this giving up would mean to be separated radically and definitively. Obviously, there is insufficient or even no fantasy or 'play activity' that could evoke or would be able to create a connection with this original symbiosis. Due to these circumstances, psychotics develop a very remarkable and 'ambiguous' relationship with music. They either fuse with the music or the musical playing so that they can no longer extricate themselves from it or they remain uninterested and unmoved outsiders. During the musical play, it can often be seen that psychotics fuse with the group or partner improvisations. To a certain extent this can be compared with what happens to an orchestra musician when he tries as much as possible to realise a common sound, a collective sonorous object, to the detriment of his individuality. Music also stimulates this symbiosis, as sounds and especially rhythms which are played simultaneously can fuse into a harmonious sound.

I notice at the beginning of a treatment the psychotic is continually searching for a common group metre or rhythm in group improvisations, so that he can fully fuse completely into the whole. This is in contrast to group music improvisations with neurotics who tend towards chaotic improvisations where each individual tries to stress his own individuality and separate himself from the others.

Another characteristic when playing a catchy group rhythm is that a different state of awareness can appear in individual group members. Intensive feelings such as ecstasy and joy, inner images of a primitive tribal dance, and a changed physical awareness - such as a feeling of intense warmth, can be experienced. Members of the group who, for some reason or other, cannot join, or be carried by the group rhythm and feel shut out or separate from the group, can suffer unpleasant experiences such as strong feelings of helplessness, anxiety and psychosomatic symptoms (for instance headaches).

The psychotic becomes frustrated when musical improvisations are not played in a general rhythm or metre. Some psychotics stop the musical play by means of words or extreme gesticulation and give clear instructions, so that a platform can develop to create a space for a common symbiotic musical play. This gives us a clear picture of how the music adopts the same characteristics as the psychotic world, and how the use of music with a psychotic

connects to his world of experience. Nevertheless, in this way, and because music is an artistic medium, it is personally and socially acceptable.

I want to illustrate this with a clinical example. Barbara, a woman who has just experienced a psychotic phase reports during one of the music therapy sessions that during musical improvisations where a general group rhythm or sound is reached, she regularly has the experience that her musical expression or play fuses with the group sound or rhythm. With it she had on the one hand a pleasant feeling of being completely taken in by the music, but on the other hand she was confronted by a sort of fearful evocation of her psychotic experience in which she loses her own identity. However, to the extent to which she can see this 'psychotic' experience during the music making as an essential component of the music itself, the fear disappears. In the light of this 'artistic' experience she gives her original psychosis another and more exchangeable meaning. In this context, the regressive psychotic experience beyond her ordinary life achieves the status of an artistic experience. It was as a musician that the music therapist defined the regressive symbiotic merging in the sound, rhythm and the group. It should be noted that the borders between oneself and others become faint when one merges into the musical object, which is what every musician experiences in a pleasurable manner.

3.2.3 Music as a transitional space

No matter how 'fusional' and regressive the music is, it also has a communicative value. The psychotic who has withdrawn into his autistic world is sometimes difficult to reach with words. Music as a non-verbal medium and as regressive object does not only give in a more evident manner access to the world of psychosis, but at the same time it is a way by which the psychotic can express himself.

I must emphasise how difficult it is for the psychotic patient to believe that through the symbolic activity of imagination and playing something of the original 'oneness experience' can be evoked and therefore clung to. Children succeed in maintaining something of the oneness with their mother in a symbolic manner while they are in the same movement of letting go. Through looking for so-called 'transitional objects' (Winnicott 1971) in the form of a blanket, a teddy bear or another object that the mother represents, they create a transitional space which keeps the balance between the symbiotic involvement of the mother and the direction of the object. It is the transitional object that makes separation possible. It is the

substitution of creative objects that can act as transitional objects that makes separation possible and bearable.

The transitional space is somewhere between closeness, the mother, symbiosis and object attraction. More specifically with regard to music the transitional space is the moment in the play when playing no longer coincides with oneself. For instance, at the moment anxiety is expressed through playing one is distanced from it - there is a separation from this anxiety. Expression no longer coincides with what is expressed and there is a symbolism. Out of an imaginary oneness a relationship with something exists, in that the anxiety itself is being played and there is no longer only a 'someone' who is anxious. There is a division between the subject who is suffering and the subject who is playing his suffering. This corresponds with the child who plays with the teddy bear which represents its mother, although fully realising that the mother is somewhere else. The bear and the mother do not fuse together thanks to the playing. The musical object is like the teddy bear, namely that which makes separation possible and bearable.

What is important here is that the music therapist can join in the playing. Through it, in a form of 'reverie', the therapist gives expression to the musical play of the psychotic. Reverie here is concerned with the attitude of the therapist who gives form to the chaotic, unbearable experiences of the patient, as defined by Bion (1967). Music therefore has the advantage that the patient need not be alone in his chaotic experience. The music therapist has the means of being with the patient without having to exclude him. He achieves this not only by his attitude and listening but also through his empathic accompaniment. This means the patient can, often for the first time, sense that someone accepts his experience, accompanies him without being swept along, and does not become alarmed while giving him the feeling that his expression is not 'destroying' anyone. These emotions can be expressed and commonly borne and this empathic participation in the playing and acceptance develops a basis for trust.

To make this more concrete I will illustrate this with a clinical example. Jeroen is a 28 year old psychotic with autistic behaviour. From his first musical improvisation for which he chose the marimba (and with which I accompanied him on the piano) Jeroen immediately established his structure (in essence his ritual) in the improvisation. He plays his inner picture with a rigid, tonal repetitive rhythm which he rarely varies. This music mirrors his inner condition. He clings spasmodically to an inner picture which he externalises in a melody which expresses his anxiety for loss of control. By means of this synthetic music he tries to

bring his collapsing psyche back together and in balance. In these regular musical improvisations, the recurring melodies allow him to get rid of yet another mood. It would be wrong to provoke him to try and break through this rigid melody. He himself must be able to let go by his own natural process and feel well enough to examine the world himself.

Again there is a likeness here to the young child in his individuation process: The mother can only let go of him to allow him to explore the world when enough security and trust is present between them (Mahler 1983). In a later stage, an interaction can exist with the therapist, in which dialogue develops in the musical improvisation. The psychotic appears to become a musician, and he does not fuse with his music but relates through his playing in a specific manner.

3.2.4 Therapist and regression

The process described above also required that, in such a moment of regression, the music therapist who accompanies the psychotic also partially regresses into a musical reverie. This is perhaps the most music therapy specific “aspect” in work with psychotics (De Backer 1996). This partial regression also occurs through the mother when she reacts to the gurgling of her baby. During the regressive moment between mother and child, the mother gives meaning to a situation which the child has experienced as being chaotic. Within her reverie capacity a mother will place the experiences of the child in some sort of order. For instance, she will feel whether the baby is hungry or not. This happens subconsciously, spontaneously and intuitively. The music therapist must communicate with the patient in the same way, to adopt a similar reverie attitude and place himself on the same level as the patient. It is important for the therapist to be sensitive to the patient's motives, in order to give them some shape. Besides insight and experience, this requires intuition and a deep trust of the music by the music therapist. The ability to share a regressive level with an adult patient is certainly not self-evident. It is a fact that child-carers and infant teachers subconsciously adopt reverie behaviour with other children as well as their own. It is not so easy to approach a reverie attitude with adults who are regressing psychotically, however. When working with adult patients one is inclined to approach them, speak and play with them according to their actual age and not as one would with a child. We are dealing with adults who must be seen as such, even though at certain moments they act on an infantile level. Therefore, the therapist must not talk in a

childish manner and an adult language is spoken although this is on a primitive, regressive level.

The music therapist must always be able to let go of the reverie attitude and swiftly return to an adult level. He must be able to fluctuate from the intuitive, subconscious level to the more conscious. This skill is necessary in order to reflect and to know exactly what the patient is expressing. The partial regression of the music therapist when music is the medium, is simply a means of treatment. In this way the music therapist finds a medium in the patient's regression which permits childish experiences at a symbolic level and teaches him to live with them.

One might consider it dangerous to offer a psychotic (who already has such difficulty in distancing himself from regressive defence) a medium that allows regression. If we improvise musically and the group of psychotics regress to a lower level of communication, with a strongly-present symbiosis, we know that when the improvisation stops, the psychotic also distances himself from the regression. This is much more difficult verbally. This way of communicating is also used in real situations. The therapeutic context can be more easily determined through music. On the other hand one can suppose that verbal reflection is indispensable for the psychotic, because this helps him when distancing himself from the regressive situation present during musical improvisation (De Backer 1996).

3.2.5 Group music therapy

During a group treatment the therapist has to have constant attention upon the numerous group phenomena in which group members and the therapist are involved. These phenomena are not seen as fringe or background events, but as an intrinsic part of the method itself. In active music therapy the main method is musical improvisation. Group improvisation means producing joint musical structures. It is unmistakable that the playful-musical expression lightens the group dynamics processes. The improvisation can be done as a solo, duet (therapist-patient) or in a group. In music, a significant improvisation indicates the presence of a spontaneous performance with a simultaneous discovery of a musical structure. This structure must rest on previously learned playing techniques or on earlier musical and non-musical experiences, and patients must discover their own musical language before they can express themselves easily in free improvisations.

The problem in connection with the patients limited musical knowledge and lack of structure in this playing can be met by drawing up game rules or agreements beforehand. These rules form the structure within which improvisation can take place and the patient might disregard or object to these rules (a response which can also be very significant for the therapy). The preparation of these rules is not without problems. The main question is how wide or how narrow the frame for improvising might be. If the rules are too strict the patient will feel restricted and impeded in his expression and self awareness. If the frame is too vague, this can lead to over-anxiety and this becomes anxiety the patient cannot deal with in this vagueness and which in turn will make it impossible for him to find a structure within himself (Priestley, 1994).

3.2.6 Containment and distance

A major influence on analytic thinking regarding the significance of the concept of containment was Bion. The concept was described by Cluckers as: "It is the creation of a psychic space in which each and every communication, however confused and painful, is received by the therapist, retained and mentally digested with the aim of removing any unbearable qualities from the patient's feelings. These feelings can then be given an acceptable form and place in the patient's experience." (Cluckers 1989, p.52). As noted earlier, this was called *containment* by Bion (1967). The patient can project in the psychic space (that is created in the therapy) his fearful, chaotic and confusing feelings which he cannot cope up with or control, and direct them towards the therapist, so that the therapist experiences the projected feelings as his own (projective identification) (Klein 1946). Music therapy offers the patient the possibility to express these fearful and unbearable experiences with and through musical instruments. The patient gets the chance to give form to his inability to cope with these experiences, and in doing so avoids the possible defence of silence. The therapist can also react through the musical interactions. The expression of the named sensations is after all chaotic, confusing, fearful or aggressive. The patient himself is often caught off guard by this emotional outburst and does not know how it will evolve. The music therapist does not need to undergo all of these passively, but will try to guide and structure these expressions. It is as if he stretches a skin around the experience of the patient - an acoustic skin - that holds together and gives form to the expression of chaos. That is already a first step for the patient, where the

confusing sensations gain a form in an intermediary space and they are heard and recognised by another (De Backer 1993).

The essence of music therapy with psychotic patients with autistic behaviour is to offer them appeasing, non-overwhelming symbolic experiences which, with the help of a musical sounding object, make separation possible. This is not easy, because closeness is considered as threatening and frightening by the psychotic, and the conscious or subconscious desire for being alone is rejected hard and long through the anxiety of identity loss. In a musical improvisation with an organic process of repetitive altercations of closeness and distancing, psychotics can experience that fusion on a symbolic acoustic level is not overwhelming. An important step is that the psychotic patient can permit non-symbiotic experiences and this is a central fact in music therapy with psychotics.

If one looks at the theme of distancing in the larger context of a multidisciplinary treatment, it is significant for the psychotic that his treatment progresses via structured, well defined therapies. Thus, through being able to go from one therapy to another with the relative therapist and specific space, the psychotic can distance himself from each happening and desire.

3.2.7 Release and instruments

The need for emotional release is an important music therapy phenomenon during group improvisations with psychiatric patients. The possibility of expressing themselves through the percussion instruments immediately evokes a discharge of primary drives. Patients experience that tensions can be expressed through music and in groups this is made possible through the creation of a collective sonorous object. Tensions are sensations which are not yet shaped. In music therapy those primitive sensations can be shaped musically. They can be experienced and expressed at a symbolic level after which the patient can progress to a more mature form of expression and communication.

Verbalisation of and, consequent insight into such a release, how to deal with it, and awakening to the conflicts evoked by those tensions, constitute an essential therapeutic moment. The question is often asked why the meaning of this release must be put into words and that it might not be enough that the tensions are expressed. The cathartic tension outlet through music without knowing what sensations that these tensions' evoke or mean, guarantees a temporary enlightenment or relief. However, this does not present that,

because as long as the underlying conflicts are not understood, the tensions can flare up at any moment.

Music therapists have written little about the instruments' symbols. Decker-Voigt (1990), Hegi (1986), Klausmeier (1986), Alvin (in Bruscia 1987, pp. 86-87) and Timmerman (2004) have mentioned the importance of the instruments' symbolism in passing. From a psychoanalytical point of view, I can write that the big percussion instruments are often considered male instruments which have the tendency to convey aggression. The strings, in contrast, contain feminine elements such as the desire for security, tenderness and eroticism, while woodwind instruments have some phallic aspects. The piano is more characteristic of the expression of narcissism, perhaps because of the fact that everybody has to listen and direct his attention to the piano player and acknowledge his virtuosity? The piano is the focal point. All other instruments have to gather around the piano.

The music therapist therefore needs to offer a wide range of instruments. The instrument selection will always convey his attitude towards music and the possibilities and limits in his music therapy practice. But the patient's instrument choice also reveals a lot about the (un)conscious symbolic meaning he attaches to the instrument. Of course, the symbolic meaning of instruments can have a variety of possible interpretations all of which are very subjective. The choice of instruments is influenced by previous experiences and the cultural background of the patient. Not only the choice of instruments, but also the mode of playing holds a symbolic meaning. The meanings which are projected onto the instruments also reveal aspects of transference. The music therapist needs not only to be aware of the symbolic meaning of each instrument, but also to prevent himself from making interpretations which are solely culturally based. Each interpretation needs to be individualised, and each projection must be viewed as an indication of the subjectivity of the patient and of the actual transferences.

Psychiatric patients mainly choose 'grown-up' instruments because they are very hesitant to accept instruments which do not connote adulthood but which are generally associated with settings for children. Grown-up instruments lower the threshold fear for the music therapy sessions and reduce the resistance to musical expression. The musical instruments also need to be sufficiently strong in order to bear outbursts of repressed emotions. If instruments were not able to resist the destructive impulses of the patient, this could be interpreted as a refusal of the music therapist to accept such emotions. Moreover,

the patient would shift from symbolism to something concrete, and that is not the aim of music therapy. The musical instruments themselves, however, will make the limits clear to the uninhibited patient who wants to express his emotions. For example, when patients 'discharge' their inner tensions by playing on the congas, I see time and time again that they first experience the physical limits of this (namely the pain threshold) and because of this, they are able to feel the psychic limits.

3.3 Specific aspects of the music therapy relationship with psychiatric patients

To understand more about my approach, it is necessary to describe several aspects which influence and determine the patient–music–music therapist relationship. The goal is not to enumerate various techniques and therapeutic factors, but to attempt to illustrate some aspects of the therapeutic relationship in a music therapy setting.

3.3.1 Why does a patient choose to come to music therapy given a freedom of choice?

It can be asked in what way the patient's perception of the image of music therapy and the music therapist is shaped when he attends music therapy sessions in a clinical setting. In other words there should be an awareness of what a person seeking help expects of the music therapist. The following example of the thought process of a compulsive patient during his first music therapy session is characteristic of patient expectations. While he was choosing a few instruments which he thought I could play, he expressed his expectations to me as follows: "You are able to assess what's happening inside of me when I play these instruments even without my making a commitment." Moreover, he was convinced that a musician who is able to understand the old and mystical language of music should be able to have insight into the patient's problems. This should happen in such a way that the patient himself does not have to gain insight. Thus, I should be able to see what he did not want to acknowledge. He did not want to commit himself and thought that it would be safer to express himself through music instead of words. This paradoxical position refers to the ambiguity of the symptom, which constantly reveals but then again conceals what it wants to reveal. His choice of music therapy stemmed from a defensive position: "I will never

dare to say all the things I have to say. That's why I want to express myself through music." Thus, on the one hand the patient chooses music therapy because he does not want to make a commitment, but on the other hand he is hoping that the music as a cryptic language will reveal what he is afraid of being confronted with. In the end, his defensive attitude reveals more than what he hides. This example clearly represents the paradox which is characteristic of human beings: hiding oneself in a revealing fashion.

On the other hand, the patient also has illusory expectations of the therapist–musician, namely that the therapist will be able to analyse the patient's issue as accurately as he can analyse music. That illusion relates to the analogy between the musical expertise of discovering and analysing themes, counter–themes, displacements, inventions, etc. and what is expected from a psychotherapist. However, music is as incomprehensible as the psychic problems. These problems cannot be expressed by the patient: there is a fear of speaking. Words are too confrontational. The patient expects that the music therapist will gain insight through the music and the use of the instruments. This kind of expectation is also very typical for hysteric individuals, who say, "I don't have to say all this, do I? In my opinion, the other person should sense my behaviour intuitively. He should understand things without my saying them. If the other person really knows me and is interested in me, then, he should understand." It is a question if it is possible for the music therapist to fulfil all these expectations, and how does the therapist deal with these conscious and unconscious expectations of the patient.

3.3.2 The language of the music therapist and the patient

It is not my intention to explore music as an abstract, non-verbal or emotional language. I want to discuss the individual (belonging) musical language of every music therapist. The musical expression of each music therapist is very unique. It is important that he learns to be comfortable with this language and that he develops and refines it. The music therapist needs to feel free in his musical expression in order for the patient to feel comfortable in expressing himself. Just as a music therapist can recognise himself in the patient's musical expression, so a patient can identify with the music produced by the therapist. As a music therapist I have seen development in the music played by my patients as a result of my own development as a therapist. The musical expression of my patients is very different

nowadays from what it was 10 years ago, because at that time I was still searching for my own musical and music therapy identity.

Each music therapist should be an artist not only because he uses an art form, but also because his psychotherapeutic ego is artistic (De Backer and Van Camp 1999). The improvisations of the patients are influenced by the way the music therapist deals with music as a medium. The music therapist's thoughts and feelings about music are very important even when not playing during the sessions. They can become evident through his attitude, way of listening, facial expression, way of thinking, and mental presence. This will indicate how the music therapist is engaged in the music, how he discovers new things and to what degree he is comfortable with it.

3.3.3 Is speaking allowed during music therapy?

An important question in relation to method and approach is whether patients verbalise their experiences for themselves or the music therapist, or whether the musical experience per se is sufficient for this processing. Within the clinical setting, where the patient gets sufficient opportunities to verbalise, there is an important advantage: here one is accustomed to using words very economically. The music therapist can always refer to these frameworks of verbal exchange. The music therapist gathers information about the history of the patients through team meetings. This enables the music therapist to free him/herself of the tendency to situate the patient in that imaginative framework. There can be a tendency for therapists to have the treatment follow therapeutic goals and to become blind to the patient-therapist process in the 'hic and nunc' because of knowledge accumulated in the past or because of the theoretical orientation. This was summed up by Bion (1962) as follows where he noted that therapeutic work must take place 'without memory or desire'. The fact that there are fewer opportunities for music therapists to cling to a fixed interpretation which can be evoked in words ensures that they have an easier time adhering to this Bion formula. Improvised music in music therapy is a medium that presents quiet complex demands for interpretation. It's easier to understand it's influence at the affective and physical level. Its primitiveness has an enormous impact on patients for whom verbal interpretation is impossible.

When time slows down and the body does not have the energy anymore to free itself from gravitation, as in depression and melancholy, or when time has stopped and the subject is excluded from a symbolically shared experience (as in psychosis), it is often solely music which succeeds in making a connection between the concrete untranslatable musical sound and rhythm and the extinguished tempo of the patient. As a child who is carried and contained by the musical exchange with his mother during the first period of life, a depressive or psychotic patient can only connect again with life through those same physical and affective exchanges. This is also true for the neurotic patient, and there are early stages which initiate the awakening to unconscious conflicts. Those early stages have everything to do with defensive formations which we often encounter in the treatment of neurosis. Words can hide, deform and simulate. Authenticity of speech, as we observe in the speech of a child, can only arise in the event of a connection with the affect.

When we act too much on the verbal, concrete level, we lose touch with the basics and with our mental and intellectual reasoning, and forgetting the emotions. An excess of words can also extinguish emotional experiences. Words can slow down the affective experiences or make them even impossible. Before an experience can reach the verbal level, it has to be fully '*ausgeföhlt*' and shaped through music. Initially, the experience is only present at an external level after which it can be internalised by the patient. It is important to realise in our music therapy practice that experience borders on insight. The experience and expression of a conflict through a form is the natural way to gain insight because experience and insight are inseparable: One cannot gain insight without the experience of the conflict. On the other hand, one can also lose oneself in a reverie of emotions and never arrive at a concrete, freeing thought and a liberating insight. The music therapist must be cautious not to go along with the patient's defences because this would degrade music therapy to a form of entertainment and consultation or to an interesting artistic leisure-time activity. However, artistic engagement in music can, in itself, also yield forms which can make the presence of experiences possible.

Through musical interactions, phenomena happen that are not always visible and audible and that only become that way if they are verbalised by the patient or by the music therapist. Also in case of certain forms of projective identification, if the therapist observes or feels something by himself that cannot be borne by the patient, it is sometimes inevitable to address this observation. This is what Priestley calls echo-counter transference (Priestley 1994).

Most of the time when the patient does not have the urge to verbalise, the experience or the feeling is not yet originated. Hence, in this stage, verbalising does not make sense. If the patient wants to talk continuously, one should ask the question what prevents him from finally making music. In music therapy when words emerge they are felt more powerfully and intensely precisely because not much talking happens in sessions. In an approach involving cautiousness, waiting and postponing, words gain great weight. I have the experience that after a musical improvisation often silence originates, where the sounds played post-resonate. When the first word then breaks through this very different level of communication, the consequence is that it has significantly more impact.

The transition from musical expressions towards talking is not easy, neither for the patient nor for the therapist. When is it necessary that one talks? How can silence be broken, how long does one have to wait? The switching of register can be experienced as something shocking. The music therapist needs to have enough insight, experience and especially self-experience in order to handle it in a good way.

It can be concluded that the therapist should set up the session in such a way that it is clear to the patient that verbalisation is not necessary but allowed when he feels a need for it. The therapist must create space for the patient to connect an intense experience with images and words. Man is a verbal creature and, it is therefore essential that he can place himself as a symbolic being within the verbal language. Verbalisation (speaking) is fundamental, not so much to gain access to the conflict or the trauma, but to work through the conflict.

3.3.4 Transference

The phenomenon of transference is present in each human relationship. Transference, however, has a special meaning within a music therapy setting. Transference is solely possible when I, as a music therapist, remain neutral when introducing myself to the patient. Because of this the patient can use me for the transferences of central people and events in his life. Through the non-intrusive attitude of the therapist, these transference phenomena can take place, unfolding in a very different way than in any other relationship. In therapy, it is essential that the images of the father and the mother become conscious. Freud (1920) called the projection of the images of central figures onto the therapist, and the repetition of the patient's relationship to those figures within the therapeutic

relationship, transference neurosis. Developing and working through this transference neurosis are essential components of the therapeutic process. Only when the music therapist assumes a reserved and neutral position is it possible for him to incarnate the patient's conflicts and ambivalences and work through them via a discussion. What does 'discussion' mean in a music therapy setting? We just said that soberness of words is advisable in music therapy. How does the music therapist deal with psychic contents and conflicts which were previously unconscious for the patient, but now show up in the music therapy sessions?

Initially, a discussion happens through means of musical reflection. The music therapist tries as much as possible to attend to and think about his spontaneous emotional reactions and those of the patient which are evoked during the session. Especially those reactions which are experienced by the patient as strange or surprising after they have been musically shaped by the therapist and used in an alluding or confrontational way are often significant. The musical holding and repetition of these themes at appropriate times contribute to the appropriation by the patient of these unconscious but therapeutically staged contents.

3.3.5 The confidence and tolerance level of the music therapist

The music therapist sometimes gets confronted with his own musical and mental susceptibilities during musical improvisations. From my experiences it is not uncommon to note that as a result of anxiety music therapy students are quick to muffle (damp down) a musical instrument when a patient expresses himself too loudly. In such circumstances a question can then arise relating to whether or not patients should sometimes be stopped or quietened down in their musical expression through direct indirect verbal gestural or musical interventions. However, in reality it is the therapist's tolerance and limitations that should be questioned. It is more a question of whether his interventions follow his own fears. For example, music therapists can harbour the fear that the use of the gong can evoke psychotic reactions in psychotic patients and, therefore, the gong should be contraindicated for this population. This issue in particular has been described by various music therapists. However, more interesting than the question of whether an instrument can induce psychosis is the question of how the music therapist deals with the primitive mechanisms of his own psyche. Whatever he has not yet worked through, he views as threatening for the patient. Moreover, the therapist's counter transference fears for psychic decompensation, which he

projects onto the patient, and which then undermines a therapeutic attitude. Fears also lead to selective listening by the therapist. It is important that the therapist remains open to such understanding and carries the feelings and processes evoked by specific sounds. The therapist needs to stay in touch with the resonance that occurs amongst sound structures, harmonies, rhythms and emotions.

Strobel (1995) gives a striking example his chapter in "Musik, Spiegel der Seele" (in Schroeder 1995). Strobel talks about self-experience courses that he organised with an older colleague during weekends. When this colleague was introduced to the monochord, she argued that this instrument could cause psychotic states in the participants and, therefore, refused to allow the use of this instrument in the group. Strobel did not have that fear because he was convinced that one could work therapeutically through unconscious materials, evoked by psychotic states. His colleague, in contrast, felt that she did not have a defence against the atmosphere of fear, insecurity and threat that she experienced time and time again. One morning Strobel found his colleague in a psychotic state. He never again experienced such an atmosphere concerning the monochord. This example clearly shows that each music therapist must be able to analyse and work through personal fears of loss of control in order to be able to deal in a therapeutic way with psychiatric patients.

This does not mean that a therapist must be capable of managing everything. On the contrary, through his musical and therapeutic experiences, the therapist gets to know and respect his own limitations and also the limitations in relationship to the patients. Returning to the example of the gong, when a music therapist becomes overwhelmed by primary fears, associated with the gong, and is not able to work through them, the only thing he can do is to muffle the gong. How this happens depends greatly on the therapist's way of thinking, experiences and his relationship with the patient. For example, it can be useful to show the patient how to deal with these limitations, how to protect oneself when the auditory pain threshold is crossed, and how to act constructively without demanding, punishing or aggressive reactions.

3.3.6 Listening attitude

How should a music therapist listen to the patient? The music therapist should listen to the patient with reverie. We understand the concept of reverie to indicate that the therapist, just like the mother, gives meaning to a situation which feels chaotic to the child. With reverie

the mother puts the particular experiences of the child into a kind of order; for example, she will know instinctively if the baby is hungry or not. In the case of the mother, this happens at a spontaneous, intuitive and unconscious level.

It is the task of the music therapist to listen and communicate with the patient in a similar way. Thus, the therapist must engage in that same type of reverie and must move to that same level in order to be sensitive to the stirrings of the patient and be able to structure them. This calls for intuition and sufficient experience on the part of the therapist. The capacity to interact with an adult patient at a regressive level is not self-evident. The music therapist must be capable of shifting immediately from regression to the adult level. He needs to fluctuate sensibly between the intuitive, unconscious level and the conscious level. This is necessary for reflection on the expressions of the patient.

There is another essential aspect when listening to a patient and his sonorous product, namely the equality of attention. This means that none of the elements of the patient's expression be treated preferentially by the therapist. This implies that the therapist must allow a free course to his own unconsciousness and must stop the motivations that normally control his attention. Thus, the music therapist should listen to the patient's musical expression without fixating on anything specific. This technical line of sight is the counterpart to the patient's free associations.

The music therapist does not listen, in the first place, with the intention of guiding or giving insight, but rather of opening himself up to what the sonorous product, as a resonance object, arouses in him. He puts aside every preconception, theory and interpretation scheme, a listening attitude that Bion defines as bifocal attention: with each session the therapist puts everything aside – anything ever said by the patient, the history of the patient – and he starts again from zero, with an uncluttered mind. In this way, all new things that come up can be fully taken in by the therapist. The theory and memories can then be geared as a function of this new material. The therapist must be willing to fully absorb the new facts without letting them fall through. If not, we run the risk that only those things are being heard which fit into the pre-existing schemes. To have psychological concepts and insights constantly ready in this way is a defence mechanism that has to do with problems of the music therapist's proximity. It is important to continuously broaden one's perspective, but so is the ability to put this insight aside during musical improvisations.

3.3.7 To interpret or not to interpret in music therapy

Psychoanalysis is based on a so-called *detecting model* to make the unknown perceptible and understandable. This model has a kind of patriarchal character. It aims at insight into the unconsciousness through interpretation. Ultimately, man can get in touch with his longings solely through language. Since psychoanalysis has extended its attention from neurosis to the early disturbances, this model is no longer adequate.

The detecting model is a model of conflict: there is a constant search for the other and for the unconscious side of the conflict. For the person suffering from an early disturbance or narcissism such conflicts are not his primary concerns, and with an emotionally deprived child one needs to think instead in terms of a lack of conflict. There is a different key symbol which the patient who suffers from an early disturbance looks towards, namely the mother who holds the child in her arms. Winnicott (1971) calls this 'holding'. This is not the world of insight, verbalisations or interpretations, but it concerns the nonverbal world, emotions and body awareness. Asper (1992) calls the corresponding therapeutic attitude 'mother specific'. This is in contrast with the 'father specific' therapeutic attitude which plays an important part in neurosis.

The mother-specific attitude involves mirroring, straightforward listening and a neutral acknowledgement of the patient. In contrast, uncovering, asking why and what for, providing insight, interpreting and confrontating all belong to the father-specific attitude. Of course, both stances are necessary components of any therapy. One cannot exist without the other. However, the plain mother-specific attitudes are extremely important to the patient with an early disturbance. Since this patient lives with the pressure of a rigorous inner judge, it is the mother-specific attitude which (s)he needs in order to integrate. This can happen best through a medium that is as close as possible to the affect of the body, such as music, and it is through this medium of music that the narcissistic patient finds the time and space to become acquainted with and to observe himself - or in short, to be able to just be himself. It is the growth process that is important here; after this, the personal choice and responsibility of the patient will be present. The child with an early disturbance did not get the chance to be truly himself, and so he first of all needs a therapist who acts in a mother-specific fashion. This has nothing to do with over-mothering, because it is not possible to replace that which has never been there.

3.4 Summary

Music has the capacity to offer countless possibilities to meet the many indescribable aspects of the human mind. The wordless experience of unity caused by this process is something that fascinates the psychotic patient, who holds on so tightly to his solitary choice, and yet can nevertheless connect with a playful, artistic experience through music therapy. Through the exchange of sounds, images and words emerge, which free him from the estranged security of his inflexible script which he has made up with the finite pleasure of a brief melody. In this way music therapy is a unique treatment method for the psychotic patient.

The therapeutic approach described above is entirely connected and integrated into the conceptual understanding of this study, and the interpretations of both the clinical and the research aspects of two patients. From the clinical perspective, this approach (congruent with the philosophy and approach of this department of the University Psychiatry Clinic at Kortenberg) involves interpreting the patient's illness and response to therapy, and acting accordingly. The reason to define it in such detail as a separate chapter is in order to provide a foundational framework alongside the research method, by which the results of the two research case studies and the analyses of results can be contextualised. From this clinical and theoretical perspective, the next chapter will go into the research perspective to describe the method and design of this study.

theoretically rooted. Strikingly, there is no published material that follows the researcher's own theoretical model, which is now explored in detail in the following chapters of the dissertation.

This literature review has some limitations due to the paucity of relevant research in the area that is the focus of this author's work. There are only a few examples of research in psychiatry, with even fewer relevant examples of research with psychotics and there are few useful examples in spite of the use of analysis of musical form and musical material in work with psychotics in previous studies. Aspects of the studies have given some relevance to the focus of the process-investigation, for example Cohen's study (1986), in terms of the aspects of rhythmic structures in the music, and Bauer's study (2000), in terms of the characteristics one finds in musical playing with psychotic patients.

While this research study is founded on a long history of music therapy within psychiatry – a history that began soon after music therapy came about in the late 1940s-1950s – it also needs to consider questions relating to dynamic therapy relationships and how the therapeutic process can be explained by what occurs musically. Previous studies do not address the issue of what goes on in musical processes between therapists and clients and how that related to the music therapy process. This study intends to investigate specific aspects of change in the musical production of the patient in relation to the musical production of the therapist, how forms of playing are changed over time in therapy and what this changing form represents in relationship to developments in the therapeutic process of the patient.

The method in this study is intended to answer research questions relating specifically to musical playing styles with psychotic patients and how these styles may have change over time, particularly to inform in order to analyse the musical elements in therapy and in order to inform the profession about how this works in praxis, and to provide some additional insight into the role and methods that therapists can use when embarking on work with this population.

Chapter 4

Research method

Introduction

This chapter will present and describe the research method used in this study. The method that was developed for the study links three processes together, to form a progression in which:

1) questions arise from the clinical practice of music therapy; 2) a theory is formulated to address those questions and tested through research; and 3) the results of the research inform and shape clinical practice (Wheeler 1995).

4.1 Main research question and sub-questions

The aim of this research was to investigate the therapeutic use of music with psychotic patients, in order to contribute to the further development of a music therapy methodology of a treatment for this population. More specifically, the study addressed the potential significance of certain musical phenomena in the treatment of psychotics.

The main research question was formulated as follows:

Can one identify the development of a process from sensorial play into musical form as a central aspect in the treatment of psychotic patients in music therapy?

In this process of the patient's music moving from a sensorial play towards a musical form, specific musical and therapeutic phenomena appear, which needed to be defined and described in order to be able to meaningfully answer this main research question. Furthermore, for the results to be understandable and have clinical relevance, it was important to examine the musical interactions between the patient and the therapist, and the musical and therapeutic interventions of the music therapist. Therefore, sub-questions were formulated arising from the main research question, as follows:

Research sub-questions:

1. How can we describe and define sensorial play?
2. How can we describe and define musical form?
3. How can we describe and which elements do we need to understand to have insight into the process?
4. How does the process of sensorial play evolve to musical form?
5. How can one describe and compare the important music therapy moments (i.e. the changes) in this process?
6. Which therapeutic interventions of the music therapist contribute to the development of musical form?

These questions were formulated within a qualitative study, meaning that they were not closed ‘yes-no’ questions, and there were no formulated hypotheses that require testing. As Bruscia states: “...a qualitative focus is not a true question or cause-effect outcome to be tested; it is the starting place from which an open inquiry will emerge.”(Bruscia, 1995, p. 403)

4.2 Single case design research

4.2.1 Qualitative research

The main research question determined the development of the research method. It was important that the research method and the design within it would provide the most relevant means by which to address and answer the research questions. In the literature, the most useful and appropriate design for this study was a qualitative design – specifically, the single case study design.

The conditions for qualitative research design (as Merriam (1988) and Swanborn (1996) described them) correspond to the expectations of this study. Qualitative research refers to a method aimed at describing and conceptualising processes within music therapy occurring in a natural therapeutic setting that is uninfluenced by research (Bogdan and Biklen 1982; Smeijsters 1996, 2002). This study fitted this model and was also primarily concerned with process, rather than with effects or outcomes and took place in a natural environment, where the familiar music therapist of the ward treated the cases. The researcher was the primary

instrument for data collection and analysis of the therapeutic material and the data was of a form that would not be appropriately treated with descriptive or inferential statistical analysis.

Through retrospective analysis, the development of the process in the therapy of the two patients that were the subjects (i.e. the case studies) provided a deeper understanding and insight into the therapy. The music therapy process was described, from which meaning and understanding was gained through considering both words and music. The aim of this qualitative research was inductive in that the researcher built abstractions, concepts and theories from the detail of the work.

The research extended over a limited time period, and only the process from sensorial play to the emergence of musical form was examined, rather than the complete music therapy treatment. Therefore the first case extended over a period of four sessions, with the second case covering a period of eight sessions. This limited time-frame enabled a depth analysis of the music therapy process of the available material.

At this stage it is relevant only to consider issues related to single case study design.

4.2.2 Single case design

A case study is expected to catch the complexity of a single case. (...) The qualitative researcher emphasizes episodes of nuance, the sequentiality of happenings in context, the wholeness of the individual” (Stake, 1995: xi-xii)

A typical single case design can be defined as an intra-subjective study that focuses on a particular individual’s (internal) changes as a result of a process unfolding over time (Fogany and Moran 1993; Hilliard 1993). Single case research designs can also be explained as one part of a whole spectrum of case-study research methods that can be applied to the investigation of individual change in clinical practice. Aldridge states: “In all, the advantages of single-case research designs are their flexibility of approach, the opportunity they provide to include differing levels of rigor, and the possibility of incorporating ethical considerations pertinent to the individual case. Such designs are appropriate for clinicians who wish to introduce research into their own practice, particularly in developing hypotheses to be tested by other methods of clinical validation.” Aldridge (Aldridge 1996, p.146)

In these two case studies, analysis was intended to search for certain patterns in the music therapy process, which could then be compared with each other, contextualised, and then

related to the existing literature. Yin (1994) discussed dominant modes of data analysis, such as the search for “patterns” by comparing results with patterns predicted from theory or the literature; “explanation building”, in which the researcher looks for causal links and/or explores plausible or rival explanations and attempts to build an explanation about the case; and “time-series analysis”, in which the researcher traces changes in a pattern over time, a procedure similar to time-series analysis conducted in experiments and quasi-experiments.

These modes will also be used in the data analysis.

4.2.3 The subjects

The subjects recruited for this research were two patients with psychosis who suffered from psychosis. They both indicated directly or indirectly a desire to benefit from music therapy. A primary inclusion criteria for the subjects in this study was that they displayed a specific way of playing, involving repetitive or fragmented characteristics in their music as a result of which they were unable to achieve any level of symbolisation; in this way the choice of individuals for the research was directed by a theoretical assumption. This theoretical assumption related to the musical personalities of the patients, and their difficulty in finding form in their music. In addition, the subjects were not randomly selected due to this method, and there was no intention to use the results from these cases in order to make comprehensive generalisations towards the larger patient population. The intention was more specifically to learn about process by detailed analysis, and as a consequence search for insight and understanding. In view of this, the two subjects, each with their own specific way of playing, behaviour and problems, would be different in the expectation that the two music therapy processes through which they would travel could be compared, to come to a clearer insight into the specific problems of psychotic patients lacking symbolisation.

Precise answers to the research questions were possible via a detailed descriptive, depth analysis undertaken of the clinical material of the two subjects. Starting with a general description of the process, fragments of material from sessions were carefully selected and were then analysed in detail and compared with each other. Two subjects were considered adequate for this type of research, because greater numbers would generate an overload of data and result in a less in-depth analysis. As Jaspers (1973) has noted, rather than a more superficial study of a greater group of subjects, a better view of the general psychopathological processes can be gained through a deeper study of fewer cases. Jaspers states that: “An in-depth

phenomenological study in a single case teaches us in general aspects that can apply to many other cases. Therefore what can be understood from one case is often reflected in the other cases. In phenomenology it is less important to count or accumulate results from many cases, but to have a totally inner insight of each individual case.” (Jaspers 1973, p. 48, translated by the author)¹

4.2.4 Development of the case study design

For the first case study a preliminary single case design was developed, where the research setting and philosophy of treatment, music therapy context, subjects, data collection and analysis were recorded and described. Data collection was a particularly important aspect in the preliminary research design, as the material would provide the basis to analyse and to examine the music therapy process and the different musical and therapeutic phenomena.

A structure for data collection was developed and the research began. This will be described in detail later in this chapter. As a result of making these early decisions in regards to data collection and analysis, it was feasible to direct and refine the research design as the project progressed, avoiding risk of drowning in an overwhelming amount of research data. Final decisions regarding the establishing of the research strategies in the first case study were well supported by Robson, who stated that “...if you don’t start, you will never get started. However, in these designs you don’t have to foreclose on options about methods. Ideas for changing your approach may arise from your involvement and early data collection.” (Robson 2002, p.165)

The first case study allowed the observation of many different phenomena from various angles, and the opportunity to try different approaches (Yin 1994). The most essential characteristic of this study as a clinical-research experience was that the design developed itself in response to the subject, rather than the subject having to conform to a pre-determined design. This was necessary in order to come to a comprehensive formulation of the theory and also because if one had applied the research method rigidly there would have been a lack of an ethical stance to the subject.

¹ “Die eindringende Versenkung in den einzelnen Fall lehrt phänomenologisch oft allgemeine für zahllose Fälle. Was man einmal erfasst hat, findet man meistens bald wieder. Es kommt in der Phänomelogie weniger auf Häufung von zahllosen Fällen an, sondern auf möglichst restlose innere Anschauung von Einzelfällen.” (Jaspers 1973, p.48)

With the second case the research design was now well developed and the greater structure led to the collection of more precise information.

The place of reliability and validity is important in all research; it was also true of this study and is considered in the following section.

4.2.5 Reliability and validity

Validity and reliability require as much attention in qualitative research, but there are differences in how they are applied when compared with a quantitative paradigm. Qualitative research is not about the objective interpretation of data (measures), but rather the personal impressions of the patient and therapist that hold greater significance. This is evident in the studies reported by Aigen (1995), Amir (1996), Tüpker (1996), and Grocke (1999). The possibility of replication of studies by other researchers is the usual requirement that governs the method of enquiry in quantitative research, in order to increase the reliability. Bogdan and Biklen (1992) state that the replication of a qualitative research study in an identical way (i.e. in order to achieve consistently comparable results) is clearly difficult, and usually impossible. For instance, other researchers have a different motivation, professional experience or theoretical perspective, and will discover other musical and therapeutic phenomena that maybe remained hidden in the first research. The subjectivity of qualitative study can be a weakness in terms of reliability, and can in itself be problematic for the reliability of the research, especially in cases where the music therapist and the researcher are the same person (Smeijsters 1997). In order to safeguard reliability as far as possible, for this study I used some techniques described by Smeijsters (1997), as follows:

- *controlled subjectivity* to explore my own countertransference (Tüpker 1990);
- *repeated observation*, in which I checked the experiences and images I had during the research interview with the first description of my impressions immediately after the session;
- *repeated analysis* which involved regularly comparing old data with new;
- *analytical memos* (Ely et al. 1995);
- *categorization* (Glaser and Strauss, 1967).

I also made use of more than one method of data collection (i.e. *data- triangulation*) and thus observation, video and audio recordings, documents, scores and description increased the reliability and validity of this study.

The most important research material - the musical material - was selected in a systematic way. This selection was independently confirmed by two people recruited for that purpose: a psychoanalyst who was familiar with the research, and a music therapist who was not familiar with the research, each of whom came to independent decisions without reference to the other. The psychoanalyst was involved in the process of selection six months after the music therapy sessions took place, and after the research interview. The independent music therapist undertook her selection from watching all the sessions 12 months later. They looked at and categorised the video-material based on the preliminary definitions of the three phases, which were important in the music therapy process (i.e. sensorial play, emerging changes in the patient's music and musical form).

Guaranteeing the reliability and validity in qualitative research demands extra attention. In my research the following measures were addressed in order to increase the validity in the following four areas:

1. For *construct validity* it was important that the data (drawn from many sources such as video and audio material, descriptions, impressions of the therapist and musical scores) was relevant and representative in order to come to a valid construction through a hermeneutic approach.

2. The *transfereential validity*, where research results can be transferred to other colleagues in the sense that they are understandable, useable and useful (Smaling, 1987), is assured in this research through the liveliness of the case data and its ability to be recognized by those who are familiar with the problems of psychosis. As Soenens (2002) reports, colleagues' awareness of specific processes in and understanding of the psychosis can introduce a renewed looking-at and understanding of the psychotic perception of the environment.

3. *Communicative validity*: another important confrontation with clinical research material was the research interview. The psychoanalyst who was involved in the research interview and closely monitored both cases from the ward and from his verbal group therapy, looked from his professional experience and theoretical background at all the sessions and made the blind spots and musical and therapeutic phenomena (which remained hidden to me) visible, debatable and insightful. This allowed a greater validity of the interpretations. The importance

of the so-called *communicative validity* is, according to Soenens (2002), highly regarded by many authors in the qualitative research. Kvale (1994) also emphasises that the validation of qualitative research is a continuous controlling, questioning and interpreting of findings during the entire research process within an intersubjective context.

4. In order to increase the *internal validity* (Yin, 1994), the thought process was presented regularly to external researchers in the course of the research. During six-monthly PhD-seminars in Aalborg, an international group of researchers and students were invited to have a critical look at the research process departing from the raw data and the research questions, up to and including the interpretations and conclusions drawn from the results. By this means, I was offered the possibility for directing or refining the research process.

4.3 Research setting and philosophy of the treatment

4.3.1 General psychiatric hospital

The University Centre Saint Joseph is primarily a psychiatric hospital, connected to the “Katholieke Universiteit of Leuven”. The specific task of the Saint Joseph hospital is described as the provider of specialised psychiatric care defined within a scientific basis and delivered by a multi-disciplinary team. The hospital has 17 different wards and comprises 355 beds for full hospitalisation, 65 beds for partial hospitalisation at night and 35 places for day-care. The hospital also functions as a development centre and highly values scientific research. In the centre there is a scientific ethical commission that monitors all research, with the possibility of redirecting projects where necessary

As a music therapist I am part of a department with a structured psychotherapeutic setting. Here, young psychotics and/or youngsters with a previous episodic psychotic history are treated in a residential setting. The setting caters for people with the diagnostic criteria for schizophrenia and the paranoid, as well as the autistic type. There are also youngsters with a schizoaffective disturbance, or a severe personality disturbance such as borderline personality disorder and schizotypal personality disorder described in DSM-IV. Symptoms such as delusions, hallucinations, thought and perception disturbances, hypochondria, grotesque interpretations, disturbances in body functions, autistic-like extreme regressive behaviour and serious contact disturbances are those most commonly found. With hardly any exception, this

concerns patients with a weak 'ego strength' (for instance deficient reality testing, deficient logical thinking, deficient boundaries, limitation possibilities).

The length of treatment generally is three to six months. Certain patients chose to stay longer and can remain for up to one year. The ward can offer treatment to 40 patients at any one time.

4.3.2 Philosophy of treatment

In treatment philosophy an important aspect to which a lot of attention is being paid is safety. Through individualised care one tries to create a climate of mutual trust so that a trusting relationship can be developed between the patient and their health care professionals. In order to facilitate this, the ward is divided into four patient groups that are attended by one or two nurses each. These people fulfil a very important function, since their presence ensures that the patient gets easy access to a more personal and supportive interaction. For these young adults, going through a psychotic decompensation is an often painful and frightening experience. In order to prevent the patient from experiencing the illness as externalised and thus to undergo it passively, one tries to look for the meaning of the different impasses that lead to the development of the psychotic escalation. One important factor is to try to put it into the perspective of the patient's own life story. There is a focus on an emphasis on the understanding of the illness for the patient, and the ability to put the chaotic experiences into perspective. Finally, one aims to find an internal autonomy and a personal project in his life by stimulating the internal growth of the patient so that a chronic prognosis can be prevented. Dr. Van Bouwel (Supervisor and chief psychiatrist of the department), names 'patience' and 'security', inspired by Bion, as the most important conditions in the therapeutic contact with the patient.

The treatment plan is based on two principles. On the one hand, one tries to offer a structured, safe and predictable environment in which the patient feels supported and understood, while on the other hand, one tries to adapt the therapeutic expectations and activities to the evolution phases of each individual patient.

The treatment plan consists of three phases through which every patient goes:

1. In the initial phase (that lasts for three weeks), the patient gets to know his peers, the team members, and the way that the ward works. The patients are not obliged, but rather

invited to take part in the therapeutic program. The accompanying nurse will “put out feelers” in this phase by making frequent individual contacts, in order to gain a fundamental basis of trust. The ‘family-intake’ (in which all the family members can talk with the psychiatrist and psychotherapist) is important in order to understand the inner world of the patient, since this aspect is otherwise hard to understand due to the presence of psychotic phenomena.

2. In the middle phase (that lasts for 4 months, on average), one expects the patient to participate in the therapeutic program. Besides the personally adapted medication, one tries to build up the inner structure and to repair the contact with reality. This is achieved through different activities, in which the patient engages with other health care professionals. If necessary, this group therapy program is extended with an individual verbal or non-verbal therapy, or family therapy.
3. The termination phase makes it possible for the patient to bid farewell to his group and to the therapeutic team. When the patient has felt supported by the team and, in this secure situation, has come into a certain dependency relationship, and saying good-bye is sometimes hard. Experiencing and finishing this separation process in a positive way is of extreme importance for a good reintegration into society. In this phase, one works on this concretely by accompanying the patient in his search for a suitable study or job, a place to live, and ways to fill in leisure time.

Several different disciplines form the multidisciplinary team of the department where the two patients were treated: nurses, psychotherapists, the ward doctor, the psychiatrist, the psychologist, the social worker, the occupational therapist, the psycho-motoric therapist (physiotherapist), the leisure time companion, and the music therapist, each fulfil their own function for the patient.

A major characteristic of the method of the approach of this ward is the basic concept of ‘containment’, that is, supporting, putting up with, and mentally digesting the intolerable elements in the personality of the patient so that they can be given back to him afterwards in an understandable form. Therefore, these team members meet regularly in a team meeting. In these meetings they think about the first inner, confused and overwhelming (psychotic)

experiences of the patient. By talking associatively together (where the recognition of the personal experiences of team members is a frequent phenomenon), a meaning can be given to the intolerable projections of the patient. In the team meeting a common mental space is present in which a free and open way of thinking can originate. The different experiences of each patient in the treatment are contained so that they can be transferred into an inner experience about which staff members can think symbolically.

The multi-disciplinary team brings with it a multi-disciplinary approach. The program offered consists of different therapies and meetings. The ward doctor highlights the medical aspects of the psychosis in a didactic way. The psychologist leads the team meetings in which the patients can discuss sensitive subjects in a not too threatening way, unlike the individual therapies that go deeper into the problems of the patient. A bi-weekly ward meeting and a weekly meeting with the nurses are also part of the program. Furthermore, there are psychotherapeutic activities that embrace verbal as well as non-verbal therapies. (An example of a treatment plan can be found in Appendix: 1)

4.4 Music therapy context

4.4.1 The music therapy room: geography and equipment

All of the clinical music therapy sessions from which the data for this study was drawn took place in one of the two group music therapy rooms on the first floor of the music therapy department. The music therapy room had a surface of 45m² (5 meters on 9 meters) and was located in the oldest part of the University Centre. It had high windows with a high ceiling, and there was a lot of direct light in the room. On one side of the room, the windows looked out onto a big beech tree. The floor was vinyl, and had a green tint that gave a warm feeling.

Figure 4.1: The music therapy room

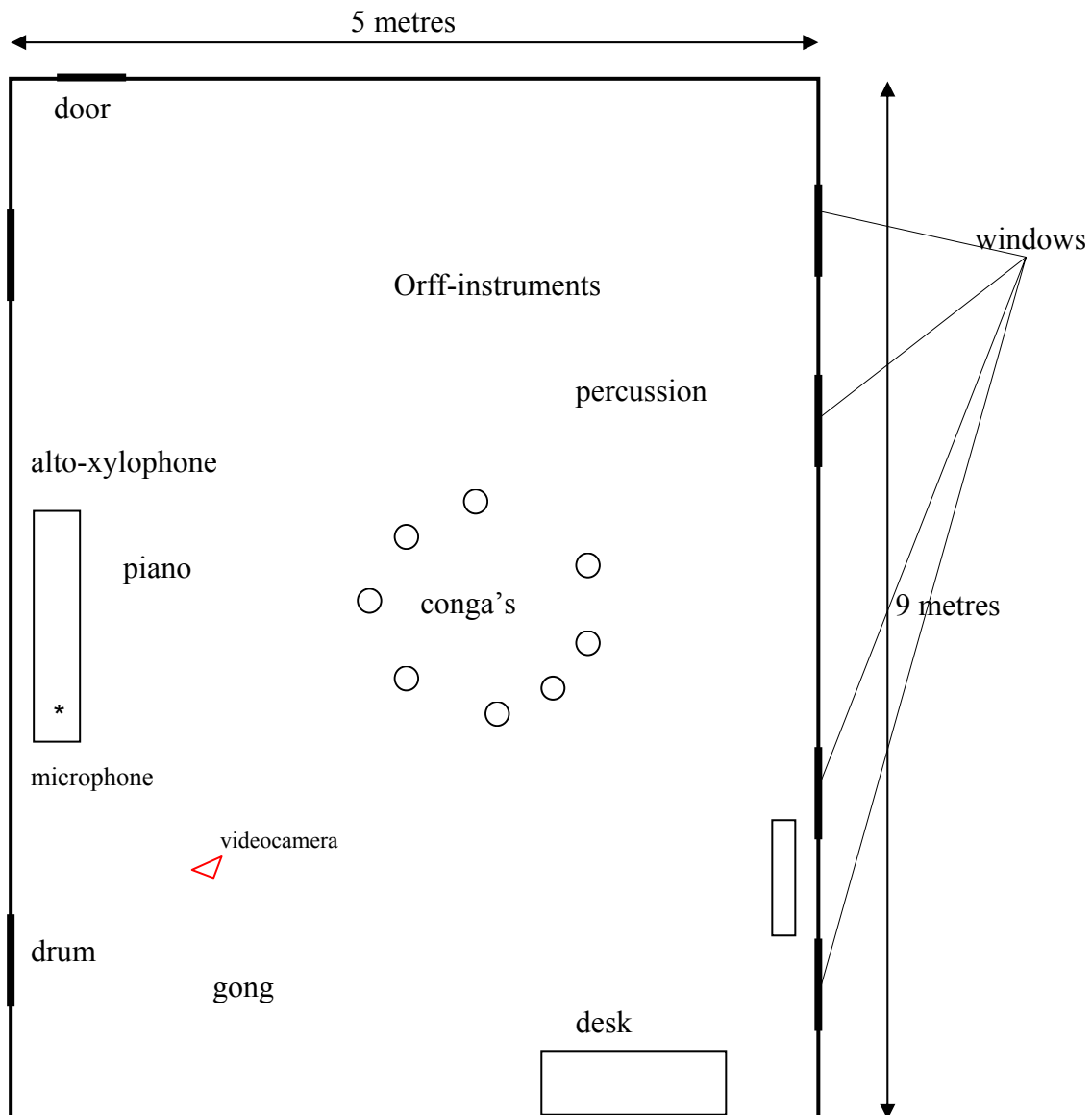


Figure 4.1 shows the typical configuration of the instruments and equipment in the music therapy room. This equipment was always set out the same way for each session, something that is typical in a psychoanalytical approach. The patients have the opportunity to use any of the instruments that are available.

Music instruments chosen for this therapy room are typical for work with psychotic patients. The primary instruments are the piano, six congas, two metallophones, a xylophone kalimbaphone and four groove drums. Other instruments are available such as tympana, bass xylophone, gong, tube bells, drums, steel drum, guitar, little percussion instruments (cabasa affuche, claves, hand drums, tambourines, triangles, woodblock, finger cymbals), but there are

also the more untypical instruments such as a trumpet, Irish flutes, psaltery and a little harp.

In the music therapy room there is a Hi-fi tower and approximately 180 CD's, with a variety of styles of music represented such as classic, folk, film music and new age. However, the opportunity to access recorded music is seldom used in my work with psychotics, and is mainly applied by my colleagues when working therapeutically with personality disturbances and adolescents. Individual sessions are almost always recorded on a minidisk for supervisory purposes.

4.4.2 Pattern of the music therapy sessions

In this department of the Kortenbergh clinic patients in each of the four treatment groups receive group music therapy sessions twice a week for 45 minutes. These group sessions always took place in the same music therapy room. The subjects who were included in the study did not receive group music therapy; their individual music therapy sessions for this research study took place in the group music therapy room shown in figure 4.1 with a frequency of one session per week. The sessions lasted for 45 minutes and took place at the same time each week.

4.4.3 Audio and video recording

Audio recording

The sessions for Marianne were recorded onto an audiocassette machine. However, a problem emerged with this kind of recording: the recording quality (and especially the verbal part) was not always clear, because of the occasionally very quiet speech of the therapist and the patient. Therefore, a minidisk² was bought for the second case study so that the recording was qualitatively better. There is also a problem with the use of the minidisk, because it is very sensitive to vibrations. The minidisk was always laid on the piano and consequently on occasions this sensitivity caused it to stop recording. The only reliable and complete audio recording was achieved through the video recorder.

² Sony; portable minidisk recorder MZ-R55

Video recording

A digital video camera³ was used.

Before the patient came in, the video and audio equipment was turned on and left in the 'record' position. After the patient left at the end of the session the recording was stopped. All the sessions were video-and audio-recorded from the beginning to the end.

Comments about video and audio recording in the therapeutic process.

The therapy sessions for this study were recorded onto videotape. This was in order to consider the therapeutic process objectively and with the necessary distance - something which is not possible during the sessions themselves. Videotaping makes it possible for the therapeutic event to not be transformed into its own interpretative and subjective memories, because rather than being retained in the memory, it exists on tape as a factual and temporal event. Blind spots in the memory can be made conscious by reviewing the session, and one can also view and listen to video or audiotapes unlimited times. Video recording enlarges the written protocol. Memories are not objective, but are manipulative, selective and changeable. In addition, from the point at which the patient came into musical form, I decided that building in a time period of a minimum of two months was necessary in order to create an objective distance before viewing the videotaping neutrally and objectively, and analysing it.

To safeguard the validity of this research it was necessary to record all the sessions. Robson (2002) is convinced that a valid description of what the researcher has seen or heard lies in the accuracy or completeness of the data. He suggests that audio or videotaping should be carried out wherever feasible.

In my research project I preferred the video material over the audio material, because video material gives a lot more information about micro movements, physical behaviour, facial expression, ways of playing and moving etc. An interesting study reported by Louven (2004) presents the arguments as to why video recording is preferable over audio recording alone. He made a comparison between sound and video recordings and concludes from the research that video registration demonstrates a greater accuracy towards the interpretation of 'feeling qualities' than audio recordings. The sole use of audio recording could give a distorted image to possible interpretations.

³ Sony Digital 18, DCR-TR7000E PAL

Videotaping for research purposes is different. All sessions are recorded and are subject to an analysis by a psychoanalyst, as well as by a music therapist. In this way, I exposed my way of intervening and thinking to third parties, without being able to 'hide behind' the bias of selected video- excerpts.

In the past I have used videotaping in my individual as well as in my group therapies, with psychiatric patients as well as with children, for didactical purposes. For students and listeners hearing and viewing musical improvisations, therapeutic interventions and processes that are videotaped in a natural environment are of priceless value for the illustration of music therapy phenomena. I am fully aware that the selection is frequently guided by the quality of eventual interventions and the aesthetics of the musical event. I have used video or audio playback only sporadically during the session, as a reflection of the musical event for the patient.

I decided to omit a cameraman from the music therapy room, because I felt that his presence would influence the therapeutic process too much. The video camera stood on a tripod during the videotaping and in view of this there was no possibility of controlling the camera in order to focus on specific details (e.g. a change of facial expression, or eye contact). I preferred a stable camera with the result that the video presents an overall picture; here, mainly musical improvisations, physical movements, posture and (when observable on the film) facial expressions were important. As a result of the fixed camera position some details may have been lost in this study, but it was necessary not to put the video recorder in the patient's or the therapist's scope of vision for the reasons outlined above.

Intra- and interpersonal (i.e. subjective) experiences and physical sensations could not be registered on the video recording. In order to overcome this, it was important that I wrote down my immediate impressions and reflections after each session. From these impressions and reflections I could register the necessary intersubjective experiences for this research.

4.5 Subjects

For ethical reasons, all case study data that would make the research subject or his/her environment identifiable were erased or changed (i.e. age, profession of the parents, names, and city). It was also important to safeguard any material that was essential to the study, and in

these cases this was done preserving the anonymity of the patient. The names of each patient were also changed for the purpose of maintaining confidentiality.

There were two subjects, one female (Marianne) and one male (Adrian), who were both diagnosed with a psychotic disorder. Marianne referred herself for individual music therapy. Adrian was referred for individual music therapy through the multidisciplinary team.

4.5.1 Subject one: Marianne

4.5.1.1 Anamnesis

Marianne reported that she had been confronted with attacks of undifferentiated fear for about 5 years. The reason for admission, however, was a vital depressive image. The patient described that she had had communication problems and that she led a very solitary lifestyle with few social contacts. Marianne was very suspicious of her parents. During the acute psychotic phase, she was firmly convinced that her mother continually persecuted her, an impression which consequently excluded any further contact with her. However, this continual persecution was experienced only as the point of culmination of an old situation in which the mother was perceived always as over-controlling and inhibitive to her development. Marianne was the youngest of a family of three children. Her father was retired and, according to the patient, rather aloof with regards to family life. The mother was a housewife. During her youth, Marianne had attended one year of guitar lessons in the music school. However, her motivation was not great enough in order to continue these lessons and after that, she did not play any musical instrument any more.

After her secondary education, Marianne began to study literature at university. She was passionate about literature and wrote a great deal of poetry and stories. Owing to the many 'literary encounters' in pubs/bars, she concentrated little on her studies and did not succeed in graduating. After her first year, she had a short but very intense relationship with a man. She finally chose another subject and university course, but also gave up that study after two years. After that time she was unemployed.

The patient (Marianne) located the beginning of her troubles around the age of 20, when this intense relationship came to an end. She then began to suffer increasingly from feelings of fear, which did not allow her to lead an independent life. She became increasingly more

convinced that her mother was controlling her and that her mother even hired other people to control her.

4.5.1.2 Presentation on admission

The patient came across as reserved in contact with others. Her facial expression was flat and she had a staring look on her face. The patient seemed to be cut off emotionally. She made a few depressive complaints: that she had a sad mood, a-dynamics, anorexia, sleeping disorder, ‘anhedony’ and fear outbursts. She expressed a passive longing for death and depicted herself in a self-deprecatory way. She spoke of being overtaken by crying fits and how she had the tendency to regress. She did not report any hallucination, and there were no disorders of formal thinking, although she had heard voices in her head once in the past. Therefore, upon admission, this 25-year-old woman was described as existing in a vital depressive situation, and she was diagnosed as functioning on a psychotic level. (Axis I: 309.28: adjustment disorder with mixed anxiety and depressed mood with differentiated from schizophrenia, residual type (295.60)) The depressive complaints cleared up gradually under an anti-depressive treatment. The patient was referred to the music therapy department for young psychotics, for a psychotherapeutic treatment of her underlying psychotic problems.

Marianne was a talented woman with a general IQ of 126 (W.A.I.S. test), with a big difference between her verbal IQ of 133 and a performance IQ of 112. The balance between the “hold” and “don’t hold”- test indicated deterioration on the organicity-scales. The patient made few complaints, and did not have an expressed request for aid. When formally viewed, one could discern a protective shield, especially in terms of her emotional life, and she could not tolerate being touched. She tried vehemently to give answers to certain questions, but at the expense of living within any sense of reality. The theme in her relationships was frequently one of demanding something from others and there were many conflicts and quarrels. Aggression and sexuality did not have a specific place in her life. She was a very dependent woman who functioned on a psychotic level. There was nothing that was manifestly psychotic to be seen, but her ‘cutting off’ and apathy could be interpreted as negative symptoms. In particular, the patient had a consumer’s question: she wanted information. She had unrealistic goals and little self-reflection.

Marianne was prescribed medication which she was taking before, during and after the individual music therapy sessions that were analysed for this study. This medication included

Risperdal (risperidon: atypical neurolepticum), with possible side effects of sedation, tiredness and somnolence, and Efexor (antidepressant), with possible side effects of stimulation of the appetite and somnolence. It was not clear if her rather depressed posture was a side effect of the medication or rooted in her depressed mental state. What was evident was that her appetite was a lot higher than usual.

4.5.2 Subject two: Adrian

4.5.2.1 Anamnesis

In the second case of the 17-year old adolescent, Adrian, there were clear arguments for child psychosis at the time of admission, with fantasies, psychotic tantrums, blending together with the mother figure, and the inability to make adequate social contacts⁴. Besides this, there were clear autistic-like features, such as going into a trance through auto stimulation, and also becoming relaxed when hearing the voice of his father (which, in a rather autistic way, gave him something onto which he could cling).

The parents of this patient (Adrian) had been divorced for five years, but were reported to have separated eight years previously. The patient lived with his father or with his mother, according to what he wants at any one time, and also according to his mood. Although Adrian could have been able to have a good relationship with his parents, stepfather and brother, this was not possible because he had the conviction that he was not able to give love to them. On a social level Adrian had become completely lonely. School was also a very emotionally charged topic. He was, at the time of admission in his third year of high school, but would have to repeat that year again. At the point of the admission he had only been to school for four weeks, even though the school year had started six months previously.

The patient described auditory hallucinations, which were mainly voices that said incomprehensible things to him, as well as visual hallucinations (in particular, colours in the sky and a spaceship that came to him), without experiencing these phenomena as anything threatening. The patient also verbalised paranoid thoughts towards others, in the sense that he thought that people did not want the best for him. These ideas, however, did not apply towards

⁴ Soenens (2002) emphasizes that the psychotic syndrome with young people is not unequivocal. Certain psychiatrists are very cautious in giving a psychotic diagnosis, while others do it more easily. Therefore, for this study it was important to provide an extended anamnesis.

his parents. The patient was reported to have a vitalised depressive presentation with confirmed anhedony, anergy, apathy, loss of initiative and insomnia.

Adrian also told how, since the age of six, he broke off branches of trees and waved them in front of his face in order to come into a kind of disassociate trance. He called this 'zwadderen' (neologism), a word that he developed for this ritual. When he went into this form of autohypnosis, he started to live very quickly in his aggressive "thought-world", from which he said he had a lot of pleasure. The patient had several aggressive explosions at home, at school and at the youth psychiatry ward, where he had been initially sent. He repeatedly damaged the ward furniture and his own belongings such as a television and a stereo cassette recorder and he said that he tried to control his aggression by damaging things.

He felt better in the psychiatric clinic than at home, partly because of the presence of peers, and partly because of the security it offered him. Adrian had a few megalomaniac fantasies, through which felt he held the power over life and death, suffering and pleasure, illness and recovery. Adrian had an enormous, intense fascination with the idea of torturing people and then killing them afterwards by cutting their throats. More recently, he also seemed to have developed rape fantasies. Adrian reported how he wanted to torture his own girlfriend, which would give him a greater sexual pleasure than to make love in a normal way. Adrian told of how these thoughts sexually aroused him. However, in spite of this, he sometimes experienced a great agony when he realised that these penetrating thoughts were not normal. It was already the case that these very aggressive, uncontrolled thoughts had been ruling his functioning for a long time. Adrian was ambivalent: on one hand, he reported that he treasured his perverse and destructive fantasies in his trance-like states moments and how they sexually arouse him, while on the other hand, he reported that he experienced a great sense of personal agony from these fantasies, and had himself suggested he should be monitored in a youth psychiatric ward. This was how he arrived at the youth ward of the psychiatric hospital. A few months later, he was sent to the open therapeutic, structured ward for young psychotics.

Adrian sang in a school choir during his elementary school period. This singing activity ended abruptly because of an admission to the children's psychiatric department. After that, he did not learn to play any musical instrument.

4.5.2.2 Presentation on admission

Adrian had difficulty integrating into the structured, multi-disciplinary approach of the ward. He did not take part in either the verbal group psychotherapy sessions or in the ‘theme’-meetings, occupational therapy, group music therapy or leisure activities. Only the sporting activities organised within the department were important to him. Words and relationships with the different therapists were too frightening and threatening for him, and the nurses reported feeling unsafe, with a sense of being under threat during interactions with Adrian.

Adrian’s facial expressions and attitude demonstrated a certain tension and the nurses had the feeling that he could become unpredictably aggressive.

During the treatment phase for this study, medication was prescribed for Adrian, but he refused to take it. He was prescribed Pipamperon (Dipiperon) a classic neuroleptic for behaviour disturbance, aggressiveness, hostility and impulse-regulation. The possible side effect of this medication is hypotension. The refusal of prescribed medication, such as seen with Adrian, might have some connection with what taking the medicine stands for, such as injury or the self-image of the patient, (Peuskens et al. 1988). The use of medication reminds the patient constantly of his illness and his weakness: “I have to be sick, because I have to take medication.” The prescription of medication or an increase of medication can mean an attack on the omnipotent fantasies of the patient because it is a sign of the loss of his control over the relationship with the therapist.

4.6 Data collection and analysis

4.6.1 Stage 1: anamnesis and diagnosis

An anamnesis and diagnosis was described for both patients. This was done in co-operation with a psychologist and a psychiatrist.

4.6.2 Stage 2: music therapy framework

The music therapy process began by studying the patients as they presented themselves, without any specifically planned music therapy strategies (types of interventions). It was then decided to adopt a consistent framework for the sessions, as follows:

Frequency and duration: sessions once a week, 45' each session.

Model: psychoanalytically orientated music therapy.

Procedure: a typical pattern of verbal introduction- musical improvisation- verbal reflection
- musical improvisation – and eventually, a final verbal reflection.

Data collection: recording of the sessions on video and audio up to the point of proto-symbolisation (denoted by evidence of the patient coming to a musical form followed subsequently by reflection at a symbolic level).

4.6.3 Stage 3: reflexive material (stages of analysis of the data)

a) After each session the music therapy/researcher wrote a description of his first impressions, using the following categories:

- of the room (condition)
- of the patient
 - the entrance of the patient (time of arrival, first impression of the patient, clothes, tension etc.)
 - whether the patient is bringing some personal material (for instance, CD's, paintings, purse)
 - the way the session started (whether there was an initial first verbal phase, or if the patient went straight to the instruments)
 - the way the session ended
- of the music therapist
 - the music therapist's own fantasies and experiences
 - any phenomena of counter transference, projective identification etc.
 - any tension
 - a relevant title for the session
 - subjective experience of the length of the session
 - the therapist's first impression directly after the session (tension, mood, emotions etc.)
 - therapeutic position and interventions
- of the music improvisations
 - giving improvisations a proposed title impressions of the musical improvisations

- interactions between the patient/therapist
- use of musical instruments
- subjective time of the improvisations
- musical interventions of the therapist

Here the music therapist used that which he himself experienced and what he experienced as coming from the patient. In order to influence the therapeutic process as little as possible, the patient was asked in a non-directive way to indicate changes. (For example, in session 4 Marianne indicated that she had rhythms in her head, and in session 8 Adrian reflected that he had come to a musical form.) Data from verbal reflection could also be used here.

The course of the session was also described from the perspectives of transference, counter-transference and projective identification.

Stages of analyses of the data

When both patients reached the stage of demonstrating musical form in their playing in the music therapy session, this point was marked as the stage at which they had made the transition from sensorial play into a music form. Following this, a period of two months allowed a lapse of time before a transcription of the music therapy sessions was made, after which the analysis of the data took place. This was deliberately delayed in order to prevent any disturbance to or influence on the continuing therapy work, and to protect the therapeutic relationship and process with the patient. Musically notated and verbal transcriptions of the music therapy sessions were made from the videotapes.

4.6.4 Stage 4: phenomenological description of the sessions

A phenomenological description of the session was made by watching the video in short sections, pausing the tape and then describing observed and experienced elements that included the musical event, the therapist's musical interventions, the patient's physical behaviour (mimic, tension), the therapist's physical behaviour, the patient's verbal material and the therapist's verbal material. Where events in the video were unclear, or where the activities going on were complex and needed closer viewing, repeated observation of the video was undertaken to ensure a comprehensive description.

4.6.5 Stage 5: therapist's personal record

The therapist/researcher wrote his personal record of what had happened after every session. This mainly consisted of his impressions and experiences of what occurred in the sessions. He also made interpretations that provided some insight into the therapeutic interventions, actions and process.

4.6.6 Stage 6: retrospective analysis

Retrospective analysis was undertaken through the process of intervision with a psychoanalyst that involved the observation and interpretation of therapeutic and musical events. This retrospective analysis was made of every session. In working together with a psychoanalyst, this method of research intervision involved using the complete video recordings of the sessions in order to make interpretations from a music therapy and a psychoanalytic perspective. In this particular setting, research (clinical) intervision consists of the music therapist (i.e. the researcher) and a psychoanalyst watching the videos together, and pondering, reflecting and fantasising on each therapeutic or musical event or change. Through this it was possible to achieve insight and assign possible meanings to what was happening in the observed sessions, where fragments could be watched as many times as was necessary. Thus, research-intervision does not take place from a supervisor - supervise situation, but, where the researcher and the psychoanalyst were equal and complementary in their reflections.

The way in which the research intervision operated meant that essentially it was not so different from a clinical intervision-situation or supervision. All therapeutic aspects such as transference, counter transference, impressions of the therapist and interpretations were considered. At the same time, special attention was given to the therapeutic phenomena that appeared at the level of the patient, as well as at the level of the interaction between patient and therapist. These features were considered specifically, within the development of the framework of the research.

The stages of research intervision were as follows:

- Starting the video.
- Stopping the video when something important has happened, followed by comments, associations, thoughts, interpretations and discussion.

- When necessary, repeating observations of sections of the session (through re-viewing the video recording).
- All comments were recorded and written down by the therapist researcher.

The analysis of the video-material as primary data ensured no loss of the context of the session and through this working method it was possible to be sure of a significant analysis and description of the therapeutic process. As such, the selection of the video material could be validated and understood on the basis of the entire therapeutic process. Robson (2002, p. 169) stated that for research good listening is used in a general sense to include all observation and sensing, not simply via the ears. 'Good' means taking in a lot of new information without bias, 'reading between the lines', capturing mood and affective components and appreciating the context. Therefore researchers need an open mind and a good memory. The good listening attitude was more grounded in the cooperation of my colleague, who understands music therapy well, and from his perspective as an experienced psychoanalyst he has developed a highly sensitive level and quality of therapeutic listening (similar to the bifocal listening, as described by Bion 1975) to therapeutic situations.

4.6.7 Stage 7: temporal structural conceptualisation of the sessions

A general summary of the structural development of the sessions was given by the timeline figures. They provide a good overview of the sessions and delineate the actions of both the patient and the therapist, with regard to:

- The duration of the sessions.
- The choice of instrument.
- The duration of the verbal reflections.
- The playing (or non-playing) of the therapist.
- The visual selection of the video excerpts.
- The duration of the different improvisations.
- The beginning and ending of the improvisations, and their position in the session.
- Other significant behaviour.

In the Marianne case study, for sessions 2 and 3, the specific tempi of the improvisations in

each session was analysed and is documented in Figures 5.3.1 and 5.4.1.

4.6.8 Stage 8: integration of the case material

After the retrospective analysis (stage 6), I will write a clinical case study report using the material I have. This is reflexive material and includes impressions, phenomenological descriptions of the sessions, transcriptions of the verbal parts, transcriptions of the music and a retrospective analysis).

Writing a case study presents a first impression of the whole story of the patient and his treatment, and provides a linear description of what actually transpired both in each session as well as in the treatment process as a whole. This creates a clear ‘overview’, and prevents the loss of the context of the therapeutic process when looking at the selected shorter musical fragments or interventions.

4.6.9 Stage 9: selection of the musical fragments

Selecting the video fragments was undertaken with great care, because this was the central research material needed to define the phenomena sensorial play, emerging changes in the patient’s music and musical form. These selected fragments also present the most important phases in the music therapy process. From the complete video material samples were carefully selected by the researcher in the following systematic way:

- *First step:* go through all the videos in order to have a total overview of the therapeutic process. Mark the changes in the musical improvisations under the following categories:

- choice of instruments;
- musical parameters (rhythm, melody, tempo etc.);
- musical interventions (patient or music therapist);
- interaction;
- physical posture;
- compare them with the therapist’s personal record (stage 5).

- *Second step:* select all the musical improvisations (undertaken by a second listening to the musical material). Mark the significant musical changes and compare them afterwards with the

first observation. Save all the musical improvisations in the session onto a videotape labelled 'video 1' (see appendix 2.1 and 2.2: column B).

- *Third step:* select the most important changes in musical phenomena that occurred in the musical improvisations saved on video 1. This selection of excerpts of variable time spans was then saved onto video 2 (see Appendix 2.1 and 2.2: column G of the excel spreadsheet for the exact detail of the selected excerpt that was identified through the analysis to represent sensorial play, emerging changes in the patient's music or musical form).

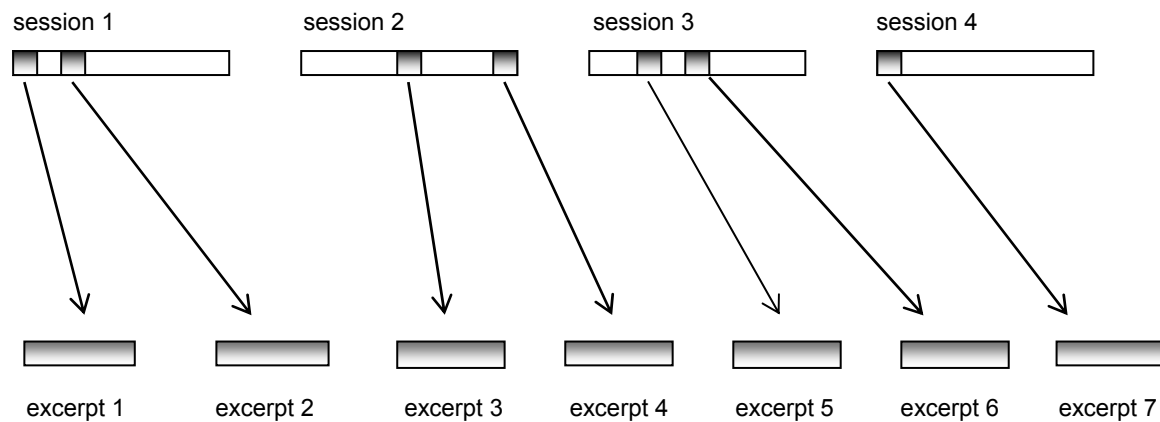
- *Fourth step:* listen to all the musical improvisations (video 1: second step) without visual observation and verify the previous selection from video 2 (third step).

- *Fifth step:* select the video-excerpts that appear to demonstrate how the sensorial play, the musical form and the most important therapeutic changes (i.e. emerging changes in the patient's music) occur in the transition from sensorial play to musical form. These final chosen excerpts were saved onto video 3 (see Appendix 2.1 and 2.2: column H) and are illustrated below (Figure 4.2)

It was decided to identify these phenomena within video-excerpts that lasted no longer than one minute each. This decision was made following feedback from colleagues during seminars and presentations, and after the shared analysis during the intervention. In a period of one minute, there is enough time to "perceive" the specific features of the three phenomena, so that the nature or the formlessness, the posture, the psychological aspects, the interactions, the interventions and musical parameters can be both audibly and visually experienced by an observer. The rationale for this was that fragments shorter than one minute would not provide enough material to allow the detailed study of different components or offer an overall context for the type of playing. Longer fragments were not necessary because all of the essential elements that can identify the patient's music to be within the categories of sensorial play, emerging changes in the patient's music and musical form could be found within the time span of one minute. This was found to be possible in both cases.

Comparing the selection of video 3 with the therapists impression notes.

Figure 4.2: Selection of video- excerpts from Marianne's sessions



Sixth step: check the selection from the research interview with the psychoanalyst and an independent, external music therapist recruited in order to provide an objective external opinion. This opinion related to the selection of the excerpts for analysis, which were based in meeting the criteria for the three phenomena of sensorial play, emerging changes in the patient's music and musical form.

In this study, the selection of video-excerpts of the session was of fundamental importance. These selected excerpts were the central research material for the analyses and results. The psychoanalyst who participated in the research interview and an independent music therapist also tested the selection of the researcher.

An external music therapist, who was not involved in this research, was recruited to watch the video material of all the improvisations in all the sessions, and to define the musical playing in them into one of three categories, as follows: sensorial play, emerging changes in the patient's music and musical form. The musical material in each improvisation could also be subdivided into any of the three categories. This independent music therapist received the description and the main criteria for each of these three phenomena. Her choice of category for the musical material and subdivision of the fragments to categories was necessary in order to correspond in all cases to the categorizations of the musical material in the excerpts selected by the researcher.

The second observer was the psychoanalyst, who had watched the video material of all sessions in the research interview and on the basis of the description and the main criteria of

the three phenomena checked if the selected excerpts were representative of the three phenomena.

In Appendix 3 the tables show the results of this correlated analysis by the external music therapist, indicating that there was a close correlation between the choice of the researcher of the video-excerpts to be analysed and the defined category of the musical material by the independent music therapist.

The categorisation of the video-material by the external music therapist was then compared with the selection of the researcher. This was necessary to check whether there were any blind spots in the sample selection.

4.6.10 Stage 10: Scores

Finally a composer who is familiar with the notation of free improvisations in a music therapy context was recruited for the study, and took a supervising role in the notation and analysis of the musical fragments. The composer and the researcher made the transcriptions of the improvisations from the video-recordings and not from the audio-recordings. Video recordings seemed to have a major advantage, especially when the patient and the therapist played the same instrument. Only by careful visual observation could the musical play of the patient be distinguished from that of the therapist. This would have been almost impossible with audio recordings alone.

The process by which the excerpts were notated, analysed, and from which interpretations were made is important, and the way in which this was achieved is highly relevant in establishing the connection between clinical process and research analysis inherent to this project. Lee (1996), Aldridge (1997), Schumacher (1998) Sutton (2001) and Ansdell (1996) used transcriptions (scores) in a regular notation system of free improvisations in their studies, and analysed the scores to achieve insight from a musical perspective into the improvisations. Lee (2000) remarked that much of music therapy research and clinical evaluation focuses on the non-musical information and not enough on the analysis of the musical material.

4.7 Analysis of the research material

From the phenomenological description of the different sessions, the analysis of the musical material, the personal impressions, the interpretation and the clinical intervision, a clear structure for presenting the results of the case studies in this research project emerged.

4.7.1. Methods for the presentation of results

Each phase of the process will be described and interpreted from an analysis of the data that was collected in the following format:

1. Description of the selected video-excerpts.
2. A notated score of each excerpt and a description of the musical elements.
3. Selected comments from the patient relating to his / her experience of playing.
4. Selected impressions and reflections from the therapist about the patient's way of playing.
5. Selected reflections from clinical intervision.

The style of presentation of the results under these headings will vary because some material contains factual description, while other aspects represent personal reflection and interpretation. Therefore in order to provide a clear method of presentation, each stage in the analysis will be defined regarding the style of information presented, and the style of presentation. The presentation of these results represents a process over time. Consequently the interpretations of the musical material in the early stages of the analysis raise questions that are added to these stages, and discussed later following the subsequent analysis of the latter stages of the therapy.

4.7.2 Description of the selected video-excerpts

The video-excerpts are the central therapeutic material for this study. Therefore it is necessary that the examiners of this dissertation have access to these video-excerpts. Therefore all the video excerpts are presented on a CD-ROM that is included with this dissertation.

The style of presentation of the data in this section is a factual description of the behaviour in patient and therapist together with an interpretation of the general atmosphere. Areas considered were as follows:

- Position of patient and therapist in the therapy room.
- Instrument of patient and therapist.
- Posture (tension of the body) of patient and therapist.
- Facial expression of patient and therapist.
- Actions of patient and therapist.
- Visual references between patient and therapist.

In addition an evaluation of the atmosphere present during the excerpt will be described, based on the context of the whole session and the improvisation, and taking into consideration the observed behaviour. Description is made here in the present tense in order to reinforce the sense of its immediacy.


4.7.3 A notated score of each excerpt and a description of the musical elements

Notated scores of the musical material in the musical improvisations were made as accurately as possible from the video recordings of the sessions. Where practicable the stable material of the patient was notated into rhythmic and melodic pattern in order to demonstrate aspects of potential structure. The musical material of both patient and therapist was included and differentiated in the scores. Dynamics, phrasing and other marks of expression were also included on the scores to give a sense of the presence or absence of affect in the musical material. In this section, musical elements are described using the musical terminology and criteria for describing music, without analysing or interpreting them. These descriptions are supported by the video soundtrack, and notated scores. The following musical parameters are included as potential descriptors: rhythm, melody, harmony, phrasing, dynamics, tempo, timbre, pulse, silence and volume.

4.7.3.1 *Structure of the musical analysis*

The scores were analysed and the notated figures marked in a structured way to identify the relevant sections and points in the scores.

The common musical structures are indicated as follows:

1. Major sections are marked with a letter: A or indicated by a structural term: Coda
2. Subsequent major sections that are variations on major sections are indicated with an apostrophe. For example A' is a variation of A
3. Smaller subsections are marked with a lower case letter, for example: **a**
4. Phrasing and complete musical phrases are indicated with slur lines, as follows: 
5. Repeated motifs are identified with a lower case letter, for example: “a-motif”
6. Variations of motifs are shown with an apostrophe against the lower case letter, for example: “a'-motif”
7. Musical cells and their variations are indicated by a lower case letter preceded with a number, for example: ‘a1’, ‘a2’.
8. Melodic or rhythmic repetitions are indicated with the following:
9. In order to structure the score wherever possible bars or measures are used, even when the measure is not exact. Where there is an extended play without bars or any sense of metre, timespan is then indicated in seconds.
10. Accents and other dynamics that are important for the structure are shown in normal musical notation terminology.
11. A vertical, wavy line indicates interruptions to the flow of the music, or to the session.
12. Other scoring characteristics are as follows:
 - a. If necessary left-hand or right-hand playing is indicated, in order to illustrate the physical aspect of the music.

- b. Other, specific musical phenomena are indicated as glissandi, ascending, descending, rallentandi and tremolo.
- c. The tempo is always shown at the beginning of a stave, with any variations in tempi also indicated in the score.
- d. Dynamic signs such as forte, piano, mezzo piano, etc. are used to signify the intensity of sound in the music.
- e. Examples may also include musical intervention where the above parameters identify inter-musical events between patient and therapist
- f. References to numbers in the text within brackets () refer to selected points in the notated score.

4.7.3.2 Glossary of musical terms

For clarity of reading and understanding from an international perspective, this glossary of terms is used in a standard way through out this text:

4/4 = time signature of the music

System = a line of music

Bar = a measure within a line of music

Chord structure:

i = tonic

ii = supertonic




iii = mediant

iv = subdominant

v = dominant

vi = submediant

vii = leading note

1 st =		= semibreve
2nd =		= minim
4th =		= crotchet
8ths =		= quaver
16ths =		= semiquaver
32ths =		= demisemiquaver
64ths =		= hemidemisemiquaver

4.7.4 Selected comments from the patient relating to his experience of playing

Verbal comments and reflections from the patient relating to his/her playing are documented in this section. The patient's original language is used in the documentation. Interpretations are made by the researcher on the comments made by the patient, in connection with musical material and its relatedness to the experiences of the patient. The style of presentation of the data here is factual (patient's verbalisations) and interpretational (therapist's interpretations).

4.7.5 Selected impressions and reflections from the therapist about the patient's way of playing

Impressions and preliminary interpretations of the therapist written down immediately after the session are documented. These notes (i.e. part of the clinic data) incorporate the therapist's reactions to the patient's behaviour. This in turn serves as a tool for gaining insight into the disordered experiences of the patient in terms of the counter transference. It gives the reader an insight on the therapist's thinking and offers an impression about the therapeutic situation. The reflections include the therapist's responses to the patient and these reflections are presented in the first person because the source of data is from the clinical diary of the case, and therefore is identifiable from the therapist's (and researcher's) personal interpretative perspective.

4.7.6 Selected reflections from clinical intervision

The method of clinical intervision is described in the research method (see / i.e. stage 6, 4.6.6)

The data used in this section is transcribed from the audio recordings of the research intervision. The data from the clinical intervision reflects a variety of aspects from both the patient's and therapist's perspectives. There are descriptions of events (musical and verbal) that occur in therapy and the therapist's impressions and interpretations of those events. Some of the therapist's intentions and interventions in the therapy sessions are documented. There are also comments that reflect the therapeutic overview of what is happening, relating to the case history and diagnosis of the patient and how this aspect emerges in the musical improvisation.

This material is reported in the third person where I as the researcher step back and look (together with the psychoanalyst) more objectively at what I, (the clinician) was discussing and interpreting in the intervision. The discussion section will address issues relating to this dual role (therapist/researcher) and how it was treated in the research study.

4.7.7 Summary of results

A summary is then presented incorporating all aspects of the analysis. The three phenomena will be summarised, and interpretations made of all aspects of the process. Conclusions will then be drawn from the behaviour of the patient, of the therapist and of the interventions that the therapist used. The summary offers an explanation of the results together with some discussion as to how the results relate to the specific case. Further discussion relating to the relationship between the results and theoretical considerations, as well as the limitations and clinical relevance of the findings from this study, will be presented within the final discussion chapter.

4.8 Conclusion

The methods detailed in this chapter were developed during the course of the research. They were then applied to each of the two cases, and the next two chapters will present the results of these cases in the format and process described above.

Chapter 5

Results and Summary of Case Study: Marianne

Introduction

These results will be documented under the three main phases of *sensorial play*, *emerging moments of synchronicity* and *musical form*. These phenomena have been found through the various analyses undertaken of the data and are defined during the course of the case study.

Each phase will be described and interpreted from an analysis of the data that was collected as described in the method section (chapter 4).

5.1 Case study: Marianne

This section presents the first subject from a clinical perspective, as a ‘case study’. A short initial description of Marianne’s behaviour in and response to group music therapy, Marianne’s own rationale for individual music therapy and her subsequent referral to individual sessions is given. There follows a description of the individual music therapy sessions presented as a clinical and therapeutic process, at this stage without any analysis from a research perspective. The description of Marianne’s therapeutic process involves both factual observations and descriptions of what she does and says, as well as interpretation of her behaviour.

Marianne and group music therapy

Marianne participated regularly in group music therapy twice a week for eight months in sessions led by a colleague of the researcher. Marianne’s image was that of a withdrawn woman, choosing the same instrument (the alto-metallophone) over and over again. Her physical posture was characteristically bent forward, with a staring glance, withdrawn into herself, and always playing in a repetitive and unchanging way with her arms pressed against her body. She did not have any contact with the other group members or the music therapist. She could be described as having an inability to create a ‘psychic space’¹. In verbal psychotherapy she expressed her wish for individual music therapy, and as a consequence this

¹ The term ‘psychic space’ indicates a space wherein thoughts, fantasies and images can happen or occur. This is according to Winnicott’s theory of a potential space (Winnicott 1971), where symbols are created and meaning is discovered through the process of creative apperception.

began two weeks later. Her participation in group music therapy stopped because it is normally not typical to have both individual and group music therapy at the same time, although not unknown in this and other modalities. For instance, a combination of individual as well as group music therapy is sometimes recommended in clinical psychotherapy. In this particular type of clinical setting (like the University Centre, St.Jozef, Kortenberg, Belgium), multi-level therapy is a part of a multidisciplinary treatment.

Marianne expressed her demand for individual musical therapy in the following way, saying: “I am blocked in my creative possibilities. There are a lot of bottled up feelings inside of me, but the moment (minute) I want to express them, I just can’t. What can I do? I would like to work on that.” Marianne had written poetry prior to her admission and she also used to play the guitar as an amateur.

Reflecting on how Marianne presented herself musically in the group music therapy sessions, it was noticeable that she played in a purely physical way, with constant repetition and using a kind of ostinato. Although Marianne expressed in a manifest way her wish to escape from her blocked and ‘bottled up’ feelings, the ostinato was a testament to the paralysis of her psychic life. Like her psychic life and, rather like a form of musical concretism, these musical elements were not marked by any movement, either of displacement (“Verschiebung”) or of substitution, because Marianne’s rigid psychic life would not allow this. It was the therapist’s task to experience, connect with, interpret and understand the meaning that lies behind this ostinato playing.

Individual music therapy

First session: “The inability to play music”

Marianne entered the music therapy room shuffling her feet in her slippers as she walked. She carried a plastic bag, which contained some of her personal belongings. She arrived punctually and she gave the impression of being worn out, rather like a woman who is completely exhausted and who had nothing more to say. Marianne seemed to react very slowly, her facial expression showed frailty and her gaze was somewhat stuck and fixed. She seemed to be emotionally empty and flattened, and her voice was without intonation and expression. The therapist experienced a certain dryness and emptiness when he greeted her and shook her hand. Her handshake did not make contact, it was without any counter pressure and vitality and to the

therapist it felt just like shaking a rubber band. The therapist told Marianne that the music therapy framework comprised sessions that last for 45 minutes and consist of active improvisation. She could decide if the session should start with a verbal part or with an improvisation. After each free improvisation there would be an opportunity for verbal reflection. Furthermore, she was free to choose the instruments, for her and for the therapist, and could decide if he would play with her or not. This opportunity to make her own choices is important in the context of transference and counter-transference, because Marianne's choice related to her own unconscious; if the therapist chose the instrument, Marianne was robbed of this opportunity.

Marianne chose the alto-metallophone, the same instrument that she had been playing for eight months in group music therapy. Through this choice she showed her emptiness, a necessity for security and the inability to bring any variation in her contact with herself or the therapist. Marianne was offered the chance to choose which instrument the therapist would use, and she also selected an alto-metallophone for the therapist.

Marianne placed the two alto-metallophones facing one another and she started to play immediately. The music she made was as repetitive and expressionless as it had been during the last eight months in group music therapy, with an endlessly alternating motoric movement, where her arms moved mechanically up and down along the keys of the alto-metallophone. Musically there was no phrasing, no dynamics, and no accentuation. Her improvisation was comparable with "musical rocking". **[Excerpt 1]** Her improvisation is an interesting example of the formlessness of psychotic patients.

In the beginning, the therapist tried to make a connection with Marianne, by exploring her pace of playing. However, the problem was that Marianne's music was not addressed to someone else. This was because of the monotonous nature of her music where its continuity was distinguished only by the succession of sounds - qualities that are typical of the repetitive nature of some improvised music made by people with psychotic disorders. Her non-communicative playing referred to the non-subjective character of the repetition, and that fact that there was also no 'other' for the therapist to refer to musically. In the beginning the therapist was only focussed on the musical aspects, and the sounds relating to this.

Intuitively the therapist knew that he would only be able to communicate if there were a psychic space. In trying to create such a space the therapist introduced a musical form, namely a "bourdon" **[Excerpt 2]** and after that, a melody, which he repeated a few times. The therapist

had the intuition to present something structured to Marianne, so that she had the possibility for assuming some of this musical material in her play. To remember and recall means to create the possibility of having memories. 'Recall' means to take up something again, to vary it, to do something with it, to elaborate upon it. If nothing can be remembered, one cannot imagine anything, because to remember something requires the necessary psychological space for imagination. The therapist tried breaking away from the pure repetitiveness of Marianne's music and coming into a kind of psychological space with her. In this psychic space the therapist experienced the other (i.e. Marianne) in himself and by doing this, he put himself through an experience of witnessing the traumatic aspects of Marianne.

He tried to stop the endlessness by playing a musical cadence. Marianne did not seem to notice this, and kept on playing in the same repetitive way. With a verbal intervention, the therapist invited her to finish her music. She stopped immediately and put the little hammers down on the alto-metallophone. This action marked the end of the improvisation.

The piece lasted for 24'06". Throughout the whole improvisation there was never one clear example of contact between therapist and Marianne. For the therapist it was dramatic, and it brought him to a place where it was impossible to improvise, or to make music.

A silence emerged that was as regressive as the music and again the therapist experienced Marianne's emptiness. He gave her the opportunity to verbalize something, but she only managed to answer his questions with yes and no. They made the next therapy appointment, after which, without showing any emotion, she took her plastic bag and left the music therapy room, shuffling her feet just like she had entered the room. It seemed as if nothing had happened during the 45 minutes of the session - as if the therapist did not exist for her. There was no resonance². The sounds that echoed were almost non-existent, similar to a landscape that is covered in mist, where one cannot see any contours, points of reference or colours. It makes one think that perhaps there is something behind the mist, something that cannot yet be seen.

While watching the video-excerpts of the first session, the therapist's posture and manner of listening is noticeable. The therapist has literally assumed the same position as Marianne; bent over, hands pressed against his body, with a rather melancholy facial expression, the

² The meaning of resonance is described by different authors. I want to refer to Gindl (2001, 2002), who sees emotional resonance as a basic experience of every interpersonal relationship. Without these experiences, people can not develop their own ability for responsiveness and mutuality. Gindl correlated this to music therapy as the body-soul-space of the patient who becomes a "sounding-board", in which sound and touch can resound.

therapist looks as depressed as Marianne. This is an illustration of a perfect form of empathetic listening, where music is experienced at the level of the body, i.e. at the sensorial level. In a way, the body posture of the listener adapts to the music. It is a kind of physical dialogue to which psychotic patients are very sensitive.

The music of Marianne is characterized by aleatoric and repetitive sounds. There is no representation; no musical form. There is no intention to build up the music from a memory, from a psychic space; everything is moving on the traumatic level. The image emerging from Marianne is one of an abused, traumatized woman.

Second session: “The traumatic instrument, a new melody “

Marianne entered the room punctually, again shuffling her feet and just like the previous session carrying a plastic bag, this time with knitting inside it. Marianne said that she had high expectations of music therapy and that after the first session she had started to knit and to crochet. It is interesting to see the parallel between the knitting and what is happening musically. Knitting is an autoerotic activity, turned into itself a repetitive occurrence, in which no disturbing object appears. Therefore, for Marianne to start knitting again only confirmed what was taking place musically: her whole being was incorporated into an “ostinato” and to start knitting again was the confirmation of her emptiness.

Marianne chose the alto-metallophone again. The choice of the therapist’s instrument appeared to be more difficult, with Marianne showing a complete indifference towards the instrument choice for the therapist. The therapist encouraged her to choose an instrument for him and went over the possibilities with her, for instance giving her the choice between a string, wind, or percussion instrument. Finally the kalimbaphone³ was chosen, an instrument that she knew from music therapy but had not yet played. The kalimbaphone is an instrument that can be compared to a thumb piano, but is much bigger and with eight wooden tone bars that are attached to a wooden sound chest. It is a primitive instrument, with a rather raw, physical sound. This instrument is played with mallets.

In comparison with the first session, one might note the appearance of the first small variation in the therapist’s playing, which is now characterised by the roughness of the timbre of the instrument. Strikingly, Marianne still opted for the alto-metallophone. She started her

³ A kalimbaphone can also be described as a lamellaphone: an instrument with a set of tuned lamellae, or tongues, fitted to a resonating box. This is also sometimes linked to the thumb piano or African thumb piano.

repetitive music again and while the therapist tried to connect with her, he felt rejected again in the emptiness of her being. Whatever he tried, he remained in an isolated play on his own. He was struck by a number of thoughts, for instance whether or not he should still try to get into contact with her. He also considered the fact that Marianne might want to maintain her regressive music, on her own, without allowing anyone in. It was possible that she only wanted him to listen receptively to what she had to say. He decided intuitively not to play any longer with her, but to simply listen to her music, and to wait to see what could evolve. **[Excerpt 3]**

However, Marianne endlessly continued playing the same, repetitive pattern. The style was purely impressionistic - for example, she played a high tone but did not repeat it. There was no structuring and no phrasing in her music; she did not develop anything and was therefore not able to repeat anything in a reprise. Marianne probably hoped that a melody might originate, but that did not happen. She also did not incorporate anything from the previous session into her music. For instance, she could have integrated the bourdon of the music therapist, but apparently she was not able to do that. The only change to the music was an acceleration of the tempo, but in the end nothing happened.

Through Marianne's *accelerando* (see timescale excerpt 2) a certain tension in the musical play was born. She seemed to be saying: "you left me to fend for myself", a comment that hung in the air between Marianne and therapist. Marianne seemed to implore the therapist to create a space. She could not create this space by herself yet; it could only come from the therapist and she totally depended on him for this. The therapist let the sounds come to him and he experienced something unbearable, that something had to happen to change this situation. The therapist felt that Marianne was indirectly appealing to him to change the situation. She had been playing for about eight minutes by herself until the therapist moved himself intuitively towards the piano, which was at the left side of him. Without having to move the chair he started to play a simple melody (figure 5.1). The timbre and the volume were well-matched with that of the alto-metallophone. It was almost impossible to distinguish his melody from hers with regard to timbre, tempo and volume, with both at the same dynamic level. Musically, the therapist put his psyche in the service of the psyche of the Marianne.

Figure 5.1: Melody of the therapist

patient is playing in an endless, repetitive way, tempo is very fast

The figure consists of two musical staves. The top staff, labeled 'Patient (Metallophone)', shows a very dense and repetitive sequence of notes, representing an 'endless, repetitive way' of playing. The bottom staff, labeled 'Music Therapist (piano)', shows a melodic line with various note values and rests, representing the therapist's response.

The suddenness of the melody was almost a shock, as if without warning someone had said, “here I am”. Here, the unbearableness of non-existence came to an end, as the therapist had all at once established a subjectivity. The clear melodic line that originated was a kind of ‘antidote’ to the state of non-existence. The melody evolved into a harmonic entirety, like a chorale. The therapist embraced Marianne’s sensorial music, even though he did not experience a connection with her. He continued playing because he wanted himself to be heard as a subject. After approximately five minutes the therapist played a definite cadence, to which the client did not react. She continued playing on her own, but again, after a sub-verbal intervention from the therapist, she stopped her music. From the short verbal reflection that followed the improvisation, it was obvious that the music did not permeate to Marianne’s perception or her thinking, and she did not recognise what had happened. She did not even notice the therapist’s piano playing, and just as in the previous session she left the music therapy room shuffling her feet.

After this session the therapist was left with many questions to try to find answers for. Perhaps the musical play did not even make sense, or have any therapeutic significance in this context. However, diagnostically, it definitely did. This playing was a perfect illustration of

how music can represent the traumatic level. The musical play was a sheer succession of single sounds, without any form, with only repetitiveness without reprise.

The choice of playing the piano (the therapist's preferred instrument) became obvious to him through the counter-transference. However it was against his training and approach to reject playing the instrument that had been chosen for him by Marianne (i.e. the kalimbaphone). Marianne had a desire to be able to exist as a subject, and intuitively the therapist felt that he could only represent this through a musical form such as a melody. At this point the kalimbaphone did not offer enough musical structure for him and the timbre was too distant from Marianne's monotonously ongoing sounds.

Third session: "The projected provocation"

Marianne again entered the music therapy room shuffling her feet. She took her place at the alto-metallophone and asked the therapist if he wanted to play the kalimbaphone again. It was the first time that she had consciously identified an instrument for the therapist and involved him as a subject in her music. It is interesting to note that she kept the same instrument (one that has more an angelical, heavenly sound) and delegated the rough, traumatic sound of the kalimbaphone to the therapist. Marianne played her repetitive music again, monotonously and without any dynamics. The therapist provided support and structure, but at the same time he tried to provoke the client rhythmically. The whole time she played "syllabically," the therapist started to play more 'melismatically'. Marianne however did not react to any provocation; there was no single variation and she never used phrases. The therapist experienced a projective identification, that anything Marianne could not bear she projected onto him. This was because it was the therapist who was playing the kalimbaphone, and so it was also he who had to tolerate or bear the roughness. This was the situation that made Marianne feel secure, that she was able to leave the expression of her traumatic psyche with the therapist, which also meant that she could keep on pretending that nothing happened. The therapist made the decision to continue playing and for a moment Marianne came a little closer to him musically. From time to time she was tempted to incorporate something of the tempo or dynamics, but this stayed at the level of exploration.

At a certain point further on Marianne showed a tendency to play in a defensive way and in so doing, she made the distance with the therapist bigger again, and the need for projection increased. After a somewhat more melodic section of music, she continued playing in a restful,

sensorial way. Each time the therapist challenged her (for example by playing a melody with some variations), Marianne gently showed no recognition of the need for any changing in her playing. She was not able to appropriate and integrate the musical material suggested by the therapist and so she drew a discreet veil over the proceedings. When the therapist played a cadence at the end, Marianne coughed, and although showing awareness of the cadence, she did not stop at the same time with him. The patient ceased to play only (and abruptly) because of his verbal intervention.

The patient coughed as a reaction to his intention to stop and the therapist interpreted this cough as a signal to round off the improvisation. It was as if she noticed that he might stop, but she did not act upon this awareness. Marianne did not have any autonomy and she could not decide for herself if she should stop. She therefore needed a verbal prompt and was completely dependent on this. There was a “fusional” connection between Marianne and the therapist, yet this was a connection without any dialogue. Her defencelessness made the therapist think about a baby that, having been fed, is put back into the crib. There is something strange about this: Marianne took up therapy because she is traumatized, but only played restful music and left it up to the therapist to take up the traumatic part of her inner life. At a certain point she followed the therapist a little, copying dynamic and rhythmic suggestions, and achieving some variety in her music on the basis of the stimulus of his music. For a while she seemed to make the projection less great, but then withdrew. The therapist experienced that he did not make a break, or play phrases, or take any space in the music. It was as if this was not possible yet, but would come later, when a real dialogue was formed.

Marianne explained in the verbal reflection that she still experienced her music as something that stood apart from herself. Nevertheless, she recognised in the therapist’s kalimbaphone music something of her previous aggressive side. The rhythms on the kalimbaphone corresponded with the rhythm in the poems that she wrote before her illness. This was a rhythmic figure she explained as aggressive against the outside world, an aggression that she could not display directly because such behaviour was not expected from her. In her family this was not allowed - or perhaps it was even denied. She commented that in the rhythm of her poems she made an attempt to shock the outside world. This was traumatic for other people because Marianne was repeating the aggression of which she was previously the victim. An image of a battered child arose spontaneously in the therapist, appearing unconsciously and arising out of his provocative playing. Marianne expressed the hope of continuing this

experiment with rhythms, even though she was aware of not being able to do that at this moment.

Second improvisation: “The preparation for becoming autonomous”

The therapist invited Marianne to improvise about rhythms and she surprised him by consciously choosing the kalimbaphone, and by asking the therapist to play this instrument as well. It is interesting that they played the same instrument and that by doing this she increasingly got the feeling that there was the potential to allow a space for this to happen. The improvisation on the kalimbaphone took a very interesting turn. Marianne started to play in a shy way, with the same alternating arm movement as she played on the alto-metallophone. The therapist took over this musical rocking and by reflecting her movement, he created a possibility for reflection. He hoped that an image could originate from this, but the therapist-patient relationship remained purely fusional, just like the mother-child relationship when the mother rocks the child to the rhythm of his crying.

The therapist started to play off the beat and with this action he began to differentiate himself from her. Now they were no longer one, but two. It was a kind of individualising, and it was the basis for a dialogue. The complexity of this situation lay in the fact that even though there were two individuals, the therapist was simultaneously resonating with Marianne in a projective identification. **[Excerpt 5]** The therapist introjected a part of Marianne. Detaching from each other was a de-projective movement and Marianne was able to take the projected part again into herself. The therapist increasingly experienced a dynamic movement in her music; he introduced rhythms and in response she tried to vary her music. She became increasingly distant from the abstract, light and ethereal aspects and moved towards the rough and more aggressive rhythmic music. **[Excerpt 6]** In the improvisation more cathartic elements were now present, because Marianne was now more able to present unbearable aspects of herself. The therapist experienced that she started to take the initiative. She played fragmented rhythms that she could not yet hold conceptually for some period of time. Each time she broke off the rhythms, she did not allow musical cells to develop and as a result of this the therapist was repeatedly made to feel that a real dialogue was not yet possible.

Through her choice to play the same instrument as the therapist, Marianne chose the fusional bond between the therapist and herself. It was as if there was no difference between them. Paradoxically, this situation made it easier to present difference, and to begin

differentiating. It also seemed to make it easier for Marianne to connect with her own aggression. In addition to this, she specifically chose the kalimbaphone, the instrument that she had first selected for the therapist and on which the therapist had played her aggression. This was the instrument on which she had projected her denied feelings and by choosing his instrument, it was as if she put herself in the therapist's place. Through this choice she identified with the therapist, or better, with the projected part in the therapist; she could now play the rough and aggressive aspects more readily. At that moment, it was Marianne who appropriated the projected material and, as a consequence, could play more autonomously. She probably would never have been able to do this by herself, without the support of the therapeutic relationship.

Some fragments of the improvisation have all the aspects of polyphony and by attuning the timbres to one another and moving in the same rhythm, both players each went their own way more freely. It was only from the moment that Marianne opened up to the voice of the other that she came into a cathartic connection with her own traumatic reality. Through the fusional affective resonance of the therapist, Marianne was able to define the distance to this reality and to allow gradually and in small fragments, a connection with traumatic material through a progressive assimilation of the musical form. It was very appropriate that this was a bit-by-bit process, because for the moment the synchronic moments still remained very fragmentary. The rhythms were not yet sustained for very long and were broken off abruptly each time. Marianne did not allow the further development of musical cells.

The therapist made a new appointment with Marianne. This time Marianne gave the therapist a rather strong handshake and left the music therapy room with more affect.

Fourth session: "The musical form 'Lieder ohne Worte'"

It was a different Marianne who entered the room for the next session. Her step was buoyant, she looked fresher and more dynamic, her glazed expression was gone and she wore a shirt with colourful motifs. Immediately she started to talk and reported that last week she was being "harassed" by rhythms and series of sounds: "They are sounds that come up in me continuously, but I could not do anything with them, I could not find any words any longer ... I also found it difficult to write them down. I tried to write them down, but ... they were irregular rhythms; they are the rhythms that also can be found in language. I don't know if I can do

something with them, because since yesterday they are gone and today they haven't come back. Since yesterday, however, I feel tensions."

The therapist invited her to improvise to these rhythms. **[Excerpt 7]** Marianne chose the kalimbaphone and asked if the therapist could play on the same instrument.

The improvisation began with a silence, a silence that Schmözl (1983) described with the term "Einstimmungs phase" in order to indicate that the musician is already present in the music before the music sounds. The retention of the music - which had already come across in the story about the rhythms and sound series - also seemed present during the improvisation. Marianne played the rhythmic figures, which were recognized by the therapist as the ones from the previous session. In her play there was now present a clear phrasing and an inner structure, and slowly a musical tension was built up. The therapist experienced this improvisation as authentic music, and as the re-appearance of Marianne's poetry that had been lost for such a long time. It was a story - an image or a 'Lied ohne Worte' - of which the therapist was allowed to be the witness. The therapist was now a listener, but as well as listening passively he looked for a metre in which to remain actively present. The play developed into a mutual interactive play, in which rhythmic themes were developed and integrated. The therapist felt completely free in taking the initiative and making use of Marianne's rhythmic ideas. The still-isolated islands of synchronicity from the previous session grew into a polyphonic mainland in which the players danced to each other's music. Marianne's body became free of the strict melancholic strait-jacket that had immobilised her. This was lifted up (*arsis*) and was placed down (*thesis*) movement within the rhythm of the music. Where during the sensorial play the therapist remained in a completely dependant relationship versus his patient (i.e. not being able to play what he wanted, not even able to think and exist), he was now free and autonomous, able to develop his own musical thoughts and to become entangled in a mutual musical interaction with the other.

This first form-giving (or proto-symbolising) was important and seemed to stem from the fact that during the following sessions the patient could continue with the creation of musical forms by making use of elements from the initial musical form. In this was she was able to establish a continuity with herself and develop her own musical style. For the first time, Marianne was able to conclude this improvisation together with the therapist.

In this improvisation Marianne reported not only that she rediscovered the rhythm in her poetry, but also that she could come into a dialogue with the therapist and recognize the

therapist as a subject. She could also experience her own restlessness and fear in the musical play. This was all new to her.

The desire to use her voice in the improvisations also arose during the verbal reflection. In order that she could be heard in society, Marianne wanted to rediscover her own lost voice in music therapy. The use of the voice in improvisations, however, was too frightening for her at this moment.

Epilogue

Marianne was released from the hospital about four months after the start of her individual music therapy sessions and left her therapist in a very touching way. She knew that she was not ready yet, but because of her release from the psychiatric centre it was impossible to continue the individual music therapy treatment.

5.2 Results

5.2.1 Analysis of data for the research

As specified in the method section, the video-excerpts were selected by specific criteria (see page 105) and the following figures illustrate the overall structure of the sessions from which these excerpts have been drawn. The relevant information here is the balance of elements and activity going on in the sessions.

5.2.1.1 Timeline of the sessions case study: Marianne

Colour code for interpreting the figures:



= video-fragments

Figure 5.2 : session 1

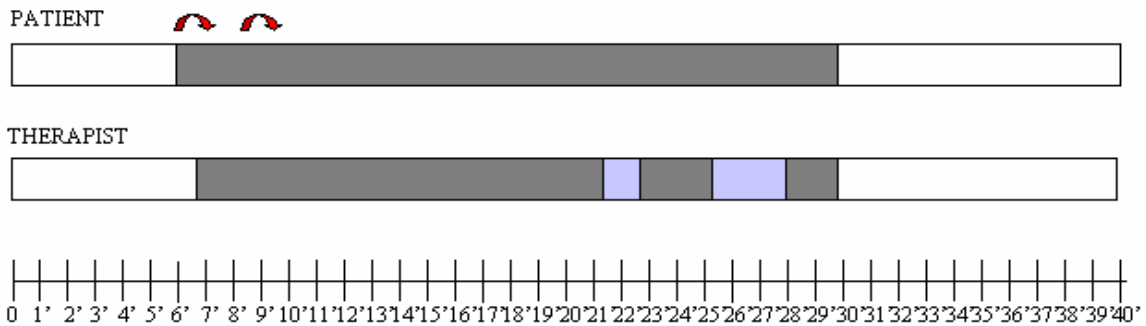


Figure 5.3.1

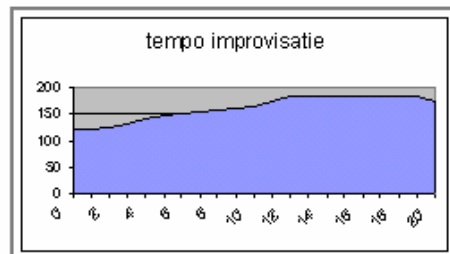
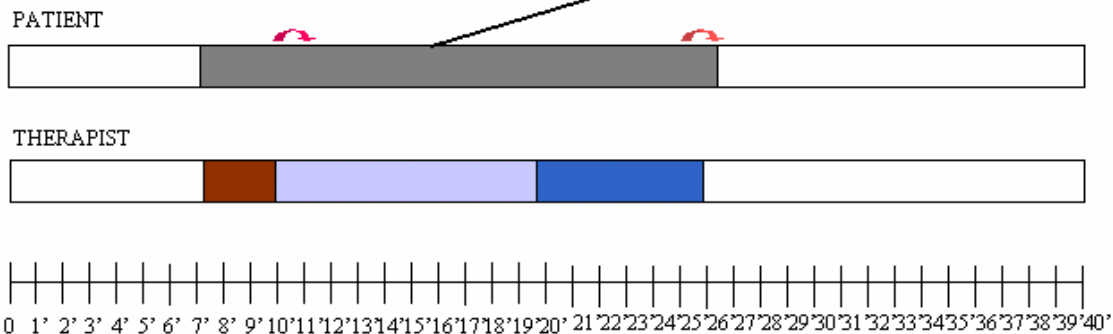


Figure 5.3 : session 2



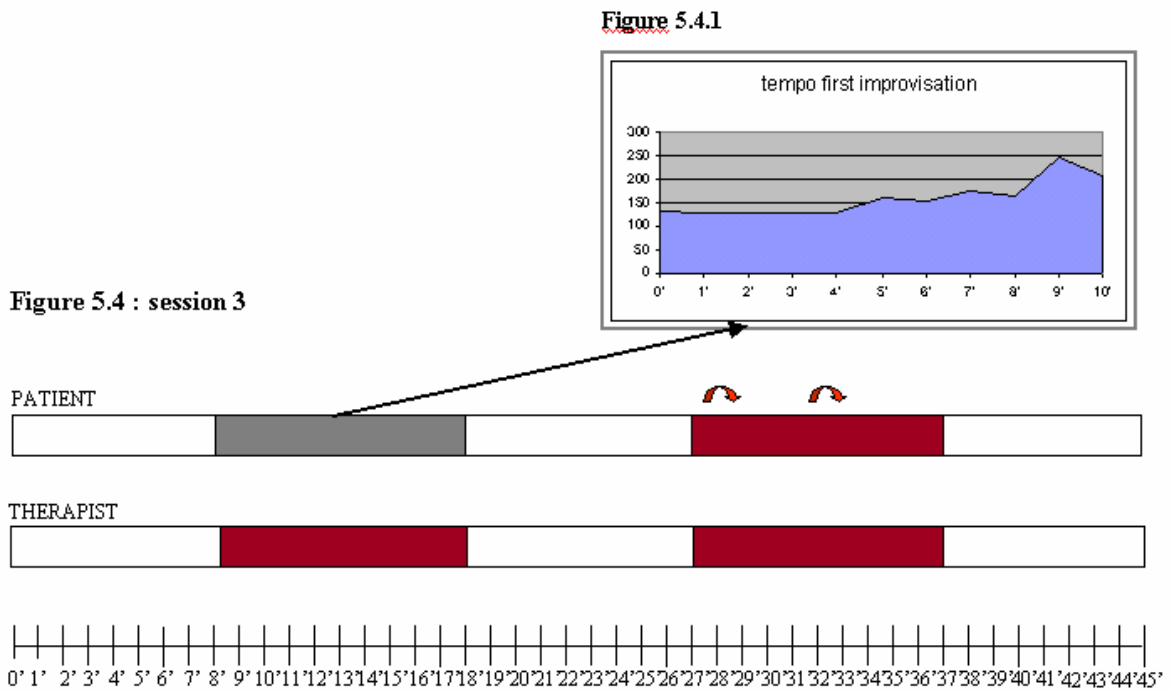
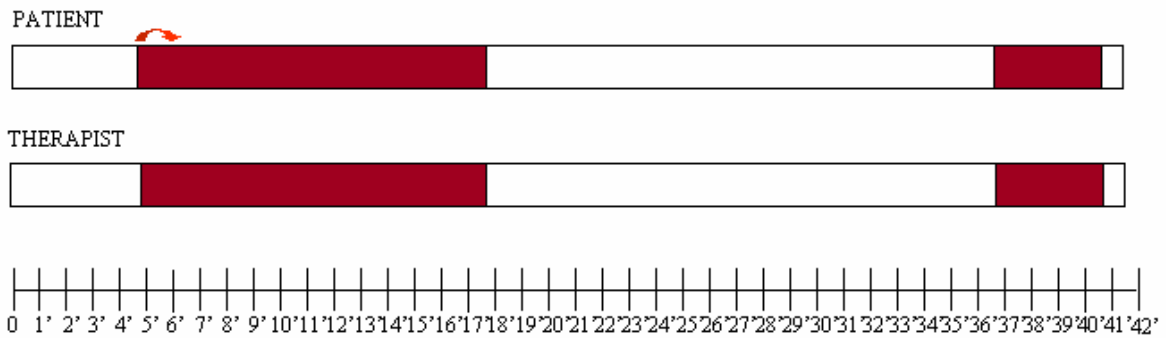


Figure 5.5 : session 4



In the figures relating to Marianne one can distinguish the three different instruments and the verbal reflections. From the analysis of these figures it is clear that the duration of the sessions lies between 40-45 minutes, which was the predetermined time scheduled for the therapy sessions. The number of improvisations per session is between one and two (see Table 5.1).

Table 5.1: Number of improvisations

Session	1	2	3	4
Number of improvisations	1	1	2	2
Duration (minutes)	24'	19.5'	Improvisation 1: 10' Improvisation 2: 10'	Improvisation 1: 13' Improvisation 2: 5'

In sessions 1 and 2, each time there was only one improvisation. From the 3rd session onwards, there were two improvisations within each session. This indicated a greater variety in sessions 3 and 4. The duration of each improvisation was between 10 and 24 minutes. The first two improvisations, which were also the longest, were illustrative of sensorial play and Marianne was only able to 'round off' these improvisations through the verbal intervention of the therapist. The improvisations in all four sessions were preceded by a verbal introduction, and followed by a verbal reflection.

One can follow the evolution in the music therapeutic process very well through the choice of instruments. In session 3, the therapist played consecutively the alto-metallophone, the piano and the kalimbaphone. In the same session, the patient exchanged the alto metallophone for the kalimbaphone and continued to play this instrument in the following session.

The figures also show that the patient began each improvisation with or before the therapist, and finished with or later than the therapist. It was notable that from time to time the therapist paused the music in sessions one and two, although from session three onwards, he no longer paused and always played with the patient. Figures 5.3.1 and 5.4.1 from sessions two and three illustrate the range of different tempi during the improvisations. The selected video excerpts represent each one of the treatment sessions. They were selected from the first (2 excerpts), second (2 excerpts), third (2 excerpts) and fourth session (1 excerpt), with the beginning of an improvisation from sessions 1 and 4, and an ending of an improvisation from session 2.

Table 5.2: Overview of the video-excerpts

video-excerpt	session	time
<i>Sensorial play</i>		
excerpt 1	session 1	00.00 - 01.00
excerpt 2	session 1	02.22 - 03.22
excerpt 3	session 2	10.42 - 11.42
excerpt 4	session 2	25.16 - 26.16
<i>Synchronicity</i>		
excerpt 5	session 3	27.20 - 28.30
excerpt 6	session 3	31.45 - 32.55
<i>Musical form</i>		
excerpt 7	session 4	04.05 - 05.05

5.2.1.2 Excerpt 1: “Musical introduction” [First session: 0’00” – 01’00”]

1. Description of the selected video-excerpts

The patient and the therapist are sitting at a slight angle to each other and between them are two alto-metallophones. The patient sits motionless, a little bent-over, without any facial expression and with her elbows pressed against her body. There is no observable tension in her body. She is not searching for eye contact with the therapist, looking only at the alto-metallophone that she chose for herself. The patient also chooses an alto-metallophone for the therapist.

While the therapist is in the process of putting a mallet on the floor, the patient starts to play, with no preparation or hesitation. Her arms move up and down in endless, alternating motoric movements. Her play is repetitive, never-ending, without phrasing, without any dynamics or nuance and without any apparent self-awareness or interaction with herself or the therapist. No noticeable single rhythmic, melodic or harmonic development occurs. There is no movement in the patient’s body that has any connection with what she is playing. The patient’s facial expression and body posture seem to be rather frozen and only her arms move loosely. The therapist sits motionless, his head bowed, his elbows resting on his legs, sunk in himself and listening to the patient’s play. His listening position seems like a reflection of the patient’s, which is that of a depressed person.

The therapist starts playing together with the patient after 24 seconds, sensing and joining the patient's metre. Immediately the therapist joins her play and his body is able to move in relation to his own musical phrasing. It is as if his body is breathing with the music he is playing.

The atmosphere is muddy, the music sounds empty and without any intention, interaction or meaning. For the listener, no source of inspiration can be found in this music.

2. *A notated score of each excerpt and a description of the musical elements*

The patient starts to play immediately, without any preparation or hesitation. There is no "anticipating inner silence"⁴ at the beginning of her improvisation. Her play is endlessly repetitive and has an interminable quality, which one can interpret as a kind of musical "rocking". Musically there is no phrasing, no dynamics and no accentuation, with no melodic or harmonic development. The music has the following characteristics: it is a random, atonal melody with alternating intervals and repetitive play. Rhythmically, there is no development and without a metre or pulse. The volume does not change and in this excerpt no musical theme can be heard.

As we can hear and experience in this musical excerpt, all notes are completely isolated from one another. No single note has any relation to what happened previously or what might happen after. There are a series of successive sounds that are not organized by silence, with no motion and no variety of dynamics. The lack of structure is significant here.

The musical play of the therapist is different. Searching for the patient's metre, the therapist begins to play the bass line. The bass line sounds more peaceful than her sensorial play, and even though without much dynamic there is phrasing. Musically, he does not provoke the patient to add any new elements to her play.

⁴ The term *anticipating inner silence* relates to the silence before the first sound is heard, and the inner sound emerging from that silence. Each authentic musical play originates from this anticipated silence, which makes it possible that one can come into resonance with oneself, and in a music therapeutic context, with the other.

Figure 5.6: Score of excerpt 1

Excerpt 1

♩ = ca. 66

Right hand

directed by the right hand

LH + RH static

Patient (alto-metallophone)

Left hand

directed by the left hand

directed by the left hand

Therapist (alto-metallophone)

no metre
no bars

LH + RH static

directed by the right hand

directed by the left hand

Alt-metallophone
Therapist

etc.....

This musical excerpt illustrates clearly the formlessness of the musical subject. Through an initial musical analysis of the succession of sounds within the melody line, the movement and direction of the melody seems to be involuntary and random. Initially one cannot see an obvious pattern, but through a closer examination, it is apparent that a few musical structures appear, such as a series of parallel thirds, fourths and fifths (3, 4, 5). The melodic movement is mainly directed by the left hand. We can also notice two musical pauses (organ points in the first and second system), where both hands appear to stagnate. It is possible to state that there is a certain (even though not yet clearly pronounced) phrasing, with structures that originate spontaneously and non-intentionally. It is as if this could be either music that starts looking for a form from its own self-generated product, or alternatively music that is the product of pure coincidence. There might also be an inherent musical tendency on the part of the patient to search for a form in the music, evidenced through the presence of traumatic repetitiveness in her playing.

The empathic listening stance of the therapist is illustrated in his musical play, in which he produces an almost identical melody line to the bass line of the patient (second system).

This happens intuitively and is definitely not consciously mirrored. The instruments are opposite to one another, so that it is out of the question that there is a direct imitation of the hands.

3. *Selected comment from the patient relating to his experience of playing*

The patient's reflection after the free improvisation was as follows:

Patient: "During the playing I am occupied with thoughts, but I cannot give this any place in the music. And then I just continue to play and then the playing becomes something routine and automatic. The play is then something mechanical, as if to hit out at something and then not think about it."

Here the patient illustrated that she could not appropriate her own material. She did not have the psychic space in which something musical could be thought about, let alone that a musical form could originate. The play was organised by a motoric act that was completely separate from her, entirely without intention and with no direction. Therefore, there was no potential for interaction or co-play with the therapist.

The patient: "If I planned to begin to colour a sheet of paper, and I don't have the desire for a cigarette or something else, I could colour the entire sheet until it is full."

Here she was pointing out the crowdedness within her psyche in a visual image. Her psyche was a compact, rigid and static space in which nothing was possible, and where there was no movement and no dynamic flexibility. Her mind was crowded with fragmented memories, fantasies, ideas, thoughts, and impressions. It was so compact that nothing could move or could emerge from her psyche. The musical sensorial play had a total compactness, was turned in on itself, had no direction, and no beginning or ending.

Therapist: "How did you experience the playing?"

Patient: "I cannot talk about that, this is difficult for me. I could describe it as something that is separate from me."

The patient experiences her musical contribution as something that is separated from her and something she is not in touch with. She does not have any feeling of connectedness with it. She recognized nothing from this music as relating in any way to her. She is not connected to her playing, and does not 'own' the sounds she is making; therefore, she is not able to describe it in words.

4. *Selected impressions and reflections from the therapist about the patient's way of playing*

During the playing, the therapist was wondering if the patient was conscious of the fact that she was playing an instrument when she produced a series of sounds. Her playing was endlessly repetitive, interminable, without any phrasing, dynamics or nuance, and without any interaction with herself or the therapist. The therapist experienced the playing as something barely perceptible, like a flow of sand through his fingers. He was not able to connect either with her or her musical play, excluded by its sensorial nature. She remained within a kind of "pleasure" state that made any kind of contribution from someone else impossible.

In the beginning the therapist tried to trace the metre that the patient would use, to join her play and to come into contact with her. But the therapist became desperate when he noticed that all his efforts were fruitless. The sound object remained an amorphous mass, floating in space without any aim, like a mush that neither the patient nor he could grasp. It was something that left from nowhere and that kept on spinning around aimlessly within itself. The autoerotic, repetitive object was static, did not move, and it could not be affected by a further musical process, where the music might open up into something new. The therapist was aware that he would only be able to communicate with the patient if there was a certain psychic space.

In the counter-transference it was impossible for the therapist to think, or even to fantasize about the patient and her music. He could not improvise freely, because he felt himself imprisoned by the patient. The experience of the therapist was uncertain, with a tensely fearful feeling not being able to make contact with the patient. The therapist did not feel free to respond to the patient. It felt to him as if this was all an experience of projective identification in his psyche and posture.

5. *Selected reflections from clinical intervention*

The patient plays in a motoric way, at a sensorial level and without being consciously aware of what she was doing. Although it does have a flowing motion, the therapist is not able to describe her play as a melody. In the beginning, the therapist sensed her metre and he started with a 'bourdon'⁵ in order to give her sensorial play a clear base, so that her music was grounded. He then developed the music towards a melody. In the beginning, the therapist

⁵ A bourdon is described as the use by client or therapist of a two note interval played simultaneously. The interval is normally a fourth or a fifth. The bourdon can be played through a stepwise melodic line.

faltered a little and played a melody under her flowing music. This introduction of a melody allows for imagination and the possibility of recapturing something and thus developing 'memory'. To recapture something is to take something up again, to vary it and to do something with it - to develop it. In this way the therapist contained the patient's music and he brought the repetitiveness to a close. This meant that he created a psychic space in which a communication with the patient could become possible. However, the patient did not react to this because she was stuck in pure repetitive state, within which there was no variation, no dynamics in the music that she was unable to stop. This could be an illustration of the absence of recapture or of memory. The therapist also noticed that he tried to introduce a certain dynamic in his music through the melody.

It is interesting that in the beginning, the therapist only focused on the music, that is, on the sound-world. It was only afterwards that he was focussed on the patient, as if he needed a musical space first (i.e. a psychic space) in which to come in contact with the patient. One can only have an image of the other if the right conditions are present where an image might arise. In music, this condition is noticeable in the reprise of a musical form (proto-symbolism). Through a melody, and its reprise, by remembering and through everything that does not fall within the monotony of the patient's music, a musical form was introduced by the therapist. The absence of musical form (melody, bourdon), occurs particularly in the music therapeutic treatment of psychosis. This pathology seems to go hand in hand with it being impossible to remember and imagine anything, or to come to an image. The therapist tried to create conditions, through the introduction of musical form, to offer possibilities for the patient to come to an image, or to remember something.

In the first instance, the patient presented herself as somebody who was traumatized, saying: 'This is my problem. I am an abused, traumatized woman'. She presented the image of a traumatized woman, musically producing a kind of aleatoric, repetitive music. She did not come to an image (i.e. a musical form) and did not have any intention to reach one. The flowing movement of her play was purely arbitrary. The patient was also not able to stop. She was not aware of the musical intervention or of the musical cadence of the therapist. She only stopped playing after the verbal intervention of the therapist.

The patient had reacted in a paranoid way towards the mother who had pursued her. Her mother had actively intruded into the patient's life and also that of the man with whom the patient lived and who abused her. She had an ambiguous attitude towards this man. On the one

hand, he was a threat, but on the other, she hoped that she might meet him again. Time and again, she hoped that they would meet again in a concrete as well as symbolic way. She also hoped to have other relationships in which only the traumatic part is present or repeats itself. This kind of ambiguity has parallels in the music, which is, in the repetitiveness and a sense of it being impossible to stop playing. The trauma came back in the endless repetitions that could never be stopped, of which no farewell was possible. It was directly paralleled in the fact that there was no farewell possible to those by whom she was abused.

Mimicry

When the therapist saw himself later on the video that he made of the session, he noticed that an outsider probably would not be able to tell who was the therapist and who was the patient. In a purely mimicking way the therapist was sitting bent-over, his hands pressed against his body and with a melancholic facial expression. This was a clear example of involuntary empathy. The music was the body in the sensorial modality, like the body of the listener that models itself to the music. Here the ‘dialogue’ between the therapist and the patient became a kind of mimicry, a fusional elimination of every subjective function on a purely physical level. This erasure of difference was also exactly what happened on a musical level - the therapist played an almost identical melody line to the bass line of the patient.

5.2.1.3 Excerpt 2: “The musical hesitation” [First session: 02.22 – 03.22]

1. Description of the selected video-excerpts

This excerpt occurs in the same improvisation as the first excerpt. The patient and the therapist are sitting a little at an angle to each other, sitting in the same posture as in the first excerpt. The patient, whose face is expressionless, is still looking towards her instrument and moves only her forearms. There is no eye contact between the patient and the therapist and both play an alto-metallophone, the patient playing her alternating sensorial melody and the therapist contributing a melody under the patient’s sensorial sounds.

When the therapist introduces the bourdon play (Figure 5.7, bar 3), the patient takes it over suddenly and unexpectedly (bar 6), and for the first time a rhythm emerges in her play. However, there is no rhythmic development and the patient goes back to her familiar sensorial play (bar 8), which could be described as an aleatoric alternated bourdon. This happens after

the therapist introduces a melody (bar 13) and again the patient hesitates.

2. A notated score of each excerpt and a description of the musical elements

The therapist first played a short melody (bars 1-2) underneath and accompanying the sensorial play of the patient, in the course of which he created a pause (i.e. a silence) and then moved to a bourdon play (bar 3). Unexpectedly, the patient imitated this way of playing and a single rhythm appeared in her music (bars 6-7). The patient did not retake or develop the therapist's rhythm but she continued with her familiar sensorial play, this time within a more aleatoric bourdon play. The patient accelerated the tempo of the music (bar 8) and the atmosphere became tenser. She used a greater pitch range on the alto-metallophone, but there was no melodic or harmonic development in her play. When the therapist introduced a melody, the patient stopped her bourdon play suddenly and unexpectedly, and switched over to her aleatoric sensorial play. However, she let the tempo which she had developed during her bourdon play continue in her alternating sensorial play. The therapist changed his playing twice, thus introducing a bourdon play to turn the music towards a melodic play, with this music holding a dynamic movement such as phrasing, pulsing and melodic development.

Figure 5.7: Score of excerpt 2

Excerpt 2

The score is divided into three main sections: **EXPOSITION** (measures 1-12), **DEVELOPMENT** (measures 13-16), and **RECAPITULATION** (measures 17-20). The Patient part (alto-metallophone) is marked with a tempo of ca. 69 and 'no metre no bars'. The Exposition section is further divided into A, A inversion, B, B' retrograde, and A' sections, with a 'hesitation' marked at the end. The Development section includes an 'imitation of the therapist' and an 'extended version of 1- 2- 3'. The Recapitulation section returns to the Exposition style. The Therapist part (alto-metallophone) includes a 'therapist plays drone' section and a 'variation on the interval a'e'' at the end.

A detailed musical analysis of this excerpt suggests a polyphonic sonatina⁶ form. A sonatina form implies three structuring sections - exposition, development and recapitulation - all of which can be found in this excerpt. After the development section, the patient falls back into the same way of playing as she presented in the beginning.

The “exposition” consists of a musical presentation of a perpetual movement, characterized by continuous quavers that are led by the accented left hand. The right hand moves along in a parallel way. The exposition can be described as an AA'-BB'-A' structure, where the A'- or B'-part could be considered a retrograde movement of the original A or B. The alternating rising and falling melodic lines are striking, with the tune carried by the left hand in B apparently an extension of the more doubtful A-version. The therapist intuitively plays a forthcoming melodic line for example where the e-phrygian is suggested in the therapist's melody and particularly in the descending line of this melody.

⁶ Sonatina: a short, easy or otherwise 'light' sonata, especially a piece whose first movement, in sonata form, has a very short development section (the term 'sonatina form' has occasionally been used for a movement with no development section).

In the third bar the therapist introduces new musical material (Figure 5.7, bar 10-12). This could be compared with an example from the classical repertoire such as *the Bells*, a composition for cembalo, where William Byrd (1543-1623) repeats a standard ii-i bourdon ostinato (*d'-a'*) (*e'-g'*) several times. Byrd lets the fifth "*d-a*" dissolve in a counter movement into "*e-g*", which harmonically gives *a* tonic- dominant effect in *d dorian*. In this excerpt (Figure 5.7) it is remarkable that after the therapist's three "cadences" (bars 3-6) a hesitation unexpectedly occurs in the patient's play. Two subdued chords appear (sounded as a simultaneous bourdon: bar 6) as a reaction to this stable, harmonic cadence appearing. For the first time, the patient introduces a phrased rhythm, although at this point it is speculative to assume that this is a form of phrasing. The surrounding figures around *e* (bar 8) are repeated three times. The therapist slowly separates the bourdon-ostinato material, interspersing it with other motivic material, structuring this and slowly changing the music to a slow and sober melody. It could be assumed that the patient then takes over by imitating the therapist's motifs. For example, the patient repeats the same chord 2 or 3 times at five different places in this last system, material that is echoed in the melodic extension of the ostinato with the therapist (bars 14-16). Just after the therapist played a complete monodic line, the patient falls back into the monotonous and repetitive sound stream as a delayed echo (sensorial play) of the beginning, a form of recapitulation of the initial musical material.

3. *Selected comment from the patient relating to his experience of playing*

There were no comments from the patient about this musical excerpt.

4. *Selected impressions and reflections from the therapist about the patient's way of playing*

During the continuous, monotonous play the therapist became aware of the fact that he wanted to encourage more variety in the patient's music and was therefore surprised and hopeful when, for the first time, the patient introduced a rhythm. It was the first rhythm during her nine months of music therapeutic treatment. However, her attitude remained the same and the therapist experienced no apparent intentional interaction. The patient remained as closed and as inaccessible as she was in the beginning. Even though the therapist had hoped that there might be a breakthrough, unfortunately this was not the case.

The therapist experienced no inner impulse to provoke the patient to change her play. Instead, he took a specific emphatic listening stance, in which he was open to the sounds that the patient produced. His own play was intuitively searching for phrasing, variation (i.e. varying alternating play with bourdon play), and musical phrases. The therapist wondered if he was looking for a musical form here. Perhaps he hoped that the creation of such space would be possible via the evocative power of music. It was possible that he could move the patient immediately and simultaneously with him, and let her 'dance' at the cadence by introducing a bourdon and perhaps a melody (see excerpt 2, bars 13-18). For the moment, he felt baffled and excluded by her isolated sensorial play, but he wondered if he would be able to create a form that she could assimilate, and through which he could exist for her. It was also possible that he might be able to choose the right form and the right moment through which the sounding music would also become her music.

The therapist was sitting there defeated and depressed. He embodied this in his posture and experienced it in his transference experience of his powerlessness to join her autistic, melancholic world. Somehow or other the therapist did succeed in a momentary breakthrough. He started a (bourdon) movement with a very slow metre, and it had an immediate effect. It was as if the patient was uplifted for a moment. It is possible to describe this as a kind of projective identification, where the therapist came to a playing style that was born out of the patient's psyche. Somehow, within this process, she was uplifted, even though it remained foreign to what was essential to her current inner state. The therapist started to play, but he felt his powerlessness, and he had the feeling that he was unable to play authentically. However, he was able to play from a clinical attitude that was not related to what happened within him, but that emanated from a therapeutic stance. The difficulty that he had doing this demonstrated how intensively the therapeutic reaction was at this point. In spite of feeling paralysed and unable to play, the therapist was able to function from a therapeutic reaction. This was only possible through resonating with the patient's world and through this the patient found it possible to be lifted for a moment from her autistic, isolated state. The experience of being lifted out of the isolated autistic state occurred outside a musical form and therefore could not be psychologically grounded.

5. *Selected reflections from clinical intervention*

This excerpt illustrates a kind of ‘musical hesitation’. The therapist played a short melody and then introduced a pause. Perhaps this silence opened up a possibility for something new to appear, because certainly a space was created through it. The therapist stepped out of his lethargy and into his bourdon play, which was a new element in his music. It had an obvious effect and the patient now played simultaneously with her stick just like the therapist did, imitating his way of playing. When the therapist introduced the moving bourdon there was a tendency towards a pulse. There was a musical hesitation in the patient’s play through her use of a sudden and unexpected phrasing. For a moment she came out of her isolation, but she was not yet completely independent. She was still reliant on the therapist, because her contribution remained in imitation.

This opening closed up again and the patient could not give up her sensorial play. She merely incorporated the change when the therapist introduced a melody, having become bogged down in her sensorial play. It is not possible to state that the patient came out of the sensorial play when she was playing a kind of imitation of the therapist’s play and this was confirmed by the fact that she did not further develop the rhythm. If the patient could internalise the metre, she would continue to play and develop something in this rush of music, and only then could something be externalised from within the patient. However, this theory cannot be assumed and the music remained a pure imitation of the therapist’s contribution. In this way, the patient never left her sensorial play. The only variation was that she happened to come into another modality - the modality of the therapist.

We can also see this in the sensorial play of a musician who, for example, puts in an extreme effort to only play as his teacher prefers (i.e. re-creating the teacher’s version of the music, with no connection to himself). This is rather like the person who sticks to the notes of the score, without any interpretation, or something similar to an adult autistic person who can play the preludes and fugues of Bach perfectly, but ends up with an affectively ‘dead’ piece of music because he does not connect with the music at an emotional level. In the example, the patient did not internalise what happened. In fact, nothing at all seemed to have happened. This excerpt is therefore interesting not only because it demonstrates another modality of sensorial play, but that it also shows how, in the counter-transference or the therapeutic reaction, something can be provoked and that in any given moment the patient could open up towards an ‘other’. It shows that there is a kind of music that joins things together, that enables links to the

other. In the moment there is this kind of graft, the other can become a subject. In this example, the patient did not yet succeed in internalising her music and she immediately sank into the sensorial. There was no graft here; there was only a reaction to the therapist's play, and nothing further developed. This is rather like the psychotic who talks, but whose words have no meaning. There is no connection with the inner life.

***5.2.1.4 Excerpt 3: "Illustration of sensorial play: the mud" [Second session: 10'42''
– 11'42'']***

1. Description of the selected video-excerpts

The patient sits opposite the therapist with the alto-metallophone she chose for herself, and the kalimbaphone that she chose for the therapist. The patient sits in the same posture as in the previous video-excerpts. Her playing is very specifically in the style of sensorial play. The therapist does not play but listens in a motionless position, leaning backwards after a while. His head is somewhat bowed and he holds both his sticks in his left hand, while his right hand supports his chin. This evokes the image of a therapist pondering over the material of the patient. Again, there is no eye contact - the patient only has eyes for her instrument, while the therapist cautiously lets his glance slide toward her. This isolated play, in which the therapist does not participate, incites an atmosphere of desolation and emptiness.

2. A notated score of each excerpt and a description of the musical elements

It was an interminable, alternating play, with no beginning or ending. As indicated in the transcription, the motion of both hands was purely arbitrary. The play was not grounded in a harmonic structure. Musically, there was no phrasing, dynamics, accentuation, nor silence, and no single rhythmic, melodic or harmonic development appeared. As could be heard and experienced in this excerpt, the notes were isolated from each other, with no single note having any relation to what happened previously or what would follow. This is a series of successive sounds that are not even organised by silence – in a sense, it was a motionless play. It can be described as a purely compressed repetitiveness, perhaps even a perfect illustration of a sensorial play.

Figure 5.8: Score of excerpt 3

Excerpt 3

♩ = ca. 58
directed by the left hand

Patient
(alto-metallophone)

1 no metre
no bars

6

11 inversion of a

The patient plays alone on the alto-metallophone, and for the whole of this excerpt the musical absence of the music therapist is apparent. This is an interminable, alternating play, with no beginning or ending. What is also striking in this excerpt is that there is a succession of sounds, without any diversity in the rhythm. There is no noticeable variability in the tempo, no perceivable accents and a lack of variation in dynamics. The play is not grounded in a harmonic structure and there is a pitch range of a tenth (between g' and b''). The music is directed by the left hand, while the right hand follows the left hand in parallel movements and sometimes in contrary motion. These parallel movements consist mostly of thirds and seconds, with a sixth-interval now and then. There is frequent repetition of motivic cells. These cells often comprise three rising and one falling second (e.g. bars 2, 3, 5, 7, 9, and 10), as seen in the motif $a' - b' - c'' - b'$ which is repeated up to five times. There is a reflection of the preceding pattern figure in bar 11 and from bar 12 one finds a frequent repetition, up to five times, of the musical cell $f'' - e''$.

There appears to be a rising musical suspense originating in the last four bars of this excerpt, where a group of 28 notes forms a seventh ($c'' - b''$) in the higher octave of the register.

An important issue to be addressed later is whether these apparent musical structures are intentional or whether they emerge by chance from a coincidental motoric movement of hands and body.

3. *Selected comment from the patient relating to his experience of playing*

There were no comments from the patient about this musical excerpt.

4. *Selected impressions and reflections from the therapist about the patient's way of playing*

During this session the patient chose another instrument for the therapist - the kalimbaphone. In this way, she introduced a variation from the previous improvisation. She chose an instrument with a timbre that had a certain rough quality, but kept this at a distance for a moment by giving this instrument to the therapist while she remained within the safety of the alto-metallophone. The patient knew the kalimbaphone from the group sessions, but she never played it during group therapy.

Again, the patient was presenting her sensorial play and as a result the therapist was driven into a sense of desperate isolation and emptiness. It was impossible for him to come into resonance with the patient or with her playing. After some hopeless efforts to join her playing, the therapist thought, "does it make sense to play with her music? Would it not be better to be only receptively present? Why would I not just accept that she'd rather remain in her regressive play, alone, without contact with someone else?" It was understandable why this paranoid woman would be so reluctant to experience any kind of contact, especially when it was as intrusive as music can be. Perhaps, for the patient, it was more important that someone just listened to her, rather than for her to feel affected by the presence of someone else demanding a response. The therapist withdrew into a receptive stance and waited patiently.

There was something unbearable in the patient's music. Through the slow accelerando of her play, a certain tension originated, as if a question appeared. The therapist experienced that the patient had addressed a plea to him, as if saying, "now, you are leaving me to my fate". Via projective identification, the therapist became aware of this. It was an unbearable plea, rather

like a kind of silent scream. The patient did not have any autonomy and in this way, her music could only be a plea in order to create a space for something new, something that could only come from the therapist. The therapist experienced that she was not able to discover this space all by herself and that she was completely dependent on him for this experience.

5. *Selected reflections from clinical intervention*

It was interesting that she chose the alto-metallophone for herself, the instrument with a more sublimated (in the Freudian sense) sound, and that she delegated the representation of the roughness to the therapist. After a while the therapist stopped playing. The patient was completely isolated and no single contact was possible. A sense of emptiness was explicitly present. The therapist's physical posture was identical to hers in that while listening he assumed the same posture. It could be posited that the therapist listened with the same body posture in order to be able to listen at the patient's level. Perhaps the therapist quietly hoped that a recollection could originate.

The patient's music could be described as impressionistic, with a challenge for the musician-therapist to understand this. There was no single structure or phrasing in this music - for example, the patient played a high tone but did not use it again. She did not develop material in this improvisation, just as she did not develop material from the previous session. She could, for example, join in the bourdon play, but obviously she was not able to do that on this occasion. The patient could not recall the musical form or incorporate anything into her music - she did not develop anything into a form. Obviously she hoped that a certain melody would originate, but that did not happen. The only change to her solo-play was that the tempo increased. At this point, one could wonder if the playing made any sense, or that it had any significance for the therapy. This was true diagnostically. This playing was an illustration of how music could come to the traumatic level. However, the question was whether or not it was possible to describe this as 'music'. In many ways it was only a pure successiveness of sounds, without any form. It was just a repetitiveness.

5.2.1.5 Excerpt 4: “Inability to end an improvisation” [Second session: 25’16 – 26’16]

1. Description of the selected video-excerpts

This excerpt is situated within the same improvisation as the third excerpt. The patient sits in front of the alto-metallophone, which is opposite the kalimbaphone. Without moving his chair, the therapist has turned towards the piano. The patient sits and plays with a motionless body apart from her forearms which move up and down in an almost automatic movement. She does not show any facial expression. The therapist turns towards the piano with his head fully in the direction of the keys. In this way no visual contact is possible. The patient plays in her very typical sensorial way on the alto-metallophone. The therapist plays a final cadence on the piano, in order to show that it might be possible for the improvisation to end. The patient, however, keeps playing imperturbably. The therapist stops playing, lets the final note continue to resonate, and turns slowly towards the patient. His head is still bowed, numbed by the empty, oppressive atmosphere. He continues to listen to her ongoing music for about half a minute. Then, he raises himself up, looks at the patient and says almost inaudibly that the patient can stop playing. Suddenly, the patient stops playing and then puts the little hammers on the alto-metallophone. She lays both her hands on her knees and sits motionless and tense. The patient and the therapist look at each other.

2. A notated score of each excerpt and a description of the musical elements

The therapist played a harmonic final cadence on the piano and let the chord continue to resonate. It was a sober, contained, grounded music that showed where the ending-point was. The patient played an aleatoric, alternating bourdon, which she finished abruptly after a barely audible intervention from the therapist. She had not let the last tones resonate and there was no preparation to round off the improvisation.

Figure 5.9: Score of excerpt 4

Excerpt 4

no musical contact between therapist and patient

ca. 96

Therapist (piano)

Patient (alto-metallophone)

1 directed by the left hand

(1 up 3 down)

inversion of bar

repetition of bar 6

(stationary)

8 recapitulation of bar 6, 7 and 8

15

(1 down 3 up)

transposed inversion of bar 1

repetition of bar 18

(stationary)

The patient plays the alto-metallophone, while the therapist plays the piano. It is striking that immediately one can notice the continuous stream of the patient's sounds. This succession of tones is completely disconnected from the play of the therapist and is in no way influenced by this. The therapist lets his music end with a cadence in c major and allows his last chord to sustain and resonate.

From the musical analysis, a flowing line is apparent in the play of the patient, which can be heard as a 4/4 metre (see bar 1). This 4/4 measure is developed from the cells (as in bars 1 and 3) and motifs (bars 2, 4, 5, 6). The pitch range of the melody is restricted to a ninth (*f'*-*g''*). The melody of the patient inclines towards an Aeolian modal harmony because the variants of some melodic cells contains notes of the mode and tend towards a tonic note *a'*.

It is evident that this music is directed by the left hand of the patient and that the right hand is either in an contrary motion (i.e. following the left hand at bars 1, 2, 13), or in parallel movements (where it evolves out of the left-hand music at bars 3-8, 14-15 and 18).

The dominant feature is the patient's stepwise melody moving in intervals of a second, with the smallest musical cell comprising the (as in bar 1) or falling (as in bar 3) interval of a second.

The first variant of this smallest cell is a group of four tones, which are usually a combination of one rising and three falling tones (bars 2-5-9-12-14-21), or three falling tones and one rising tone (bars 4-11). Through the frequent repetition of these motifs, even bigger units originate, which in turn are repeated. The motivic material in bars 4-5 and 6 is a repetition of bars 11-12 and 13. Bars 18 and 19 are an inversion of bar 5.

The central feature of the twenty bars is a single bar (bar 10), where the pedal note occurs as a single, motionless point that marks the movement of the music towards a tonic-dominant cadence. Just as in the first musical excerpt, there is some evidence of a non-intentional and consequently coincidental phrasing on the part of the patient.

It is striking that the group of the “1-up and 3-down” (bar 2) motifs come to the fore. Tonally and harmonically, within the ‘b’ and ‘g’ pitch range, the music naturally moves around the tonic note. A logical explanation for the melodic line is that motifs originate and centre around a’ in this fragment - for example in bars 5 - 6 and bars 18-19 where the melodic figure ‘a’-g’-a’-b’ emerges. Here the a’ is heard twice, but because there is a rising movement from the g’, there is the effect of the g’ working unconsciously as a dominant cadence, as it is the leading note of the Aeolian mode. In this way the a’ pitch becomes strengthened within this motivic material. It is notable that these two forms (1 up and 3 down motif and 1 down and 3 up motif) follow frequently after each other. This may be because the first group (1 up and 3 down motif) is centred on the tonic, with the second group (1 down and 3 up motif), centred on the dominant. We can see that these two groups give a direction toward the same tonic and this phenomenon is seen in bars 4-5-6-8-9, 12-13-14 and 18-19. There is no noticeable musical interaction between patient and therapist during the first four bars. The melodic line of the patient is not embedded in the structured play of the therapist and these two musical parties stand completely separate from each other.

3. Selected comment from the patient relating to his experience of playing

In the verbal reflection the patient said absolutely nothing about what had an impact upon her during the improvisation. Nothing penetrated her conscious state; for instance, the patient did not even notice the melody on the piano.

4. *Selected impressions and reflections from the therapist about the patient's way of playing*

As an answer to the call that the patient gave through her repetitive, endless play, the therapist intuitively sat down at the piano and started to play a simple melody. He played this melody so cautiously that it was almost impossible to distinguish it from the patient's playing in regards to tone, colour, pace and volume. By playing the piano, the therapist broke the promise not to choose an instrument that the patient did not allocate for him. This promise-breaking was inspired by the therapist's desperation and the fundamental need to exist, not only partially, but within the completeness of a musical form, played on his own personal melodic instrument.

The therapist felt isolated from the patient and her musical play. He played to survive, in order to exist within her sensorial play. He tried to break through the endlessness of the patient's play through the presentation of the hint of a musical form, by playing a cadence and therefore suggesting the end of the improvisation. However, the patient did not seem to notice anything of this and she kept on playing imperturbably in the same repetitive way. Only when the therapist invited her verbally to end her play, did she stop immediately, without any rounding off, and then put down the little hammers on the alto-metallophone. At this point the therapist experienced a silence that was as regressive as the play. He felt her emptiness intensely. It was as if this compact silence was a continuation of her sensorial play, within which it was not possible to notice a difference between playing and not playing.

5. *Selected reflections from clinical interview*

One possible interpretation of this music would be that not being able to stop can be linked to the patient's issue of reacting in a paranoid way to her intrusive mother and her former boyfriend. On the one hand there is the threat and the fear of seeing that man again, but on the other hand, she longs to meet him. This kind of ambiguity is reflected in her inability to stop playing. It is the repetitiveness and the traumatic element that is in turn repeated continuously. This traumatic repetitiveness cannot be stopped, as if no farewell could be given to those who abused her. The patient had always hoped to meet that man again or that she would have relationships in which only the traumatic elements were present. This compulsion to repeat was expressed in the patient's not being able to stop the improvisation.

The patient's posture after stopping the improvisation was also interesting. It was as if she looked for support by holding both her knees with her hands, and perhaps this was the only way that she could stop her automatic locomotive movements. There was an experience of compact silence; no sound was produced, but the silence remained as a sensorial phenomenon. The patient remained seated in this sensorial posture and there was no difference between how she sat and how she played. This was also apparent in the way that she played, because she did not move to the music. In this instance it was not even possible to describe this play as music. The playing and not-playing remained sensorial. While with the therapist some changes were noticeable during the play (for example, when a phrasing took place), with the patient there was no such variety.

Epilogue: after the session

The improvisation had lasted for 19'14". During the improvisation not only was there no connection between patient and therapist, but there was no possibility for such contact. This had a dramatic effect on the therapist, resulting in his inability to improvise or to feel able to create any music at all. After the session the therapist was left with an empty and powerless feeling. This emptiness was very intense, but in contrast to the patient, the therapist was able to tolerate and digest it by improvising afterwards on the piano. Carrying all that had affected him during the session, the therapist went to the piano and played a simple melody, aiming to bring the emptiness and powerlessness into a form and allowing the music to process what was there. The melodic theme that appeared was sober, flat and disconsolate, almost without any rhythm, but with a clear phrasing. While repeating the simple melody he added a second, accompanying voice. The improvisation developed into a polyphonic texture, with the theme supported by the clear second voice. Everything became more dynamic and a harmonic development arose. The simple melody was transformed into a powerful, rhythmic chord-play that made the therapist feel he was able to come into resonance again with himself, and with the hopeful image of the patient who had asked him a question and had come to his session. The improvisation developed into music that was full of fantasy and ran through all possible variations of the melodic theme. This theme appeared frequently and unexpectedly throughout the improvisation, each time with a different countermelody bringing its own sound colour. It was only when he succeeded in forming a 'musical image' of the impressions of the past session that the therapist was able to round off the improvisation with an extended cadence. The mental

digestion of musical improvisation made it possible for the therapist to withdraw from a submergence into the mimicry. The therapist found it was possible to contain the empty and melancholic affect in an image and could thus experience the patient's questions on a musical and psychic level.

5.2.1.6 Excerpt 5: "The chance/first meeting"[Third session; second improvisation: 27'20" – 28'30"]

1. Description of the selected video-excerpts

The patient and the therapist are sitting across from each other, with the kalimbaphone standing between them. Both patient and therapist are sitting close to the instrument with both visually focussed on the instrument.

The patient's body is more mobile and involved in the play. An intensity that corresponds to the tension in the music is noticeable in her body, suggesting that the music is integrated and embodied within her. The rhythmic movement in the music is also noticeable in the therapist's body and there is a definite enthusiasm showing in his music. However, there is no tension in this enthusiasm and a real authenticity speaks through the interplay. Between patient and therapist a dynamic, rhythmic question and answer interaction appears. Both are musically involved with each other and there is strong musical connection and contact between them. They are searching for each other's rhythm, through the experience of interacting. There are sequences in the music where the little mallets used by the therapist and patient on the instruments move rhythmically in the same tempo. It is like a dance, where both patient and therapist move in the same way. On one occasion it develops into a rocking rhythm in which the patient as well as the therapist move together, although it is the patient who interrupts this shared musical movement by way of short rhythmic impulses. There is no real development of rhythmic themes because the patient always stops any potential development. However, after an *accelerando* and a *crescendo* a new rhythmical theme follows. On one occasion it becomes a rocking rhythm in which both patient and therapist move, until the patient again stops this.

For the first time, silence appears in the patient's music. This silence is necessary for patient and therapist to be able to react to one another; it gives a space for this, for the one to be heard by the other and for each to hear themselves.

The improvisation is coloured rhythmically, with variation of dynamics and all musical parameters. Playing with mallets on the wooden keys kalimbaphone as in this improvisation does not sound aggressive, but more like a playful, musical game.

2. A notated score of each excerpt and a description of the musical elements

In this excerpt a clear rhythmic play emerged, in which different rhythmic figures succeeded each other in a surprisingly fast way. There were variations in tempo, dynamics, metre, accents and a richness of different rhythms that appeared suddenly but also soon disappeared. The potential rhythmic developments were always halted by an *accelerando* and a *crescendo* from the patient, which the therapist followed. On each occasion a new rhythm originated after the *accelerandi* (in itself a kind of musical discharge) (C, A', C').

The swinging, rocking character had its origin within the improvisation process. It became a real musical duet, where the body movements of patient and therapist moved synchronically in the same pulse. The sudden silences, like pauses or a held breath, appeared for the first time and intensified the musical interaction within the duet.

Figure 5.10: Score of excerpt 5

Excerpt 5
 ♩ = ca. 120

Patient
 (kalimbaphone)

Therapist

1 2 3 4 5 6 7 8 *accel.*

9 10 11 12 13 14 15 16

17 18 19 20 21

5 accents 6 accents 7 accents

B

unstable pulse

SYNCHRONICITY occurs *p*

C *silence occurs* *pause* *pause* *pause* *pause* **B**

interactive play

A'

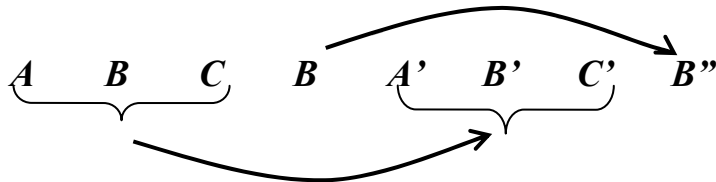
1 2 3 4 5 *accelerando* 6 7

B' *swinging synchronicity* **C'** *pause*

B'' *interactive play*

This is rhythmically the most complex of all the music excerpts. One might even speak of a rondo form here, because a number of the musical segments resemble each other and recur in a varied form and order. Table 5.3 demonstrates the music structure built in to excerpt 5.

Table 5.3: *The rondo-form, with thematic material*



As indicated in Table 5.3, the themes progress as follows:

A runs until the first semiquavers in the fourth system of Figure 5.10

B begins at the demisemiquavers-series at the same point on this first page

C begins on the second page after the two fourth sixteenths series played by the therapist

B is resumed at the first system of the second page where the semiquavers are repeated

A' reappears at the end of the second system of the second page, in the last bar

B' begins at the sixteenths in the fourth system of the second page

C' begins where the fourth system semiquavers of the previous theme (*B'*) ends

B'' is the transition from the last system of eighths back to the sixteenths notes series

Analysis of excerpt 5 provided the following description of the musical characteristics:

A is characterized by regular accents every four eighths, which as a rhythmical ostinato suggesting the 2/4 bar feeling. This is repeated 20 times. Above the ostinato there is improvised music, with a return of the upbeat motif with demisemiquavers in bar 7 and bar 11. The transitional stage from *A* to *B* is characterized by synchronized accents and a crescendo from mezzoforte to forte.

B is a continuation of *A* because it evokes a higher musical density by the apparent acceleration of the tempo, or like a doubling of the number of notes per pulse. There is a “diminutio avant la lettre” - a sort of “alla breve” feeling - that is first introduced by the

therapist and then answered by the patient. There are also pulse-accents played sporadically, but not as much as in the ostinato play of the therapist in A.

In terms of musical content, C is a continuation of B. In this fragment there is certainly more tension than in A. This fragment is, however, abruptly broken off. In this instance, it is possible that the tension is no longer bearable for the patient.⁷

C is characterized by a more musical interaction between lower-and-upper parties: question (accent) and answer, silence and sound. The first silent pauses appear, resulting in a certain phrasing of the rhythmical play. The same musical question and answer repeats four times and moves towards B. B is now much shorter than in the beginning, as found in the re-exposition of a sonata form when the recurring thematic material is transposed and often curtailed. In addition, the return of A in A' has the same re-exposition characteristics, in particular, a musical recognition by the player who, at the same time is also a listener. This makes A' approximately half the value of the accented beat as A. In fact the section from A to B builds up initially to the high point C, after which there is a diminuendo within the B to A' section.

The upper part develops the two-quaver rhythm into dance-like music in triplet time (seen in A', system 7), which in turn moves towards B'. This seems like a build-up to a second high point (C'), which has less power and tension than the first high point at C. This small fragment of C' is interesting because here we have the mirror of C. The patient uses and adapts musical material from the previous C section.

It is striking that it is the therapist who takes up the Left Hand role in this musical excerpt. The therapist plays in a very sober way with clear accents (bars 1-20). This continues until bar 20. The patient develops a melodic rhythm line over the simple play of the therapist, with different variations used. When the patient takes over the pulsed music from bar 21 the therapist ceases playing the accents and a shared, accented music appears. This then develops further into less constrained, freer play and after this the therapist places accents and thus structures the play. As a result, the music becomes more homogenous.

⁷ In the baroque rhetoric one speaks of a *tnesis* here, *tnesis* being the Greek term for an abrupt interruption, and here of a continuing stream of sounds. J.S. Bach also made use of this rhetorical means, such as in the fugue in *c* of the *Wohltemperierte Klavier*, book II. Here one sees this typical *strettofuga* at the beginning of the fourteenth bar (14 = Bach), exactly at the halfway point of the whole fuga of 28 bars. At this place he will place a triple octave *G*. Here the semiquaver stream of sounds stops unexpectedly and the second part begins with *strettos* in all possible forms.

3. *Selected comment from the patient relating to his experience of playing*

The patient experienced the timbre of the kalimbaphone as the aggressive aspect of herself.

The patient reported, "Aggression is my battle against the world. The rhythm in my thoughts is the aggression that I just cannot show." The patient wanted to write a poem on one single rhythm, a rhythm that the outside world did not expect from her at all and out of this thought she decided to experiment with rhythm.

Patient: "For the moment it is this that I cannot really get off my chest, the aggression that I put in my poems, in the past. This is the reason why I am fascinated by Dadaism⁸."

The patient wrote poems before she became psychotic, but then she lost this capacity.

4. *Selected impressions and reflections from the therapist about the patient's way of playing*

From her renewed play on the kalimbaphone the therapist concluded that the patient wanted to experience the traumatic with others. She wanted to allow something from the rhythm of the poems to emerge, material which she knew shocked others, and which served as a revenge for the attacks that she took in the past and present.

During the improvisation the therapist experienced moments of complete freedom, a freedom that he had not encountered previously in improvisations with this patient. During this improvisation he could let go of the dependency and cautiousness, and a feeling of pleasure occurred - a music-making pleasure. During this kind of play the therapist drew on an inner source of energy that was fundamentally connected with a deeper awareness of himself in the therapy setting. He also felt more powerful in his play and did not have to hold back in playing with the patient as in previous improvisations. A space was created that allowed all interaction and within it was a moment of intense contact and a real co-play, with a convergence of the different rhythms. The therapist had an intense experience of the patient coming close and distancing musically. He was moved by this music, with its intensity and mutuality and with the fact that this was a shared musical space within which he no longer wondered that the patient might be able to hold or not. In the co-play the therapist felt that he could play in the same timbre of the play of the patient. In this sense the tonal quality of the sounds was connected to each way of playing.

⁸ Dadaism or da'da originated in 1916 from the anarchistic movement in art and literature.

5. *Selected reflections from clinical intervision*

The therapist invited the patient to continue improvising after the first improvisation, and the patient chose to play the kalimbaphone together with the therapist. It is interesting that the patient and the therapist played one instrument together and that it was the kalimbaphone - the rough-sounding instrument. The patient had abandoned the instrument she had been playing (i.e. the clear, soft-sounding, rather heavenly alto-metallophone) for the rough and outspoken rhythmic music of the kalimbaphone. By choosing the same musical instrument as the therapist, she opened the possibility for a more symbiotic and close musical interaction. The therapist's instrument (the rough-sounding instrument), now became a shared instrument. The patient identified with the therapist and she also started to play the rough sounded instrument, which was able to carry her traumatic material.

With her choice to play the same instrument the patient allowed the beginning of a fusion with the therapist. The former distinction between the instrument of the patient and that of the therapist was no longer there, yet in this fusional context it was almost natural that this differentiation occurred. This was an interesting paradox because of the fact that the patient and the therapist were playing the same instrument, that the patient identified with the therapist and that a space originated where both could become independent. The patient found the freedom to create musical images. The therapist also felt this way during the play. He was no longer the one who played in a particular way for the patient and he could now be autonomous. In the moment that the patient connected with her traumatic experiences and then integrated this she made it possible for the therapist to achieve some autonomy. She gave the therapist the freedom not to be in the purely objective position anymore. He experienced that he was no longer abused and that she was not draining him. The patient stopped projecting onto him, but at the same time there was projection on another level. There was no projective identification, but rather an identification with the projected part in the therapist. The therapist was now able to play with complete freedom because the patient carried what was previously projected through identification with the therapist.

One question remained that related to which position the therapist now would take. At this point his status changed and it was mainly the patient who realised that she had an identification with what was projected. For the patient, the therapist became a representative of the repelled and the traumatic, which was the very thing that she must resist connection to and

protect herself against at all costs. Significantly, it was this that she then appropriated and therefore was able to develop into autonomous play.

5.2.1.7 Excerpt 6: “A playful musical space” [Third session; second improvisation: 31’45” – 32’55”]

1. Description of the selected video-excerpts

This excerpt is a continuation of the previous one and comes from the same improvisation. The patient and the therapist are sitting opposite each other. The patient and the therapist sit opposite each other, their supporting the kalimbaphone that is between them. In this excerpt the therapist looks more directly at the patient. In this way the therapist can record how the patient responds to the musical questions or interventions visually. Both patient and therapist are embodied in the music. The play is communicative, with ‘questions’ and ‘answers’ occurring within the shared dynamic music. The therapist plays provocatively in the first section and the patient is able to handle this therapeutic provocation. This suggests that she can alter her playing. On one occasion, after an *accelerando*, the patient creates a silence, which becomes very tense and full of expectation. The therapist looks at the patient questioningly. The patient does not look at the therapist, but she answers the expectant silence with a single sound on her instrument. The therapist reacts by also playing one beat with both sticks, after which the patient repeats her single sound and the therapist answers in the same way. The kalimbaphone play develops in the style of ‘drum-rolls’ and it is the patient who brings about this variation.

This is a dynamic and tense play.

2. A notated score of each excerpt and a description of the musical elements

A striking musical element in this excerpt was the development of short silences or, held spaces (bars 3, 4 and 10). Here, the patient created a silence that was also noticed by the therapist, through which an opening appeared within which something else could emerge. It was a conscious, tense silence, with a sense of anticipation of what might originate from it. After this, a question-answer dialogue developed which became the patient’s conscious play with hesitations and could be described as a play of silence and sound. More space was therefore created in this music in which patient and therapist were focused on each other.

A new musical discharge by patient and therapist then occurred. There was an accelerando and a crescendo that flowed into a sudden silence because of the patient's halting of the play and because of this, a musical dialogue between patient and therapist could originate again. The musical dialogue developed into a shared play in which a new rhythm was created by the patient that was in turn responded to by the therapist. As in the previous excerpt, variability of some musical parameters was present, with the additional use of diminuendo and crescendo.

Figure 5.11: Score of excerpt 6

Excerpt 6

♩ = ca. 132

Patient (kalimbaphone)

Therapist

1

hesitated silence

hesitated silence

1+3/16 1+3/16

A

rit. *accel.*

relaxed silence **B**

about 3 times

5 1+3/16 1+3/16 1+3/16 8 10

A'

1+3/16 1+3/16 1+3/16 1+3/16 *rit.*

about 2 times

12 1+3/16 1+3/16 15 **C**

17

Here the patient and therapist played the same instrument - the kalimbaphone. In the musical analysis of this excerpt a contrast can be noticed, between a *perpetuum mobile*⁹ (bars 1, 5 through 9 and from 12 to 13) and the more pulsed interactive play (bars 2-3-4-10-11) in which there are a number of pauses or phrase points. These can be described as *sounded suspended silences*. Through these silences the music gains in intensity. These two ways of

⁹ Composition which from beginning to end is in the same lively tempo, moving forward with notes of the same note value.

playing can be described as the A- and the B- themes. Within this there is some variation: the A-theme incorporates many fast notes, while the B-theme can be termed as an interactive dialogue in which simple binary cells occur.

The three pieces of the A theme (A, A', A'') were not framed in terms of metre, while the therapist created stability and form through playing accents every four notes in A' and A''. In A (bar 1) the patient initiated a dynamic change where the rhythmic movement flowed into light and short staccato notes with silences (bar 2). Following this, the new rhythms of the therapist (bars 3 and 4) that are then varied by the patient signal the appearance of the first interactive play and phrasing.

A structure emerged in the *perpetuum mobile* when the therapist brought in accents (bar 5) and the patient answered musically, by slowing down. For a moment patient and therapist are playing in the same pulse (bars 6-7) and it was here that the therapist felt autonomous and free for a while (i.e. a moment of synchronicity). However, the connectedness of this playing-together was broken by the patient, through her speeding up in bar 9. After this the A' theme was established, a pause was allowed, and out of this pause an interactive play appeared where a brief dialogic exchange was developed three times by the therapist, using the same time interval as that of the patient (bars 10 and 11). The time intervals here were symmetrical, presumably because in this moment the patient assimilated and understood the interaction of the therapist. In spite of this, the patient did not let the B' theme develop further, because she interrupted this possible musical development by introducing the *perpetuum mobile*.

In the A'' theme the *perpetuum mobile* of the patient continued even after the contribution of accents by the therapist - a contribution which was probably an attempt to create a feeling of metre. This establishing of pulse was a continuation of the pulsed music of the therapist in the A' theme. The therapist's development of metre in the A' theme [bar 15] was taken over and varied by the patient, despite the fact that the therapist continues with the same theme in his music. The patient followed her own impulse to play in a 4/4 metre (bar 15) which is safe or stable for her and for the musical structure. This rhythm of two semiquavers, the second three semiquaver (bar 15) developed into a two- quaver and one crochet rhythm for the motif emerging in section C (bar 16). The more up-beat character of the music emphasised the accents and out of this emerged a new stability. The therapist re-introduced the patient's C-motif, bringing phrasing into the interactive play. Here, both players are connected with each other musically, a phenomenon which made the playing-together stronger.

The most striking new musical element was the occurrence of silence. This was experienced as a form of musical phrasing and through these silences new elements emerged.

The experience of a moment of synchronicity originated within the therapist, out of his and the patient's shared capacity to play accents. Thus, the play could come into a metre, out of which a structure developed. The therapist experienced that he had found the necessary space in order to play this accented music.

3. *Selected comment from the patient relating to his experience of playing*

The comments the patient gave were the same as described in the previous excerpt.

4. *Selected impressions and reflections from the therapist about the patient's way of playing*

The therapist was fascinated by the silences created by the patient and within these he had the sense of an intentional or deliberate contact between them. The therapist sometimes experienced the musical dialogues as a held breath and he was curious about what was going to come and about being carried along by the musical interaction. It was a strong experience of intense pleasure. A space was created in which the therapist could play and engage in interaction with the patient. It was a moving back and forth together, a coming into a rhythm with the patient. At some points the therapist felt completely free and could follow the musical flow, with no need to think about what was possible or not, or to feel that it was necessary to take care of the patient.

5. *Selected reflections from clinical interview*

The example of musical synchronicity as illustrated in this excerpt had all the qualities of polyphony with both players being able to go their own way with a real sense of freedom through a harmony of timbres and a sharing of rhythmic elements. It was only from the moment that the patient was able to open herself up to the voice of the other that she came into a cathartic connection with her own traumatic reality. Through the fusional affective resonance of the therapist, the patient was able to independently define her distance to this reality and tolerate, bit by bit, a progressive assimilation of the musical form. This was gradual, because at this point the moments of synchronicity were infrequent and short in duration. The rhythms

were not yet sustained for very long and were stopped abruptly each time as if they were musical cells that she apparently could not yet allow to develop further.

5.2.1.8 Excerpt 7: “The musical form” [Fourth session; first improvisation: 04’05” – 05’05”]

1. Description of the selected video-excerpts

The patient and the therapist sit opposite each other. The kalimbaphone stands between them and it is striking how the patient takes time before starting to play. Her body is more relaxed and her face has more expression. The therapist sits bowed, his face facing downwards, waiting for what is to come. The patient starts her improvisation and her whole body is involved in the play. From the first sound she produces, she is aware of what she is playing. She presents a rhythm, very clear and assertive and at this point it is useful to consider whether or not she already has a rhythmic image of what she wants to play. In her play, pauses, silence, rhythmic and melodic variations are present.

The therapist listens in his bent over position and very cautiously joins her play. This is almost inaudible and his play is cautious and neutral; he is afraid of manipulating the patient or of disturbing the patient’s musical play. The patient develops her own play which is full of varied rhythms that in fact develop toward a rhythmic melody. The hesitations, where she previously would have sunk into a sensorial play, are now used in order to come to an intentional musical play.

There is no eye contact between them, but the therapist is musically in completely open state to her and perhaps he is surprised by what the patient plays.

2. A notated score of each excerpt and a description of the musical elements

This is a good musical illustration of musical form. The improvisation begins with an anticipating inner silence. After this, it is the phrasing which makes the structuring of the patient’s music possible. The appearance of silence is therefore extremely significant. While there could not be any silence or phrasing present in the sensorial play one experiences a hesitation in the musical play, and the silence that creates possible space to come to a musical impression. Instead of drifting again into sensorial play, the patient now has the space to allow musical form to emerge, because here she is almost physically holding herself back. From the

first two tones a rhythmic development is present. Different rhythmic motifs succeed each other and there is a dynamic “bow of tension” present in the rhythmic development. The varied rhythmic cells that are present in the music are notable. These rhythmic cells are resumed in later sessions and thereby, further developed and varied. The therapist makes himself present in a neutral musical way.

Figure 5.12: Score of excerpt 7

Excerpt 7

♩ = ca. 100

A **B**

Patient (Kalimbaphone)

Therapist

hesitation

a **b** **a1** **b1** **b** **a2**

a2 **b** **hesitation** **a** **b** **b2** **b2** **b3** **b4**

C *piu vivo quasi marziale*

D

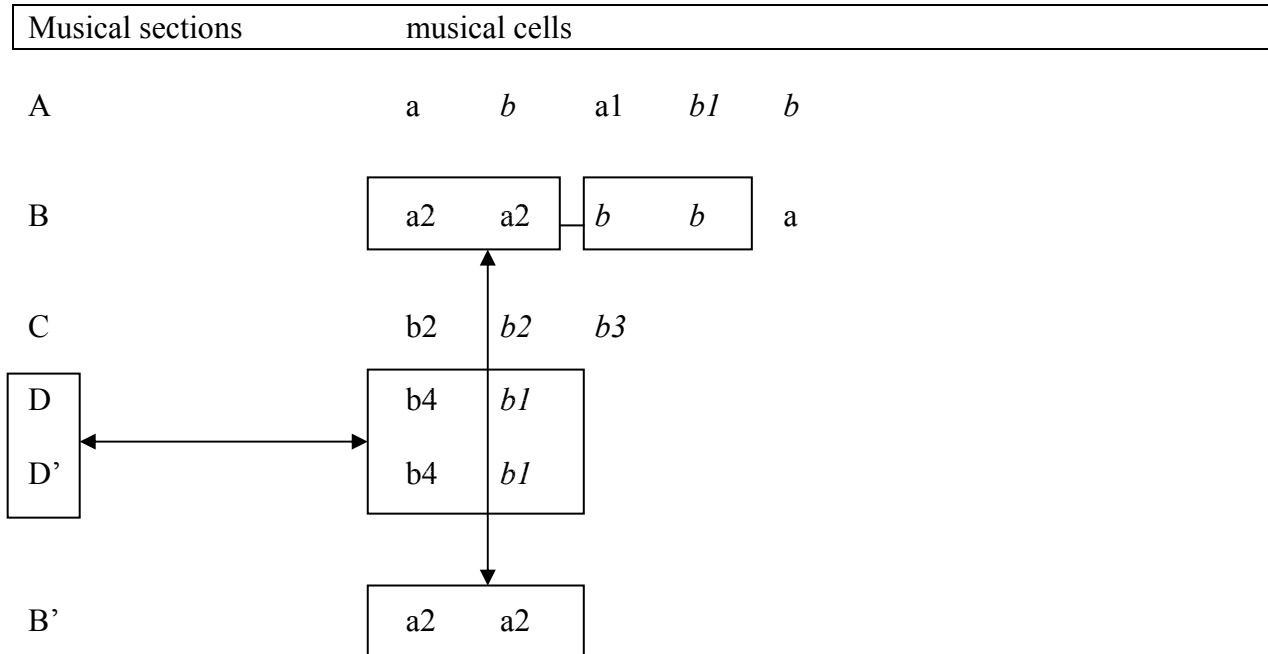
b1 **D'** **b4** **b2** **B'** **a2** **a2**

|| = indefinite silence

We can sub-divide this excerpt into six musical sections: A, B, B', C, D and D'. When we analyse the cell-form of this musical excerpt, we can divide the primary cell units into an *a-type* and a *b-type*. The type a1 cells always generate a sonorous movement from a higher pitch to a lower pitch. Type b cells move from a lower pitch to a higher one. The a-type can be identified by at least three derived variations (a1, a2, a3), with further possible derivations present); the type-b cells have at least five variants (b1, b2, b3, b4, b5). The accented beats within a pulse are played by the right hand, with the lighter accented beats played by the left hand.

A schematic representation of the chain form of the cell motifs in this excerpt is as follows:

Table 5.4: Schematic representation of the chain form of the cell motifs



One can speak here of a flexible, *song-form stanza*, where the ‘musical sentence’ “C” forms the trio (as in a minuet trio form).

There is a stable balance between number of the a-type and b-type cells. The first full musical section (A) is the longest in duration, and the musical cells relate primarily and closely to each other. In this way, this section of the music provides an example of strong musical coherence. Thereafter as the musical sections follow each other, the links between the cell material is less relevant and there is less variation in the musical material between each cell form. In spite of these factors, there is a fluidity of musical coherence in this example, which is seen most clearly in the carry over of musical material in the B-sections and the repetition of the musical material found in the D-sections. However, it is actually the occurrence of pauses or silences that are remarkable in this musical excerpt. Throughout the whole excerpt the silences serve an important role in the structure and dynamic development of the ‘musical form’.

3. *Selected comments from the patient relating to his experience of playing*

The patient's verbal reflections after the first improvisation were as follows:

Patient: "This is the ideal instrument to do something like this. It is close to my rhythms, that I heard in the past few days."

Therapist: "They are dynamic rhythms."

Patient: "I experienced them as restless."

Therapist: "You experienced the rhythms as restless?..."

Patient: "What I experienced was, that was...that what I always experience when I come over here. That is that a lot comes out of me here, that otherwise remains hidden."

Therapist: "The music is not that neutral."

Patient: "No, this time it was not just beating on a bar, it is... it really brings me to an external sense of something that I experience deeply inside myself... I allow something to be heard from within myself"

Therapist: "How did you experience my way of playing?"

Patient: "It depends how you are playing. When you play more in the background, it gives me the feeling that something can happen in my play. I experience my play as a reaction to your music. And...when you are playing more actively, I feel it is more like a battle."

Therapist: "Did you experience my music as too much in the play?"

Patient: ".....No, it is not too much, sometimes I find it interesting because in these moment a dialogue emerges. "

Therapist: ".....question and answer, this is something new. "

Patient: "...Yes, it is...it really has a significance, it has a...it is...a way of living and surviving. If there is at one side, the society, and at the other side, the poet, who does not fit into society, then the poet can react to that society. Because he does not fit into that society, he is almost doomed to be a poet, but it is also thanks to that society that he is a poet." (The patient sees herself as a poet.)

Therapist: "A dialogue originates, the one only exists because of the other."

Patient: "Yes."

Therapist: "Because of this you can make yourself be heard."

Patient: " ...It is more the restlessness that I experience and the aggression that is in me...and...the feelings, contradictory feelings...that are in me...but feelings that are inhibited

in me, the introverted part of me...On one hand I fear the rhythms, but on the other hand, it could also be an expression of the fear I experience.”

The hesitation in the music and the acceptance of silence (such as also heard in the patient’s play) came clearly to the fore here. Her talking in a monotonous way developed into a far more dynamic manner of speaking. Accents, phrasing, nuances in pitch, change in tempi, and timbre were all clearly noticeable in her more dynamic speech, within which she could also bring out her inner impression into a structured form. In the resonance of her play the patient could reflect something of her experiences. In this sense it became clear from her speech that she had developed an inner space in which she could reflect

4. Selected impressions and reflections from the therapist about the patient’s way of playing

From the moment that the patient allowed the anticipating inner silence to unfold, the therapist was looking forward to what might come from the patient. It was a waiting, within which there might be an opening up of oneself. In the transference he experienced that the patient had the necessary space for an inner image for music that might appear, an impression which was eventually confirmed in her music. For the first time the patient’s music came to the fore and the only thing that the therapist could do was to join her pulse in order to stay with her as a listener or witness. He wondered whether it was necessary to play with the patient, because here she seemed to be an autonomous person, who was not dependent on others. Just by playing the metre, the therapist was musically present without influencing her music and without disturbing her rhythm. He followed her in a neutral way and felt that something was developing within the music. He had started to play because he feared that without his support the patient could slip away into her sensorial play again. His therapeutic role was to maintain the tension that originated in her play. In the patient’s improvisation he experienced the anger that she kept a long time to herself and now could experience in the musical co-play with him.

5. Selected reflections from clinical intervention

This development also occurred in between the third and fourth sessions. One can assume that the patient was mentalising (processing) the experiences of the third session between this and the next session, during which the rhythms appeared, as she reported, ‘in her head’. At the

beginning of the improvisation the patient presented the result of a therapeutic process between sessions three and four. During that time, she kept busy with her personal rhythms. It became apparent that she could mentalize her musical images and now she came to her session with a musical form, something that she referred to as ‘poetry’.

The important fact here is that she came with a musical form, a form that she had prepared mentally from the rhythms and silences that had originated in the music of the previous session. Punctuations, commas, full stops and exclamation marks appeared. The patient had allowed this to be heard when she instigated a poetic musical play. The patient left a space in between verses and she also allowed the spaces that she made visually present in the poetry move into the musical form.

The patient played in a much more varied way than in the previous session. She was now able to allow silences. The patient reported that she was ‘bothered’ by rhythms during the week. She did not say, “I heard rhythms”, but rather, “I was bothered by rhythms”. The rhythms forced their way through, they were in her head and she could not get rid of them. To the therapist this showed that the rhythms could be identified as on the traumatic level.

The patient brought these rhythms in association with her poems and by playing them, she evoked her lost poems in a symbolic way. The rhythms were clearly presented in a musical form, and from this form partial aspects of her musical theme were used and developed later on in her improvisation. It was interesting that now she used the metre as a poetic text. It was as if she read a text, or was reciting poetry.

The patient’s improvisation was a kind of recitative without any words, a “*Lied ohne Worte*”¹⁰ One could wonder if poetry without words was not a more intensive art form than poetry with words. In this improvisation the relationship between the prosody of language and music integrated in an autonomous music. It was this relationship that directed the patient to choose music therapy. She wanted to give words to something that was wordless. Poetry did not work any longer for her, and she felt blocked, saying: “I want to be able to write poetry again, I am not able to, because I am blocked.” Through her therapy, the patient became conscious of losing the rhythm in her poetry. For the patient, poetry consists of rhythm, not of melody. In the course of the therapeutic process, this rhythm came back. Suddenly, the “*Lied ohne Worte*” appeared. It was a melodic rhythm that was cemented in a structure, just like word

¹⁰ “*Lied ohne Worte*” (‘Song without words’) can be described as a short piece of a lyrical nature. It is thus like the romance, but unlike it in being confined to piano music. This German form of piano-composition was invented by Mendelssohn (between 1829 – 1845).

in poetry is cemented in the linear structure of the language, and as such is rhythmic rather than melodic.

The patient played rhythmic figures that the therapist immediately recognized as the ones from the previous session. In her play there was now clear phrasing and an inner structure. A musical tension was being built up slowly. The therapist experienced this improvisation as authentic music, and as the re-appearance of the patient's poetry that had been lost for a long time. It was a story, an impression, a "*Lied ohne Worte*", of which the therapist may have been the witness. The therapist now became the listener, but he searched for a metre with which to stay actively present.

5.3 Summary of the results case study: Marianne

From the analysis of the 7 video excerpts, three clear phenomena come to the fore, namely *sensorial play* (excerpt 1-4 (figures 5.6, 5.7, 5.8 and 5.9)), *moments of synchronicity* (excerpt 5-6 (figures 5.10 and 5.11)) and *musical form* (excerpt 7 (figure 5.12)). These three phenomena will be summarised, and conclusions will be drawn from the behaviour of the client, and also of the therapist. The summary here also examines aspects of the musical process, and finally the therapeutic interventions.

5.3.1 Sensorial play (excerpt 1-4)

This section covers two areas: those relating to the patient and those relating to the therapist.

The patient

In the first four video excerpts, the random and repetitive play of Marianne was especially striking. This was music with no phrasing and without dynamics or nuance. There was no melodic or rhythmic development. None of the repetitive musical material played by Marianne was recapitulated, varied or developed. The music was not at any time embedded in a harmonic structure. All the notes seemed isolated from each other where no single note had any relation to what happened previously or afterwards. The sensorial play was an amorphous mass; it appeared to float in space aimlessly, rather like a mush of sound where neither therapist nor patient could feel a sense of structure or direction. The musical play starts with no apparent

preparation, then continues in a style that seems to aimlessly circle around without any defined direction, and then seems unable to move to a definite ending.

The patient compared her play with colouring-in an entire a sheet of paper (excerpt 1). She refers to a packed compactness of the psyche, in which no motion is possible. The patient cannot independently round off the improvisations and she only stops playing after the verbal interventions of the therapist.

The only musical changes are the extended *accelerandi*. This phenomenon could relate to a certain inner tension that appears within the patient (see Figure 5.3.1 and Figure 5.4.1). Sometimes the patient enters into another modality of playing, such as in excerpt 2 (figure 5.7; bar 6 and bar 17), where she moves from an alternating way of playing to a *bourdon* way of playing (bar 6). However, she cannot free herself from this sensorial way of playing.

During excerpts 1 – 4 (Figures 5.6, 5.7, 5.8 and 5.9) the patient cannot appropriate the musical play. There is no inner experience related to the presented musical material. The patient reflected that she experienced her own play as something strange or alien to her. She had no connection with it and was in an emotionless state. Comments from the patient after the improvisation (sensorial play) of excerpt 1 were as follows: “During the playing I am occupied with thoughts, but I cannot give this any place in the music. And then I just continue to play and then the playing becomes something routine and automatic. The play is then something mechanical, as if to hit out at something and then not think about it.” And further: “If I planned to begin to colour a sheet of paper, and I don’t have the desire for a cigarette or something else, I could colour the entire sheet until it is full.” The playing originated from a purely motoric act that appeared to be completely disconnected from her. The movements of her left- and right hand were purely arbitrary.

The silences after the improvisations of excerpt 1 and 2 were identical to the compact, sensorial play. It is interesting that in these silences the patient remained seated in the same sensorial position and that there is no difference in her body posture between when she was playing and when she was not-playing at this sensorial level. In the first four excerpts there is no eye contact between the patient and the therapist. The body of the patient reflects her sensorial play; it is motionless, apart from the rigid movements of both her arms. In addition, one cannot notice any expression in her facial expression.

The music therapist

The therapist felt entirely imprisoned within his relationship with the patient. The therapist could not play what he wanted; he was dependent upon her and this directly affected any intervention he made. He could not even think about what he wanted. The therapist did not exist as a subject for the patient and no single interaction was possible. One could state that in the first four excerpts he experienced a complete absence of inter-subjectivity.

One specific experience to be noted was that in his co-play with Marianne's sensorial music the therapist could not maintain a pulse and became lost in an endless and empty play. The effect was so strong that therapist himself even started to play in a sensory motoric way ('sensorialising') in the improvisation of session 2.

5.3.2 Moments of synchronicity (excerpt 5-6)*The patient*

At a certain point in this therapeutic process a completely new phenomenon appears. It is unexpected and unintentional, and can be noted for the first time in excerpts 5 (figure 5.10; measure 4 – 5 and measure 8-9) and 6 (figure 5.11, bar 5 - 9) – namely, moments of synchronicity. These moments can best be described as the shared inner experience of patient and therapist of freedom and autonomy in their play. Although both have the feeling that they are able to come to a co-play¹¹ for the first time and the musical lines of both integrate into one intertwined structure, where nevertheless the experience of personal freedom and autonomy is still primary.

The patient and the therapist feel completely free towards one another and are able to play and to think freely, to exist and to develop their own musical thoughts. This complete and mutual dependency in the creation of a shared musical object leads – paradoxically – to a liberated feeling of being able to make music entirely independently.

From the point that moments of synchronicity appear, one can observe musical changes in the play of the patient and the therapist. The patient changes musical instruments for the first time in this music therapy treatment. Instead of a smooth-sounding instrument (the alto-

¹¹ Co-play: *Sammenspiel*; *Zusammenspiel*; ensemble; *samenspel*; interplay; combined play, a kind of playing together in musical improvisation or musical repertoire between two or more people where they recognize and are aware of each others' music.

metallophone), she chooses an instrument with a more raw sound (the kalimbaphone), which could represent the more traumatic aspects of some experiences for her.

A shared timbre emerges, because the patient and the therapist play the same instrument. In the moments of synchronicity, varied and complex rhythmic figures appear. There is a variation in tempo, phrasing, accents and silences, although one cannot yet talk of a musical or rhythmical development. Any rhythmic changes are clearly broken off on each occasion by the introduction of *accelerandi*.

In addition, a specific feature of the phenomena of synchronicity is the appearance of silences, which, in this instance, one can compare with holding one's breath. It was like holding on to a moment. These silences do not appear coincidentally, for they are repeated several times and this suggests the potential for a meaningful pattern. They ensure that musically something new can originate. The silences also give structure to the improvisations (see excerpt 5 and 6). In the moments of synchronicity a musical dialogue originates, rather like a question and answer, or a play of silence and sound.

With the patient one sees that some intentionality emerges in the play, especially in the examples of hesitation (excerpt 5). She does not get lost in the routine of the sensorial play because there is some evidence of a musical form being prepared (excerpt 5, bars 1-21). The patient has the freedom to create images, even though she is not yet able to further develop this towards a musical form. In her music making, and the movements that accompany it, Marianne starts metaphorically to 'dance' for a few moments to the music of the therapist, but still breaks it off every time. The body and the facial expression of the patient correspond to the swinging and rocking character of the music during the synchronicity.

In excerpt 5 the patient talks about a desire to articulate her rhythms, which are a symbol for aggression (see case study). These can be represented in the shared musical space.

The music therapist

The therapist becomes more independent of the patient and no longer has to be so cautious as in the beginning of the therapy. The therapist is no longer in the purely projective position. This is because the patient takes the projected part into herself by identifying with the therapist. There are moments of moving together to the rhythm of the shared play and the therapist is moved by the unexpected music. These are intense moments of enjoyment, pleasure and co-play in a shared space. In these moments of synchronicity the therapist experiences a total

freedom and a feeling of pleasure – rather like a “making-music-pleasure”. The play gives him energy, through which it becomes a more powerful experience.

In the synchronicity a “subjectivity” emerges, through which the therapist becomes autonomous and therefore becomes a subject. Patient and therapist are equal in their respective music. One could therefore call synchronicity the first phase of symbolisation. In the sensorial play the therapist could not possibly join with the same timbre as Marianne. Only in these moments of synchronicity does the timbre of the therapist match that of the patient and then begins to co-resonate at the same level of the affect. This was possible when the patient could appropriate the (for her) “traumatic” instrument, with its specific sound colour. The patient did not have to let this be carried by the therapist.

One could compare the moment of synchronicity with a dance, where the dancer answers the music immediately and in the same movement as that within which the music was created. It is a surrender to the impulse. This impulse comes firstly from the therapist, after which it becomes shared with both therapist and patient being able to move musically within this structure. Moments of synchronicity appear suddenly and unexpectedly.

5.3.3 Musical form (excerpt 7)

Musical form appears for the first time in excerpt 7 (session 4). The appearance of moments of synchronicity lays the foundation for a musical impression structure. The moment of polyphonic resonance is the pre-condition necessary in order to achieve a musical dynamic build-up within the improvisation. In this framework a musical form can originate and develop. When the moments of synchronicity occur within this framework, some psychic or musical space opens up, out of which a musical image (some type of small recognizable structure) can develop or occur. The musical form is arrived at when clear rhythmic themes start to appear, which are then further exploited or varied. We can also recognize them in the structuring of the musical figures, through the silences that are experienced as phrasings. The silences produce phrases in the melody. The presented musical material is no longer experienced by the patient as external and foreign to her and she can now come into resonance with her inner world. Another specific feature is that the musical improvisation is marked by a clear, mentally-prepared beginning and ending.

The patient

At the beginning of the improvisation, the patient allows a silence to appear, which is inherent to the concept of *anticipating inner sound*. This in itself is significant. From the first two tones onwards, a rhythmic development is audible. This suggests that the patient now has a psychic space available, within which an inner musical image can be developed. The appearance of rhythm allows the possibility of emerging form, involving a kind of pattern that is not the same as the previous 'traumatic' music, and does not fall back into the traumatic. This process facilitates an opening towards something less constricted, where such an opening can include a movement towards a complete musical form. Therefore, in this example, from the first two notes of the rhythm and during the first six phrases (section 1, Figure 5.12) a new space developed.

The musical form is established by the presence of musical elements such as phrasing, rhythmic and melodic variation, rhythmic development, dynamics, accents, pulsing and structure. The form is embedded in an inner structure, in which the necessary phrasing is present in order to be able to speak of a musical form. There can now be musical thoughts, which are a form of musical thinking. The musical structure defines a beginning and an ending and there is also musical direction present. Each note is heard in relation to the previous and the following notes. It is possible to consider linear development (i.e. connected musical sounds that make up phrases) instead of the succession of unrelated sounds typical in sensorial play. The patient can appropriate the musical material and she can now reflect verbally about her inner experience.

The therapist

The musical form is a kind of musical story, of which the therapist can be the witness. The therapist does not have to carry or hold the play in this excerpt but he can be present in a musical, neutral way.

5.3.4 Musical process

The musical scores demonstrate a definable musical process that supports the interpretations from the analysis, and underpin the concepts of sensorial play, synchronicity and musical form.

Sensorial play

In the musical scores of excerpts 1-4 one clearly sees the image of the sensorial play of the patient – namely, an endless, repetitive play. In the first four excerpts there are no musical phrases or sections; however, one can find a continuing rhythmic or melodic line, without any phrasing or structure (i.e. excerpt 3, Figure 5.8; bars 1-15).

The therapist mainly takes the Right-Hand role here, through which a melodic form is brought to expression, with the exception of excerpt 3, in which the therapist listens and does not play. In excerpt 2 there is a melodic development in the musical play of the therapist, with variation and audible phrasing (excerpt 2, bars 2-3 and 8-9, bars 13, 13 and 17), and in excerpt 4 there is a harmonic cadence in the therapists play (bar 1-4). The play of the therapist is a play in which there can be musical thought and direction.

Analysing the music of excerpt 2 a sonatina-form can be found in the sensorial play of the patient. This sonatina-form was not first developed by the patient, but originated from the music of the therapist. The therapist played an alternation of a melody and bourdon-like music during the sensorial play of the patient. This was an attempt by the therapist to escape the whirl of sounds that was the patient's music. If one were to leave out the music of the therapist, the overall musical form would disappear entirely. In the co-play with the patient (who is playing in a sensorial manner), there was an attempt to attach some musical form into something that was formless. The patient connected her play to that of the therapist. The patient imitates the therapist, purely from a kind of mimesis. In a certain way, the therapist tries to influence the patient, to focus her into the imaginary space. This space that the therapist wants to create for Marianne is purely imaginary because the play of the patient does not come from within her.

Moments of synchronicity

Only when there are moments of synchronicity does the musical play of the patient start to develop and it is at this point that she takes the Right-hand role for herself (excerpt 5, bars 1-21). Rhythms with variations, dynamics, silences, phrasing, etc. start to appear (excerpt 5, section C onwards). These can be thought of musically, and one can clearly see from excerpt 5 that the therapist is able to take the Left-Hand role for himself (bars 1-21). He only has to support the metre or the pulsing of the patient, where he has to be musically present first in

order to come into musical interaction with the patient afterwards. In this phase it was notable that the image of the music changes. Instead of a flat, steady rhythmic and melodic pattern without any structure, a more structured play evolves, in which sections are repeated with a variation. In excerpt 5, as well as in excerpt 6, sections A, B and C are repeated and varied. The structure was also defined by the *accelerandi* with consecutive silences that always originate from the patient. There is a clear rhythmic development that cannot yet be held by the patient and interrupted by the *accelerandi*. However, one can see these short musical developments as a first step towards a musical development.

Musical form

When the musical form appeared in excerpt 7, initially the therapist didn't have to support the patient musically (section A). The presence of silences is especially striking. One might say that the music is structured from the silences and it is because of these silences that a tense, dynamic and phrased or formed play evolves. In Marianne's musical form there is an outspoken rhythmic thematic development (i.e. section A). The musical cells 'a' and 'b' are already present in the first section and are revisited several times and varied in the other sections. The structure of the excerpt is in four sections – A, B, C and D. The musical material in these sections developed during the evolving improvisation, within which Marianne makes variations of cells that are developed in the different sections. This development (recapitulation of cells or motives) and variation of small musical motives or cells is essential for the development of musical form.

There is a clear rhythmic development here, which can also be observed audibly as a melodic development. The patient took on the musical form of the Right-Hand role for herself, while the therapist maintained a musical pulse as a basic Left Hand accompanying role in the co-play.

5.3.5 Therapeutic interventions

This study was also concerned with identifying, analysing and defining specific interventions by the therapist that could be seen to facilitate, influence or support the therapeutic process of the patient. In the analysis of this case, there are some significant examples of interventions that facilitated the process of the patient's playing from sensorial play to musical form.

The therapeutic reaction

In the sensorial play, it is impossible for the therapist to come into contact or resonance with the patient. Through the counter-transference the therapist feels imprisoned and entirely helpless; however, the therapist continues to play despite this, the therapist continues to play. This is something that evolves out of a therapeutic reaction and the therapist hopes that his structured musical play will influence or connect with the patient's sensorial play and that through his musical intervention something can be developed and a moment emerges in which the patient can co-resonate or make the first step to "dance" to his music.

The therapist tried to exist alongside the dominating sensorial play of the patient, and tried through introducing musical structure to create musical conditions that would enable Marianne to come to an image. It is an intuitive search for phrasing, allowing silences to originate, along with variation and musical phrases.

Anticipating inner sound (or silence)

The anticipating inner silence is the silence in which the player is already present in the music before it sounds. This silence before-the-playing is necessary in order to create an inner space, in which the player anticipates the unknown that will come. The therapist, his responses and his actions are guided by the power that comes from this silence. Marianne did not allow this anticipating inner silence into her sensorial play. From this point the therapist introduces this anticipating inner silence at each beginning of an improvisation. In this way, he can come into resonance with Marianne and with himself when she cannot extricate herself from the sensorial play.

The empathic listening

The posture of the therapist is striking in the first two sessions. He sits in pure mimicry, bent forward, his hands pressed against his body and with a melancholic facial expression. This is an illustration of unintentional empathy. The body of the therapist models itself according to the music. The "dialogue" between the therapist and the patient becomes a kind of *mimicry* here, existing and living on a purely physical level. There is no differentiation between the physical posture of the patient and the therapist. This intentional avoidance of differentiation is also exactly what happens at a musical level. The therapist plays an almost identical melody

line to the bass line of the patient [excerpt 1 music line 2]. This is a confirmation that the therapist is at the same level as the patient.

Therapeutic provocation of the therapist

It is in the third session that the therapist counters the amorphous, sensorial play of Marianne through the insertion of off-beats rhythms within own rhythmical structure. With this provoking intervention, the therapist introduces an opening into the compact, closed and un-contactable psyche of the patient. Yet, while the patient's psyche is un-contactable in this moment, the therapist has hope and expectation that there was still the potential for this to happen in the future. Even though Marianne could not yet respond to the efforts of the therapist to try to give form to her play, or to allow a connectedness to the traumatic split-off part of herself, she comes musically close to this and takes over the tempo and dynamics of the therapist. This therapeutic provocation seemed to be necessary in order to offer Marianne the possibility of letting the sensorial play loose for an instance.

The mentalisation after the session

With Marianne, it became clear to the therapist how important it is to digest the emptiness that a patient leaves behind after a session. The therapist makes Marianne's intense emptiness tolerable and digestible here by improvising afterwards. Everything that the therapist was affected by during the session came into form through improvising freely. Improvising became a kind of musing on the 'absent' aspect and parts of Marianne. Facets of herself that Marianne was not yet able to connect musically with (such as varying, phrasing, giving form, or improvising briefly), the therapist can hold in her place. Through this, everything could be experienced, symbolised and understood, in order that the therapeutic process could be continued. For the therapist it is a mentalising (psychic and musical digesting) in which the indigestible might become digestible and through which he can be open to what might emerge in a future session.

Musical form as an 'antidote'

At a certain moment in session 2 the therapist played a melody on the piano - a musical texture that was heard above the endless sensorial play of the patient (Figure 5.1). From a therapeutic reaction the therapist wanted to be heard as a separate entity. He acknowledged his existence in

Chapter 6

Results and Summary Case Study: Adrian

Introduction

The results for this case will be presented in the same way as results for the first case were structured. The three main phases of a *sensorial play*, moments of *synchronicity* and *musical form* were also found through the various analyses undertaken of the data. Each of these phases will be examined through an analysis of the data as described in the method section (chapter 4). In order to provide a clear method of presentation, each stage in the analysis will be defined regarding the type of information presented, and the style of presentation. As in the case of Marianne, the presentation of these results represents a process over time. Consequently, interpretations of the musical material in the early stages of the analysis raise questions that are incorporated into the text, and discussed following the subsequent analysis of the later stages in the therapy.

6.1 Case Study: Adrian

This section presents the second research subject as a ‘case study’ from a clinical perspective. A short initial description of Adrian is followed by his own rationale for individual music therapy, and his subsequent referral to individual sessions. There follows a description of the individual music therapy sessions, without an analysis of the clinical data in relation to the research questions. This is presented as a therapeutic process, involving both factual observations and descriptions of what Adrian does and says, as well as an interpretation of his behaviour. In comparison with the Marianne case study, Adrian’s pathology is considerably more complex, and therefore the first section of these results, where the sessions are documented in a case study form, there will be considerably more interpretation due to the need to present insights into the patient’s therapeutic process.

Findings from the Marianne case study indicated the presence of *sensorial play*, *synchronicity* and *musical form*. The analysis of the results of Adrian’s sessions also revealed similar characteristics and styles of playing indicating the presence of these same phenomena.

It is therefore relevant to include the terms *sensorial play*, *synchronicity* and *musical form* from the beginning of the results section of the Adrian case study.

Adrian's attitude at the onset of therapy

Adrian had difficulty integrating into the structured, multi-disciplinary approach of the ward. He did not take part in either the verbal group psychotherapy sessions or in the 'theme'-meetings, occupational therapy, group music therapy or leisure activities. Only the sporting activities organised within the department were important to him. Words and relationships with the different therapists were too frightening and threatening for him, and the nurses reported feeling unsafe, with a sense of being under threat during interactions with Adrian.

Adrian's facial expressions and attitude demonstrated a certain tension and the nurses had the feeling that he could become unpredictably aggressive. During the weekly team-meetings, team-members expressed their powerlessness about providing Adrian with a reliable treatment and they came to the conclusion that he would be better off with individual music therapy.

Individual music therapy

Session one: "Getting acquainted"

Adrian was punctual for his first appointment and he greeted the therapist with an insecure handshake. He appeared unsure and tense, avoiding eye contact and looking shyly about him. Adrian immediately sat at the piano and played the introductory melody of 'Für Elise'¹ and then asked the therapist if he could teach him the piece. This was piano music that he had known from his school days and which he had rediscovered on the 'Napster' website. Unable to play the piano, he was unaware why this piece was so important to him or why he wanted so much to be able to play it. The therapist did not respond to his request and instead explained that music teaching was not part of a music therapy treatment. The therapist explained the framework for individual music therapy and that the sessions would take place every Monday afternoon. Adrian was invited to agree with the framework of the music therapy treatment.

After this verbal introduction Adrian asked whether he was allowed to improvise at the piano on his own. After this question, the session continued.

¹ Albumblatt 'Für Elise' (Album leaf 'For Elisa'). Composition by Ludwig van Beethoven (1770-1827)

Sensorial play

Without any apparent mental preparation or any sense of *anticipating inner silence*, Adrian began to play. He played fragmented melodies which sounded like broken (arpeggio) chords. Looking at the way he played (leaning back on his chair, with his hands dangling), it seemed as if he wanted to withdraw from the playing or perhaps even to remove himself from the whole situation. **[Excerpt 1]**

Adrian immediately played in a way that is commonly found in some psychotic patients. He seemed to be lost in an endless process of creating sounds that had no apparent meaning. In this short improvisation (and also in subsequent fragmented improvisations from this first session), there was no clear beginning, and no intended end, giving an impression of “no past and no future”. It was an endless repetition of successive, short and fragmented sounds, where nothing appeared to, or could develop. Adrian’s playing was pure sensoriality, existing entirely within itself, where nothing further could happen. There was no sign of dynamics or musical development.

Within this music, some fragmented pieces of sound could be heard, rather like isolated events, disintegrating within an empty sound-space. There was no sense that his playing was connected with his internal emotional state - everything happened externally to Adrian, nothing could be integrated and the therapist experienced an intense emptiness in Adrian’s musical improvisation. The therapist found it impossible to reach any point where he felt any emotional experience or reaction. The therapist did not experience any contact with Adrian, either in his attitude or speech, or in his musical playing. Everything the therapist offered was ‘spat out’ at him immediately. All contact was avoided and the therapist had a sense that what lay behind Adrian’s behaviour was a delicate and brittle fear. The therapist was therefore very careful not to overwhelm Adrian, aware that he could retreat and that he might then stop the treatment immediately.

It was the experience and interpretation of the therapist that Adrian forced him to believe that only he (Adrian) had control over the situation, the musical playing and the session as a whole. In the transference, the therapist experienced tension and a desire or need to express aggression. At the same time, the therapist felt that Adrian considered this aggression to be too threatening, because he could not control it. He was anxious that he might lose all contact with himself once he had released this aggression.

Whilst listening to the improvisation, the therapist had the impression that Adrian was losing himself in a meaningless experience. Adrian's improvisation was not grounded in the way that it had no support or space within it. The therapist longed to offer Adrian some structure by giving him the opportunity to improvise together and as soon as this was suggested, Adrian agreed at once.

Holding on

Adrian and therapist were seated next to each other at the piano, with Adrian on the right hand side. Without preparing himself mentally or entering into resonance with himself, Adrian immediately started to play. The therapist however did take time to enter into resonance with himself, Adrian and the therapeutic situation. He briefly looked at Adrian and slowly rested his right hand on the piano keys and played an open neutral octave ($g' - g$). Not only did the opening musical sentence of the therapist offer a calm foundation, but it also sounded expectant or anticipatory. In this way the shallow mood created by Adrian was transformed into a deeper therapeutic atmosphere.

Comparing the tempo held by Adrian in the previous improvisation, this pace was now much lower. During the first improvisation, Adrian's playing was very busy and nothing could develop from it. Now the therapist offered a more sustained, sober style of playing, providing a musical underpinning that was unambiguous and clear. This was serious music, but not without engagement from Adrian.

The tempo of this music was less forceful, but there was also the potential for confrontation as well as compliance. The therapist left space for something new to happen. A tension full of expectation emanated from this playing, where the therapist waited to see what would happen, also noting that this tension and expectation was not present in Adrian's playing. The therapist slowed down his own playing in order to create a therapeutic space and mood. Adrian was completely dependent on the therapist's playing and was not actively involved in the improvisation, during which neither musical voice could find each other. This was a musical interplay on two levels, without contact between either (i.e. between Adrian and the therapist). The therapist quietly continued with his melody whilst Adrian tried to impose his own disjointed contribution; however, nothing came of this. When the therapist introduced a musical ending Adrian did not collaborate with this, abruptly breaking off the improvisation.

Whilst the therapist felt that he could not hold Adrian's sensorial playing, he also knew that his music at this stage seemed to have no effect on or meaning for Adrian

In this session, playing and talking mingled together. The unboundaried nature of the transition from playing to talking and vice versa was unique to Adrian's therapy and it characterised the sessions up to and including the seventh session. Throughout this period of therapy it was impossible to distinguish between playing and talking; this phenomenon could be described as a kind of "mud".

Adrian gave short answers to the therapist's questions and looked straight ahead, at the keys of the piano and then towards the therapist. Finally, he took the cymbal that was beside the piano, struck it a few times and played a hasty tune on the piano – indicating perhaps that he was rather lost in this situation. The therapist experienced the disjointed playing of the cymbal and the piano as an escape from any conversation. On the one hand Adrian signalled that empathically the therapist came too close, and on the other he nullified any hint of a connection between himself and the therapist, stating "it means nothing, I feel nothing". For this reason the therapist kept his distance and only partially acknowledged the resistance shown by Adrian. He did not make eye contact with Adrian and the 'game' between them remained in the musical play, rather than in any non-verbal exchange. Then, hesitantly, Adrian put his hands on the keys and played a few notes. He stared ahead as if he did not know which way to look and very briefly played the same motif as during the first improvisation (in three-four time). As the therapist intuitively repositioned himself slightly backwards, more space appeared between him and Adrian. Adrian now spoke directly to the therapist, who listened attentively. While listening, the therapist tried to hold Adrian mentally. He felt that because Adrian was continually switching between playing and talking, this inherent tension indicated that something was the matter, or that something unexpected might happen. The playing and talking that followed were fragmented. The therapist then positioned his chair closer to the piano and therefore closer to Adrian. Free improvisation followed and showed some release in the tension.

The impossible play

There followed four fragmented improvisations that were distinguishable by Adrian's inability to begin or end the music [**Excerpt 2**]. The inability to 'anticipate an inner sound' was present during all the improvisations and throughout the entire music therapy session. There was no

structure, rhythm or phrasing noticeable during and between the playing and talking. The interaction seemed to be a kind of singular ‘mud’, where nothing could be grasped or held onto and nothing was allowed to develop musically.

Appropriating the musical material in this way was therefore impossible for Adrian. The music remained totally external, strange and aimless. The therapist was thrown into a turmoil within which it was impossible to develop any structure in his music making. Adrian was immediately tempted to fill up every silence, perhaps also experiencing this as an emptiness that needed to be filled. By doing so, he made it impossible to create a psychic space where ideas could develop and where there could be fantasies or thoughts. It was also impossible to reflect verbally, because everything remained external to him. He frequently broke off a sentence and started to play repetitively or in fragments for a while, only to stop suddenly.

Adrian agreed another appointment with the therapist and the session was concluded. Directly following this first session, the nursing staff reported that they found Adrian very aggressive, tense and restless. In his living space on the residential unit Adrian reacted - he kicked chairs and tables, but significantly did not cause any damage and after an hour, he calmed down.

Second session: “Managing boundaries”

During his next appointment Adrian announced to the therapist that he wanted to stop the individual music therapy treatment immediately. His tone of voice was fearful and aggressive. The therapist observed that Adrian had found the music therapy too intense to continue.

Adrian said: “I felt very upset after the first music therapy session. It stayed with me for three to four days... In any case, I want to stop. The music therapy only made me feel worse.”

Therapist: “At the team discussion it was felt that it could be beneficial if you could experience yourself through music. Maybe music, like speech, seems too threatening for you”

Adrian: “In any case, I want to stop. This music therapy only makes me feel worse.”

Therapist: “At times I feel that music does something for you. At this moment you see this in a negative light... You indicate that music is threatening and it is possible that the session is not sufficiently structured, making it difficult for you to bear or hold onto any of the experiences you might have, and that upsets you.”

Adrian: “I just want to stop. So, see you Jos.”

Therapist: “I am wondering if you might not regret ending the therapy so early on, before you had a chance to really evaluate how it might be useful for you.”

Adrian: “I am disappointed because this doesn’t solve anything for me.”

Therapist: “You say yourself that something happens, which is not the case with the other therapies, and that music appeals to you. Maybe as a therapist, I went too fast... You indicated that you wanted to play ‘Für Elise’ piece, and maybe I can help you with that.”

Adrian: “I don’t want any more to do with this.”

Adrian stood at the open door looking in the direction of the therapist. It was a tense moment and Adrian’s mood and posture showed fear and uncertainty.

Therapist: “It is positive that you indicate to me that you find music threatening. And that you warn me about this. We could talk more about it in the next session.”

Adrian: “It makes me worse. I’m sorry but I’m quitting.”

The therapist then offered a further appointment.

Therapist: “It is up to you to decide whether you continue with the therapy. Adrian, you show me that something is happening and you can use this in a therapeutic way. If you want to engage with this, I will be there with you”.

Without closing the door Adrian returned to his department. The therapist wondered if this was an indication that the door had not been closed for good. The therapist had noticed that there was a paradox in what Adrian had said. On the one hand Adrian reported that in the first session he no longer felt anything, while on the other hand, he now said that it was too much for him. It was interesting to note that Adrian always expressed the fact that the therapy didn’t interest him or that he couldn’t care less – for instance he said, “I can’t take any more, the music is too much for me, it makes me worse, I have to go”. Equally, he was very much aware that the session had an effect on him for the following three to four days. This was remarkable, because normally he would take off in an easily way from this kind of experience and would not allow anything new to happen.

The therapist agreed to teach Adrian ‘Für Elise’ and indicated that he could learn the piece as part of a process that moved towards free improvisation, while remembering that any of this kind of ‘teaching’ took place within the music therapy situation. Being aware of the transference, the therapist could sense an intense fear and an uncertainty which Adrian himself could not bear. In situations like this it is the role of the therapist to carry what cannot be held by the patient. For this reason, the therapist was clear and unambiguous about the usefulness of

the therapy, and adhered strongly to the arrangement for the next appointment. However, a sense of failure remained with the therapist. After a brief conversation with a psychotherapist colleague it became clear that Adrian's disclosure of limitations should not be seen as finality but rather as an essential feature of the therapy. After this discussion, confidence returned to the therapist and the treatment continued.

Third session: “‘Für Elise’ returns”

Adrian arrived at his next session, albeit a little late. It was as if in some way he allowed the therapist to feel insecure about whether he would arrive or not, giving him the feeling that it was Adrian who controlled the therapeutic framework. It was Adrian who was in charge and control and it was he who decided whether or not he should attend.

The therapist was able to give form to this uncertainty about the absence of Adrian by improvising on the piano before he arrived. Improvisation before or after a session is a part of this music therapist's method of work. After a confusing or chaotic session - or in this case, in search of an audible silence - he uses a free or 'reverie' improvisation, to reflect and to enter into resonance with the image of the missing patient. Adrian is the kind of patient who wanted to quit the therapy and who now left the therapist in doubt as to whether or not the treatment would be continued. The therapist wondered how this could develop further. Improvisation in cases like this allows the therapist to mentalize what it is that, for Adrian, cannot be digestible at this time.

The first tones resounded in the empty music therapy room for a long time. A melody developed, and by using the piano's sustaining pedal the therapist managed to link the sounds so that there was a sense of flow. With the therapist's addition of the left hand, the melody became more harmonically embedded. The bass sounded strong and full and the music created an atmosphere that was cradling, comforting and consoling. The therapist let the last sound float away, as if his ear was 'glued' to it; the resonating silence created calm, filling the emptiness. Whilst improvising, the therapist had the image that he needed to give Adrian more space and to accept and respect his fears and limitations. He had an insight that Adrian saw the learning of 'Für Elise' as the essence of music therapy and that Adrian could grasp this as an opportunity to control the therapeutic framework. Within this, he could manage Adrian's resistance. Teaching him 'Für Elise' meant knowing where both of them were going and it was in some way comforting to have this certainty. Music therapy was still too much of an

unknown territory for Adrian. 'Für Elise' could throw him a life line, with some sort of implicit guideline relating to what could be allowed to happen within music therapy. With 'Für Elise' he could control in the same way as he maintained control over the session by turning up or not.

Initially the therapist did not accept Adrian's 'Für Elise' proposition, realising the real issue was that the therapeutic space itself was too threatening. When the therapist ignored the suggestion, Adrian distanced himself totally from the treatment, saying: "I won't be coming any more...when I'm in this strange and scary environment, I'm afraid of losing control and striking out. It's far too dangerous for me, I don't need this." While the therapist was thinking in a reverie-like way about this, Adrian came in to the room. The therapist approached him and greeted him with a cautious hand shake. Adrian's hand shake felt frail and scared (therapist projection). Adrian showed a nervous and timid attitude, looking briefly at the therapist. Adrian apologized for being 20 minutes late; he had forgotten about the session. The tension this caused in the therapist is a communication of an affective projective identification (Rosenfeld 1971).

Adrian immediately asked to start with 'Für Elise'.

'Für Elise'

This was not a piano lesson in the traditional sense. The therapist played a few notes of the piece which Adrian then imitated. This was based on visual and audible copying - a type of rote learning. It was learning through imitation; the therapist goes first, Adrian repeats. Small steps were taken, each beginning with the familiar start of 'Für Elise'. In a sense it was a repetitive pedagogical learning experience.

Adrian stressed again that for him the learning of 'Für Elise' was about achieving a certain goal within the music therapy treatment. He made it known that this 'learning' was symbolic for the usefulness of his time spent in psychiatry. In this way, he could symbolise or encapsulate something about his psychiatric stay, what it meant to him, and what he could take with him when he left the psychiatric institution. 'Für Elise' has been attributed with various functions during the therapeutic process with Adrian. The different modalities and interpretations of 'Für Elise' will be discussed before the epilogue at the end of this case study.

Adrian's boundlessness

The boundlessness in Adrian's play comes clearly to the fore at the start of the next improvisation. Adrian had already sat down at the alto-metallophone and, assigning the therapist an alto-xylophone, he started to play. The therapist then set down his assigned instrument in front of Adrian, who was already playing, and continued to play without even looking up or taking the therapist into account. In this way therapist and patient could not start the improvisation together [Excerpt 3]. There was no contact at all between them. The therapist could only try to join the almost repetitive play of Adrian, a feat which was almost impossible. The therapist felt like an object that was not allowed to or could not take part in the musical play. Adrian was also not able to conclude the same improvisation. He played glissandi, which erased the play metaphorically. As a consequence there was no clear boundary between making music and not making music [Excerpt 4].

The inability to round off the interpretations

Adrian continued to bring the verbal interpretations to an abrupt end. He was unable to leave anything to resonate. The playing could not be made into something substantial and was prematurely concluded, resulting in the fact that Adrian could not appropriate it. The playing disappeared into nothingness.

The way in which the therapist ended the improvisation allowed Adrian to hear and experience how an improvisation could reach a conclusion. Reacting intuitively, the therapist let the last tone or chord post-resonate (this was also a feature in the later improvisations). In this way, some resonance of what had gone before could be heard and the transition between past and future could be made into silence, and eventually become internalised. Being able to round off an improvisation in this way is the forerunner of *musical form*.

Introducing ostinato

During a verbal reflection after the third improvisation, Adrian accidentally played the beginning of an ostinato. He directed his mallets onto the lower register of the alto-metallophone and played repetitive broken chord triads (*a-c'-e' / a-c'-e' / b-d'-f' / b-d'-f'*). The therapist became aware from the transference that Adrian surprised himself with this ostinato,

although he made it clear that it had nothing to do with him. He commented, “it has nothing to do with me, what I played was something purely mechanical.”

The therapist moved intuitively to the (alto-metallophone) and took over Adrian’s ostinato music. By this, the therapist showed Adrian that the awakened ostinato was important and that he wanted to hold onto it for a moment. This created an opportunity for Adrian to improvise melodically on the existing ostinato, however this did not work for long and Adrian gave up almost immediately. He was not yet ready to create a melody; he could not accept the Right Hand role and let go of the previous playing. Both patient and therapist now played the Left Hand role and although Adrian could have allowed himself to be carried along by the therapist’s music, what emerged was a defensive playing, as if a battle against the therapist. Adrian stopped abruptly, as if to say “I cannot win over you”. This can be seen as a confirmation that Adrian was waging war with the therapist and that he was not willing to entrust and to join in playing with him. The therapist sensed a certain frustration coming from Adrian. It was interesting to see that Adrian’s narcissism came to the fore in the music. It was as if the narcissist was fighting tooth and nail against any form of dependency.

Session 4: “La vie en rose”

Adrian looked nervous. He sat down on a chair, not knowing what to do with his hands. At the beginning of the session the therapist taught Adrian the next fragment of ‘Für Elise’. The improvisation could begin after this introduction. Adrian was seated at the alto-metallophone and the therapist at the piano. Adrian’s posture reflected a sensorial play: it was as if his elbows were glued to his knees and he had a nervous expression on his face. He just played along, aimlessly, and without direction. During the verbal reflection, Adrian suddenly seized back the mallets, fiddled with them a little, and started to play the alto-metallophone again. The ostinato theme of the previous session re-appeared (*f’-a’-c’*) (x4). Adrian created a brief pause and continued to play the following ostinato motif (*e’-a’-c’*) (x4); this could be heard as an extension of his previous ostinato. Abruptly Adrian stopped playing. Intuitively the therapist asked Adrian if he would like to continue to play the ostinato, above which he (the therapist) would also play. He positioned himself at the same alto-metallophone and improvised melodic lines above Adrian’s ostinato. Soft, warm, full sounds resonated through the sunny therapy room. The atmosphere became melancholic and tender, and seemed lonely and abandoned, yet at the same time intimate and positive. The sounds merged beautifully, as if they belonged

together. Images of the film 'La vie en rose' were awakened in the therapist's mind and this gave him a comfortable feeling. It felt good that Adrian could support the melody, allowing something to happen for the first time even though the therapist had prepared the way. Adrian took part in the improvisation and for the first time he could 'hold on' to a theme which was his. For a brief moment, he accepted the therapist's playing.

Suddenly, Adrian broke off the improvisation. The therapist added a short cadence to the abruptly rounded-off the improvisation, so that nevertheless the improvisation found a conclusion. Perhaps the melody came empathically too close to Adrian, or the music touched something in him, because he put down his mallets and said brusquely, "it was alright". With these words, Adrian partly accepted the playing although he was not yet ready to acknowledge the ostinato as his, accepting the safety of: "It was alright."

During the verbal reflection which followed Adrian described the therapist's melody as a variation on his own ostinato. Adrian could dare to hold onto the music in this improvisation. This was made possible by the therapist playing a melody above his accompaniment, thus giving a musical meaning to the ostinato.

A moment of synchronicity

During a subsequent improvisation within this session, the first moment of synchronicity appeared. Both Adrian and the therapist were seated at the piano. The therapist created a silence while Adrian, sinking deeper into his chair, watched expectantly. Adrian's first tones were fragile and insecure. The therapist quickly added a second voice and the playing evolved into something fuller and faster. Adrian repeated small motifs filled with chromaticism and tension. The therapist followed Adrian's efforts in exploring his limitations, yet perhaps going too far in his dynamic playing, because Adrian suddenly stopped. At this point the therapist continued the same music, and Adrian joined in again. The playing continued for a while but suddenly Adrian stopped. The therapist then introduced an invitingly gentle melody and as a result of this, an alternating dialogue was created. In Adrian's musical reply to the intervention there was an example of him attempting to imitate the therapist. The therapist's play was so complex it acted as a provocation that made it impossible for Adrian to play and the atmosphere changed into a kind of musical whirlpool. Through phrasing, a space was created and Adrian was invited to add his own ideas, thus finding his own musical space. Adrian talked and laughed throughout the improvisation, as if by talking he could take control of the

resounding music. He felt unable to enter into the unknown and was surprised by what was happening. The music had changed suddenly, from a calm mood into something much more dynamic. This music was propelled by the therapist. Both therapist and patient shared the same pulse and for the first time the therapist felt free and autonomous. He was guided by the music and could give himself to it. The fear of losing Adrian had disappeared and the therapist enjoyed playing together with him. The dynamics of the music evolved into a chaotic cluster of sounds within a piano tremolando [Excerpt 5]. This could be described as “darkness”. After this music emerged, and whilst the sounds from this “muddle in the darkness” were still resonating, Adrian played some clear notes and a short melody began. The therapist’s musical response to this was to play another melody. The playing then developed into an alternating dialogue, with repetitions of the therapist playing a melody and Adrian answering it. This alternating playing was created out of a longing by the therapist to retain the improvisations.

Harmonious sounds emanated from this alternating playing, out of which the pulsed playing continued. This was held briefly, also introducing (revealing) a ritardando ending. It was captivating how both players slowed down together, as if they were simultaneously ‘lying down’ in their playing, leaving the last tones to resonate.

Adrian perceived part of the music as chaotic, containing anger and frustration. However, during this improvisation, neither the aggression nor the anger frightened him. This time, Adrian did not need to control it. The therapist experienced for a moment the freedom to play alone, without being influenced by Adrian’s fear of aggression. For the first time the therapist felt that he did not need to carry Adrian, check his limitations or be frightened of losing him. After the verbal reflection, the session came to an end. This time, Adrian did not need ‘Für Elise’ in order to hold himself together and he calmly returned to the department. The conclusion of the last improvisation had allowed Adrian the experience of holding onto his chaotic and aggressive fantasies.

Session 5: “The confronting silence”

Adrian arrived promptly and took his seat at the piano and the therapist sat to his left.

Adrian started to practise the first part of the ‘Für Elise’. He sighed and by the movement of his hand indicated that he wanted to give up, as if to say, “that’s it, I give up.” However, the therapist continued supporting him by teaching Adrian ‘Für Elise’. When Adrian finally gave up practising, the therapist suggested that they could improvise together.

The unattainable waltz

Without first entering into resonance with himself, Adrian immediately started to improvise melodically. His sounds were vague and fragile, as if they could break apart at any moment. Briefly, a waltz emerged, but it was brittle, fragmented and interspersed with fragments of the 'Für Elise'. It was through this music that Adrian drew himself back from the unknown experience of free improvisation. The therapist tried to join in this playing, but it seemed impossible. Adrian would not allow the therapist to join him in his sensorial playing and he introduced a splitting in the interplay. The improvisation stopped abruptly, accompanied by the typical hand movement by Adrian that indicated, "that's it, I give up".

Confronting silence

Adrian said he was searching for a melody and quite unexpectedly started to play short consecutive scale figures in a higher register. This flowed into a fragment of 'Für Elise' which introduced a new improvisation. The beginning of this improvisation was just as fragmented as the previous one. The therapist joined in carefully. You could hear a clear transition from a two part metre to a three part metre. Intuitively, the therapist slowed down the tempo, creating a possibility for introspection. In slowing the music, the therapist introduced a silence. Adrian followed this *rallentando* but might have been in imminent danger of having to stop the playing, perhaps because he found this slowing of the music with its silence too confronting. He suddenly increased the tempo, as if the tension of this faster tempo had to be maintained, and again abruptly broke off the improvisation. However, on this occasion the therapist intervened with a melody. For him, the improvisation was not yet over. He wanted to hold on to Adrian's disintegrating, fragmented playing and to offer him the opportunity to own his music.

Whereas before he had played the Left hand role, the therapist now intervened explicitly and played the Right hand role. The therapist then introduced something musical: the music now became an authentic conversation, through which Adrian was offered the opportunity to reconnect with what was for him confrontational playing. Adrian imitated the melodies of the therapist within this musical turn-taking. The therapist played a melodic sentence, which Adrian imitated, in a caricature of a teacher-pupil relationship. Through the therapist's

initiative, Adrian was given ample space to form a musical answer but instead merely imitated his musical question. Very quickly there was no alternating play anymore, but a mimicry, where the therapist gave a musical answer that Adrian merely repeated.

After a few imitations, the therapist challenged Adrian by making his playing increasingly difficult to follow, so that repetition became impossible for him. The therapist consciously broke through Adrian's imitating playing because he felt it went nowhere. Adrian could not do anything with it – for instance, he could not make musical variations on the material presented by the therapist. The fragment showed that Adrian was too frightened to develop his own version of the music, and thus be able to connect with his own desires. He preferred to imitate, rather than to initiate. He ignored the opportunities offered by the therapist to express himself in his own voice. Even though Adrian was presented with a therapeutic space where he could use his own voice, he could not (or chose not to). This is a common experience in verbal psychotherapy with psychotic patients, where there can be found the unspoken question, “what do you want me to talk about - what do you want me to say?”

The imitative play was interrupted. The therapist played complete musical phrases over a repeating motif and the improvisation acquired more of a foundation through the therapist adding a bass-line and increasing the tempo. In this way the musical play assumed a more liberated character. The improvisation became even more dynamic through the use of off-beat rhythms, and in addition the therapist increased the tension by adding an *accelerando* and a *crescendo*. The music sounded heavy, full and dark.

In this part of the improvisation the therapist filled in a great deal, playing in a more dominant fashion, which meant less space for Adrian. During the previous section of the improvisation, Adrian had shown that he could not handle an open and empty space. The therapist did not intend to be dominant. Quite the contrary, he gave opportunities to Adrian - but Adrian refused to accept them. With a response clearly influenced by countertransference, the therapist musically filled the empty space for him. Adrian forced the therapist to be dominant; by playing a few fragmented melodies in a disengaged way, without any movement or energy. Had the therapist not acted on this therapeutic reaction, the playing would have come to a complete halt. Here, in one sense the therapist was the voice of Adrian. The music was not his, but it was Adrian's. Through the music, the therapist experienced the pain associated with the lack (or rejection) of a symbolic dimension. It was more pain than sorrow as the therapist felt in his body the tension of a faint physical pain. The heavy, full and dark

playing created another space for an ending to occur, which was something new in the therapeutic process. The therapist felt that this was rather forced upon him by Adrian and was left with no choice in this matter. Adrian finished the music by sounding the highest tone on the piano. The therapist let this last sound resonate and, by so doing, opposed the sudden and abrupt end to Adrian's improvisation. He thus showed him an alternative way of dealing with the ending.

During the subsequent verbal reflection, Adrian said he felt it was a "heavy improvisation". As a result of Adrian's transference, the therapist felt an intense pain. The therapist wondered if this might be an echo of the traumatic affect of the dissonant music. The therapist felt that Adrian was pleased it was over and that the confrontation with the dissonant, traumatic playing must have been very hard for him.

It did not take long before Adrian touched the piano-keys again. The therapist thought that he might be running away. Sections from 'Für Elise' appeared again, as a safe, protective, tonal, known and rehearsed type of music. To grasp onto this again meant the same thing as escaping from the relationship with the therapist.

To re-position the therapist as the teacher made it possible for Adrian to maintain contact for a longer period of time. The contact with the therapist was side-stepped but this was not true of the contact with the therapist as a teacher. The therapist distanced himself both musically and physically by leaning backwards. He did not join in the playing and felt left to his own devices. In this way Adrian neutralised the therapist and reduced him to a safer subject, that of music teacher. 'Für Elise' was the safe haven for Adrian within the turbulence of the therapy.

Adrian did not even have to talk about 'Für Elise' and he could submit himself to the therapist as a teacher and father figure. At this stage in the therapy process, Adrian was totally submissive to this 'father', cannot 'succeed' over him, and consequently he cannot own his voice when facing his father. This situation was in itself striking, because the therapist knew that Adrian would never be submissive and that in school situations he could never listen to the teachers, always arguing with them. Adrian had found his teachers too authoritarian and because of having to conform to this regime, he ended up leaving school. Now, within the therapeutic frame, he placed the therapist in a situation which he had previously avoided. By asking to be taught 'Für Elise', Adrian symbolically refused to use his own voice. The therapist had to speak for him, as Adrian could not speak for himself. The imitative quality of the

improvisation was characterised by Adrian's submissive posture towards the therapist, which prevented him from speaking with his own voice.

In the verbal reflection Adrian focused on his voice. He told the therapist that he had sung in the school choir from the age of nine to twelve years. He said that he liked to sing, but stopped when he was referred to child psychiatry. He now felt shy and was anxious about using his voice. Adrian then spoke about locking himself in the house in order to avoid contact with others. Interestingly, during this narrative Adrian held onto a pair of mallets, as if he needed these for as long as he could, in order to cope with this contact with the therapist. Having a conversation about himself was still too threatening and by hitting a few bars on the alto-xylophone next to the piano from time to time, the conversation was interrupted, and thus contact was avoided. When anger and aggression came into the verbal reflection, Adrian took his chair and sat at the alto-xylophone. It was as if he felt trapped and by making a physical distance, so he distanced himself emotionally.

The 'Silence of the lambs'

Immediately, Adrian started to play the alto-xylophone repetitively, endlessly and without thinking this through. His seemed totally separate from his playing. It consisted of loose, fragmented pieces. The therapist tried to join him by accompanying musically on the piano. To Adrian's repetitive and sensorial playing he added the 'Right hand'. The therapist searched for linking musical themes between them so that he could have the possibility of connecting with Adrian. However, this was all in vain because Adrian always changed the metre of the music. There was a sense that Adrian felt totally destructive because he continuously destroyed every attempt by the therapist for inviting mutual play. There was no aim and no direction in the music, no structure and no shape. Reflecting on his counter-transference, the therapist experienced being unable to enter into resonance with the playing of his patient. He felt excluded and powerless and sensed a provocative quality within Adrian's improvising. The therapist questioned whether or not it was worthwhile continuing to contribute to the improvisation and decided to purposely add musical phrases. Adrian played a few glissandi suddenly and unexpectedly, in doing so figuratively wiping everything away. In response to this and in an attempt to offer an underpinning, the therapist added a bass line to the music, but he was unable to establish a connection with Adrian.

By inserting the 'Left hand' the therapist attempted to contain Adrian's trauma within a form, yet at this particular moment this was impossible. Adrian abruptly broke off the improvisation and then asked the therapist, "have you seen the film 'The Silence of the Lambs'?"². Here, his facial expression was remarkable, because it appeared that Adrian enjoyed this question and was excited by even asking it, thus showing that there was something about the dark nature of the film that aroused him. The therapist wondered if this touched upon the real and fundamental aspects of his problems.

The film 'The Silence of the Lambs' deals with the silencing of innocence, and in a figurative sense the lambs themselves are symbolic of the innocence of childhood. The therapist wondered if Adrian had made the connection between this and his personal story. This could perhaps be related to the school choir that he had sung with and which he had left when his pathology broke through. It was possible that he linked his admission to child psychiatry with the 'Silence of the Lambs'. Perhaps he thought, as an innocent child, that he was silenced when he was admitted to child psychiatry - and that this silence became unbearable. The voices in the school choir ('the heavenly voices') were silenced when Adrian was admitted for psychiatric treatment. For Adrian this was synonymous with the violence and perversion in the film. Adrian said, "I too will never be able to use my voice or sing again".

It was interesting that Adrian continuously interrupted the improvisations. Words and music alternated: play, breaking off, saying something, talking etc. On the one hand, these verbal interruptions were part of the improvisation - music and words followed each other. Music related to what Adrian said and uncovered certain aspects of his inner life. On the other hand, Adrian was also acting out, in order to escape from the improvisation that might reveal something. Another factor was that Adrian could not maintain a conversation. During family therapy, he always had to stop the conversation, briefly leave, and calm down; after this he then re-joined the therapy. Adrian always ran away, because just talking was still too much for him. Verbal psychotherapy was too threatening and too confrontational for Adrian. He did not want it and he could not make use of it; however, during the music therapy sessions, he could alternate between talking and playing. While he acted as if nothing was the matter, from a therapeutic point of view there was a great deal happening in his music.

² Story by Thomas Harris, filmed by Jonathan Demme "A mass murderer on the run. Psychopathic serial killer "Buffalo Bill" 's victims are young women which he subsequently skins. The FBI engages young student Clarice Starling to find this maniac. She enlists the help of Dr Hannibal Lecter, also known as Hannibal the Cannibal because he likes his victims 'raw'. She discovers a pupa of a 'death' butterfly in the throat of Buffalo's victims. Dr. Hannibal 'feeds' her bits of information to solve this riddle and to discover the hiding place of "Buffalo Bill".

'Für Elise' was also a substitute for leaving the session. In Adrian's case music therapy could be compared to verbal psychotherapy. For him, music therapy was the only way to engage in a psycho-therapeutic treatment. Music and words signified a continual process; everything that he needed to say could be said in the music.

The impossible ending

An improvisation followed, with Adrian seated at the alto-xylophone. He seemed lifeless and unable to enter into an eventually a mutual play. For a brief moment Adrian seemed to join the therapist's rhythmic, pulsating and dark playing, but then he distanced himself with repetitive and sensorial playing. Adrian looked at his watch, stood up unexpectedly and almost demanded, 'Für Elise'. Clearly, the improvisation had proved too much for him. Words were no longer possible and Adrian clung onto 'Für Elise' in order to remove himself from the mud of 'The Silence of the Lambs'. The session was concluded with the therapist teaching 'Für Elise' to Adrian.

Session 6: "Stravinsky appears"

Adrian arrived 15 minutes late. Meanwhile, the therapist improvised on the piano in order to give form to Adrian's absence. The therapist's improvisation started abruptly, with pronounced rhythms and a certain drama. The therapist wondered if this might be the expression of his lingering fear that Adrian might stop his therapy. The dissonance and sharpness of the music evolved into a flowing, dynamic and harmonious playing. Some strongly played chords appeared at regular intervals and then increasingly came to the fore. It was possible that these chords were a reflection of the unbearable pangs of pain emanating from Adrian's inability to achieve a musical form.

The improvisation then developed into explicitly melodic playing, and then finally concluded with a clear finishing cadence. The music had filled the space within which Adrian and the therapist could allow a much-needed silence in order to enter into resonance with himself and with the absent Adrian. Suddenly Adrian arrived, apologized for being late and took his place at the piano. The sixth session opened with 'Für Elise', and it gave Adrian a 'good feeling' that he could learn something in the music therapy session. He also noticed that

he was using 'Für Elise' to ease tension. As usual, the therapist played some fragments which Adrian imitated and then practised.

Following this, a short discussion took place about the next improvisation. Adrian was asked if he wanted to play by himself or with the therapist. He did not answer but suddenly played two descending chords on the piano: $e''-c''-a'$ (x2) and $d''-b'-g'$ (x2). The therapist recognised this as a variation of the ostinato motif from the previous session.

Quietly alone in shapeless sounds

Adrian continued to improvise on these broken chords. While he made the music melodious, there were nevertheless no melodies, but rather short, independent melodic fragments that were isolated from each other. They did not form a unity or totality; and Adrian could not come to a form in his music. He broke off the playing with an 'I've had enough' gesture, saying, "I cannot do it ...I cannot handle it". The inability to improvise was now very easily experienced by the therapist. There was then a painful silence, which was hard for Adrian to bear.

The therapist broke the silence and played Adrian's broken chord figure ($e''-c''-a'$). Adrian responded to this with another melody, which was answered in turn by the therapist with another melody. Alternating play developed, containing longer phases, when at a certain moment Adrian added a minor second which initiated the birth of dissonance. The therapist repeated this dissonance in his playing. In doing this he experienced a certain feeling of enjoyment and wondered if this might lead to a joint play. The length of the exchanges increased, but Adrian could not develop his own space and instead began to imitate the therapist's melodic playing. There was a hopeless quality to this, as if nothing could develop from it. Adrian could not take any initiative and tried to imitate the therapist as closely as possible.

The therapist challenged Adrian with complicated melodies which were impossible to imitate. After a few desperate attempts, Adrian broke off the improvisation with his typical 'I've had enough' gesture. The therapist, however, continued with his music and started to play more dynamically. His intuition would not yet let him abandon playing. He allowed himself to be led by the music and developed a certain continuity from this. The therapist could produce his playing from within and there was direction and form to it. Adrian could recognize himself in this dynamic playing and joined in with the therapist's music. The alternating play became

sharper, louder, stronger and livelier, and had a relieving effect. This time Adrian managed to round off and close the improvisation with the therapist.

*'L'histoire du soldat'*³

The verbal reflection after this improvisation was interrupted when Adrian resumed playing. A short motif appeared suddenly on the piano, which was then continually repeated. The therapist reached for the piano keys and tried to enter into resonance with Adrian. His music was characterized by repetitions of Adrian's short motif. Adrian accompanied, playing the Left Hand role where normally the melody or the Right Hand role would be. The therapist felt that Adrian was not quite ready to develop the melody, even though he had offered him this possibility. Perhaps this was the reason that he suddenly asked Adrian to change places with him in terms of Right Hand / Left Hand roles.

The playing continued with Adrian's accompaniment now in the Left Hand. He played his ostinato with insistence and the therapist felt that Adrian was now more ready for musically collaborative work. The music became a kind of musical walk, with the therapist's playing sounding strongly rhythmic and almost cheerful. The atmosphere was reminiscent of Stravinsky's 'L'histoire du soldat'. The tempo increased and the therapist played the melody in octaves. It became a musical march, where Adrian and the therapist synchronised in the movement of their upper bodies to the metre of the ostinato. For the first time, mutual resonance and contact emerged. The playing-together came to a united conclusion and ended simultaneously.

At certain times during the improvisation the therapist was able to play freely and autonomously. Adrian had taken the Left Hand role and the therapist the Right Hand, possibly in preparation for Adrian's further melodic creations. Adrian confirmed that this improvisation was different, saying, "I had more of an idea what I wanted". He had also experienced that he could lose control.

³ 'The soldier's tale' is a classical music-drama for violin, bass, clarinet, bassoon, trumpet, trombone and percussion composed by Igor Stravinsky (1882-1971).

Being able to finish together

Adrian introduced a new improvisation. He took the Left Hand role again, still seated on the left hand side of the piano. It was a recapitulation of elements of the previous improvisation, indicating that Adrian might have wanted to re-live something that he had experienced earlier. Perhaps he wanted the therapist to give form to his repetitive ostinato playing. Two minutes later Adrian marked the end of the improvisation by slowing the tempo and in this way the therapist and patient could finish the playing together. It gave the therapist hope to note that Adrian could end an improvisation which in itself was a recapitulation of material from a previous improvisation. Adrian asked to finish the session with the 'Für Elise'. In doing so, he withdrew to the safe anchor of a comforting and predictable world.

Session 7: "Allowing silence"

Adrian was very punctual and the therapist noticed that he appeared physically relaxed. He looked for eye contact with the therapist, after which he moved over to the piano and started to play a fragment of 'Für Elise' with both hands. Adrian told the therapist that things were not going well for him, in that he had difficulties in going outdoors. He also reported that engaging in free improvisation still felt very confrontational and frustrating, as he never knew what was coming next. Every time he played, something unknown appeared.

Adrian broke off this reflection by playing randomly on the piano. This was a formless musical babble from which no musical co-play developed, until suddenly, 'Für Elise' appeared again. As the therapist did not want to engage with the defensive reactions Adrian was demonstrating in his behaviour, he suggested that they improvise on the ostinato that was used in the previous session. The therapist would take the Left Hand role and Adrian the Right Hand, allowing the opportunity for melodic improvisation.

The failure

The therapist commenced with the ostinato. The atmosphere was calm and supportive. Here, Adrian imitated the therapist's ostinato, which was all he was able to do given that it was impossible for him to improvise melodically. He felt unable to detach himself from his Left Hand role and move towards the freer Right Hand role. Despite the therapist's support, Adrian

was too afraid to enter into something new. His reticence and defensiveness was remarkable considering he also had the most extreme fantasies.

Adrian gave up playing quite quickly and said, “I cannot do it”. Without going into the problem, the therapist asked Adrian to change the places with him. Adrian accepted the suggestion immediately and took the ostinato while the therapist played the Right Hand part.

The turn around after endless rotations

Therapist and patient played together. To further support Adrian in his uncertain state, the therapist took over the ostinato and then developed a melody above this. It was an insecurely played melody, reflecting the therapist’s careful responses to Adrian. When Adrian played a descending chromatic tune (and thus departed from the ostinato), the therapist followed with chromatic playing. The tempo slowed and a play-space was created, within which rhythmic and dynamic playing emerged, leaving behind the ostinato figure. The therapist and Adrian briefly played together within pulsed music, but Adrian was unwilling to develop this further, instead playing something on the black key lower register that was reminiscent of Chinese music. This music was also not allowed to develop, because Adrian stopped playing and asked a question about the technical aspect of the piano music. He did not let go of the keys whilst he was talking, continuing to murmur musically, as if expressing by this his frustration that he could not find “his music”.

Sighing frustration

Adrian returned to play his known ostinato themed music. The therapist reacted with a melody and for a brief moment a co-play existed. However, Adrian was not able to hold onto this, moving on to black key pentatonic playing and then returning to the white keys. The only constant feature was that he fluctuated between different styles and times. He was unable to sustain his music, and the result was a noisy musical ‘mud’, until Adrian suddenly stopped playing and the improvisation finished.

It is possible to make the connection between this music and Adrian locking himself in the house. Adrian felt frustrated that he did not have the courage to go out and meet new people. For Adrian, the concept of ‘outside’ meant the same as his inner trauma.

Musical reverie

Adrian's playing of the ostinato was by chance during a fragmented verbal reflection, but it led to nothing. Intuitively, the therapist persevered, playing the ostinato with the left hand as well as the melody with the right hand. The play remained slow and was a musical reverie that explored the possibilities of Adrian's musical theme. This was not a musical demonstration of what was possible, but rather a calm reflection of this theme. The therapist's music sounded comforting and this caused Adrian to re-join the playing. He took over the ostinato and let the therapist improvise on the melody. The atmosphere then changed into a more melancholic space.

Making use of Adrian's own theme (the ostinato), the therapist improvised music which confronted Adrian with a desire or longing for a musical form of some sort. It was a musical reverie to which the music therapist added this desire for form. It was also a musical reverie with another kind of desire, that of actively exploring the unknown. It can be compared with the reaction of a mother to a crying child, where the fragmented and chaotic responses of the infant are responded to within an overall perspective of the mother's form-giving input.

'Confused soul'

Adrian and the therapist changed places at the piano; the therapist sat to the left hand side and took over Adrian's ostinato. Adrian started to improvise a melody and his music was related to the reverie-play developed by the therapist in the previous improvisation. Here, Adrian dared to improvise. His hands no longer slumped on the keys he was playing independently and he really appeared to be engaged authentically in the music. The therapist played the ostinato as soberly and carefully as possible and limited himself to subtly supporting Adrian. He was surprised and happy that Adrian could sustain this music for so long. It was possible that this was a preparation for the emergence of some initial musical form. At a certain point the therapist played one octave lower, distancing himself symbolically from Adrian. This was really 'going outside' of the house that Adrian could not leave. Despite the therapist's feeling that the play could be continued, Adrian suddenly stopped. He was not yet able to sustain playing or to bring the improvisation to a structural conclusion. It was plainly too soon for Adrian to internally keep hold of this overall structure, or to work towards an ending in this way.

The therapist verbally reflected his impression of Adrian's first ever development of a melody.

Adrian responded: "that's possible, I suppose ... I can never find the right words to express myself. I cannot explain. I just don't know what it is."

Therapist: "But something happens, when you play like that?"

Adrian: "Well, I don't know, I don't feel anything. Just like everything I do, it doesn't feel right." Adrian interrupted his own words with a fragment of 'Für Elise'.

Therapist: "What would you call your piece, Adrian?"

Adrian: "Confused soul... It has a melancholic feel."

At this point, the therapist wondered why Adrian said that he could not find the right words to express the way he felt. Perhaps Adrian felt no need to put how he felt into words because he could not allow a connection with his feeling self. Adrian expressed his experiences in a negative way (for instance reporting, "there is nothing to say"), yet, at the same time, he described the music as "melancholic".

Adrian had now clearly identified the core of his music therapy. He realised that what had happened was essential because it had some connection with loss. Everything pointed to a 'letting go', which was connected with his own early losses and the attempt to 'go out' (that is, to leave and to go outside). It was confusing for Adrian to be confronted with such feelings. Suddenly 'Für Elise' re-appeared, perhaps because this material was too painful for Adrian to bear. It was possible that he was running away in the psycho-emotional sense, because this confrontation was too painful for him.

Changing position from the Left Hand and the Right Hand role

The therapist's change of position was interesting. The therapist knew intuitively that he had to change places if he wanted to stay with the therapeutic process and in this way he prevented the process repeating itself endlessly and therefore becoming meaningless.

Something had become possible through the change from the Right Hand to the Left Hand role. For the first time Adrian could detach himself from the Left Hand role during this improvisation, where he was not imitating the therapist anymore and his playing was purposeful. It was a step towards the adventurous 'daring to go' stage of the process. Adrian connected with the anticipation he felt from the therapist's music, and it became clear that something new in him was helping Adrian let go. When the therapist took his seat on the left, it

meant as much as saying to Adrian, “it’s OK, off you go”, and rather like a father or mother would say to a child, “it’s your turn to do it yourself”. It can be hypothesised that this is symbolic of the art of music. The abandonment of repetition gives rise to the creation of music which in turn becomes a compensation for the loss, which in this case is the loss of the traumatic theme.

The therapist felt intuitively that he had to be careful and to give Adrian plenty of time and space. Due to this care on the part of the therapist, all was made possible, including the therapist adding several variations to the music. The therapist joined in naturally, did not react as a ‘*metronome- mother*’ but also contributed his own wishes. Adrian could interiorise or mentalize this material, and thus he could create his own music.

Respecting Adrian’s boundaries

Adrian wanted to play by himself using both hands, but this just would not work for him and suddenly a loud higher cluster of tones could be heard. Adrian dropped his right elbow on the keys and he hung his head. The therapist suggested that he continue to play where he had ended. Adrian replied, “If I do that, I’ll go mad”. He was afraid that the unknown feelings would come to the fore and that he would be unable to control them. The therapist gave Adrian the message that it was good to know his own boundaries and to accept them. Adrian then started to play ‘Für Elise’ and continued with this until the session ended.

This session proved to be an interesting one, illustrating that within the impossible there was always hope. The therapist did not allow himself to be intimidated by Adrian’s destructiveness and his unbearable material. The therapist stayed with him and did not give up, holding to a sense of Adrian at times when there was a feeling of hopelessness. The therapist kept his faith in Adrian, and in the music itself.

The use of the Left and Right Hand role concept was interesting in the development of the ostinato. Up to the eighth session, the Right Hand and Left Hand role accompanied the ostinato alternately. When Adrian played the ostinato and the therapist improvised on it, Adrian felt that he could hold on to something and through this and the melodic playing of the therapist, he discovered that a melody need not be endlessly repeated, but that it could be developed in a linear way. When the therapist played the ostinato, Adrian was given the freedom to search for his own melody.

Session 8: “Musical form”

Adrian arrived late for this appointment and the therapist improvised at the piano whilst waiting for him. The desire to improvise was strong, not because he feared that Adrian would not turn up, but rather because of the need to think about him. The improvisation opened with a few simple chords that developed quite quickly into harmonious and rhythmically accentuated music. Suddenly Adrian’s ostinato appeared and the therapist improvised melodically on it. It was possible that this was the continuation of the mentalisation of the previous session, within which the state of melancholy had been important. The same melancholic atmosphere appeared without the therapist being aware of it. The nature of the improvisation was determined by the music itself as the therapist further explored the ostinato. The melody contained features of the therapist’s musing about Adrian’s melancholy. Perhaps the therapist fantasised about the possibility of a musical form, and a desire to briefly experience what was possible. The therapist finished the improvisation and in a resonating and melancholic silence he waited for Adrian.

As soon as Adrian arrived, he took his seat at the piano. He told the therapist that he wanted to buy a piano with his savings and that his father thought he ought to take piano lessons. According to his father, playing the piano was the only constructive activity in Adrian’s life. The therapist noticed that Adrian was much more relaxed and that he told his story easily, also listening to the therapist in the same way.

Just like the previous sessions, Adrian started with ‘Für Elise’. He now added a broken chord accompaniment to this and it was notable that the accompaniment was a variation of Adrian’s ostinato, where he also used broken chords. The therapist interrupted the teaching of ‘Für Elise’ and asked Adrian whether he had thought about his ostinato. Adrian replied immediately by playing the ostinato. The therapist sat on the right hand side of the piano and started to improvise on this.

A small variation

This improvisation consisted of three parts, distinguishable by the interruption of the ostinato, which was in itself a variation of itself. Adrian abandoned the original ostinato and played a variation, which had a different metre (2/4 instead of 6/8, from compound to simple time),

returning to the original ostinato after this variation. The fact that Adrian could return to the ostinato in its original form confirmed that he was able to hold on to something. The therapist was now allowed to play a variation on this ostinato. However, the improvisation was ended abruptly by Adrian, who in doing this did not leave any space for reflection. Immediately, even though it was technically impossible, he started to try and play the ostinato and melody with both hands and reported that he felt very frustrated. The therapist then gave him the opportunity to improvise only melodically, which Adrian accepted.

The Gregorian melody

Adrian's melody was interesting: musically, he did not need any support from the therapist - he added an inner metre and a harmonic schema which the therapist had not presented. The melody showed the characteristics of Gregorian music; it was played in a harmonic arrangement, but without a second voice. Adrian circled this inner harmonic schema, in a way that was inaudible, but implicitly present. This could be interpreted as a first moment of internalising. Adrian presented a melody, which was a very important moment because during the previous session the melody had been initiated by the therapist. Now, Adrian presented his own melody which differed musically from melodies in previous sessions. Even though his melody was a carefully played exploration, it was important that Adrian searched out and explored the space without the intervention of the therapist.

Suddenly 'Für Elise' re-appeared. The therapist took his seat on the left hand side. He wanted to hold this precious moment of the melody and did not want to react to Adrian's 'Für Elise' defence mechanism. For this reason, the therapist proposed that they alternate playing a melody and they took turns to play musical sentences. This musical dialogue was interrupted by an outside person who urgently had to ask the therapist something. The consequence of this interruption was that Adrian immediately played 'Für Elise'. The therapist wondered if Adrian played 'Für Elise' as a '*Reizschutz*'⁴, and that perhaps in his state of narcissism he wanted to show how well he could play. Another interpretation could be that this was another aspect of defensiveness – the intrusion and the feeling of violation that can come from someone entering the therapy space.

⁴ "Reizschutz" can be described as a psychic shield. With this shield the ego filters particular sounds or noise away from the environment. Through this the phenomena of inner silence can arise or a restricted auditory reception of the environment.

After this short interruption the improvisation continued, developing into something powerful, dynamic and sustained and the therapist was free to play autonomously. The therapist noticed Adrian had made a remarkable improvement, compared to the session before. It now became clear how crucial this previous session had been. Since the melancholic improvisation, Adrian was much more relaxed, ready to face frustrations and to play together with the therapist. He wanted to continue and to explore the unknown, to play and to search in order to reach his own goal. It was as if he experienced this for the first time. A few sessions ago, Adrian would not have been capable of it. This improvisation was the confirmation of a process begun in the previous session, where it was felt that something significant and fundamental had happened - namely, the introduction of a Gregorian melody and the maintaining of the implicated harmony containing an image. Adrian ended this improvisation himself with a melodic cadence concluding with a descending melodic movement. However, it was the therapist who really held onto this music, letting the last chords resonate into the silence.

Improvisation at this level and with this type of aggressive tendency had not been possible before. The playing was built up dynamically, but was not experienced by the therapist as a type of discharge. Adrian could not reflect verbally on this improvisation and as before he let the therapist explain the session musically. The therapist felt that his words reached Adrian and that he understood them.

'Le sacre du printemps'⁵ or meeting Stravinsky

Adrian played a few fragile tones on the piano. A new improvisation developed, where the first section was spent looking for a way to play together. The therapist introduced a melody in the lower register which contrasted with Adrian's high and shrieking tones. Adrian answered by playing a descending scale twice and the improvisation then took a new turn [Excerpt 6]. It became a powerful, rhythmically accentuated and dynamic play. It was remarkable that Adrian maintained this kind of dynamic and powerful playing for such a long time. He seemed to enjoy it and there was no sign that he rejected this dynamic music, contrary to previous

⁵ The Rite of Spring (1911). The title of the improvisation is based on the composition of Stravinsky (1882-1971). It is a ballet in two parts. This composition is above all a rhythmic innovation, and as in the improvisation with Adrian there are also static rhythms in ostinato patterns, which generate enormous latent energy. These are contrasted with the dynamic irregular rhythms that change at bewildering speed.

sessions when he had been afraid to engage in powerful playing. There was after all a danger that this could slide into something aggressive or destructive.

Adrian even managed to laugh whilst playing, although it felt as though it could still be threatening to exceed his boundaries. The therapist felt that his relationship with Adrian was no longer fragile. During the previous sessions, he had felt he could lose Adrian at any moment but now he was much more relaxed and showed more confidence, and he allowed himself to be guided by the music. He acknowledged his own boundaries and at a given moment he concluded the improvisation musically. It had been enough for him.

Adrian reflected verbally that this improvisation went further than he had actually intended and that this was the reason he had rounded it off. Yet this premature ending to the improvisation was different to the other sessions. In the past, Adrian always avoided dynamic improvisations and the therapist was unable to involve him in energetic or vigorous playing. He was unable to play free variations without the fear that Adrian would break off the improvisation abruptly. Adrian now followed this through and the therapist felt that he could continue playing dynamically.

Musical form appears

Adrian played a fragment of 'Für Elise' for a very brief period. He let one tone resonate for a very long time and the therapist adjusted his chair and introduced the ostinato with his left hand. Through this Adrian discovered the opportunity to search for his own melody and during this playing-together, Adrian also discovered his Right Hand role. Adrian paused, allowed the "anticipating inner sound" and started to improvise melodically [Excerpt 7]. From the beginning, the therapist knew that Adrian was open to being guided by the music. Further melodic and harmonious developments emanated from this very first tone.

The melody that emerged was not what he intentionally wanted to play and he followed the music without having any control over it. Adrian was inspired by the music. There was a linear development: phrasing, recapitulation, a melodic tension and development, for instance with the melody circling around a single note were embedded into the harmony of the ostinato. The Right Hand role represented the melody and with it, the first musical form. The melody contained everything it should: rhythmical variation, the use of pauses, the tension of melodic direction, etc. The repetitive, endless playing was over and made way for a playing that could be developed in a linear fashion. The therapist rounded off the music with a cadence, feeling

that the improvisation had been enough for Adrian. There was a resounding silence belonging to the improvisation. Perhaps this was an inner representation of what was sounded in the music. Adrian reflected verbally that this melody was in harmony with his ostinato. He recognized the ostinato the therapist played as something belonging to him. The melody was part of the ostinato.

An ostinato improvisation followed, where the therapist felt free to vary the music rhythmically as well as harmonically. This involved all the piano keys, both black and white. Adrian obviously felt good about his music, which now included rhythmic variations, trills and repeated musical motifs. Adrian not only developed flexibility with his musical material, but also acquired a new vocabulary. After the improvisation; the session ended with 'Für Elise'.

Epilogue

In the following session, Adrian's improvisations were demonstrating greater and greater degrees of freedom. He was no longer afraid to lose himself in the music. He did not fend off his aggressive and destructive impulses, he could deal with them and feel this in an overall perspective. The therapist no longer had to be cautious in his musical and verbal interventions. Having reached a musical form, the process of working with Adrian's problems could begin. Adrian now consistently attended music therapy sessions every week.

'Für Elise' became less prominent, and gradually Adrian felt able to let go of this safe and transitional object. He started piano lessons two months after the stage of reaching musical form in his therapy. He swapped the exclusivity of 'Für Elise' for other musical pieces that touched him emotionally. He brought the second piano concerto of Rachmaninov as well as pieces for piano by Mozart and Bach. He started to listen to piano concerti, compared different performances and interpretations, and looked for scores on the internet and in music shops. There was a constant common denominator to the pieces he sought out. To start with, they were predominantly classical or early romantic pieces. Later, he chose late-romantic music (such as Tchaikovsky or Rachmaninov) only to finally return to Bach. It was striking that he was always looking for piano music.

Adrian had become more independent and looked for new music. This substitution of the musical object was essential. Adrian could let go of one object ('Für Elise') and substitute it with another. He discovered his essential need did not remain with 'Für Elise' but that it could be replaced by other compositions. This was essential to the symbolising process.

Adrian was no longer dependent on the therapist to learn music and he could now practise pieces independently. He also learned to play new pieces outside the piano lessons. He contributed less to his piano lessons than to the work on his own chosen pieces; it was these pieces that he presented in the music therapy.

The piano lessons took on a symbolic role, representing authority and his father. By studying his own choice of pieces for piano, Adrian created a space where he was able to experiment, independent of his father and the piano teacher. After a year of individual music therapy, Adrian completed his music therapy treatment, was able to live independently and returned to his studies.

Following the Adrian Case Study, particular attention is now given to interpretations relating to the role of 'Für Elise' in Adrian's therapy, because of its central significance to the therapeutic process as a whole.

'Für Elise'

'Für Elise' as limiting experience

For Adrian, learning 'Für Elise' was the aim of the music therapy treatment. This way, he created for himself a framework in which he could control the music therapy and knew where it would lead. Within this framework he needed to engage himself with something that he did not know. Improvising music was threatening for him, because it could lead him to unknown aspects of himself - to the uncontrollable and the traumatic. The way he wanted to work with 'Für Elise' was a kind of implicit limitation of what could and might happen in music therapy. 'Für Elise' was, in this way, a limiting experience. A different kind of limitation lay within the choice that he grasped in order to either come or not to come to the session.

Escaping from the therapeutic relationship

When Adrian played 'Für Elise' it meant to him a process of escaping from the therapeutic relationship and of eliminating the therapist. Adrian kept his distance from this musically. The function of 'Für Elise' was to neutralise this transference and to put the therapist again in an ordinary music teacher's role. In this way Adrian was safe, but at the same time, the situation was ambiguous. Adrian putted the therapist into the role of a music teacher who would teach him 'Für Elise' through the imitation method, knowing that he was usually somebody who

never subjected himself in the way of agreeing with something the teacher desired or requested. In the past he always battled with teachers. Adrian was always the one who did not feel any sense of 'belonging' in the school situation, because of his sense that teachers were too authoritarian.

Breaking down perverse and aggressive fantasies

During the fourth session Adrian reported that he regularly played the first fragment of 'Für Elise' to break down his perverse and aggressive fantasies. Starting from this session, 'Für Elise' regularly appeared in the musical improvisations and verbal reflections. This always happened when the music threatened to overwhelm him, when he did not get a grip on the musical aspects, or when the verbal discussion came too close to him.

'Für Elise' as a "musical bandage"

Starting from the sixth session, 'Für Elise' framed the setting. During the weekly team meetings the staff talked about the problem that Adrian had controlling his aggression upon his return to the ward after each music therapy session, and how he behaved tensely and threateningly towards the others. Therefore, since then (from session 4 on) every session started and ended with 'Für Elise' as a kind of "musical bandage", a secure frame for each session, after which evidence of tension and incidents of aggression disappeared.

'Für Elise' and perversion

It was apparent that 'Für Elise' took on a protective factor for Adrian and in doing so it provoked and aroused him. 'Für Elise' was not only a safe, protective object that guarded against the excessiveness of the ecstasy and against aggressive impulses, it also gave him the possibility to live in an ecstatic state, indicating that 'Für Elise' had taken on a somewhat perverse character. At a certain point Adrian said to the therapist: "It must be unbearable for you, that I always come here with "Für Elise", demonstrating that the transference towards the therapist was also perverse, with Adrian continuously manipulating him. Adrian strongly provoked the therapist through the transference and it was therapeutically necessary that he (the therapist) could bear all of this.

'Für Elise' and variation

Adrian imitated and reflected on the free musical improvisations. He could not develop or create anything and for him 'Für Elise' was a fixed given, and not created by him. Adrian was afraid to develop his own discourse and 'Für Elise' stands thus for the refusal to speak freely. From this perspective 'Für Elise' was a dead and repetitive object that Adrian could not integrate into a new context. 'Für Elise' stood alone and no variation was needed. 'Für Elise' could not be articulated, it was a foreign body that defined him, but that could not be articulated with the rest and was, in this way, traumatic. Adrian could never do anything with it that could be elaborated. Every time 'Für Elise' appeared only in its unbearable form (the fragmented - e' - d#' - e' - d#' - e') it had no meaning or value except as a defence mechanism. This happened at moments that Adrian was confronted with the trauma. One could say that 'Für Elise' was a defence against the trauma, but at the same time it was re-presenting the trauma. In 'Für Elise' the trauma appeared re-appeared, and he wanted to overcome it by learning it, and therefore controlling the trauma. The trauma coincided with the object. It was not a form in which the trauma could appear, it was the trauma itself.

Transference and counter-transference

Within the transference process the composition 'Für Elise' was 'dead'. The transference was not integrated; it could be anybody who sat with the Adrian, who was a patient who imitated rather than engaged. There was no dynamic in the transference and counter-transference. One would expect that the object was integrated, but instead it remained completely dissociated, consisting of separate parts that had nothing in common with the rest. This was also how the therapist experienced it, allowing it to appear, but not engaging with it, not investing emotionally in 'Für Elise', and experiencing it as a waste of time, yet at the same time accepting its existence from a therapeutic stance. In spite of the interventions made by the therapist, nothing changed – the therapist played a fragment of 'Für Elise' and Adrian imitated it. In a sense, the therapist died a little in his inner self.

6.2 Results

6.2.1 Analysis of data for the research

As specified in the method section, the video-excerpts were selected by specific criteria (see page 105) and the following figures illustrate the overall structure of the sessions from which these excerpts have been drawn. The relevant information here is the balance of elements and activity going on in the sessions. A figure for session two is not included as it was a short verbal session with no musical activity.

6.2.1.1 Timeline of the sessions case study: Adrian

Colour code for interpreting the figures:

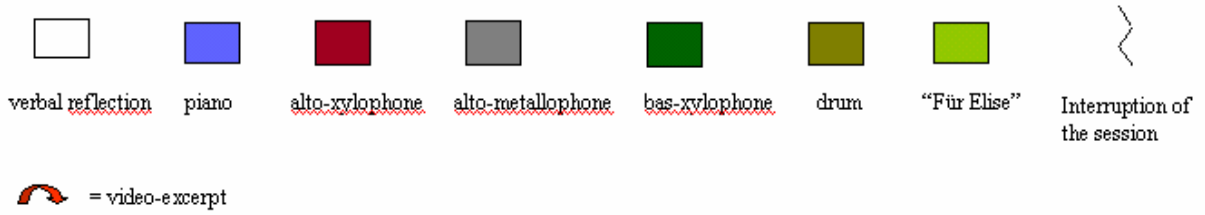


Figure 6.1 : session 1

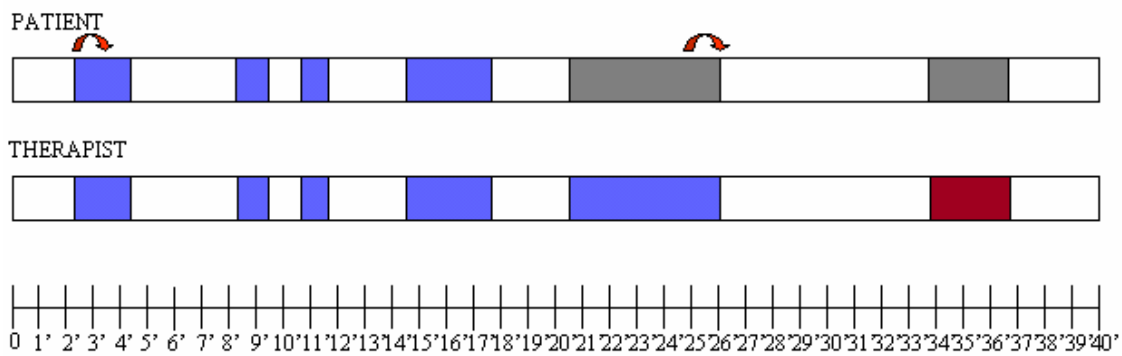


Figure 6.2 : session 3

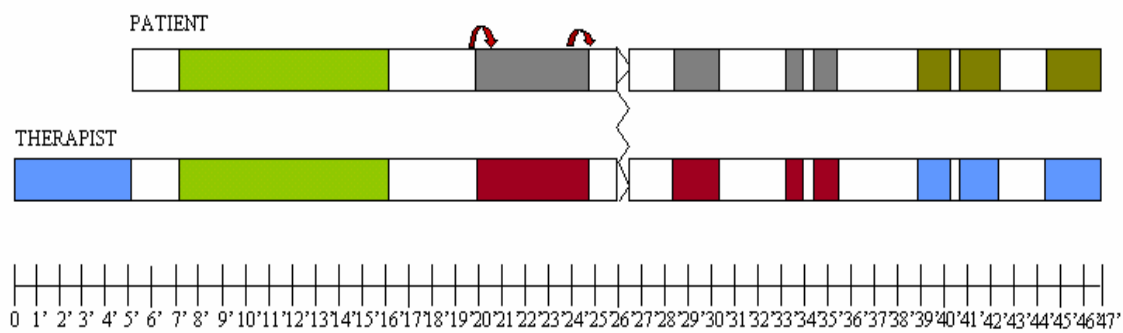


Figure 6.3 : Session 4

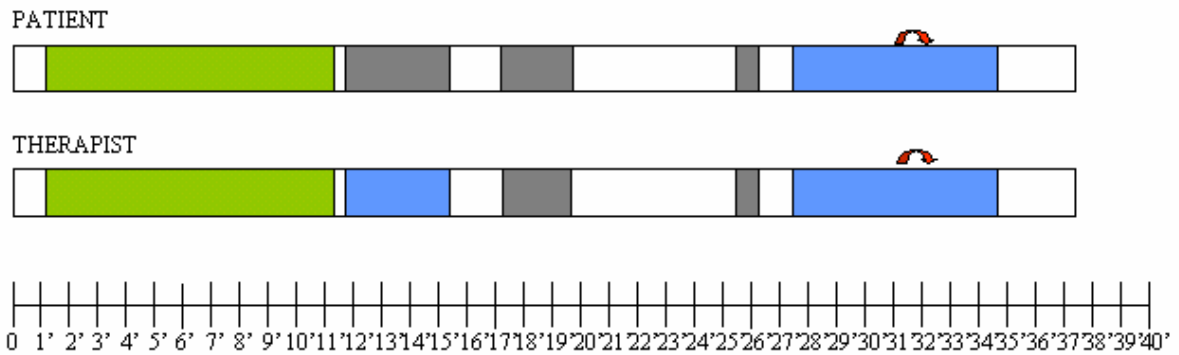


Figure 6.4 : session 5

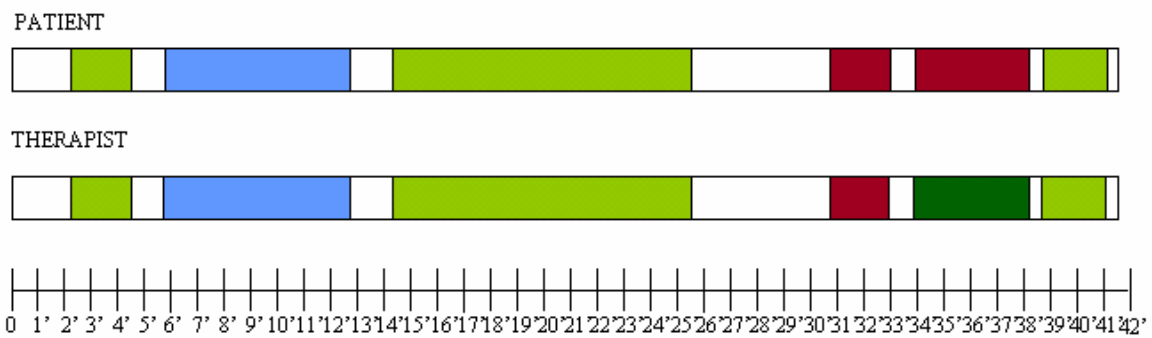
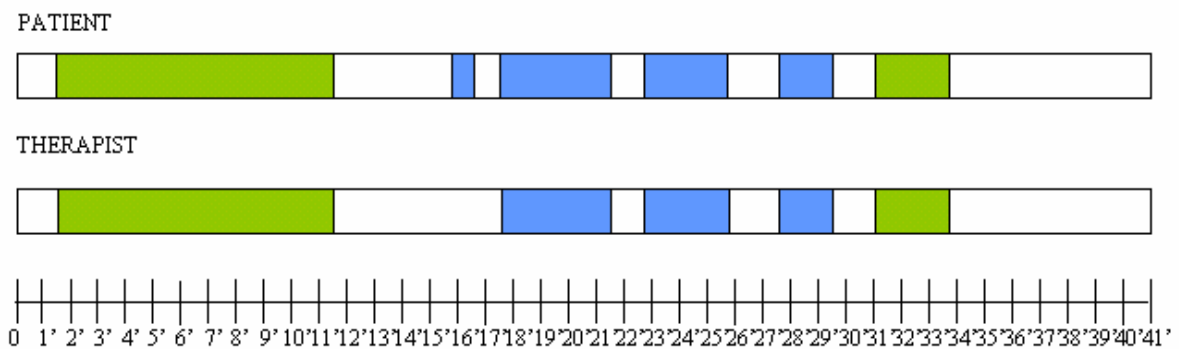


Figure 6.5 : session 6



Colour code for interpreting the figures:

		
Verbal reflection	piano	“Für Elise”


 = video-excerpt

Figure 6.6 : session 7

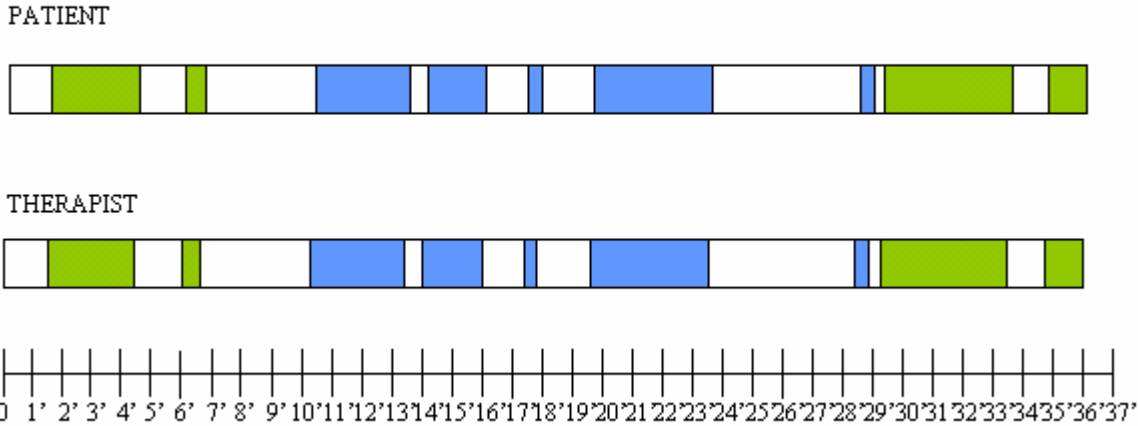
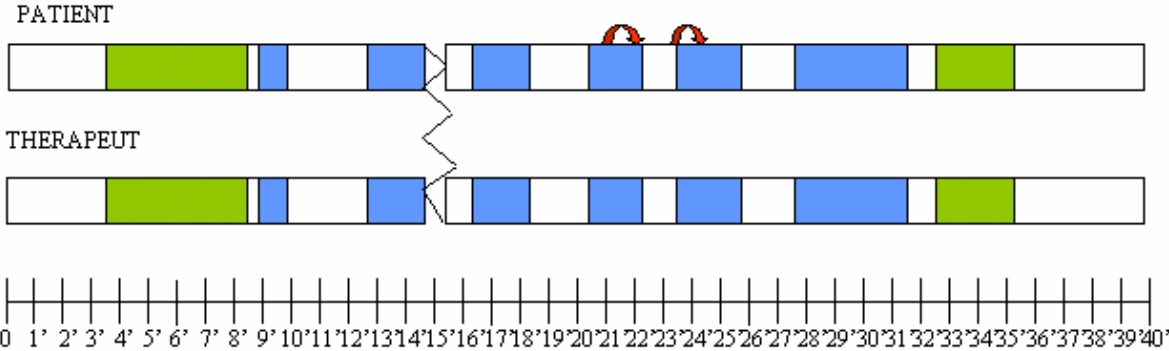


Figure 6.7 : session 8



In these figures it is possible to distinguish the use of 5 different instruments, the verbal reflections, 'Für Elise', and the interruptions within the sessions. The figures are precisely documented to a time line on the x axis (in minutes), with both the therapist and patient's activity documented, and a key to symbols and colour coded sections provided at the beginning.

In sessions 3 and 8, there was an interruption by the person in charge of the construction work taking place next to the therapy location during the time of the treatment. This person did not have a therapeutic significance for the patient, apart from his intrusion causing the patient to react in a two-layered way, i.e. showing-off as well as playing defensively.

These figures show the duration of the sessions falling between 36 and 42 minutes. In session 3, the therapist's "reverie-play" about the absent patient has been added at the beginning, which gives a total of 47 minutes. In sessions 4 and 7 the music therapy is concluded earlier, at the insistence of the patient and also because the therapist felt that this was appropriate therapeutically.

Table 6.1: Number of improvisations

Session	1	2	3	4	5	6	7	8
Number of improvisations	6	0 verbal	7	4	3	4	5	6

Table 6.1 shows the number of improvisations per session lies between 3 (session 5) and 7 (session 3), without the musical intervention of "Für Elise".

These improvisations were always preceded by a verbal introduction and followed by a verbal reflection. The duration of the improvisations were between 20 seconds and 7 minutes. It is notable that the duration for teaching 'Für Elise' was between 2 and 11 minutes. The figures also show how short musical fragments are varied by verbal reflections. The very short fragmented musical interventions of the patient in the verbal reflections could not be shown visually.

During the appearances of 'Für Elise', the development of its use by the patient is striking. 'Für Elise' is first introduced in the third session and opens each session thereafter. As of session 5, 'Für Elise' also concludes each session. 'Für Elise' has the function of a holding

symbol, a kind of ‘sonorous bandage’ which provides the patient with a safe structure to which he can return.

The musical instrument that the patient mainly chose for the improvisation was the piano (21 times), while the alto-metallophone was chosen only 5 times, the alto-xylophone 4 times and the drum even less (3 times). In the last three sessions, the patient only chose the piano. The piano is also a favoured instrument for the therapist (25 times). This clearly shows that the piano was very important for the patient’s therapeutic process.

In the table we see that the patient begins either with (or before) the therapist, but ends the improvisation together with the therapist. Only in session 1 and 6 does the patient play a solo improvisation.

Table 6.2: Overview of the video-excerpts

Video-excerpt	Session	Time
<i>Sensorial play</i>		
excerpt 1	session 1	02.12 - 03.12
excerpt 2	session 1	25.21 - 26.21
excerpt 3	session 3	19.51 - 20.51
excerpt 4	session 3	23.03 - 24.03
<i>Synchronicity</i>		
excerpt 5	session 4	31.16 - 32.31
excerpt 6	session 8	21.12 - 22.12
<i>Musical form</i>		
excerpt 7	session 8	23.25 - 24.25

6.2.1.2 Excerpt 1: “The fragmented play” [First session; first improvisation: 02’12”-03’12”]

1. Description of the selected video-excerpts

The patient sits alone at the piano, leaning backwards and with a bent back. His hands hang, poised over the piano keys. The therapist sits 1,5 meters diagonally to the left, behind the patient, with crossed arms and legs, and with his head and body slightly bowed to the left. He positions himself this way in order to be able to listen attentively to his patient. There is no eye contact between them.

2. A notated score of each excerpt and a description of the musical elements

The patient begins to play immediately, without any mental preparation. He plays his first musical theme in a 3/8 metre. At the first count of the measure, he plays a bass note with the left hand; with the right hand, he plays a note on the second and the third beat. This first theme has a flowing and repetitive character. There is then a second, more formed, dotted-note theme, followed by a third theme (a variation of theme 1). Finally, in the fourth and last theme the patient appears to be searching for a melody, but cannot achieve this and as a result a broken melodic impulse follows. The whole atmosphere sounds melancholic and brings to mind an image of someone who is lost. Everything the patient plays lies outside himself, and nothing can be integrated. The play consists only of repetition without any development. The music remains in the same register, within the same octave.

Figure 6.8: Score of excerpt 1

Excerpt 1

The score is written for piano in 3/8 time. It consists of four systems of music.

- System 1 (bars 1-8):** Labeled "Patient (piano)" and "A". The tempo is marked "ca. 120". The right hand plays a melody of eighth notes, and the left hand plays a bass line of eighth notes. An "interruption" is marked at the end of bar 8.
- System 2 (bars 9-16):** Labeled "(piano)" and "B". The tempo is marked "ca. 168" and "accelerando". The right hand plays a melody of eighth notes, and the left hand plays a bass line of eighth notes. An "interruption" is marked at the end of bar 16.
- System 3 (bars 17-26):** Labeled "(piano)" and "A'". The tempo is marked "ca. 120" and "a tempo". The right hand plays a melody of eighth notes, and the left hand plays a bass line of eighth notes. A "sequence" is marked at the end of bar 26.
- System 4 (bars 27-34):** Labeled "(piano)" and "A'" and "Coda". The tempo is marked "morendo". The right hand plays a melody of eighth notes, and the left hand plays a bass line of eighth notes. A "cfr. bars 6-8" is marked above bars 27-28.

The form of this fragment refers to a classic song-form (a lyric canzonetta), with a remarkably stable metre in triple time.

Table 6.3: Overview of the structure of excerpt 1

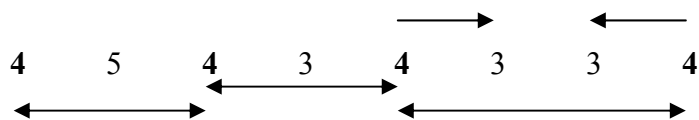
Section	A	B	A'	A''	Coda
Bar:	1-8	9-18	19-26	27-31	32 ...

The first A- section consists of 8 bars (5 + 3). Bars 3 and 4 form a sequence of the bars 1 and 2, and are then repeated in bars 6 and 7, which one can think of as a kind of post-statement. The *a* pitch is the fundamental note [or tonic] for the entire A-section.

Bar 9 can be considered as a transition bar to the B-section and with regard to the time and rhythm is different from the A- and B-sections. The B-section in every respect contrasts with the A-section. Everything revolves around the tonal centre of the *b'* pitch, which is repeated just like the fundamental (or tonic) *a'* pitch in the A -section. The B-section is mainly chromatically inspired, with the pulse becoming increasingly more irregular through the appearance of a variety of shifts of accent.

In these asymmetric bars one can detect “palindrome”⁶ rhythmic structures. From bar 10 we can count the number of quaver notes following each time the note *b* is stressed as the tonal centre.

Figure 6.9: Representation of the internal relationships of the quaver note figures



⁶ Palindrome means a piece or passage in which a retrograde follows the original (or ‘model’) theme from which it is derived. The retrograde normally follows the original directly. The term ‘palindrome’ may be applied exclusively to the retrograde itself, provided that the original preceded it. In the simplest kind of palindrome a melodic line is followed by its ‘cancrizans’, while the harmony (if present) is freely treated. The finale of Beethoven's Hammerklavier Sonata op.106 provides an example. Unlike the ‘crab canon’, known also as ‘canon cancrizans’ or ‘canon al rovescio’, in which the original is present with the retrograde, a palindrome does not present both directional forms simultaneously.

When we count from bar 10, we notice a continuous repetition of the 4 note figure varied with 3 and 5 quaver notes. There is also a palindrome group of 4-5-4 (bars 10-13), which forms the second palindrome group of 4-3-4 (bars 13-15). After this there is the palindrome group of 4-3-3-4 (bars 15-18) in which we see also a crab canon 3-4 (bars 15-18).

The joining together of these palindromes (of which the last group of quavers is also the beginning of the following group) is a chain-technique. This is similar to that used by the Polish composer Witold Lutoslawski (1913-1994).⁷

The A'- section (as of bar 19) is also comprised of 8 bars, this time in the following format: 2 (bars 19-20) + 3 (bars 21-23) + 3 (bars 24-26) bars, where the group of three bars (bars 21-23; bars 24-26) is a sequence of falling duplets, each related to the other. One can also consider bars 21-23 as a variation of bars 6-8.

The A'-section is the mirror of the A-section: in bar 1 the left-hand plays the tonic (*a*), followed by a grace note (*b-a*), the *b* dissolving to the tonic (*a*). In bar 19 the left-hand now plays in the key of the flattened sub-median where the right-hand answers by starting from the *f* and ascending to the *g* (which is now not a grace note but a "pivotal note").

Section-A" (bars 27 to 32) is only 6 bars long and has no musical coherence: the second section of A" (bars 30-32) refers to section A (bars 6-8). Bars 31-32 are a transposition of bars 21-22 and bars 24-25.

The so-called coda could be described as a falling apart of tones without any motivic significance. The coda refers to bar 1 through the motion of the second intervals, but this in itself does not indicate any single consistent musical direction. It is only in the Coda-section that the musical coherence falls apart, perhaps because of the withdrawal of the ostinato bass as in sections A, A' and A".

3. *Selected comment from the patient relating to his experience of playing*

Immediately after this improvisation, the patient asked the therapist if he could teach him 'Für Elise'. The patient went no further in his first musical introduction and it was as if there had been no improvisation.

⁷ Lutoslawski found a way to create musical forms combining unrelated strands of music whose short, discrete sections overlapped one another like the links of a chain. Elements of this method can be found in many of Lutoslawski's earlier works, but the first to emphasize it was Chain 1 (1983), for fourteen instruments. Chain 2, subtitled 'Dialogue for Violin and Orchestra', followed in 1985. The latest work to adopt this approach was Chain 3 (1986), for large orchestra.

4. *Selected impressions and reflections from the therapist about the patient's way of playing*

The therapist experienced this fragmented play as the expression of the patient's fear of giving himself to the unknown of the music. At the same time, the fragmented play had a quality of something fragile and empty.

The patient sat seemingly nonchalantly at the piano, but the therapist experienced a certain tension and uncertainty from the counter-transference. The position and the way in which the patient played the piano gave the therapist the feeling that the patient would like to have withdrawn from the piano and also from the therapist.

The patient repeatedly attempted to start a melody, but could not hold on to this material. The therapist experienced the patient as being caught up in something meaningless, because the patient did not let the last tones resonate and he did not seem able to create any space to let something new appear. The patient could not even hold onto what was played and his music was like mud.

The patient's lack of reflection could be a confirmation that he could not appropriate the presented musical material and placed the play outside himself. This may also have been an expression of his resistance to improvise, as with his question of asking to learn 'Für Elise'. Improvising was a risk for him and in order to speak about it, he must let go of his defences, and leave the safe place. The question about learning 'Für Elise' was therefore connected to his sensorial play. To learn something in this way meant to obtain control over what cannot be controlled in the music. Music, and most of all, improvising, is about being able to give oneself over to the unknown, and that was still too difficult here, and possibly too soon for the patient.

The therapist experienced the patient's indirect question as transforming the music therapy framework into a music lesson; in bringing 'Für Elise' into the session, an active defence against the 'danger' of improvisation was triggered.

5. *Selected reflections from clinical intervention*

There was no beginning and no end to the patient's music, yet there was a certain zest noticeable in his play, which contained elements of a musical figure within which something could have developed. However, the patient repeatedly destroyed this by breaking it off and introducing a new rhythm or melody, because it was too risky for him to give himself up to an

unknown path. He therefore broke it off and then, not letting anything new originate, he revealed evidence of his narcissistic problem. The patient could suggest what should be possible to begin with, but was too afraid to develop something. The danger that his attempts would fail, or that it would not be good, was too great and by repeatedly breaking off from playing, the patient's music took on a fragmented character. One could assume that the patient's play was a form of active resistance. Rather like someone who comes in and says, "Well, I'm not going to say anything", the patient was not ready for the risk of music-making. The moment where the patient should have been able to come to grips with what he could originate musically was entirely absent here. The patient tried to control the aspect of being 'caught' by the music, in the sense that he had to play musical beginnings which were beautiful for him but he was unable to succeed in this. He remained in one place, almost encircled in that one small musical sentence, fearful of being overwhelmed by the music—against which he continuously fought.

In this excerpt, the absence of musical form is well illustrated. There was no beginning, no end, no rhythmic, melodic, nor harmonic development, no dynamics.

**6.2.1.3 Excerpt 2: "A musical wandering" [First session, fifth improvisation:
25.21 – 26.21]**

1. Description of the selected video-excerpts

The therapist sits at the piano on the edge of his chair while the patient sits next to the piano at the right, behind the self-chosen alto-metallophone. The patient holds the mallets very loosely while he is playing, with his arms resting on his legs. He creates an impression that he is playing in a very nonchalant and almost careless way. The music suggests a restful and absent feeling and drifts without any obvious focus. The patient continually repeats the same note. It is the right hand that is dominant, and through the left-right movement of the right wrist, the mallet sways back and forth without any intention of playing a particular sound. The therapist is completely submerged in his own play, which also sounds too loud to be able to hear the sounds or possible melody of the alto-metallophone.

Abruptly and unannounced, after a short period the patient breaks off from the musical play, sits bolt upright and looks disinterestedly towards the therapist. He holds the mallets tightly, playing a little with them, but does not discard them. With this action, it seems as if the patient's musical play has not yet ended. The therapist then closes the improvisation by quickly

playing a final cadence and taking his hands away from the piano. He lets the last chord resonate by using the pedal of the piano. He faces immediately towards the patient, making a turning movement on the chair without the chair moving.

The whole excerpt is a demonstration of two people who, while they are both playing, are not playing together. They appear to have absolutely nothing to do with each other. There is no musical or visual contact between the patient and the therapist and the quality of the whole play is elusive. It is a disinterested play, without any dynamic movement or development.

2. A notated score of each excerpt and a description of the musical elements

In this fragment, the patient is playing repetitively, his left hand sounding rather stagnated with his right hand sustaining a melodious movement. The therapist's playing also sounds monotonous, without any musical development or variation in the theme. Both patient and therapist are in total isolation and apart from each other in their respective music. There is no musical interaction; the therapist does not attempt to get involved in the playing of the patient. When the patient abruptly ends the improvisation, the therapist concludes (bar 13), ending the improvisation with a cadence (bars 14-15) which leaves the last chord resounding.

Figure 6.10: Score of excerpt 2

Excerpt 2
♩ = ca.100

Patient (alto-metallophone)
Therapist (piano)

1 a a' (minus f) b

6 b b

10 transition a a'' A'b' Codetta

This is a rather complex musical excerpt. Both players improvise together, but their music is somewhat unrelated, and because of this they do not appear to be making music together. This is confirmed by the fact that both players do not play in a common metre and also that the musical structure of one player does not correspond with that of the other.

The musical play of the therapist is an example of a symmetrical song form:

Table 6.4: overview of the structure of excerpt 2

Aa	pre-phrase	bars 1-2
Ab	post-phrase	bars 3-5
Ba	pre-phrase	bars 6-7
Bb	transition	bars 8-11
A'a'	re-exposition	bars 11-13
A'b'	codetta	bars 14-15

The musical fragment is tripartite (A B A'), where each part divides symmetrically into two musical phrases: Aa and Ab (bars 1-5) and Ba and Bb (bars 6-10), followed by A'a' (bars 11-13) and A'b' (bars 14-15). It is interesting that the bass line from the therapist does not hold this symmetry, because here we can distinguish two types of motifs - the a-motif (= bars 1-3) is marked by a classical i-vi-iv-v modulatory progression that returns exactly in Ab (bars 3-4) and in A'a' (bars 11-13) (although in the former case the f is omitted).

In the codetta (A'b') the a''-motif (bars 11-13) appears in the most shortened form, without i and v. This a-motif always has a cadence-like and tonality-confirming quality. The b-motif that appears in the middle section (bar 5 and repeated in section Ba and Bb) is a reflection of the a-motif and can be seen from the time c-major appears as a vi-iii cadence, or in *a* Aeolian mode as a tonic-dominant progression. The other notes, such as the *f* and *g*, serve as transition notes to the (dominant) resolution to the *a* (tonic) Aeolian.

The patient could not allow himself to join the clear, harmonic, stable and pulsed music of the therapist. Instead, he constantly played contrary to the therapist's quadruple time, creating triple time music with variations. The patient played the first two intervals with his right hand while maintaining the main pulse with his left hand, and through this way of playing a musical image appeared in the music. Throughout the whole excerpt the patient's play was in contrast to the metre of the therapist's and because of this the music sounded complex and polyrhythmic.

The patient's contribution can be described as in a 'pianistic style' on the alto xylophone. All motifs descend harmonically, with the main notes moving around the dominant note *g*". In this way one can determine a harmonic grouping in this invention of motifs. When the accent in his left-hand is the note *c*, the entire section is rooted in a C major tonic. However the music as a whole revolves around the leading note *b*.

3. *Selected comments from the patient relating to his experience of playing*

Immediately after the improvisation, the patient said: "It does nothing for me; I experience nothing." He still held the mallets firmly and played a broken downward chord (*b'-g'-e' / b'-g'-e'*) three times on the alto-metallophone. He continued: "I always play the same. I find it frustrating that I can not find my ideal melody." He played some short melodic motifs on the alto-metallophone as he said this. He was in search of the ideal melody, but did not find it.

4. *Selected impressions and reflections from the therapist about the patient's way of playing*

The therapist improvised as if on 'automatic pilot', caught where the music lacked dynamic qualities or a sense of direction. He felt as though he was in a regressive state, experiencing the improvisation as boring and senseless and with an endless quality. He sat trapped in the musical play and therefore could allow no room or opening for the patient.

This way of playing felt foreign to the therapist. Normally he played an accompanying melody or harmony below the patient's music. However, he felt that if he played accompanying chords he would be covering everything up and this would not be effective in the therapeutic work with the patient. The therapist felt that it would be overwhelming for the patient to have the therapist too close-by, and he would not have been able to bear this kind of connectedness. He could not tolerate any domination, and he had to be able to be on the same ground as the therapist. The patient also appeared to need to determine and control the therapeutic framework. The therapist could not take up too 'fatherly' or authoritarian a stance because this would only emphasise the patient's feelings of impotency, forcing him into a dependent position.

From the beginning of the improvisation, the therapist realised that the timbre of his playing on the piano did not match the patient's timbre of playing on the alto-xylophone, with the consequence that the musical interplay did not work very well. There was no sonorous connection and a feeling of integrated musical chemistry was absent. While at the piano, the therapist felt that he was not able to match the timbre and therefore resonate effectively with the alto-metallophone. Through the transference, the therapist felt it was impossible to connect with the patient's music; perhaps this very timbre echoed the transference.

The patient seemed to be in search of an ideal image. However, it was a fragmented, directionless search, without any reference or focus. The manner with which he played had nothing to do with the therapist and it was as if he said: "Here, maybe you can do something with it; I, in any case, cannot; do whatever you want to do with it." His stance gave the therapist the impression of someone who thought he could not be helped and who had difficulty in finding interest in something. Verbal reflection was impossible or too threatening for the patient.

5. *Selected reflections from clinical improvisation*

The patient displayed an almost provocative listlessness, only showing that he could not let himself into the musical play through the manner with which he held his mallets so tightly clenched. This was a refusal to engage, where the patient could not give himself over to the therapeutic relationship. He wanted to control everything.

The patient, as well as the therapist, played for himself: isolated, playing endlessly and in a purely sensorial way. There was no apparent resonance between patient and therapist.

What the therapist played was less interesting – it was a washed-out music, without tension and structure, and with a lack of any sense of tonal direction. The patient's play was also endless, and one could see that he did not reach any kind of form. The musical texture was polyphonic and because of this both therapist and patient played together, they were at the same time isolated from each other, sharing a space within an endless music where there was no musical development possible (including the negation of melodic development due the lack of phrasing).

The therapist reflected that the playing together was meaningless. The only way the improvisation could come to an end was through the curt and abrupt breaking of the musical interplay by one person, which the patient finally achieved.

It was noticeable that the therapist adopted a nonchalant posture after the improvisation. It was as if the therapist endorsed that there was nothing significant happening, in that he was also withdrawing from the music and from the therapeutic relationship. Unwilling to turn his chair towards the patient, the therapist reflected the superficial feeling of the improvisation. This was a mirror effect of the same temporary state that the patient had hinted at previously, with the play that he repeatedly broke off. The therapist felt that he should not come too close to the patient, but rather that he needed to therapeutically hold the patient's material, in order that he would not lose him. The patient showed some inclinations towards a musical form, but he could not hold or develop this: for example, he presented the beginnings of musical figures that had the potential to be musically developed, but he broke off these ideas every time.

6.2.1.4 Excerpt 3: “The narcissist is completely impossible” [Third Session, First improvisation: 19’51” – 20’51”]

1. Description of the selected video-excerpts

The patient chooses the alto-metallophone and begins to play immediately, even before the therapist was able to take an alto-xylophone for himself. The therapist lets the patient know that he needs a stand in order to set the alto-xylophone higher. The patient looks up, but plays on, undisturbed. The therapist moves a stand in order to set the alto-xylophone up. The patient stops playing, and feels the head of the mallets, perhaps wanting to know how hard they are. The therapist moves his chair closer, making some noise (possibly to attract the attention of the patient), and sits down. It is striking that this disturbance does not cause the patient to look up, or that his sensorial play is not influenced or broken off by it.

While the patient plays on, the therapist considers the situation and then looks indirectly towards the patient. He allows an anticipating silence in himself and listens to the patient’s sonorous play before he carefully joins in. He plays a melodic theme with the right hand, which becomes embedded in the patient’s metre. Then, the therapist straightens his body and engages in a melodic style of playing. However, this music has absolutely no influence upon the patient.

Through the specific sound colour of the alto-metallophone, the patient’s music sounds quite flowing, while the therapist’s staccato sounds on the alto-xylophone have a quality of concealment.

2. A notated score of each excerpt and a description of the musical elements

The patient starts to play without any mental preparation. It is strange that the patient does not even wait for the therapist before playing, nor does he allow the possibility of mutual play. The therapist eases himself gently into the sensorial modality of the patient’s playing. The patient plays in a triplet pattern without any rhythmic variation, accents or rests. His play goes on endlessly, his sticks move up and down, continuously alternating between the right and left hand. The differing timbres of both instruments and the way in which each player improvises is well differentiated. The patient sustains monotonous play, while the therapist plays two tone chords, as well as incorporating rests, accents and rhythmic variations into his play.

Figure 6.11 : Score of excerpt 3

Excerpt 3

$\text{♩} = 132$

A

Patient (alto metalophone)

interruption

B

ascending

right hand

left hand

descending

C

Therapist (alto-xylophone) 1 question

Patient

Therapist

2 answer question answer

In this excerpt there is a complete absence of musical coherence. We hear the patient play repetitively, with no noticeable variation of rhythm, nor any musical logic. Section A is incoherent and has no apparent musical significance. This music is directionless and appears to lead nowhere.

After a short interruption in section B, the music changes into a kind of triple time (3/8). Each time the left-hand plays two notes (typically in intervals of a 3rd), the right-hand answers musically with one tone, with the difference in intervals between the left- and the right-hand ranging from a seventh to a ninth. The patient lets his right-hand ascend step-wise in 2nds within an overall range of a 5th, indicating the build up of a simple melody. In section C the melody stagnates because of the repetition of two notes (*b - d'* and *c' - e'*), and in response to this, the therapist joins the pulse and metre of the patient. The therapist plays a pre-phrase and a post-phrase in the tonality of *a* minor: *b' - a' - b' - c''* and *a' g' - a' - f'*. This final motif is a mirror image of the first motif. There is no apparent musical intention from the patient to enter into

co-playing. The patient does not enter into the metre of the therapist and continues to play in a repetitive way. In this example it is obvious that the patient is unable to be engaged by the musical structure developed by the therapist.

3. *Selected comments from the patient relating to his experience of playing*

No comments; see excerpt 4.

4. *Selected impressions and reflections from the therapist about the patient's way of playing*

The patient chose the alto-metallophone for himself. He made no choice for the therapist, even after the therapist had asked him to several times. The therapist finally chose the alto-xylophone himself, a choice that was intuitively based on an interpretation of the transferences of the patient's wishes. This instrument choice resulted in an interesting contrast in sound colour - the flowing, reverberating sound of the alto-metallophone versus the short, pointed quality of the alto-xylophone timbre. The therapist realized afterwards that through his choice, he differentiated himself from the patient. There was, therefore, a certain distance created. The question that needed addressing from this session was whether or not the therapist wanted to avoid everything flowing together where the two sounds would be heard as one, as a harmonic (symbiotic) sound, in order that the patient could play his own sound, and hear his own melody.

It was striking that therapist and patient could not begin together. The therapist felt irritated that the patient had not allowed the possibility of playing together, even when he had introduced a silence. The therapist was also confronted by the patient's limitless state which showed him the lack of the patient's boundaries. The therapist experienced no intersubjectivity, either in the musical interplay or in the introduction to the musical play.

It was very difficult for the therapist to find a way to achieve any resonance with the patient's music. Initially, the therapist felt a certain sense of hope in the music, but this soon changed and it became impossible to come into contact or resonance with the patient.

5. *Selected reflections from clinical intervention*

The patient played without allowing any acknowledgement or resonance with the therapist, in spite of the fact that their instruments were placed opposite each other. It seemed that for the patient the therapist was only an object, and did not exist as a subject, resulting in a significant lack of any inter-subjectivity.

One could speculate that the patient demonstrated an active resistance towards the ‘anticipating inner silence’. One could also have expected that the patient would stop playing when the therapist came to sit by him, in order to create an anticipating inner silence together with the therapist. From this anticipating inner silence, both might have been able to give themselves over to the inner sound, from where a shared play could originate. There was, however, no phrasing and no intermediate space in which something would be able to grow between them. In this way the patient appeared to prevent anything from beginning. It was a beautiful illustration of how the patient avoided engaging with the therapist.

It was noticeable on the video that the therapist was slightly irritated that the patient had not waited for him, through the way in which he set his instrument up. He certainly let himself be heard by using his foot to loudly move the block on which he set up the alto-xylophone. One could speak here of a counter-transference reaction, where the therapist did not realize that he was so loud, and coming across to the patient as being so irritated.

The physical aspect that comes to the fore in this excerpt was interesting. In the anticipating inner silence, the therapist moved his body almost infinitesimally in congruence with the metre of the patient’s sensorial play, perhaps in an unconscious attempt to achieve resonance with the patient’s music. A little while later, the therapist literally straightened himself up. The straightening up was a minimal movement - a sitting up straight - but it showed that the therapist could direct himself toward the patient whenever he had found his own inner sound. One can also consider this as a mental straightening up, of ‘righting oneself’ with the patient. Here the physical aspect is directly connected with the therapist’s ability to join the patient’s play.

6.2.1.5 Excerpt 4: “An uninterested end” [Third Session, end of the first improvisation: 23’03” – 24’03”]

1. Description of the selected video-excerpts

The patient and therapist sit across from each other. The patient plays the alto-metallophone, the therapist, the alto-xylophone. During the musical play there is no noticeable contact or interaction between them, neither musically nor visually. Both play in an isolated way, although the rhythm and the metre sometimes flows in parallel.

At the end of the improvisation the patient seems bored, and for an instant looks in the direction of the window. The therapist notices this, draws the improvisation to a close, and looks at the patient. The patient reacts by stopping and he plays a couple of glissandi on the alto-xylophone. He does not lay his mallets down afterwards, but continues to hold them and plays a little more along on the alto-metallophone. After this he keeps playing in the air and looks insecurely at the therapist.

2. A notated score of each excerpt and a description of the musical elements

In this fragment, the therapist brings his music to the fore, playing dynamically and introducing variations. The patient appears to be inspired by the playing of the therapist, as he plays a clearly recognisable rhythmic figure (bar 7) that has emerged from the therapist’s musical material. However, both players continue to maintain their isolated playing.

The therapist introduces phrasing in his playing by allowing a silence, and then subsequently re-joins the patient’s metre, at first cautiously, but gradually establishing powerful and accentuated rhythms in order to anchor the playing. The tempo is faster than in excerpt 3 and a certain tension develops. However, it is merely an illusion that the playing together exists within a ritardando from bar 28 (coda), because the patient does not allow this to happen and starts to play glissandi. This means that once again it is not possible for the patient to find a way to end the improvisation.

Figure 6.12: Score of excerpt 4

Excerpt 4

The score consists of two staves: Patient (alto-metallophone) and Therapist (alto-xylophone).
Section A: Bars 1-6. Tempo: ca. 56. Key signature: one flat. Time signature: compound duple (6/8). Motif 'a' is introduced. A 'rallentando' marking is present.
Section B: Bars 7-18. Tempo: 80. Key signature: one flat. Time signature: simple duple (2/4). Motif 'b' is introduced and repeated 11 times.
Section C: Bars 19-21. Labeled 'Inversion of a motif'.
Section B': Bars 22-27. Labeled 'Inversion of b motif'.
Coda: Bars 28-32. Includes 'rallentando' and 'Glissando' markings. Ends with a *ppp* dynamic.

This excerpt of 32 bars can be split into five parts:

Table 6.5: Overview of the structure of the excerpt 4

Section:	A	B	C	B'	CODA
Bar:	1-6	7-18	19-21	22-27	28-32

Section A evolves in compound duple time. The first 4 bars possibly refer to the key (tonality) of A minor, but this becomes diffused as of bars 4-6. In bar 6 the therapist interrupts the patient's music.

In section B (bars 7-18) however, the patient's playing develops further with a repetition of a new rhythmic motif, consisting of a double-dotted quaver note followed a demisemiquaver note (a type of hopping rhythm), in simple duple time, which recurs 11 times. In section B and B' the presence of the third interval in the patient's music is particularly noteworthy. The

therapist responds by playing a repeated “4 semiquaver-1 crotchet” accompanying figure. The therapist complements the rhythmic figure of the client by playing semiquavers during the longer double dotted quaver note of the patient, and then a long crotchet when the patient plays quavers. In this way the therapist intuitively hears the ‘silence’ in this rhythm and by sounding throughout this dotted-rhythm ‘heartbeat’, he helps to contain the brief silence for the patient.

In section C we see a merge of a and b-motifs and rhythmical elements of b (i.e. the 3/8 cell) appear. The melodic line is also the mirror image of section A. In section B’ (bars 22-27), the patient musically incorporates the original b-motif of bar 7 again.

The Coda-section is a musical fade-out of the important motifs that flow towards the two glissandi. These glissandi have the effect of erasing what happened previously.

3. Selected comments from the patient relating to his experience of playing

After this improvisation, the patient can barely put anything into words. He continues to play some fragmented notes on the alto-metallophone, while the therapist gives him the possibility for reflecting about the improvisation.

The patient: “The whole improvisation says absolutely nothing to me. I do not have anything to do with it.”

Here, he emphasized how impossible it was for him to develop a psychological space, in which he would be able to make the play his own.

The patient laid out, in the following commentary, the link to his home situation.

The patient: “At home, I close all the curtains of my room, so that no one can see me. Only then do I feel at peace with myself.”

4. Selected impressions and reflections from the therapist about the patient’s way of playing

The therapist experienced the patient’s play as endless and empty. He tried to come into interaction with the patient through such things as bringing in new rhythms, phrasing and melodic varieties. This went nowhere, and the patient himself could not integrate the therapist’s dynamics into his music. The therapist felt totally powerless and imprisoned in a therapeutic space that was empty and without resonance. The patient’s seeming lack of interest was confirmed when he looked up and stared outside. By doing that, he distanced himself from the

improvisation and gave a signal to the therapist to round off the improvisation. The therapist experienced that he must be very careful and respects the boundaries of the patient. By stopping, the patient had swept everything away, and that with his glissandi on the alto-metallophone, the improvisation itself was brushed aside. It gave the therapist the impression that nothing could be experienced as significant and that everything that he presented might have no meaning.

With the patient's glance toward the therapist after the rounding-off of the improvisation, there was a threat of something dangerous. Perhaps the patient had to keep an eye on everything; apparently, the improvisation did not interest him, but in the meantime, he kept an eye on everything. He would avoid every possibility of joining in himself that could be understood as a way in which he was engaging himself in the process. In this sense, the therapist experienced that it was an active diversion on the patient's part.

Most of all it was the sense of being trapped by the patient and the lack of possibility of functioning freely that caused the therapist to be unable to play. He was constantly on his guard not to provoke the patient. The therapist experienced right from the beginning of the improvisation that he could join the timbre of the patient's play.

Here, the patient made links with the aggressive and destructive parts of himself. When he closed the curtain, he created the illusion that he did not have to see anyone and was set free from all fears. 'Inside' meant safety for him and within that framework, he could let anything happen. Learning 'Für Elise' was such an example of a musical 'indoors' and through this the patient set the limits of the music therapy sessions. 'Für Elise' was an example of the contained, and was therefore a boundary experience: 'Für Elise' kept everything inside and through this boundary there grew a safe space in which something could happen. The traumatic was outside - the uncontrollable, what was not symbolized and could not be taken up in the inner space.

The patient's fear of improvisation was apparent and in the way he responded he was able to express his being shut away. He had a fear of coming into the world particularly through improvisation where what he might play could be a means by which others could 'see' him. In that sense, this again mirrored his specific pathology. His resistance towards improvising was the same as his resistance to going outside and giving himself to the world. Thus, the therapist always gave the patient the opportunity to improvise, knowing this was possible for him.

5. *Selected reflections from clinical intervention*

The entire improvisation was almost nothing more than a succession of random sounds. Nothing musical developed, and because of a lack of linear development there was also no possibility for a musical conclusion. In a certain sense, the therapist could not end the improvisation himself, as he would have liked, and it was as if he was being forced towards an ending. The therapist rounded off the musical play after the patient's lack of interest became apparent when he gazed out of the window and away from the improvisation. He gave the therapist the impression that he should end the play. The patient stopped the improvisation by playing glissandi on the alto-metallophone with both mallets, and by so doing he literally and figuratively swept away everything that had sounded. Nothing could exist and no memory of the play could remain present in the post-resonance. One might also connect this to the narcissism of the patient, where everything that came up was immediately discarded, and nothing important or essential could be allowed to happen or be retained. The patient continued to strum the instrument and then looked at the therapist with a fearful glance. During the verbal reflection, the patient could not let the sticks go, and occasionally played some notes here and there.

The patient alternated verbal commentary with the musical play. His pattern was: playing music, breaking it off, then going back to talking. When just talking, he tended to run out of things to say quickly and then failed to continue. In the family therapy sessions he frequently ran outside when the family spoke. He could not sustain a verbal conversation and had to break this off every time. After he had somewhat recovered he would sometimes come back inside, only to run outside again when it became too much for him. Verbal psychotherapy was something that he could not handle. It was too threatening for him, too confrontational. However, music therapy appeared to be more successful for him, because he could alternate between saying something and making music, and to act as if nothing happened, while everything had happened. In music therapy, learning 'Für Elise' was a parallel form of escaping in a different modality when compared to going outside in verbal psychotherapy sessions. One could consider music therapy in the same way as a verbal psychotherapy, because in one way it offered the only possibility for sustaining therapeutic contact and music and verbal interaction with a sense of continuity. There was something happening musically that the patient was not able to put into words.

In not being able to stop (e.g. the glissandi and afterwards, holding the mallets and playing in a vacuum with them), the patient's unboundaried way of behaving came to the fore. There was no beginning and no ending to the improvisation. The patient began playing without giving a "beginning" to the improvisation, and without starting together with the therapist. He could not round off and finish the improvisation, being unable to stop and the play ran over into the verbal part.

**6.2.1.7 Excerpt 5: "The darkness" [Fourth session; fourth improvisation: 31'16"
– 32'31"]**

1. *Description of the selected video-excerpts*

The patient and the therapist sit together at the piano. It was the patient's suggestion that they play the piano together. The patient sits at the right side of the piano, while the therapist sits somewhat set back from the piano and therefore leaves more space for the patient. The faces of the patient and the therapist are not visible on the video recording of the session. From the beginning, the music breathes a dynamic and dramatic atmosphere. The therapist pushes the music forward and the pulse of the music is visible through the movement of both the patient's and the therapist's upper bodies. At one point, both move in a synchronic way (31'44 – 31'53).

During this musical interplay the patient frequently looks at the therapist, through which a mutual understanding and trust seems to be developing. The moment of dynamic pulse ends in chaos, in clusters of sounds that were to be described by the patient as "darkness". The rumbling in the "darkness" is let go and while the sound still resonates on afterwards, the patient plays a small melody (section D). The therapist replies with another short melody - a musical reply to the patient. It evolves into music that has the to-and-fro of a dialogue, where the therapist plays a melody fragment and stops, and the patient replies with a complementary melodic fragment. The improvisation takes on a completely different character, and evolves from a dynamic, chaotic and dark play into something transparent and restrained, and with a developing sense of musical structure.

2. *A notated score of each excerpt and a description of the musical elements*

From the beginning, the music in this excerpt features a driving character that develops throughout, mainly due to the therapist's accentuated and insistent playing. The patient seems

to allow himself to be affected by the playing of the therapist. He is swept into the feeling of the powerful and dramatic playing. The playing together develops around a compact chord, which emphasises the pulse (from bar 22). This powerful playing concludes in a ritardando that is sustained by both players, subsequently transforming into a kind of tremolo that perhaps reflects playing “the darkness”. Out of this dark and messy playing some clear tones emerge (i.e. at the end to the tremolo play just before the 48 second marker point of the tremolo section) which introduce a clear melodic phrase or fragment of the patient (from section D on). The therapist answers this melodic fragment and a dialogue develops within the melodic playing.

Figure 6.13: Score of excerpt 5

Excerpt 5

8^{me}.....

Patient

Therapist

(Piano four hands)

ca. 138 **allegro barbaro** *mf*

fff **synchronicity occurs** *ad libitum*

7

13

8^{me}.....

B

19

C

molto rallentando 36"

46" **D** 48" *mf*

mf

The musical score is presented in a multi-staff format. The top staff is for the Patient, the middle staff for the Therapist, and the bottom two staves for the piano accompaniment (four hands). The score is divided into sections A, B, C, and D. Section A starts at measure 8 and includes a tempo marking of 'ca. 138 allegro barbaro' and a dynamic of 'mf'. Section B begins at measure 19. Section C, starting at measure 36, is marked 'molto rallentando' and features a dense, tremolo-like texture. Section D starts at measure 46 and includes a dynamic of 'mf'. A note 'synchronicity occurs' is placed above the piano accompaniment staves between measures 7 and 13. The score includes various time signatures and rests, and is marked with '8^{me}.....' at the beginning and end of the excerpt.

This excerpt provides a clear example of the power of musical intensity and shows an enormous diversity of rhythm and musical rhetoric.

Table 6.6: Overview of the structure of excerpt 5

Section:	A	B	C	D
Bar	1-21	22-24	25	26-end
	Repetitiveness	Pointillism	Climax	Fall out

The beginning of this excerpt has a fast tempo and a repetitive density with striking dynamics. In bar 2, the therapist introduces strong chords and clear accents, and maintains them. Only in bar 11 can the patient join the music in a completely synchronous way and take up these pulses himself.

In the B section this dynamic playing suddenly breaks off (like a *tnesis*, a rhetoric technique in baroque music) and the patient imitates the pulsed music found in bar 22. The patient becomes totally wrapped up in the musical tension, especially when this then transfers into aggressive choral clusters. After the clusters, twelve seconds follow in which indefinable tremolos are played by patient and therapist. At the 46 second marker point in the tremolando section, there is a change. The patient introduces three random clear and high tones, and transforms the tremolo play at the 48 second marker to a subdued and pastoral mood. A melodic dialogue emerges between the patient and the therapist.

3. Selected comments from the patient relating to his experience of playing

The therapist asked the patient which title he should give to this improvisation.

Patient: "Chaos".

Therapist: "Chaos ..."

Patient: "Yes, aggression, frustration, anger... "

Therapist: "Is this aggression not being transformed into music?"

Patient: "No, it makes me peaceful... and I could control my aggression and anger. This time I was not afraid of my anger."

4. *Selected impressions and reflections from the therapist about the patient's way of playing*

While the choice of the piano was the patient's, the therapist also had a certain desire to play *his* musical instrument. After the improvisation the therapist had the impression that the dark play or the 'hell' had been made possible simply through the choice of the piano. The capacity, the possibility and especially the ability to sit beside (and not across from) each other and play together on one instrument probably gave the patient the safety to acknowledge the theme "descent to hell" and to develop it into a form. The patient looked time to time to the therapist, with an expression that reflected his feeling of acceptance and understanding of their musical playing together in this very dynamic way. The therapist experienced that the patient could tolerate this way of playing.

From time to time the therapist felt free and autonomous in this play. He was guided by the music itself. This was the opposite of the previous improvisations, where he felt trapped in the play and by the attitude of the patient. The fear of losing the patient had disappeared completely. The therapist experienced this play as a pleasant thing. After the descent into the "darkness" the therapist did not know how the musical play would further develop. He did not expect the patient to finish the music in an obvious way and wanted to prolong the improvisation for a while. Intuitively he introduced a short melody, feeling understood by the patient who continued the alternating melody. This gave the therapist hope that the patient could hold onto the intensive and dynamic play and, furthermore, let it continue to resonate on afterwards in a new, alternating musical play. This was a musical play in which musical images could be developed.

The therapist invited the patient to symbolise the improvisation by giving it a title. Intuitively, he felt that for the first time the patient could experience this musical play as something coming from himself. It was striking that the patient could allow himself to be carried musically by the therapist. Through this, he could detach a little from his aggressive fantasies and experience another aspect of himself in the play. It was also the first time that the patient did not lose himself in his aggression or destructive urges. He could hold onto this chaos and aggression, possibly indicating that he had been able to give some form to his images in his musical play.

5. *Selected reflections from clinical intervision*

One can see here how the shared play of the patient and the therapist developed into a moment of synchronicity. The pulsed playing of both is striking and although it was introduced by the therapist, it can be interpreted as a shared move forwards. The quality of the music comprises something cheerful yet at the same time something aggressive. Was it a first step for the patient to allow his aggression to be externalised, something that he had previously always guarded against? The therapist felt clearly that it was possible to develop something from the patient's uncontrollable aggressiveness in the opportune moment (Kairos), an aggression that he did not know how to manage.

The course of this excerpt is interesting. The musical playing together that can be seen and heard ends in a deep, dark and chaotic sound mass -'the hell'. Here a new quality or style of playing appeared. The musical play became an exchange, with alternating melodies that could be clearly heard and could be interpreted as a musical digestion of what came before, in the psychic space that developed. It may well have been because of the experience of synchronicity and that the patient could allow the aggressive aspect of himself without having to run away from it, as was the case in the previous session. The patient could now experience that his aggressiveness had form, and that the aggressiveness could be held within the form. From here he was able to let the music evolve into an alternating play, without having to break it off abruptly.

In this excerpt one can clearly see and hear that the patient as well as the therapist feels free and safe to play.

6.2.1.6 Excerpt 6: “Le Sacre du Printemps” [Eight session; fourth improvisation: 31'16” – 32'31”]

1. Description of the selected video-excerpts

In this excerpt, the patient and the therapist sit together at the piano. The patient is on the left side, while the therapist sits on the right, on the edge of his chair. The therapist's chair only has two of its four legs on the floor, which could pose a question as to how intensely the therapist is present in the play. The excerpt opens with the patient's two downward and one upward melodic movement, which changes from chromatic flowing music into a dynamic rhythmic

play. This is supported but also pushed forward by the off-beat-rhythms and accents of the therapist. The hands and fingers of patient and therapist seem to be like dancers in a dynamically developing musical play. Their bodies move in a synchronistic way with the pulse of the musical play. Both players look at one another regularly, from which one might question whether these glances between patient and therapist are of understanding, or something that seems to say: “can we go that far in the music?” The patient appears to be surprised yet happy, perhaps aware of how far the music might develop. The musical play appears to represent feelings of pleasure and freedom.

2. A notated score of each excerpt and a description of the musical elements

The patient and the therapist are seated together at the piano. The up and down melody contour found in section B (bars 8-15) was introduced by the patient in section A (bars 1-6) with three descending phrases followed by one ascending using similar rhythmic patterns. The therapist, who was at first accompanying in a tonal, harmonious manner, becomes watchful (at the beginning of bar 7), then carefully abandons his structured tonal accompaniment and joins in with the chromatic movements. Musically, both patient and therapist are in harmony with each other. The chromatic playing becomes accentuated, syncopated, dynamic and dance-like (from bar 19) and develops into strongly accentuated playing with cross rhythms. These cross rhythms give a driving character to the playing. The rhythmic input of both players is independent and at the same time complementary.

Figure 6.14: score of excerpt 6

Excerpt 6

The score is for a piece in 3/4 time, marked $\text{♩} = \text{ca. } 60$. It is divided into three sections:

- Section A:** "introduction - choral", marked *mp* (piano four hands).
- Section B:** "two part invention", marked *mf* and *piu mosso*.
- Section C:** "toccata", marked *ff*.

At the end of section C, the text "synchronicity occurs" is written below the staff.

This excerpt can be divided into three large sections. Because of their musical character one can describe them as an introductory choral section (A); a two-part polyphonic, chromatic invention (B); and then because of the accented, pulsing quavers we have at the end a toccata (C). The excerpt contains material that also can be found in the other excerpts. For instance, the invention consists of chromatic motifs that also appear in video-excerpt 1, the pitch of which corresponds exactly with the beginning of the B-section in video-excerpt 1.

In section B a chromatic polyphonic duel is fought between the patient and the therapist, in which both parties each have their own form of musical logic. On one occasion they coincide in an octave *d* (bar 13). This chromaticism is sustained for a long time and it is fascinating and significant that the patient can continue that playing style for so long. In section B the therapist plays small descending chromatic groups, departing from the central note *b*, which is also repeated five times and played in an octave. This same note *b* was very important in the B-section of fragment 1 and from this note *b* (bar 9) there is a further movement. At this

point the patient plays big chromatic lines over a range of more than an octave interval, both descending and ascending. The chromaticism is broken up when the patient starts the accentuated and rhythmic C-section ‘toccata’, which recalls the *allegro barbaro* from the A-section in video-excerpt 5. From here the fragment is further developed musically. The overall mood of this music is reminiscent of Stravinsky’s ‘*Sacre du Printemps*’.

3. *Selected comments from the patient relating to his experience of playing*

In this excerpt, the patient is heard to round off and close the improvisation, as if to say that this was enough for him.

Just as in the previous session, he said: “I don’t have any words to talk about my feeling. I could only feel when I would stop... it was more than I wanted.”

Therapist: “How would you describe the music?”

Through asking for a description of the music without any reference to emotional material, the therapist indicated that it was not a problem when the patient could not talk about his feelings. Via the description of musical metaphors the therapist gave the patient the possibility to keep the necessary distance from what was going on within the improvisation.

Patient: “It is also hard to talk about music.”

In the conversation that followed, the therapist musically described the improvisation to the patient. For instance, how dynamically this improvisation developed from the patient’s musical introduction and was pushed forward by the off-beat rhythms that were brought in by the therapist. The therapist suggested that the music achieved a new level of freedom in order for it to develop in this way. He also suggested that it was good that the patient had set his boundaries, clearly something new for the patient.

4. *Selected impressions and reflections from the therapist about the patient’s way of playing*

In this improvisation the therapist experienced that he could be led by the music as an autonomous person. He felt that the patient gave him the freedom to vary his music without having to be dependent on him because he could end the play at any time. However, the patient was able to sustain his own playing throughout the improvisation. The therapist experienced that the patient was able to hold the power and dynamics of the music. The experience of being

connected, and of being able to play freely whatever he wanted definitely came to the fore. The fragility and insecurity in the relationship with the patient disappeared because a safe space was developed, one that was also full of pleasure and dynamic musical play. The patient - who previously could barely hold onto anything and who broke off everything - started to become confident in the musical play. He was able to sustain his engagement, and even to make use of it. Allowing the off-beat rhythms was a very important moment. This was the confirmation for the therapist that the patient could let go of his dependency and allow the therapist to play freely. On the other hand, the therapist had the impression that he had drawn the patient into something. In the past the patient had tried to interrupt or to avoid the dynamic musical improvisations. Perhaps the improvisation might not have been too intrusive for the patient this time, and it was not too much for him to allow this for himself. The cautiousness and the fear of the therapist were still present afterwards, but little by little a certain trust started to develop, in order that the patient could allow more material to emerge. For the first time the therapist experienced that the patient could feel and set his own boundaries. The therapist experienced a 'Stravinsky-feeling', through the intensity of the rhythms and the dynamics. It was the same as the vitality and drive such as that found in Stravinsky's 'Le Sacre du Printemps'.

5. Selected reflections from clinical intervention

With this improvisation the therapist experienced the patient had made significant progress since the previous sessions. In this session his attitude was much more relaxed and he was much more prepared to take on frustrations and opportunities for playing together. By continuing to play and to keep searching in order to come to some musical form, it was as if he had only experienced these things for the first time. He had not shown a capacity for being able to do this in earlier sessions, perhaps indicating a first step towards an appropriation of the musical material. It was the patient who introduced the theme, which originated from a downward movement that continued into a powerful, very rhythmic, accentuated and dynamic play. It is interesting that the patient allowed the therapist to introduce off-beat-rhythms. Here he gave the therapist a very great freedom and contrary to the previous sessions, the therapist could develop his play musically. He was able to play autonomously and did not feel trapped by the patient.

It was very significant that the patient was able to hold this kind of play for so long. This dynamic way of playing had some danger in itself for him, because he could still slide into the

aggressive stance or to cross his boundaries. It was as if he found in it a certain pleasure, and could not refuse to engage in this dynamic music. The therapist's looking up and smiling at the patient could be taken as a token of understanding. During the play the therapist already experienced in himself that the relationship was not so fragile anymore, while in the previous session he constantly had the feeling that he could lose a connection with the patient. The therapist and the patient were more relaxed and trusting of each other, as a consequence of which the patient was more open and experimental in his playing.

In this excerpt one experiences clearly that the patient and the therapist let themselves be led by the music. All control fall away and the music developed out of itself. This was probably an important experience for the patient, especially in the context of his narcissistic personality. The music appeared without the players' conscious awareness of what would happen. The music was not created to then be further developed, it was created in the moment and was already formed in some way. The therapist as well as the patient were surprised by what appeared in the music and in what could be eventually appropriated during the second phase of this music. This was what the therapist and patient were striving for: namely, a musical form which then could be appropriated. It is important that a musical form originated, with which the patient could identify at a certain moment.

This excerpt was a more refined and developed form of synchronicity. In the previous excerpt (excerpt 5), the moments of synchronicity appeared within a more chaotic music.

6.2.1.8 Excerpt 7: "The musical form" [Eight session; fifth improvisation: 27'2" – 28'30"]

1. Description of the selected video-excerpts

The patient sits at the piano on the left side of the therapist, supporting his chin with his right hand. The therapist re-introduces an ostinato with his right hand, while his left hand rests on the chair. It is the ostinato that was developed by the patient during the previous sessions and it consists of two broken chords played with an accent on the strong beat. The ostinato sounds rather static and restricted. The patient listens to the ostinato in a relaxed way and creates a melody. The potential is established for the development of a tonal melody immediately, from the first note played. It is striking that the patient plays this melody with both hands. The melody can be played with one hand, but the patient prefers (probably from a technical point-

of-view) to play it with both hands, although he does not use all of his fingers. The patient is totally concentrated on the melodic development. He lets himself go entirely in the ostinato. Completely formed, varied melodic phrases emerge in the patient's playing and the music is fluent and does not falter. It is as if the music breathes. The musical play of the patient and the therapist is so entangled that it sounds as though the music comes from one person, not two.

2. A notated score of each excerpt and a description of the musical elements

Patient and therapist are seated together at the piano. The therapist opens with the ostinato which the patient initiated and developed during previous sessions (from session 4 on) and holds on to this ostinato. Using accents in the music, the therapist emphasises the pulse, which comes clearly to the fore and therefore supports the patient. The patient begins his playing with one note, which he lets resonate. From this single tone a melody develops. This melody is fluent, without hesitation and clearly embedded in a harmonic structure. The different characteristics of a musical structure are clearly present: there is a melodic and dynamic development, as well as phrasing which structures the musical fragment. There are melodic variations and the musical sentences are always musically led.

Figure 6.15: Score of excerpt 7

Excerpt 7

chaconne
♩ = ca.132

Patient (RH) Therapist (LH)

(piano four hands)

1 9 17

In excerpt 7 a *chaconne* in *a*-Aeolian (church mode) can be heard, with a harmonic ostinato, a vi-i 6/4 progression which is divided between two symmetric bars in 6/8, followed by 11 variations on this. Through the vi-i 6/4 progression there is an overall effect of a tonal space that is open and diffuse, where the descending interval of the second (*f-e*) becomes dominating in this musical frame. The harmonic ground notes of this ostinato form the interval *f-a* which can also be seen in the ostinato-bass of excerpt 1 (Figure 5.1, bars 19-32). This interval also has a central role in the improvisation of the patient.

The therapist sustained a constant and unchangeable ostinato. Yet, while confined harmonically, the patient is able to break through this limiting feature by improvising melodic lines which reach across two bars of the ostinato. Significantly, the ostinato has a small variation in bar 20. This is the only variation of the ostinato, but it fits perfectly in a harmonically structured way with the melody line of the patient.

The first section consists of 10 bars, divided as follows: 5 + (2+3). Structurally these subdivisions can be seen as in the A section, followed by an A'-section, divided into parts of 2 (*a'*) and 3 (*a''*) bars.

From the score one can clearly see the natural phrasings in the melodic line of the patient. There are three anchor points that always begin in the same way, namely with the tonic *a*. This one note (*a*) is held for a long time and is followed by a descending line (*g-f-e*). This phenomenon can be seen in bars 6 -8 and 10. The descending tetrachord motif '*a-g-f-e*' is characteristic at this point.

Just as the A-section, the B-section consists of three musical sentences from 3 (B), 2 (B') and 4 (B'') bars. A third transposition from cells *g-a* to *d-c* is also notable. The C-section is a transformation or a continuation of the B-section, but is rather transitional, because of the descending movement to *c-b*, which suggests a resolution of a *v-i* cadence.

In summary, the structure can be described in the following way:

Table 6.7: Overview of the structure of excerpt 7

Section:	Intro	A	A'	B	B'	B''	C
Bars	1-2	3-5+6-7	8-9+10-12	13-15	16-17	18-21	22-24

Within this excerpt the rhythmic figures (consisting of 2 or 4 semiquavers) have a certain fluidity, occurring ten times in bars *3-5-6-8-10-11-13-16-18-22*. This intuitive improvising is a sign of a developed feel for music. It is striking that there is no interruption of the chaconne melodic line, even for a moment. In this excerpt there is also a recapitulation and variations of motifs 'a' and 'b'.

3. Selected comments from the patient relating to his experience of playing

The patient says that the melody suits his ostinato (played by the therapist). Here he could recognize the ostinato he created in an earlier session as belonging to him. The patient said he also perceived the melody as connected to him, something he was not surprised about. This was the opposite response to the therapist, who was surprised and gratified at the beauty of the rather unexpected melodic invention.

The patient recognizes this improvisation as something that belongs to him, as something that comes from him. It is not something that lies outside of him.

4. *Selected impressions and reflections from the therapist about the patient's way of playing*

Intuitively the therapist played the ostinato with his right hand, which then acted as a physical boundary. If the therapist had played the ostinato with his left hand, the impact upon the patient of his body positioning would have felt more like an embrace and therefore too overwhelming. In this way the therapist still kept some distance, emphasising the patient's independence.

At once, the therapist experienced that the patient was creating an inner space. The patient's melody originated from an anticipating inner silence: it was a silence that was connected to the musical form. It was also a silence that was allowed by the patient and it was likely that he was able to appropriate this.

Suddenly the ostinato was placed in a harmonic context, above which melodic phrases were woven. The therapist immediately recognized this as a musical form that the patient could appropriate. The therapist was enthused and encouraged by this, as the patient did not play the music consciously, but he could allow himself to be guided internally and be carried along by the ostinato. The therapist experienced his patient as an independent person in the sense that the patient could allow his independence to come to the fore in this musical context. The therapist felt free to play the ostinato. He was not caught or captivated by this musical play of the patient, but rather, he experienced a new freedom to move and to listen to the new music that appeared out of the patient.

5. *Selected reflections from clinical intervention*

In this excerpt one saw and experienced clearly that the patient took his time to join the musical ostinato that the therapist offered. The listening attitude of the therapist could be described as one of an anticipating inner silence. From the first note (the *a'* note that was kept by the patient for a moment before continuing to elaborate upon it), an inner space originated, in which the patient was clearly touched by the music. He did not have any control over this music - it appeared in spite of the fact that he was inventing something in order to allow it to appear. The music was there before he was really aware of it. He allowed himself to be driven by whatever came, a process that was rather like dancing to the music.

In this improvisation the patient adopted the Right Hand⁸. Here the patient really began to ‘talk’ (musical play) symbolically. During the whole process the theme ‘Left Hand’ and ‘Right Hand’ was present. In the previous sessions the therapist felt he had to play the Right Hand, which meant that he had to explore the melody; now he could resume the Left Hand role and in the same way reclaim the therapist function. In response the patient now undertook the Right Hand role.

In this improvisation the melody was everything that a melody could be musically: there was rhythmic variation, with pauses; a melodic direction; and harmonic tension. Silence and phrasing were also identifiable. All the elements of the musical form were clearly present here. The repetitive, endless music was gone and in its place was something that could be developed linearly. The therapist was being experienced as a subject by the patient in the music interplay. At the same time, the patient could develop his own music autonomously and freely, establishing his musical independence within the ostinato and using the experience of being carried along by the ostinato.

The essence of the musical form is in the preparedness to give up something, so that something new can originate. The musical form implies the ability to end and to let go. At the moment when sequences are able to emerge, one can consider this as a point in time where the first elements of musical form can exist. Within the linear development of a melody something can also be released, and in the form of sequences a further step on can be reached. Here, not only something was retained but it was also reclaimed. Sequences can be viewed as the first elements of musical form in the sense that from the first musical fragment new and different fragments will follow, while the first theme remains recognisable.

In the later improvisations the first motif was played and further developed but every time something of the original was kept.

⁸ The Right Hand role versus Left Hand role concept: The Left Hand is a symbolic metaphor for the musical and therapeutic role of the therapist. It has a supporting function and makes possible the free improvisation of the Right Hand, which is a musical and therapeutic metaphor for role of the patient. The therapist gives as much support as the Right Hand needs in order for the patient to be able to freely express himself (Van Camp 2001).

6.3 Summary of the results case study: Adrian

Just as was observed in the Marianne study, three clear phenomena emerge from the analysis of the seven video-excerpts from the Case Two. These are *sensorial play* (excerpts 1-4), *moments of synchronicity* (excerpts 5 and 6) and *musical form* (excerpt 7). These three phenomena will be summarised, with conclusions drawn from the behaviour of the patient, and of the therapist. The summary also examines aspects of the musical process, and finally, the therapeutic interventions.

6.3.1 Sensorial play (excerpt 1-4)

The patient

In the first four excerpts the patient presents two different ways of playing: namely a *fragmented* play (excerpt 1, Figure 6.8) and a *repetitive* play (excerpts 2, 3 and 4; Figures 6.10, 6.11 and 6.12). In excerpt 1, the patient presents a play which could be heard as a certain development towards a musical phrase or form, if it were not for the fact that the patient fragmented the music by breaking it off unexpectedly and abruptly each time. These pieces of fragmented play are not related to what went before or what came afterwards.

The music in the next three excerpts (2, 3 and 4) is characterized by the repetition of musical cells. In this repetitive play the notes are isolated from each other, and separated from both the previous notes and the ensuing ones (e.g., excerpt 2; Figure 6.10, bars 1-13). There is only repetition and no rhythmic or melodic development, or dynamics. Neither in the fragmented nor in the repetitive play can one point out a beginning or an ending.

It is significant that the patient is not able to allow the ‘anticipating inner sound’ in excerpt 1. In excerpt 3, he cannot begin an improvisation together with the therapist. This means that there is no point of departure from where something could be developed musically. The patient’s abrupt breaking-off of the improvisation in excerpts 2 (Figure 6.10, bar 13) and 4 (Figure 6.12; bar 29) happens arbitrarily; the ending is not prepared for musically or mentally. The patient either abruptly breaks off the improvisations (excerpt 2; Figure 6.10, bar 13), or his playing of glissandi (excerpt 4; Figure 6.12, bar 30) makes it impossible that there could be an end to the improvisation. Nothing of what is being played can post-resonate or remain.

The lack of a mutual connection between the played musical cells, the lack of a rhythmic and melodic development, and the inability to introduce and round off the play mentally

indicates that there is no inner experience with regard to the presented musical material. It seems as if the play is only the consequence of the rather autonomic movement of his hands, without any connection with the psyche, and without any intention from the patient. The patient's facial expression suggests that there is no inner emotional connection with the music played. Everything occurs outside the patient. He is not able to appropriate his own musical play. Obviously, this has to do with the patient's fear of moving from his narcissistic problematic state into a dependency position within the therapeutic relationship, and through this to enter into the unknown of the music. The patient shows that this movement towards the unknown is as yet too threatening by both the abrupt breaking off of the music and the nonchalance of his play and attitude.

The patient is also not capable of articulating something about the presented musical material. Time and again, he fragmented his verbal reflecting by playing unexpected, isolated sounds. Between the talking and the playing there is no "caesura". This illustrates the amorphous quality of the patient's music.

The patient also actively offers resistance against the free improvisation through the introduction of 'Für Elise'. As a result of this the patient transforms the music therapy session into a music lesson, and the music therapist into a music teacher. In excerpt 2 (Figure 6.10; bars 1-13) the patient demonstrates a provocative listlessness, which is also an expression of resistance. Furthermore, the patient wants to control the therapeutic framework by deciding whether or not the session will take place, by arriving too late or by threatening to finish the therapeutic treatment.

In the four excerpts, there is no inter-subjective relationship between the patient and the therapist, with no single musical or visual contact or interaction visible. The nonchalant attitude of the patient (as well as that of the therapist) reflects the inability or the unwillingness to invest in the musical play or in the therapeutic relationship. The patient's facial expression is one of fear and uncertainty. The absence of inter-subjectivity is perfectly illustrated in excerpt 3 (Figure 6.11), in the introduction to the play.

In excerpts 2, 3 and 4 neither of the players comes to a common timbre at any time. This becomes evident from the fact that the therapist cannot interweave his own timbre in any way that relates to the timbre of the patient's music. It is particularly evident in excerpt 2 (Figure 6.10; bars 1-13) that the therapist experiences that his timbre does not match the patient's. He

cannot connect with the timbre of the patient and resonate with the patient as well as with himself. The patient cannot come into resonance with himself, the therapist or the musical play.

The therapist

It seems impossible for the therapist to come into resonance with the patient in these four excerpts. The therapist does not exist as a subject for the patient. There is no single interaction possible.

In excerpt 2, the therapist feels entirely imprisoned in the therapeutic relationship. The therapist's actions and interventions emanate from the fragility of the therapeutic relationship and from the uncertainty and fear of the patient. Because of this, the therapist cannot play what he wants to play. After the improvisation in this same excerpt the patient's fear is reflected in the therapist's nonchalant posture, because here the attitude of the therapist is one of fear of coming too close to the patient. The therapist cannot hold or give form, either musically or mentally, to the fragmented or repetitive play of the patient. In excerpt 2 (Figure 6.10; bars 1-13) the therapist is musically drawn into the sensorial play of the patient. He starts to *sensorialise* and ends up in a senseless, disconnected and endless play.

In the different improvisations, the therapist tries to hold his and the patient's music by letting the final note or chord post-resonate. The therapist does this in order to have a form of memory about the played material and also to make a possible transition towards a post-resonating silence, or to create a psychic space in which what was played could be held. The therapist experiences the patient's music as endless and empty.

6.3.2 Moments of synchronicity (excerpt 5 - 6)

The patient

Moments of synchronicity in the play of the patient and the therapist appear in excerpts 5 (Figure 6.13) and 6 (Figure 6.14). In excerpt 5 a new atmosphere and timbre evolves, that could be called "the darkness".

A certain musical structure appears in the play of the patient (Figure 6.13, section A (bars 2-21), B (bars 22 – 24), C (bars 25 and 36"- 48") and D (from 48")), which is picked up and sustained by the therapist, and because of this the patient is able to go along with the rather aggressively coloured, dynamic play.

The patient can allow this timbre and does not have to break it off, possibly because something from the traumatic part of him resonates with it. A common inner experience of freedom and autonomy originates in both players. The therapist's fears that the patient could lose himself in his aggression or destructivity disappear entirely. The patient can hold onto this dynamic and is able to give form to it, although he has to rely on the therapist's support for this. The moment of synchronicity in excerpt 5 (Figure 6.13; bars 4- 25) and 6 (Figure 6.14; from bar 19 till the end of the excerpt) appears for both players totally unexpectedly. The music develops from within itself; it appears without the players having any control over it.

The pulsing and rhythmic character is noticeable (Figure 5.13; bars 2 – 11 and Figure 6.14; bar 19 till the end of the excerpt). Even though the music is played on a harmonic instrument (the piano) the co-play is rhythmically coloured. There is a complex rhythmic play with off-beat rhythms and shifting accents in the therapist's music (figure 6.14; bar 19 till the end of the excerpt). Both players are surprised by the timbre and obviously enjoy it.

The audible silence that appears in excerpt 5 (Figure 6.13; section C from 46'' – 48'') is striking. Here the music slowly fades after the 'darkness' and from this fading away a little silence emerges, after which there originates an alternating, melodic play. In excerpt 6 the patient can feel and indicate the boundary of what he is able to manage by rounding off this improvisation. One cannot yet define the presence of musical form because the musical developments are still at a purely rhythmical level and not yet able to be further developed into a melodic or harmonic play.

In the moments of synchronicity a subjectivity comes into being. The patient and the therapist are two equal people, playing together. The therapist becomes a subject in the relationship with the patient, and the patient's repeated glances towards the therapist confirm this co-play. In both excerpts one can see the moment of synchronicity in the bodies of both players. Patient and therapist move synchronically and this movement corresponds with the pulsed, dynamic musical play.

In excerpt 6, one sees in the run-up to the moment of synchronicity, where there is a dancing play of the fingers of both players (Figure 6.14; bars 8 - 18). It is like a ballet of fingers, an overture to the dance. The patient's experience of delight in this play is reflected in his facial expression.

The therapist

In the moments of synchronicity, the therapist feels like an autonomous person who can be guided by the music and who is no longer imprisoned in the transference or in the tense attitude of the patient. The therapist can let loose the cautious play that is embedded in the dependency of the patient's transference. The therapist now experiences that the patient can allow more to happen within the inter-subjective therapy space. The therapist feels that he will not 'lose' the patient if the play becomes more dynamic. Therefore, the patient can surrender to the music, and the play of off-beat rhythms and accents is a clear musical expression of this phenomenon. The therapist experiences pleasure in making this music and this is reflected in his dynamic play.

6.3.2 Musical form (excerpt 7)

The concept of *musical form* is seen in excerpt 7 (Figure 6.15) for the first time, immediately after the moment of synchronicity in excerpt 6 (Figure 6.14). The question can be posed of: was it at this moment of synchronicity that we find the start of the appearance of the musical form?

The patient

The patient allows a short, necessary, anticipating inner sound, from where the first note of a tonal melody is developed. The melody is embedded both in and on a harmonic structure that the therapist offers to the patient, namely the ostinato that was developed by the patient in the previous session (Figure 6.15; bars 1- 24). The patient clearly takes the Right-Hand role and develops an autonomous musical play where he allows himself to be carried by the musical ostinato of the therapist. This in itself means as much as allowing dependency.

The patient's music breathes through the natural phrasing of the melody. This melody has an effortless direction and it is clear that the patient lets himself be guided by the music, and that he is inspired by the music itself. Each musical fragment and each note are in relation to the previous and the following one. It is a matter of linear development, which is a confirmation of the possibility that musical thoughts are being developed by the patient.

This is a musical improvisation in which all musical elements are present. There is a clear beginning, there are melodic themes and variations, dynamics, structured musical phrases,

phrasings and silences, tension and relaxation, “dribbling” (circling) around a note and musical recapitulation, as well as an inner musical structure.

The patient can appropriate his created music and he does not experience it as foreign to himself. Therefore, the patient can verbally reflect upon what was played.

The therapist

Influenced by the transference, the therapist takes the Left-Hand role, literally and figuratively. Through the therapist playing the patient’s ostinato, the patient is able to graft his melodic music on this (see Figure 6.15; bars 3 – 24). The Left-Hand, the therapist, is musically neutrally present and can be witness to the emerging form in the patient’s music (Figure 6.15; bars 1-24). The therapist can also get the feeling of the patient’s musical play and experience from the first note that the patient could appropriate his music. The therapist can experience himself as a subject in relation to the patient.

6.3.4 Musical process

The musical scores show a clear musical process, as outlined below.

The sensorial play of the patient is to be found in excerpts 1-4. The musical play in excerpt 1 exists of short, self-standing fragments, where a possible musical development of section A is interrupted by a new rhythm (B section, bar 9). This in turn is interrupted by another style of playing (section Coda; bar 33) and because of this, the whole excerpt (figure 6.8) has a fragmented character (bars 1-8; bars 9- 8; bars 19-32; bar 33). This fragmented play can also be seen in excerpt 3 (figure 6.8) where section A is interrupted by the patient by stopping abruptly the music at the end of the first system and there is a change to a new way of playing. Excerpt 2 (figure 6.10) is characterised by a continuous and steady rhythmic and melodic line. However, there are not yet musical phrases to be found, because of the general lack of phrasing or structure. It is obvious that sensorial play is defined by a motoric act of alternating left-hand and right-hand, as seen here (figure 6.10; bars 1 – 13) as well as in excerpt 3 (B and C sections). The repetitive character of the sensorial play becomes even clearer in excerpt 4 (figure 6.12), where the a- (bar 1) and b-motifs (bar 7) are repeated several times without further development.

Another significant factor for this sensorial play is that the ending of an improvisation (excerpt 1) is not musically prepared for by the patient. In excerpt 3 (figure 6.11), the patient does not allow the therapist to start together with him, beginning without preparation, and without any reference to the therapist. In excerpt 2, the improvisation is broken off abruptly by the patient, where the therapist plays a cadence to try to conclude the improvisation (figure 6.10; bars 14-15). In excerpt 4, the play is ended by the playing of glissandi and again the therapist plays a cadence to give structure to the ending (figure 6.12; bars 28 – 30).

The therapist tries to give form to the improvisation and to the sensorial play of the patient in excerpts 2, 3 and 4, and in excerpt 2 and 3 he plays clear musical phrases. Direction within his play comes out of the material being musically digested and it is noticeable that the therapist takes the Right-Hand role. In excerpt 2, there is musical development over which the patient presents his repetitive endless play. It is striking that the patient's metre stands separately from that of the therapist (Figure 6.10; bars 1-13). This indicates that the patient cannot or does not want to join the therapist's music, even though the therapist presents a clear musical structure (Figure 6.10; bars 1-15). It is directly related to excerpt 1, in which there is also no structure in the patient's music. This not-playing-together is continued further in excerpt 3, where the therapist again offers a musical structure. A question-and-answer play develops, which the patient cannot or does not want to join and here again, the two musical parties play entirely separately from each other. Only in excerpt 4 can one see the play of the patient as a taking on of the Right-Hand role. However, it remains a repetitive play, where the therapist fills up the double-dotted rhythms in section B. The evolution of a potential musical form is based upon the therapist's music, to which the patient's play in vain tries to attach. Moments of synchronicity appear in excerpts 5 and 6. Here there is a clear rhythmic development, which occurs at the same time within the music of the patient and the therapist (Figure 6.13; bars 2 - 25 and Figure 6.14; from bar 19). This rhythmic development also gives structure to the improvisation.

In excerpt 5, powerful, pulsed music develops, to which both the patient and the therapist make their own contribution (Figure 6.13; bars 2- 21). Right- and Left-Hand roles are shared by both working together. There is a common process where pulsed music flows out in a dark, rumbling play (referred to as "the darkness"), which is concluded by the patient, and out of which an alternating, communicative play originates.

In excerpt 6, the appearance of the moment of synchronicity play can clearly be heard in the chromatic music where patient and therapist play together, but autonomously (Figure 6.14; from bar 19). This chromatic play further develops into pulsed toccata-like music.

A specific feature of these excerpts is the powerful dynamic play heard during these moments of synchronicity.

Musical form emerges and appears in excerpt 7, where the therapist introduced an ostinato, and sustained this ostinato while the patient played a chaconne (figure 6.15; bars 3 - 24). It is especially striking that this is the first time the patient allows the first note of his melody to resonate further, in order to let the music develop from there. Phrasing is clearly present in the musical form, which adds structure to the musical fragment. There is a direct melodic and thematic development and sense of direction. The musical motif a (bar 3) is resumed several times with variations. There is a consistency in the musical excerpt providing a musical recollection of the motif.

Sections A (bars 3 – 7) and B (bars 13 – 15) are also re-developed in a varied way. Here the therapist can take the Left-Hand role in a neutral way, while the patient takes the role of the Right-Hand and fully explores the musical space. It is also interesting that the therapist varies the ostinato in bar 20 once, intuitively following the patient's melodic line, which is an expression or confirmation that the patient and therapist are a musical team.

6.3.5 Specific therapeutic interventions

The post-resonance

The issue of the final note's post-resonance is very important after the improvisation is over. When the patient is not able to let the sounds resonate, or is not able to round off that which was played, it indicates that he cannot appropriate his music. As a consequence, what has been played disappears into nothingness, and thus cannot be developed into a musical form. Thus, the concept of post-resonance is a necessary preparation for musical form.

In excerpts 2 and 4, we see how the patient abruptly breaks off the improvisation, again and again and how it is the therapist who makes it possible to round off the improvisation. In the first place this is achieved not by introducing a final cadence, but by letting the final tones post-resonate. Because of this, the therapist makes it possible for something to become transformed into the silence itself, and thus towards a possible internalisation.

Right versus Left Hand role

This case in particular demonstrates the therapeutic aspect of the Right Hand role versus Left-Hand role concept. This is a metaphor for the patient-versus-therapist role. In this example, the importance of the therapist's alertness and flexibility in terms of not only taking the Left-Hand role but also the Right Hand role has been shown. Finally, he will most consistently adopt (take up) the Left Hand role, the role that belongs to him, during the therapeutic process.

Chapter 7

General discussion

Introduction

This study concerning the relevance of music therapy for patients with psychotic disorders explored the means by which a certain form and finite quality can be generated and established in order to effect the disintegration and timelessness of the psychotic world. The intention of analysing these clinical process was to show that music is active on the level at which the central issues of psychosis can also be situated. In view of this aspects of the musical experience were very important in this research, in order to reveal how music therapy has a full place within treatments and interventions for people with psychosis. For this research two subjects were chosen. Both displayed a clearly identifiable musical characteristic that was also typically presented in other psychotic patients, specifically an endless repetitive play of certain rhythms or melodic sequences, or a fragmented musical play.

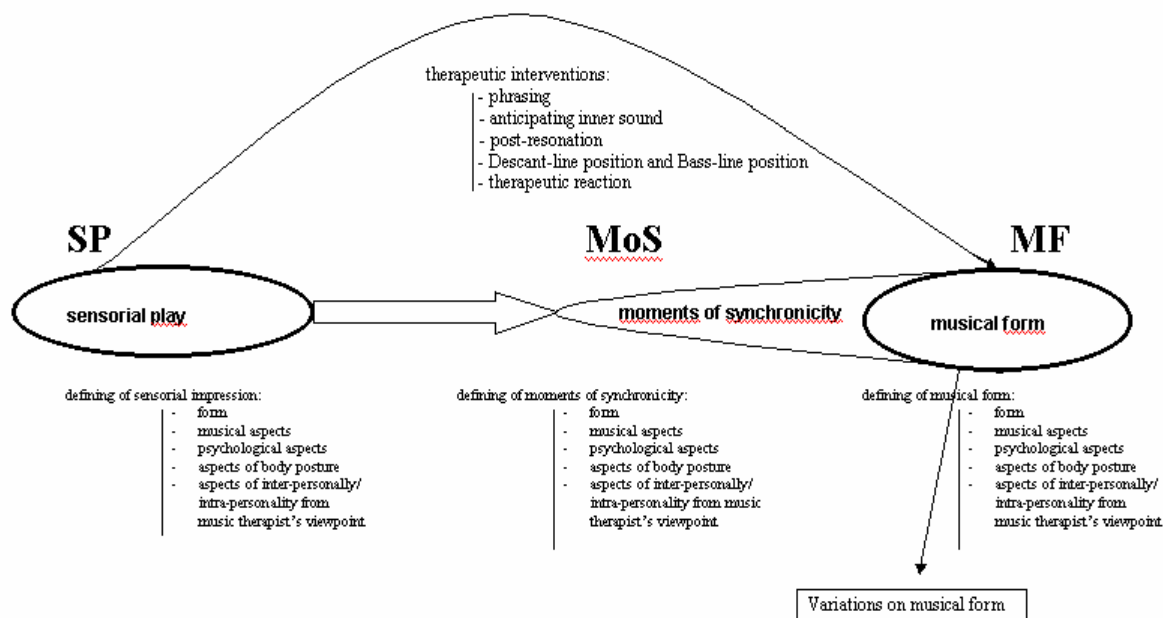
This study made use of a 'single case design' because of its practically-oriented character. The case studies were audio as well as video- recorded and analysed in the form of a 'clinical research-intervision'. The analysis and interpretation was from an analytical music therapy perspective. This frame of thinking was made use of to the extent that it was developed within the research of psychosis, and as a consequence was of central importance in the research intervention and for the interpretations of the therapist. The specific changes in the musical parameters were also examined and selected, and insight was gained into musical processes as well as psychic processes. This made it necessary that not only a music therapist participated in this study, but also a psychoanalyst and a composer.

A feature of this study is that the research was always treated from a clinical perspective, and the design was developed in response to the subjects (patients), rather than the subjects having to conform to a pre-determined design. This was necessary in order to stay true to the unique characteristics of the clinical situation and, as a consequence, to come to an adequate formulation of the theory.

This research was primarily inspired by clinical material, without reference to or departure from a fixed theoretical assumption, and therefore the analysis of the data did not refer to existing therapeutic phenomena such as projective identification, containment, holding, splitting etc., but emerged from the music therapy practice itself. In this research process I was not only focussed on the outcome, but I always put the musical and therapeutic process at the centre and acted as a neutral observer in trying to determine what was essential, and what could be observed, experienced and used in the research. In this sense the research could be called *clinically applied research* (Wigram 2001).

An unexpected and important finding in the research study was the identification of the stage during which the moments of synchronicity emerged. From the analysis, it emerges that this stage is essential to the therapeutic process. The different therapeutic interventions facilitate, influence and provide possibilities through which this process could take place. Figure 7.1 shows a schematic overview of the process, tracing its movement from sensorial play (SP) via moments of synchronicity (MoS) to musical form (MF).

Figure 7.1: Process description



To present the findings, the main research question and sub-questions of this study will provide the structure for a systematic summary of the results, as noted in the remaining sections of the chapter.

Can one identify the development of a process from sensorial play into musical form as a central aspect in the treatment of psychotic patients in music therapy?

The results demonstrated a music therapeutic process departing from sensorial play and moving through moments of synchronicity to musical form. From the literature review we can describe sensorial play as a significant way of making music for the psychotic patient. Psychotic patients demonstrate through their pathology an inability to create a psychic space through which they can appropriate the musical object and give it a symbolic status (Bion 1967; Freud 1911; Lacan 1981; Ogden 1986; Van Bouwel 1998 and Van Camp 2001). This inability expresses itself through an endless repetitive and monotonous play, or a fragmented play that the psychotic patient does not experience as something that belongs to or comes from him. This means that when playing music a psychotic patient is not able to recognize his own playing.

This research has shown that music therapy offers psychotic patients an opportunity for the creation of a certain psychic space and thus can create the possibility for a certain degree of potential symbolisation. In order to demonstrate this more specifically, the sub-questions addressed this in detail, the findings of which are given below.

7.1 Findings from the sub-questions

The sub-questions are as follows:

- How can we describe and define sensorial play?
- How can we describe and define musical form?
- How can we describe the elements and identify which ones are needed to understand and have insight in the process?
- How does the process of sensorial play evolve to musical form?
- How can one describe and compare the important music therapy moments (i.e.

changes) in this process?

- Which music therapy interventions of the music therapist contribute to the development of musical form?

These sub-questions structure this section of the dissertation, within which the findings are given and explored.

How can we describe and define sensorial play?

From the results of the two case studies I came to the following definition and categories of sensorial play.

Sensorial play

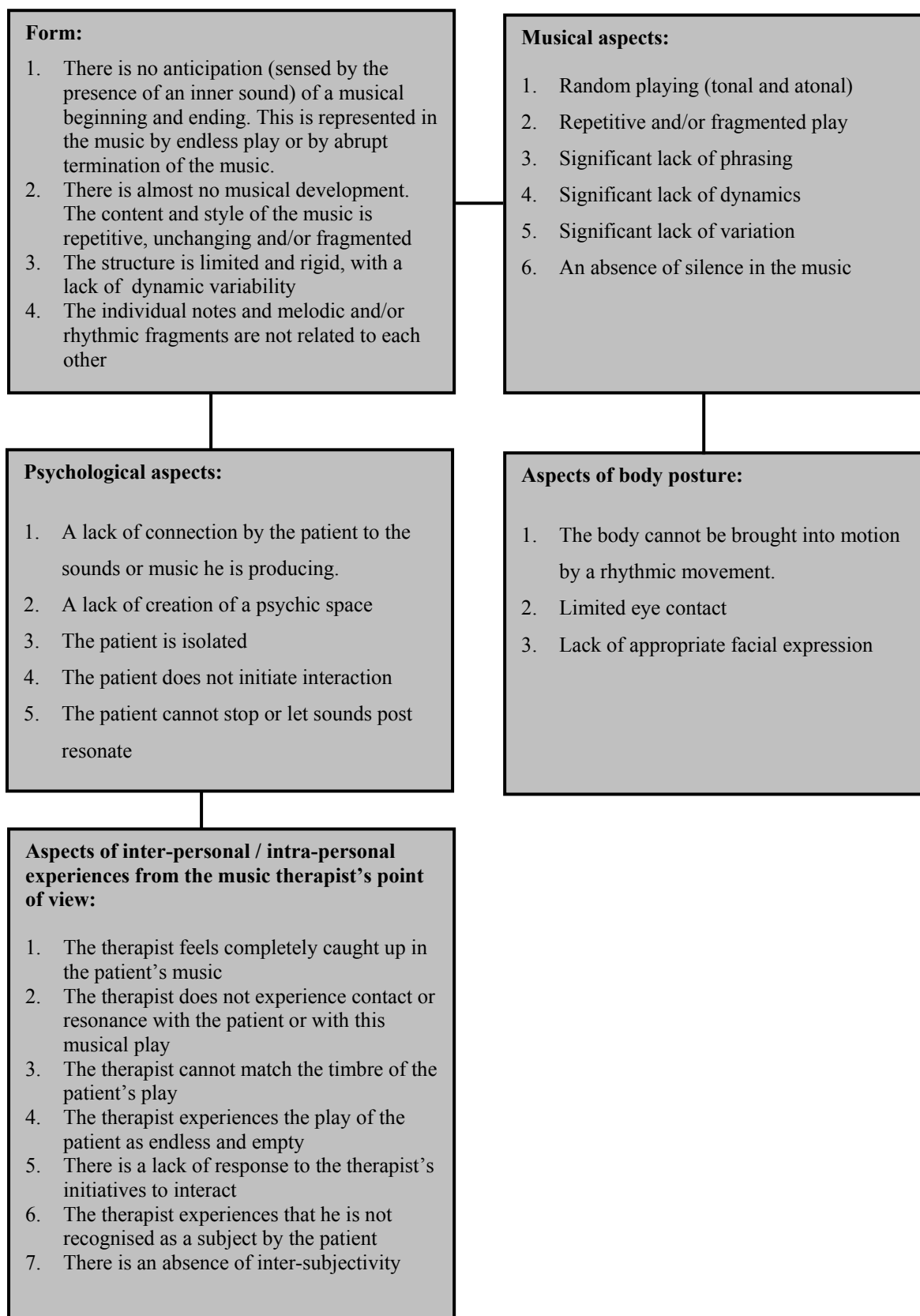
Sensorial play is a term describing the characteristic playing of a patient where, while producing sounds, the patient is not able to connect with or experience these sounds as coming from himself. The patient's music is characterised by repetitiveness and/or fragmentation. The improvisation cannot really be begun nor ended, and there is no clear melodic, rhythmic or harmonic development, no variation and no recapitulation. The patient is perceptually and emotionally detached from his own musical production.

Further explanation:

Therefore, improvising is not a real 'experience' for the patient. He is not inspired or affected by the music and he remains disconnected from the sounds and the playing. There is an absence of shared playing and inter-subjectivity with the therapist in the sense that the patient does not engage in the joint music. The sounds remain outside the patient and do not have any connection to him. In terms of the psychopathology of psychotic patients, one can say they cannot create a psychic space that allows symbolisation, thus making it impossible for them to appropriate musical material. The music therapist experiences the patient as isolated, and becomes completely caught up in the patient's music (i.e. the musical behaviour) and is not free to introduce his own musical images and because of this, no interaction is possible, and it is impossible to engage in a shared timbre in the 'co-play'.

The following list of features of sensorial play, itemised within defined categories, is inclusive, and some, but not all, items are present in an analysis of improvised music.

Table 7.1: Criteria of Sensorial Play (CoSP)



With Marianne and Adrian we can see different modalities of sensorial play. Marianne's sensorial play (Figures 5.2; 5.3; 5.4; 5.5) has an endless and unstructured, not-phrased repetitiveness, without any dynamics or variation. Adrian's sensorial play is more diverse: on the one hand, there is a repetitive play (Figure 6.10 and Figure 6.11) while on the other, there is fragmented play (Figure 6.8) in which he allows the initiation of a musical development each time, after which he destroys it by abruptly breaking off the music. Psychically, there is a certain investment from Adrian. He is not entirely isolated, but there is a resistance against a possible dependency because of his narcissistic problems. With Marianne there is no active resistance. The therapist just does not exist. One can define sensorial play from this problem setting as the impossibility (Marianne) or resistance (Adrian) to come to musical form.

How can we describe and define musical form?

From the results of the two case studies I came to the following definition and categories of musical form.

Musical form in a music therapeutic context

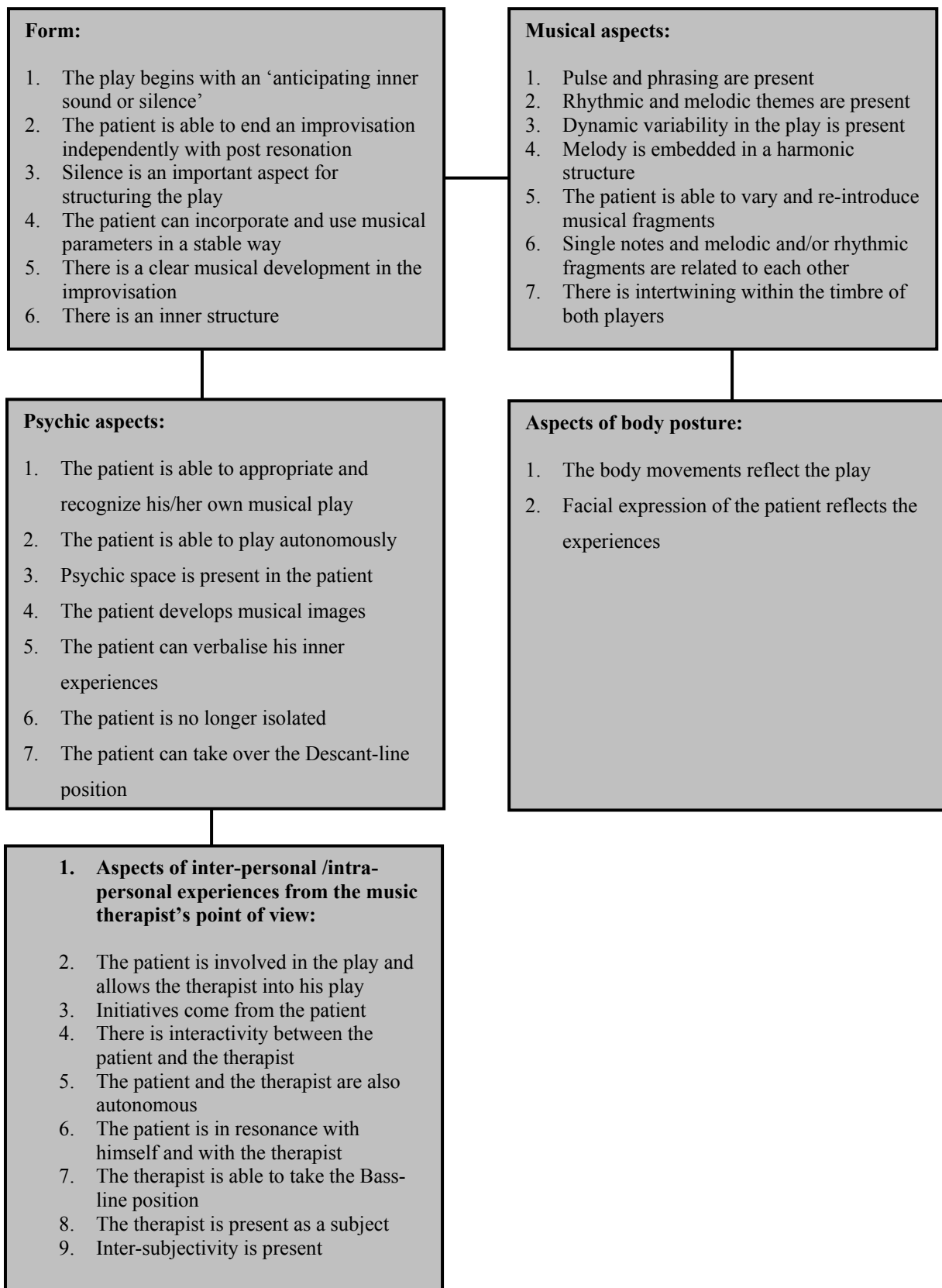
Musical form is a term describing a musical structure that is created within a symbolising process and which develops from the foundations laid during moments of synchronicity. Clear rhythmic and melodic themes may appear that can be further explored or varied. Musical figures can be characterized by phrasing and pauses. Features of the musical improvisation typically have a clear beginning and ending and these are prepared for mentally by patient and therapist. This is always an inter-subjective phenomenon between patient(s) and therapist, who experience being equal to each other and feel free and autonomous to play, think, exist and develop their own images and thoughts. There is an intertwining of the timbres of both players.

Further explanation:

During this process the sounds that are generated in a musical improvisation are guided by something unknown to the subject. The music resonates with an inner awareness of something that is no longer experienced as external or unrelated.

The following list of features of musical form, itemised within defined categories, is inclusive, and some, but not all, items are present in an analysis of improvised music.

Table 7.2: *Criteria of Musical Form (CoMF)*



The anticipating inner silence was observable with both Marianne and Adrian, just before the beginning of the improvisation (Figures 5.12 and 6.15), from which point their musical form emerged. The way that Adrian allows the first tone to post-resonate in order for the music to continue to develop out of this was remarkable (Figure 5.12). This post-resonance (out of which a space originates in order to let develop something new emerge), was clearly identifiable in the rhythmic play of Marianne (Figure 6.15). By allowing silences to appear, the music became more structured, and an intense and dynamic play originated. These structuring silences were experienced as phrasing. It was remarkable that these were presented with Marianne, as well as with Adrian.

With both patients there was a pronounced thematic development and direction in their music. Marianne displayed a pronounced rhythmic thematic development, while one could see a melodic development in Adrian's music. The rhythmic cells heard in the Marianne example (Figure 5.12, musical section A, music line1) and the musical motif from Adrian (Figure 6.15, bar 3-4) were recapitulated several times in varied forms. In view of this, the musical excerpts achieved consistency and a musical recognition appeared.

Both Marianne and Adrian could clearly take up the Descant-line position in musical form, while the therapist took the Bass-line role in a neutral, empathic attitude. Here he could be the witness of the development of a musical performance in which the entire being of the patient was presented.

The relation between appropriating the musical material and stopping the audio and video-recording.

From the research we know that, in the appearance of the musical form, the improvised music is not experienced as something external, but appropriated and experienced as something personal to the patient. This was confirmed because both patients asked at that moment to stop the video. This can indicate that neurotic mechanisms start to function, where both patients became conscious of the fact that these musical productions belonged to them and, as such, could be interpreted. There was a neurotic danger that because of this, they had allowed themselves to be heard in that they inadvertently exposed too much of their inner life.

How can we describe the elements and which ones are needed to understand and have insight in the process?

In this study a specific research design was developed whereby the process from sensorial play towards musical form was the main focus of attention. Data was gathered and analysed in a systematic way as described in the research method. By reducing the video material of all sessions of each patient to seven video-fragments (all of which were selected systematically), the essential and necessary steps in the therapeutic process could be described in a structured way and be examined methodically. From these analyses and results a clear picture could be identified of the process in the two case studies and insight into the processes involved could be gained. It was striking that for the analysis of sensorial play for both cases, four video fragments were necessary, with two video fragments for analysing the phenomenon of moments of synchronicity, and one video fragment to demonstrate the presence of musical form. The lack of cohesion and inability to show sensorial play in one form or image are notable and relates to the statement of Langer (1953), that “If form is hard to define satisfactorily, formlessness is still harder (cited in: The New Grove, 1980 p. 710)”. In musical form everything is presented; therefore, for this category only one video fragment was needed to be selected and examined.

For the musical process the scores of the musical fragments were indispensable, because from this concrete musical data musical material could be analysed in a systematic way. From this musical elements and structures became visible and the musical processes were discovered in the results of both cases (see pages 174-176 and 261-263). Finally, in order to be able to examine the therapeutic processes the impressions of the therapist and the research interviews were the main source of information and were of crucial importance.

How does the process of sensorial play evolve to musical form?

The development of sensorial play towards musical form happened in both case studies via the appearance of moments of synchronicity. From the results of the two case studies I came to the following definition and categories of moments of synchronicity.

Moments of synchronicity in a music therapeutic context

Moments of synchronicity is a term describing points in time in which there is a shared inner experience of the patient and the therapist, in which they feel free and autonomous in their play during a musical improvisation. This shared experience appears unexpectedly and unintentionally, and is characterised phenomenologically¹ by attunement between the musical parameters of the patient and the therapist.

Further explanations:

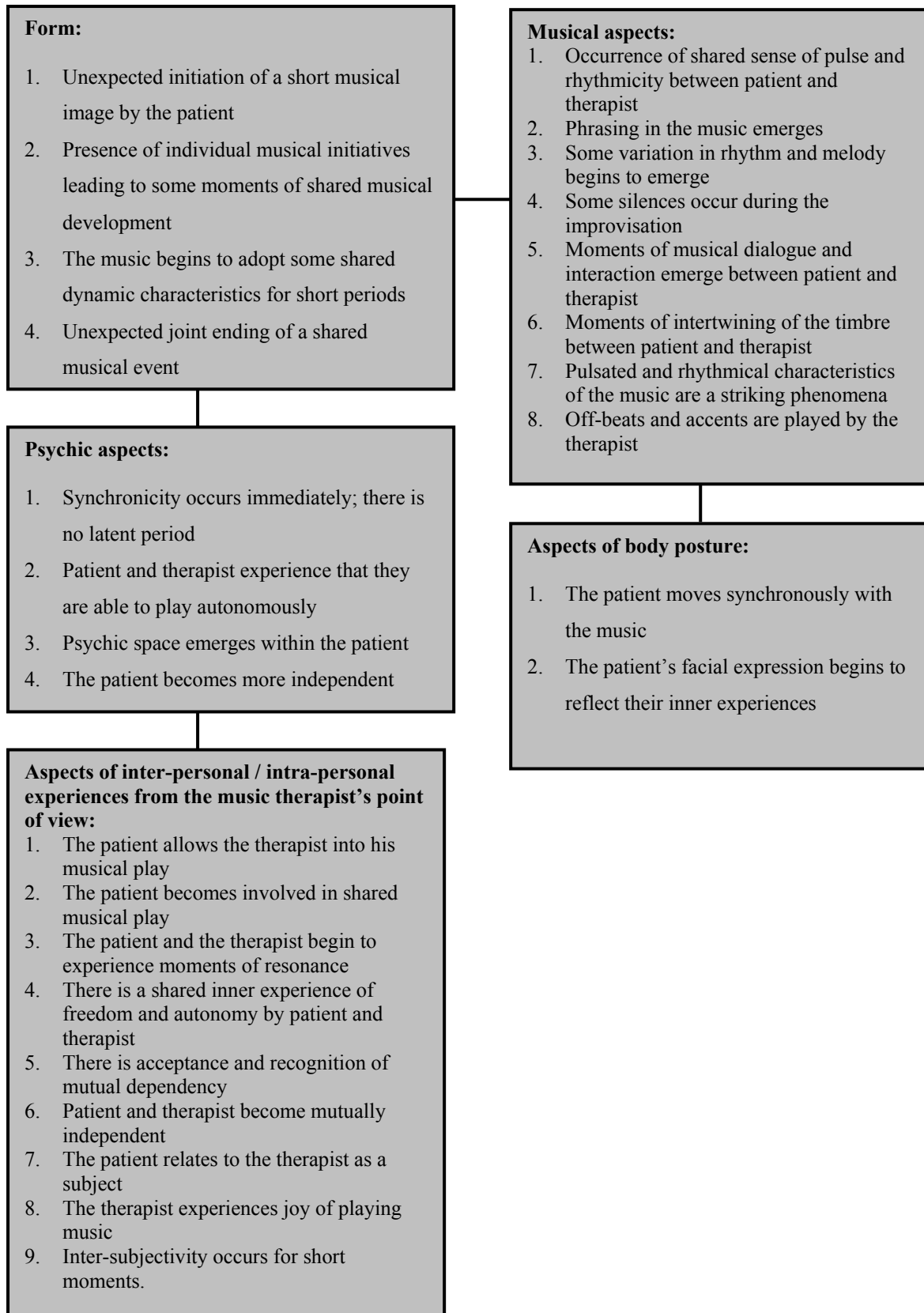
Both patient and therapist have the feeling that they are able to come into a genuine shared play for the first time with an intertwining of two musical lines into one entity, or one whole, for example, where both share the same pulse with shared accents in the meter. Underpinning this is the paradoxical experience of each individual's freedom and autonomy. The mutual dependency in the creation of a shared musical object leads to a liberating feeling of being able to make music in a completely independent way. The patient and therapist are free in relation to one another and can play, think, exist and develop their own musical thoughts. This paradox involves emerging autonomy in the patient and therapist, while at the same time, there is acceptance and recognition of mutual dependency. During this, brief moments occur where the timbre of both players intertwines.

These moments of synchronicity can be brief, unexpected and infrequent, acting as possible precursors for the development of the musical form. Moments of synchronicity usually appear at a specific or 'right-moment' in a shared experience.

The following list of features of moments of synchronicity, itemised within defined categories, is inclusive, and some, but not all, items are present in an analysis of improvised music.

¹ *Phenomenological* can be defined as something that exists and can be seen or heard. It is part of the concept of synchronicity, but is not a description of the concept, because synchronicity is experienced on a more inter-subjective level.

Table 7.3: *Criteria of Moments of Synchronicity (CoMoS)*



In the moments of synchronicity we can find the same musical elements present in the musical material of both patients, as follows: a first initiative to develop phrasing in their music by permitting pause and silence to happen; variations through some rhythmic and melodic development as well as some variability in dynamics; and a first apparent level of control or intention to ‘round off’ an improvisation, or to bring it to a clear conclusion. However, it is important to emphasize that these moment of synchronicity only last for a moment each time they occur, and they are not continuous. Holding or continuing these musical elements occurs when they become consistent and stable enough to develop into musical form. When there are moments of synchronicity, the first musical interactions are present, and on a psychic level a first inter-subjectivity originates. The body is then, for the first time, able to co-resonate with the music. It is also the first time that the timbre of both players intertwines.

The specific interventions of the therapist (which will be discussed in the following sub-question) were necessary to give the patient the opportunity to make the therapeutic process of sensorial play towards the musical form.

In addition, there are still three phenomena essential for the development of the musical form: silence, timbre and inter-subjectivity. These three phenomena are now discussed.

Silence

An interesting aspect found through the analysis undertaken for this study is the phenomenon of silence. It is mainly through the pioneering work of Sutton (2002) that music therapy practitioners and educators are becoming more and more conscious of the relevance of silence. This study illustrates how silence is an important aspect as an organising principle during musical improvisation. Silence is the driving force of the inter-subjective play in improvisations during which there are moments of synchronicity of musical form. Paradoxically, it is only thanks to moments of silence (which act as a kind of punctuation) that phrasing became possible, that sounds became structured, and that musical form originated with both patients. In the musical form, silence added an important dynamic in the structure of the sounds and rhythms that were being played.

From the analysis we see that because of their pathology Marianne and Adrian could not allow any silence. In sensorial play from the Marianne case study (Excerpts 1-4;

Figures 5.6, 5.7, 5.8, 5.9) and that of Adrian (Excerpts 1-4; Figures 6.8, 6.10, 6.11, 6.12) there were repetitive and cumulative sounds played without any apparent relationship between them, no phrasing and no variability or development of dynamics, rhythm, melody or harmony. In sensorial play one could talk of a compact silence, in which no movement or dynamics is possible. In contrast to this there is the concept of open silence, which is a silence that allows a psychic space and can be seen as in a similar way to Winnicott's 'potential space' (1971).

In the clinical work of this research, through phrasing, holding sounds, or delaying and slowing down the tempo, an open silence was introduced. Through this, the pure repetitiveness of sensorial play could be broken through, allowing the first moments of synchronicity to appear. The silence created a space in the compact mass of the psyche, through which the full presence of the sound (in terms of repetitiveness in sensorial play) was transformed into sounds, which, in turn, gained a certain mutual value. The space made it possible for the endless heaviness of sensorial play to be brought into motion. The musical form originated here. The introduction of silence in this phrase was a kind of symbolising act.

An illustration of silence as an essential condition to come to musical form is found in excerpt 7 (Figure 5.12) in the case of Marianne. In excerpt 7, bar 2 Marianne paused for a little while and in so doing, allowed an open silence originate. By allowing this silence, a space originated through which Marianne could let herself be guided by the silence and, thanks to the silence, could initiate new rhythms (Figure 5.12) and new rhythmic themes. She continued playing intuitively and for the first time her play exceeded the mere filling in of silence. Something new could originate. In the Adrian case study it is also possible to see how the tempo is slowed down in excerpt 5, section C (46''). Patient and therapist started to play on a different level; a space was created in which silence was brought in. The music therapist introduced silence mainly by phrasing, slowing down the pace, letting sounds resonate and respecting the so-called *harmonic silence*.²

² By harmonic silence I mean that with the sounding of each tone, not only this tone sounds, but also the resonating 'silence', of all tones that preceded it, and of all tones that will follow. It is the silent absent or not yet present tones that define the harmony.

It is thanks to phrasing as a connecting activity of the musical time that one can come to musical form. Through phrasing a 'significance space' originates amongst the players, just like a phrasing connects the musician and the listener (Hoffmann 2002).

In common with Hoffmann (2002), Loos (1986) and Streeter (1999a) I see phrasing as a connection of the past with the future. Silence can only be felt if there is a connection with what previously happened, where what previously has sounded continues to sound in the bridging tension of the phrasing and becomes a time bridge to the continuation of the music. This phrasing makes it possible for a new start to originate. Without this tension bridge the time space loses its bridge character, becomes empty and does not have any significance.

Timbre

Through the analysis, the phenomenon of timbre seems to be an essential element in the development of musical form. From the moment of synchronicity an experience originates with the therapist when his timbre can suddenly be intertwined with the timbre of the patient, so that in that moment he came into resonance with the patient. One could state that a shared unconsciousness originates here with both players, in which the two timbres co-resonate with each other. With 'timbre', I refer in this context not only the timbre of the play or a tone, but also the co-resonating of the psyche or of the affect. It is not audible, but can only be experienced. At the moment that the two timbres intertwine a psychic given originates - an intersubjectivity. I had this experience every time during moments of synchronicity. A shared unconsciousness could be developed and could come into resonance. From the analysis it was clear that the first moments of synchronicity appeared at points where the patient as well as the therapist played the same instruments and therefore could intertwine the sound colour more easily and co-resonate in the play.

It is striking to note that in the Marianne case study the moment of synchronicity appeared as soon as she played a new music instrument for the first time (i.e. the kalimbaphone). For Adrian the piano was his preferred instrument and it was the effect upon him of the timbre of the instrument that could have influenced the therapeutic process. There is probably a correlation between the therapeutic process and preferences for the specific timbre of these particular instruments. One could state that the specific timbre of

the instrument in relationship with the transference to the therapist gave the possibility to resonate with the traumatic aspects in the patient.

Intersubjectivity

In sensorial play the subjectivity is annulled. Subjectivity can only be present in the moment when a psychic space is developed. This psychic space allows a certain differentiation to occur, through which one can articulate an intersubjectivity. This happens for the first time when a moment of synchronicity appears, from which the subjectivity function starts to function. A first step is taken towards symbolising. In spite of the fact that the two patients in this study could not yet hold onto this inter-subjectivity, it still emerged, although for a short-lived period. For the first time in the therapeutic process, the therapist then experienced that he existed, and that (as a subject) he could come into a therapeutic relationship with the patient.

Which music therapy interventions of the music therapist contribute to the development of musical form?

In the analysis of the two case studies, there were some significant examples of interventions that facilitated, influenced or supported the process of the patient's playing from sensorial play to musical form. Outside the fundamental therapeutic phenomena such as transference, counter-transference, holding, containment and projective identification it covers the following therapeutic interventions:

- Taking the Bass-line position and Descant-line position
- Anticipating Inner Sound (Silence)
- Post-Resonation
- The empathic listening in sensorial play
- The therapeutic reaction
- Therapeutic provocation of the therapist
- Mentalisation after the session
- Absence of the patient (reverie)

These areas will now be explored in the following section.

*Taking the Bass-line position and Descant-line position*³

In the two case study reports the metaphors of Left-hand-role and Right-hand role (Van Camp 2001) were used in order to describe the therapeutic relationship between the music therapist and the patient. From the results and the analysis I would like to expand the Left-hand role and Right-hand role more fully as metaphors and describe them as the *Bass-line position* and the *Descant-line position*. The Bass-line position is the metaphor for the *stance* of the therapist in the therapeutic relationship with the patient, within which lies the accompanying and supporting roles, and the harmonic basis upon which the melody of the patient can start to develop and can be embedded. On a psychological level, the Bass-line position can also be described as the containing, supporting, and resonating knowing. It is a therapeutic space that the therapist creates and within which the patient can move and possibly for the first time co-resonate with the harmonic foundation the therapist offers. The therapist, who is seen as a longing and supposed-to-know subject, will in no single way be willing to fill in the question or desire of his patient. The Bass-line-position therefore is closely connected to the abstinence rule in psychoanalysis and because of this, the filling in of the Descant-line position lies entirely open and is unknown for the patient, as well as for the therapist. It is the patient who will move from the transference into a psychic space and will be able to give form to their traumatic experiences and memories. The Bass-line-position only supports and makes free improvisation in the Descant-line possible.

In the two case studies it is noticeable that both patients could not take or own the Descant-line-position because of their sensorial play. The pressure and powerlessness of the patient was so painful that I, as a therapist, could not do anything else other than assume the Descant-line-position, (which belongs to the patient), myself (for example see case study Marianne: Figures 5.7 and 5.9 and case study Adrian: Figures 6.10 and 6.11). This is a type of ‘antidote’ against the destructiveness of sensorial play in order that the therapist could exist. Within this frame the therapist could give a musical form to something that the patient was not yet able to accept. It was only in the moments of synchronicity and the emerging musical form that Marianne and Adrian could take the Descant-line position themselves and could entrust the Bass-line position to the therapist. In this study it came

³ In the polyphony of the 15th and 16th century the descant is synonym with the treble-line. Also by keyboard instruments the descant is the highest register of the keyboard.

clear that I, as a therapist, mainly took up—in a regularly alternating way the Bass-line-position and Descant-line-position during sensorial play of the patient, in order to keep the therapeutic process at a certain dynamic level where I could continuously sense what the patient could tolerate, and accept what the patient could not tolerate or accept. In the two case studies I was continuously alert as to whether the patient could go into the Descant-line-position for a moment and could, or could not hold on to it . The moment when the therapist can take on the Descant-line-position is based on intuitive sensing. The therapist needs to have enough insight into their counter-transference that this reverie-play in the Descant-line-position could be found to be disturbing or manipulatory. The therapist has to put his psyche at the service of the patient and needs to have enough insight in his own desires (i.e. his counter transference). As noted by Van Camp (2001) it remains a difficulty that in work with weak patients such as psychotics, there is always the imminent danger that the pressure on the therapist becomes so great that he gives in to the desire of the patient and takes the Descant-line-position upon himself. Through this the therapist will coincide with the patient. This, however, will obstruct or even destroy the therapeutic process and make the patient entirely dependent on the therapist.

Anticipating Inner Sound (AIS) (silence)

One can describe the anticipating inner sound as the musical presence of an inaudible sound, in the silence that the music therapist experiences and listens within at the moment that he is going to play music with his patient. In the silence before the improvisation the player anticipates the unknown that will come. This '*preparation silence*' allows one to come into resonance with oneself and, in a music therapeutic context, with the other, where it is necessary to create an inner space. Each authentic musical play derives from this.

The anticipating inner sound is not only inaudible, but also completely unknown and unpredictable. It is the sound through which the player lets himself be surprised while listening, and which is the guideline for the musical improvisation. This sound is not thought out, it does not belong to anyone, but is heard by the 'third ear' (Reik, 1975) of the music therapist when he displays a receptive attitude towards the presence of his patient. The player lets himself be guided by the power that originates from this empty sound. After the silence that precedes the improvisation, the first tone sounds and one knows from this point how the improvisation will elapse. In music therapy, it is of major importance to see

how a patient enters into improvising, for instance whether or not he is able to allow this necessary anticipating inner silence and let himself be guided by something that he does not know. Alternatively, the patient might immediately fill up every possible silence with sound or noise.

In both cases in this study, the patients had a tendency to fill up each space and every silence when they were engaged in sensorial play. They failed to allow the possibility of, or prevented the creation of a psychic space in which imagination could originate, and within which one could fantasize or could think. The inability to allow an inner sound was not only observable in the sensorial play of the improvisation, but often stretched out over the entire music therapy session. The musical production remained entirely external, strange and undirected and the appropriation of the musical material became impossible.

Post-Resonation (P-RES)

An almost unnoticed intervention of the therapist in the case studies was the point at which he typically let his final notes post-resonate in the sensorial play of the patient. Post-resonating is where the therapist holds the play for a little while and does not abruptly break off in the way that Adrian was continuously doing (excerpt 1). Post-resonance had a very great therapeutic value, because by letting the last sound of the improvisation die away, the played piece could post-resonate internally in the silence and the unconscious could become active. This post-resonance defines the therapeutic event and embraces the confirmation that one is in a therapeutic relationship. Allowing post-resonance and silence to appear happens intuitively within the therapist, and cannot in any circumstance be considered as a consciously applied technique, because at its root is the therapist's embedded knowledge. With awareness of the insight into this therapeutic phenomenon, the therapist can appropriate this therapeutic attitude, and it can then become part of the therapeutic improvisation.

The empathic listening in sensorial play

Besides the bi-focal listening stance (Bion 1975) the “gleichschwebende Aufmerksamkeit” (‘equal listening stance’) (Freud 1916-17) and the listening without “memory of desire” (Bion 1962), the empathic listening stance was especially noteworthy in this research, and

was certainly a feature when the patient was still caught up in sensorial play. Pedersen (1998) wrote about the therapist listening through their body to the body of the patient. This physical listening stance mainly becomes visible in the video analyses, where the physical attitude of the therapist is identical to that of the patient. One can state that the therapist listens to the body of the patient through his own body, where one listens on the level of the affect. Here the therapist tries to come into resonance through the body with the affect of the patient.

The therapeutic reaction

This is a reaction of the therapist to the projected powerlessness and lack of freedom of the patient, which the therapist experiences in a fundamental way in sensorial play. In his therapeutic desire the therapist will continuously try to come into resonance in his musical play with the sensorial play of the patient. The therapist hopes that the musical forms that he is playing will graft themselves onto the sensorial play of the patient, so that a first contact originates in which the patient can co-resonate for a moment, or comes briefly to an inner movement. The therapeutic reaction is the steadfast attitude of the therapist that is necessary to create enduring conditions in order to come to an inner imagination. It is being alert for the play of the patient and intuitively seeking the emergence of phrasing, structure, pulses, while letting silences and possible variations emerge.

Therapeutic provocation of the therapist

This is connected to the therapeutic reaction, although this intervention is more direct. With Marianne, as well as with Adrian, the therapist provoked sensorial play by opposing it carefully and undertaking this mainly with counter rhythms. One can state that, because of this provoking intervention, the therapist tried to create an opening in Marianne's compact, closed and lack-of-contact play, and Adrian's rigid, controlling and fearful play. Even though both patients were not yet prepared to allow that something might come into process, they could abandon their sensorial play for a moment by, for example, taking over the tempo or dynamics of the therapist. Therapeutic provoking is not a technique, but an intuitive event in the desirable play of the therapist, who senses when he could allow this intervention to occur. In this way there it is not a conscious intervention, but rather an

intervention which is directed from a given transference. When this happens too soon, the patient cannot allow this opening and thus increases the resistance towards it.

Mentalisation after the session

Holding and working through the sensorial play of the patient was sometimes unbearable for the therapist. The therapist has however, unlike the patient, the possibility to make all of this tolerable and digestible by improvising with this in a reverie style after the session. Through this (mentalisation) play the therapist could create everything that affected him during the session in a musical form. Mentalising through these musical improvisations made it possible for the therapist to back himself out of the mire of sensorial play. He could then integrate this emptiness or the compactness of the affect within an inner imagination (impression) and let the hope and desire exist in order to continue the therapeutic process.

An illustration of this is found in the first session of Marianne (Figure 5.2), who left an intense, full emptiness behind. However, unlike the patient, the therapist had the possibility to make the vibrating affect in his body bearable and digestible through a musical improvisation. By improvising he could allow a therapeutic silence, which was essential for the mentalisation of the full emptiness full of repetitiveness. Via the play he gave form to the sensoriality that remained external.

Absence of the patient (reverie)

The empty space that originates when the patient is very late for therapy, or does not show up at all, has a therapeutic value. Ogden described, “that the patient's physical absence creates a specific form of psychological effect in the analyst (and in the analysis) and that the analytic process continues despite the patient’s physical absence. In this way, the specific meanings of the patient's presence in his absence are transformed into analytic objects to be fully experienced, lived with, symbolized, understood, and made part of the analytic discourse.”(Ogden 1997, p. 43) The music therapist, however, has the potential to form an image of the patient by improvising and by reflecting about the patient and because of this the therapeutic process can be continued. This therapeutic level of thinking was a remarkable and necessary experience for the therapist in the Adrian case study. For example in sessions 2, 6 and 8 the therapist waited for Adrian who came too late. Adrian continuously wanted to exercise control over the music therapeutic treatment because of his

narcissistic problems and, by arriving late, created a situation where it was he who controlled the framework. For the therapist, it was therapeutically valuable to improvise in order to be able to think about the patient. The musical improvisation was, as described in the Adrian case study report (Third session: p. 188), a purely intuitive play, where the therapist let himself be guided by the music. As a result of this, the therapist could come into resonance with himself and the imaginary image of the patient and the therapeutic process could be continued and held. This process of ‘giving form’ musically and mentally had its reflection on the therapist’s therapeutic attitude and listening during the proceeding meeting with Adrian.

Further findings in the moments of synchronicity and musical form

The way in which the moments of synchronicity and musical form appear is a confirmation that no meaning can be described to the music in itself (Bruscia 1987; Bruscia in Wigram 2004; De Backer and Van Camp 2003b). Music in improvisation expresses something from us, and this is opposite to the general assumption that one can express oneself through music. Music is not the expression of a subject, rather the subject is the expression of the music (Van Camp 2001). The musical form that Adrian developed is a beautiful illustration of this. In his musical form musical motives appeared that are identical to the compositional motifs of Dowland’s song: ‘Flow my tears’. Adrian did not invent these musical motives of Dowland, but yet, he plays these in his musical form. It is the music which leads Adrian to something unknown. This cannot be viewed as a confirmation that Adrian expresses himself in the music.

We can see the same phenomena in literature. The writer allows himself to be surprised (*the happy accident*) or overwhelmed by a series of untraceable and thus never interpretable, syncretic associations. This process (*the fertile motif*) is organized by an autonomous *I* (Ehrenzweig (1977)). It is a process of surrendering that repeats itself endlessly while the work evolves; the reader only sees the final result. The writer is also not only influenced by his own associations, but by what he (partly through a happy surprise) finds ‘there’ on his page (i.e. discovering the piece of art as an autonomous object). This can be correlated with what Marianne and Adrian experienced when they reached musical form. It is an autonomous play. The writer is a spectator of his own work. In the same way

Stokes (1965) described, “The artist is in the fullest sense the spectator of his own work; not just of the finished work, but of the work in all stages” (Stokes 1965, p. xxvii). Beethoven did not really “invent” the famous first notes of his fifth symphony. They occurred spontaneously in his mind. This is also the case with musical findings in the musical form of Marianne as well as of Adrian.

7.2 Relation of the findings to the literature and to existing theoretical understandings

The relationship of previous studies and literature to the musical play of psychotic patients.

This study holds a rather unique position when considered alongside previous studies in the field of music therapy. By this I mean that the findings of the study are novel and not found in previous studies from researchers who describe the process of music therapy with psychotic disorders.

In order to examine possible connections with previous research and clinical reports, the three phenomena of sensorial play, moments of synchronicity and musical form will now be used as a structure for defining the relationship of this research to previous literature.

Sensorial impression

The repetitiveness and absence of variation and dynamics in the music produced by people who have psychotic disorders have been described in previous music therapy research studies such as those of Bauer (2000), Hengesch (1974) and Pellizzari (1993). Pellizzari (1993) connects this constant repetitive play of the psychotic with a failure in the symbolization process, whereas Schaverien (1997) identified it with an absence of symbolic forms, and Bauer (2000) and Hengesch (1974) linked this to an inability to appropriate the played material. The patient’s repetitive thinking has also been described in the psychoanalytic literature by Billet (2003), Van Camp (2001), Schaverien (1997) and Fink (1997), as an expression of the psychotic patient’s inability to conceptualized something in image form. Hengesch (1974) also described other musical characteristics of sensorial play,

such as the inability to conclude an improvisation. In another study Bauer (2000) and Hengesch (1974) noted that psychotics have the tendency to play very loudly. This last characteristic was not conformed in my research.

It should be noted that in the findings of this study *sensorial play* is described as a type of play where there are absent elements. This means that the criteria (Table 7.1) are characterised by missing elements: there is no musical thought possible, there is an absence of dynamics, of rhythmic or melodic development, of phrasing, of variation, and on a psychic level there is the absence of a psychic space and intersubjectivity.

From the concept of Bion (1962) one can see sensorial play of the psychotic patient as the inability to introject the Alpha function and because of this the patient remains imprisoned in a world of bizarre objects, in which no thinking is possible. The fragmented play of Adrian (excerpt 2 and 3) could be compared musically with the cast-off Beta-elements of Bion (1962). The psychotic patient possesses no mental space in which inner sensations can be experienced and in which there is space for thinking (De Waelhens 1972; Dührssen 1999; Kortegaard 1993; Schirmer 1991; Van Bouwel 2003 and Van Camp 2001).

The psychotic patient who cannot break loose from the repetitive, formless, sensorial play is at the level of the autistic-contiguous position (Ogden 1992), in which the specific play of the patient is a purely motoric act, through which the patient cannot be inspired. The endless, repetitive and monotonous musical character of the sensorial play of a psychotic patient can be compared with a sonorous “second skin” (Bick 1967), which serves as a defence against fear of the continuous threatening loss of boundaries, and of the falling into an endless and formless space.

Sensorial play is directed from a purely motoric act, without any connection with the psyche of the patient. It can be compared with a *musical rocking*, which also can be found in autistic forms as described by Tustin (1984). Making use of autistic forms in an exclusive and rigid way blocks every further psychic development. This was apparent in Marianne’s inability to break loose from her sensorial play during the eight months that she attended the group music therapy. This illustrates that she did not possess a psychic inner world.

Sensorial play can be viewed as a pathogenic rejection, or “Forclusion” or decline as noted in Lacan’s theoretical thinking (Lacan 1981). The repetitiveness and formlessness of sensorial play are central as the radical refusal of the psychotic versus the symbolic. This

pathogenic “Forclusion” translates musically into an endlessness and formlessness that remains insensitive to the synthesising process of achieving musical form. With its specific sonorous character, sensorial play is at the same level of psychotic pathology as already noted when describing the world of the psychotic as formless and endless, where thinking and symbolising is impossible (Van Bouwel 2003). Sensorial play can also be linked to the delusion thought processes of psychotic patients. Sensorial play circles around in an aimless repetitiveness, which can be compared with delusion experiences. The delusion is completely univocal and does not allow any new significances and development (De Backer en Van Camp 2003a).

In contrast to what previous theorists have described as the fragmented and open endless space of the psychotic mind, the findings of this study suggest that the repetitiveness of sensorial play can be described as coming from a psyche that exists as a packed, compact mass. The psyche is so compressed and filled up that thinking becomes impossible. No single movement in a person’s way of thinking is possible. Therefore, it can be seen that the compact and compressed psychic space experienced by the subjects in this study can only spin around its own axis. The therapeutic process towards musical form or inner image suggests that in this compact mass, a small opening can emerge. This is possible because from the therapeutic reaction to music, the therapist is at the same level of the affect of the patients, and waits for the moment to bring his musical play into resonance with the different layers of the trauma from the patient. A part of the compact psychic space can be appropriated because of this opening, after which it can then be mentalised. This can occur specifically through the appearance of a musical theme or the appearance of rhythms or melody from the patient and therapist, which means that a first step towards symbolising can take place. In this first opening in the compact mass one can see brief moments of synchronicity happening.

Development of a psychic space

The psychic space that is created can be compared with the transitional space (Winnicott, 1971), which is not present, or is at least much less accessible during psychotic phases. It is about a personal world into which no one is allowed. On a musical level sensorial play is a psychotic sonorous object, which is isolated and unimaginable, and which the findings of this study suggest to be the impossibility of the patient to symbolise. Intersubjectivity

originates between the subject and the Other from moments of synchronicity and finally in musical form and in this way music can offer possibilities for a patient to come to a transitional space. This psychic space is where a patient can play, think and be in interaction with others. It can be described as an intersubjective dialogue in which the patient and therapist influences and are influenced by the other (Dosamantes, 1992).

The process towards moments of synchronicity and musical form

The most relevant connection was to relate the concept of synchronicity to Lacanian theory of psychosis (Lacan 1981). Sensorial play can be considered, according to Lacan's theory, as a 'lack-in being' (Lacan 1955, p. 179). Sensorial play is at the level of the 'real', which according to Lacan is characteristic in psychotics who cannot take a step towards a symbolic representation. The 'real' is the state where the object sought for or desired no longer exists and yet, there is a continual search for this lost object. The 'real' is located in the gap between the object and the wish; it is not itself - the *object* of desire - but rather it is *the desire* itself. It is in this area that the 'lack-in being' of the psychotic state resides (Lacan 1955, p. 179).

The characteristic of repetitive *behaviour*, which is situated at a traumatic level (Van Camp 1999; Tustin 1984, Fink 1997) and manifests itself in sensorial play, is disrupted by moments of synchronicity. From here, a process of becoming a subject can be started. This happens in the development towards musical form when substitutes appear for that which has been lost. This study suggests that music can create a transitional space (Winnicott 1971) in which a transition is made possible in order to progress from an authentically traumatic level to a symbolic level of images and words. Van Camp (2001) states that music is able to move blocked sensations in the body, and to connect them via mediation of the musical form.

Moments of synchronicity mean a first step towards musical form or symbolisation. Central to this process is the appropriation through which autonomy originates. Just as a child appropriates the voice of the mother, the psychotic appropriates his music, something which is not foreign to him (Van Camp 1999). The psychotic no longer reflects himself and starts to look for what has been lost. This is termed the 'objet a'⁴ by Lacan (1981). Musical

⁴ "Objet a": which might be simply defined as the 'object of desire'.

form does not yet have the status of what Lacan names as a lost object: ‘objet a’. In moments of synchronicity a first step towards symbolising happens because a distance is created - not because of the language, but because of recognition. Later on, a step is taken in the direction of significance through the musical form. This indicates a first step towards symbolising (proto-symbolising).

In moments of synchronicity the *jouissance*⁵ is released. The ‘real’ makes place for a step towards form. The immediateness through which the patient is caught up in the experience is significant. Just like a dancer starts to move immediately when some music starts suddenly and unexpectedly, and a child engages rhythmically to the voice of the mother, so the psychotic comes into the rhythm of making music with the therapist. Moments of synchronicity are therefore equal to the word “Bejahung” (Lacan 1981), because it also becomes clear that there are major resistances in the psychotic patient to be able to say ‘yes’ to the possibility of symbolisation by allowing moments of synchronicity and musical form to originate. When this happens, we can state that a reparation process in the music takes place.

The paradox of becoming autonomous in a dependent relationship can also be found in the musical polyphony of the 16th century. Here, two separate lines of music each follow their own path. They sound together but are nevertheless autonomous. Synchronicity as a term mainly refers to the rhythm, while polyphony emphasizes the autonomy of the two melody lines. Van Camp (2001) compares the relationship between therapist and patient when they improvise simultaneously with musical polyphony. They play together, but each follows his own melody line.

In the literature we find that music therapists have previously used the term synchronicity to describe some specific musical and psychic contact that occur between two subjects. For example, Bruscia (1987) used the term *synchronicity* in reference to a technique for empathy within an improvisational session. He described synchronicity as a technique where, “the therapist does what the client does, as the client is doing it, timing the process so that their actions coincide. Synchronizing can be accomplished with various levels of precision. When synchronizing, the therapist may attempt to match either many aspects of the client’s response or only certain dimensions. Moreover, the therapist may

⁵ Lacan describes *jouissance* as an experience of unlimited enjoyment, pleasure ordinarily associated with sexual climax.

stay within the same modality of expression (unimodal), or transfer to another (cross modal)” (Bruscia 1987, p. 358). This correlates with a later definition by Wigram using the term mirroring, where it is described that, “Doing exactly what the client is doing musically, expressively and through body language at the same time as the client is doing it. The client will then see his or her own behaviour in the therapist’s behaviour” (Wigram, 2004, p. 82).

Lenz and Von Moreau (2003, p. 127) described an important aspect of synchronicity as, “the stepping into resonance”. They described synchronicity, (as it has been further and more specifically defined in this in this study) as the moments where two people are emotionally connected closely with one another.

Moments of synchronicity can be related to Stern’s “now moment” concept (Stern et al. 1998, Lenz and Moreau 2003). He describes this as a fiery, immediate moment that appears unexpectedly and is qualitatively completely different than the previous one. It is interesting that Stern states that this ‘now moment’ has to be completely caught at the right moment, in the same way as was found for moments of synchronicity. “A ‘now moment’ that is therapeutically seized and mutually recognized can become a ‘moment of meeting’”. The now moment has disequibrated the initial intersubjective context; thus, it must be enacted mutually. Only when this enactment has been performed, mutually recognized and ratified, will a new intersubjective state come into being” (Stern et al. 1998, p. 305). This means that just as in moments of synchronicity, inter-subjectivity is also developed here. Moments of synchronicity can be “moments of breakthrough” (Wigram, 2003) of the repetitive playing in sensorial play and become a moment of meeting that heals. Such moments of meeting are also to be seen in the study of Pfeiffer et al. (1987), who described them as a significant improvement of contact.

The concept of Stern’s ‘now moment’ also emerges in the music therapy literature where people have described musical engagement. Wigram has developed a concept of *matching* which he defined as: “Improvising music that is compatible, matches or fits in with the client’s style of playing while maintaining the same tempo, dynamic, texture, quality and complexity of other musical elements” (Wigram 2004, p.84). Moments of synchronicity are also connected with some criteria found in the study of Amir (1996) where the presence of meaningful moments in music therapy process was examined by interviewing music therapists and clients. Some meaningful moments were defined as

important in Amir's study, such as moments of freedom, wholeness and integration, completion and accomplishment, intimacy with self, ecstasy and joy, surprise and inner transformation. These same qualities are also seen in moments of synchronicity, which confirms that moments of synchronicity discovered in this study are meaningful in the music therapy process for the patient, as well as for the therapist.

The moments of synchronicity can also partly be found in the study of Erkillä (2004) who developed the concept of Basch-Kahre (1985) further in which a process is described starting from chaotic thinking (as the result from overwhelming inner impulses) to projected fragments (meaningless music) to objects of projection (music therapist/music) to the emotional sensomotoric thinking (emotional sensomotoric configurations) to operational thinking (necessary for comprehension) and to come to a secondary process thinking (conscious (cognitive) level). In the transition from chaotic thinking to operational thinking, Erkillä (2004) describe the phase where chaotic fragments start to 'condensate' through projection. It is a phase where the first primitive meanings emerge into the expression of the patient. The therapist can recognize and experience transference and countertransference and musical forms becoming meaningful. This is also recognizable in the criteria of the moments of synchronicity.

Musical form

The coinciding of the development of a psychic space with musical form became clear in this research. Several authors, such as Bion (1967), De Waelhens (1972), Dührssen (1999), Schirmer (1991), Soenens (2002), Van Bouwel (2003) and Van Camp (2001) have placed the development of a psychic space as central in the treatment of psychotic patients. It is the necessary condition in order to come to symbolisation which, when translated into music therapy practice, refers to a process of coming to a musical image. Dührssen (1999, p. 44) also emphasizes the importance of developing a psychic space so that the patient would increasingly identify himself as a subject within this space. This is also a criterion for the creation of musical form.

From the theory of Lacan, the inner image (or musical form) can also be described as follows. The image is what comes instead of that which has been lost. Lacan (1981) addressed the symbolic, or the absence of the object, with the term 'Name of the Father', suggestion that it concerns a function, and not a concrete father who is present or not present. The passing on of the Name of the Father means the initiation of a capacity to

appropriate the language in such a way that the child is able to pronounce its own name in a language that is not foreign to him. (Van Camp, 2003b) This means that musical form offers a possibility for allowing the patient to appropriate his own musical material, and is therefore able to play autonomously as an individual, while also coming to symbolisation.

In previous music therapy literature the importance of musical characteristics that represent structure have been mentioned as essential in the treatment of the psychotic patient. This aspect of structure which is inherently present in musical form as defined in this study can be related to the work of Schirmer (1991) concerning clinical work with psychotics. This refers to structuring as part of a process leading to the creation of a protective space in which patients are able to begin relating to themselves and to others.

Daser (1991, p.105) describes the presence of a psychic space as a metaphor for a successful structuring and integration within the therapeutic event, where the therapist is no longer an unknown figure for the patient. He then becomes a subject to the patient. The emerging forms can then be viewed from different points of view. One can compare this in the present study with the patient's ability to surrender to the musical play, therefore allowing the different themes to be varied. Schirmer (1991, p. 325) also described structured music as a proto-symbolisation and indicates that this is a first step towards a final symbolisation.

As a consequence, this research tries to give an answer to Van Deest's statement that music therapy possesses the possibility of allowing a symbolisation process to occur in psychotic patients. Van Deest (1994) states that concerning an issue of nearness and distance musical symbolising can facilitate positive experiences, and thus the fear of nearness and distance in psychotic patients can be reduced. It is important to note that psychotic patients can develop a psychic space as shown by Van Bouwel, who states that, "within this mental space the psychic pain is made bearable, thoughts can originate and the patient does not have to be victim of his psychotic experiences any longer"(Van Bouwel 2003, p. 132).

I agree with the theory of Langer's description of form as follows, "form is always a perceptible, self-identical whole; like a natural being, it has a character of organic unity, self-sufficiency, individual reality' (Langer 1953, cited in *The New Grove*, p. 709). It is very easy to see this in the coming into being of musical form in both cases. From the musical analysis it seems that the development of structure is necessary in order to come to

musical form. This was already examined by Hoffmann (2002) and Bruscia (1987), who placed phrasing as a central element in the development of structure and, as a consequence, musical form. That musical form in this study is seen as a process is also acknowledged in the literature of Van Camp (2001). He sees musical form as a forming force, rather than a purely structuring given. Bruscia (1982) and Van Camp (2001) see the development of musical form in the further development of themes and their variations. As Bruscia states, “the act of musical creation requires what the existentialists would call the power, will, and freedom to choose among several options for continuation.” (Bruscia 1982, p. 30)

When the entire development activity of variation and process – which can be considered as a form of primordial mourning labour – is accomplished, the psychotic patient also succeeds in ending his improvisation musically (De Backer and Van Camp 2003a). The appearance of musical form means that the traumatic affect and verbalisation will no longer be disconnected from one another and from now on, the psychotic patient can speak for himself

Just as it seems from the relationship of the findings to previous literature, there is little attention paid to the musical and therapeutic process in the treatment of psychotic patients, with its connected therapeutic interventions. I hope that this study contributes to the further development of a theoretic foundation for possibilities and limitations of musical experiences in a therapeutic context. As Risch (1996) reported, music therapy will only be able to keep its niche on the basis of its specific medium that music possesses the power to create an inner world, and an experience of space.

7.3. Limitations and validation in the study

Two subjects

A possible limitation of this study is that only two objects were examined so that it is difficult to speak of an external generalizability (Maxwell in Robson 2002, p. 176). In spite of this, a good argument can be made for such a study. The two subjects studied are clinically very different from each other, even though they present within the category of psychosis. Through my twenty years of clinical experience I can state that the two case studies can be seen as exemplary. The characteristic ways of playing of sensorial play

correspond to what I have seen with many other psychotics. This means that in the case studies, the specific characteristics (which themselves are without question fully linked to the pathology of psychosis), present all musical and mental characteristics. From a statistical point of view these two cases are too limited, but these two exemplary cases are worked out in depth. The theory which was developed in this study can also be an initial impetus to enable an understanding of the therapeutic process with other pathologies in which the symbolising function is affected. I agree with Robson (2002), who argued that this does not preclude some kind of generalizability beyond the specific setting studied. He mentions Sim (1998, p. 350), who interprets that, “Here, the data gained from a particular study provides theoretical insights which possess a sufficient degree of generality or universality to allow their projection to other contexts or situations”.

The aspect of intersubjectivity and timbre

Important and essential aspects such as the intertwining of timbre and inter-subjectivity are not visible or audible, but are only experienced by the therapist, as became clear from the research. It is about specific resonance phenomena, which always remain as subjective observations. As a consequence, questions can be asked about the objectivity of the inter-subjectivity, and about the experiencing of the intertwining of the timbre and the experiencing of silences. In order to create the possibility for being as objective as possible, the present counter transference and subjective interpretation and perception of the research material were examined and controlled via a specific research methodology and validation. The reflections on the sessions and writing down the impressions for this research were undertaken more expansively and comprehensively, more profoundly and more consequently than in a normal daily setting. Via research intervision and research supervision the blind spots and the possible counter transference were made conscious, through a process of second opinion and cross-checking the analysis.

It is important for clinical practice that the clinical music therapist is conscious about the fact that resonance phenomena can only be experienced, and are neither audible nor visible. Supervision, experience and insight in therapeutic processes and phenomena are indispensable in order to be able to experience them.

Aspects of video-registration

I was conscious of the implication of videotaping the therapy situation. One potential weakness experienced as a result of videotaping was the fear of making mistakes, of not being a skilled therapist, so that one gets caught up in the pressure to perform in order to make the therapeutic process possible. This could become so great that one started to manipulate and change his/her natural way of working and intervening. Schumacher (1998) likened this fear to that of taking an exam, stating: “Man möchte ein gutes Bild abgeben”⁶. This pressure can be projected to the patient, so that through countertransference the patient is put under pressure. Daitzmann (cited in Knill 1983, p. 48) reports a feeling of “unbestimmte Überwachung – man kan nicht sagen, wer es einmal sehen wird und dass Patienten das Gefühl hatten, ihre Handlungen wurden “verewigt” werden.... “⁷. Therefore, it was necessary to always consider if videotaping was possible with certain patients. Through my twenty years of clinical practice with children, as well as with psychiatric patients, I have rarely had the feeling that my therapeutic actions, my thinking, my observation and making music have not been influenced by the video camera. The video camera was more consciously apparent than the minidisk. The patient, as well as the therapist, had to adapt to the presence of the video camera. From the therapist’s perspective this was possible after one session.

Aspects of the score

Scores and illusion

We will see that the phenomena of sensorial play, moments of synchronicity and musical form cannot solely be identified by analysing the musical scores, but by achieving insight from the transference and counter-transference (i.e. through inter-subjectivity). We can state that by notating the fragments, musical form appears automatically. Through the process of notating music in scores we are already making an interpretation. The notated score is only an illustration of which some musical elements are present, such as repetitiveness, phrasing, variations, musical themes, musical developing, form etc. For example, it is an illusion to illustrate sensorial play only in a score, because there is the

⁶ One wants to give a good impression.

⁷[2] Unclear control – one can not say who will see it one time and patients have the impression or feeling that their actions are immortalized for ever ...

danger that one could construct a musical form in sensorial play. A musician or music therapist will intuitively look for a form in the score (see example Appendix: 4). For example, after having listened to the initial excerpts of music from Marianne's improvisations (Figure 5.7) more than twenty times, I started almost involuntarily to recognise a melody in it. This was probably related to the fact that I was not able to assimilate the material at a sensorial level. As the therapist, I heard Marianne's sensorial play from a distance. Therefore I was no longer influenced by the powerlessness of the improvisation, because I could now step back and create something independently myself. This was an interpretation, just as for instance, when one interprets an existing score and searches for new forms in it. This was a very inner process of work, and can be described as a mentalisation. This was no longer related to the improvisation, because the improvisation could only be judged from the transference or the absence of inter-subjectivity.

Score as a shadow of the reality

I had the experience that small nuances in metre, specific rhythms, tonality, dynamic and timbre were very difficult to transcribe, and did not lend themselves easily to being described in a regular note system. This was especially the case with the fragments in which synchronicity originated. One could consider the score of improvisation as a shadow of reality. The musical notations were especially helpful to be able to analyse the improvisations. Through this material, I could keep the music in a visual reminder, and then be able to hear it again in my head. As Sutton described: "the basic transcriptions were used as a reference point from which the improvisations could be mapped and studied via repeated listening" (Sutton 2001, p.14). I never looked at the score as a pure score, but as a symbol of the sound material with its entirety, and as thus not able to register nuances and features.

Validation

For the research, as described in chapter 4, it was important that ensuring reliability and validity was undertaken in a careful way. The controlled subjectivity necessary to explore my own counter-transference was mainly made conscious through the analysis of my experiences after each session, and the clinical supervision and research intervention that

allowed this in the research. It was, for example, essential that in the research intervention the psychoanalyst involved was not only interested in the co-reflecting about the video material, but also especially in the listening to and attending to the way in which I reflected upon the therapeutic actions and interactions in the video material. During this part of the analysis of the research results, the phenomena of countertransference - which came clearly across via verbal reflection and the transference towards the psychoanalyst were essential in order to make conscious the countertransference phenomena in the therapeutic process. These were kept at a minimal level and were carefully controlled. The repeated observation of the videos, and the subsequent repeated analyses were also closely monitored and gave me the necessary framework with which to correct possible subjective interpretations and prejudices. For validation, a combination of transference validity, communicative validity and internal validity were very important and because of this, each step was critically and carefully reflected upon by colleagues, and by the psychoanalyst collaborating in the research intervention. The six-monthly PhD seminars in Aalborg were particularly enriching and offered a necessary confrontation for guarding the validation of the research.

7.4 Clinical applications

Therapeutic process

For clinical music therapists working in psychiatry this research offers a theoretical frame of thought through which it is possible to achieve insight into a possible course of therapeutic process with psychotic patients. This insight can increase the trust and confidence offered by the interpretation of musical or psychic changes in the patient, such as phrasing, development of silence, an initiation towards a structure etc. and most essentially, being continuously alert to these possibilities. It urges one towards a waiting, curious listening stance for the right moment (*kairos*) in which the therapist can come into resonance with the patient. The patient will indicate when he is open to the potential for moments of synchronicity and it is up to the therapist to sense these moments in an attentive way, and to go along with them by, for example, putting in musical accents, playing off-beat rhythms or by introducing an initial form. The process of timing involves trusting the patient to demonstrate that he is ready for such changes in the engagement

patterns. As Ogden expressed it, “symbolisation usually develops over time if one is patient and does not force it. Forced symbolization is almost always easily recognizable by its intellectualised, formulaic, contrived quality.” (Ogden 1997, p. 161) Therefore, it is so important that the knowledge of the understanding and treatment of psychotic states needs to be clearly specified.

Therapeutic interventions

Specific therapeutic interventions were also examined in this research. Some therapeutic interventions were new for the music therapist/researcher, such as the concepts of *anticipating inner sound*, *therapeutic reaction*, *therapeutic provocation*, *post-resonation* and the importance of the different modalities of *silence*. In this study it became clear that these interventions could not be defined as a conscious technique because they are not used consciously, but tended to be intuitive. Therefore, these are not intended as techniques that should be used consciously to solve a problem, but rather with the awareness that these are acts that are embedded in a therapeutic attitude, and which are initiated during the therapeutic process. They should not be taught simply as concrete techniques, but as skills that can only be developed and appropriated through one’s own therapy or through self-experience and supervision. As Casement commented: “No-one can make someone else grow. Therefore, a therapist has to understand the growth processes, as well as the dynamics through which they can be barred.” (Casement 1989, p. 203). A therapeutic process is not manipulative. Creating a psychic space does not work through the input of techniques. One cannot manipulate the ‘right’ moment to occur, such as a moment of synchronicity, consciously. Stern et al. stated that “if the therapist “knows” what to do, he has probably missed the “now moment” or has quickly hidden behind technique” (Stern et al. 1998, pp.304-305).

This is a constant waiting with an expectant attitude, curiousness, and always allowing oneself to be surprised every time that something appears and trying to understand what it is about. There is always a tension within the relationship between knowing and not-knowing. The “binocular vision” of Bion (1975, pp. 63-64) is a very interesting concept here, where he underlines that the therapist can learn to follow with one eye these aspects of which he knows that he does not know, while he focuses the other eye on what he thinks he knows. There is a fertile tension between this knowing and not knowing.

The therapeutic interventions of the therapist, which were essential in order to come to musical form, are described. Gaining insight into therapeutic intervention can make the clinical music therapist more conscious of what is necessary in order to help the psychotic patient move towards the development of a therapeutic space and imagination. For the practising and student music therapist it is necessary that therapeutic interventions are directed from a theoretical frame of thought.

7.5 Future research

The theoretic frame of thought which was developed from this research is not only useful for psychotics, but probably also for other pathologies in which the symbolizing function is affected, such as autism, moderate and severe developmental disability, psychosomatic disorders, addictive pathologies and borderline problems. In my music therapy practice of many years with autistic children, I observed the same characteristic phenomena found in sensorial play in their music. The repetitive character and the absence of intersubjectivity has been noted in other research, such as within a study about autism (Schumacher 1994, 1998; Lecourt 1991) and one concerning developmental disability (Schultz 1987). In order to further understand this, additional research is needed to see if the same necessary phases that the process in this study goes through can be found again with the other pathologies and where specific therapeutic interventions facilitate or support this process. The use of this research design can make it possible to compare the process and the results with this range of different pathologies.

Questions remain, amongst which is Klein's concept of projective identification (Klein 1948), where it assumes implicitly that something unbearable can be imagined psychically. On the other hand, it seems from this research that the psychotic patient is not able to develop a form in his sensorial play, which also means that he is not able to come to an imagination and thus not yet have available a psychic space. The therapeutic response described in this research cannot be equated with projective identification, such as was described by Klein. It is rather the case that one projects on an affective, physical level, and with this the therapist comes into resonance. Further research remains necessary in order to examine this resonance phenomenon.

Another interesting subject for future study would be the possibility of further examining the modalities of the three phenomena of sensorial play, moments of synchronicity and musical form. This is necessary in order to further develop and refine the theory in order to come to a more general theory. In a broader research perspective, which would specifically focus on this, one will probably come to greater diversity of potential specific therapeutic interventions.

A further possible area of inquiry study could also cover the possibilities and limitations of an individual form of treatment in comparison to a group therapy treatment. A noticeable given in this research was that Marianne came to musical form in four individual music therapy sessions, while whereas she could not break free from her continuous sensorial play during nine months in group music therapy. For Adrian, the group music therapy was even more threatening because of his narcissism. It was therefore surprising that Adrian came to musical form in only eight individual sessions.

In extending this research one might also examine if the individual music therapy process and its specific therapeutic interventions could also be applicable in group music therapy. For instance, one issue might be the influence of the other patients upon the therapeutic space. It is certain that this would be a much more complex study, because the group interventions and the transference-phenomena increase proportionally, depending on the increased number of group members.

7.6 Ways in which the researcher was changed by the process of research

The development of my identity as researcher evolved as part of an overall process. As I wrote in the introduction chapter, this did not happen self-evidently, because learning to look and listen in an objective and systematic way to the therapeutic material and the musical improvisations was new for me. I discovered how to set aside interpreting from my clinical thinking. This enabled a more open and objective view of the personal material of the patient and because of this the use of musical scores gave me the possibility of holding onto something and examining it over time. This offered opportunities to better analyse the unconscious or conscious structures and to understand this in a music therapy context. This process has considerably influenced my therapeutic thinking and acting, the impact of

which has surprised me in a positive way. Something that in the beginning was for me a purely doctoral research exercise seemed towards the end to be more and more a thorough analysis of therapeutic and musical processes, interventions and thoughts about the patient.

Studying and describing clinical music therapy in a structured and detailed way is a very disciplined process. The systematic development of a research design from the basis of clinical practice is a process requiring a continuous reflection about the developing steps, and a requirement to anticipate which steps are really necessary in order to answer the research question. A different thinking frame with particular reference to issues of validity and reliability is demanded if one is to be open to unexpected, new and sometimes surprising findings without falling into an interpretation of the material. Thanks to the different PhD seminars and, especially to my supervisor Prof. Dr. Wigram, I learned to integrate this new attitude into my daily practice as a music therapist and lecturer. In one way, this research is not finished and never will be finished. It has been difficult for me to take leave of this work through writing it down in this dissertation. However, through this research I have acquired more insight in the research culture itself and I have developed a good basis to further refine these skills in the future.

Through the process of doctoral study I have learned that research can contribute significantly to the formation of the theoretical frame of thinking of a clinical music therapist. Staying alert to the validity and reliability in qualitative research is an attitude that I developed.

7.7 Conclusion

The results of this study identified the development of a process from sensorial playing into musical form as a central aspect in the music therapy treatment of psychotic patients. In order to answer the research questions it was necessary to first describe and define sensorial play and musical form.

Firstly, in this research sensorial play and musical form were defined in order to examine the possible therapeutic process. From the analysis of the musical and therapeutic process it seemed that a new and unexpected phenomenon emerged, which was essential in this therapeutic process, namely the concept of moments of synchronicity.

The results of the study also demonstrate how the development of *musical form* within a music therapy process can counter and reduce sensorial play. In a music therapy context, we can describe musical form as the origin of the musical conditions so that that enable the sounds which are generated during a musical improvisation to be no longer experienced by the subject as external, as something that is foreign to him, but instead can come into resonance with an inner self (Gindl 2001b, 2002) During the point at which *moments of synchronicity* emerge one can see as a moment that is the most decisive, but because of this, the most precarious in the creation of an appropriate musical form. In the two cases reported in this study, this precarious moment always takes place during an inter-subjective event. The moments of synchronicity have been described as the shared experience of patient and therapist, where they feel free and autonomous in their play. In relationship to each other, both patient and therapist are free to play, to think, to exist and to develop their own musical thoughts. This moment of polyphonic resonance is the condition that allows a musically dynamic build-up to originate within the improvisation, wherein rhythmic and melodic themes appear, which can further be explored or varied in the musical form. The musical figures are characterized by phrasing and pauses and another specific feature is that, for the first time, a clear, mentally prepared beginning and ending mark the musical improvisation.

One can describe *sensorial play* in all aspects as the opposite of musical form. It is a play of the patient during an improvisation with the therapist, where the patient produces sounds, but does not come to music, let alone appropriate these sounds. The improvisation does not generate an experience within the patient and he is not inspired by the music. The patient does not experience his musical play as something that comes from himself, but rather as sounds in which he does not participate. The sounds are outside of him, and they do not belong to him. On the basis of his pathology the psychotic does not have a psychic space which allows symbolising and which would make it possible for the musical objects to be appropriated. Sensorial play is endless, without beginning or ending.

It became clear from the research that specific phenomena such as silence, timbre and inter-subjectivity are important phenomena in the therapeutic process. They manifest themselves not only on a non-visible and non-audible level, but can also be experienced by the patient or the therapist. It is also possible to examine the specific and differentiated

therapeutic interventions of the music therapist, because these are important to facilitate and support the possibility of developing musical form. The therapeutic methods of interventions (such as *anticipating inner sound*, *the therapeutic reaction*, *post-resonation*, *the empathic listening stance*, *therapeutic provocation*, *mentalisation after the session*) seemed from this research not to be applied by the therapist as concrete techniques, because they are not used consciously, but rather are directed from the transference. Through self-experience and supervision these interventions can become insightful and appropriated, and will contribute to a reliable and authentic therapeutic attitude in therapeutic interventions with psychotic patients. From this research, I hope to have developed a theoretical frame of thought that is applicable in clinical practice, to provide psychotic patients with possibilities for developing a psychic space within which symbolic thought and experiences can exist, and as such, make an ending to his “unimaginable storms” (Jackson and Williams 1994).

These musical analyses offered me the possibility for exploring the musical material and for finding hidden structures and musical developments. A very interesting aspect was the research inter-vision in which my own countertransference became clear and several interpretations could be made conscious. This was significant not only for this research, but also as a useful process for the supervision of daily clinical practice. The conclusion of this study makes me aware that at one level the research is still continuing, as many new and interesting questions have come to my attention. This study created a fertile basis from where new music therapeutic insights and theories can be developed or examined in the work with psychotic patients, and also with other patients where the symbolising function is affected.

This study is not an end, but rather like a phrase that connects the past with the future. It can be likened to the silence that can only be felt if there is a connection with what previously happened, and where what previously has sounded continues to sound. Within the bridging tension of the phrasing there exists a time bridge that connects the past to the continuing music, which makes it possible for a new beginning. Something from this study has now to emerge into the future, where other music therapists can take what was learned in this study to inform their own work. Future research should also be undertaken, to explore the inner world of psychiatric patients, and in this way to continue the development of music therapy theory and clinical applications.

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a clear melodic line. The melody steadily develops towards a harmonic entity, like a chorale, that holds the sensorial play of the patient (Figure 5.1). This is not connectedness, but the taking up of an isolated sonorous object within a subjective space. The therapist's intuition to introduce a melodic form was inspired by his need – a need that originated out of desperation – to be allowed to exist. This was the therapist's attempt not to be swept along by the sensorial play of the patient.

The findings from these results, and the descriptions in the case study summarised here present the process through which Marianne went and the interpretations of that process based on the research questions and the clinical process. Both aspects, and the combined conclusions from these two perspectives, will be addressed in the discussion. What has been learnt as a result of the musical analysis of the therapists interventions will also be discussed, with reference to their future relevance for clinical practice.

English and Danish Summaries

English Summary

Introduction

This study examines the transition of sensorial play towards a musical form as a central aspect in the music therapy treatment of psychotic patients. From my twenty years' experience of clinical work with psychotic patients I came to the conclusion that there was a tendency towards an endless, monotonous and repetitive play in the musical improvisations of these patients, where certain rhythms or melodic sequences are repeated continuously, or the play is fragmented, dispersed or incoherent. Previous research and case study reports confirm that this way of making music is characteristic for the psychotic patient. Psychotic patients do not experience their play as something that comes from themselves, and they do not mentally take part in the sounds that they produce. They are not inspired by their music. This is the case because of their pathology, the consequence of which is that they do not possess any psychic space in which symbolising is possible and where the musical object could be appropriated. In music therapy this translates into an inability to create a musical form.

This study reveals that with psychotic patients, music therapy can contribute to the creation of a psychic space, which gives the initial impetus to a certain symbolising process. Essentially there is a transformation, during the therapeutic process, of sensorial play towards an experience that can be integrated, a musical form.

Hardly any music therapy research can be found which describes and examines this essential therapeutic process in the work with psychotic patients, even though it is recognised that this symbolising process is fundamental in the treatment of psychotic patients (Bion 1962; Dührsen 1999; Van Bouwel 2003; Van Camp 2001).

This study was undertaken using a single case design in order to describe and examine this therapeutic process. The phenomena sensorial play, moments of synchronicity and musical form are defined. For the results of this study to be relevant and useful to clinical practice, therapeutic interventions and the attitude of the therapist were also explored and analysed.

Research method

Design

A case study design was applied in order to answer the research questions, and two subjects were recruited who met the inclusion criteria. It was decided to limit the subjects in order to undertake a very comprehensive and multidimensional analysis of data to explore in detail the process of therapy.

A feature of this study is that it was always treated from a clinical perspective, and the design was developed in response to the subjects (patients), rather than the subjects having to conform to a pre-determined design. This was necessary in order to stay true to the unique characteristics of the clinical situation and, as a consequence, to come to an adequate formulation of the theory.

If one were to apply the research strategy in this clinical research in a rigid way, one would not be able to give any respect towards the research subject. Therefore it was important to refine the research methodology as much as possible in order to come to a more adequate description of the subject and how the therapy was effective for them.

Participants

The two subjects recruited for this study were patients who diagnosed with psychosis and were treated in the psychiatric hospital where the therapist/ researcher works. The female patient referred herself for individual music therapy. The male patient was referred for individual music therapy through the multidisciplinary team of the ward. A primary inclusion criterion for the subjects in this study was that they displayed a specific way of playing involving repetitive or fragmented characteristics in their music that correlated with an inability to mentalise, meaning they were unable to achieve any level of symbolisation. Each patient received one 45-minute individual music therapy session each week.

Treatment sessions and data collection

The music therapy treatment of the two patients took place in their familiar therapeutic environment. The therapist was a full member of the ward staff where these two patients were hospitalised. The treatment itself was kept as authentic as possible, without any conscious interventions that could influence or contaminate the research.

A description of the anamnesis and behaviour of the patient in group music therapy (only for the first case) was written. All the music therapy sessions were audio- as video recorded, up to the point when the improvised music of the patient included a musical form (i.e. case one: four sessions; case two: eight sessions). After each session, the music therapist recorded his first impression of the session, the patient, his own experiences, and the musical improvisations.

Analysis of the data

A phenomenological description of all the video-recorded sessions was written down by the therapist/researcher. He also analysed his own personal record that he made after every session. A retrospective analysis was undertaken with a psychoanalyst that involved the observation and interpretation of therapeutic and musical events. All therapeutic aspects, such as transference, countertransference, projective identification, and impressions of the therapist were considered. All the comments relating to these areas were recorded and were subsequently transcribed by the researcher. A temporal structural conceptualisation of the sessions was made to provide a clear visual overview of the whole sessions and delineate the actions of both the patient and the therapist. From each patient, a clinical case study report was written using all the reflexive material (i.e. impressions, phenomenological description of the sessions, personal record, transcription of the music and retrospective analysis) the researcher had. These case study reports were necessary to provide a linear description of what actually transpired in each session and in the treatment process, and in order to place the analyses of the selected video fragments into the context of a therapeutic process.

The selection of the video fragments was undertaken based on pre-established criteria for sensorial playing and musical form, and was validated through research intervision and by an independent music therapist. The analysis of the selected video fragments was undertaken through a careful and systematic process, and documented as follows: a description of the selected video-excerpt, a notated score of each excerpt and a description of the musical elements; selected comments from the patient relating to his experience of playing; selected impressions and reflections from the therapist about the patient's way of playing; selected reflections from clinical intervision.

Results and discussion

From a systematic analysis of the selected video fragments of the session, one could clearly observe an evolution in the musical play of the patients, and in their psychological and inter-relational behaviour. The musical analysis of these video fragments made clear many hidden musical structures. Through these extended analyses, three clear phenomena (that can also be defined as musical/therapeutic phases) could be distinguished in the music therapy process, each with their own specific characteristics with regard to form, musical aspects, psychological aspects, aspects of body posture and aspects of inter-personal / intra-personal experiences from the music therapist's point of view.

On the basis of the analysis, these three phenomena (i.e. the three phases in the therapy) were described as: sensorial play, moments of synchronicity and musical form and were defined as follows:

Definition of sensorial play in a music therapy context

Sensorial play is a term describing the characteristic playing of a patient where, while producing sounds, the patient is not able to connect with or experience these sounds as coming from himself. The patient's music is characterised by repetitiveness and/or fragmentation. The improvisation cannot really begin or end, and there is no clear melodic, rhythmic or harmonic development, no variation and no recapitulation. The patient is perceptually and emotionally detached from his own musical production.

Definition of moments of synchronicity in a music therapy context

Moments of synchronicity is a term describing points in time in which there is a shared inner experience of the patient and the therapist, in which they feel free and autonomous in their play during a musical improvisation. This shared experience appears unexpectedly and unintentionally, and is characterised phenomenological by attunement between the musical parameters of the patient and the therapist.

Definition of musical form in a music therapy context

Musical form is a term describing a musical structure that is created within a symbolising process. Musical form develops from the foundations laid during moments of synchronicity.

Clear rhythmic and melodic themes may appear that can be further explored or varied. Musical figures can be characterized by phrasing and pauses. Features of the musical improvisation typically have a clear beginning and ending, and the patient and therapist prepare mentally for these. This is always an inter-subjective phenomenon between patient(s) and therapist, who experience being equal to each other and feel free and autonomous to play, think, exist and develop their own images and thoughts. There is an intertwining of the timbres of both players.

Process

From this study it emerged that moments of synchronicity were an essential step in the transition of a patient's sensorial play towards a musical form. These moments can be brief, unexpected and infrequent. In these moments the therapist is experienced as a subject by the patient. The timbres of both players intertwine and both players are able to come into resonance with one another. What is notable and remarkable in this process is that different modalities of silence originate, that make a musical development possible. The phenomena of silence, timbre and inter-subjectivity have a common characteristic that is not always audible or visible, but can be experienced by the patient or the therapist.

From the research one can see that in the first instance the patient cannot hold these moments, as found from the unsustained moments of synchronicity. This is only possible when musical form originates and stabilises. A common musical and psychic space then originates, and can be termed a transitional space (Winnicott, 1971), in which intersubjectivity can be fully present, and in which images can be created and where the patient is able to take a step towards a symbolic order, and is no longer imprisoned in what is the Real¹. The patient is now able to create a mental space in which something can be thought and in which something of meaning can take the place of chaos and repetitiveness. This is a space in which ideas can be mentalized and in which the psychotic patient is not subject to the 'unimaginable storms' (Jackson 1994). The patient and therapist are independent and autonomous from each other. Musical themes can be developed, recapitulated, varied and appropriated.

¹ The Real refers to Lacan's concept of the impossible, the unnameable, the inaccessible and the unimaginable reality, and by definition can never be symbolised and assimilated (Lacan 1981).

Music therapy interventions

This study also entailed a description and interpretation of the music therapy interventions and the attitude of the therapist. Because of this, it became clear that interventions such as taking *the Bass-line position and Descant-line position, anticipating inner sound, post-resonation, the empathic listening stance, therapeutic provocation, mentalisation after the session, improvising in the absence of the patient* make possible, facilitate and support a therapeutic process. It is essential that these music therapy interventions are not techniques that are applied intentionally (through pre-planning or directed activity), but rather, belong to the attitude of the therapist in relationship with the patient. The interventions are used ‘at the right moment’ through an unconscious response to the transference.

Limitations of the study

A limitation of this study is that only two subjects participated to this research. In this sense, it is hard to talk about an external generalizability. However, these two subjects, who display two different kinds of clinical profiles of psychosis, can be seen as exemplary. Because of the in-depth and extended analysis of these two cases, the theoretical insight, gained through the findings of this study, can be considered as good-enough in order to also relate them to other therapeutic contexts or situations.

Implications in clinical practice

For the clinical music therapist working in psychiatry, this study offers a theoretical framework through which one can achieve insight into the course of a therapeutic process with psychotic patients. Not only are these theoretical insights valuable in the treatment of psychotic patients, but also for other pathologies, where the symbolising function is affected, such as patients with developmental disability, autism and borderline problems. This, however, will be a subject for future research. The insight into influential music therapy interventions, that were specific for the development of a therapeutic process with these two patients, will also be important for clinical practice. This study demonstrated the specific relevance of music therapy as a contribution to the treatment of psychotic patients. This clinically applied research (Wigram 2001) offers the clinicians a theoretical frame of thought that can be applicable in the clinical practice with psychotic patients.

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Dansk Resume

(translation: Dr. Niels Hannibal)

Baggrundsinformation

Dette studie undersøger overgangen fra sensorisk spil til musikalsk form som et centralt aspekt af musikterapeutisk behandling af psykotiske patienter. Jeg er på baggrund af mine tyve års kliniske erfaring i at arbejde med psykotiske patienter kommet til den konklusion, at der hos disse patienter i deres musikalske improvisationer er en tendens til endeløs og monoton repetition: Enten bliver bestemte rytmiske og melodiske sekvenser kontinuerligt repeteret, eller spillemåden fremstår fragmenteret, diffus og usammenhængende. Tidligere forskning og case-studier bekræfter, at denne måde at skabe musik på er karakteristisk for den psykotiske patient. Psykotiske patienter oplever ikke deres musik som kommende fra dem selv; de tager ikke mentalt del i den lyd, de producerer, ligesom de ikke bliver inspireret af deres egen musik. Dette synes at være en konsekvens af deres patologi: De besidder ikke et psykisk rum, i hvilket symbolisering er mulig, og hvor det musikalske objekt er anvendeligt. I musikterapi fremtræder dette som en manglende evne til at skabe musikalsk form.

Nærværende undersøgelse afslører, at musikterapi kan bidrage til skabelsen af et psykisk rum for psykotiske patienter, som herigennem kan gives et begyndende incitament til at gå ind i en symboliseringsproces. Essentielt sker der gennem den musikterapeutiske proces en transformation af patientens spillemåde fra sensorisk spil mod en oplevelse, der kan integreres, her kaldet: musikalsk form.

Der findes stort set ikke musikterapiforskning, der beskriver og undersøger denne essentielle terapeutiske proces i arbejdet med psykotiske patienter. Ikke desto mindre er det anerkendt, at denne symboliseringsproces er helt grundlæggende i behandlingen af psykotiske patienter (Bion 1962; Dührsen 1999; Van Bouwel 2003; Van Camp 2001).

I denne undersøgelse anvendes et single case-design til at beskrive og undersøge den terapeutiske proces. Fænomenerne 'sensorisk spil', 'øjeblikke med synkronicitet' og 'musikalsk form' defineres. Da tanken er, at resultaterne af dette studie skal være relevante og brugbare for klinisk praksis, udforskes og analyseres de terapeutiske interventioner og terapeutens attitude også.

Forskning metode

Design

Der er anvendt et casestudie-design til at besvare forskningsspørgsmålet, hvortil der er rekrutteret to personer, der lever op til inklusionskriterierne. For at kunne udforske den terapeutiske proces i dybden, blev det besluttet at begrænse antallet af individer, således at analysen af data kunne blive mere omfattende og dybdegående.

Et kendetegn ved dette studie er, at det hele tiden har det kliniske perspektiv med. Designet er derfor udviklet som en respons på deltagerne, frem for at deltagerne har skullet tilpasse sig et forudbestemt design. Dette var nødvendigt dels for at kunne bevare den kliniske situations unikke karakteristika, og dels - som følge af dette - for at kunne nå en fyldestgørende formulering af teorien.

Hvis man anvender en forskningsstrategi i den kliniske situation, der er for rigid, er det samtidig ikke muligt at vise personen, der undersøges, tilstrækkelig respekt. Derfor har det været nødvendigt at raffinere undersøgelsesmetoden så meget som muligt med henblik på at kunne give en mere dækkende beskrivelserne af deltagerne og af den betydning, terapien har haft for dem

Deltagerne

De to subjekter, der blev rekrutteret til dette studie, var patienter diagnosticeret som psykotiske, og som havde været behandlet på det hospital, hvor terapeuten/forskeren arbejdede. Den kvindelige patient tog selv initiativ til at komme i individuel musikterapi, medens den mandlige patient blev henvist til individuel musikterapi gennem afdelingens multidisciplinære team. Et primært inklusionskriterium for deltagerne i dette studie var, at de foreviste en specifik måde at spille på, der indeholdt repetitive eller fragmenterede karakteristika. Dette forudsattes at korrelere med deres manglende evne til at mentalisere således forstået, at de ikke var i stand til at symbolisere på noget niveau. Hver patient modtog én musikterapi-session af 45 minutter hver uge.

Behandling og dataindsamling.

Den musikterapeutiske behandling af de to patienter foregik i deres kendte terapeutiske miljø. Terapeuten var fuldgældigt medlem af behandlingsteamet på det hospital, hvor patienterne blev

behandlet. Behandlingen blev udført så autentisk som muligt, dvs. uden nogle bevidste interventioner, der kunne influere eller besmitte forskningen

En beskrivelse af patienternes anamnese, og for den ene patients vedkommende også af vedkommendes adfærd i gruppemusikterapi, blev skrevet. Alle musikterapisessioner blev audio- og videooptaget indtil det tidspunkt, hvor deres improviserede musik begyndte at indeholde musikalsk form, dvs. for case 1: fire sessioner og for case 2: otte sessioner. Efter hver session noterede terapeuten sine umiddelbare indtryk fra sessionen, disse være sig af patienten, hans egen oplevelse og af den musikalske improvisation.

Analyse af data

Der blev produceret en fænomenologisk beskrivelse af alle de videooptagede sessioner af terapeuten/forskeren. Han analyserede desuden sine personlige optegnelser fra hver session. En psykoanalytiker foretog ligeledes en retrospektiv analyse, der involverede observation og fortolkning af terapeutiske og musikalske begivenheder. Flere terapeutiske aspekter blev taget i betragtning så som: overføring, modoverføring, projektiv identifikation og terapeutens indtryk. Alle kommentarer, der relaterede til disse områder, blev optaget og efterfølgende transskriberet af forskeren.

En tidlig strukturel beskrivelse af sessionerne blev fremstillet for såvel at formidle et klart visuelt overblik af hele sessionen som for at kunne identificere og afgrænse patientens og terapeutens handlinger. Der blev skrevet en klinisk case-rapport for hver patient. Hertil anvendtes det samlede reflektive materiale, dvs. indtryk, fænomenologisk beskrivelse af sessionerne, personlige optegnelser, transskription af musikken og den retrospektive analyse, som forskeren havde til rådighed. Disse case-rapporter var nødvendige, idet de leverede en lineær beskrivelse af, hvad der faktisk viste sig i hver session og i behandlingsprocessen som sådan. Desuden var de nødvendige for at kunne indplacere de udvalgte og analyserede videofragmenter i den terapeutiske kontekst.

Udvælgelsen af videoeksempler blev gjort ud fra en række i forvejen etablerede kriterier for sensorisk spil og musikalsk form, som blev valideret gennem forskningsinterventioner og af en uafhængig musikterapeut. Analysen af de udvalgte videoeksempler blev gjort ud fra en omhyggelig og systematisk analyseproces og indeholdt følgende: En beskrivelse af de udvalgte videoudsnit, en notation af hvert videoudsnit samt en beskrivelse af de musiske elementer, udvalgte kommentarer fra patienterne, der relaterede til deres oplevelse af at spille, udvalgte

indtryk og refleksioner fra terapeuten om patientens måde at spille på samt udvalgte refleksioner fra kliniske interventioner.

Resultater og diskussion

Ud fra den systematiske analyse af videoudsnit fra sessionerne var det muligt at observere en udvikling i såvel patienternes musikalske spillemåde som i deres psykologiske og interrelationelle adfærd. Den musikalske analyse af videoudsnittene viste desuden mange gemte musikalske strukturer. Ud fra disse udvidede analyser kunne tre fænomener, der også kan beskrives som musikalske faser, udledes af den musikalske proces. De tre fænomener indeholdt hver for sig specifikke karakteristika med hensyn til form, musikalske aspekter, psykologiske aspekter, kropsholdning samt aspekter i den interpersonelle og intrapersonelle oplevelse set ud fra terapeutens perspektiv.

På baggrund af denne analyse kunne følgende tre fænomener: 'sensorisk spil', 'øjeblikke af synkronicitet' og 'musikalsk form' defineres, som følger:

'Sensorisk spil' er en term, der beskriver den karakteristiske spillemåde, hvor patienten ikke er i stand til at forbinde sig med eller opleve lyde, som vedkommende selv producerer, som kommende fra sig selv. Patientens musik er kendetegnet ved repetition og/eller fragmentering. Den musikalske improvisation har hverken en begyndelse eller en slutning, og der er ikke nogen tydelig melodisk, rytmisk eller harmonisk udvikling, ligesom der ikke er nogen variation eller sammenfatning. Patienten er perceptuelt og emotionelt afskåret fra sin egen musikalske produktion.

'Øjeblikke af synkronicitet' er en term, der beskriver det tidspunkt i processen, hvor der indfinder sig en delt indre oplevelse mellem terapeuten og patienten. I disse øjeblikke i den musikalske improvisation føler de sig begge frie og autonome. Denne delte oplevelse opstår uventet og er ikke intentionel. Den er fænomenologisk karakteriseret ved afstemning mellem patientens og terapeuten musikalske parametre.

'Musikalsk form' er en term, der beskriver en musikalsk struktur, der skabes i den symboliseringsdannende proces. Musikalsk form udvikles ud fra det fundament, der skabes under øjeblikke af synkronicitet. Tydelige rytmiske og melodiske temaer kan opstå således, at de kan udforske eller nuanceres efterfølgende. Musikalske figurer er karakteriseret ved

frasering eller pauser. En typisk egenskab ved denne musikalske improvisation er, at den har en tydelig begyndelse og slutning, og at patienten og terapeuten forbereder sig mentalt til disse. Denne oplevelse er kendetegnet ved at være intersubjektiv, ligesom patienten og terapeuten oplever hinanden som ligeværdige og føler sig autonome og frie til at spille, tænke, eksistere og udvikle deres egne indre billeder og tanker. Der kan iagttages en sammenkædning af begge deltageres musikalske klange.

Processen

Resultatet af dette studie viser, at øjeblikke af synkronicitet fremstår som et væsentligt skridt i patientens overgang fra sensorisk spil hen mod en musikalsk form. Disse øjeblikke kan være korte, uventede og sjældne. Et andet kendetegn for disse øjeblikke er, at patienten oplever terapeuten som et selvstændigt subjekt. Klange fra begge deltagere smelter sammen, og begge er i stand til at resonere med den anden person. Det er bemærkelsesværdigt, at det i denne proces er de forskellige modaliteter af stilhed, der opstår, som gør den musikalske forandring mulig. Fænomenerne stilhed, klangfarve og intersubjektivitet har det fælles karakteristika, at de ikke altid er hørbare eller synlige, men kan opleves af patienten og terapeuten.

Denne undersøgelse viser, at patienten i første omgang ikke evner at fastholde disse øjeblikke, som det iagttages i de uunderstøttede øjeblikke af synkronicitet. At fastholde disse øjeblikke bliver først muligt, når der er opstået musikalske form, og den stabiliseres. Et fælles musikalsk og psykisk rum fremkommer og kan beskrives som et overgangsrum (Winnicott 1971). I dette overgangsrum kan intersubjektivitet forekomme fuldt ud, og patienten kan begynde at skabe indre billeder. Her er patienten i stand til at tage et skridt mod en symbolsk orden, og er derfor ikke længere fanget i det, som kaldes "the Real"². Patienten er nu i stand til at skabe et mentalt rum, i hvilket der kan tænkes, og hvor mening kan erstatte kaos og repetition. Dette er et rum, i hvilket ideer kan mentaliseres, og i hvilket den psykotiske patient ikke er underlagt "unimaginable storms" (Jackson and Williams 1994). Patienten og terapeuten er autonome og uafhængige af hinanden. Musikalske temaer kan udvikles, sammenfattes, varieres og tilpasses.

² "The Real" refererer til Lacans begreb om det umulige, unævnelige, det utilgængelige, det man ikke kan forestille sig og det utænkelige. Det som pr definition aldrig kan symboliseres eller assimileres (Lacan, 1981).

Musikterapi- interventioner

Dette studie giver også anledning til en beskrivelse og fortolkning af de musikterapeutiske interventioner og af terapeutens indstilling og holdning. Ud fra denne beskrivelse og fortolkning er det blevet klart at følgende interventioner muliggør, faciliterer og støtter den terapeutiske proces: *the Bass-line position, the Descant-line position, anticipating inner sound, post-resonation, the empathic listening stance, therapeutic provocation, mentalisation after the session, improvising in the absence of the patient*. Det er afgørende, at disse musikalske interventioner ikke bruges som teknikker, der anvendes intentionelt, f.eks. ud fra forudgående planlægning eller i form af styrede aktiviteter, men i stedet indgår som en del af terapeutens forholdemåde i relationen med patienten. Interventioner anvendes ”i det rette øjeblik” som en ubevidst respons på overføringen.

Undersøgelsens begrænsninger

En begrænsning i dette studie er, at den kun indbefatter to subjekter. Ud fra det perspektiv er det vanskeligt at generalisere undersøgelsens fund. Imidlertid kan disse to patienter med psykose ses som eksemplificerende. Med afsæt i den tilbundsgående og udvidede analyse af disse to cases, betragtes den opnåede teoretiske viden i dette studie som tilstrækkelig til, at den kan overføres til andre terapeutiske kontekster og situationer.

Implikationer for klinisk praksis

For den kliniske musikterapeut, der arbejder i psykiatrien, tilbyder dette studie en teoretisk ramme gennem hvilken, der kan opnås indsigt i den terapeutiske proces med psykotiske patienter. Denne teoretiske indsigt er ikke kun værdifuld i behandlingen af psykotiske patienter, men også for behandlingen af andre patologier, hvor symboliseringsevnen er påvirket, f.eks. patienter med udviklingsforstyrrelser, autisme og borderline-personlighedsforstyrrelse. Dette er emner for fremtidig forskning. Indsigten i musikterapi-interventioner, som fik betydning for udviklingen af en terapeutisk proces for disse to patienter, vil også være vigtig for klinisk praksis. Dette studie demonstrerer den specifikke relevans, som musikterapi kan have i behandling af psykotiske patienter. Denne kliniske forskning tilbyder en teoretisk ramme, der er brugbar i klinisk praksis med psykotiske patienter (Wigram 2001).

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St.-Joris

Program Group D

	<u>MONDAY</u>		<u>TUESDAY</u>		<u>WEDNESDAY</u>		<u>THURSDAY</u>		<u>FRIDAY</u>
9.15u tot 10.00u	Theme meeting	9.15u tot 10.00u	Social work meeting	09.15u tot 10.15u	Group psychotherapy	09.00u tot 09.30u	Ward meeting	09.00u tot 09.45u	Music therapy
10.15u tot 11.15u	Occupational therapy	10.15u tot 11.00u	Cleaning room	10.15u tot	Cooking and cleaning	09.30u tot 12.00u	Occupational therapy	10.30u tot 11.15u	Movement therapy
13.00u tot 14u	Women's group	11.15u tot 12.00u	Movement therapie	12.00u	Individual	14.00u tot 15.00u	Group psychotherapy	14.15u tot 15.15u	Meeting with the nurses
14.15u tot 15.00u	Movement therapy	13.45u tot 14.15u	Meeting with the ward doctor	14.00u tot	or group	15.30u tot			
15.15u tot 16.10u	Meeting with the nurses	15.45u tot 16.30u	Theme meeting	17.00u	leisure time	16.45u		16.00u tot 17.00u	Occupational- therapy
16.15u tot 17.00u	Music therapy								

Appendix 2: Categorisation of video tapes

The analysis of the improvisations includes the following information:

Column A: the original video recorded timings.

Column B: improvisations divided into smaller sections copied onto a new video-recording.

Column C: categorisation of some aspects of the style of playing.

Column D: defines whether there is a beginning or an ending to the improvisation.

Column E: defines whether the patient is playing alone or with the therapist.

Column F: defines the instruments used by the patient and therapist during the improvisation.

Column G: describes the style of playing as defined by the researcher.

Column H: definitive selection of excerpts to be used for analysis.

Appendix 2.1: Categorisation of video tape case study: Marianne

original video	video 1					video 2	video 3
A	B	C	D	E	F	G	H
Session 1							
00.5.52 -	00.00 - 02.41	monotonous and endless	no beginning	partner improvisation	metallophone	sensorial play	selection sensorial play
	02.41 - 03.19	first rhythm, after therapist	bourdonplay	partner improvisation	metallophone	sensorial play	selection sensorial play
	03.19 - 05.28	back to alternated play	alternated play	partner improvisation	metallophone	sensorial play	
	05.28 - 06.33	back to bourdon play	bourdonplay	partner improvisation	metallophone	sensorial play	
	06.33 - 12.02	back to alternated play	alternated play	partner improvisation	metallophone	sensorial play	
	12.02 - 13.25	back to bourdon play	bourdonplay	partner improvisation	metallophone	sensorial play	
	13.25 - 20.45	back to alternated play	alternated play	partner improvisation	metallophone	sensorial play	
	20.45 - 22.05	back to bourdon play	bourdonplay	solo	metallophone	sensorial play	
29.54	22.05 - 24.02	abrupt ending after verbal	no ending	partner improvisation	metallophone	sensorieel spel	
Session 2							
07.00 -	00.00 - 00.07	Marianne plays solo	no beginning	solo	metallophone	sensorial play	
	00.07 - 02.47	th. plays together with pat.	alternated play	partner improvisation	metall./kalimba	sensorial play	
	02.47 - 13.23	therapist don't play	alternated play	solo	metallophone	sensorial play	selection sensorial play
	13.23 - 18.35	th. plays a melody (piano)	alternated play	partner improvisation	metall. and piano	sensorial play	
	18.35 - 18.49	th. round off his playing	alternated play	solo	metallophone	sensorial play	
26.16	18.54 - 19.16	abrupt ending after verbal.	no ending	solo	metallophone	sensorial play	selection sensorial play
Session 3							
first improvisation							
07.55 -16.55	00.00 - 09.00	monotonous and no contact	no beginning	partner improvisation	metall./kalimba	sensorial play	
second improvisation							
27.00 -	00.00 - 00.20	no real contact	no begining	partner improvisation	kalimbaphone		
	00.20 - 01.30	interaction, attunement	phrasing	partner improvisation	kalimbaphone	synchronicity	selection synchronicity
	01.30 - 04.45	breaking off the contact		partner improvisation	kalimbaphone		
	04.45 - 05.55	again attunement, silence	phrasing	partner improvisation	kalimbaphone	synchronicity	selection synchronicity
37.00	05.55 - 10.00	interaction	ending	partner improvisation	kalimbaphone		

Appendix 2.2: Categorisation of video tape Case Study: Adrian

original video	video 1					video 2	video 3
A	B	C	D	E	F	G	H
Session 1							
02.12 - 04.20	00.00 - 01.10	fragmented play	no ending	solo	piano	sensorial play	selection of sensorial play
08.34 - 09.34	01.15 - 02.15	agression/psychotic	no ending	partner improv.	piano	sensorial play	
10.34 - 11.35	02.20 - 03.21	agression/psychotic	no ending	partner improv.	piano	sensorial play	
14.28 - 17.41	03.25 - 04.45	agression/psychotic	no ending	partner improv.	piano	sensorial play	
20.26 - 26.22	04.50 - 05.59	no contact, no ronclusion	no ending	solo	piano and metallophone	sensorial play	selection of sensorial play
33.54 - 36.52	05.59 - 06.06	searching for structure	no ending	partner improv.	xylophone and metall.	sensorial play	
Session 2							
	00.00-12.00	verbal session					
Session 3							
19.51 - 20.51	00.00 - 01.26	repetitive play	no beginning	partner improv.	xylophone and metall.	sensorial play	selection of sensorial play
23.03 - 24.03	01.26 - 02.39	no conclusion	no ending	partner improv.	xylophone and metall.	sensorial play	selection of sensorial play
28.45 - 30.15	02.10 - 02.40	therapist left hand		partner improv.	xylophone and metall.	sensorial play	
33.22 - 33.51	03.10 - 03.39	therapist right hand	no ending	partner improv.	xylophone and metall.	sensorial play	
34.28 - 35.46	03.53 - 04.14	free improvisation	no ending	partner improv.	xylophone and metall.	sensorial play	
38.03 - 40.21	04.18 - 04.40	free improvisation	no ending	partner improv.	drum and piano	sensorial play	
40.35 - 42.23	04.45 - 05.51	free improvisation	no ending	partner improv.	drum and piano	sensorial play	
44.20 - 47.00	06.00 - 07.08	free improvisation	no ending	partner improv.	drum and piano	sensorial play	
Session 4							
11.26 - 15.26	00.00 - 01.00	free improv., no contact		partner improv.	piano and metallophone	sensorial play	
17.10 -19.30	1.00 - 1.14	la vie en rose'	no ending	partner improv.	metallophone	sensorial play	
25.20 - 26.14	03.06 - 03.52	halting play	no ending	partner improv.	metallophone	sensorial play	
27.25 - 28.00	04.16 - 05.05	free improvisation		partner improv.	piano		
30.16 - 32.31	05.05 - 06.30	melody occurs	imitation	partner improv.	piano	synchronicity	selection of synchronicity
34.30 - 34.40	06.30 - 07.02	ending ends abruptly	no ending	partner improv.	piano	chaos	

original video	videoband 1					video 2	video 3
A	B	C	D	E	F	G	H
Session 5							
5.43 - 6.43	00.00 - 01.00	free improvisation	beginning	partner improv.	piano	sensorial play	
7.34 - 8.34	01.00 - 02.00	free improvisation	first dialogue	partner improv.	piano		
9.23 - 10.23	02.00 - 03.38	free improvisation	dialogue	partner improv.	piano		
12.20 - 12.53	03.43 - 04.13	free improvisation	ending	partner improv.	piano		
30.45 - 31.43	04.13 - 05.15	free improvisation	beginning	partner improv.	piano and xylophone	sensorial play	
32.40 - 33.04	05.15 - 05.43	free improvisation	no ending	partner improv.	piano and xylophone	sensorial play	
34.30 - 35.47	05.43 - 06.48	free improvisation	relaxed play th.	partner improv.	xylo. and bassxylo.	sensorial play	
37.13 - 38.26	06.48 - 08.05	free improvisation	no ending	partner improv.	xylo. and bassxylo.	acting out	
Session 6							
15.30 - 16.32	00.00 - 01.00	improvisation impossible	no ending	solo	piano	senorial play	
17.33 - 21.15	01.00 - 02.46	alternated play	no ending	partner improv.	piano	senorial play	
22.38 - 25.55	02.46 - 04.18	free improvisation	ending	partner improv.	piano	transition to Descant-line position	
27.32 - 29.40	04.25 - 05.25	free improvisation	no ending	partner improv.	piano	senorial play	
Session 7							
10.21 - 13.33	00.00 - 01.36	<i>f,a,c'</i> - theme	break off	solo	piano	<i>f,a,c'</i> -theme occurs	
14.00 - 16.04	01.36 - 02.37	<i>f,a,c'</i> -theme		partner improv.	piano	th. takes over the Descant-line postition	
17.24 - 17.44	02.37 - 03.57	<i>f,a,c'</i> -theme		partner improv.	piano	pat. cannot hold the theme	
19.44 - 23.43	04.00 - 05.44	<i>f,a,c'</i> -theme	Adrian Discant	partner improv.	piano		
28.34 - 28.55	05.45 - 06.06	<i>f,a,c'</i> -theme	both hands	solo/partner	piano		
Session 8							
08.51 - 09.55	00.00 - 01.04	bourdon: <i>f,a,c'</i>	no ending	partner improv.	piano	new musical element (bourdon)	
12.55 - 14.49	01.04 - 01.43	abrupt end	no ending	partner improv.	piano	Gregorian improvisation	
16.25 - 18.29	01.43 - 02.45	free improvisation	ending	partner improv.	piano	Ritenuato	
21.07 - 22.14	02.45- 03.49	free improvisation	ending	partner improv.	piano	free improv.	selection of synchronicity
23.24 - 24.25	03.49 - 04.49	<i>f,a,c'</i> - improvisation	Adrian Discant	partner improv.	piano	free improv.	selection of musical form
27.24 - 31.34	04.54 - 06.16	<i>f,a,c'</i> - improvisation	ending	partner improv.	piano	Adrian: variation in <i>f,a,c'</i> improvisation	

original video	video 1					video 2	video 3
A	B	C	D	E	F	G	H
Session 4							
first improvisation							
04.05 - 05.05	00.00 - 01.00	silence occurs, contact	AIS, beginning	partner improvisation	kalimbaphone	musical form	selection musical form
05.05 -16.48	01.00 - 12.00	interaction	phrasing	partner improvisation	kalimbaphone	belongs to MF	
16.48 - 17.48	12.00 - 13.00	contact	ending	partner improvisation	kalimbaphone	belongs to MF	

Appendix 3: Categorisation of the improvisations by an external music therapist

Case study: Marianne

Session case study Marianne	Duration improvisation	Type of playing as described by the independent music therapist	Excerpts selected by researcher
Session 1: improvisation 1	00.00 – 24.06	Sensorial play	00.00 - 01.00 (sensorial play) 02.22 - 03.22 (sensorial play)
Session 2: improvisation 1	00.00 – 19.16	Sensorial play	10.42 - 11.42 (sensorial play) 25.16 - 26.16 (sensorial play)
Session 3: improvisation 1	00.00 – 10.05	Sensorial play	
Session 3: improvisation 2	27.02 – 37.00	Moments of synchronicity	27.20 – 28.30 and 31.45 – 32.55 (moments of synchronicity)
Session 4: improvisation 1	00.00 – 13.03	Musical form	04.05 – 05.05 (musical form)

Case study: Adrian

Session case study Adrian	Duration improvisation	Type of playing as described by the independent music therapist	Excerpts selected by researcher
Session 1: improvisation 1	02.12 - 04.20	Sensorial play	02.12 – 03.12 (sensorial play)
Session 1: improvisation 2	08.34 – 11.34	Sensorial play	
Session 1: improvisation 3	10.34 - 11.35	Sensorial play	
Session 1: improvisation 4	14.28 - 17.41	Sensorial play	
Session 1: improvisation 5	20.26 - 26.22	Sensorial play	25.21 – 26 - 21 (sensorial play)
Session 1: improvisation 6	33.54 - 36.52	Sensorial play	
Session 3: improvisation 1	19.51 - 24.03	Sensorial play	19.51 – 20.51 and 23.03 – 24.03 (sensorial play)
Session 3: improvisation 2	28.45 - 30.15	Sensorial play	
Session 3: improvisation 3	33.22 - 33.51	Sensorial play	
Session 3: improvisation 4	34.28 - 35.46	Sensorial play	
Session 3: improvisation 5	38.03 - 40.21	Sensorial play	
Session 3: improvisation 6	40.34 – 42.18	Sensorial play	
Session 3: improvisation 7	44.20 - 47.00	Sensorial play	
Session 4: improvisation 1	11.26 - 15.26	Sensorial play	
Session 4: improvisation 2	17.10 -19.30	Sensorial play	
Session 4: improvisation 3	25.20 - 26.14	Sensorial play	

Session 4: improvisation 4	27.25 - 28.00	Sensorial play/ moments of synchronicity	31.16 – 32.31 moment of synchronicity
Session 4: improvisation 5	30.16 - 32.31	Sensorial play	
Session 4: improvisation 6	34.30 - 34.40	Sensorial play	
Session 5: improvisation 1	5.43 - 6.43	Sensorial play	
Session 5: improvisation 2	7.34 - 8.34	Sensorial play	
Session 5: improvisation 3	9.23 - 10.23	Sensorial play	
Session 5: improvisation 4	12.20 - 12.53	Sensorial play	
Session 5: improvisation 5	30.45 - 31.43	Sensorial play	
Session 5: improvisation 6	32.40 - 33.04	Sensorial play	
Session 5: improvisation 7	34.30 - 35.47	Sensorial play	
Session 5: improvisation 8	37.13 - 38.26	Sensorial play	
Session 6: improvisation 1	15.30 - 16.32	Sensorial play	
Session 6: improvisation 2	17.33 - 21.15	Sensorial play	
Session 6: improvisation 3	22.38 - 25.55	Sensorial play	
Session 6: improvisation 4	27.32 - 29.40	Sensorial play	
Session 7: improvisation 1	10.21 - 13.33	Sensorial play	
Session 7: improvisation 2	14.00 - 16.04	Sensorial play	
Session 7: improvisation 3	17.24 - 17.44	Sensorial play	
Session 7: improvisation 4	19.44 - 23.43	Sensorial play	
Session 7: improvisation 5	28.34 - 28.55	Sensorial play	
Session 8: improvisation 1	08.51 - 09.55	Sensorial play	
Session 8: improvisation 2	12.55 - 14.49	Sensorial play	
Session 8: improvisation 3	16.25 - 18.29	Sensorial play	
Session 8: improvisation 4	21.07 - 22.14	Sensorial play/moments of synchronicity emerged	21.12 – 22.12 moment of synchronicity
Session 8: improvisation 5	23.25 - 24.25	Musical form	23.25 – 24.25 musical form
Session 8: improvisation 6	27.24 - 31.34	Musical form	

Appendix 4: Aspects of the score

In the research analysis the question came up as to whether sensorial play was recognizable purely on the basis of a notated transcription in musical scores. More specifically it could be asked whether sensorial play could manifest itself on a purely musical level, or if it was also necessary to identify relational and psychic levels for it to be perceived. In order to give a definite answer to this question, a musician-composer was asked to analyze a video-fragment from the second session of the Marianne case study, in which her music showed features of sensorial play (Excerpt 3, Figure 5.8). In order to avoid influencing, interpretation or the evocation of prejudice or bias, the composer did not receive any information about the study, the patient or the aim of his task. The composer first wrote out the musical fragment in a score, including the accents he thought he was hearing. He then made an intuitive interpretation of the music on the basis of played accents and audible repetitive patterns. In addition, he interpreted the fragment on the basis of motifs, which are based on tierces. He distinguished four different motifs, specifically: a, b, c and d (Figure 1, 2 and 3). The composer made two interpretations of the same piece on the basis of these four motives.

The transcription of the musical play in a score allowed one to identify the appearance of underlying forms that are not recognizable or able to be experienced in a therapeutic interpersonal relationship. The composer has introduced a sense of form and structure into the score of sensorial play. From a purely musicological or musical point of view, one can find different motifs and structures in sensorial play. However, this interpretation negates the phenomenon of intersubjective relating, the therapeutic aspect of what takes place precisely within the improvisation and the therapeutic relationship. From the aspect of countertransference we know that the motifs played by Marianne are based on the movement of the arms or the upper body and that no variation is possible. It is necessary that one sees the musical analysis within this music therapeutic framework, so that the research remains within the thought framework of the music therapy event.

It is also important that one has to be able to analyze the musical material from the context of psychopathology of the patient, taking account of phenomena that are specific to the psychopathology of psychosis, such as repetitiveness, fragmentation and the absence of intersubjectivity. Non healthcare workers often do not recognize these aspects, because they are not familiar with them. They often begin to interpret the music in other ways, because they are not familiar with or have no knowledge of the consequences of the pathology. The

composer who interpreted this musical fragment also had no of the psychopathology and its consequences for the musical material. Composers who are familiar with contemporary music will intuitively search for different kinds of structures in the most repetitive or complex music such as minimal music, or will self-imposed (*“hineininterpretieren”*) structures.

Figure 1: Original score

The image displays eight staves of musical notation, each containing a sequence of notes. The notes are primarily eighth and sixteenth notes, often beamed together. The notation includes various dynamic markings, specifically accents (>) placed above several notes. Double bar lines (//) are used to indicate the end of phrases or sections within the staves. The overall structure is a single melodic line across eight staves.

Figure 2: Intuitive analysis (Based on played accents and auditive repetitive pattern)

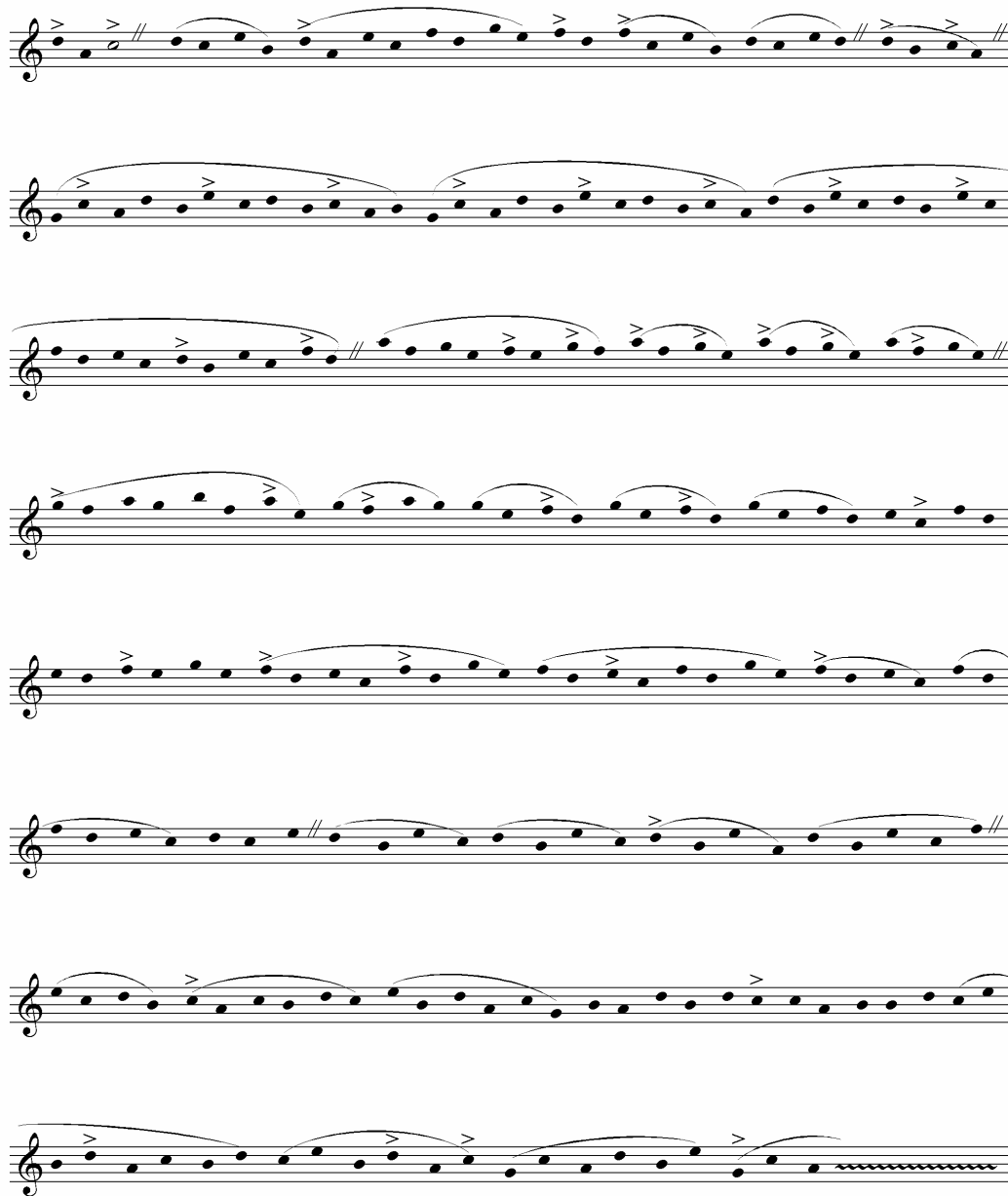


Figure 3: Analysis (based on motifs, built on tierces)

basismotieven

1 / analyse op basis van motieven

2 / alternatieve analyse

The figure displays a musical score with five systems of staves. The first system shows four basic motifs labeled 'a', 'b', 'c', and 'd'. The second system, labeled '1 / analyse op basis van motieven', shows a longer passage with brackets identifying motifs 'a', 'd', 'c', 'a', and 'c'. The third system, labeled '2 / alternatieve analyse', shows the same passage with brackets identifying motifs 'a', 'd', 'c', 'a', 'b', and 'c'. The fourth system shows a passage with brackets identifying motifs 'd', 'c', 'c', 'd', 'c', 'c', 'd', and 'd'. The fifth system shows a passage with brackets identifying motifs 'c', 'd', 'd', 'c', 'b', 'd', and 'd'. The sixth system shows a passage with brackets identifying motifs 'c', 'd', 'c', 'c', 'c', 'c', and 'c'. The seventh system shows a passage with brackets identifying motifs 'b', 'a', 'b', 'c', 'c', 'c', and 'd'. The eighth system shows a passage with brackets identifying motifs 'b', 'a', 'b', 'c', 'd', 'd', 'c', and 'c'. The ninth system shows a passage with brackets identifying motifs 'b', 'c', 'd', 'c', 'd', 'c', and 'd'. The tenth system shows a passage with brackets identifying motifs 'b', 'c', 'd', 'c', 'd', 'c', and 'd'. A question mark is placed above a note in the seventh system.

1

2

3 a b c d

3a

a d c a c

d c c d c d d

c d c b d d

b a b c c c d