SONG AND METAPHORIC IMAGERY IN FORENSIC MUSIC THERAPY

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Abstract

The present research study grew out of my professional practice as a music therapist, and seeks to put forward a new approach to the relationship between theory, research and clinical practice – while still relating in meaningful ways to a broad range of existing work. Music therapy in the UK is a broad and expanding profession, encompassing a notably diverse range of theoretical approaches and practical applications. Such approaches and applications may use, for example, free improvisation, songwriting, or listening- and response-based techniques. And there is a range of specialised literature dealing with each of these areas, as well as a number of broader, overarching studies dealing with the overall field. Within the tradition of a model based largely on musical improvisation, which has been my own practice, the use of pre-composed songs might be regarded as unusual, perhaps even as anomalous. But I hope to show that it is in fact a useful and profoundly revealing process which is firmly rooted in an ethos of active musical participation. This thesis examines the use of songs in forensic psychiatric music therapy for women, and offers this use of song as an alternative model of musical creativity within such a context.

My research project as a whole is approached from the philosophical framework of behaviourism; and the thesis is written from a 'social constructionist' perspective of the creation and enactment of self-identity, grounded in a belief that life and music become inextricably associated during the constructive process. As its major source of evidence, the study presents a longitudinal case study of one woman over the entire three-year course of her therapy. Her song choices are examined according to an adaptation of therapeutic narrative

analysis, framed within a chronological view of events. Music remains a central focus and presence within the study, both as a vehicle for song texts and as a therapeutic medium in its own right; and the archetype of sonata form is invoked as a structural framework for analysis and the production of meaning.

Images and bi-polar constructs are abstracted from the songs and their metaphoric content interpreted in the context of known life experiences and the progress of the therapy sessions themselves. Results reveal a strong use of generative metaphoric imagery which is humanized yet also, crucially, emotionally decentred or depersonalized. This then leads to assertions of a process of 'Music Therapy by Proxy'. There are also clear indications of the relevance of the passing of time as a dimension of the therapeutic process, resulting in a pattern which I term 'Reverse Chronology'.

The songs which were used during the course of therapy provide words, imagery and, in addition, a musical substrate or continuum which 'carries' the textual-and-visual components but also has its own expressive and therapeutic importance. All these elements have their place and function within the therapy as described. Song as a concept is further defined as a transformative or metamorphic process enabling the expression of deeply personal, often unheard or 'suppressed' voices. Emerging from this process, seven core themes are identified. These then provide the focus for a wider discussion concerning the significance of song and imagery for women in forensic therapy, and the issues which arise from them. Finally, suggestions and recommendations are made for music therapy practice and for possible new directions in future research.

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My attendance, and presentation, at a PhD research symposium at Aalborg University in Denmark strengthened my research methodology and expanded my reviews of literature into international fields, as well as enhancing my confidence. I would like to thank Professor Tony Wigram and his team for the invitation to attend, and for their encouragement and support.

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Introduction

As the opening narrative presented in Chapter One will serve to show, this research project in Music Therapy grew out of a long-term, sustained period of clinical practice as a professional music therapist, working in secure forensic psychiatric units with women clients.

I. Main Aims

The main aims of this preliminary section are (i) to provide an overview of the personal context in which the research originated and first evolved, and thus how and why it came to be as it did; and (ii) to function as a guide to the constituent elements and distinctive features of my approach to my work on the study, its ongoing development, and final presentation. It has been very much a personal journey of discovery, of increasing my knowledge and deepening my understanding; and my role in this journey has in effect been a combination of clinical music therapist, participant in the study, and investigative researcher, with varying degrees of emphasis on each role at different points in the whole process of the thesis.

Underlying and enriching all of these are the beliefs, values, emotions, qualities of experience and ways of thinking which I have brought to the study as an individual person. And this is also what I have sought to draw out from the individual women with whom I have worked over the course of my practice, for it is these unique characteristics above all which have shaped our relationships in the music therapy sessions. Ultimately, it is their stories that I wish to tell here. And so for this reason, in order to give voice to their experiences in as

faithful a way as possible, I have concentrated in the first place on relating and examining the information which they presented to me in its most direct form. What the women presented – very unusually, in my experience of musical improvisation within therapy – were songs: generally, the repetition of simple, pre-composed songs. These songs, and the layers of meaning which they make possible, form the main body of data within the project. This circumstance in turn gives rise to an apparent anomaly in a research thesis on music therapy that is being submitted to a University Department of Music: the fact that it contains, on the surface, no direct examination or analysis of music *per se*, of how the generation of 'new' extempore music may function as part of the therapeutic process. The songs themselves obviously do constitute a body of music in some sense, a sort of 'core repertory' if you will. But because they are pre-existent compositions, 'given' rather than invented, my approach had to be modified in order to come to terms with this (for me) new and unusual therapeutic situation.

As a result, therefore, this research focuses primarily on the words of the songs, on the relevance of the meanings contained within them at different levels, and (perhaps most importantly) on how they are used and transformed in the therapeutic situation over time. Nevertheless, music remains all-important and omnipresent, for it is the 'carrying medium' through which the words of songs are brought to life; their declarative values realised in time and place; their meanings expressed and emphasised; their experiences and emotions shared and communicated. The essence of these creative accomplishments and potentialities of music cannot, perhaps, be transcribed directly into expository

prose and fixed on the page. Its functions and effects are (so to speak) latent within the songs, and indeed the whole song-process, rather than being explicitly foregrounded as an active function of the therapy itself. Yet music's nature as a medium with real outcomes and effects still exists as a potent force throughout this work.

II. Structure and Presentational Style

This thesis is presented as a form of narrative, beginning with general accounts of my early work in forensic music therapy and leading on, through subsequent stages of the first conception of the project, to a more specific focus on a coherent research idea and its initial formulation, then evolving into more detailed and specific modes of enquiry and interpretation which enabled implementation, development, and completion of the study. The narrative is therefore written from my own point of view, drawing on a range of personal experiences and interpretations as both therapist and researcher. In order to reflect this perspective, the written account makes substantial use of personal pronouns and possessives (a practice which will be further discussed, and justified, in Chapter Two, section 2.1.4). The writing itself embraces a range of styles including the anecdotal, often using the present tense, as well as the reflective and analytical, thereby serving to demonstrate the stage-by-stage changes in my modes of thinking and argument, and their evolution over time.

This happened gradually, as I was increasingly able to take into account the context of the therapy sessions and the women's personal life experiences, both present and past. I have endeavoured to give a clear sense of this evolutionary

character in the final written form of the thesis. Such a mode of presentation was a deliberate choice, aiming to imbue the work with the immediacy and vigour, and also the sense of direction, of an unfolding journey and the interpretative discoveries that may be made along the way. The remainder of this section will give an example of this approach. It begins and ends with personal vignettes from my own life. These function as vignettes in the sense that they serve to characterise how I think about music therapy and about this research study in particular, thereby illustrating an important doctrine of the thesis: my belief that each individual's ways of thinking, feeling and acting are constructed and determined, in part, according to the broad social and ecological context in which he or she lives.

At one time, more years ago than I care to remember, I was a choirgirl in a small village church in Lincolnshire. A visiting clergyman gave a sermon on the Lincolnshire countryside and how its wide open spaces, with flat fenlands and a notable absence of imposing natural features, may leave visitors feeling that there is nothing to look at, no topographical incident, no scenery worthy of note.

But, he went on to say, after spending time in these surroundings one's focus gradually acclimatises, enabling the mind to fix on the smaller details of the beauty of the natural world, of the created order – and reminding us that everything which exists is significant and valuable if one can only find the right scale and perspective. Every narrative, like every landscape, has, in this sense, its own *telos*, its own range of significance and mode of signifying:

Reflecting back on this sermon now reinforces, and perhaps in part explains, my deep-seated belief that environment (physical, social and cultural) shapes our thinking, our behaviour and our interactions in fundamental ways. The individual and the social (including the cultural and the environmental, here subsumed within the category of the ecological) are in this sense symbiotic. And it leads, too, to a simple but profound realisation: that what is *not* there may be significant precisely by its absence, since this serves to define and give extra clarity and 'presence' to that which remains. Let me explain…

I still live in rural Lincolnshire. There are no mountains, or even many hills, nearby; there are no great forests or lakes to inspire wonder and excitement, a sense of the sublime and of possible drama or, perhaps, transcendence. For precisely these reasons it has, over the centuries, become valued for its suitability as arable farmland (and also for the positioning of Royal Air Force and other airfields). To 'furriners', people coming from outside the county, it may appear uneventful and perhaps tedious, but that is often because they are missing the detail that is there. They are looking for the wrong thing, or searching on the wrong scale. If we are so used to seeing what we expect to see,

as for example in the grand presentations of nature, then in their absence we will not always be alert to what is around us, nor ready to look for significance (of an insightful and perhaps even a revelatory kind) in what remains.

The same may be true of music therapy. As the name of the discipline implies, we expect to encounter music of various kinds, and to consider its varied uses and functions, in therapeutic work of whatever sort it might be. Indeed, one of the chief discourses of the music therapy literature is to investigate how different clients use and respond to different kinds of music, and how we may thereby better understand the functioning of music in its therapeutic dimension. Music therapy practitioners and researchers of a wide variety of approaches and experiences have all contributed to this discourse. But the expectation they have mostly all shared was that the medium they were primarily concerned with was the using and making of music in a distinctly active mode. Recent developments in music therapy have tended to emphasize the equality of improvisation, receptive and performative modes. Yet all these approaches may be seen as active in the general sense that perception and response, and the reflective-therapeutic process that emerges, may be seen as engaged and active. My understanding of my own practice is grounded in the belief that this active dimension (and what I refer to as 'process') is a crucial element of the therapy viewed as a whole.

Over the course of my own career as a music therapist the active practical improvisation of music was always, by training and by preference, the medium in which I worked. It was only when I began to work in secure forensic

psychiatric units with women that the absence of practical music-making became apparent, as I describe later on in Chapter One. Sometimes, these women would not touch the instruments I had brought to the sessions, not wanting to join me in improvised playing, but asking instead for songs which, even then, they often declined to join in singing. Perhaps that was their cultural expectation of what 'music' should be; or possibly, in my frustration at what I felt was not being able to do my job properly, I may have been missing the significance of what was really happening. Was this a possibility? What, I asked myself, lay beneath the requests for pre-composed songs, and how did this relate to what I knew of the process of music therapy?

Near where I live there is a disused airfield, a relic of World War II. Part of it is shown in the previous photograph, on page 4. Runways cross the ploughed fields, but from the road you hardly notice them. It is only on closer inspection that you see the thousands of tiny sedums growing out, step by step, so as to carpet the tarmac. The evolving beauty of nature covers the stories that lie beneath, and time heals whatever physical scars there may be. But the previous 'narratives' of the place can be uncovered if you take the time to wander along and investigate the layers of the paths, and the layering of the years.

Thus it may become clear that, both in the therapy sessions and in this thesis, it is frequently the *absence* of music which is significant, or may be so. For by removing this primary expectation of the medium itself, at least in its usual form, we are better able to focus on the smaller details of the perhaps less obvious truths that underlie its surface realities, and which thereby construct its existence as a mode of therapeutic experience and the kinds of meanings it may have for the individuals concerned (in the present case, the women involved in my music therapy sessions).

The telling of this narrative is, therefore, a journey along just such a hidden pathway. It is a story of intense personal involvement which develops and transforms throughout the course of the successive chapters, as each level of meaning is uncovered and exposed to interpretation. This process is described as one of metamorphosis, of internal change and growth in response to events and conditions, to external stimuli and to cultural or environmental context. In fact, this theme of metamorphosis is set to become a central metaphor for the entire research project and the underlying processes it has uncovered. So, too, will be the use of images (not unlike the photographs introduced here, in this one respect at least), for they serve not merely to illustrate significant points but moreover to encapsulate, in a perhaps rather abstract yet also very direct form, some trace of the relevant underlying beliefs or intentions. They may be said to function as illustrative metaphors which then become part of the process itself.

And so it is at this point, in my Introduction, that I invite you, the reader, to join me in wandering, though with purposeful intent, along the course of this hidden

journey, following a no doubt less well-trodden path which reveals something of its relevance as we near the end, and of course the destination, of the project.

III. Music and Experience

This sharing of an experiential journey bears a close resemblance to my understanding of music and how it functions – for music almost always offers the archetype of a mutual experience, be it something shared directly between those involved in a performance or in the more indirect relationship existing between composer and performer, or performer and listener. In music therapy such reciprocity is vital, for it is built on a triadic relationship between therapist, client and music where each influences the others and co-constructs, through musical interaction, a shared meaningful experience. That music can accomplish this when at times another medium can not is, I believe, because music can be assigned emotional meaning, a personal significance above and beyond that which is inherent in the simple organisation of related sounds. Our response to sounds may be basic and primordial, and we may be culturally programmed and conditioned to fashion and respond to these as communicative

language.[1] If the exact nature of our communicative style is to a large extent determined by the culture in which we are brought up, so, too, is some of our response to music, for what we hear and declare to be 'music' is in turn strongly influenced by our personality and social experiences throughout life. With this in mind, this thesis seeks not only to detail the ongoing musical experiences of the women clients during music therapy sessions, but also to delve back into some of their past experiences of life and social relationships in order that their understanding and responses to current musical presentations may be interpreted more deeply and accurately, and the issues which first brought them to music therapy more fully understood, acknowledged and addressed.

IV. Context

This study may exhibit a clear independence of approach and presentation in the first place because of its nature as a personal journey, grounded in the realities of professional practice and experience. But it does not in any sense exist in isolation, and, in fact, has a strong indebtedness to a broad spectrum of existing work. As I have indicated, the main case study itself arises from clinical practice as a music therapist, before being expanded into a fully developed research study through a cycle of reflexive thinking and interpretative evaluation, coupled with the application of specific research methods adapted from a variety of disciplines (chosen on the basis of their suitability for such an approach). The process of creating a 'combined approach' of this kind will be discussed in detail in Chapter Two, serving to define the research framework for the ensuing chapters and also ensuring that the interpretative perspective and the

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[1] The underlying theoretical basis for these beliefs is presented in Chapter 2, section 2.1.1, where ideas relating to behaviourism are discussed.

analysis have, in addition to their personal qualities, the rigour of design and procedure needed in order to meet appropriate standards of trustworthiness by which a case study or studies may be given full status as research. Thus, although any results emerging from this study may be intrinsically interesting in themselves, for their individuality as evaluated material, they may also be placed within a broader context, demonstrating a potency of significance and value across a wider spectrum – both in the broad human and social sense, and in the professional field.

Chapter Three presents the results of an extensive literature search which relates elements of this study to existing research, theory and practice, both in music therapy and in fields as diverse as language and psychiatry. But this is not merely descriptive, for, in the process of examination, ideas have been absorbed and modified and adapted – so that this body of literature itself also becomes an active contributory factor in the overall process of research.

Chapters Four and Five present the main case study in detail, analysing and interpreting the data to produce a range of concluding assertions, and thereby articulating an interpretative stance or 'position'. Chapter Six then returns to examine further related literature, linking the ideas and assertions back into the broad ecological context of music therapy practice and discourse, and establishing a basis for future research – thus, too, the continuation and further development of the line of approach outlined in this study.

Throughout the course of the thesis there are three areas in particular, or

perhaps better: three underlying factors or conceptual fields, which may be seen to have shaped its progress and to have contributed greatly to the credibility and trustworthiness of the final assertions. These have already been touched upon but are summarised here as a reminder. Firstly, there is a focus on Interiority: a belief that our unique identities, what we may agree to call our 'minds', 'souls' and 'personalities', are formed, in part, by our experiences throughout life and the contexts in which those experiences occur; and furthermore that significant events, including (perhaps self-evidently) the experience of words and music and songs, become strongly associated or linked with emotional states. These inner states of being are held in memory, consciously or otherwise, as a kind of record or soundtrack of our lives; and the most significant of these foci may actually be the underlying forces or impulses which serve to drive and determine our thoughts and actions.

Secondly, the concept of Voice: when such forces or experiences, present or past, are too difficult or painful to be disclosed, or when current circumstances prevent disclosure from occurring, an alternative method of communication may be found to give voice to necessary personal expressions in whatever form is possible at the time, thereby allowing the speaker to reflect on, and make some sense of, their experiences. This process is thus incipiently therapeutic. And music, through instrumental expression or through song, may be a means by which this can be achieved and enhanced. In this sense it becomes a substitute or a proxy, but one which is without doubt a real means of empowerment for an individual in therapy. This thesis attempts to remain true to the voice of the women whose experiences it narrates, and to endeavour to

discover how – and why – voice became so important an issue for them in their conflicted state, hovering between the rival needs to reveal and to conceal.

And finally, a few notions relating to Nature: specifically, to the nature of the relations between life and music – that is, the way in which music, despite seeming to be abstracted from life, in fact has deep roots (by a mechanism of affinity we can observe and discuss and maybe testify to, without perhaps fully understanding) in our heritage and emotional experience. If emotions and experiences are linked together and understood according to how we interpret them contextually, within the situations of our ordinary human existence (what could be called our 'lived reality'), then it becomes a human necessity to communicate with other people so as to construct meaning for ourselves and to arrive at acceptable forms of behaviour within the given social environment. Music is both a symbolic means of expression and communication, and also an active agent of social integration in different ways at different stages throughout our lives. It is, therefore, a constructive and enabling process which both forms and informs our emotions and our behaviour. Music and life are inextricably joined and understanding the one will usually offer, if not total comprehension, then at least appropriate kinds of insight into the other.

And so a journey of discovery begins, with the conception of an idea in Chapter One and the subsequent development of a narrative, a story of one woman and her quest for personal insight, her memories of lived experiences through the medium of the performance of remembered songs – what I shall call her 'life in music therapy'.

<u>Chapter One: Conception</u>

'When the pie was opened the birds began to sing

Wasn't that a dainty dish to set before the king!'

(Sing a Song of Sixpence, Anon.)

1.1   Research and Clinical Practice in Music Therapy

Imagine the life-cycle of a butterfly and the various stages through which it passes: a progressive, step-by-step metamorphosis from egg through caterpillar to chrysalis and, finally, emergent butterfly. This describes, by analogy, the overall process of my research: a journey in knowledge and understanding which took the form of a gradual evolution, arising out of my professional work as a music therapist with women in secure forensic psychiatric units.

At some point in the normal ongoing cycle of clinical practice, reflection, and evaluation I realised I still had a good number of unanswered questions relating not only to the work with my clients, but also to the wider fields of women's issues, forensic therapy, musicology and the psychological role played by music in the interior sense of self, and the music therapy profession in general. I felt I needed to explore these more thoroughly, in the full knowledge that taking such a step would no doubt in turn raise fundamental questions about my understanding of my own work, its purposes and assumptions. In order to distinguish between the information gathered and analysed in my clinical work

and the broader, more self-reflexive stance of my subsequent research study, I adopted in the first instance the following research definition:

> Research is a systematic, self-monitored inquiry which leads to
> a discovery or new insight which, when documented and disseminated,
> contributes to or modifies existing knowledge or practice. Research
> differs from clinical practice in the need for metareflection on the data,
> goals, roles, beneficiaries, use of knowledge, and consumers.
> (Bruscia 1995a, p.27)[2]

Taking this framework and its genuinely idealistic and distinctly purposeful aspirations as a guiding principle, I sought to give shape to my ideas, and to resolve the various intellectual and interpretative challenges as they presented themselves during the course of the study in as realistic and creative a manner as possible, while always seeking to remain true to the reality of the practical experiences and data with which I was working. In this way my research path began to open up.

I should make it clear now that my metamorphosis from clinician to researcher has been a gradual, always connected and in many ways also a natural evolution; and further that, throughout this process I was determined that the

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[2] Since this thesis was planned and written, but prior to final submission, the work of Bruscia referred to in several items (1995a, 1995b, 1995c, 1995d and 1995e) has been published in a second, much revised edition (see bibliographical items Wheeler, B.L. 2005). These chapters by Bruscia have been extensively reworked and specific quotations used by me no longer exist in the same format. 1995b and 1995c have been combined into Ch 11 pp.129-137 *Designing Qualitative Research*. Other chapters relating to the original references include Ch 7, pp.81-93, *Research Topics and Questions in Music Therapy* and Ch 14, pp.179-186, *Data Analysis in Qualitative Research*. The original references have been maintained throughout the thesis as these represent the ideas and inspiration which influenced the initial design of this study.

primary importance of initial music therapy sessions with clients should never be underestimated, nor lost sight of. Latent in these sessions are the information and ideas which will eventually become the formative basis for the research and its interpretative ideas and structures. However, at this present stage of writing, early on in the thesis, it is the broader process of Bruscia's (1995a, p.27) notion of 'metareflection' (as given in the definition of research on the previous page) by which these ideas come into being that it is most vital to focus on, that is, the initial moments at which questions were asked, associated ideas grew, and a concept for research was constructed. And so it is this initial stage, with its variety of situations, contexts and possibilities, as well as what they subsequently gave rise to, which I need to make clear to the reader. This chapter therefore aims to present an opening narrative, through brief case descriptions of early music therapy sessions, of how the metaphor of a research butterfly was first conceived, how it articulates my own position and the development of my work as both clinician and researcher, and, finally, what it represents in terms of a creative and intellectual response to the challenges I encountered as my work progressed.

Music therapy as a profession continues to encompass a vast array of approaches to work in a variety of settings, from special schools, day centres and hospitals to prisons and hospices. Definitions of music therapy are equally diverse and an all-encompassing version must by necessity be fairly broad. Bunt (1994) offers a clear, simple summary which may serve as a point of departure:

Music therapy is the use of sounds and music within an evolving

relationship between client and therapist to support and encourage

physical, mental, social and emotional well-being. (Bunt 1994, p.8)

This provides a straightforward framework within which to articulate more detailed ideas on what the music therapy study as a whole is founded. An APMT (Association of Professional Music Therapists) introductory leaflet further emphasizes the relational model which lies at the heart of the musical and therapeutic experience:

Fundamental to all approaches, however, is the development of a

relationship between the client and therapist. Music-making forms

the basis for communication in this relationship………[and] much

of the music is improvised, thus enhancing the individual nature of

each relationship. (APMT, no date)

Another leaflet, the APMT careers leaflet, adds a few words which underline the idea of exchange, that is, the mutual or reciprocal character of the internal dynamic governing the whole experience, musical as well as social:

By using music creatively in a clinical setting, the therapist seeks

to establish an interaction, a shared musical experience leading to

the pursuit of therapeutic goals. (APMT, no date)

In my personal understanding of the nature of music therapy two elements from these definitions are pivotal: the creative, improvisatory nature of the music;

and the shared experience from which a relationship develops. The music is spontaneous, arising from the experience at that given moment, and is created by both therapist and client within an open, relational context. In all my previous experience as a therapist these two elements formed the core or essence of my approach; and in all my sessions with children and adults with learning disabilities, sensory loss, autism and communication disorders, physical disabilities, or mental health needs I never had cause to question this belief. These expectations were challenged only when I began to work in secure forensic units.

1.2 Challenging Expectations in Forensic Music Therapy

During 1999 I began sessions in two medium-secure forensic psychiatric units for women. In the first I ran an open group generally attended by five of the six residents and lasting about an hour. Six months later I started in the second unit where five women attended individually for around 30-45 minutes each. Having previously worked in both acute admissions and long-stay wards in a psychiatric hospital, I expected the work to be similar. As usual I would present clients with a range of accessible tuned and untuned percussion instruments and we would improvise together, creating music that expressed and explored their emotional states, whether their feelings were sad, elated, angry, aggressive or thoughtful. I approached forensic work with recent memories of loud, energetic, vibrant and evocative improvisations that had lasted 40 minutes or more. My expectations were that these would be heightened, that clients with a history of

violence would inevitably play more demonstratively and aggressively, with improvisations becoming louder and more turbulent.

What I encountered was the exact opposite. Many clients were in fact reluctant to use instruments at all. When they did play they tended to choose small, quiet instruments such as an egg rattle or an harmonica rather than a drum or cymbal, and a range of individual preferences, or indeed fixations, was soon established. Improvisations were often unsustained in length, lacking in melodic inventiveness, insecure in tempo and rhythm, and surprisingly restrained in nature, being repetitive and seemingly devoid of affect. Similar results are reported by Sloboda (1997, p.123), working in a Regional Secure Unit for mentally-disordered offenders, who notes that 'many patients are extremely reluctant to make noises which might be construed as violent or aggressive, and are more concerned with controlling the sounds they do make'. She notes the monotony and frustration of dealing with the 'unchangingness' of musical expression (Sloboda 1997, p.128). Boone (1991, pp.437-445) also notes the 'perseverative quality' to the musical choices of a male forensic patient who found 'random' improvisation difficult, although he was able to play loudly,

In contrast, Hoskyns (1995, p.142) found a group of adult recidivist offenders were able to 'channel frustration through loud, intense sound-making……[and] acknowledge and identify with strong emotion expressed in music', though she also found others who were shy and tentative, and she notes that group members often seemed to polarise towards either extreme of 'the 'dominant-withdrawn' dimension' (Hoskyns 1995, p.139). Hoskyns's research examines

how group music therapy can effect a change in activity in either direction, but she does not appear to consider any underlying reasons for such initial polarisation. And yet this underlying dimension and what it might be seen to cause in a given group of individuals is the key observation which led to my own research – the overwhelming tendency towards the withdrawn end of such an activity spectrum by the women I worked with and my interest in discovering the factors that lay behind it.

Flower (1993), in describing work with an adolescent in a secure unit, expresses:

> How unusual it was for a client to make such an immediate and spontaneous use of improvisation. Other individuals seem to experience great difficulty in impulsive playing….their limited imaginative play often meant that popular tunes were endlessly and painfully recreated on the piano. (Flower 1993, p.42)

It was the detail of this recreation of popular tunes that initially drew my attention. Women would attempt to play tunes themselves or, more often than not, decline any use of instruments at all but rather request, or even demand, that I play tunes for them. Generally, their choices were for well-known songs and indeed sometimes these were repeated week after week.

Since this situation had not occurred to the same extent before in my clinical practice, I assumed that it could not be the result of my therapeutic orientation,

that is, that neither I nor my approach was in any way responsible for leading the women into choosing these songs. My initial supposition, then, was that this must be due to one or other of the following:

1   Music therapy was a new input to these units and clearly I had not set up appropriate referral procedures. The women attending were not those requiring therapy but rather simply those who enjoyed music, and singing especially, and wanted entertainment or education. When this was made clear to them I would expect these women to withdraw from the sessions.

2   The women were appropriately referred as requiring music therapy but did not wish to attend. They were playing a game of tick-list attendance but were simply avoiding becoming involved in a therapeutic relationship by distracting me into repeated song performances. Again, I would expect these women to terminate sessions after a few weeks, once the novelty had worn off.

3   The women were appropriately referred and wanted to attend but either: (a) they did not understand the nature of music therapy, and were just doing what they thought was expected of them (i.e. providing 'nice' music), and hence needed further explanation and encouragement to improvise. With support over time I would expect a gradual change towards improvisation as our shared experiences and therapeutic relationship grew; or else (b) they found self-expression extremely difficult and needed the support of a familiar 'prop', in this case a well-known song. This would be similar to

Sloboda's (1997, p.128) description that 'patients can take refuge in involvement with the instrument rather than the therapist, because an inanimate object might seem safer and more reliable than another person'. It may be that a pre-composed song also has an element of safety in its familiarity and constancy – its 'stability' if you like - that is absent in free musical improvisation. It functions in this sense as a known point of reference. Like an instrument which waits for a player, it lies inanimate until brought into awareness or existence by the activation of memory, by a singer or interpreter. And so, through the shared security of song participation; creating a space for relationship and for therapeutic encounter, I would expect a tentative but growing trust to develop, the dependence on inanimate songs to lessen, and improvisation to begin.

Wrong again. The majority of women continued to attend, albeit with the same unreliability in attendance and punctuality mentioned by Hoskyns (1995, p.143). Songs remained prevalent, although some improvisation did exist and, in a few cases, flourished. At times we used instruments to improvise with, or accompany, the songs. Occasionally, I tried to vary the songs by changing the words or the tempo, or by continuing to improvise in the same style as the song after it had finished. Yet, seemingly inevitably, we returned to the same incessant requests. Some women used the same song for many months; others chose a song only once or twice but then had a never-ending supply ready to take their place.

The place of songs in music therapy will be discussed further in Chapter Three.

At this point in the progress of my sessions I operated on the basis of 'if you can't beat them, join them' and I therefore continued to respond to clients' requests even though I felt I wasn't quite 'doing therapy properly'. What I saw as the essential notion of therapeutic relationships built on joint creative improvisations was largely absent.

So why did the women still continue to attend? The therapy itself seemed to be validated by the clients' commitment, yet I didn't feel fully involved in the sessions. Was there something happening of which I was unaware? What was the relevance of the songs?

Over the course of the first year there were several incidents which began to provide me with answers. The three vignettes that follow serve to illustrate significant moments of realisation. All names throughout this study have been changed to protect the confidentiality of the patients. For a fuller discussion of the ethical issues of this study see Chapter Two, section 2.3.4.

1.2.1 Moira

Moira has referred herself for music therapy and asked to see me. As I currently have no vacancies for sessions I arrange to meet her informally on the ward. Her case notes tell me she is a middle-aged woman with a diagnosis of a psychopathic personality disorder who has spent several years in a high-security hospital before coming here. She has a history of destructive aggressive behaviour and has self-harmed by cutting and setting herself on fire.

We are sitting in the kitchen, drinking tea and chatting about her love of music. She wants individual sessions, saying it is more 'personal', and that she misses playing the keyboard as it helps her when she's angry. As I sip my tea and reply to her questions I am struggling inwardly to keep my composure as a therapist. The extent of her self-injury is shockingly evident and I strive to maintain eye-contact without staring at the burns to her face. I think I'm succeeding until the following apparently casual conversation hits me forcibly:

M: "Is there a keyboard in the room?"

C: "Yes, there is…….you'll be able to play that one."

M: "We could play duets together, couldn't we?"

C: "Yes."

M: "We could play 'London's Burning'."

1.2.2 Brenda

Brenda has had music therapy before, with a previous therapist, and she is keen to continue. She reads music and plays the keyboard, bringing with her a collection of sheet music, mainly well-known songs and hymns. It is one month into individual sessions and Brenda has established her routine. She chooses a piece to play and repeats it several times while I prompt her with tips on technique or accompany her on the guitar or small percussion. The 'performance' is painfully slow. Brenda suffers from lymphoedema and her right hand is swollen and stiff, yet she refuses to use other easier instruments until she has completed what she calls her keyboard 'exercises'.

It's a gloriously hot summer day and, yet again, Brenda is playing the first piece in her book: *Frosty the Snowman* (Nelson and Rollins 1950). I am struck by the incongruity and begin to question whether these sessions are meeting Brenda's needs. She has a mental illness and a psychopathic disorder and lived for over 30 years in a high-security hospital before moving here. What exactly are the issues I need to address and how can I move her on from lesson-style keyboard repetitions into something more expressive? In an attempt to share her musical experience I begin to sing along to her *largissimo* rendition of 'Frosty'. The slowness makes me elongate the vowel sounds and the words appear to be emphasised as I sing:

Frosty the snowman was a jolly, happy soul

With a corn cob pipe and a button nose and two eyes made out of coal.

Frosty the snowman is a fairytale, they say

He was made of snow but the children know

How he came to life one day.

At the very moment I sing 'came to life one day' Brenda, without pausing in her playing, says, "My hand's dead." The analogy strikes me instantly: hot and cold – life and death. An entire adult life spent cocooned in an institution. Perhaps, like Frosty, Brenda needs to 'come to life' but doesn't know how. Perhaps her restricted life has left her emotionally cold and numb, unable to express her true feelings. Instead she has turned inward and focussed the coldness physically, inanimately, in her now dead hand.

I have no reply, other than to reiterate a rather lame, "Oh, does it feel numb?"

before returning to the song, just in time to sing:

> Frosty the snowman was alive as he could be
>
> And the children say he could laugh and play
>
> Just the same as you and me.

Exactly. Frosty is a metaphor for Brenda. She is alive on the inside and wants to be the same as everyone else but her circumstances don't allow it. Yet, somehow, hearing the song seems to release her freedom of expression, as if it brought the thoughts and feelings into awareness. Brenda begins to speak to me about feeling ignored by the staff, "They're cold towards me," and scorned by other women on the unit. Her personal relationships, present and past, become the focus for the sessions as she begins, physically and musically, to explore other instruments. At last I feel I know what I'm working on and our therapeutic relationship can move forward.

1.2.3 Angela

Angela is a young woman in her thirties who has been a regular attendee at the group session since it started in January. In the first week another client introduced the song *Edelweiss* (Rodgers and Hammerstein 1959) from the musical film 'The Sound of Music' and Angela adopted it. It is now October and she is still requesting the same song almost every week. For some reason, presumably connected to the film's storyline, she calls it "Nun music" rather

than using its proper name, yet she insists that nothing else must be changed. Over the months I have gradually made alterations, firstly by altering some words, incorporating her name to make it more personal:

[Angela, Angela] (Edelweiss, Edelweiss), Ev'ry morning you greet me

Small and white, clean and bright, You look happy to meet me……

Indeed, she does look happy to meet me each week and there is nothing in her manner or her music that reflects the turbulence of her experiences of life. Angela has a mental illness and a mild learning disability, as well as some physical problems. After early family difficulties she exhibited behavioural problems and physical violence, which resulted in her being taken into psychiatric care as a teenager. She moved on to a high secure hospital for some years before coming here but behavioural problems persist, noticeably in the tearing of her own clothes. But this does not happen in my music therapy sessions. Here she is calm, quiet and unassuming, as long as her routines are accepted. She sits in the same place by the wall, likes to show me her clothes, which must be blue, and she has a favourite instrument. For 22 weeks she played the wind chimes but, suddenly, she changed and today it is the woodblock, as it has been for the past 10 weeks.

Her music is quiet and continuous, though she varies between tapping and scraping the woodblock. She is pleased by her playing and asks me, as she often does, to tell staff, "How well I've done", and she asks for reassurance, "I've been good, haven't I?" At times she has been so relaxed she has fallen asleep,

oblivious to the group continuing to play music around her. Occasionally now, she allows me to improvise with her 'Nun music', and we use it to greet other people by name or to comment on the music:

Angela, you can play, You can pla-y the woodblock.

At first she would stop playing at the end of the song, regardless of what I did, but today she continues as I carry on improvising on the keyboard in the same style as the song. It feels very much as I describe it to others in the group: it is 'Angela's music'. Yet I still don't know why.

Gradually an image forms in my mind, an image of calmness, acceptance and reassurance, of goodness and safety: a religious archetype. To me, dressed completely in blue and with all her blue and white belongings, Angela seems to be associated with the Virgin Mary; to her, perhaps, her desire for release from her violent past and her need to be 'good' are summed up and reflected in her musical choice of 'Nun'.

Angela never ever sings along to *Edelweiss*, unlike Brenda, who does sing the words to *Frosty*. Perhaps because Frosty represents the coldness that Brenda feels whereas the attributes of 'nunness' are something to which Angela only aspires. Is this then my role as a therapist: to provide for her the means to participate in a musical experience that creates an otherwise unachievable emotional reality?

1.3 The Value of Songs and Song Words

These examples of the initial songs chosen by three women became metaphorical butterfly eggs. They encapsulate the basic premise from which the research began to grow: the realisation that it is the song words themselves that are important, not just the music nor the actual process of singing but the lyrics and what these represent to the clients concerned. Indeed, as mentioned earlier, Angela never sang, and Moira and I only spoke about her song, it was never even played, yet both were of vital importance in building a working relationship between client and therapist.

However, it would have been easy to assume that this was so simply because, as the music therapist, I was so absorbed in the process of therapy and needed a supposition on which to base my clinical practice. Was my intuition correct or would other therapists see it differently? A small inquisitory caterpillar hatched and began to explore……

I decided to test my ideas through a peer review. At a team meeting at my place of work, Nottingham MusicSpace, I gave a short presentation of my therapy work and invited discussion around how music therapists view the use of songs. The six therapists present had experience in a range of clinical fields: forensic; mental health; palliative care; physical and sensory loss; autism and communication disorders; and child and adult learning disability. Unfortunately this discussion was not recorded, as at this time it was part of a team-building exercise and an element of my clinical development rather than of a research

project. However, we seemed to agree that therapists tend to use songs, both improvised and pre-composed, for the following reasons:

1. To add structure to a session, e.g. setting the boundaries in time with a greeting song and a closing song.

2. As an immediately accessible means of contact and involvement, e.g. using a familiar nursery rhyme to get a child's attention and then involve them in using instruments or in interaction, perhaps through altering the words to give a commentary on their actions whilst retaining the repetition of well-known tunes.

3. To create an atmosphere, or to introduce topics for further work, e.g. using old songs with elderly patients with dementia as a means of evoking reminiscence.

Common to these uses was the assumption that songs in music therapy are a valuable means to an end; they serve to motivate individuals to interact with both therapist and instruments so that more creative improvisation can take place. Songs did not seem to be valued for themselves and often song words were changed or melodies used without thought to any effect that the original words may have had. Several therapists agreed with my feeling that songs were to be used when necessary but perhaps not specifically encouraged. Certainly the fixation on particular songs week after week was viewed as a problem to be addressed rather than a therapeutic process to be evaluated in more depth.

With these misgivings in mind I challenged the team to study the song choices of my clients. By this time I had identified the initial requests of nine out of the ten women as being significant. I presented the team with all ten brief case histories, matching these as far as possible for diagnosis, life history (including basic factors irrespective of whether I felt them to be relevant) and issues presented in therapy. I also gave them, separately, the lyrics to the initial songs chosen, or responded to, by nine of the women, and asked them as a group to discuss these and try to match them up with the case histories. The complete details given to the group are provided in Appendices A1 and A2.

The result proved to be strikingly successful, although done informally and with a small amount of additional questioning and prompting. What was noticeable was the level of agreement between therapists and the choice of factors that they considered, often skipping over the diagnosis to pick out parts of the life histories or therapy issues. This may be a typical client-centred or personal approach that is habitual for trained therapists. Yet what struck me most as an observer was the way in which major links were dismissed at first. One example was the discussion concerning Gracie where the team noted that she might have been physically abused by a husband in the Navy but took one look at *What shall we do with the Drunken Sailor?* (Traditional) and commented, "It can't be that, can it? That's too obvious."

This reveals something that therapists need to consider. Perhaps we do ignore things that are blatantly obvious, used as we are to deeper analysis and interpretation. For me, this raised the question that was to become a significant

part of the research: do songs, or more specifically the song words, operate at differing levels of meaning?

1.3.1 Levels of Meaning in Song Words

I was reassured by the peer review that other therapists could see the links that I felt existed between lyrics and case histories. As I had noticed them distinguish between obvious and interpretative links I decided this needed further evaluation. What followed was a period of reflection and analysis, a chrysalis-time, when I returned to my early session songs and assessed them for these varied links or 'levels of meaning'. I found three broadly identifiable levels, which are again illustrated by the three vignettes (1.2.1 – 1.2.3) and summarised in Figure 1.

Level 1:   **Explicit-Stated.** The association between song words and clients' case histories is clearly obvious and stated in words that detail the meaning without the need for interpretation.

Example: Moira – *London's Burning* – self-harm by fire.

Gracie – *Drunken Sailor* – abuse by husband in Navy.

Level 2:   **Implicit-Contained.** The association is not directly expressed but is implied by being contained in the words in a manner that can be interpreted. This may involve the use of metaphors that relate to the direct experience and emotional state of the client.

Example: Brenda – *Frosty* – coldness – physical and emotional numbness.

Level 3:   **Implicit-Construed.** The association is not directly expressed but is implied through an interpretation of the words, images or metaphors using an understanding of the clients' past experiences or current context.

Example: Angela – *Edelweiss* – Nun – goodness – anti-violent desire – reaction to past offences.

The term 'level' refers to the depth of interpretation needed to obtain a meaningful association. It is a mode of operating and does not necessarily imply levels of progression on the part of the client. However, I began to wonder why clients operated at different levels and whether this bore any relation to the stage of therapy and the current relationship with me as the therapist. If clients continued to use songs in therapy, did they change between the levels, that is: is there a 'song process' which operates as a component of music therapy over time?

Within the chrysalis these ideas took shape as I returned to my clinical notes to analyse the second songs chosen by the same three women……

Figure 1: Levels of Meaning in Song Words

Moira	Brenda	Angela
Diagnosis Psychopathic disorder Destructive aggression Obesity/Depression Self-harm by cutting/burning ***Life history*** Large family – incest – birth of child. Rift with family – death of mother. Several years in high-secure hospital. ***Issues presented in therapy*** Expressive improvisation. Descriptive imagery, often concerning 'servants'. Need to 'perform' to staff.	Psychopathic disorder Breast cancer (treated) Pre-occupation with physical problems/Diabetes Adopted – treated as 'little girl'. Sexual abuse outside of home – self-harm. Attack on family member - 30 years in high-secure hospital. Demanding, obsessional behaviour. Complaining of 'dead' hand. Feelings of 'not being heard'.	Mental illness Learning disability Hallucinations Multiple sclerosis Fostered – behavioural problems – violence – psychiatric care – absconded. 15 years+ in high secure hospital. Insecurity/social isolation. Insistence on 'favourite' instrument. Need to be reassured that she has been 'good'. All blue clothes and belongings. Wants teeth removed.
Song words London's burning……. Fetch the engine……… Fire, fire……… Pour on water……..	Frosty the snowman was a jolly, happy soul……….. He was made of snow but the children know how he came to life one day	Edelweiss, Edelweiss Ev'ry morning you greet me Small and white Clean and bright You look happy to meet me
Level of meaning Level 1: Explicit/Stated Burning – self-harm	Level 2: Implicit/Contained Frosty – coldness – emotional and physical numbness	Level 3: Implicit/Construed. Edelweiss – Nun – goodness – anti-violent desire

1.4 Second Songs: A Song Process?

1.4.1 Angela

It is three months later, session 42, just before Christmas and Gracie is preparing early, singing one Christmas carol after another. Angela is still playing the woodblock but we haven't had the 'Nun music' for six weeks. She's had a difficult time lately with increasing mobility problems, an additional diagnosis of multiple sclerosis, and the need to use a wheelchair. Last week she ripped up all her precious blue clothes and had to borrow something to wear to come to the session. Suddenly she interrupts the Christmas carols and requests, "Hello to Gracie", a greeting song I often use at the start of the session, which Angela occasionally asks for but never sings. But this time, as I play to each of the group in turn, she makes quiet breathy sounds, as if trying to sing. I feel she is trying to link with Gracie and join in her positive Christmas spirit.

Gracie immediately begins singing *Little Donkey* (Boswell 1959) and I follow on the keyboard. This time Angela's voice is firm and clear as, for the first time ever during sessions, she joins in singing, mid-way through the song. She sings:

> Little donkey, little donkey, had a heavy day
>
> Little donkey, carry Mary, safely on her way.

My impression of Angela as the Virgin Mary was reinforced, but I felt also that she was beginning to express her feelings about her loss of mobility and her

need for physical assistance, being 'carried' in a wheelchair, none of which had been openly expressed in music or conversation in earlier weeks. (This issue will be explored further in Chapter Four.) The session ended with a positive discussion about the ways women in the group had helped each other.

For Angela, this seems to be a change of level:

Song 1:	*Edelweiss*	Level 3	Implicit-Construed
Song 2/3:	*Hello/Little Donkey*	Level 2	Implicit-Contained

1.4.2 Brenda

Brenda's second song, and also her third, comes immediately after our breakthrough with *Frosty*. Both are chosen from her sheet music and are repeated in a couple of sessions but pass without notice at the time.

Song 2, *Cockles and Mussels* (see Woodgate 1951) confirms the issues of life and death as Brenda plays and sings:

Cockles and Mussels! alive, alive O!

Alive, alive O! alive, alive O!

Crying 'Cockles and Mussels! alive, alive O!'

Song 3, *Auld Lang Syne* (Robert Burns, Traditional) seems to confirm the issues in her past and raise the question of how she deals with them:

"Should auld acquaintance be forgot and never brought to mind?"

In the months that followed we were able to openly discuss Brenda's childhood, family relationships, and her index offence, a violent attack on a relative, who later died. Brenda's memories were often 'brought to mind' and later improvisations helped her to express her anger, grief and loss.

Brenda's songs seem to remain at the same level:

Song 1:	*Frosty*	Level 2	Implicit-Contained
Song 2:	*Cockles*	Level 2	Implicit-Contained
Song 3:	*Auld Lang Syne*	Level 2	Implicit-Contained

1.4.3 Moira

It's still our introductory meeting. In the pause that follows her mention of *London's Burning* I feel at a loss as to how to respond. I merely reply "yes" and the conversation continues:

C: "What other sorts of music do you like?"

M: "Do you know 'Elusive Butterfly'?"

C: "Yes…Val Doonican sings it, doesn't he?"

C and M, both singing unaccompanied:

> Don't be concerned, it will not harm you
>
> It's only me pursuing something I'm not sure of in the night.
>
> Across my dreams, with nets of wonder
>
> I chase the bright elusive butterfly of love. (Bob Lind, 1966)

It was to be a few months before I realised the significance of this song. I was able to offer Moira regular sessions soon after this meeting though she refused to attend for another 11 weeks. She had great sensitivity to music and improvised expressively, invoking emotive scenes of far distant places and people that she also verbally described in great detail. As our musical and therapeutic relationship grew, Moira began to trust me and talk directly of issues that concerned her. Six months after sessions started she began to tell me about the familial incest that had occurred as a child, and the baby she had given birth to that had been taken away. The following week she cut herself for the first time in months and had to be taken to hospital for emergency treatment.

I recalled her second song and it at last made sense. She was reassuring me, after the shock of *London's Burning*, that she wouldn't hurt me; her anguish was turned inwards, harming herself. She didn't know why but she still pursued the love of her family, she grieved for the relationships she'd had and the child she had lost: the love she had known but was now told was wrong. Like Angela, she chased unattainable goals and she represented this, knowingly or not, in the metaphorical image of an 'elusive butterfly'.

This is a clear change of level for Moira:

| Song 1: | *London's Burning* | Level 1 | Explicit-Stated |
| Song 2: | *Elusive Butterfly* | Level 3 | Implicit-Construed |

Although there does seem to be some change in level of meaning for some of the women, this gives no indication of why this should occur or how it may

relate to the therapy. The idea of a 'song process' therefore becomes a major focus for the research that follows, and will be addressed further in Chapters Four and Five through the presentation and detailed, in-depth examination of a narrative of one woman's complete cycle of song choices.

1.5 Elusive Butterflies: a Generative Metaphor

Moira's choice of the song *Elusive Butterfly* seemed to encapsulate my entire work in forensic music therapy into one metaphoric image, and it was at this point that my 'research-butterfly' finally hatched in its mature form. The life cycle of the butterfly, through its embodiment of the transformative concept of 'metamorphosis', becomes a metaphor in itself, a creative representation which is applicable on three levels: not only to the actual usage of a song itself, but also to the therapy process and finally to the research methodology. Yet it is, I would suggest, far more than merely a useful description or a convenient analogy, for it has the generative potential to procreate new related metaphors, such as that of 'egg' or 'caterpillar'. These may be categorized and described in words, as explained below in sections 1.5.1-1.5.3, or they may be encapsulated into summary images, as depicted in Figure 2. In each of these states, whether of word or image, the metaphors seem to serve as vessels or containers which both hold explicit or implicit meaning and also provide frameworks through which meaning can be accessed and interpreted. Thus, in this sense, the metaphors not only provide information for study in a clear and connected (yet not constraining or prescriptive) way, but furthermore become part of the methodological process of analysis itself.

Figure 2: The Generative Metaphor of Metamorphosis
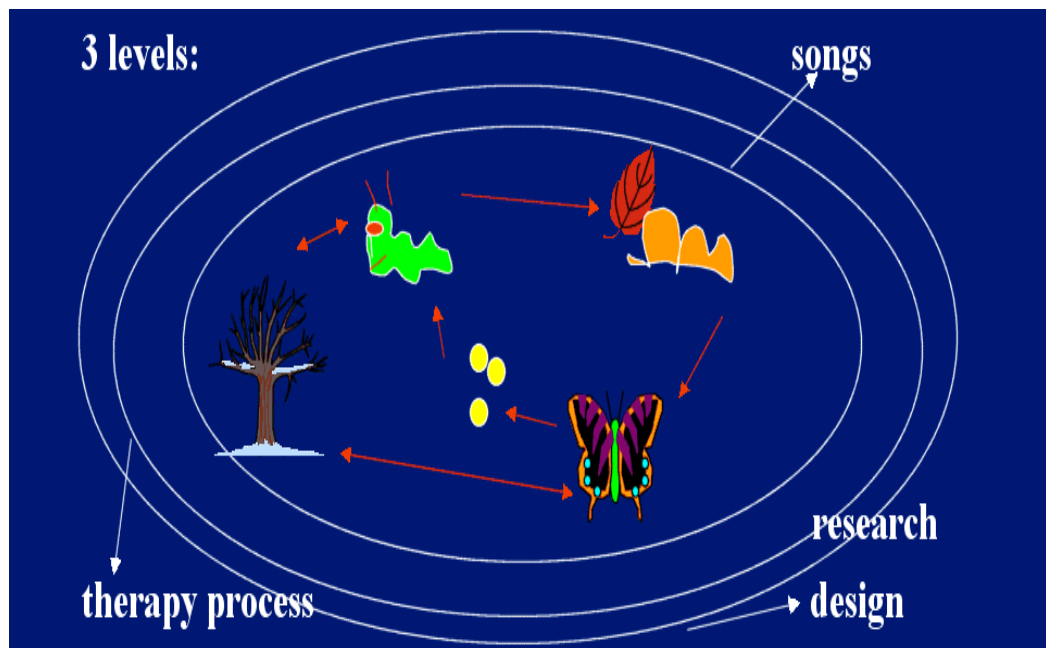
1.5.1 Song Metamorphosis

Eggs – the words of the initial songs chosen by the women seem to be metaphors of an indicative kind, containing a genetic blueprint that presents and holds in readiness the significant elements that will be addressed in the course of later therapy.

Caterpillar – the initial exploration of a relevant song, in which the important 'performance' elements are established and developed, building a shared experience between client and therapist.

Hibernation/Chrysalis – the repetition of a song without obvious development or elaboration, allowing the client time to internalise and accept its significance.

Butterfly – the adaptation of a song, musically, vocally or structurally, by client or therapist, opening up new horizons and new possibilities of expression.

1.5.2 Therapy Metamorphosis

The women themselves appeared as elusive, in both personality and behaviour. Their constant changes of mood varied from volatile and aggressive to withdrawn and uncommunicative. I was often left feeling quite uncertain about how to approach them, as a mistake in timing or perceived attitude would result in the women either leaving the room or verbally or physically attacking me. There was also the issue of non-attendance at sessions, as illustrated by Moira herself. She would flit, butterfly-like, between therapy room, ward, and her own room, and suddenly stop attending for weeks at a time, though she would not relinquish her place for someone else. Felicity did the same, regularly finding a nurse to take her out for a walk at the very moment I appeared on the ward. Despite these difficulties, however, our relationships grew and therapy progressed. We seemed to go through more or less the same cycle of events on a regular basis, and a similar pattern was repeated with varying degrees of contact and avoidance, engagement and withdrawal:

Eggs – the means of establishing communication, the basic musical or verbal elements that the client initiates and to which the therapist responds and then nurtures, for example, a sound, rhythm, comment or gesture.

Caterpillar – a 'testing' stage, trying out instruments, sounds, songs; searching for a way of working together. The therapist provides the 'vegetation', physically, musically, or emotionally, which the client explores. When something significant is found, the contact may be overwhelming and the client then withdraws or reacts against this.

Hibernation/Chrysalis – the client does not attend, or else attends but disrupts sessions or avoids any contact. During this time the therapist is important in maintaining the status quo, a secure environment allowing the client to rest, recuperate, or change internally, until they are able to cope with further contact.

Butterfly – the client returns to try out new ideas and express new feelings, perhaps starting from the same point at which they left off, allowing these issues to be readdressed successfully. For this the therapist provides the enriching nectar of music, allowing the client to feed and explore, and further eggs to be laid, that is, further developments to be envisaged and new stimuli introduced by the client, allowing the cycle to begin again.

1.5.3 Research Metamorphosis

This represents a mode of thinking about research, and also a structure by which it can be approached and carried forward. It supports a research paradigm that is grounded in the idea of a heuristic, (see for example Moustakas (1981), an approach which is based on a process of gradual (self-) discovery, with particular significance being assigned to the human dimensions of experience and creativity. Consequently, this mode of research stresses the importance of personal immersion in all aspects of the investigation, together with a combination of dedicated intellectual exploration and spontaneity of intuition in order to reflect, and also reflect *upon*, the human experiences which are involved. It is, therefore, needs-led, arising out of the clinical situation and developing over the course of a 'natural', non-prescribed, sequence of events. An idea is conceived, and from this idea the individual 'eggs' of specific

research questions are carefully laid out in clear and articulate form. Caterpillar-like, the literature is surveyed so as to place the ideas in an appropriate context before the research process itself can begin to 'pupate' and mature, and the emergent issues and themes are thereby released to arrive, finally, in new pastures.

The ensuing chapters of this study are therefore presented according to a model that mirrors these stages, and they also form an integral part of the generative process, for each chapter grows out of its predecessor, being informed by it and connected to it in a functional and productive way, rather than adhering to a preordained or prescribed route. The conduct of the research is detailed and methodical, and maximally sensitive to its materials and context; but its goals and stages are not fixed in advance.

Hence, Chapter Two aims to clarify and lay out the 'eggs' of the specific research ideas and questions, newly-formed from the experience and data of my own professional practice. As music therapists increasingly seek to examine and explain their work in a manner which has meaning for therapists, their clients, the general public, and wider academic research communities, there is a growing trend towards the adoption of phenomenological principles, examining the nature of meaning as it emerges in context and from within the experience itself. The accessing and exploration of meaning may in this sense be seen to have a larger, more diverse mode of operation than may have been previously suspected by many – not by any means only those who are professionally involved in music therapy, in a clinical or a research capacity, or both.

What follows here is, then, a determined effort to base research within a music therapy practice that adheres to professional norms and policies, whilst ensuring that it also meets rigorous academic procedural and interpretative standards of clarity and trustworthiness. It aims, too, to consider the broader perspective, benefiting by placing the study at the 'nodal point' of intersection with other professional disciplines where commonalities may exist in clinical practice, client group, presenting issues or analytical procedures. Music therapy in all its diversity may by this means be located in relation to such complementary fields as psychology, psychiatry, art therapy, sociology, criminology, linguistics and so on. Thus, the transformative/metamorphic process of research adopted here, which will be discussed further in Chapter Two, section 2.1.4.1, gives rise to the notion that music therapy may be viewed to this extent as a combined discipline, whereby the detailed frameworks for research can be successfully determined from within clinical practice and from the musical experiences on which it is based, while at the same time being allied to, and influenced by, wider professional and cultural concerns, as well as by academic systems and approaches. This belief will be put forward and examined in greater detail in the following Chapter.

Chapter Two: Eggs
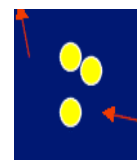
2.1   Defining the Research Framework

The purpose of this chapter is to introduce the underlying beliefs and principles, 'philosophically, methodologically, and personally' (Bruscia 1995b, p.389)[3], which have provided a defining framework for this research. In setting horizons for my work such a frame does not, I suggest, compromise the scope of my enquiry and the kinds of insights that may arise from it along the way. Nor does it precondition my observation of, or response to, the clients with whom I entered into the therapeutic process. Rather, it may be said to mark a point of departure. It grounds my modes of understanding and interpretation, and, to that extent, my principles and working methods.

The end of Chapter One has demonstrated the point in my clinical practice at which I was able to identify the main areas of interpretative interest as song, metaphor and image, and had developed my initial concept of a generative metaphor of metamorphosis (that is, of metamorphic change and evolution). What is now needed, in order to formalise and give it the dependability of research, is Bruscia's (1995a, p.27) notion of a 'systematic… inquiry' (as given within the definition of research in Chapter One, section 1.1 of this thesis). However, defining an appropriate methodology for inquiry also requires an explanation of the personal philosophical journey undertaken along the way.

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[3] For all references to Bruscia (1995) refer to footnote 2 in Chapter One, page 15.

2.1.1 Philosophical Background

The essential philosophical and theoretical perspective from which this research was conducted is that of behaviourism - an approach to psychology (others include cognitive, psychoanalytical and humanistic) which owes much to early American exponents such as J.B. Watson (1931) and, later, B.F. Skinner (1974). The behaviourist movement came to prominence in the early 1900s as attempts were made to apply objective procedures to the experimental study of man, in contrast to the earlier predominance of more obviously subjective or introspective studies which focused on (usually philosophical) ideas relating to human consciousness or the soul. It concentrated mainly on the collection and analysis of observable phenomena, searching for regularities or patterns, or clear associations between events, and the data used was essentially observed behaviour.

> We can observe *behavior – what the organism does or says –* And
>
> let us point out at once: that saying is doing – that is, behaving.
>
> (Watson 1931, p.6)

Whilst this statement is of course intended to stress the observable nature of behaviour (and, in relation to this thesis, the necessary inclusion of words and language within the category of behaviour, that is, in the form of speech acts and other similar kinds of declaration or manifestation), it also points to one of the most common criticisms - or one might perhaps say, misunderstandings - of the behavioural approach: the use of the term 'organism' in relation to human

action. For this might be seen as devaluing the richness and independence of the human condition (considered in terms of feeling, thought and agency), or as ignoring the essential uniqueness of human experience - and, indeed, such criticisms became much more widespread following the preponderance of early laboratory experiments investigating animal behaviour, using dogs, rats or monkeys. But, as Skinner (1974) explains, his own research with pigeons is reproducible; it also allows for the manipulation of variables within a known and controlled environment; and it thereby assists in establishing a simple and understandable basis for behavioural understanding *before moving on to* the much more complex world of humans. In other words, his intention was always to identify foundational mechanisms, which could be reliably established in a clearly observable way, without prejudicing the further investigation of the far richer and more complex world of human action, feeling and motivation.

Skinner trained pigeons to respond by pecking at the stimulus of a light source in order to gain a reinforcement of food, thus helping to shape their behaviour through a process of 'operant conditioning' and so demonstrate the reality of associative learning. This procedure works through the basic responses of the animal (in this case, hunger, but also embracing other inward and innate reactions such as pain or pleasure), and so in this sense behaviourism retains close links with physiology. Watson's use of the term 'organism', as quoted above (1931, p.6), can then be seen to refer to the mechanistic nature of a whole range of human responses at a basic sensory, biological level.

Behaviourism does not deny the existence of more complicated feelings, however, such as emotional responses or other human cognitive processes. Rather, it sets out to examine how they may arise from primary responses in richer and more complex configurations. Skinner (1974) also frequently writes of humans as organisms, yet the term is used not in a reductive, mechanistic way but in a much more positive sense of integration. Rather than adhere to notions of a clear mind-body demarcation, behaviourism views the human organism holistically, recognising consciousness and the realities of human experience as internal states or events within the body that function in such a way as to provide (often urgent) stimulation, of which an individual may become aware, and which, therefore, may have a direct bearing on behaviour. In other words, these states or events relate directly, at a foundational level, to the idea of motivation. And so, in this way, the essentially human qualities of emotion are seen as complex conditioned responses, produced when the original stimulus that evoked a sensory reflex from the nervous system has become associated with a secondary stimulus, or perhaps network of stimuli, which in turn becomes capable of provoking the original response. As an example, an infant being fed by its mother may experience the sensory reinforcement of the (primary) satiation of hunger and additional (secondary) responses such as increased arousal and feelings of security. In describing these responses as 'pleasure' or 'enjoyment' we are describing the whole complex bodily reaction to that experience, and this reaction may in turn become associated with additional environmental or social aspects of the experience. The sense of pleasure may then become generalised, appearing as a conditioned response to the mother herself, to other people, or, perhaps, to the sound of speech or song,

such as a lullaby produced by the mother on repeated occasions during the early feeding sessions. Therefore, in this view, much of our behaviour (including language and social actions) is deemed to be acquired or learned, and our range of responses, including that to music, is constructed associatively and through experience. Thus the perceived reality of such responses may be far removed from the original stimuli in which they originated.

Watson (1931) explicitly emphasizes his holistic beliefs and intentions:

> Let me emphasize again that the behaviourist is primarily interested
>
> in the behaviour of the whole man…..the commonsense answer to
>
> the question "what is he doing and why is he doing it?"' (1931, p.15)

The question 'why' is crucially important in this quotation. Behaviourism may be criticised for concentrating too exclusively on observable data and thus for not accounting for the human processes of intention, motivation and thinking (that is, the meaning behind the action).But this is not in fact necessarily always the case at all – behaviourism merely operates from a different philosophical view of meaning, or the way meaning is 'produced' within a context: a view of meaning as, in the first place, simply a way of telling what someone is doing.

Clearly, human beings may respond in different ways to seemingly identical situations. If we have a choice, a range of available learned responses to a given situation, which one do we choose? According to Watson (1931, p.250) it is 'The one which my previous organisation and my present physiological state

call forth'. And so, rather than ask blankly 'why' certain behaviours occur, it would seem more pertinent to consider the complex web of circumstances, internal and contextual, present and past, from which the behaviour is elicited.

Behaviourism, understood in this holistic way, has a dual but integrated role in setting a broad and inclusive framework for this research, providing a broad philosophical underpinning and also a general approach and methodology. It works not in a reductive, mechanistic (and in that sense anti-personal) way, but rather with a strongly holistic approach to human experience, grounded in personal history and in the way personality and responses have been formed and shaped over time. In this sense, it has a strong philosophical and indeed a proto-psychological dimension, as Skinner was quick to observe: 'Behaviourism is not the science of human behaviour; it is the philosophy of that science.' (1974, p.3); and, in addition, 'It is really [to be understood as] a methodological approach to psychological problems' (Watson 1931, p.18).

Philosophically, I adhere to the notion of a holistic approach to the varied functions of the human organism, in all their multiplicity, as they function within or are expressed through the body and its complex systems (physical, visceral, nervous, perceptual/cognitive, including language and consciousness). My view is that there is a strong physiological basis for human behaviour, with learned responses being acquired and shaped through environmental interactions, and that these interactions provide a further powerful system of shaping and reinforcement. This whole complex system produces, or rather underpins, the rich mixture of responses and inner states we call 'human

experience'. In terms of method, I adopt the practice of searching for empirical data, based on observable behaviour (including complex behaviours such as speech and song), and the practice of studying this data interpretatively to determine significant patterns which may serve to indicate what possible structures, or underlying organisational factors, might lie behind them.

None the less, my positioning with respect to behaviourism is an independent and perhaps in certain respects a highly individual one. It is in the specific design of this research project that my path begins to veer away from the traditional scientific and experimental approach to behavioural studies, many of which have replicated and expanded the early laboratory experiments using human subjects, such as Watson's (1931) studies of fear responses in children. Such experiments may have the advantage of a very rigorous kind of objectivity; and these kinds of studies are consistent with a quantitative paradigm and a clear scientific focus on the testing of theories. One of their disadvantages is that they take human participants forcibly away from their natural environment and thus from their usual structures of 'natural' response and interaction. For a project such as mine, such an approach would necessitate a profoundly undesirable move away from the natural course of music therapy sessions (my clinical practice), and would in that sense prejudice any understanding which might arise of the actual relationship between theory and practice (including the collection and interrogation of data). For it is the very fact of using the actual course of music therapy practice as the basis for my process of thought and research that is of prime importance in this study.

It is this particular aspect of research design, therefore, that constitutes one of the clear challenges facing any therapist-researcher seeking to examine and clarify aspects of his or her own clinical practice. One must decide whether, and if so to what extent, the normal progress of therapy might be deliberately altered or manipulated so as to examine particular phenomena, or whether new participants might feasibly be found specifically for research purposes. One important study which addresses such issues is that of Elefant (2002). She used pre-composed songs to enhance the communication skills of girls with Rett syndrome and was able to demonstrate their capacity for learned choice-making. The research method she employed was a single case, multiple probe design in which repeated intermittent measurements were used during periods of baseline and intervention sessions. Elefant maintained throughout a familiar setting, therapist and materials to take into account the difficulties of the Rett population in becoming acclimatised to new situations and also to reduce the effects of new influencing variables. Yet the sessions themselves were highly controlled and the whole process is in fact described by her in terms of 'trials' and 'investigation' which 'had the flavour of therapy sessions' (Elefant 2002, p.227), rather than as naturalistic therapy which also offered research insights.

Although it is true that Elefant's research is not specifically described as behaviourist, there seems to be a real and significant commonality of approach in the clear emphasis on observation of behaviours, a process of learning in choice-making, and a recognition of the wider environmental context through a need to maintain acquired skill 'by generalizing it to areas other than the therapy room' (Elefant 2002, p.274). She illustrates very clearly how music

therapy can be used to develop particular skills or therapeutic goals. In this respect, in the 'administration' (Elefant 2002, p.65) of pre-composed songs, this research appears to possess clear links with some of the more defined behavioural programmes that developed after the earlier laboratory studies.

The growth of stimulus-response psychology set out to examine the stimuli which elicited behavioural responses, the reinforcements (that is, the rewards and punishments) which maintained such responses, and how patterns of behaviour could be shaped and modified by changing these rewards and punishments. This led to the development of particular programmes of behaviour modification which aimed specifically to transform aspects of human behaviour, and thus tended to focus on concepts of treatment geared towards specific goals, rather than on the facilitation of individual personal development through emphasis on the building of interactive relationships between client and therapist within a structured but essentially open context.

In music therapy, this more prescribed approach to clinical practice became more prevalent in America during the 1970s and also became popular in Australia. Magee (2000), for example, writes of her early work with brain-damaged clients in Australia drawing on neurobehavioural models of treatment, using 'familiar pre-composed music embedded in the client's long term memory' (Magee 2000, p.95). And she contrasts this with the cultural differences she found on arrival in England, where music therapy was dominated by - indeed largely defined by - live co-improvised music between client and therapist. Magee and Davidson (2002) describe the setting up of a

quantitative pilot study to explore the effectiveness of these two approaches, using statistical measurement of mood changes before and after therapy. They demonstrated that the therapeutic application of music produced changed behaviour, but realised that this did not – and could not - show why such changes occurred. In order to address this, Magee (2000) describes her next collection of case studies as including the central analysis of clients' own verbal and musical material in addition to observational data, and using techniques of modified grounded theory to search for patterns and emerging themes.

Magee's research stresses the benefits of the researcher, as therapist, being immersed in the evolving data, being sensitive to the therapeutic material, and acknowledging the importance of interactions between client and therapist, not only within the therapeutic process itself but through collaboration in the interpretation and further use of results, and the ongoing development of the path of the research. Such a personal and particularized approach to combining clinical practice and research seems relevant to (and indeed necessary for) my study, arising as it does out of my own practice. But it also presents a methodological difficulty to the extent that the research ideas developed so far (that is, those relating to the use of metaphorical images in songs) had grown out of my ongoing clinical practice. To engage the women in a collaborative research process which aimed to raise their awareness of the subject matter would inevitably alter the nature and course of the continuing therapy sessions and, consequently, also the results of the research; yet to deny them this opportunity would raise ethical dilemmas about the status of their participation and about the nature of their immersion in the project. Similarly, Magee's

(2000) data collection and evaluation occurred simultaneously, with themes being analysed and followed up with clients in interviews more or less immediately, whereas it was only at a point in the initial development of my research, about one year into the course of therapy sessions, that the very early song choices began to appear to be significant. In order to be able to examine these, and thereby initiate the process of interpretation and the production of meaning, with this current group of women, some retrospective analysis was evidently required. But as a practising therapist, it is my firm belief that the integrity of the therapy is always paramount, and that the normal ('naturalistic') course of therapeutic practice must be maintained throughout. The practice, therefore, informs and grounds, and to some degree dictates, the conduct of the research. This seemed, and still seems to me, an inestimable strength of the approach. But one consequence was that the exploration of the relevant ethical issues and research procedures was notably complex and ramified, and required a very subtle balance of arguments and judgements to be made. A detailed account of this whole process is given, and the issues fully discussed, in section 2.3.4 Ethical Review.

For all these reasons, this research is not theory-orientated or outcome-based but is essentially process-based. It does not seek to provide direct and incontrovertible (measurable) evidence of the effectiveness of a particular intervention, nor to explain (and ultimately predict) a given aspect or aspects of universal human behaviour. It aims, rather, to examine in depth and detail the circumstances surrounding the behaviours – musical responses, initial song choices and evolving 'song references' in this particular case – presented during

music therapy sessions with a particular group of women. As the narrative of my research gradually unfolds, it will, I hope, become increasingly clear how the whole complex of associative responses – to music, to songs, to words and images – was able to function freely in these women, unburdened and untrammelled by any preconceived theoretical or experimental ideas, over the whole course of our sessions; and also how the therapeutic force(s) operating within the sessions (of music as active agent, and of song images as condensations of past experience) was able to exercise itself through precisely this underlying, and hence largely invisible, network of responses and their associated emotions. .

2.1.2 Research Tradition

As my ideas had begun to emerge from the ongoing music therapy sessions, I felt it essential not only to continue with the usual emphasis on my regular week-to-week therapy practice, but also to incorporate within my current approach the larger process of therapeutic development and reflection through which I had passed already. The early sessions, from which the concepts for the study first emerged, were all inextricably linked with the awakening and growth of my own perceptions, my developing interpretations, and my understanding of them (as well as my understanding of my own current practice). Thus, the ongoing course of music therapy and my own evolutionary growth as practitioner and observer combined to become an integral part of my notion of a metamorphic process operating within the research dimension of my project. In this way, the world of therapy (practice) and the world of reflective thought and

analysis (research) were intimately linked, conjoined within an evolving temporal continuum. Therefore, I was able to adopt an approach based primarily on the idea of an emergent process, with an evolving (rather than preordained) approach to understanding and explanation, which would allow events to occur and to be analysed and interpreted in a maximally responsive and flexible way. This fits easily within the frame of a qualitative research paradigm, as defined by Creswell (1994) in the following terms:

> An inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting.
> (Creswell 1994, pp.1-2)

The concept of the natural in such work is stressed by Lincoln and Guba (1985). They prefer the term 'naturalistic' over 'qualitative', describing a worldview which assumes a set of axioms, or basic beliefs, where the nature of reality is 'multiple, constructed and holistic'; in which researcher and participant, or 'knower and the known', interact to influence one another; and where 'all entities are in a state of mutual simultaneous shaping' (Lincoln and Guba 1985, p.37).

This focus on interaction, shaping and construction is perhaps particularly applicable to the therapy situation where therapist and client interact musically to shape each session and the path of the therapy itself, whilst their individual perceptions and interpretations construct the reality of the experience for each

of them. Such an interactive cycle of shaping may make it impossible to distinguish the precise causes and effects of particular actions. This would be an unusual approach for a behaviourist concentrating on specific stimulus-response processes but it is perfectly suited to my focus on the wider environmental circumstances in which actions, or behaviours, are elicited and constructed.

To research such an evolving reality requires an emergent or 'inductive model of thinking' (Creswell 1994, p.94) in which, as Bruscia (1995b) states:

> The researcher's experience with the phenomenon takes precedence over the methodology, so that the researcher is continually adapting the focus and procedures of data collection according to what he or she experiences during the process. (Bruscia 1995b, p.390)

Thus in naturalistic, qualitative research there is no established procedural sequence (Bruscia, 1995b); hypotheses and theories are not a preordained basis for study, but may emerge during or after the collection and analysis of data.

However, even within such a naturalistic process there are many research traditions that provide frameworks for inquiry. Cresswell (1998) examines five of these traditions (biography, ethnography, grounded theory, phenomenology and case study) and describes how they vary in approach to research conception, design and presentation, with each having a different focus or purpose. I considered each of these and their potential relevance and applicability as a mode of inquiry for this research:

Biography has its roots in human and social science and its purpose, broadly, is to present a life history, a portrait, of an individual and identify the meaningful experiences and events that shape it. For music therapy this has some relevance, as a client's past and current experiences may be considered as part of the process of therapy. But this research is centred on songs so individual biographies, though they may be included and considered if they form part of the context in which the songs appear, are not, in fact, the prime focus. There are no defined examples of biographical studies in music therapy that have directly contributed to the process of my research but I have been influenced by the creative processes of Killick (1994) in his collation of biographical data from conversations with people with dementia, his interpretative organisation of this data into poetry and its resultant insightful perspectives into life experiences (of which more details are provided in Chapter Three, section 3.2.1). Whilst Killick does not define this process as research, I find the use of an artistic and literary medium, in this case poetry, inspiring and this reinforces for me the potential to examine my work, and the women's life experiences, through the crystallized images formed from the words in song lyrics.

Ethnography has its origins in anthropology and sociology and focuses on the everyday life of cultural groups. This could be an appropriate tradition for a behavioural researcher as it has potential for the observation of natural behaviour, language use, and learned patterns within social systems, and a secure forensic unit could fall within this definition. This perspective has some bearing on my thinking for, as stated in Chapter One, I had only noticed the constant requests for pre-composed songs when I began music therapy sessions

in the forensic units and not in previous work in other clinical situations. However, an ethnographic researcher typically immerses him or herself in the life of the group and I am but a time-limited visitor, only present during music therapy itself and, for the purposes of this research, interested only in those aspects of the life of the group which impinge on the music therapy process, which, therefore, sets a delimiting focus on the study.

Grounded theory as a research tradition has its origins in sociological studies. It takes a particular concept, phenomenon or situation and its intended purpose is to discover or generate a theory, grounded in data from the field which is subject to systematic processes of analysis. This is the approach adopted by Magee (2000), as stated earlier in this chapter, and it is one that allows for, or depends upon, an evolving inductive process, and the use of participant material. But, for me, this is also its main drawback, for the primary use of interviews and repeated presentation of ongoing data analysis back to participants would disrupt the natural progress of music therapy sessions which I believe to be an essential requirement in my research.

Grounded theory is also one of the strategies used by Bonde (2005), who advocates the use of multiple-methodology in order to address epistemological and ontological issues. I am impressed by Bonde's depth of philosophical argument for his flexible research design and his commitment to combine the most appropriate aspects of quantitative and qualitative methods to meet the purposes of his study which, like mine, is not outcome-based and uses metaphors to conceptualize a process of music therapy, e.g. the word

'influence' used to mean music therapy 'flowing into' the bodies, minds and spirits of cancer survivors (Bonde 2005, title and Appendix 9). From this, I take the determination to find and adapt a flexible research design which will encompass my ongoing therapy sessions, and my changing viewpoints of the research process, rather than one which requires adaptation of practice to fit a predetermined system. Also, as yet, I have no concept from which to develop a generalized theory: I am investigating a phenomenon from my own clinical practice and wish to examine the circumstances from which it arises without, at this point, suggesting that it may also occur in other situations. For these reasons, I do not choose to adopt a grounded theory approach, though I acknowledge that I may develop theoretical ideas or assertions as the research progresses.

Phenomenology is often used in social or psychological sciences and its purpose is to understand the meaning or essence of lived experiences. In its human focus and respect for individuality it is clearly relevant to music therapy research and can be used to explore the nature of interactions between client, therapist and the music itself. It is concerned with the collection of detailed descriptions of observable realities and so can involve retrospective material and a reflective process of recollection. The data is then systematically coded and categorised to find meaningful statements and themes and to distil the essence of their meaning in a textual form. Two music therapy studies which use this approach, and which relate to the subject matter of this thesis, are those of Amir (1990) and Grocke (1999).

Amir (1990) examined the meanings of improvised songs created with a traumatic spinal-cord injured young adult. She used a seven-step method to analyse audio and video material as well as transcribed interviews and included syntactical analysis of musical elements and observable behaviours as well as semantic elements of extracted referential meaning. What I find personally relevant in this work is Amir's reflections that the truth or correctness of the knowledge gleaned from this process cannot be measured – they are unique to this client and they are understood by the researcher viewing the musical experiences as part of a wider holistic human experience.

Grocke (1999) explored the study of pivotal moments in Guided Imagery and Music (GIM) therapy from the perspective of seven adult clients and two therapists as well as examining the role of structured elements of the music. Two aspects of this work seem relevant to me – the recognition of the unique experiences involving interaction between client and therapist, so that the therapist's experiences are also deemed critical in the research process, and the examination of images from a neuroanatomical model. This has similarities with my physiological thinking but Grocke's philosophical approach is humanistic rather than behaviouristic and her concentration on meaning, and meaningful experiences, differs from my consideration of context and more causal relationships. So in my case, although studying what could be a clearly defined phenomenon (that is, the repeated and unusual presentation of pre-composed songs within music therapy based on an improvisational model), phenomenology as a methodology does not quite seem appropriate, especially when combined with a need for participants to be verbally fluent enough to

describe their experiences after the event – a point which is noted by both Grocke (1999) and Amir (1990).

I turn to Cresswell's (1998) final research tradition to shape my path of inquiry: case study, which is common in human and social sciences and has broad boundaries which are flexible enough to accommodate a wide variety of research situations. Creswell defines case studies as those:

> In which the researcher explores a single entity or phenomenon
>
> (the case) bounded by time and activity (a program, event, process,
>
> institution, or social group) and collects detailed information by
>
> using a variety of data collection procedures during a sustained
>
> period of time. (Creswell 1994, p.12)

Yin (2003) differentiates between case studies that are explanatory, exploratory or descriptive (p.3) and goes beyond a definition of mere data collection to present case study as a comprehensive research strategy which follows a set of prespecified procedures, that is, an articulated research design which has its own logic in the collection and analysis of empirical data. Case study is particularly suitable for the investigation of 'a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident' (Yin 2003, p.13). This blurring of boundaries makes the technical characteristics of data collection and analysis vital, as the inquiry needs to cope with the potential variety of interesting variables arising from multiple sources.

An influential example of case study as a defined methodology in music therapy research is provided by Aasgaard (2000) who studied the phenomena of improvised song creations in the paediatric oncology setting. In particular, Aasgaard presents a longitudinal case study of one song and the exploration of its 'life' (p.70) both in the therapy room and, more significantly, in other areas of the child's social situations. The research, therefore, has 'an ethnomethodological undercurrent' (Aasgaard 2000, p.73), examining the song in its naturally occurring settings.

Aasgaard takes 'a constructivist stance' (p.73), understanding meaning by interpreting relevant and representative data. Through collecting data from multiple sources (including music therapy records, descriptions, interviews, conversations, video, written music etc) and searching for interesting and significant events in order to find out 'how things happen and are experienced, rather than why' (p.74), Aasgaard builds a detailed picture of the child's life in hospital and concludes that a song can produce a variety of musical and social interactions and that 'the 'meanings' are often the interactional processes' (p.77) where, according to context, a given statement or behaviour may relate to the meaningful dimensions of expression, achievement or pleasure. Aasgaard relates these to the varying roles that the child has in her social situations and how these can be used creatively to promote health: an ecological perspective which recognises that music therapy does not work in isolation with the individual client but in an interactive process within that person's social community.

I find much resonance between Aasgaard's approach and my own. It is closely aligned in being a longitudinal study of a song phenomenon based in its natural context; in its acknowledgement and active respect for the part played by social interactions in shaping both behaviour and meaning; and in its emphasis on the methodological strength of interpreting detailed data and constructing it from the point of view, and duality of experience, of a researcher who is also the music therapist.

This interactive nature between researcher and holistic data, evolving over time, is consistent with the assumptions of an inductive qualitative design where the initial, perhaps tentative conceptual framework is developed through the process of data analysis and the final resultant product (in the form of a patter or model) may be considered as a theory. Lincoln and Guba (1985, p.49) refer to 'pattern theories' where the researcher collects detailed information then searches the data, forming categories or themes until a pattern or theory emerges. These will take the form of interconnected thoughts or parts linked to a whole: a system of ideas that is able to inform and illuminate. In order to make sense of the relationships, metaphor or analogies may be used rather than a schema of deductive reasoning and causal statements. Indeed, Lincoln and Guba themselves use metaphors in their replacement of the concept of deterministic causality with the needs for explanation and management – using 'web of circumstances', 'communication net' and 'pattern of influences' to describe the idea of a 'mutual simultaneous shaping' where 'everything influences everything else, in the here and now' (1985, p.151).

Though the abandonment of causality may be difficult for a strict stimulus-response behaviourist, it rests easily in my conceptual picture of a wider environmental context, and the use of metaphors has already evolved as a central part of my approach. This again seems to emphasise the importance of the researcher's direct involvement in the process and its potential for meaning, or, in my case, the right of the therapist to interpret data from therapy sessions in a way that reflects the experience and makes greatest sense for those involved. As the women in my clinical practice already seemed to be presenting their experiences through metaphor and imagery, as described in Chapter One, the continuation of the interpretation and categorisation of these metaphors as part of the research process seems to represent a natural and appropriate progression. This then helps in the process of deciding exactly what data to collect: the words of the songs that the women choose are a direct and tangible reminder of their experiences during the therapy process. They are not the experiences themselves but are a means by which those experiences may be notated and reflected upon.

Aldridge and Aldridge (2002, p.1) use the word 'traces' as 'a general term referring to material left behind as an indicator that something has happened. These traces are empirical data'. The problem remains in finding an appropriate methodology that enables the researcher to describe and interpret these traces, be they in the form of music, song words or images. As Aldridge and Aldridge (2002, p.1) also state, for music therapists, the chief difficulty 'is how to analyse the piece of work that we have before us using a systematic procedure that has therapeutic and clinical validity, and that remains true to the art medium itself'.

They present a flexible form of research design, therapeutic narrative analysis, which is 'hermeneutic…. concerned with the significance of human understandings and their interpretation' (Aldridge and Aldridge 2002, p.4). They propose that data traces are described and interpreted at different levels of abstraction as they become removed from the initial experience. In order to define the significance of events, the researcher must know the context in which those events occur or are described. This suggests that, for the music therapist researcher, it is important to collate information from various sources - such as musical and verbal transcriptions of sessions, interviews and case reports. Such methods, therefore, can be retrospective as well as prospective. Significant events inevitably become linked together as we try to relate the whole therapeutic story of what happened, how it happened and 'what happened next' (2002, p.2). Differing sets of meanings are created or generated according to the context.

Aldridge and Aldridge (2002, p.2) propose that linking together events or 'episodes' forms a narrative or story. It is the episodes themselves (or patterns of meaning, behaviour or actions), which are the basic units for research through the generation of constructs and identification of categories for analysis.

> By combining a constructivist approach with a communications
> perspective, meanings are chained together to understand the
> therapeutic process. (Aldridge and Aldridge 2002, p.1)

After this process of analysis, the various 'understandings' are synthesised together in order to form a completed research narrative. A comprehensive example of this approach in practice is provided in a later volume (Aldridge and Aldridge 2008) which explores the concept of melody within music therapy. It includes many notated examples of musical improvisations (from a breast cancer patient and a man with reactive depression) and examines the specific elements and transitional forms which determine the creation of the melodies, showing how interactions between patient and therapist are affected by the melodic statements of the patient.

Melody is the outward expression of that pattern which connects.
The task of scientists and artists is to discover those patterns that are
implicit in the world which connects us. In the therapeutic narratives
here, we see how those patterns are made explicit. The melodies,
performed as melodic improvisations, make explicit traces of that
which is implicit. By performing, we give expression to the tangible.
(Aldridge and Aldridge 2008, p.325)

It seems logical to suppose that such connective patterns may also be present in the performance of pre-composed songs, with the images constructed from the lyrics being an explicit expression of some, as yet unknown, connection. This method of research, therapeutic narrative analysis, outlines a form of systematic inquiry particularly suited to my purpose as a music therapist researcher. It allows for the collection of data through normal clinical practice, and an emphasis on subjective interpretation based on the understanding of context.

The concept of a narrative account being used for analysis lends itself well to the traditional qualitative case study design and this seems especially pertinent to my initial approach in Chapter One, in which I introduced my research ideas through brief narratives or case vignettes. For this reason, I choose to continue to structure the core of my research as a case study that is broadly laid out, while also being investigated and interpreted in detailed, in-depth fashion in line with an evolving adaptation of therapeutic narrative analysis, of which more specific procedural details will be given in the Data Analysis section 2.3.6.

Three different types of case study are identified by Stake (1998), each with its own purpose: intrinsic, undertaken because one wants better understanding of a particular case because of its intrinsic or unusual interest; instrumental, examined to provide insight into an issue, where the case facilitates understanding of an external interest; and collective, an inquiry into a phenomenon, population or general condition, where understanding of a small number of cases may lead to theorising about a still larger collection of cases. Stake (1998) adds that studies may not fit neatly into these categories. Particularly in intrinsic or instrumental cases, we may have several interests simultaneously, often changing: 'there is no line distinguishing….[them]; rather a zone of combined purpose separates them' (p.88). He sees them as 'heuristic more than functional' (p.88).

The same will be true of this case study. My narrative account will develop from intrinsic interest in the 'cases' in my personal work as a music therapist. For the purpose of deepening and strengthening the subjective interactional

experience I choose to focus on one woman only - a single central case study. This will also serve to clarify the specificity and boundedness of the case.

However, my intrinsic interest in the therapeutic narrative of this case is focused specifically on her use of song, instrumentally limiting the choice of data to be analysed. Also, although the experiences of this one woman may, or may not, be typical of other women in the secure units, the initial understanding of her therapeutic process may lead to the emergence of themes or issues of importance for them all. At times then, the research may include retrospective reference to data obtained from the remaining women, in order to support or refute the emerging interpretations. In this way the intrinsic case study will occasionally focus on the combined purpose of instrumental and collective study.

Later in this chapter further information will be given on my reasons for the choice of this particular woman (section 2.3.2) and on the validity of case study as research (section 2.4).

2.1.3 Statement of Research Framework

The purpose of this study is to understand the importance of the role of song for women in forensic psychiatric music therapy. It is guided, philosophically and theoretically, by behavioural perspectives and assumptions. Consistent with the naturalistic tradition of a qualitative paradigm, it is based on ongoing clinical music therapy practice and is bounded by a central single case study of one

woman, resulting in a narrative account. The research incorporates an emergent design and inductive narrative analysis, focussing on the use of metaphors for data categorisation and interpretation.

2.1.4 Personal Presentation

As both therapist and researcher I have two parallel narratives to present. One is the account of the therapeutic process and the other is the story of the research development. By this second story I mean the process by which my personal research ideas were formed, contextualised and evaluated. As a qualitative researcher I value this subjective experience and development, and in writing I seek to acknowledge it through an idiosyncratic presentation that reflects not only the work undertaken but also the concurrent growth of my personal thoughts and interpretations. I wish then to present an ongoing narrative, one which I invite readers to co-experience as an unfolding event, and from which they may draw their own interpretative conclusions.

In writing a narrative one is writing for an audience and, in order to be optimally effective, an appropriate choice of literary style is required. By effective, for the purpose of this thesis, I mean achieving the aims of conveying accurate information alongside a sense of the experience of the entire process, and enabling the reader to make a judgement on the validity of the findings that are presented. Aigen (2005, pp.210-213) describes such functions of research reports and the use of specific narrative devices in order to achieve particular goals. As he describes, a typical experimental quantitative report would be

presented in a standard format, based upon the procedures followed during the research, whereas qualitative reports may be more variable in form and content, being structured more according to the presentation of the experiential meanings which the researcher intends to convey. The choice of words and the style of writing may be seen not only as a form of communication but as a process of construction, for interaction with them, as either writer or reader, helps to shape our personal understanding or reality.

By this point in the thesis it is probably clear to the reader that I have chosen the stance of informality over a more formal, impersonal compositional style in both format and text. This is deliberate, being an affirmation of the underlying naturalistic epistemology from which this self-reflexive text arises. In the emergent nature of my research design, and my ongoing engagement in subjective interpretative procedures, there may be several ever-changing layers of meaning and a flexible structure is required in order to accommodate, explore and expand these moving patterns coherently. In this respect, my individualistic, and possibly unconventional, approach is equally as valid as a more traditional academic style, for it is eminently adapted to fulfil its purpose and do justice to the material which it presents.

This thesis is written from my point of view, sometimes as therapist and sometimes as researcher. Brooks and Warren (1972, p.247), writing about modern rhetoric, use the term 'point of view' to indicate the relation of the narrator to the action, either as observer or participant. I, of course, am both: as a participant (therapist) in the music therapy sessions I am directly involved but

I am not the main character, so my writing is not entirely autobiographical; as an observer (researcher) I record and analyse extracted data and have an interest in its outcome. Defining the movement between these points of view is one of the challenges of being what may be called a 'narrator-involved observer' (Brooks and Warren 1972, p.248). Writing a flexible narrative, without a pre-determined course engages with this shifting of focus and encourages the focus on the development of layers of meaning and emerging areas for further study.

I acknowledge and take ownership of the presentation of my point, or points, of view, by choosing to write in the first person, making substantial use of personal pronouns and possessives, such as 'I' and 'my'. This, I advocate, tells the story of what happened, in the music and in the therapy (and what happens now during the research), as directly as is possible to the reader. This personal style aims to lessen the distance between writer and reader, bring the reader nearer to the action, and thus to convey more closely the sense of an experiential journey. For the same reasons I, at times, employ additional literary devices such as the use of the present tense, or the phrasing of questions inserted into the narrative. These are used to give immediacy to what is being described, be it outward actions or behaviours, subjective emotions, or internal ruminations and insights, and so they have the advantage of responsiveness, leading the enquiry into new paths of exploration. They remind us, too, of the personal nature of this research, demonstrating the choices I made along the way; allowing readers to develop their own, possibly alternative, perspectives and, above all, helping to keep the voices of the women as the central focus, enabling their stories to be heard.

The central case study that I will present is a longitudinal event, occurring over a time span of three years. As such, the storytelling capacity of a narrative is essential for, 'In narration, the intention is to present an event to the reader…to give the impression of movement in time, the sense of witnessing an action.' (Brooks and Warren 1972, p.45). Such movement in, or through, time is a key concept in my metaphor of metamorphosis, the natural process of internal change over time, which forms an over-arching frame for my presentation, and, it will be discovered, time is set to remain a central feature throughout the research itself and my subsequent concluding assertions.

My research, however, violates Brooks and Warren's (1972, p.228) definition of what the nature of narration is for, they state, a narrative's purpose is to present actions, and, by making interpretations which consider the causes of the actions to be of primary interest, then my writing's intention becomes primarily expository rather than true narrative. But, I believe, this literary distinction is vital, for it transforms a case of story-telling into a case study for research, and narrative analysis becomes the prime focus by which understanding of meaning may be achieved.

In order to guide readers on their journeys to understanding, along this continuum of time, I will explain three points, which may assist in clarifying my current intention and perspective:

2.1.4.1 Research Metamorphosis

My initial idea of metamorphosis as a metaphor for the research process was introduced throughout Chapter One, and described briefly in section 1.5.3 and Figure 2. This is not intended to be a theory nor a model of a scheme of work. Instead it is a concept that reflects rather than prescribes a pattern of thinking and re-evaluating according to the context of the research in progress. In its cyclical nature and its use of insightful interpretation it is analogous to the hermeneutic circle as described by Aigen (1995) and Ruud (2005). Hermeneutics originated in the science of the interpretation of scared texts and it retains an emphasis on knowledge acquisition with a focus on the insightful interpretation or understanding of hidden meanings. It begins with an evaluation of a chosen small part (of a text or phenomenon) and an examination of how this connects in the context of the whole. The composite whole is then examined to give deeper understanding of the meaning of its individual parts. Therefore, it is a temporal cyclical process of constant evaluation and re-evaluation of phenomena and the structures we develop in order to understand them.

Ruud (2005, p.37) describes a form of poetic hermeneutics which is concerned with the role of language in this structuring process – exploring how metaphors and narratives may be used to transfer meaning between phenomena. To me, this appears to be essentially concerned with human action and it has similarities with my philosophical approach based on a cycle of shaping holistic bodily responses to experiences in context. As regards the hermeneutic circle, I

share the opinion of Aigen (1995, p.292) of this circularity as being 'vital, transforming' but do not share the view of this (in the context of this research) as an 'analytic movement' (p.292) between phenomena and theories. My use of the cycle is more broadly conceptual, or illustrative, and it is applied to my generative structure of a research metamorphosis, as presented in Chapter One, section 1.5.3. It is an embodiment of my stance as a researcher at any given moment: the articulation of my current perspective, reflecting a changing focus on phenomena, literature, specific data, abstracted images or metaphors, or interpretation and evaluation. This is of vital significance in generating my progress through the research narrative and, as a concept, it will be contextualised further in Chapter Three, section 3.5.2 by comparison with existing literature on the use of metaphors in therapy. As an ongoing event I present its current state by signposting through chapter headings and occasional images as well as descriptive text.

2.1.4.2 Words and Images

My use of images seems to be at odds with the definition of qualitative research as given by Creswell (1994, pp.1-2), quoted earlier in section 2.1.2, in which the inquiry process is 'formed with words'. As a music therapist much of my understanding inevitably arises from music and the experience of creating music. To define it in words would be to move to a different level of abstraction (Aldridge and Aldridge 2002) (see this thesis, section 2.1.2) and in the translation much of its essence would be lost. The problem of talking about music therapy was presented by Ansdell (1996, p.4), who termed it the 'music

therapists' dilemma'. By implication it also becomes the music therapist researchers' dilemma. My solution is to present my thoughts and feelings at the lowest possible level of abstraction. The sensory and affective experience of music often conjures up pictures in my mind, as do people and actions. In effect, I sometimes think in a series of visual images which, for me, seem to be a form of shorthand, making words unnecessary.

Thinking in pictures rather than words was recognised by Ronald Davis (1997) in relation to people who develop dyslexia. He sees the ability to think multi-dimensionally as a perceptual talent, an intuitive and creative way of solving problems holistically. Davis suggests that people with such visual thinking skills are very aware of their environment and learn experientially, through interaction with their surroundings. If this opportunity is denied then confusion leads to disorientation but, once understanding on a deep level is accomplished, then individuals are able to act intuitively, without thinking about how they achieve this success. Schools using the Davis approach to teach language skills to children with dyslexia, such as using clay to form letters physically, recognise the need for orientation, making connections in context, and using such creative processes actively and positively:

> The ability to move one's point of perception from behind the eyes
> (or inside the head) to other locations in space for the purposes of
> creating mental images, making recognitions and resolving confusions.
> (Hearter Montessori 2003, p.18)

I use images, then, not just because they appear to me as the least abstracted form of thought but also to locate and illustrate my current point of perception, or point of view. Perhaps the women in music therapy sessions use them, too, to aid in their thought processes and resolve some of the dilemmas and confusions which they face. Additionally, Creswell's (1994, pp.1-2) definition of the qualitative paradigm also requires 'reporting detailed views of informants' yet many of my clients were unable to express their views verbally, hence their referral to music therapy as a means of communication and self-expression. If, as their music seems to suggest, they may be indirectly expressing themselves through images depicted in the words of songs, then its notation in pictorial form may capture some small sense of their intention or experience.

This is why images appear at points in this study. They are not simply decorative nor illustrations of important points but, in serious or humorous guise, they represent the least abstract form of direct personal experience during both therapy and research. There are many options available to depict these images and many possible paths of translation leading from them. I construct those which seem to be most relevant, based on my experiences with the women during the music therapy sessions, aiming to stay as close as possible to their voices or perspectives. These images form the focus for the more detailed analysis presented in Chapters Four and Five, but I recognise that this is only one interpretation of events and the latent significance of the songs, lyrics and images is offered for readers to also interpret and reconstruct according to their own epistemology.

2.1.4.3   Problems

Creswell's (1994, p.1-2) definition (see section 2.1.2) also speaks of qualitative research as a process aimed at 'understanding a social or human problem' and many research reports begin with 'The Problem Statement'. My problem is that I do not appear to have a problem. As described in Chapter One, my research grew out of personal and clinical interest in my work as a music therapist; there was no specific pre-determined problem that I needed to address. George Spindler (in Aigen 2000, p.22) refers to this as the 'problem problem'. I could have resolved this by formulating a statement concerning the lack of recognition in music therapy of the value of pre-composed songs, or of the women choosing songs rather than the creativity of musical improvisation. Both of these are important facets of this study, but defining them as a problem seems to imply a value judgement; that somehow the women should not have chosen songs, that they were not playing by the rules. To do this would be to remove the women from their central place in this research and to make them objects of study in the search for a theory. I wish the women to remain as unique human beings involved in musical interactions. As their therapist, the continual choice of songs was unusual and challenging and fascinating, but to call it problematic would be to deny them this invitation to participate in the 'shared musical experience' (see this thesis, section 1.1) that defines music therapy as a creative process. I respect their choices and listen to their concerns as voiced through songs. For this reason I choose not to accept a problem but to adopt a far more positive 'focus'.

This minor adaptation of research reporting remains true to the principles of emergent processes, meeting the individual needs of this study, and so the remaining sections of this chapter are a mixture of a variety of design formats, but owe greatest acknowledgement to Creswell (1998) and Bruscia (1995c).

2.2   Research Focus

2.2.1 Selecting the Focus

The central focus of this research is an exploration of the role of song in forensic music therapy, as revealed through a narrative of one woman's experiences. As a starting point for study this is deliberately broad. My intention is that, consistent with an emergent design, the focus will emanate from my involvement as both researcher and therapist in the process of music therapy itself. As part of an ever-changing process, I will focus on whichever aspects best reflect and clarify my understanding of the experiences concerned. Inevitably, as I lean towards the most self-meaningful aspects the focus itself may shift or be redefined throughout the study. This is not to deny the existence of other possibly influential data, but rather to view the focus as:

> …a motivational center which inspires and guides the researcher's inquiry, rather than an end goal which defines and delimits it.
> (Bruscia 1995c, p.402)

In this respect the outcome, or end product, of the research is left open and the interaction with the data, combined with a process of self-inquiry, becomes a vital part of the research narrative itself. The purpose of this section is to explain the process of self-inquiry that led to the selection of this focus; to define major terms used in the study; and to set out the main research questions.

The initial topic emerged from my practice as a music therapist and the issues which were raised when I began to work with women in forensic psychiatry (as narrated in Chapter One). The rationale for my choice was a combination of personal interest and availability of professional resources: to use my ongoing therapy practice would enable me to have active participation in a natural setting, providing direct experience of the processes involved. In this way the selection of women in forensic psychiatry, as a type of client within the discipline of music therapy, was pre-determined.

The focus on the role of song emerged naturally from the clinical work as I observed women repeatedly choosing songs rather than improvisation with instruments. However, the focus is not on the songs themselves but on their role within the therapy process, that is, on how the songs are used by the women. Therefore, songs become data sources, one of the materials from which inferences are made about the case.

In order to set clear boundaries for the research, and reduce the amount and complexity of available data, it is necessary to narrow the scope of the study

still further. The following section defines the delimitations of the study and addresses limitations or possible weaknesses in its design.

2.2.1.1 Delimitations and Limitations

This study is set within the specialised clinical field of **music therapy in forensic psychiatry**. Any findings may not be generalisable to other fields of psychiatry or mental health, nor to other non-psychiatric settings such as prisons, nor to the practice of music therapy as a whole. By researching ongoing therapy practice this study can not be classed as a clinically controlled trial with a random selection of subjects from which generalisations could be made. However, any deliberately assigned group of forensic clients within a health or prison service system, by their nature as patients, would already 'comprise a highly selected non-random group' (Aldridge 2000a, p.4) from which results could not be generalised to other trial groups.

This study focuses on **women** clients only, because of its emphasis on researcher as therapist in the 'natural' setting of forensic units for women. Therefore, any findings may not be generalisable to male clients in forensic settings. However, in my personal more limited experience of music therapy with men in both forensic psychiatry and general psychiatry I noticed that women and men seemed to approach music therapy differently in their choice and use of song, with men being more actively involved in instrumental improvisation in preference to the songs and quieter, more intermittent improvisations of the women. Whilst such observations are not a prime focus of

this research, the broader scope of women's issues may influence events and experiences for the female participants in this study and further consideration is given to this topic in Chapter Six.

Though the central focus of the narrative narrows to that of a single case study of **one woman**, there is no evidence to suggest that she may be a typical case characteristic of all women or all forensic cases. But, as a brief exploration of my initial group of ten women indicated that nine of the ten seemed to be using songs in some way metaphorically (see Chapter One, section 1.3 and Appendices A1 and A2), then it may be that 'this sample of one, weakly *represents* the larger group of interest' (Stake 1998, p.100). Yet, as a therapist, I am not interested in a generalised group norm but in what is important for my individual clients, in what is pertinent to their situations. The randomised trial thus 'appears to be theoretically relevant….but has all too often randomised away what should be specifically relevant for the clinician and patient' (Aldridge 2000a, p.12). To look for meaningful significance then, I choose strength and depth of data over greatness of number: a single case which, though not generalisable, may have some 'typicality' and which offers the best 'opportunity to learn' (Stake 1998, p.101). This is particularly important in music therapy research where immersion in a single case allows for 'a close analysis of the therapist-client interaction' and 'the assessment of individual development and significant incidents…in the relationship' (Aldridge 1994, p.333).

Focussing on multiple occurrences strengthens the depth of such 'idiographic' interpretation (Bruscia 1995d, pp.319-320): in this case the use of all songs by one woman over the entire course of her music therapy, using several sources of data (as detailed in the Procedure section 2.3).

By narrowing the focus to concentrate on **songs** it could be argued that other vital aspects of the case are overlooked, such as the use of instruments. Whilst this may be true it is also necessary in order to make the amount of recordable data more manageable in terms of both volume and time available, allowing a deeper focus on one area of interest. Other factors were considered during the natural course of therapy, and will be discussed in this study if it is felt that they impinge significantly on the process of song choice and use.

Similarly, the focus is restricted chiefly to **song lyrics** rather than the actual music or melodies involved. This could be viewed as an abstraction, separating words from the vital creative process of music-making inherent in the music therapy tradition. However, this focus arises from the women's original choices: it is they who chose to use and talk about songs. The music itself is the vehicle by which the words are made manifest, and its central role is not denied. I discuss the interaction between text and music as part of a co-constructive therapeutic process in Chapter Three and, in Chapter Four, musical analysis will be included if it appears significant in the sessions at the time of instigation of a song choice or if it is instrumental in using or altering song lyrics, that is, in the context of each song as part of an overall process.

A central concern in the separation of words from music, particularly in the written recording and presentation of words, is that they can not convey the same degree of feeling, intention and expression.

> With words we can lie, the expression gives the clue to how
>
> what is said is understood. It's not what you say, it's the
>
> way that you say it; and that's where the music
>
> comes in to communication. (Aldridge 2000b, pp.1-2)

Marginalisation of the music is clearly a weakness in a study in a discipline which cites communication through music as one of its most important facets. But it is also possible to see this as a strength in this study. The very women who inspired this research were those who declined to participate in active music-making yet still attended sessions. The women who seemed unable or unwilling to express their feelings and intentions, these were the ones who turned to songs. Perhaps it is that, by removing what we intuitively know and expect to be of importance then, in its absence, what is left will serve to indicate more crucially why it is missed. To be specific, focussing on words, and understanding how the women choose and use songs, may reveal more about their lack of instrumental involvement, and consequently the significance of music and musical processes, than would a study of their musical improvisation.

This focus now becomes not only a boundary or limit for the study but also a seminal agent in the formulation of the research questions that follow. Before these are stated some major terms used in this research will be clarified.

2.2.1.2 Definition of Terms

Song – For the purposes of this study, song is defined as any vocal music, having a combination of melody and words, excluding vocalisations and improvisations. It is generally, but not exclusively, pre-composed, that is, already in existence as a defined piece of work by another composer or lyricist. This may include such works as traditional songs, pop songs, folk songs, hymns, nursery rhymes and so on.

Choice of Song – This refers to the initiation of, or request for, a specific song by a client in therapy, or the use of a song by the therapist. In all cases the song is defined as an active choice only if it is significant in terms of its repetition on multiple occasions or in terms of the client's observed involvement in it by participation in singing; musical, verbal, or emotional expression; or through gesture or other active behavioural response. In this way, a song initially chosen by one woman in a group may also become the defined choice of another woman, according to her responses. Songs that are merely mentioned, or those played by the therapist or other group members without apparent response from the client, are excluded. Such points of contact are inferred necessarily by the therapist-researcher through personal experience, rather than through measurable data collection.

Songs may be sung either by client or therapist, or both. They may be sung unaccompanied or involve the use of instruments. In some instances the music alone is played and the words left unsung; at other times the song may be

discussed but neither sung nor played. Improvised songs (those created spontaneously during therapy sessions), or those pre-composed by the therapist for a specific purpose and introduced into a session, may become a relevant 'song' as defined only if they are deemed significant in terms of repetition or response as given above.

2.2.2 Research Context

The narrowing of the focus and the emphasis towards the interpretation of personal meaningful moments includes those deemed by the therapist to be significant for the client concerned. Yet I, as therapist, might only discover this significance much later in the therapy process than the moment when it is experienced. I need to consider the context in which these musical events, and the client's life experiences, occur. The ongoing therapy session is an immediate context and the use of this natural setting rather than an artificially designed experiment allows the researcher to relate directly to the participant and her surroundings so that essential features of the study can be experienced from an inside perspective.

Bruscia (1995e, p.71 and, in more detail, 1998) defines this approach to music therapy practice and research as 'ecological', recognising that an individual does not exist in isolation but in a physical environment and a social community. Promoting change through music therapy in either individual or context will facilitate changes in the other, through their wider interaction. 'The phenomenon and its context are inseparable and reciprocal in influence'

(Bruscia 1995e, p.71). If one considers such a potentially complicated inter-relationship in its natural holistic setting then there are myriad cycles of stimulus and response which structure developments. With, perhaps, no immediately clear cause and effect, the researcher may need to explore other contexts in order to understand what occurs in the music therapy session itself.

Bruscia (1995c, pp.404-405) describes various frameworks or perspectives in which a research study takes place:

1.   The researcher as a person, and personal motivations, factors and needs.

2.   The researcher's professional framework and interests.

Both 1. and 2. have been addressed through self-inquiry and will be incorporated throughout this study, as evident in the description of choices made in Chapter One, in the defining of the research framework and focus in Chapter Two sections 2.1 and 2.2.1, and in the later section 2.3.3 The Researcher.

3.   The interpersonal context of the researcher, including the relationships with authorities and staff where the study takes place. This will be discussed throughout the Procedure section 2.3.

4.   The disciplinary context or the relationship of the study to existing research, theory and practice. This was introduced in the discussion of Delimitations and Limitations in section 2.2.1.1 and will be explored more extensively in the literature reviews in Chapters Three and Six.

5. The environmental context. As stated above, this will be the naturalistic setting of the therapy sessions, and will be described throughout the narrative.

6. The participant's personal context. This will be outlined in the Ethical Review, section 2.3.4.

7. The socio-political context or the communication and impact of research findings on other groups or organisational systems. I will address any implications for music therapy, women, forensic institutions, or musicology in Chapter Six.

Many of these contexts will overlap and interrelate, with some being more predominate than others at various times and in differing situations. Aldridge (2002, p.1), in his presentation of criteria for systematically reviewing studies, states this as a worldview: 'I see evaluative criteria as local and context specific according to the politic of the relationships involved – an ecosystemic paradigm.' But the same evaluative criteria are needed as a therapist-researcher attempting to study the use of song within a client's ecosystem of relationships: the question remains of which other contexts may be exerting influences. In addressing theses, Aldridge (2002, pp.1-2) reduces his core questions to 'Does this research make sense to me?' and 'Do I find it legitimate?' As a participant-researcher in the therapy sessions the making sense is personal but often requires the examination of other contexts, and the legitimacy, as Aldridge states, can be based on 'social understanding' according to the group in which one finds oneself.

Therefore, in order to focus on song use in the context of a woman in a forensic music therapy session, songs must be located within the personal biography and social environment of the woman herself in order to isolate the meaning and reveal the experience for her (Denzin 2001, p.79). This can be done through the construction of a narrative, by thickly describing all occurrences of songs through personal stories that include social, emotional and historical detail. By fitting knowledge about songs, obtained through analysis of sessions, back into the social world of the individual the intention is to indicate how lived experiences structure the process of music therapy for that individual.

> The stuctures of any experience are altered and shaped as
>
> they are given meaning by the interacting individuals.
>
> Contextualization documents how this occurs.
>
> (Denzin 2001, p.80)

My aim in composing a research narrative is both to understand and to make explicit the shared meanings embodied in songs as they occurred within the cultural context of an interactive therapist-client relationship. Further discussion on narrative will be given in the literature review in Chapter Three. The remainder of this chapter, Chapter Two, will clarify the procedures by which data relating to songs in the context of forensic music therapy was collected and analysed.

2.3　Research Procedure

2.3.1　The Setting

The initial work with ten women, as described in Chapter One, was carried out in two medium-secure forensic psychiatric units in two counties in the East Midlands. Both were part of the same parent company, dedicated to providing care and treatment to women in single-sex units, with the aim of rehabilitation and eventual reintegration back into their local communities.

The women were all detained under sections of the Mental Health Act, with classifications of mental illness or psychopathic personality disorder or a dual diagnosis of both. Index offences included a range of violent incidents involving actual or threatened harm, and many instances of arson. Other women were detained under Civil Orders, without a criminal conviction, mainly being at risk due to self-harming behaviour such as cutting, burning, swallowing foreign objects, and strangulation. Most women had been admitted from high security psychiatric hospitals but others were referred directly from the local areas. In many cases long profiles of social problems or offending behaviours were compounded with personal histories of drug use or experiences of physical and sexual abuse.

The units were led by a Resident Medical Officer, and staffed by nursing and care teams, supported by psychiatrists, psychologists, psychotherapists, social workers, occupational therapists, and part-time art, music and drama therapists.

The work involved in the single case study at the centre of this research took place in the smallest unit. This is a large converted house, with six bedrooms, inconspicuous on the outskirts of a rural village. Set out still as a family home it has a lounge, dining room and kitchen, but no designated therapy room. Music therapy sessions take place at one end of the dining room, which doubles as a craft room, with comfortable chairs arranged in a small circle on a carpeted area away from the tables. It is informal, welcoming and accessible, but this has its drawbacks too. The room leads out to an enclosed garden and is the main thoroughfare for those who go outside to smoke, so interruptions are inevitable. Members of staff make every effort to avoid coming through at session times but residents are free to wander in and out as they wish.

As a visiting therapist I supply all my own instruments. There is no piano but I bring a keyboard, guitar, and a range of inviting and accessible percussion and ethnic instruments, including a selection of drums, cymbal, xylophones, wind-chimes, rainsticks, whistles, small hand-held percussion, chime bars and bells.

Music therapy is provided for two hours every week. With six residents I am unable to see everyone individually so the choice is to prioritise referrals or to run a group. Individual sessions would be difficult due to the lack of privacy so I opt for an open group session; that is, all residents have an invitation to attend but may choose not to if they wish. Once I have arrived and set up the instruments, I visit the office to talk to staff about any issues that have arisen of which I may need to be aware; then I personally visit all residents to encourage them to attend. The session is flexible, beginning when one or more are ready

and ending when we agree to finish. Such flexibility is essential as some women may be in the dining room as I arrive and will begin to play the instruments without me, whilst I fetch the others, and the ending is often determined by the routine of the next tea and cigarette time. This can be frustrating but I believe it is important to respect the choices of the women in what is their own 'home' and, nevertheless, sessions usually last between forty-five minutes and an hour and a quarter. One woman never attends but, out of the other five, I have a regular core of two, supplemented by any or all of the others, so sessions tend to have three or four members but could be only one or up to five.

My broad aims are that the women have an opportunity to express themselves through music, and verbally too, if they wish. Communication and social skills are also a priority as six diverse women living together in one house with restricted outside access need a means of working together as a group, or at the very least, a means of coping with each other and the tensions that arise. Social awareness and co-operation are on my agenda, but so too is the opportunity to raise concerns and express strong emotions without fear of reprisal or disapproval. For this reason I have banned staff from the sessions. This is the women's time and often they want to complain about how they are treated, or how they perceive they are treated, and as a visiting therapist I can be talked to as an 'outsider'. I have explained this to the staff and they are happy to comply, and so I work alone, but confident that, in the small unit, members of staff are within calling distance should I require assistance.

2.3.2 The Case

By the time I had decided to undertake a research study, that is, having developed my ideas as given in Chapter One, I had been running the therapy group, and individual sessions in the second unit, for almost one year, and already had collected a large amount of case material in the form of my usual session notes. As I felt that the natural subjective process of developing my original ideas was an important part of the research process itself, I wanted to use this material retrospectively rather than to repeat therapy sessions with another group of women for a specific analytic purpose. Because I needed to set boundaries for the research and had narrowed the focus to that of a single case study, I decided to choose one woman only and to describe her experiences throughout the entire course of her therapy. This would set a clear and natural boundary of a complete process over a substantial but not predetermined time.

From the ten women with whom I was working I chose 'Angela', one of the three examples from Chapter One (section 1.2.3) for both personal and pragmatic reasons. For the practical purpose of data accessibility Angela was more consistent in attendance than most of the other women. She was a resident in the smaller unit, attended the first open group session and was one of the few who continued to participate on a regular basis, whilst other women attended intermittently or had ceased attending for various reasons, particularly in the second unit where I saw individual clients.

However, more important was my intrinsic interest in Angela's case. Her initial use of song was not as obvious at the start as that of other women but this made it all the more intriguing. Her choices in songs, in music, in instruments, and in style of performance were all perseverative, rigid and repetitive, and her behaviour in the group very controlled, in spite of obvious personal and social difficulties in her immediate environment. Yet she was committed to music therapy and I wanted to know what meaning it had for her, and how our relationship was developing through the music. So Angela was chosen, not as a necessarily typical example, but as a deeply inspiring and interesting individual.

As described briefly in section 1.2.3, Angela is a young woman in her thirties with a diagnosis of mild learning disability and chronic schizophrenia, as well as various physical problems. She had been in a high security hospital for several years after early family difficulties and behavioural problems. Occasional violent outbursts persist but are more often directed inwards, noticeably in the destroying of her own clothes and belongings. Her main reasons for referral to music therapy were outlined on her referral form as being the need to:

- Express feelings that are too difficult to talk about.
- Identify blocks to emotional expression and growth.
- Increase self-esteem and confidence, and develop healthy coping skills.
- Be heard and accepted.

2.3.3 The Researcher

My role in this study is a multiple one. Not only am I the researcher but, as the music therapist, I am also a participant in the study. My personal and professional values and experiences affect the choices I will make, both in defining the path of the research, and in my interactions with Angela in the natural course of the therapy sessions. In our client-therapist relationship we are not independent but are interrelated and will impact on each other to determine the data. Therefore, it will be my thoroughness as a 'researcher-as-instrument' in the collection and analysis of data that ensures interesting findings rather than the reliance on a defined method to produce results (Aigen 1995, p.296).

The need to ensure the credibility of this research will be reviewed in section 2.4. In this section I will present my stance as a researcher in the belief that the recognition of my personal context, of my perspectives and preconceptions, will raise awareness of any potential for bias and reduce any influences they may have.

My perceptions about therapy are shaped by twenty years of broad experience with children and adults with learning disabilities, mental health problems, emotional and behavioural difficulties, communication disorders, and sensory or physical disabilities, both within music therapy specifically and in other work in schools, hospitals, day centres and the probation service. I bring with me to forensic therapy expectations and biases about the nature of psychiatric work, the constitution of offences, the concept of a victim, the effects of

institutionalisation, and the demands of a social system. Some of these were immediately highlighted and dismissed; for example, my expectation that women with a violent history would play loudly and aggressively in music therapy was soon quashed. Other views persisted, particularly that of institutions upholding undermining expectations of acceptable self-expression, insisting on verbal communication above all other forms in addressing problems, and restricting access to, and value of, some forms of therapy within a medical model of care.

Such considerations inevitably affect my practice as a therapist and so by implication they also affect this research. However, one of the benefits of having had experience in so many client fields rather than becoming a specialist in one main area, is that my approach is client-based and focuses flexibly on what actually happens in the session rather than on a prescribed form of treatment towards specific aims. The motivation for this research is on therapeutic interest in the case without any requirement for validation of music therapy as a clinical intervention. As a sessional, community-based therapist my job does not depend on the results of the study, nor does any organisation have a vested interest in any expected outcome. As such, I can operate as both an insider in the therapy and an outsider in the institution, and I am able to openly acknowledge my biases and work within them, whilst recognising that as part of my personal context, they may also influence the course of the research. But, as I am part of the research, this is an additional source or determinant of the data, rather than a factor which might distort any results.

My predisposition as a music therapist leans towards what I describe, in my own terms, as an organic-behaviourist approach. A behavioural approach to music therapy is rare in the United Kingdom and demographic data from a survey of the profession by Stewart (2000) showed that, of 124 respondents indicating an influencing model, only 8 or 6.45% claimed that Behavioural was one which informed their work, whereas the largest categories showed 88 or 71% indicated Mother-Infant Interaction, 75 or 60.5% were Psycho-analytically informed, and 53 or 42.7% had Humanistic influences. I suspect that this is partly a result of an apparent belief that behaviourism equates with behaviour modification and it is this procedural approach which is rejected rather than the more general principles behind the philosophy, which were presented in section 2.1.1. Techniques of modification imply that certain behaviours are in some way unacceptable or inappropriate and need to be altered, and this in turn may lead to a focus on the presenting symptoms of a diagnosis rather than the internal processes of an individual person. But this is not my main focus: as stated in section 2.1.4.3 I do not view the use of songs as a behaviour which needs to be changed but as an interesting and unusual phenomenon arising for unknown reasons within my usual improvisational approach.

My working practices are client-centred, responding creatively to what is presented in the sessions, and to an outside observer my approach during music therapy may even seem similar to those of a therapist more analytically or psycho-dynamically informed. It is the underlying philosophy which is behavioural - a belief system focused on human behaviour as a learnt response, based on internal physiological drives but constructed socially in direct

response to environmental factors. The fundamental differences become apparent more in the ways of thinking about, and interpreting, the music therapy practice. This is why I have added the prefix 'organic' to the classification of my behaviourist approach. It is not based on the specific work of any other therapists but instead is used to distance my approach somewhat from behaviour modification techniques but still remain firmly rooted in the broader philosophical and theoretical concepts of behaviourism.

Any emphasis in sessions is on observable behaviour considered within a holistic environment. This includes the interrelationship between client and therapist and the construction between us of a communicative process based on shared understandings, given meaning by our own knowledge and life experiences. Feelings and emotions are interpreted and understood as manifestations of stimulus-response systems given meaning by an individual's personal and social history and context. Clearly this will influence the type of data I may choose to record and analyse, and how I may interpret it. My approach to music therapy also emphasises music as the main communicative agent on which the relationship is constructed. This focuses my perspective on musical issues of aesthetics and epistemology, that is, on how music and song are perceived and how they affect or become the therapy process.

My own musical biography affects the research in a more obvious manner. With training in classical music and interest in diverse styles such as traditional, 'old-time', folk, country and ethnic music, I have a limited knowledge of modern pop, rock and other idioms. In the improvisatory nature of my sessions I can

play or support only what I know, or in a style of which I have some experience. Any specific request outside that knowledge has to be responded to by the 'you hum it, I'll play it' approach. Failing that, it must be left until I can find the music, by score or tape, and reproduce it. At times, then, there will be missed opportunities, where songs that I do not know will not be immediately accessible and the moment of impetus will have passed.

In addition to these underlying issues I can define the following personal beliefs and expectations that may bias the data collection and analysis:

- Song use is more pronounced in women in forensic music therapy than in other client fields. This assumption is based on personal experience and underlies and inspires this study, but it is not the remit of this research to attempt to prove or disprove this belief.

- Metaphors exist in song lyrics and some may be depicted in images. This assumption is a consequence of my personal method of constructing and relating knowledge. The interpretation of these is not supportive proof of their existence, nor that my views are the only interpretation possible. The provision of an in-depth descriptive narrative will ensure that readers are able to make their own interpretations of the data.

- Song choice and use will not be affected by the advent of the research but will remain as natural therapy occurrences. After deciding on the research focus I worked for a further two years with Angela. I was conscious of moments during these sessions when the introduction of a particular song would have supplied perfect illustrative data but made every effort to be

sensitive to the client and only use material that intuitively felt right therapeutically. For example, during a conversation with Angela about her compulsion to finish sessions at a set time to get her next cigarette it would have been easy to introduce a song containing references to clocks ticking. But this was not required for the purposes of therapy as Angela was already able to openly discuss this issue and we were making practical alterations to accommodate changes to the ending of sessions. A song may have provided further images to record, and the underlying issues (the security of routine and trust in other people) would have been illustrated by Angela's behaviour in the session, but the song would be unnecessary and not something I would have done in the normal course of a session. Therefore, I aimed to continue using only that material (song, improvised music or conversation) which I would have used in the absence of a research study. However, in the heightened impetus of an active music therapy situation one often does not have the luxury of time to make such conscious decisions and many responses rely on experience and intuition but I do acknowledge that there were some clear moments of struggle between being a therapist and being a researcher.

2.3.4 Ethical Review

A major consideration for any researcher is the question of ethical practice in relation to the participants in their particular research study. Here, the question is compounded by the fact that the research project in question arose directly out of my own ongoing clinical practice. As a therapist, one's professional duty

towards the well-being of the client is paramount, and when considering any client as a potential participant in a research project, the issues necessarily become complex, ramified and subtly balanced.

Arising out of my reflections on my own practice, and based on wide consultation with professional colleagues across different areas, I was able to explore the various requirements, constraints, and possibilities. This was done, firstly, in close discussion with my supervisor, in which we agreed that the best available advice (in both the therapy and research fields) and documentary support (in the form of pamphlets, regulatory statements, statements of best practice, and other relevant music therapy research studies) should be brought together to make the ethical dimension of the project as full and transparent as possible, and as sensitive as possible to the needs of the case. Secondly, I cast my net more widely, and across a broader range, in seeking further advice and information where necessary from a variety of specialist sources. In all these searches and deliberations, I sought to combine the specific needs of the case with the best available professional opinion and expertise.

In the UK music therapy is a profession that is state registered through the Health Professions Council (HPC), a regulatory body formed to protect the health and wellbeing of service users by setting standards for good practice for a variety of health professions. The HPC's 'Standards of Conduct, Performance and Ethics' were first published and promulgated in 2003, when the Register was formed, and have recently been revised (July 2008). This publication focuses on providing guidance to registrants, agreeing a number of broad

principles which inform and influence the 14 standards of expected behaviour. These standards apply to all aspects of practice and treatment, which implicitly includes research – although this is not specifically mentioned. Those standards directly relevant to the present study are:

> 1. 'You must act in the best interests of service users' (HPC 2008, p.8).

> 2. 'You must respect the confidentiality of service users' (p.8), which includes the obligation of using information only for the purpose for which it was initially provided.

> 9. 'You must get informed consent to give treatment' (p.12), a stipulation which includes making a record of an individual's decision.

The HPC stresses that there is more than one way in which these explicit standards can be met, and, rather than dictating rigid procedures and protocols, it states: 'As an autonomous and accountable professional, you need [in all cases] to make informed and reasonable decisions about your practice' (HPC 2008, p.5). In order to help individual therapists to make such decisions, advice and guidance may be sought from employers, colleagues and professional bodies. The central importance given here to the notion of personal and professional accountability, based on information sought from a variety of sources, is particularly important in this study, not least because when these standards were first promulgated, in 2003, I had already been actively working on my research project for three years.

At that time, as a member of the Association of Professional Music Therapists (APMT), the professional body in the UK which also provides advice and

guidance specifically for music therapists, I turned to the APMT Code of Ethics for information. In 2008, this Code remains broadly similar to that given in earlier years. Like the HPC, it makes no specific mention of research ethics, but it does focus very clearly on the need to act 'in the best interests of the client' (p.1), a stipulation which includes the following recommendation:

> (i) b) Before using any verbal, written or recorded information acquired within the therapeutic relationship, for the purposes of publication, public presentation or broadcasting, the nature of the use of such material should be explained to the client (and/or guardian), and his/her permission obtained. The use of case material for articles in professional journals would not fall under this clause. In all cases anonymity should be respected. (APMT 2008, p.1)

Thus the decisions I faced in setting up and conducting my own study all centre around (i) the problem of applying such ethical codes to research, as well as to ongoing therapeutic practice; (ii) in determining what exactly are the best interests of my clients; and (iii), from the APMT quotation given above, deciding what constitutes a guardian – a decision which relates directly to the question of who could and should give permission for research data, arising out of ongoing clinical practice, to be recorded, analysed, discussed and disseminated in appropriate professional fora.

The concept of a guardian also appears in the UK Department of Health's 'Research Governance Framework for Health and Social Care' (2005), the first

edition of which was issued in March 2001. This provides a framework of legislation, together with standards and criteria of good practice, in five domains of professional provision, including research ethics, where protecting participants' dignity, rights and safety is the prime consideration. In particular, the ethics section 2.2.3 (DH 2005, p.7) emphasizes the importance of informed consent before participation in a research study, and the arrangements which need to be in place when seeking consent from vulnerable adults, such as those with mental health problems or learning difficulties. (These might include, for example, the provision of information in an appropriate, perhaps pictorial, form.) It also mentions the special safeguards in place for people who are unable to give consent on their own behalf. The available safeguards include that of consultation with a relative or carer, who is able to give an independent view of their interests on the basis of proximity and close observation – and also, in a sense, from a position of responsibility.

The Department of Health material does not explicitly cover the case of a guardian, as someone charged with the welfare of those placed under their care. But it seems clear that, so far as authority in the matter of the giving of permission and consent is concerned, the sphere of intimate knowledge of a patient's welfare and character and way of thinking (the carer) will inevitably overlap with that of moral and psychological responsibility for their best interests (the guardian). Such a recognition is important in order to ensure that the patient's welfare and best interests may be effectively and appropriately safeguarded.

Complications may naturally arise when considering the extent to which an individual has the capacity to make informed decisions. Dileo (2005) provides a comprehensive investigation of the issues which this entails. They include discussion of the potential for cognitive, physical or emotional impairments to compromise an individual's capacity to comprehend the complete information disclosed to them – information which should include not only a description of the research procedures themselves, but also details of any potential risks which could be associated with them, and assurances of confidentiality and anonymity in all future dissemination, in whatever fashion the results might be used afterwards.

Two examples of different approaches to music therapy research which both address issues where there are complications with the question of informed consent are those of Elefant (2002) and Warner (2007). Elefant's study of the use of songs with girls with Rett syndrome who have communication impairments (as detailed earlier in section 2.1.1) includes parental consent forms, though this would anyway be standard practice with children under the age of eighteen. Warner (2007), in a summary of her research into group music therapy in a community home for adults with severe learning difficulties and challenging behaviours, mentions the use of photographs and video to work towards informed consent for those unable to use words.

The Department of Health has procedures in place to ensure that appropriate standards are met and the rights of participants respected. This requires that all research involving National Health Service patients is submitted to a research

ethics committee prior to commencement. For researchers working outside the NHS, such as the independent units where I was working, there are generally institutional review boards or associated academic committees who maintain standards of integrity in the conduct of research.

The University of Nottingham's current 'Code of Research Conduct' (2008) sets out the standards of work performance and ethical conduct required for all research associated with the University. Regarding the issue of informed consent, section 4.1 'Personal Data' (p.3) states that researchers must normally have each participant's explicit informed written consent to obtain, hold and use personal information 'unless there are ethically and legally justified reasons for doing otherwise'. Its Appendix B 'Research Ethics Review Checklist' (pp. 9-11) refers to 'participants who are particularly vulnerable or unable to give informed consent'. Both these statements of necessity require the exercise of closely considered, informed judgement, with special sensitivity being given to the needs and circumstances of the particular project in hand. They clearly also require additional guidance and advice, insofar as their interpretation and application to individual cases in research studies conducted outside the NHS, are concerned. The University procedures for research governance and for the consideration of ethical issues have been reviewed at various points since 2000, when my research began. The earlier 'Code of Research Conduct' (2000; all quotations are taken from the University of Nottingham *Research Students and Supervisors: A Guide 2000-2001*, pp. 92-5) refers to ethical issues in a more general fashion, for example in relation to the use of data and personal information, to confidentiality, and to such additional requirements as may be

specifically relevant in particular areas ('special standards of work performance and ethical conduct [which may be necessary] in relation to particular categories of research'), this general category of additional requirements being assumed to include any relevant 'professional considerations [that may need] to be taken into account' (ibid.).

Accordingly, as my initial research progressed and my ideas began to be formed, I turned to professional colleagues within the working environment itself for guidance, seeking advice in particular on how to address the complicated issues of consent, and the retrospective use of data which I had collected from the early music therapy sessions during the course of my regular clinical practice.

Fundamental questions relating to ethical practice include: the idea of benefit to the participants (or at the very least of doing them no harm); the honesty and integrity of the researcher; the freedom and autonomy of the participants; and their right to privacy (Maranto 1995, p.81). Ideally, participants should be fully aware of the nature, process and risks of any research before giving their consent to becoming a participant in such a project. When reviewing the situation with respect to Angela's music therapy, and that of the other women who were then my clients, and envisaging the possibility of using the experience of these sessions as the basis for a substantial case study within a specific research framework, a number of questions arose.

Firstly, as a person with chronic schizophrenia coupled with a learning disability, Angela has only a limited capacity to grasp and comprehend detailed information, in terms of understanding and consistency of response. It was clear to all concerned with her welfare, not just myself as therapist, that her understanding might feasibly be assisted by simplified explanations, and just possibly by other forms of presentation (visual, for example); but that fully informed consent would be extremely difficult to achieve with any degree of confidence.

This is compounded by a clear recognition of the likelihood that such knowledge could cause her psychological stress, increasing some symptoms of her schizophrenia, most especially her paranoia, if she felt in some way that she had become an object of study. There are occasions as a therapist when it is very clearly in the best interests of the client to withhold information until a point in the therapy where disclosure can be approached safely. I had vivid personal experience of this during the same period with another client, Brenda (see section 1.2.2). When a case report that I had written, which I had thought was confidential, discussing her monopolisation of the keyboard, was given to her to read *before* we had addressed this issue in the sessions, Brenda was wholly unable to cope with my description of her behaviour, and this had a devastating impact on future sessions for a period of some months.

Secondly, although in the absolute I obviously wanted to be completely open and straightforward with Angela, I was convinced that what would inevitably amount to complex and involved explanations of the research dimension might

make a negative impact not just on her personal well-being and her sense of security and stability, but also on the course of her therapy itself (which naturally remained my overriding concern). Since the specific research ideas emerged only during the course of the reflective process of analysis of the sessions and the direction my work was taking, as I sought to evaluate the trajectory of my clinical practice, some of the relevant material inevitably predated the initial design of the project, and was thus partly retrospective. We were now a year or so into our therapy sessions, and had built up a very good therapeutic relationship. To have introduced the new technical idea of a research project at this stage would, I felt sure, hinder rather than help her progress along this path of therapy. Similarly, it is not my usual practice as a therapist to verbally interpret and reflect back to clients, as my emphasis is always on musical communication. And so, to take research results back to a client specifically in order to validate or otherwise gain a response to any interpretation and analysis would constitute a further disruption to this normal therapeutic approach. The disturbance to the process itself, and the confusing change of perspective this far into therapy, could very easily have affected our work in unforeseeable, perhaps negative, ways that I judged were best avoided. To stay within the realm of a naturalistic paradigm, and to allow the therapy to take its course unhindered, I wished the setting of the case to remain as uninfluenced as possible by any specific intervention, or indeed by any external considerations of an academic or overtly investigative kind.

A further factor to be considered in envisaging the possibility of seeking informed consent was that I felt very strongly, on balance and after serious

thought, that it would be impossible to be confident of gaining a true and consistent response. Angela had a marked tendency towards vulnerability and, at times, an extreme willingness to please, such that an urgent part of my task in setting therapeutic aims for her was that she should be helped to develop her self-esteem and her psychological autonomy in the direction of being able to take her own decisions confidently. At this point in time she could be easily coerced indirectly into a state of insecurity, and thus be induced to change her mind in order to be seen as co-operative. I had previously experienced this with Angela when trying to ask her permission to tape-record sessions. My intuition told me she objected or at least resisted, yet verbally she agreed. But when I reworded the question to make sure she understood she then refused only to agree again when other group members did so later in the session. Having built a strong client-therapist relationship with her over the course of the previous year, I was uncertain that she would make a clear and consistent decision, however carefully it was worded: there was a strong possibility that she would either consent just to please me, or else out of perceived fear that music therapy would cease entirely if she declined; or it might be that she would instinctively refuse without fully understanding why. In other words, even where she did appear to understand the situation, her response was not clear and consistent.

In order to avoid such potential confusion and the likelihood of distress and consequent disruption for Angela, I decided to approach the unit's Medical Director, for permission on her behalf, and that of the other women too. The Medical Director recognised my position, including the importance of my past work to the overall scheme, and was happy to give permission and to confirm

the way I had chosen to conduct the whole project, with the research going in tandem with the therapy and the past work forming an integral part of the project. Her formal assent was given in writing, a copy of which is provided in Appendix B1, with the exact address removed to ensure confidentiality. I also wrote to the Medical and Research Director of the parent company, who was also involved with its Ethics Committee, enclosing a research protocol and asking directly if formal Ethics Committee approval should be sought. He replied that this was not necessary as the work was already underway, and assent had already been given. A copy of his response is given in Appendix B2.

On this basis, I was able to proceed with appropriate assent from two authoritative sources in a position of knowledge and responsibility. The research dimension was able to develop without causing any disruption to the benefit and sense of growing security (and the ability to discuss openly) that Angela was increasingly able to enjoy from the ongoing progress of her music therapy.

As both written responses had stressed the importance of the need for anonymity, I ensured this by:

- changing the names of all women involved.
- not directly naming the units involved, nor stating their addresses.
- broadening biographical and personal details such as age, precise diagnoses, family background and offences.

- omitting specific identifiable features even though they might be extremely pertinent to the case study, for example, one main theme concerning metaphors within names has been excluded from this narrative.

Thus, full anonymity and confidentiality were built into the project, and any material that might compromise this was on principle excluded, however helpful it might have been in enlarging the scope of the research and in strengthening its interpretative arguments. At no stage did I offer Angela, nor indeed any of my other women clients, ambiguous or misleading information. I was always clear and straightforward in response to any questions that she/they asked, giving as much information as I felt they needed and could cope with, without causing confusion or distress. Angela knew that I wrote notes after sessions, since I often did this in the dining room with her present. She would ask if I wrote about her and what I was writing. I replied that I was writing down what we had done in the group, what music we had played, what instruments we had used, what songs we had sung and what we had said about them, so that I could remember them and think about them again later on. She also knew, as did all the women, that I had access to the case files kept in the office, and that I would discuss her case with other appropriate staff, including any disclosures she might make of which I felt staff should be informed. Angela was familiar with this position and understood it fully; and she was happy to use me as a mediator between herself and staff, often saying such things as: 'I've done well, haven't I? Tell [*name of staff member*] I played that' – even though she was perfectly well able to tell them herself, if she chose to. Her freedom to choose attendance at the open group was made absolutely clear to her, but in

fact she was very rarely absent, though at times she voluntarily chose to withdraw at the end of sessions, with the 'time for a cigarette' becoming a regular clock-watching issue.

I respected Angela's privacy and autonomy as an individual by accessing her case files only when issues arose during therapy that I needed to clarify by searching her previous life history. I used only what I would have done as a music therapist, and made no further study of details or incidents purely for research purposes. I also respected what I felt to be her clear decision not to be tape-recorded, despite her inconsistent answers to the initial question (see above). (In the event only two tapes were made of the group in three years of sessions.) Detailed information on all procedures for collection and storage of data over the course of research is given in section 2.3.5.

All these decisions lead to the further fundamental question: Is Angela a participant in the research, or a subject in the study? The initial answer might seem to be that she is both. But it will be clear from everything that has gone before, and from all that has been said, that I am sure she is very much a participant, first and foremost. The seeming anomaly comes precisely from the fact that the research project arose directly out of a clinical situation, from my own ongoing practice as a therapist. My understanding of the situation as a whole was essentially this: that Angela, and indeed each of the other women who from the outset formed part of the group, collaborates with informed consent in the sense that she is familiar with the nature of the therapy on offer; that she knows what participation in the sessions entails; that she is free to

attend, or not, as she feels and decides each week; and that she is always free to leave whenever she chooses. She also knows, as they all do, that case notes and files are kept; that the therapy is evolutionary and cumulative; that there is a process over time, not just of therapeutic effect, but of reflective insight and, hopefully, increased awareness and understanding on all sides.

Such a list of ways in which participation is freely entered into, voluntary and self-aware, does not, of course, include the specific technical question of the elaboration and presentation of research findings in a formal sense - which is to say in the form of a written research project, with the attendant possibility of wider dissemination. But it does effectively blur the perhaps too-clear distinction between (active) 'participant' and (passive) 'subject'. Her double perspective, as both client and dialogue partner, is matched by my own, as both therapist and researcher, reporting on the therapy and on our process of dialogue. Moreover, the idea of Angela's free and willing participation in the therapy, with its inbuilt dimension of cumulative progress through the material and interpretation-through-discussion of the songs themselves, is in every sense crucial to the project as a whole. Nevertheless, it is clear that a certain tension remains between the two terms and their possible implications. My solution to this dilemma, throughout the thesis, has therefore been to try to avoid the use of either term ('subject' or 'participant'), but instead to lay the emphasis more straightforwardly on 'clients' or 'women'.

Yet one point remains that is, to me, (and surely would be to any therapist finding themselves in a similar situation) germane above all: namely, that it is

Angela's full and willing participation *in the music* that is fundamental to the research. It is she who is 'in' the music, as much as if not considerably more than I. Hence, the therapeutic evolution which the music describes (especially the song material which structures and enacts the whole process) stems directly from her willing collaboration and involvement. If she had not wished it, it would never have happened. Certainly, the path of song would never have been opened up, let alone traversed in the way it was. Consequently, it is her voice that I use as much as possible in presenting the data, precisely so as to give her perspective on the experience. What is (inevitably) missing is any direct formal response, on her part, to my interpretations and analysis of the data. Yet, to the extent that the data emerged and was interpreted constantly and repeatedly during the therapy process itself, in the natural course of the actions and responses involved in our relationship, then, in some way, we had indeed achieved a full reciprocity of interpretation and a kind of verification of understanding. For this reason, finally, I am confident in my belief that Angela is a true participant, in the full and equal sense of that term.

2.3.5 Data Collection and Storage

The raw data for this study is based on session notes written immediately after each group music therapy session by the therapist-researcher. In normal clinical practice it is required for a music therapist to write such notes but individuals may differ in precisely what and how this is done. My session notes are handwritten and begin with basic recording of the date, the session number, its duration, and the members of the group who are present. After the first session

initials only, for reasons of confidentiality, subsequently denote any names. The notes then consist of basic material detailing what actually happened during the session. This could include what instruments were used, how they were held and played, what music was used and how it was introduced, where people sat, who made choices and decisions, how people interacted with each other, and any relevant actions or events. Reconstructions of dialogue are also included when appropriate. Although observational and intended to be an accurate recording of what took place, these notes rely on the therapist's recollection and, as such, will be influenced by, and limited to, those things she deems to be most significant or interesting.

Into this account I add other data from multiple sources that I believe relate to the events in the sessions or illuminate the actions of individual clients in some way. This could include information gained from reading a client's referral form, case file or archive material; reports from other professionals involved in their care and treatment; observed incidents outside of the music therapy session itself; and formal or informal conversations with staff or the client herself. The source of this data is acknowledged within the session notes.

Another important addition to these descriptions is the therapist's reflective notes. I add in to my session notes a parallel journal of my thoughts, feelings, insights, questions and speculations. These are enclosed in brackets to distinguish them from actual recorded events. These session notes are stored in a locked file to which only I, as therapist, have access.

For research purposes a photocopy was made of this original chronological account, deleting names and other identifiable data. All mention of songs was highlighted and coded in the margin by title, or a summary word from the title, and significant developments (in therapy terms) or unusual events were marked by an asterisk. The result is a detailed narrative account of 136 group sessions chronicling the entire course of Angela's music therapy from start to finish over a time span of approximately three years. This data remains confidential and is stored in a locked file to which only I, as researcher, have access. An example of part of this account is given in Appendix C. This has been typed for clarity.

2.3.6 Data Analysis

The chronological narrative account of Angela's music therapy sessions forms the core of data to be presented and analysed in Chapters Four and Five. As consistent with an emergent design, the exact procedure for analysis will be determined from the data that arise, with no specific outcome expected at the beginning of the research.

My intention in broad terms is to search the narrative account for occurrences of songs and experiences or events, using the marginalized coding from the session notes, to produce a time-line for further analysis. This will be submitted to a cyclical process of segmenting, sorting, coding, and reassembling, or decontextualizing and recontextualizing (Tesch 1990, pp.115-123), loosely following the guidelines provided by Aldridge and Aldridge's (2002) form of

therapeutic narrative analysis. This will be implemented in two stages, applying to differing levels of context.

In the first stage, in Chapter Four, the time-line of songs will be decontextualized, abstracted from the account as a pattern of episodes, phases or narrative phrases. The words from these songs will be analysed for constructs, that is, subjective perceptions that give a sense-impression of the focus of each song. These will consist of direct quotes, interpretive metaphors or abstracted images. Where possible these will be verbally categorised as bi-polar constructs, identifying aspects or qualities inherent in the songs. For example, in section 1.2.3 of this thesis Angela's choice of *Edelweiss* leads to a metaphoric image of the 'Nun', which in turn could produce the construct 'goodness-badness'. The aim of this categorisation is to clarify the researcher's perspective, making the data presentable and open to interpretation.

Aldridge and Aldridge (2002, p.10) use computational analysis to present their constructs in the form of a principal components analysis, showing a spatial conceptual structure of the data, and a focus analysis, showing an hierarchical conceptual structure. Both of these serve to present the data for further interpretation. As my focus is on the narrative of a course of music therapy over three years I intend to present data in terms of its temporal process. By this I mean that, instead of plotting principal components or hierarchies, I will graphically display constructs in linear form, as they are used both chronologically, over the course of sessions, and biographically, as they appear

to relate to Angela's life experience, in order to explicate processional understandings.

Metaphoric constructs thus provide a framework for recontextualizing, analysing the song episodes according to the content of the sessions in the context of the individual's experience. Such reconstruction of a completed narrative synthesises gained understandings and interpretations in order to link meanings together and inform the research process. It may be that, from the interpretations that emerge, it will be possible to identify categories or themes, clusters of personal meaning or issues of contextual importance, which can then be subject to further meta-analysis.

The second stage, in Chapter Five, will decontextualize again, abstracting the constructs gleaned in Chapter Four, searching for further patterns, and regrouping into themed categories. These will be recontextualized, using insight into Angela's personal experience for interpretation, to provide the basis for debate on the wider cultural domain of relevant theoretical practice.

It is possible that personal issues for Angela may emerge that relate to broader contexts such as forensic psychiatry, the culture of institutions, the role of women, and music therapy and musicology in general. Any such themes extracted in Chapter Five will be addressed and compared with existing research and current theories in Chapter Six.

2.4 Significance and Verification

In order for a case study to qualify as research…..[it] must

include additional levels of analysis, measurement, or study.

(Wheeler 1999, p.5)

The rigour of any additional design and of the process by which it is

implemented are vital not only for defining a case study as research, but also for

ensuring that the research has significance or value both in itself and in a wider

context – hence, that it is valid and trustworthy.

Validity is a general term used in scientific research to establish the

truthfulness of a piece of work…..correct in its conclusions or

correct in the way in which those conclusions are reached.

(Aldridge and Aldridge 1996, p.225)

In traditional scientific research, verification is established in terms of the

validity and reliability of its procedures but, as Aldridge and Aldridge go on to

point out, truthfulness relates not only to the research itself but also to the

researcher, especially in qualitative work with its subjective emphasis on

experience and interpretation.

Lincoln and Guba (1985) propose that naturalistic qualitative research can be

verified more relevantly through establishing the criteria of trustworthiness.

They replace internal and external validity, reliability, and objectivity, with the

concepts of credibility, transferability, dependability and confirmability as the means of establishing trustworthiness (p.300). In this section I will show how my research meets these four quality standards throughout the process of data collection, analysis and report writing. This will serve to verify and hence confirm the believability and accuracy of the present study.

Credibility refers to the accuracy of information both in terms of what data is collected and in how it is interpreted by the researcher. In the first place, the length and sustained nature of the study will confirm the accuracy of my data. Prolonged engagement of three years in the setting and with participants ensures immersion in the culture of the institution and the development of trust in relationships between myself and the staff on site, and in the therapist-client relationship between Angela and myself. Consistent recording of all music therapy sessions over three years minimises the risks of obtaining misinformation or studying out-of-the-ordinary events. This also assists in establishing the dependability of my data through consistency of both time and depth. It shows the results which may be obtained through a sustained process of observation, focussing with maximum intensity of interrogation and insight on one individual case – and thereby appropriately reducing the distance between researcher and participant.

Credibility and dependability of interpretation and results are perhaps more difficult to verify. This is usually done through a process of consultation and feedback from participants, checking whether the researcher's view matches the reality of the individual's experience. As discussed in the Ethical Review,

section 2.3.4, this did not happen with Angela, though I believe that my process of acting on my interpretations musically in the ongoing dialogue of the therapeutic relationship has contributed towards corroborating the truth of the data and of my interpretations of it.

Though the method of triangulation, or of the convergence of interpretations and findings, is difficult to demonstrate with Angela herself, it can be achieved through other means. Data collection is strengthened by the use of multiple sources - as I did by using referral forms, case notes, session notes and other observations (section 2.3.5). My early interpretations were triangulated, albeit informally, through checking by peer reviewers, the team at Nottingham MusicSpace who participated in matching the ten songs with the ten case histories (Chapter One, section 1.3). I have also used peer debriefing as a means of establishing my confirmability. Clinical data issues have been discussed with other members of the staff team within the forensic unit, notably the art therapist and an occupational co-ordinator, to gain a further inside perspective and ensure bias-free data as far as possible. Independent professionals, including a psycholinguist and a mental health specialist working in the field of dementia, reviewed research issues in general and those concerning metaphor in particular.

Such collaboration and consultation are important means of ensuring confirmability, but so too is self-inquiry (Bruscia 1995c, p.403). This, as I have already suggested, has been a continual process throughout this study, from the early reflective therapist's journal interwoven into the session notes, to the

explicit stating of personal assumptions, perspectives and biases (section 2.3.3), and the detailed narrative form of presentation of the research in which I aim to make clear my own processes of construction and understanding. This also increases the transferability of the study, giving future researchers an increased chance of undertaking similar research, even though my client Angela is, of course, a unique individual and, in that sense, a specific and unrepeatable case. The provision of a rich, thick description of the case and the research process gives a useful and reliable framework for comparison, whilst the narrative gives a holistic picture, allowing the reader to vicariously experience the world of music therapy from Angela's perspective.

The intention of this research, initially, is to establish its value on a self-informative basis, that is, to gain insight into my own work as a music therapist and to improve my clinical practice. It may be that it will have a more extended, perhaps even a more universal significance, informing the practice of other music therapists by increasing their awareness and understanding of the role of song and any potential benefits of song usage in appropriate therapeutic contexts. The eventual findings may also lead to assertions of a wider nature, perhaps providing pointers for potential extensions of such study and the opening of new pathways for future research in fields as diverse as music therapy, forensic psychiatry, women's issues, sociology and musicology. Such potential significance and applicability will be reviewed at the end of this thesis, in Chapter Six.

Chapter Three: Caterpillar
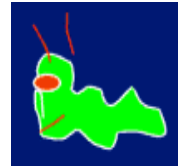
The purpose of this chapter is to contextualize the present study and its approach, and to position it within the wider field of music therapy as a combined discipline, (see Chapter 1, section 1.5.3), thereby demonstrating its relationship to existing research, theory and practice across a broad range. In doing so, the intellectual and research perspective is held in balance with the clinical and practical; in addition, relevant perspectives from such areas as psychology, psychiatry, social and cultural anthropology, linguistics, and also art therapy and the use of metaphoric imagery, are brought in to complement and shed further light on the central body of work presented in this research study.

This chapter is divided into five sections, each addressing different but progressively inter-related aspects which all connect to the research focus, methodology and presentation. The first section gives an overview of that part of the existing music therapy literature which relates to the use of songs in various clinical areas. The second section introduces ideas about the processing and interpretation of language in psychiatry, and goes on to relate this to the processing of emotion in music. The following two sections address the use of narrative within research and therapy, as both a model of enquiry and an active process, and introduce the broader concept of life-long musical soundtracks. The final section considers images and archetypes in therapy and music, and emphasises the central role of metaphor as a generative process.

3.1 Songs in Music Therapy

3.1.1 Songs in Forensic Psychiatry and Mental Health

Music therapy in forensic psychiatry is a small but significantly expanding specialization within the wider field of mental health provision. Statistics published by the Association of Professional Music Therapists' Survey of Membership 2000 (quoted in Bunt and Hoskyns 2002, pp.13-14) showed that, of 490 practising members, 157 worked with people with mental health problems. This makes it the second largest client category after that of learning disability; yet, of those working with adults, only 25 worked in forensic psychiatry. This ratio is currently changing, since recent years have seen general psychiatric hospitals close, consequently discharging patients to community provision, while forensic units have proliferated for those remaining patients who require secure facilities (Sloboda and Bolton 2002, p.134). It is therefore not surprising that, as yet, there has been relatively little literature published on forensic music therapy, compared to that in general psychiatry, and even less that specifically addresses the use or role of song in this field.

A monograph of collected articles and papers published by the British Society for Music Therapy (1994) provides examples of early literature, (from 1960 onwards), relating to the use of music therapy within general psychiatry. These articles are often descriptive, detailing in practical terms how music is presented and used within the ward or hospital environment. And much of this work has an emphasis on learning and performance that might be considered rather unusual within an improvisational approach to music therapy in the UK today,

but it does nevertheless recognise the importance of emotional responses and self-expression as part of the therapeutic nature and function of music. Songs were seen as extremely valuable, not only in themselves for personal enjoyment and relaxation, or for participation and socialisation, but also as a springboard, leading to discussion, movement or improvisation. Music therapy often consisted, in part, of listening to records, perhaps accompanying them with percussion instruments, or participating in songs led by a therapist at the piano. These songs were pre-composed, well-known traditional or folksongs, hymns, carols, and light operatic or musical medleys.

As early as the 1960s, Lovett (1969) described the difficult atmosphere of closed wards for women patients in a psychiatric hospital, and the use of show songs round the piano to give a feeling of participation and self-respect, as well as encouraging movement. She noted that hymns were popular, something I too noticed with several of my clients in the forensic units. Similarly, Gruhn (1961) reports that singing sessions seemed to be the ones most enjoyable and conducive to group integration in her work with chronic patients who were institutionalised and regressed. She refers to operatic and musical medleys, traditional songs, carols and marches, and light classics. Although singing was used to stimulate movement or discussion, Gruhn also discusses the benefits of the actual act of singing itself, as a physical and emotional form of expression and a mood-changing experience.

Similar sessions of 'Therapeutic Sing-Songs' are described by Fenwick (1970) in the geriatric wards of a psychiatric hospital, where 20-30 patients take part in

a 'programme' of mainly old-time songs and march music, accompanied by percussion instruments. Yet Fenwick recognises the importance of particular songs for individuals, noting that 'patients' memories are re-awakened' (p.21) and that with 'a general increase in awareness and responsiveness…sometimes the process of regression appears to be reversible…In an interesting case recently, the deliberate introduction of a man's favourite song dispelled his paranoid delusions which had lasted for four weeks' (p.22).

In the USA, an early research study by Goward (1974) introduced a programme of singing, rhythm band, and listening to records for regressed psychotic patients on a tuberculosis psychiatric ward. Although patients were selected for inclusion and introduced to a fairly prescribed schedule with an emphasis on rehearsal and performance, results indicated increased social awareness and feelings of well-being, with active participation in singing and rhythm being of greater interest than passive music activities.

Although these early works stress the importance of participation in singing, the use of large groups necessitated a structured approach that lacked the flexibility to respond totally to individual needs or instigation. In later years there was a shift towards smaller group or individual sessions and therapists were able to facilitate rather than direct. In consequence, musical activities became less occupational and more overtly expressive and therapeutic, and exploratory instrumental and vocal improvisation became more prominent as the basis for music therapy interventions. Such changes are graphically presented in a report by Wardle (1986).

A new emphasis on communication through improvisation is clearly reflected in more recent compilations of music therapy literature. In the sections relating to clinical practice and research with adults in 'Music Therapy in Health and Education' (Heal and Wigram, eds. 1993) there are passing mentions of song usage, such as greeting songs or vocal improvisation within sessions. Only a chapter by Erdonmez (1993) is more specific, outlining examples of familiar songs accurately sung by patients with Alzheimer's disease, thus addressing issues of memory recall and confusion, and the use of singing as an avenue of self-expression for patients who have lost their powers of expressive speech through left hemisphere cerebro-vascular accidents. Erdonmez writes from the perspective of Australian music therapy which has a far more substantial tradition of songs and songwriting than the British tradition. (Further examples of this approach are given later, in section 3.1.3, with the work of O'Callaghan, 1994 and 1996.)

In a further compilation, 'Clinical Applications of Music Therapy in Psychiatry' (Wigram and De Backer, eds. 1999), the story is fairly similar, in that song is often presented as an adjunct to other methods, notably musical improvisation. Odell-Miller (1999) mentions vocalising and song improvisations around the theme of endings, within her working model of practical music-making using improvisation as the focus. In contrast, Hanser (1999) uses receptive listening to pre-composed, recorded songs and instrumental music, paired with relaxation techniques, to assist individuals in coping with the pain of childbirth and the anxieties of old age. Similarly, Gaertner (1999) uses live and recorded songs

and instrumental music to make contact with patients with Alzheimer's Disease, prompting memories and releasing emotions.

Stige (1999) mentions song writing and performance in a list of other approaches supporting his main method of instrumental improvisation, but he also presents the case of Harold, a client with a personality disorder attending a psychiatric clinic, who introduced into sessions his own song book of traditional and popular songs. Stige focuses on musical changes in improvisation or the performance of a song, such as tempo or rhythmic stability, and on Harold's verbal associations to the music. Meanwhile, Harold himself differentiates between making music and, more importantly for him, listening to music, and he focuses on its effects. For Harold the 'sound' (Stige 1999, p.76) is important not, he says, the song or the lyrics. He uses music as a 'disconnection' (p.74), to relax and forget his problems, yet it is also a 'connection' (p.74), enabling him to reflect on specific autobiographical memories and experiences. In order to work as his therapist, Stige has to adjust his own value system to understand the meaning of music for Harold. As they together communicate and construct a process of working that creates meaning in music therapy, Stige writes:

> When creating personal meaning, we use the signs and symbols
>
> accessible to us in the culture of which we are a part. (Stige 1999, p.81)

Though not directly addressed by Stige, it seems possible that, though Harold focused on the sounds themselves, his decision to use songs as well as recreating the aesthetic through improvisation, could be a direct form of

communication. The immediacy of a shared cultural understanding of the signs and symbols presented in the lyrics may serve to make his associated life experiences more directly accessible for his therapist.

There are two chapters within Wigram and De Backer's compilation that focus more directly on songs, words or singing. Sekeles (1999) discusses the interaction between music and words, including greeting songs and the technique of free singing of associations in a style of incantation or recitation. Sekeles presents the case of Ruth, a woman diagnosed with pathological mourning after the loss of her son. Early in her music therapy, Ruth chose to listen to a song from Mahler's *Kindertotenlieder* (songs of the death of children), which she then depicted visually in a drawing. Such a choice of song makes a clear and graphic connection with the woman's bereavement, and Sekeles's research demonstrates how personally articulated artistic rituals, in songs, art or poetry, can be used to perpetuate the memory of a dead child and provide an outlet for expression when other forms of self-expression are limited. This, too, may perhaps be interpreted as a form of proxy: see below, Chapter Five. Initially unable to express herself verbally, the therapist then introduced breathing exercises that led to spontaneous vocalising, vocal dialogues and, eventually, verbal conversation and musical improvisation.

This emphasis on the connection between mind, body and spirit through vocal improvisation is also the basis for the analytically oriented process described by Austin (1999 and, in more detail, 2001). Here the therapist uses vocal holding techniques, often a simple repetitive two-chord structure over which sounds are

vocalised, facilitating emotional connections. Words may be added, leading to free associative singing, interpreted by the therapist. Austin mentions the significant messages often contained in the words of songs that spontaneously come to mind (1999, p.153), and that the emotional content of a client's singing can be viewed on several levels: conscious, unconscious, and intrapsychic (p.154). (See Figure 3, this thesis.)

Both Sekeles and Austin stress the importance of the act of singing itself, both physically and psychologically. It is this synthesis of the fundamental expression of the voice that forms the basis of the psychotherapeutic process of voice movement therapy as proposed by Paul Newham (1993). This approach uses breathing, sound and movement in conjunction with suggested moods and imagery, in order to release the voice, body and mind from constriction and inhibition. This is similar to the work of practitioners of vocal harmonics or overtone chanting, who use toning as a means of self-transformation or healing (Goldman, 1996). Sometimes this vocalizing is combined with visualisation as this use of guided imagery 'enhance[s] the intention of the sounding' (p.103).

Whilst these approaches differ from my sessions in that they stress the importance of the voice itself rather than the song, there may be commonality in the use of imagery, the different levels of meaning on which the song or singing operates, and the intention of the performer or listener. Perhaps the difficulties that forensic clients face in participating in free improvisation, as introduced in Chapter One, section 1.2, extend also into the realm of the voice so that songs or words, rather than singing, become a more accessible means of self-

expression. The small amount of literature available in forensic or psychiatric music therapy that directly addresses the use of songs and words gives some corroboration to this notion, as shown by the following three examples:

Thaut (1987) reports on a programme of music group therapy for mentally ill prisoners. Techniques of guided music listening and supportive verbal interaction are used where patients formulate personal agendas of desired change and choose songs or instrumental compositions to listen to that express the desired feeling, thought or memory, or have some associative or symbolic value. Thaut notes that, where patients are able and willing to respond on a verbal level, songs, and music, have evoked insight, raising issues and reflections on significant emotions and life experiences.

Both Smith (1991) and Boone (1991) relate cases of individuals using their own poetry, or song-writing, during music therapy sessions. Smith (1991) describes how Jean, a depressed suicidal woman with a personality disorder in a psychiatric hospital, brought her own songs to a music therapy song-writing group. The creative writing process helped Jean to unlock repressed memories and gain insight about herself, whilst sharing her songs with the group helped her to express thoughts and feelings and develop positive self-regard. Boone (1991) reports on how Michael, a patient with paranoid schizophrenia in a psychiatric forensic unit, found instrumental improvisation difficult but brought his own poetry to individual music therapy to set it to music. His poetry was a graphic depiction of his feelings about his illness, his sexuality, and his family, much of which was portrayed through metaphor, for example 'Tooth Decay'

representing the process of his illness. The addition of music enabled him to match and release the emotional energy that drove his delusional and violent thoughts, providing an intense cathartic experience.

All three of the above examples are from the USA, where directed programmes of music therapy are more common than in England. Boone's approach is more non-directed, accepting Michael's musical and poetic ideas and working with them. Yet all of these rely to some extent on the verbal abilities of the clients, a factor which was often lacking in my clients who had an additional diagnosis of a learning disability. Whilst much of the research and literature in this section in some way recognises the importance of songs, in listening, singing or composing, very little of it seems to focus specifically on the client's choice and use, (in my own understanding, what I would describe as an active use) of pre-composed songs as a major influence in sessions.

My use of the term *active* stems from my own position within an improvisational model of music therapy in the British tradition. But distinctions within countries are now blurring as research modalities and practices are increasingly shared on a global basis. The authors and editors of a recent series of three wide-ranging and well-respected books on music therapy methods and techniques provide a range of examples of notably eclectic methods drawn mainly from Australia and the USA, and they give equal emphasis to improvisation, songwriting and receptive methods as the three main forms of music therapy intervention. For example, Grocke and Wigram (2007) provide examples of receptive techniques including those of song lyric discussion, song

reminiscence and imaginal listening, both guided and unguided. In each of these, the main focus is on listening to music and responding in ways which may be either silent or verbal, and discussion may be structured on different levels from basic responses to insight-orientated exchanges (Grocke and Wigram 2007, pp.157-178).

Baker and Wigram (2005), in the second book of the series, describe the use and relevance of songwriting in music therapy, for example for purposes of safety, support, stimulation, reflection, emotional exploration or the development of functional skills. But they do distinguish between songwriting 'for' or 'with' clients (p.13), where the process of writing with clients becomes itself the therapeutic intervention, rather than being a technique used for a specific purpose.

This book provides an example of a case study by Rolvsjord (2005), using songwriting with clients in a psychiatric hospital, who recognises the common musical form of songs in Norwegian culture and builds on known repertoire, collaborating with clients to self-generate lyrics and adapt melodies. In this 'resource-oriented approach' (p.99), which recognizes and amplifies clients' competencies, song creation is seen as a way of expressing and communicating feelings and life experiences in a beautiful and communicable way – one which can be used to regulate the intensity of emotions when working with trauma (p.115).

Such positive approaches to the creation and use of songs can only be

welcomed for their contribution to defining and expanding the knowledge base of music therapy, and the wider understanding and availability of a broader range of techniques, thereby increasing the options for both therapists and clients. And yet, what I find distinctive and perhaps more thought-provoking is that these interventions are deliberate and planned, with the therapists' having from the outset underlying supportive theoretical perspectives, whereas my own use of pre-composed songs was not intended but indeed emerged in a gradual, progressive way from the therapy itself. Indeed, the seemingly spontaneous, though repetitive, appearances of songs in our sessions arose from the clients themselves and did not fit, at first, into my usual improvisational approach. In order to consider from a wider perspective the purpose(s) and effect(s) of these songs, or the contexts which give rise to them, I turn, in the next two sections, to clinical areas other than mental health where pre-composed songs have also been developed as specific interventions.

3.1.2 Songs with Children

One of the prime approaches to the creative use and development of songs in music therapy with children, or indeed any client group, is that of Nordoff-Robbins. They have published extensive accounts of work with children who have a range of special needs, including learning and physical disabilities, developmental delay, autism, and communication disorders. In a major music therapy resource, Nordoff and Robbins (1977) describe the use of free vocalising and singing by the therapist in order to evoke responses from the child and lead to an expressive rapport, using supportive flexible improvisation to encourage the child's own vocalising. Repeating a word or phrase spoken by

the child allows him to experience it as a musical expression of his thought (pp.101-108). Simple songs can be developed around tones that the child can sing. These may be improvised around occurrences in the session or pre-composed for specific purposes, such as rhythmic or vocal work. In both cases the content is important, using words pertinent to the child. Songs are then freely developed through improvisation as they come to have meaning for the child and his responses become interactive (pp.108-113).

Robbins (1993) expands on this creative process, explaining how improvised songs are spontaneous musical responses to a perceived need of the child at that moment. Repetitions of these songs provide a defined 'framework of experience' (p.11), a dependable means of exploring further through improvisation that matches the mood of the child. Similarly, known favourite songs can be initiated by the child's singing or playing, or introduced by the therapist. These are not for performance but for interaction, where improvisation around the child's responses and actions gives the child both awareness of the therapist and some degree of control in their relationship. In this way songs which are, or which become, remembered, are clinically appropriate as a vehicle for musical expression and activity, connecting the child's 'personal musical life' with success and self-esteem in music therapy, thus strengthening the client-therapist relationship. Therefore, songs play an important role in music therapy as a:

> potent modality for bringing children's musical memories into
>
> expression and communication. (Robbins 1993, p.14)

However, Robbins stresses not only the impact of the words in echoing thoughts and deepening feelings but also the vital importance of the quality and mood of the music in supporting the child. The therapist must adapt such musical elements as style, tempo, harmony, richness, warmth or playfulness in response to the child's mood, as suggested by behaviour, posture, facial expression or mode of playing. This creative process is one of 'living music' reflecting the image of the living child (Robbins 1993, p.25).

Therefore, songs are created in the context of particular courses of therapy, even if they are of a pre-composed basis. They originate in therapists' responses to individuals or groups when children positively identify with them.

> Songs have a unique potential to stay strongly in memory: the
> statement of a thought is combined with the expressive movement
> of a melody, and given form through rhythmic and harmonic structure.
> When the thought has personal significance for a child…..the child
> can carry the song in memory from session to session. It becomes
> a source of inner strength. (Ritholz and Robbins 1999, p.7)

Songs as a source of inner strength, Ritholz and Robbins claim, can generate feelings of self-worth in children so that the effectiveness of songs extends into the lived time between sessions. Yet it is not just the repetition of these songs that is important but also the context of its communicative aspects. It is necessary to keep the essential integrity of the song but to change it to enhance its quality of spontaneity and artistry. How it is sung is also vital as this

expresses the attitude of the therapist and her personal commitment to the client. These aspects, too, become held in the memory of the song.

The notion of personal significance is taken up by Aigen (1996) in his research on the essence of the Nordoff-Robbins approach. He expands the ideas of musical and interpersonal contact engaging children in meaningful activity. In order to provide a meaningful experience for the child, the therapist offers a musical form or structure that contains a latent universal human experience, such as a feeling of wholeness and completion, which is outside of the child's current capacity to create for himself. This musical form could be 'an interval, melody, idiom or song structure' (Aigen 1996, p.16). It is the intent with which the therapist manipulates the dynamic forces of these elements that differentiates between engaging a child with music and building a foundation for deeper clinical work (pp.17-18).

Repetition, as mentioned above by Robbins (1993), is a basic element in musical structure. As Aigen (1996) states, repetition in, and of, a song in music therapy serves to meet a child's developmental need for familiarity and stability. Yet the evolution of these elements and structures through improvisatory experiences can endow them with new meanings when created around the child's mood.

> Songs truly connected to the moment are the primary way to
> musically engage children. (Aigen 1996, p.20)

According to this philosophy, pre-composed songs can also be used and adapted. They are merely another musical resource in the therapist's repertoire, acquired 'only with the intent of using the material as dictated by the needs of the therapeutic moment' (Aigen 1996, p.20).

Aigen (1997) provides a major work giving examples of this approach with both improvised and pre-composed songs in 'Here We Are in Music: One Year with an Adolescent Creative Music Therapy Group'. He demonstrates the engagement of individuals with particular songs, how songs were used to bring the group together, and how the group used songs interactively to work through times of conflict and confrontation.

> These songs are the expressive forms through which group
> members expressed their needs, accomplished growth and
> related to each other. These musical manifestations of the
> group process contain the experiences held by the members
> of the group…..These experiences are not peripheral to the
> therapy, but actually contain the therapy. (Aigen 1997, p.62)

In summary, the Nordoff-Robbins approach values songs as a vital part of a creative process. When used with intent to match a child's mood they can become personally significant and form the basic structure for improvisation and a communicative relationship, making meaningful experiences. Songs become musical expressions of thought that can be held in the memory.

The main focus of this approach is the creative interactive improvisation between client and therapist based on the song, or some element of it, according to the child's mood at that therapeutic moment. There is recognition of the importance of words that are pertinent to the child, and of the meaningful musical memory extending the effectiveness of songs into life outside the sessions. However, what seems to be missing in relation to this research study is a focus on the understanding of memories of songs pre-existing outside of the therapy sessions, that is, the importance of the meaning of the words or songs as they exist in themselves prior to any further development and improvisation during therapy. What is it that makes a pre-composed song personally significant enough in the first place to be mentioned, initiated, or responded to by a child during a session?

An article by Heal (1989) begins to answer this question. She presents John, a teenager with a moderate learning disability, who has suffered abuse and deprivation and is highly defended. John is unable to improvise or cope with free musical activities. He prefers the safety of the repetition of favourite known songs. Heal examines the meanings of the words in John's choice of pre-composed songs, connecting his symbolic language with his personal feelings in order to create shared meanings in the songs. She details how these songs can both express and contain his emotions in a structure that is digestible for him. John at times chooses to link songs to well-known fairy tales, again representing crucial personal emotions and experiences in symbolic terms from the secure context of a commonly shared external form. These songs act as an intermediary, enabling him to communicate with the therapist without

potentially painful direct human contact.

And so, my thoughts begin to focus more specifically on the personal feelings and symbolic associations which may lie behind a client's particular choice of song, and I turn back to the field of adult music therapy to consider more deeply the relevance of real human life experiences. Lee (1992), working with people with terminal illnesses, agrees that pre-composed music can be an important tool as it 'provides a vehicle through which the client can express issues often too difficult to articulate verbally' (p.44). Yet he adds a note of caution, suggesting that it could act as a block in accessing other therapeutic avenues. Like Heal (1989), Lee states that 'it can act as an intermediary object' but that it could be one 'whereby the client is able to side-track difficult issues' (p.46). This was also my initial concern as described in Chapter One, section 1.2.

In order to distinguish between pre-composed songs as symbolic communications or side-tracking blocks, greater emphasis must be placed on the meaning behind clients' choices of specific songs and the way in which they are used in the context of the music therapy sessions. The next session focuses on palliative care, where songs have been a particular subject for further intervention and research.

3.1.3 Songs in Palliative Care

Beggs (1991) describes the use of life review techniques in music therapy with an elderly violinist in palliative care. Here music and verbal discussion were

paired to explore important life events. Mr H. chose songs to play on the violin while the therapist posed questions about his musical past. The result was a musical profile, sequenced chronologically from childhood, through youth to adult years. The music facilitated reminiscence, evoking memories of significant events and people, giving space for reflection and therapeutic evaluation, and putting the client's life into perspective.

This emphasis on song choice was put forward by Bailey (1984) as a structured intervention. She felt that songs were effective in providing cancer patients with both 'means for support and tools for change' (p.5). Songs provide melodies and words, which stimulate emotion and cognition, and provide an opportunity to experience or re-experience events and feelings. Songs are unique in that they need the human voice as a medium for the words to be expressed, thus providing intimate contact and a framework for enhanced communication, whilst 'verbal messages about people, places, feelings, events, and desires encourage resolution of issues and processing of grief' (p.5).

Bailey (1984, pp.7-10) claims that the song choices of cancer patients, and their families, usually encompass one or more of nine major themes: hope, pleasure, the world, reminiscence, relationships, needs and desires, feelings, loss and death, peace. She links these to three stages in the music therapy process - contact, awareness and resolution, whereby patients focus on others (the world), then themselves (feelings etc.) before resolving issues (peace), sustained throughout by themes of hope and pleasure.

Throughout this process the therapist discusses the song choice and the themes with the patient or family, choosing songs that have personalised connections and that match the mood presented, such as dissatisfaction, depression or loneliness. In this way songs provide meaningful outlets for self-expression and a positive means of improving illness management mechanisms.

O'Callaghan (1994 and 1996) found similar results by analysing the lyrics of 64 songs produced by palliative care patients through a structured approach to song writing, which included choosing and discussing topics, grouping ideas for verse and choruses, then devising accompaniments. She used modified grounded theory and content analysis research approaches to code and classify concepts in the lyrics and develop categories that were condensed into eight themes: messages, self-reflections, compliments, memories, reflections upon significant others, self-expression of adversity, imagery, and prayers.

Other examples of song choice in palliative care include Whittall (1991) and Martin (1991). Whittall describes how discussion and reflection on the words of songs chosen by a woman getting married in a palliative care unit enabled her to become aware of the metaphors in the lyrics relating to death. This helped her to gain insight into her feelings during the dying process and to work through the pain of leaving her husband. Martin shows how feelings of loss can be dealt with, not only by the choice of religious, spiritual or nostalgic songs, but by less overt requests, such as *Puff the Magic Dragon,* a children's fantasy song chosen by the sister of a patient. This vividly depicts issues of loss and acted as a springboard, bringing feelings and reactions to awareness and acceptance.

However, many of these techniques of structured song choice and life review involve discussion and reflection with the patient about their choices, the songs or music, and the themes or issues raised. Although variations in approach can be made to accommodate physical and cognitive difficulties, there is still some prerequisite for the patient to have a clear mind, some degree of verbal ability, and a willingness to participate. My forensic clients did not participate in such structured approaches and often lacked the lucidity of both speech and thought to engage in discussion. Nevertheless, song choice continued to predominate sessions. If, for them, the importance of the song process is not in its verbalisation, then are they operating at another more circuitous or intrinsic level of awareness or response?

Ricciarelli (2003) focuses not on verbalising but on participation, through choice, singing or listening and the evocation of the music itself. He demonstrates how the acoustic guitar can be the ideal instrument for work with cancer patients in the hospital or Intensive Care Unit setting. It is an unobtrusive companion for the human voice and is suitable for many genres of song tradition. This versatility is a crucial advantage in being 'able to recreate the music of the patient's place of origin, a Tarantella, a Japanese lullaby, a German folksong' (Ricciarelli 2003, p.4).

'Tapping these rich traditions can instantly evoke powerful images' (Ricciarelli 2003, p.4) and songs may be a way for an otherwise reserved patient to express his true feelings. Some palliative care patients may try to be brave in order not to burden loved ones but their song choices may mirror hidden emotions,

allowing them to express and release sadness, fear, pain, anger, and a sense of loss. For the therapist to learn a patient's request and respond to it is a means of establishing trust. Songs provide a bonding experience, bridging the gap between patient, family and staff - a form of 'network therapy' (Ricciarelli 2003, p.4).

Ricciarelli (2003, p.5) describes spiritual songs as a 'rite of passage', helping to prepare for death, connecting with one's own spirituality and offering consolation that death is part of life.

> Rituals are important facilitators of a dignified death…..
>
> honouring the belief that death may be a moment of enlightenment…..
>
> a glimpse of what our life is really about. (Ricciarelli 2003, p.6)

Similarly, O'Callaghan (1996, p.89) suggests that the lyrical themes in songs meet patients' physical, psycho-social, and spiritual needs, giving an opportunity to creatively express personally significant experiences, and enabling them to 'live out their life'.

Perhaps it is that in my work with forensic clients there is a need to express similar themes, but that these may be too painful to remember or that the women may be too scared or ashamed to admit to them. When coupled with a limited creativity as a consequence of their pathology, expression through improvised or structured song writing becomes even more difficult and pre-composed songs are a natural substitute. Also, perhaps such songs may become

a 'rite of passage' (Ricciarelli 2003, p.5) towards their own moments of enlightenment, a recognition and acceptance of their selves and their lives leading, not to death, but to a new start: a conceptual journey or metamorphosis.

Yet, for me, the question remains how such a song process is used. Are the women aware of such a process and actively choosing to use it, or is it in some way an unconscious act? If so, how and why does this occur? My thoughts now begin to move away from the significance of songs in palliative care, to consider the wider, yet also more fundamental, field of the processes by which music, language and emotion are felt and understood and combined together to create meaning in a song (again, a question of emergent insights and the production of meaning within a musical context using pre-existent words).

Amir (1990), as presented earlier in the discussion of the research framework in Chapter Two, section 2.1,2, uses a seven-step phenomenological method for musical analysis in order to discover the meanings of created songs for patients. She goes beyond the words and the music to integrate 'everything that happens in one moment and leads to the next…..the gestalt of mind, body, and spirit of both patient and therapist who share this journey' (p.63).

Aasgaard (2000) (also introduced in Chapter Two, section 2.1.2) also discusses the life of the song, not just its making and the meaning of its content and context, but the 'how, when and where the song is being performed' (p.72). He views music therapy as a 'health-promoting intervention' (p.70) with the activity of song creation in paediatric oncology settings as a way of 'performing

health'. He focuses less on the inner world of the child and more on the child as a 'social being' (p.72) and he considers the child's interactions with other people. He presents a longitudinal case study of one song's life history from a constructivist stance, that is, 'that to understand this world of meaning one must interpret it' (p.73). He gains therapeutic insight from the study of the song's chronological history and suggests that 'the 'meanings' are often the interactional processes' (p.77): the words imply different meanings in different contexts, according to how the song is used by whom in the social events in the child's life.

Aasgaard presents a changing ecological health perspective, in which the child presenting herself in song can be understood both as 'being health' and as 'an act of transcendence' (Aasgaard 2000, p.80). The child grows as a person by taking on new roles as she interacts with others through the creative act of the song.

It is important then for me to follow the chronological, ecological path of Angela's songs as they are presented and used within the forensic unit. Perhaps there is some creativity in the interactions between the two of us, or with others in the group, in the 'performance' of a pre-composed song that will give interpretative meaning to the lyrics. The improvisatory, creative nature of music therapy may yet be seen, in this case, in the use of the songs as well as the lyrics and themes of the songs themselves.

3.2 Language and Emotion in Music and Psychiatry

In order to examine the creative process present in the use of a song, and to be able to give interpretative meaning to its lyrics within the ecological context at the moment of performance, it is necessary to consider how the client understands, responds to, and uses both language and music in respect of their emotional content and expressive purpose.

3.2.1 Language Use in Psychiatry

The attempt to construct meaning from the use of a song or its lyrics reinforces the supposition that different people in varying situations may interpret words in a variety of ways. Language, as a means of communication, only functions when people share an understanding of its symbols and the presumed common life experiences and feelings to which it refers.

However, as Johnston (2001) explains, people with a severe mental illness may have a perception of reality that is different from the norm. Someone with schizophrenia or a psychotic illness may be struggling to make sense of the world around them, and this may be reflected in their seemingly chaotic utterances. In order to develop effective communication, Johnston proposes that we attend not just to the denotative meaning of words but also to their connotational field. This broader, more diffuse use of language means we have to get to know patients well enough to be sensitive to their surmised meanings and acknowledge and respond to the truth of their intention. For example,

Johnston quotes a patient saying she had been abducted by aliens. This makes sense when we know that the woman had been taken to an asylum against her will by people she did not know.

I experienced similar conversations with my forensic clients on many occasions. I once arrived for the group session wearing a black dress. 'Jackie' (Client E in Appendix A) peered closely at me for some moments before asking in a serious tone, "Have you been to a funeral or are you a witch?" She also believed that my singing caused the rain, and that my drumming was controlling her brain and telling her to do things. These beliefs frequently resulted in outbursts of violence towards me or the musical instruments. Instead of dismissing her ideas, my knowledge that she had schizophrenia and a paranoia of persecution helped me to understand the reality of her world view and respond appropriately to the fears behind her questions, statements and actions. It is important that we 'respond to the feeling, not the content' as:

> People write their own thesaurus in their minds. Meanings and
>
> values are put together in accordance with their life histories.
>
> (Johnston 2001, p.37)

Thus, in examining the chronology of Angela's song choices, I need to be sensitive to her world view and surmise meaning from the intent of our shared feelings within the therapy group and my knowledge of her previous and present life experiences. I need to extract the connotational or symbolic associations that have made these songs significant for her so that I can distil

the essence of her therapeutic reality.

Killick (1994) distils this same essence of reality in his life history work with elderly patients with dementia through a technique of turning conversational prose into poetry. He encounters similar language difficulties and points out the impossibility of discovering meaning through cross-questioning. Yet he claims:

> It is possible to enter the minds of people with dementia….
>
> and to be vouchsafed insights, however fragmentary, of their
>
> lives and experiences;…..these insights are…..an achievement
>
> in their own right. (Killick 1994, p.6)

Interpretation becomes possible through the practice of empathetic attention and an instinctive and spontaneous response to the tone and inflection of the language used. The listener must develop 'a feeling for the possibilities of language':

> Contrary to what one might expect, people with dementia do not
>
> use language stripped to the functional. On the contrary, often the
>
> level of communication is poetic, making full, if unconscious, use
>
> of its associative power. (Killick 1994, p.11)

Killick uses these 'possibilities' to produce poems that are capable of communicating what it is like to live with dementia. They indicate the original authors' emotional state, show signs of the breakdown of mental processes, and

catalogue any awareness of the effects of the disease. They are, in effect, a series of small personal testimonies. Songs may serve a similar function in forensic music therapy. For example, in her second song choice, *Little Donkey*, (see Section 1.4.1) Angela was beginning to show her awareness of her loss of mobility.

Commonly perceived language 'problems', such as bizarre vocabulary, incomplete sentences or disconnected phrases, could instead be seen as communicative gateways to interpretation and understanding. They 'may well form part of a narrative we cannot grasp' (Killick 1994, p.19). I formed the same idea of a narrative gateway in earlier work with a child who had dyspraxia (Chambers 2000), using the metaphoric image of a train travelling so fast it connects quickly to each station, allowing only a glimpse as it passes through, and leaving the therapist to fill in the surroundings, the unsaid thoughts that have been processed but not verbalised as the client has already moved on.

Di Franco (1993) describes similar communication symptoms for psychotic patients, where disassociation of ideas reveals 'psychotic shattering' and 'a communication level very different from the one we define as 'logical'' (p.87). He proposes that structured music can be broken down into sound levels providing a 'star-like communication' (p.88) that reaches into the mesh of psychotic disruption, often using an intermediary or transitional object: a concrete element which functions as a bridge between therapist and patient. With the development of a relationship the music therapy process develops in an evolutionary way, re-establishing a more straight-forward integrated 'linear

bi-uniform communication' level (Di Franco 1993, p.88).

Irrespective of whether the communicative symptoms are due to dissociation of ideas or the experiencing of a different reality, where we are unable to see the associations that do exist, it seems that the communication problem belongs to the therapist rather than the client, being an issue of received interpretation rather than stated expression. Therapists must fill in the gaps using their experience of the relationship, combined with knowledge, feeling and intuition. If songs are used as intermediaries, they allow the clients to remove themselves from the explicit terms of the conflict, and thus outside of the intense emotional state under scrutiny, so that it can be observed, analysed and processed without the more direct and individual pressure that may be present in expressive musical improvisation or direct verbal conversation. Like pictures in art therapy or poetry in verbal therapy, songs may be important as intermediaries precisely because they may trigger associations, at a sound, word or memory level that function coherently as a non-verbal process when modes of pathology will generally inhibit more usual pathways of communication. As such, they become a valuable resource for the client-centred therapist.

If songs can be chosen for patients with dementia as a non-verbal means of expression that contain and express inner feelings, stimulate reminiscence and a feeling of identity (Ridder 2002), it is conceivable that, conversely, my forensic clients' reminiscences and struggles with identity (due to pathology or emotional inability to accept past issues in their lives) may stimulate them to choose associated songs as a safe medium for expression, consciously or

otherwise. This concept of communication through associative narrative informs a greater part of this thesis and will be developed further in section 3.4. What must also be borne in mind at this stage is the importance of music and emotions in this constructive process, for the pre-composed songs bear someone else's language. Could it be that the significance of the words are carried in the memory by the emotional association of the music itself?

3.2.2 Emotion and Music in Psychiatry

Many studies of patients suffering language deterioration due to cognitive deficit have investigated the differences and interactions between brain hemispheric dominance concerning language or musical perception, processing and production, as discussed by Aldridge (2000). Such studies contribute to explanations as to why singing and music may remain, or become, a potent means of self-expression when speech itself becomes difficult. Yet it is, for me as a therapist, not just the practicalities but also the human intent behind these communications that are of interest. Pavlicevic (2002) writes of the 'dynamic interplay' in clinical improvisation between therapist and client, using reciprocal mutual musical interaction within a relationship as a vehicle for innate dynamic forms of emotion to emerge and be processed.

Such mutuality and musicality can be seen also in dementia care (Simpson 2000) where therapeutic relationships can be based on pre-composed songs. Here, improvisations and interactions within the known structure enable a dynamic participatory 'performance' with another person that reinforces one's

sense of self. Within this shared, 'lived' experience music therapy can 'facilitate…evolution of personal and spontaneous ritual' (p.183).

So we return again to the human need for ritual as a means of finding meaning in our lives and the creation of rites of passage to mark our way through life's journey (see this Chapter, section 3.1.3). But how does the psychiatric patient create these rituals? Schizophrenia can be understood as an inability to find meaningful symbols for emotion (Kortegaard 1993): a lack of integration of the normal process of emotion – symbol – thought. If the schizophrenic individual is non-symbolising and cannot compare experiences and emotions to build a meaningful picture of the world then the result may be anxiety. Like Pavlicevic, Kortegaard stresses the importance of music as a mutual sound expression that is in dynamic movement. It has an adaptive function: being accepted by the therapist in whatever form the patient expresses it, and transformed into a mutual reality through musical participation within the therapeutic relationship. It serves as an external structure that creates new symbols capable of being synthesised and internalised, thus removing the anxiety. This process could work through either improvisation or song. Perhaps song is particularly appropriate for my forensic patients in that traditional, culturally-understood songs present a clearer structure from which to begin the transformation and, seemingly, are further divorced from potentially emotionally overwhelming musical expression.

In addressing psychopathy, Mitchell and Blair (2000) assert that there is a complex interaction between social and biological factors, including a deficit in

amygdala functioning within the forebrain, which may be a risk factor for the development of difficulties with emotion. They examine the two main explanations that attempt to characterise psychopathic emotional processing: firstly, in terms of an abnormality in experiencing fear and, secondly, a primary dysfunction in empathy, particularly in the processing of sad expressions. Like Kortegaard, Mitchell and Blair (2000, p.356) claim that the psychopathic individual has a 'discordance' between the verbalisation and experience of emotion. To quote Johns and Quay (1962) (in Mitchell and Blair 2000, p.6) they 'know the words but not the music'.

The very choice of this musical metaphor as an illustration of emotion suggests a connection between them. But is it possible to separate these components of words, music and emotion at all?

The consideration of interconnections between emotion, language and music for the psychiatric patient has a parallel in musicological considerations of the nature of music itself. Chua (1999, p.6), writing about absolute music, claims it does not have a history of music but a history of 'discourse', in that 'absolute music does not have a fixed meaning but is subject to the mutations of those who speak about it'.

> The history of absolute music is…..a clamour of contradictory
> discourses, each vying for power in the construction of its meaning….
> [It] has a decentred and fragmentary identity that can only be
> elucidated as a constellation of discursive ideas. (Chua 1999, p.6)

Conversely, the fragmented reality of the psychiatric patient's inner emotional world, of which disconnected language is a symptom, can be constellated and elucidated through musical discourse. That is, the dynamic use of a stabilising intermediary, the song, in a therapeutic relationship, can be used to construct new meaning and enable the client to internalise and make sense of his or her experiences.

Sloboda (1999, p.451) believes that music is a combination of cognition and emotion. Like language, music has structural regularities: a cultural syntax to which we acquire sensitivity through exposure. These structural expectations enhance the powerful emotions that are at the core of our engagement with music and which contribute to its valued psychological benefits. He highlights a range of research studies that suggest emotions are mediated through music in three distinct ways:

1. Episodic Associations. These are idiosyncratic autobiographical associations where music reminds us of significant earlier life events, people or places.

2. Iconic Associations. These are brought about by the physical characteristics of the music resembling the sound effects of non-musical events, such as a storm, or suggesting emotional characteristics.

3. Structural Expectancies. Here the unfolding structures of the music create and resolve tensions, producing physical and emotional responses.

These three types of emotional engagement in music are developed further by Sloboda and Juslin (2001). They now distinguish between two sources of emotion in music:

1. Intrinsic Emotion – where there is a relationship between the intensity of affect and the specific structural characteristics of the music, i.e. structural expectancies as defined in (3) above.

2. Extrinsic Emotion – where emotional content is determined by contextual factors external to the music, such as memories, associations and personal priorities. This includes both iconic and associational/episodic as defined in (1) and (2) above.

In the same volume, Bunt and Pavlicevic (2001) take these sources of emotion and apply them as examples of connections between music and emotion in improvisational music therapy.
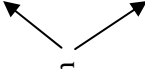
Such distinctions also have clear parallels with my three levels of interpreted meaning in song words, as presented in Chapter One, section 1.3.1. Indeed, many of the authors in this Chapter 3 have put forward similar levels in relation to interconnected aspects of language, emotion and music. Figure 3 collates these into a single chart, where the two or three levels presented by each author are summarised in the vertical columns under the author's name. The levels have been arranged in horizontal rows in order to illustrate the perceived connections between them and to allow clear comparisons to be made. For

example, my category of Explicit-Stated meaning in song words (from Chapter One, section 1.3.1) defined an association between song words and a client's case history which was clearly stated without further need for interpretation. In Figure 3, I link this to the straightforward denotational and functional use of language described by Johnson (2001) and Killick (1994), the linear communication of Di Franco (1993) and the client's awareness of emotional content in singing (Austin, 1999). I link these to Sloboda and Juslin's Intrinsic source of emotional engagement in music, making a connection between the specific intrinsic life history and experience of the client and its direct relationship with the song in question through explicit statement in the lyrics.

Similarly, my two categories of Implicit meaning in song words, which rely on different degrees or depths of interpretation, relate to more complicated levels of language use and emotional content in singing which will require understanding of the individual's context and intent. These link further to Sloboda and Juslin's two Extrinsic sources of emotional engagement in music (which I have split according to the earlier categories defined by Sloboda (1999)) where factors external to the music, such as personal autobiographical associations, are less structured, more diffuse and variable, and thus require further consideration of individual context in order to extricate meaning.

Figure 3: A Comparison of Levels of Language, Meaning and Emotion

Chambers Section 1.3.1 — *Levels of Meaning in Song Words*	Johnston (2001) — *Levels of Language Use*	Killick (1994) — *Levels of Language Use*	di Franco (1993) — *Levels of Communication in Music Therapy*	Sloboda (1999), Sloboda & Juslin (2001) — *Levels of Emotional Engagement in Music*	Austin (1999) — *Levels of Emotional Content in Singing*
Explicit – Stated	Denotational	Functional	Linear Bi-uniform Communication	Intrinsic – Structural Expectancies	Conscious
Implicit - Contained				Extrinsic – Iconic Associations	Unconscious
	Connotational	Poetic	Star-like Communication		
Implicit - Construed				Extrinsic – Episodic Associations	Intrapsychic

Sloboda and Juslin (2001) recognise that these sources of emotion may combine or interact in idiosyncratic ways, creating ambiguity and rendering generalizability problematic. In considering the implications for research they recognise that little attention has been paid to epidemiology, or how people experience emotion under various circumstances, and they propose that a crucial area for future research therefore is the interaction between person, music and context. This necessitates a move in methodology to 'dynamic models that are better suited to the time-dependent nature of emotional responses to music' (Sloboda and Juslin 2001, p.98).

This supports my intention to present Angela's song choices as a therapeutic narrative, detailing my interpretation of our mutual musical relationship within the context of the music therapy sessions. A time-line analysis of the words, images and metaphors of the songs, combined with our musical transformational use of them, should serve to offer insights into the underlying emotional process that may construct the metamorphic journey of music therapy.

3.3 Narrative in Research and Therapy

3.3.1 Narrative Analysis

The concept of narrative analysis as a methodology to study a personal transformational journey is an accepted field in which a number of research disciplines converge. In this section I will first examine the notion of narrative and the key concepts which make it a model for inquiry, relating this to my

study of Angela's case narrative, and leading to the proposal that narrative is not only an analytical tool but an active process in its own right.

In its simplest form a narrative is the retelling of a story or anecdote. It is an account of personal experience that Mitchell defines as 'a means by which human beings represent and restructure the world' (see Cortazzi 1993, p.1). Engaging in its telling is, according to Branigan (see Cortazzi 1993, p.3), 'a perceptual activity that organises data into a special pattern which represents and explains experience'. These emphases on organisation, representation and explanation make analysis of narrative an ideal methodology for studying the experience, beliefs and culture both of individuals and particular groups, whilst the element of restructuring naturally leads into a therapeutic understanding of the processes of personal change and growth.

Cortazzi (1993) details three key concepts intrinsic to this narrative process: reflection, knowledge and voice. Reflection is a personal journey where telling a story helps us to make sense of its content through reliving the experience, constructing and reconstructing it. Relevant questions from an audience can assist by making this process interactive, enabling us to try out new constructions. Knowledge, based on our previous personal experience, helps both teller and listener to interact positively by knowing what and how someone else knows and learns. This 'practical knowledge' is characterised by Connelly and Clandinin as:

…a particular way of reconstructing the past, combined with

intention for the future to deal with the needs of present situations.

(in Cortazzi 1993, p.9)

In Angela's case narrative the vignette in section 1.2.3 serves to illustrate both concepts. Angela relived some personal aspect of her past through the repetitive performance of *Edelweiss*; as her therapist I interacted with her by changing small parts of the song text or music, allowing her to reconstruct the experience in various ways and accept the freedom to explore and change her future intentions, i.e. her aspiration to be 'good'. The medium of song was particularly pertinent to the need of her present situation – it allowed her voice to be heard. 'Voice' is Cortazzi's third concept. It concerns empowerment, people's need to talk and their right to be heard in a way which represents their reality and self-understanding. Elbaz (see Cortazzi 1993, p.11) describes why story is a fitting medium in this process, including meaningful context, structured expression, and traditions of moral lessons that allow criticism to be voiced in socially acceptable ways. When a story is formed as the text of a song it can enhance further the power of what is said: the text becomes 'ideology expressed in aesthetic terms' (Watson 1983, p.6).

Angela's difficulties with language (due to a combination of mental illness, learning disability and general inhibitions interacting with other women in the group) would make storytelling problematic for both her and her audience. A pre-composed song overrides these obstacles to communication: as a song it is socially acceptable; as a personal experience it is meaningful; as a musical construction it can be emotionally reconstructed by therapist or 'teller' (client)

whilst retaining the integrity of its intention; and as a co-performance it can be supported or maintained by the therapist, or the group, allowing the teller to lead or listen as and when she feels empowered to do so.

It is the participatory nature of these relationships between teller and listener that are critical in a sociological or socio-linguistic model of narrative inquiry. Crucially, narrative is a form of self-presentation but interaction through conversational rituals makes it an exchange where each participant relies on others to complete his picture of his own self: a process of impression-management (Cortazzi 1993, p.37). In this way, human experiences are mediated by interpretation as we actively manufacture our own worlds, conferring meaning onto situations and events by negotiating definitions through social interactions. This defining process will be affected by other theoretical constructs, including personality traits, cultural prescriptions, role obligations and physical environments, but the conceptual paradigm remains that of symbolic interaction. We act not according to given definitions but by how we see things, as Bogdan and Biklen summarise (1992, pp.35-38). Also, as they record, we construct our own 'self', a definition of who we are, through attempting to see ourselves as others see us by interpreting their responses to what we present. This 'loop' of social interaction allows us to change and grow as we learn more about ourselves.

'This way of conceptualising the self has led to studies of the self-fulfilling prophecy and…deviant behaviour' (Bogdan and Biklen 1992, p.38). Perhaps too, it lends itself to studies of positive therapeutic change, as Angela's self-

constructed 'nun' concept indicates. Does the presentation of this aspiration through an image facilitate the interaction process for her: negating the need for complicated verbal explanation by presenting a pre-defined, culturally understood iconic figure to the listener? Does it also allow Angela to be personally removed from the musical transformations, which can be tested on the song, whilst retaining the observational opportunity of receiving the group's responses to these presentations, reflecting on them, and constructing meaning from them? Such group experimentation and validation would yield an interpretive reconstruction or 'narrative unity' (Connelly and Clandinin, in Cortazzi 1993, p.17) 'in which storytelling is a key element and in which metaphors and folk knowledge take their place'.

> Situations call forth our images from our narratives of experience
>
> and these images are available to act as guides to future action.
>
> (Connelly and Clandinin, in Cortazzi 1993, p.17)

I will return to the role of stories, folklore, images and metaphors within the musical and therapeutic case study in more detail in section 3.5. For now, let us return to the story of the narrative process itself and examine it from a metaphorical perspective. Goffman (1974) analyses not the symbolic interactions themselves but the individual's subjective experience of those interactions: the 'frame' of implicit rules or premises that define the situation and shape the meanings generated within it. The primary frameworks of a particular social group constitute a central element of its culture and will influence the way in which individuals perceive 'strips of experience' and come

to organise their actions around this cognitive understanding. Goffman (1974, p.504) uses a semi-musical metaphor to illustrate the presentation of these 'strips' through narrative. It is a reproduced dramatisation to 'replay…a tape of a past experience'. The notion of a musical autobiographical 'tape' will be examined in more detail in section 3.4.

Into this 'replaying' of a personal perspective 'listeners can empathetically insert themselves…vicariously re-experiencing what took place' (Goffman 1974, p.504). The role of the listener, being in this study the roles of myself as therapist and that of the women in the group as co-participants, in responding to the presentation is vital therefore in negotiating meaning for the animator of the narrative. As Goffman suggests, saving 'face' in difficult situations is a motivational basis for the ritual organisation that governs interaction. As meaning is constructed through these exchanges, narrative is not only a tool or methodology through which to analyse behaviour, but an active constituent in the transforming of that behaviour. It becomes part of the metamorphic process itself.

3.3.2 Narrative Practice in Therapy

This section will introduce the role of narrative in the wider field of therapy, and the role of the therapist in facilitating this process, before addressing its particular application within music therapy.

Psychotherapy, as a kind of conversation or transaction, offers a particular type of narrative reconstruction, embedded in a cultural milieu of time and place

(McLeod 1997, p.17). Here storytelling acts as a bridge to the self, giving clues to the client's self-concept or feelings which go beyond the actual story itself. Yet it is also part of a process, representing a primary point of connection between therapy and culture:

> The telling of personal stories…is an essential mechanism
> through which individual lives become and can remain
> aligned with collective realities. (Mcleod 1997, p.2)

This recognition of a cultural foundation to therapy shifts the focus of attention away from the treatment of a specific problem where a client's narrative may be fitted into a pre-existing theoretical frame. Instead, the storyteller becomes the centre of a conceptual framework, a narrative event which helps them create a 'satisfactory-enough alignment' (McLeod 1997, p.27) between their individual experience and the wider story of the culture in which they live. This social constructionist perspective is an alternative way of understanding narrative that builds on existing approaches in psychotherapy.

McLeod (1997, pp.54-82) reviews approaches that are foundationalist or constructionalist. The foundationalist, often psychodynamic, therapist often takes the story of a client's life history. This is then analysed for underlying fundamental emotional or behavioural structures, that is, it becomes a source of evidence for a problem rather than a distinctive form of communication or a way of knowing in its own right. The constructionist, often cognitive, therapist emphasises the human capacity actively to construct meaning through

processing information. Story is seen as a form of representation of underlying schemas or dynamic sequences of actions in relation to external objects, which can then be subjectified and re-constructed.

Both of these approaches relate to something which exists in the individual: they focus on a mechanism that needs to be fixed. The social constructionist approach journeys from this internal to an external focus, where stories exist within a culture and are to be entered and inhabited by persons, sharing and creating coherent meanings. This can be achieved only through analysis of the historical and cultural contexts of social life, developing a local knowledge of the client's process rather than a grand theory. This aligns closely with my stated research framework (see Chapter Two, section 2.1.2) of a naturalistic, emergent paradigm, and my intention to submit the narrative account of songs and experiences to a cyclical process of de- and re-contextualising (see section 2.3.6).

By shifting the view of what constitutes a 'client' from an internal self to a person who is a social being, each individual 'can be understood as a living 'text'' (Gergen, in McLeod 1997, p.84). When a person's life story is too painful or chaotic for them to deal with alone, the therapist's role is to work through listening and sensitive interpretation to externalise the problem, offer an alternative version of the story (a deconstruction), assist the client to reconstruct and adopt a more satisfying or tolerable version that becomes part of their interpersonal world outside of therapy. Here the therapist aims to enable clients…

…to achieve narrative truth, to create stories they can live by,

and live with. (McLeod 1997, p.86)

Narrative truth is co-constructed from the clients' or tellers' experience and their satisfaction in the way it is told. It may be distinct from historical truth or the objective facts of their lives. This concept of a cyclical process of co-construction over time reinforces my belief that truthfulness and trustworthiness in the musical narratives between myself and Angela corroborate the validity of this research (see section 2.4). It also serves to restore the women's experiences of the music therapy process to their central place in the research and confirms my resolution to adopt this as a positive focus rather than accepting it as a problem (see section 2.1.4.3).

McLeod (1997, pp.98-106) goes on to give examples of narrative therapy from a social constructionist perspective. As with my concept of music therapy as a 'metamorphosis', many of these examples use metaphors, both in the depiction of the therapist or client (e.g. as 'detective' p.85, or 'author' p.95) or in the symbols used to make meanings explicit in the narrative. In order to depict feelings and experiences to the listener, the tellers use words, images, movements or music to symbolise what is felt, and may draw on narrative resources from the stock of stories that are culturally available to them, including religious or fictitious, both modern and traditional. This was my experience also, in the presentation of songs that included hymns, folk-songs and childhood favourites and the metaphoric images imbedded in their texts.

However, a shared conversational, co-constructed narrative in therapy is not the same as a written story but is based in oral traditions. To preserve this mode of expression and capture more of the lived experience some therapists record the narrative in poetic form (McLeod 1997, p.143). Music also may serve to retain this oral tradition, combining the expressive performance elements of the music with the more easily accessible symbolism of shared song texts.

Killick and Allan (2001, p.202), working in the field of communication in dementia care, suggest that narrative transcripts can be shaped into poetry due to their perceived natural symbolic content and striking features of metaphor and allusion; an unconventional use of language that may be due to a 'heightened level of imaginative experience' (p.224). Using empathy, intuition and interpretive skills, the writer engages in much editing, 'paring away of material until an essence is revealed' (p.203) which consolidates an identity and makes a person 'real' (p.213). Killick proposes that this realness is vital in the basic need for people with dementia to remain as social beings in a Western culture which disposes us to understand differentness in medical terms, whereby changes in communicative skills are attributed to the course of the condition, invalidating the individual's uniqueness and ultimately isolating them. Finding alternative means of communication allowed their feelings and experiences to be expressed so that 'their personhood became a reality' (2001, pp.14-18).

Writing and recording spoken and non-verbal encounters that are 'in the present moment' can capture aspects of them, 'externalising' them and giving a permanency, a kind of 'external memory' (Killick and Allan 2001, p.191) that

facilitates thoughts and feelings through ordering and developing. It can give rhythm and pace to shape the discourse and reflect back to the teller what belongs to them, reinforcing their identity. This mutual interaction helps to address the 'landscape of meaningless' (Killick and Allen 2001, p.120) that has developed around dementia, both in terms of individuals' pursuit of meaning to make sense of their experiences and our attempts to make sense of their words, actions and expressions.

As a music therapist, Manso Witt (2002) uses pre-composed songs in working with clients who have dementia. By choosing songs which have a narrative storyline she stimulates patients' responses, enabling them to express their feelings and reflect on meaning in their lives. She stresses the importance of songs that are already in the 'musical landscape' of a patient's memory, as each briefly remembered song serves to replace some lost cohesion and contributes to the creation of personal interpretive narratives which retain meaning and dignity for the person concerned.

In effect, this re-collection of memories into a narrative framework that links events together is a 'composition of the self' (Aldridge 2000, pp.15-16). These 'compositions' remain incorporated in a responsive self and can be musically prompted through fostering relationships that return to the ecological connections of body and self. Linking meanings and actions enables 'performed health' to be an activity that therapists can endeavour to address. 'And it is music that forms the basis of relationship through rhythm and timbre' (Aldridge 2000, pp.16-17).

Odell-Miller (2002) presents music therapy case examples of musical narrative in dementia care where relationships are built on interactions around expressed sounds, which may include pre-composed songs or instrumental material, using the expressive affect of natural musical instincts in a process of clinical improvisation. The music therapist provides an overall musical structure in time that encourages rhythmic precision and preserves it, and other faculties, from further deterioration. The continuation of this narrative over time may maintain a patient's orientation by producing interaction and synchronicity where other means of communication have failed.

Only a few music therapists write more specifically about the use of pre-composed songs in this process of improvisatory musical narrative. Henderson (1991) examines the case of 13-year old 'Patricia', from a tribal environment in South Africa, who mingled traditional drumming rhythms with an incorporated Christian religious perspective. She used songs sung in English to express her personal traumas of abuse and witness to murder, sometimes working symbolically using animals in stories, before releasing her own emotions that, initially, could have been perceived as forbidden or overwhelming. After using Christian praise songs concerning 'breath of life', Patricia also began to play the recorder for her deceased sister, figuratively putting 'breath' back into her (Henderson 1991, p.213).

Trondalen (2001) describes a similar catalyst whereby 14-year old Sara, who had ceased talking, began to use birdcalls and a kazoo, literally allowing her to ''blow life into' her 'dead' voice' (p.66). Sara used play songs and lullabies

from her cultural heritage in improvisations that created a personal narrative. The lyrics suggested themes for exploration and helped her story become visible, both to herself and others. Such an 'identity-song' (Trondalen 2001, p.66) can be seen as a symbol that both contains and mediates meaning and can be used to transfer experiences from music therapy back into daily life.

Yet the question remains: from the vast landscape of songs within our cultural heritage that may be, or may become, personally and socially meaningful, how, or why, do we choose those significant enough to present, or respond to, in a music therapy session? Is there a plot to this musico-narrative tale?

3.4   Songs as a Soundtrack to Life

As my metaphoric caterpillar continues his journey through the literature, placing the eggs of research ideas in their appropriate contexts, he arrives at the point of significance of specific songs in personal musico-narrative structures. Here he meets a fellow creature, also symbolically generated from musical research: an 'earworm' (Kellaris, cited in Linkie 2003). The study of earworms, or 'stuck song syndrome', investigates those songs that get stuck in your head, inflicting themselves in an endless cycle of repetition for hours or days. In Kellaris's group of 559 subjects only 2% reported no experience of earworms, showing how pervasive they are, and women were found to be significantly more irritated by them than were men.

It may be that during therapy, or in their efforts to avoid meaningful emotional disclosure, women simply suggest the tune that is currently stuck in their heads.

But are these songs random occurrences or do only those of some significance become stuck? Perhaps the answer is irrelevant, for the effect may be the same. If we accept the interconnections between emotion, language and music (see section 3.2.2) and the construction of meaning through a narrative process (see section 3.3.1) then the repetition of songs, for whatever reason, can become a catalyst for physical or emotional response. Levine (1991, p.49) describes the 'language connection' between the mental expression of emotion through words and pictures and the physical expression of emotion through bodily sensations. She concludes that much illness is self-created, with words being a trigger for the symptoms of disease.

> A "seedthought" is a thought you think frequently that emanates
> from, or creates, your core beliefs…..[it] is an idea planted
> through the mind that grows into manifestation in the body.
> (Levine 1991, pp.49-50)

As Levine (1991, p.67) suggests, if we can uncover seedthoughts and find the patterns of belief that lead to disease, then we can also choose seedthoughts to create new patterns to make us well. This is illustrated by Brenda's vignette in section 1.2.2. The seedthought 'They're cold towards me' was translated physically into her cold, numb hand, and expressed musically in the endless repetition of the seemingly 'stuck song' *Frosty the Snowman*. Further into her therapy, putting life and warmth into the performance of *Frosty* may have created a new seedthought for Brenda to begin to believe in herself as a warm, expressive person, enabling her to reconstruct her relationships with the staff

and other residents. What is not apparent is whether Brenda actively chose this song because she sensed its relevance at some level, or if it was introduced coincidentally, being the initial piece of sheet music in her collection that may have become 'stuck'. In either case, its repetition ensured it became a vital part of her constructed therapeutic narrative.

Consideration of song recall is not new in psychotherapy. Diaz de Chumaceiro (1998a) provides a detailed account of interpretations of unconsciously induced songs in psychoanalytical literature from 1900 onwards. As early as 1907 Freud was writing about experiences of music evocations in everyday life:

> If anyone takes the trouble…..to note tunes that he finds himself
> humming, unintentionally…..he will pretty regularly be able to
> discover the connection between the words of a song and a
> subject that is occupying his mind.
> (Freud 1907, cited in Diaz de Chumaceiro 1998a, pp.337-338)

Freud later described the humming of tunes as 'chance and symptomatic actions' that are 'small indications of more important mental processes and are fully valid psychical acts' (Freud 1916, cited by Diaz de Chumaceiro 1998a, p.341).

> Tunes hummed "thoughtlessly"…..were revealed as an expression of
> the subject's suppressed intentions or as a result of a clash between two
> intentions one of which was permanently or temporarily unconscious.
> (Freud 1923, cited by Diaz de Chumaceiro 1998a, p.343)

Although emphasising that these actions contained meaning that could be uncovered analytically, Freud's ambivalent attitude toward music led to his concentration on interpretation of dreams rather than of song material and analysis of lyrics did not become widespread, though he continued to use musical examples to illustrate his writings about dreams and the recognition of consciousness, such as those mentioning opera (Freud 1954, p.488 and p.497).

Nevertheless, what has been recognised is that evocations of music are spontaneous only in their timing, not in their dynamic contents:

> Unintentional music evocations are tunes (with or without lyrics),
> which, contained in one person's short- or long-term memory,
> have been involuntarily remembered and unconsciously triggered
> by the other [in a dyad], via an unconscious inductive process.
> (Diaz de Chumaceiro 1998, p.335)

This has significance for the music therapist: it recognises the importance of pre-composed songs already in the client's memory, the role of the therapist in evoking these, and the implied responsibility of the therapist, as co-constructor in a narrative process, to interpret and re-present the suppressed intention expressed in the song.

Two later research studies were conducted where psychotherapists consciously and deliberately induced song recall rather than waiting for it to occur unintentionally. By asking, "What song comes to mind?" and analysing the

evocations of both clients and therapists 'songs proved to be a condensation of current conflicts in life and in treatment…. "song syntheses"' (Diaz de Chumaceiro 1998b, p.380).

For the music therapist this creates powerful therapeutic potential: the simple act of choosing or using a song, by client or therapist, can become a gateway through which previously unaware or suppressed thoughts and feelings can be accessed and their latent associations acknowledged, whilst the recreation of mutual song performance facilitates personal exploration, growth and change.

Rolla (1993) considers in more detail the significance of musical recall or memory in unconscious processes by correlating subject's earworms, or 'inner music' (p.ix), in parallel with their daily activities and concurrent emotions and thoughts. He concludes that musical patterns or impulses are based on personal experiences or associations and are consistent with the emotional state of the participant…

> as if an actual inner soundtrack had been unknowingly
>
> recorded within the psyche. (Rolla 1993, p.ix)

74% of the musical memory impulses reported by Rolla's participants were vocal rather than instrumental. As such, their primary manifestation in a lyrical musical soundtrack becomes not only an integral part of human psychological makeup but also, using a Jungian approach to therapy, a source of inner

guidance, an investigative tool for understanding general unconscious processes:

> Correlation between unconscious musical impulses and mood
> is generally determined by an individual's prior associations….
> [and] lyric content….may infer, reflect or reveal areas of
> psychic conflict or concern, as well as a desire for resolution.
> (Rolla 1993, p.25)

The individual may be unaware of these associations, with the unconscious mind independently choosing and processing specific musical motifs into memory where 'depending on a certain attraction and/or meaning already established by the psyche, the motif becomes the underlying supportive structure of an emotional state or conflict as it moves toward resolution' (Rolla 1993, p.27).

Inner music therefore suggests active listening on a level below that of conscious emotion. When accompanied by mood alteration it may serve a similar function to the Jungian notion that dreams exist on some level for the express purpose of 'inner repair' (Rolla 1993, p.34). Recurring musical impulses correlate to specific emotions or psychological states and may cluster around a centre of meaning from which patterns tend to radiate, surfacing when the subject encounters a circumstance perceived to be similar to a previous one in some way. These clusters, or 'dynamic core groups' (p.41), function to offer insight into inner conflicts, ambitions or desires when placed in the context of

life histories. They can become an 'inner music score', disclosing personal reactions to relationships or perceptions of life experience (Rolla 1993, pp.41-47).

Although the Jungian focus, in dream series analysis, is on clusters around centres of meaning, Rolla (1993, p.83) recommends a technique of self-realisation using the musical impulses which form the dynamic core groups, in conjunction with life experiences, to create and record a chronological 'personal soundtrack'. This 'soundtrack process' is in effect a taped therapeutic musical narrative, providing a synopsis of life that both reveals and integrates emotions, actions and experiences.

So, irrespective of an outward focus on chronology or on centres of meaning, it seems that our lives are continually being musically mapped: the soundtrack or tape of a narrative plot is recorded within each of us, labouring incessantly but, to our conscious minds, seemingly held in abeyance until liberated, resolutely or instinctively, in times of need.

The concept of music as a soundtrack is expanded into a wider perspective by Ruud (1998). He first considers music's function in constructing personal meaning, 'as a map that helps organise a sense of identity…'

> As a well functioning soundtrack…[music] locates incidents in
> time and space and adds depth and dimensions of inner space to
> life events. (Ruud 1998, p.92)

But Ruud asserts that this musical structuring, which gives credibility to our individual autobiographies, also reflects, and is formed by, social and cultural entities. He views music not as a universal language but as a created system of cultural symbols:

…A cognitive system in which sound represents memories, associations, histories, and traces of situations in which other people's subjectivities and experienced realities are represented. (Ruud 1998, p.92)

Supportively, but adding an emphasis on emotions, with music and the construction of feelings being embedded in a social context:

Musical emotions are a form of social representation, which is negotiated as an interaction between cultural/ideological values of a society, the values and beliefs operating in a social grouping or subculture in that society, and the individual's own social and personal experience. (Sloboda and O'Neill 2001, p.427)

Through assimilation of this cultural system of signs we are able to contain and perceive meaning. Ruud gives examples of the importance of childhood relationships and musical experiences in this process. For example, parents' lullabies may be associated with, and come to symbolically represent, the feeling of trust contained within the relationship, and in later life the songs may be recalled to help overcome difficulties in frightening situations. On a greater

cultural level, song traditions, such as the Norwegian *skillingsviser*, contain dramatised narratives of darker emotions or suffering. Children often prefer them and 'these songs became some sort of training in emotional tolerance, in the ability to contain and sustain emotion….[music] becomes part of the repertoire of ways of responding to the world' (Ruud 1998, p.40).

Similarities exist here in the English traditional music of nursery rhymes, hymns and popular folk song: ingrained childhood culture which features repeatedly in the seemingly innocuous song choices of the women in my therapy sessions. If these songs are true instances of autobiographical soundtracks resurfacing, indicating and containing emotional states, then both the personal histories and cultural associations which they symbolise are of importance for therapeutic analysis. For example, from Appendices A1/A2, Gracie's folksong *Drunken Sailor*, dealing with her relationship with her husband; Ruth's hymn *O Little Town of Bethlehem*, depicting the stability her chaotic life lacked; Felicity's *Tenessee Waltz* and later folksong *Clementine*, proclaiming the loss of her family, work, home and freedom; and, later in therapy, Jackie's singing of self-consoling lullabies for her own lost child.

Many of the cultural symbols and signs contained in these songs are represented in the lyrics in the form of images, metaphors, archetypal figures, fairytale and folklore which we inherit and absorb throughout childhood, and it is examples of these within therapy which will be considered in the following section of this thesis.

3.5 Metaphor in Therapy

3.5.1 Images, Archetypes, Fairy and Folk

The most clearly defined use of images in the therapeutic process is possibly
that of art therapy. Although looking explicitly at the personal processes
involved, with the finished product being of secondary importance (Liebmann
1994, p.8), the objects or images created can be described as 'an externalised
statement, a symbolic representation of what is felt or thought' (McCourt 1994,
p.44). McCourt writes of the particular relevance of this process for offenders in
prison, where the main commodity is time in an artificial world of
powerlessness. Making marks brings decision-making and confirms unique
identities. It brings into focus personal experience 'in images…[that] affords the
opportunity to look at it rather than denying it'.

Music also may be a symbolic representation that focuses personal experience
but specific literature examining the use of imagery in music therapy is sparse
and is generally associated with the specialized technique of Guided Imagery
and Music (GIM), in which programmes of pre-recorded classical music are
used to evoke imagery and emotions, and process these in relation to the client's
life issues. Erdonmez Grocke (1999) categorises the diverse experiences and
imagery stimulated in her clients by GIM. These include visual experiences,
such as colours, scenes or figures; somatic or transpersonal imagery pertaining
to the body; abstract imagery, such as mists or clouds; symbolic shapes or
spiritual experiences. Many significant figures appear in imagery, in human or
animal form, and these may reflect archetypal figures or experiences, such as

Robin Hood, a Viking, the witch, a wolf, or a hero's journey or battle. These figures are thought to represent aspects of the client's self which are unacknowledged, split off or fragmented, and engaging in dialogue with them within the imagery experience enables integration of the different parts of the self. Erdonmez Grocke (1999, p.203) terms such moments of insight which have a transformative effect on the person's life 'pivotal moments'. These, be they in imagery or music, are indicators of change and, as such, lend themselves to further analysis when researching a deeper understanding of the personal processes contained in music therapy.

Tomaino (2000) explores the potential of familiar music to stimulate images and recollections in elderly women with dementia in a way which words or photos cannot. She concludes that the visual images presented in, or stimulated by, music link to intact memories and 'a song can be an engram…a representation of a piece of one's history' (pp.208-209).

Other examples of music therapy using images include Heal (1989) and Tyler (1998), both presenting case histories involving the use of pre-composed songs, images and fairy tales. Heal relates one child's (John) use of known songs to the work of Bettleheim, demonstrating how a song can serve a similar function to a fairy tale by symbolically representing crucial moments of a child's development. Heal analyses John's words and sounds about frogs and toads in terms of Bettleheim's fairy tale symbolism, depicting the difficult feelings an abused child faces in growing up through archetypal creatures that undergo their own transformative metamorphic life cycle.

Tyler (1998) describes her work with an autistic girl, Jennifer, who recounted fairy stories repeatedly during her music therapy sessions. These stereotypical archetypal stories helped Jennifer depict and cope with family separations in her early life, yet their repetition perpetuated her withdrawal and isolation. Tyler gradually introduced musical unpredictability to engage and transform her responses into more creative expression and a new persona emerged, using other symbolic images that finally freed Jennifer to express her spontaneous 'True Self' (p.63). This musical adaptation to support the emancipation of stuck images is similar to my increasing improvisation around *Edelweiss* that gradually helped Angela to acknowledge that the 'Nun music' was also 'Angela's song' (see Chapter One, section 1.2.3).

Fairy tales naturally lend structure to a personal narrative. Following a literary model, Propp (in Cortazzi 1993, p.87) showed that the 'plot' structures of Russian folktales had 31 functions or significant actions, appearing in invariant order. In an anthropological narrative model, these cultural actions can be viewed as symbolic behaviour that has meaning, both referentially, in its content, and socially, in its moral values. Music therapy can utilise these functions, adding personal contexts and emotions to the structures to enhance expression. Indeed, Blackburn (1992) uses the nature of fairy tale as a metaphor for music therapy itself. She presents two different emphases on the concept and enchantment of fairy tale: Bettleheim's belief that fantasy enables us to find meaning in our lives by using images to structure our day dreams and understand our conscious selves in order to cope with our inner problems and conflicts; and Tolkein's view that fantasy is desirable precisely because it

allows us to create our own life-enriching realities and have some escape from worldly problems. Where both views concur is in our relationship to the characters personified, be they human or animal. We identify with them as they face the universal emotions that we also experience. In the struggle between Good and Evil, in the stories of loss, death or separation we re-experience injustice, loneliness or fear and gain insight and acceptance in dealing with our own life issues.

Such universality is a theme in the extensive literature that exists on the psychoanalytic significance of fairy tales. McLeod (1997, p.59) reviews their deterministic or ambiguous interconnection in the construction of individual identities and life-narratives, and the attractiveness of fairy tales or Biblical stories of a 'mythic' nature, 'retold so often that they have come to express fundamental truths about life and existence'.

However, Gilligan (1996), in his work in forensic psychotherapy with violent offenders, suggests that myths are important not because they are fantasies but because they may have originated back in history as attempts to describe and cope with actual crimes and atrocities. Their attraction therefore is not in fiction but in depiction. Perhaps this makes them all the more appealing for the women in my study, whose own life soundtracks record horrific instances of violence, abuse or crime.

What is not in doubt is the abundance of examples of fairy tale usage in psychotherapy. Brun, Pedersen and Runberg (1998) devote an entire treatise to

the symbolic and archetypal material contained in fairy tales and the interface between fiction and the real world of patients in a psychiatric hospital. They explore symbols in conversation and guidance, and therapeutic endeavours using mythic tales such as Pinnochio. Brun (1993) goes on to categorise and interpret three groups of symbols: Nature (e.g. the wood, flowers, moon, bird, animals, water); Magical/Mythological (e.g. angel, dragon, witch); Cuturally Created (e.g. king, tailor, key, gold, mirror).

McAdams (in McLeod 1997, pp.62-63) expands on the importance of exposure to fairy tale in early childhood to construct a model of development that spans an entire life-course. Through the analysis of structured life narratives he aims to identify a 'personal myth that brings coherence to all the stages in a life'. The 'plot-lines' that emerge show metaphoric themes, such as life as a journey or a battle. McAdams interest is in the motivational structure underpinning the story: the tension between 'agency' and 'communion' in a person's life. The story character, or 'imago', represents how this dimension can be enacted in life, mediating between the individual and his experience. These imagoes are often archetypal figures, such as Warrior, Lover, Teacher or Survivor, and they become a 'personified and idealized concept of the self'.

If such archetypal characters appear within the music of an individual's soundtrack (see section 3.4), as in the case of Angela's 'Nun' (see section 1.2.3), the latent personal myth takes on a potentially public face. Extrication of the images could create a visual narrative, a cinematic incarnation that encapsulates the musically constructed life identity of the individual: in effect,

what I term, a coded recitative. This is similar to the process of art therapy that can result in 'metaphorical portraits' (Mackie 1994, p.246).

3.5.2 The Metaphoric Process

Personal metaphors feature strongly in psychotherapeutic literature (e.g. Rasmussen and Angus 1996) and references are increasingly testifying to their use as a communicative process rather than as a separable event. Rolvsjord (2001) explores how the teenaged 'Sophie' used metaphors from the lyrics of songs she chose while learning to play the piano to initiate therapeutic work concerning grief and traumatic life experiences. Initially, Rolvsjord introduced symbols from the songs into verbal communication, clarifying and facilitating the use of 'the star' or 'the flower' (p.80) as a medium of communication, allowing Sophie to talk through her related memories. Sharing the songs musically shifts the focus onto implied metaphors, having moved from silence through lyrics to mutuality through music:

> Playing these songs together confirmed our mutual understanding…
> and therefore words were not that important at this stage in the
> therapy. (Rolvsjord 2001, p.82)

Such musical use of metaphoric song lyrics as a bridging process is addressed by Bruscia (1987) in his work on improvisational models of music therapy, as he describes the paraverbal therapy developed by Heimlich. Here the presentation of song lyrics metaphorically is a therapeutic manoeuvre that not

only enables clients to gain insights into their problems in a non-threatening way, but also, as shared communications….

> [Lyrics] can bridge the chasm of anxiety and distrust that often
>
> exists between client and therapist, and among clients.
>
> (Bruscia 1987, p.308)

From a social constructionist perspective of the narrative process (see this thesis, section 3.3.2) this bridging must have particular importance for clients who already have heightened levels of anxiety due to their diagnosis and life experiences. Coupled with the additional peer pressure of group work in forensic music therapy, the reciprocity of metaphorical lyrical performance becomes ever more pertinent to the structuring of the therapeutic narrative.

It is not surprising then that metaphor as process is becoming noticeable in research in all fields of arts therapy. Knocker (2002) writes of the use of metaphor in dramatherapy, linguistically through stories, and actively through play, with both creating opportunities for validation or resolution of the individual's identity and past or present conflicts. She questions current debates over the extent to which overt interpretation of metaphorical material is necessary, trusting the intuitive judgement of therapists in meeting the needs of their clients. This fits admirably within the constructionist mould, with the joint active negotiation of the metaphor being the core process of the therapy itself and, as I presented in Chapter Two, section 2.4, with the extension of this mutuality over time contributing to its own corroboration of credibility.

Such a central systemic approach is advanced by Ellis (2001) in postulating a model for the process of dance movement therapy for people with psychotic conditions. Ellis describes how the 'movement metaphor' (e.g. falling apart, carrying, flowing, following) acts as a mediator or bridge, being a kinaesthetic experience….

> …that involves the therapist and client constantly shifting between *symbolic* and *knowing realms*, and that utilizes the premise that there is mutual influence between 'meaning and action'. (Ellis 2001, p.187)

Again the therapist's intuitive response to metaphorical or symbolic material may inform an intervention or action without it reaching conscious attention: the therapeutic process may exist solely within this recursive relationship and it is the nature of artistic expression which facilitates its creation.

Using a cyclical inter-relationship between meaning and action at the interface between the symbolic and knowing realms also arises in therapeutic work with existing groups or systems. Individuals in a family relate to one another according to a structured 'family dance' of behaviour (Napier and Whitaker in Gladding and Heape 1987, p.109). Family therapy based on poetic metaphors in the lyrics of popular music not only provides insight into interactional patterns but also can be used dynamically, through experimentation with new musical selections, as a technique to make constructive changes in family lifestyles. Gladding and Heape (1987) present the case of 'Larry', whose alcoholism contributed to his marriage break up. He came to recognise how his favourite

songs justified drinking and blamed women, and how these lyrics reinforced his behaviours. Changing the songs provided a basis for acting in a different way; learning the steps to a new 'dance'.

A note of caution is offered by Cederborg (2000, p.217) who considers it vital to examine the values and meanings in metaphors and who will lose or gain if used as an intervention to implement 'the world view of the predefined normative standard for family life'. Yet such values and meanings prevail in the wider cultural context in which family groups operate, and individuals construct their own social contexts according to these values. McMullen (1999, pp.105-106) analysed the talk of 'depressed' women during psychotherapy. Metaphors of darkness, weight and descent defined two broad cultural imperatives that shaped and supported their gendered devalued condition: 'don't be too mothering' and 'don't be too child-like'.

The core message is about the importance of autonomy in a social-historical context which reinforces the construction of an immobilising deficiency for women. Here arts therapies may have an advantage in that the mutual act of creation revolves around personal spontaneous expression itself rather than following a pre-programmed course towards a defined end result, and the autonomy of the individual in negotiating and testing new ways of responding is paramount.

Jungaberle, Verres and DuBois (2001) stress the importance of an individual's social or biological frame in generating musical meaning, recognising that

personal experience effects how we react to music and actively compose meaning from it. This in turn affects our musical behaviour in a therapy context and has its own associative potential as, crucially, 'there is a distinct difference between music and music experience' (Jungaberle, Verres and DuBois 2001, p.6) with no categorical polarity between 'emotional' and 'cognitive' but rather a reciprocal relationship between ideas and experience. Music, they propose, has inherent metaphorical concepts (e.g. space, tension) which are more than just linguistic phenomena: they are a natural part of music related information processing and one of the 'organizing principles' (p.6) of music experience. Bonde (2002) expands the notion that music is metaphoric in itself, enabling representation of imaginal and enactive experiences: it is a 'Virtual Soundscape' (p.10)

Cox and Theilgaard (1997) use an actual musical metaphor as part of the title of their work on the hermeneutic potency of metaphors: 'The Aeolian Mode'. This form of dynamic psychotherapy is dependent on the therapist's capacity to access the 'music in the wind' (p.22) from the Aeolian Harp, the hidden communication from the patient, by means of a process of poiesis. For psychotic or psychopathic patients, images hold experiences too painful or broken to tolerate analysis, stories so disturbing they have been banished beyond verbal access, but which can be activated by metaphor, crossing the threshold between conscious and unconscious. At a point of dynamic instability, when the patient may be receptive to self-reflection on previously repressed experiences, autogenous therapeutic interpretation may be mobilised by the mutative potentiality of metaphor, filling out the core issue and allowing it to be

supportively confronted or developed through parallel themes. This allows the patient's story to be told, an opportunity he needs to seek 'so that he can learn his own life-story at first hand' (Cox and Theilgaard 1997, p.3). The key paradigm of the Aeolian Mode is crystallized in one sentence:

> But the image has touched the depths before it stirs the surface.
>
> (Bachelard, in Cox and Theilgaard, 1997, p.xiii)

This central placing of the role of metaphor is supported by Contemporary Metaphor Theory, as described by Eynon (2001), which challenges conventional linguistic approaches. From the constructionist perspective of cognitive linguists, metaphor is fundamental to all human thought. This poses the question of which comes first: language or metaphor? Contemporary Metaphor Theory suggests that language is inherently structured by metaphorical processes based primarily on bodily experiences. It is derived from 'primary process symbolism' (Eynon, 2001, p.354) where a fundamental biological structure is the basis for our understanding of abstract concepts such as emotions and relationships, and imaginative metaphors build on this structure. This has implications for psychotherapy in that novel metaphors provide clues to the 'image-schemas, the symbols, that unconsciously order our conscious verbal productions and thus our psychic reality' (Eynon, 2001, p.363).

How much more central then must metaphor be for the music therapy process?

Participation in music-making provides a primary source of sensory and kinaesthetic experience on which associative ideas can be built within a co-negotiated meaningful relationship, enabling personal realities to be constructed.

The goal of Jungaberle, Verres and DuBois (2001) was to formulate conceptual metaphors in descriptions of musical experience during music psycho-therapy. They discovered 40 metaphorical codes, at different levels of abstraction, which generated 4 'families' (p.9): music as 'force, power or energy'; as 'interaction'; as 'space'; as an 'object, structure or living being'. Giving the music living characteristics, as if it were human or a creature, occurred with overwhelming frequency (e.g. 'witch-like', p.11). They interpret this in accordance with Arnie Cox's 'mimetic thesis':

> We understand the sounds made by others in comparison
> with the sounds we have made ourselves.
> (Cox, in Jungaberle, Verres and DuBois 2001, p.11)

As a music therapist I suggest that the converse is true too: that when our own expression is too painful or confusing we come to understand our own sounds in comparison to those made by others, and song is the process by which this occurs.

Jungaberle, Verres and DuBois (2001, p.12) present a 'metaphorical circle', a cyclical musical process of metaphorical transfer where musical issues are

treated like issues of life, using natural or social environments to understand acoustical processes, but also life issues are treated as if they were music, in the form of actual musical metaphors.

> Extra musical structures influence the experience of music, while
>
> also the experience of intramusical structures can be transferred
>
> to subjective life worlds outside of the narrower realm of music…
>
> music may become a metaphor we learn by.
>
> (Jungaberle, Verres and DuBois 2001, p.12)

Not only do we learn by metaphor but we 'live by' metaphor, according to the cognitive semantic theory of Lakoff and Johnson (in Bonde 2002). Here metaphors are seen as the basis of our conceptual thinking, structured by the natural dimensions of experience, and generating similarities of a new kind. In relating this to music therapy, Bonde uses three metaphorical levels based on the narrative theory of Paul Ricoeur and applied to the metaphorical psychotherapy of Ellen Siegelman:

1)   *'How it was'*: the client's life world, original understanding, presented as a narrative episode configured around a core metaphor.

2)   *'How it came to be and may be changed'*: the metaphoric therapeutic narrative, a midpoint of mimetic action, a configuration of the Self.

3)   *'How it may become'*: the outcome of the therapy, the full narrative.

These levels are connected through a 're-configuration' (Bonde 2002, p.18) of temporal aspects, enabling us to see the past and the world in new ways and to develop constructive modes of intervention.

In essence, Bonde's three levels, Jungaberle, Verres and DuBois' metaphorical circle and the generative constructionism of cognitive semantics and Contemporary Metaphor Theory return this literature narrative full circle to its starting point – my original concept of 'Elusive Butterflies: a generative Metaphor of Metamorphosis' (see Chapter One, section 1.5 and Figure 2).

And so, my research caterpillar completes its review of appropriate literary vegetation and 'sustenance'. Chapter Three has established a clear basis from which to approach the study of song in music therapy. It has laid out both the historical and conceptual background of literature relating to theory, practice and research from a range of music therapy approaches and fields of work, and set these within the context of relevant complementary disciplines. This material finally returns us to the original starting point at which my clinical practice and analysis in music therapy originated and began to be structured into a research study. But we return, nevertheless, to an idea which has already transformed itself - for the idea of metaphor, and its ability to generate a range of further conceptual similarities, now has the additional weight of broad contextualization to support and reinforce it. What may have been an interesting yet seemingly isolated idea has now become a significant framework through which the raw data presented in music therapy can be approached and analysed in a structured, progressive and reliable manner.

As previously explained, in Chapter Two section 2.3.2, I chose to concentrate this research on one complete case study of the entire course of music therapy for one woman, Angela. This provides us with a large and significant quantity of material, both descriptive and factual, and hence offers a clear focus for the extraction of songs, images and metaphors. This work of analysis and interpretation forms the centre of my research, and, representing such a major contribution to the study as a whole, will constitute the entire contents of Chapter Four, and indeed much of Chapter Five. This exclusive focus is a deliberate part of the intellectual process. It places Angela, her music and her experiences at the heart of the research and enables her voice to be heard.

For this reason there are no distracting asides of external literature references. Instead, these essential references and commentaries will return in Chapter Five where a comparative approach will be adopted afresh. But, for now, the focus is entirely on internal discovery and examination as we return to Angela and the full descriptive narrative of her personal journey through music therapy. We settle into the 'chrysalis' stage in my model of research metamorphosis - an inner transformative story or 'pupation', constructed through a soundtrack of song and narrated through personal generative metaphoric images. Chapter Four opens with a succinct telling of an outline history of the case. This is followed by a brief reminder of the procedures used for data collection and analysis before the in-depth examination and interpretation begins. This is the full presentation of Angela's story, so, if you're sitting comfortably, then we'll begin: "Once upon a time….."

Chapter Four: Chrysalis

Angela attended the first music therapy group session introduced into the medium-secure forensic psychiatric unit where she was a resident, and continued to attend on a regular basis until her eventual release nearly three years later. (For a review of the setting within this institution the reader is referred back to Chapter Two, section 2.3.1; an introduction to Angela was given in Chapter One, section 1.2.3 and Chapter Two, section 2.3.2.) Over the course of this three-year period a total of 136 sessions took place, of which Angela attended 121. She therefore missed only a small number of sessions (numbers 27, 29, 33, 39, 45, 49, 51, 53, 58, 67, 70, 80, 93, 105 and 135), these absences being due chiefly to medical appointments or shopping trips arranged by staff. It was very rare for Angela to be present in the unit but decline to attend.

Chapter Four presents and analyses *in extenso* the raw data from these sessions, and seeks to give a clear sense of the stages by which it was ordered and interpreted, and also of how it gave rise to the insights and assertions given in summary form at the end of the chapter. The reader is invited to re-experience the progress of this journey with as much of the same sense of presence and discovery as possible, and so the present tense is often used to heighten this feeling of immediacy. The data from the sessions was first collated and arranged into a descriptive narrative account as described in Chapter Two, section 2.3.5 and illustrated by short example in Appendix C. As previously specified in section 2.3.6, the first stage of therapeutic narrative analysis

produced from this account a straightforward chronological graph of specific song occurrences: in effect, a timeline. And Time is indeed the significant factor in the decision to produce this graph. Unlike charts which collect the data from several different people or events in order to make normative comparisons between them, this timeline shows all the song choices from one complete case, aiming to make explicit the idiosyncratic meaning for Angela as it progressed over a course of several, perhaps many sessions. It gives depth, integrity and authenticity to the data, and so helps to contribute towards the verification of the research. In particular, it makes the occurrence of the songs coherent, clearly visible and identifiable to all readers, allowing a search for patterns within them to be more objective, as there is no requirement for prior knowledge of the therapy sessions themselves.

From this timeline graph I decontextualized, or abstracted, a pattern of episodes or phases, which then, in turn, acted as a focus for recontextualization. Recontextualizing the identified episodic patterns entailed returning to the context of the narrative account of session events once more, so as to be able to use the experiences as aids in interpretation – thus, as a means to understanding the significance behind the songs. From each song I explicated a sense-impression: a plausible, clinically constructed impression or focus, offering in succinct form a sense of the whole experience – almost a summary of its qualities or sensation, its 'feel' if you like. This inferred or 'apparent' meaning was thus encapsulated in a visible or verbal construct: a metaphor or an image. These, as previously explained in Chapter Two, section 2.1.4.2, I took to be the least abstract form of relating direct personal experience, and a 're-creative'

representation of the type of communications presented by the women during music therapy. Internal motivations and expressions thus become part of the methodological process, a tool for analysis, when they are extracted and reapplied as an external framework for interpretation.

These constructed sense-impressions, of metaphor or image, are then subject to further decontextualization, according to the process of therapeutic narrative analysis which I adapted from Aldridge and Aldridge (2002, see Chapter Two sections 2.1.2 and 2.3.6). The constructs are regrouped into themes for further analysis in Chapter Five. This process is hermeneutic, in the sense that it aims to interpret the material as part of a broader, in-depth search for human understanding, and it is also heuristic, in the sense that it is an intensive journey of gradual and increasing discovery 'in the moment' – both for me, as researcher and therapist, and for Angela, as a woman seeking to understand her life and experiences.

It is also a cyclical process of analysis (collation of data – decontextualization to identify an overall episodic structure – recontextualization to produce explicit interpretative structure – decontextualization again at a deeper level of context), that is, a process by which events or episodes may be linked together to produce a story that is then analysed, and its various meanings synthesized together into a coherent research narrative. In effect, this cyclical process is analogous to one of metamorphosis: it mirrors the internal workings within the chrysalis as the raw or immature data transforms itself stage by stage into potentially meaningful themes and issues. These will emerge during Chapter Five, ready to

be analysed for theoretical insight into music therapy and its wider cultural domain. But, for now, we return to the beginning of the cycle and the presentation of Angela's story.

4.1   The Timeline of Songs

Analysis of the descriptive narrative account deriving from the music therapy sessions reveals Angela's choice of 25 different songs over the course of the 136 session timescale. Here, the terminology 'choice of song' in any given instance refers to those songs judged to be significant by the therapist-researcher, at the actual time of the music therapy sessions, primarily in terms of initiation or response by Angela, as outlined in the definition of terms in section 2.2.1.2. As stated previously, this may include songs which were chosen by other women in the group, or which emerged from their activities, rather than initially being suggested by Angela herself *ex nihilo*. However, if she has actively connected with this music, as demonstrated by some observable behaviour or emotional response, then I have deemed this to be an active decision on her part, a personal selection or more particularly a choice of engagement. This is as valid within the broader therapy process as any direct election of a song may be, for, as I see it, there must still be something significant in its content or context which appears important enough to stimulate her to respond and thus warrant her engagement and attention. Other songs may have been mentioned or used, and there were occasions when named songs were used but not judged to be meaningful (in terms of my perceived response from Angela at the time), and so these were not recorded in session notes or the

narrative account.

Plotting the significant occurrences of each of these 25 songs throughout the course of therapy produces the timeline of songs shown, in somewhat contracted form, in Figure 4. When looking at this as a purely visible structure, in order to find a starting point for analysis, it is apparent that, on initial inspection, Figure 4 splits into three sections or phases of seemingly balanced length, beginning respectively at sessions 1, 42 and 94. Over the entire period of nearly three years this gives an overall ratio of 41 : 52 : 43 sessions. Viewed in terms of musical categories, there appears to be a clear analogy to a formal archetype: a structure resembling the classic three-part 'sonata form' founded on a dynamic model of presentation, tension, evolution and resolution.

At this point within the thesis I make no claim that this is a manifestation of underlying processes, either in the 'musical' development of each theme or subject (that is, the songs themselves considered as melody, harmony, rhythm or lyrics) or in the progression of themes, issues or foci within the therapeutic relationship. Rather, I see it as a methodological research tool which can assist in analysis by providing a longitudinal and evolutionary structural framework for the examination of patterns over time. In effect, I apply the temporal and dynamic structure of the three-part form to the timeline of songs in order to break the data into smaller, manageable 'thematic' sections that are then accessible for further inspection and interpretation.

Figure 4: Timeline of Songs
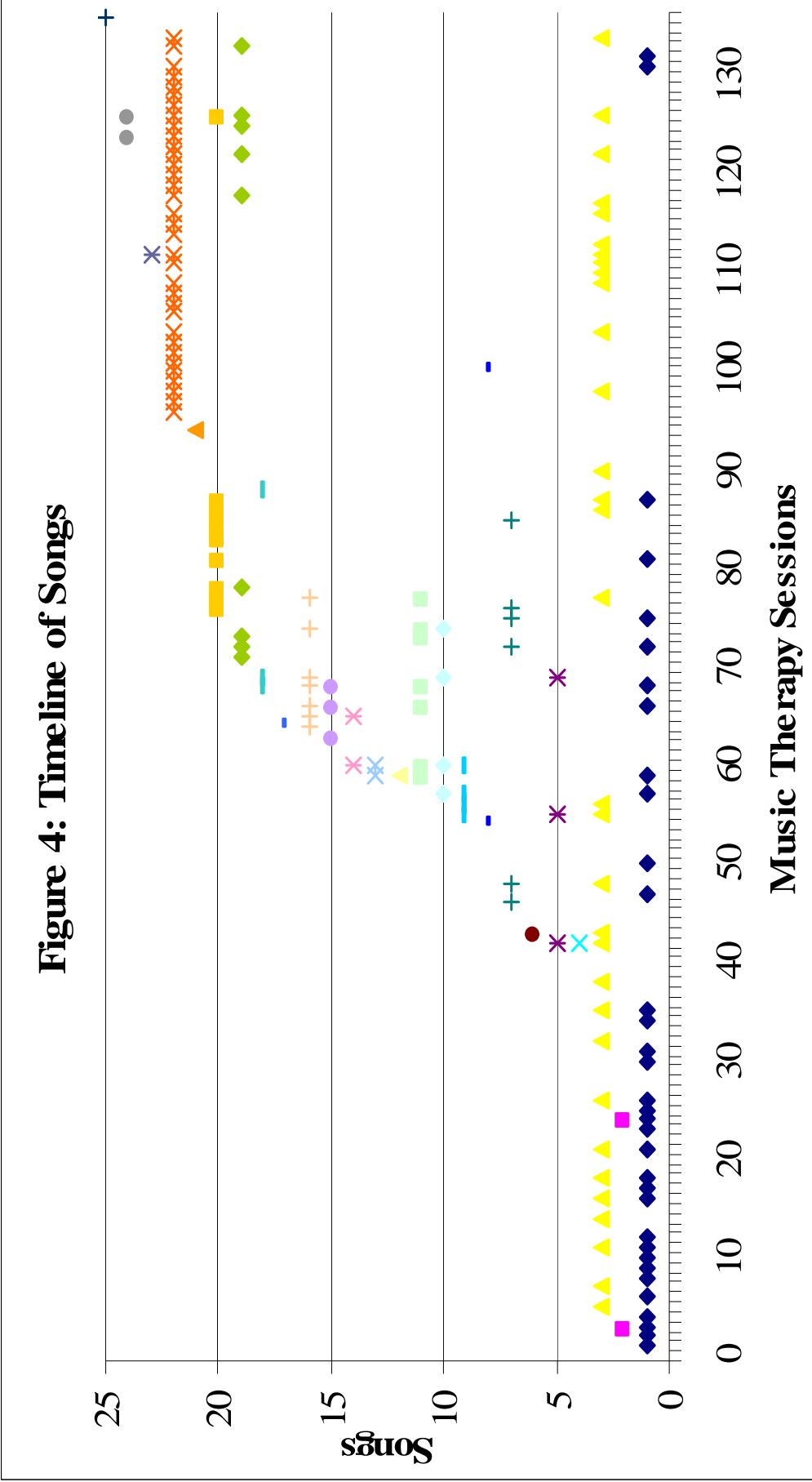
I. Exposition – sessions 1-41 might be described as the first and second subjects, which in the guise of Songs 1 and 3 occur consistently throughout, with only occasional episodes of Song 2. In place of the expected 'closing group' there is in fact a clear break, manifested in an absence of song for three sessions (numbers 39-41) before the initiation of the next phase.

II. Development – sessions 42-93. The first and second subjects (Songs 1 and 3) recur more sporadically; but there is now, in addition, a wealth of new material: new songs are introduced and abandoned in rapid succession as if in exploration, in what appears to be an experimental or searching manner. As in the exposition, there appears again to be a 'silent codetta' of three sessions without song material (numbers 91-93).

III. Recapitulation – sessions 94-136. The first subject (Song 1) is almost entirely absent, substituted with an insistent Song 22, though Song 1 is finally restated towards the end (sessions 131-132). The second subject (Song 3) continues to appear occasionally but the exploration of new material and its 'experimental' quality has now largely finished. The coda here appears to be a straightforward single statement of Song 25.

This sectionalization of the timeline, and the ordering of episodes within it, has initially been constructed on a visual basis, without recourse to the therapeutic or musical context. This is used as an organizational approach to provide a framework of guidance for a more systematic interrogation of the data that underpins it. I now examine the three sections according to the questions which

arise from a consideration of the developmental patterns (or structures) that would be expected in an archetypal sonata form, with its complexes of rhythm, theme and development leading to resolution. This process of interrogation indicates three important questions for me, of a structural or progressive nature, which now become the focus for the next stage of analysis:

1. Are what I have analysed as the first and second subjects 'true' statements of the main material (whether construed in terms of externally observable music, or of internal experiences) on which the entire course of therapy is founded?

2. Does the Development section really explore and extend into new regions the foundational material presented in the Exposition?

3. Can it be maintained that Song 22 is indeed a 'recapitulation' of the first subject (Song 1) in a reconstructed or otherwise renewed format?

To search for detailed and credible answers to such questions clearly requires recontextualization: returning to the narrative account and using the framework of the sonata-form pattern as a tool through which to interpret the content of the individual songs and their relationships to the experience of the sessions (from the viewpoint of both client and therapist), in order to extract an impression of the focus of each song.

The remainder of this Chapter will be presented in the three phases or sections of sonata form:

4.1.1 Exposition

Exposition: Sessions 1-41
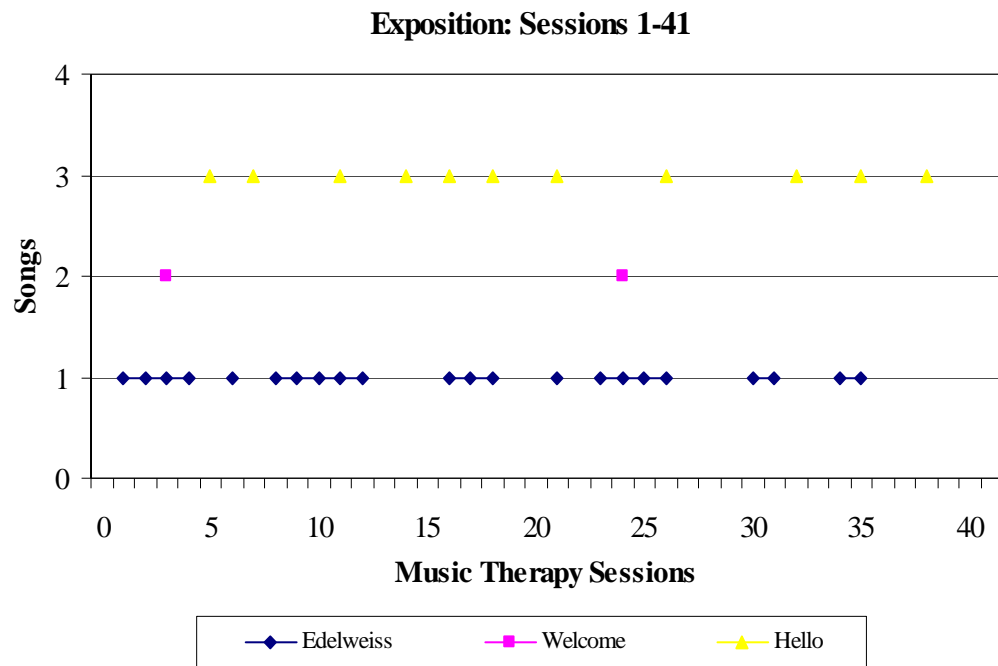
It is instantly clear that Angela used only three songs during this extended period of therapy over ten months. As discussed in Chapter One, section 1.2, such monotony of presentation must be validated somehow by the client's commitment to continued attendance. Meaning for Angela must be contained either in the nature of the song itself, in our mutual relationship in its performance, or perhaps simply in her ability to instil some element of control into a disordered life through such perseverance.

On first inspection of this Exposition, Song 1 (*Edelweiss*) appears to be the first subject and Song 3 (*Hello*) is the second subject. Song 2 (*Welcome*) can be seen either as a bridge passage leading from first to second subjects or, as another greeting song, as part of a second subject group. Thus, in form at least, there are two main themes.

Songs 1 and 3 were presented earlier in Chapter One (sections 1.2.3 and 1.4.1) in the brief vignettes of women's initial song choices but I will now explore their content in greater detail.

4.1.1.1 Songs 1-3

Song 1 (*Edelweiss*) was introduced into the very first group music therapy session by Clare and Angela seemed to connect to it from the start. As I sang and played the keyboard she chose to play a cabasa then changed to the wind chimes, occasionally tapping with a small beater but generally making sweeping glissandi that had little in common with the structure or tempo of the music. This became her only instrument until session 22, apart from a brief encounter with an orange-shaped shaker in session 21. She then played only a small glockenspiel for several weeks until adopting the woodblock in session 32, which she kept with little variation throughout the rest of this period. Angela's approach to *Edelweiss* was also clearly defined and consistent: she did not sing at all and expected me to play repeatedly with no variation. At the end of each repetition of the song she would stop playing the wind chimes and steadfastly ignore all my attempts at involving her in free improvisation. She seemed sated with the simple perfect expression of this song, and the lyrics themselves seem to provide a clue to its meaning for her.

Edelweiss, Edelweiss, Ev'ry morning you greet me.

Small and white, Clean and bright, You look happy to meet me.

Blossom of snow, may you bloom and grow, Bloom and grow forever.

Edelweiss, Edelweiss, Bless my homeland forever.

(Rodgers and Hammerstein 1959, pp.60-62)

From these words I can construe several impressions of relevant content, based on my participant experience as therapist in the sessions. Firstly, there is a greeting; a sense of recognition and acceptance that was patently missing from Angela's social situation: the other women often ignored her or were verbally abusive. Their comments made it clear this was a racial issue, Angela being the only Black woman in the unit, and discussion with other staff revealed this had been a major issue in her previous secure hospital, resulting in official investigation and eventually contributing to her move to this unit. Ironically, this may be also an interpretation of my second impression: the whiteness of flower and snow representing purity. This is supported by the dominance of the colour white in Angela's clothes and possessions, such as her handbag, which was second only to her dedication to blue and rejection of objects of any other colour. It is this combination that, early on in therapy, had formed in my mind the image of Angela as the Virgin Mary. Finally, there is the wish to 'bloom and grow' which could be an aspiration for Angela's future; an expression of what she hopes to gain from the therapy process. Comparing and combining these impressions elicits the following bi-polar constructs, which will be carried forward into Chapter Five for further analysis:

greeting : ignoring

recognition : denial

white : black

purity : pollution

growth : decline

These subjective constructs are sanctioned by Angela's own terminology: when requesting *Edelweiss*, from as early as session 4, she referred to it as 'Nun music'. Although, presumably, this is taken from the storyline of 'The Sound of Music' film itself, with Maria being a nun, as a single verbalization it conjures up a metaphoric image, the archetypal 'Nun' that crystallizes the interpreted impressions into one meta-construct:

Goodness : Badness

That this relates to Angela's emotional aspiration was indicated as early as session 2, and frequently thereafter, by her requests that I, "Tell [name of staff] how well I've done," and reassure her, "I've been good, haven't I?"

Songs 2 and 3 are both greeting songs and, therefore, further reinforce the impressions of a desire for recognition and acceptance. I initiated Song 2 (*Welcome To My World*) in session 2 as Clare said she liked Jim Reeves. Later on, in session 4, after playing her usual intermittent wind chime glissandi throughout the song, Angela stopped and clapped.

      Welcome to my world; Won't you come on in?

Miracles, I guess, still happen now and then.

Step into my heart, Leave your cares behind;

Welcome to my world Built with you in mind.

Knock and the door will open; Seek and you will find.

Ask and you'll be given The key to this world of mine.

I'll be waiting here With my arms unfurled,

Waiting just for you; Welcome to my world.

(Winkler and Hathcock 1962, pp.54-56)

Perhaps Angela recognised that the 'miracle' of acceptance that she craved could happen through the open door of therapy where music is the key. Certainly, at this time, it did allow her to 'leave [her] cares behind' as the anger and violence for which she was known was rarely exhibited during sessions. In the unit she was tearing apart all her clothes, yet I saw only the 'good' Angela who relaxed so much she occasionally fell asleep during the music.

From my brief impressions of *Welcome* I take the construct - open : closed.

Some images spring to mind (open door, key, heart) but, as Angela never requested this song, none speak strongly enough in her voice to be taken forward as an image for analysis. Angela adopted a simpler greeting song that pervaded the entire course of therapy; my improvised song:

Let's sing hello, Let's sing hello,

Let's sing hello to [Angela].

This is a simple pentatonic tune played in compound time over an ostinato bass of open fifths. I played to each group member in turn, sometimes at the request of Gracie or Clare. Angela responded by playing her wind chimes intently with an expression of serious concentration, and would look at me and smile as I sang her name, pleased to be acknowledged.

The construct is the same as that of Song 1 - greeting : ignoring.

4.1.1.2 Exposition Discussion

In discussing a piece of music or a written narrative there are many descriptive or explanatory terms which may be common to both fields. Brooks and Warren for example (1972, pp.43-45) use the words 'form', 'elements of composition' and 'theme' when examining the functions of a piece of writing, and 'exposition' to describe one of four kinds of discourse when 'the intention is to explain something….in short… to inform' (p.44). Within a musical exposition the same intention may be present, with the two themes or subjects providing a clear statement or indication of the initial musical basis of the piece, and thus laying the foundations for the elaborations and developments that will follow. These rhetorical-structural divisions are legitimately applied to both spheres.

In section 4.1 I raised the question of whether the first and second subjects indicated within the timeline of songs are true statements of the main material on which the 'sonata' of Angela's therapy is founded. At this stage of analysis, this idea appears to be supported. Emotionally, Songs 1 and 2-3 seem to reflect

Angela's current aspirations, her desire to be recognised and acknowledged as a good person – in short, to be 'greeted'. Musically, their performance allows her to successfully experience these positive feelings and their repetition gives a sense of structural stability and control, and therefore adds to her emotional security and enables her to relax.

It is precisely this combination of emotional 'theme' and musical 'involvement' which has risen in precedence, and which I shall continue to focus on throughout this thesis. Although considering the musical archetype of sonata form, I am not analysing the detailed musical progression from one song to another, nor, indeed, suggesting that such development may be either present or absent: I have instead followed the path which beckoned most prominently from my initial consideration of the data and my experiences during the sessions. But analysing the song words and images from Angela's perspective rather than from my own in no way diminishes the importance of the music, for it appears to be, not simply a vehicle or carrier for the lyrics but, in addition, the driving force which connects the images with the underlying emotional themes and process. It is Angela's active participation in the songs, by listening, playing instruments, or by singing, that brings the issues depicted in the song words to life, bringing a palpable sense of reality and engagement and thus personal presence to the experience itself, in the moment.

It is this musical association, too, which unites therapist and client and builds a working relationship which is both musical and therapeutic. Making alterations to the music thus functions to adapt or enhance the intention and purpose of the

songs in question; and it was this process of re-creation that, slowly but surely, began to address Angela's needs, as I altered aspects of the music and she became freer and more ambitious in her own explorations.

Nevertheless, it is important to acknowledge that although the recognition and expression of Angela's aspirations and her achievement of relaxation, as described above, may be temporarily therapeutic, they are not therapy *per se*. Acknowledging hopes and wishes is a starting point, but therapy also has to empower Angela to engage with and somehow address the bad experiences in her life, and to find new ways of dealing with past and present difficulties, in order to achieve her aspirations even partially.

The words of Songs 1-3 provide some indication of her problems, for example, with acceptance within the group, and their repetition may provide some degree of personal awareness and reflection but this does not allow for any detailed and adaptive personal expression of her feelings around these issues. This is where music therapy has an advantage over verbal psychotherapies. I began to personalize the songs: changing the tempo, dynamics or harmonies to match Angela's perceived mood; imitating and incorporating her glissandi; altering the words of *Edelweiss* ("Angela, you can play…") and acknowledging it to the group as 'Angela's music'. Once this personalization was established, Angela was able to relax and share control of the song, allowing its repetitive structure to change. After singing the words I improvised with the melody, keeping the same phrase structure, and I ventured into expressions of sadness or loud bursts of energy. Eventually, Angela felt supported enough to join me and in session

26, for the first time, she continued playing after the song ended. By session 32 we could improvise 'Nun music' and finally, in session 34, 'Angela's music'. She was nervous and expressed concern but focussed on her newly discovered woodblock and seemed unable to stop. She would not hold a pulse, and moved if I matched her timing, but there was much rhythmic imitation and group interaction, and laughter turned to a more serious blues feel which I supported on the guitar, without objection from Angela at this change from the keyboard.

Being accepted musically and discovering that she could interact with others with some degree of influence gave Angela trust and confidence in her own right to self-expression. She became more assertive in her improvisations and her personal expression came to the fore. Throughout the Exposition her songs and musical playing had been stable, relaxed and aspiring, giving no hint of the tumultuous life experiences of her past and the ongoing events that developed during this period. Occasionally, issues ventured into the therapy sessions but Angela's musical life remained resolutely separate and strong negative emotions were never expressed musically. During the Exposition these two lives ran a parallel course, but personal events began to predominate until a major clash in session 41, at the end of the break in songs that replaced a musical codetta, and this may have been the cathartic turning point which necessitated musical development through the active integration and expression of emotion.

In the early sessions Angela was active and could be quite talkative, even loud and argumentative if anxious, but small changes in her demeanour rapidly

escalated. Her relaxation appeared more as fatigue and in session 13 she struggled to speak at all. At session 15 she arrived late, being physically helped by staff, then fell to the floor asking for help to get up. This was repeated two weeks later and prompted staff debate around physical problems or attention-seeking behaviour. For session 18 she arrived in a wheelchair. She would not talk about this but demanded attention in new ways; for the first time she asked to be sung to in the *Hello* song ("Me"), but would not wait for anyone else to have a turn, instead insisting on her "Nun music" then obsessing about her "navy blue skirt". In the next week she was diagnosed with multiple sclerosis and, after a brief spell with a walking frame, she did not walk again. In her usual fashion, this was not brought to music therapy immediately and was mentioned only once, in session 23, when she told me she was going to see a doctor to find out why she couldn't walk. Evasively, her conversation, now somewhat stilted, focussed for several weeks on her blue clothes and white handbag, or on her trips to the dentist, both topics which would take on greater significance over the next few months.

However, her emotional distress at such a life-changing diagnosis could not be kept out of sessions for long, particularly in combination with her new-found trust in expressive improvisation, and in session 41 her aggressive behaviour in the unit spilled over into the session. She had ripped apart all the clothes that she possessed. Staff had borrowed some trousers for her as she was still determined to attend but in the middle of the session, possibly activated by my discussion with Gracie about what made her 'happy', Angela began to try to tear these too.

Therefore, the three week codetta both demarcates and summarises the statements of the Exposition. After an absence (session 39) and a week with no songs (40), session 41 brought to the fore Angela's struggle with emotional expression. She seemed unable to discuss her problems or to express her feelings musically or verbally but, over the next few weeks, songs appeared which provided just such an essential opportunity, allowing her to address issues and explore new ways of dealing with them. A period of Development began, both musically and therapeutically.

4.1.2 Development

Development: Sessions 42-93
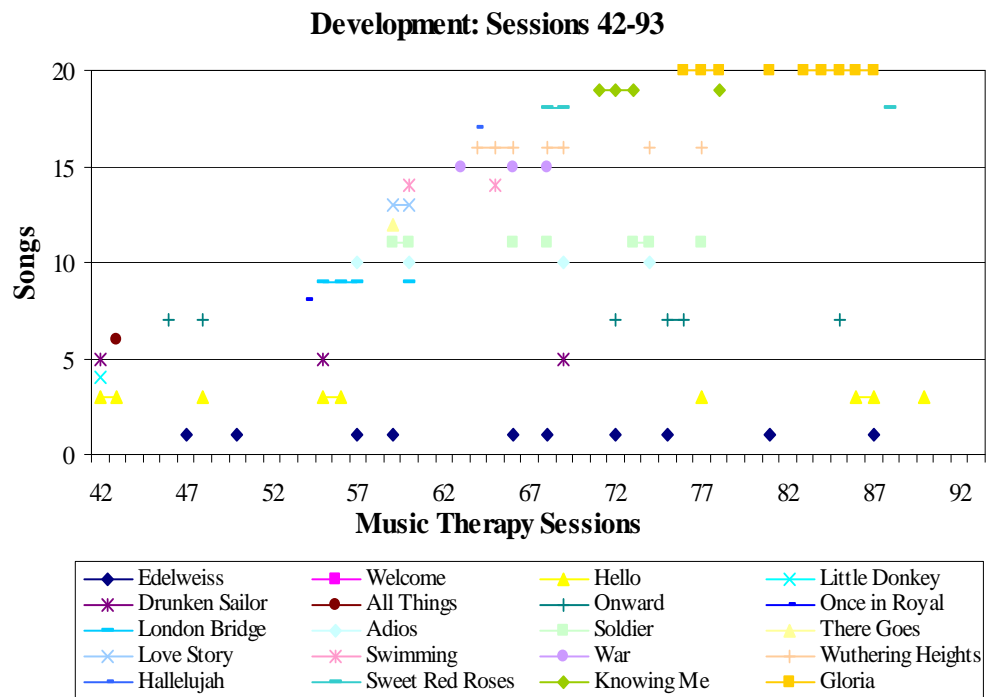
In stark contrast to the 3 songs of the Exposition, the Development contains 19 songs over a slightly extended period of 52 sessions. 17 are new songs which burst into the sessions at frequent intervals and often disappear just as rapidly.

None, it seems, have the staying power of Songs 1 and 3, which continue to occur, though with less insistence than in the Exposition. But their strength, perhaps, is in this rapidity, demonstrating Angela's release from her earlier containment within an unchanging structure. Is this a true Development, building on the themes presented in the Exposition? Is it an indication of Angela's feelings that lie behind her need for Goodness?

After the trauma of clothes-tearing in session 41 or, perhaps, because such a display of strong emotion had been held and supported in the session without criticism, Angela presented both a need for self-expression and a growing belief in her rights to assert herself within the group. Session 42 certainly showed unprecedented changes in her social and musical interaction, reaching out in surprising ways. She asked for her "usual", the woodblock, and played quietly while Gracie repeatedly sang Christmas carols and talked reflectively about her health and family. Suddenly, Angela asked for "Hello to Gracie", her first active use of the familiar Song 3 to greet another person and initiate positive exchange. The success of this simple act inspired confidence and the immediate progression of further exploratory forays into uncharted musical territory.

4.1.2.1 Songs 4-8

As narrated in section 1.4.1, the next new Song 4 followed immediately in session 42. Gracie, still imbued with early Christmas spirit, began to sing *Little Donkey*:

Little donkey, little donkey, on the dusty road,

Got to keep on plodding onwards with your precious load.

Been a long time, little donkey, thro' the winter's night.

Don't give up now, little donkey, Bethlehem's in sight.

Ring out those bells tonight, Bethlehem, Bethlehem.

Follow that star tonight, Bethlehem, Bethlehem.

Little donkey, little donkey, had a heavy day.

Little donkey, carry Mary safely on her way.

(Boswell 1959, pp.27-29)

During *Hello to Gracie* Angela had made quiet breathy sounds as if trying to sing. I had responded to these musically but had not commented for fear of inhibiting her. Now, for the first time in eleven months of music therapy, she sang firmly and clearly, joining in mid-way through the chorus "Little donkey, little donkey, had a heavy day. Little donkey, carry Mary safely on her way". This time I commented that we were all singing together as a group. Angela acknowledged this and, in a burst of eagerness, picked up the glockenspiel to play briefly before returning to her woodblock.

The timing of Angela's singing at these words is significant. It reinforces my vision of her as Mary, another archetypal figure of Goodness, and this is the metaphoric image that I extract.

But there is another deeper, darker relevance contained in these lyrics that begins to express Angela's feelings at her current situation: having to be carried as she can no longer walk; and the weariness of 'plodding onwards' when it's 'been a long time', tempered with optimistic determination to 'follow that star' (Nun) now her goal (Goodness) is 'in sight'. From these sense impressions I abstract the following constructs:

carry : abandon

heavy : light

onward : backward

follow : leave

Song 5 appeared in the next few minutes, again initiated by Gracie who led the way out of this reflective mood with loud drumming and a raucous rendition of:

What shall we do with the Drunken Sailor,

What shall we do with the Drunken Sailor,

What shall we do with the Drunken Sailor,

Early in the morning? (Traditional, s.l.:s.n.)

I drummed, too, and the music was lively and exaggerated. Gracie laughingly said she was beating me (musically or physically?) and, feigning shock, I sang, "What shall we do with Gra- -cie-?" then, "What shall we do with Angela-?" Angela laughed and began to sing again while I repeated the song and she "la la la-d" when I altered the words. My impression is that this was a positive

interaction where Angela enjoyed being included in a fun exchange of music and humour. Nevertheless, my question has a serious undertone (What *shall* we do with Angela?) and I abstract from this uncertainty the image of the Drunken Sailor and the construct:

 questioning : stating

Session 43 continued in the same vein as a happy, but rather manic and unfocused, Gracie started more Christmas carols, hymns and other songs; lost her train of thought; and talked over all of them, effectively monopolising all attention. Not to be sidelined again, Angela declared her presence with a firm "Hello" during the greeting Song 3, the first time she had actually responded vocally in this way. To keep her motivated I asked if she had a favourite Christmas carol and her response was, "All Things Bright and Beautiful."

> All things bright and beautiful,
>
> All creatures great and small,
>
> All things wise and wonderful,
>
> The Lord God made them all. (Alexander, no date, p.596)

More a hymn than a carol, but this Song 6 was the first time Angela had been able to name a choice of something 'favourite' when asked, and it is a further expression of beauty, goodness and inclusion of 'All', leading to the construct:

acceptance : rejection

This musical hymn theme continued through Songs 7 and 8 but the emotional theme returned to develop issues presented in earlier conversations during the Exposition: notably, the dentist. Session 44 began with Angela alone and she appeared to replace the absent Gracie's recent constant conversation with her own barrage of questions. Her tooth hurt, she said, and the dentist would take it out, wouldn't he? She was not interested in it being repaired, only removed. This is analogous with Boone's (1991) report of a patient's use of poetry, where 'Tooth Decay' represented the progress of his illness (see section 3.1.1). Angela's wish to have her tooth removed rather than repaired is a metaphor for her approach to life and therapy: wanting an instant fix where badness is not addressed but simply does not exist and only the good, perfect teeth remain. I talked through the idea of having the bad part of her tooth replaced whilst I musically supported her woodblock improvisation with my xylophone, playing clashing semitones to represent this conflict. She relaxed and began to talk and play about Christmas but, at the arrival of Clare, she became quiet and asked to leave.

Angela was absent in session 45 but returned in the next session, complete with virtual dentist. Gracie was in pious mood again and introduced Song 7:

> Onward Christian soldiers! Marching as to war,
> With the cross of Jesus Going on before.
> Christ the royal Master Leads against the foe;
> Forward into battle, See, his banners go! (Baring-Gould, no date, p.867)

Angela agreed to play 'marching' music to my drum, and said she was going to the dentist. This was her first imaginative suggestion for an improvisation during a song and it pulls together several of the issues occupying her thoughts at the time. Her 'war' against badness is moving forward, led by the 'Master' dentist with his ability for a quick fix, and the idea of marching suggests recognition that her inability to walk also needs fixing. This may have been brought to prominence in this particular song because of the woodblock, which fell apart at the beginning of the session and could not be fixed, forcing her to try a banana shaker instead. Using Angela's words I extract the metaphoric image of The Dentist and the constructs:

war : peace

broken : mended

"Mended?" was Angela's opening gambit in session 47. She was pleased that I had fixed the woodblock and kept thanking me. After a reassuring return visit to the Nun music we talked of the dentist, making vocal exchanges over a musical improvisation.

Song 7 returned in session 48 but Angela was very weak, struggled to play the woodblock as she could not use both hands, and had to try several small shakers instead. As Gracie sang *Onward*, Angela chose to fly rather than march, perhaps acknowledging that the weakness in her legs necessitated a more varied mode of transport. To the earlier constructs I add:

travelling : stationary

The following weeks were disrupted by a few absences but when Angela was present she continued to speak of the dentist and about shopping for blue clothes. Physically, she improved slightly and could play the woodblock again but, in session 54, I encouraged her to join me playing a set of coloured handbells. Naturally, the dark blue one appealed and she played for the rest of the session, and indeed for most of the Development period, giving all our music a tonal ostinato of 'A'. Song 8 appeared briefly as she explored the blue handbell. Gracie began to sing and Angela joined in too:

> Once in royal David's city Stood a lowly cattle shed,
>
> Where a mother laid her baby In a manger for a bed.
>
> Mary was that Mother mild,
>
> Jesus Christ her little Child. (Alexander, no date, p.582)

My metaphoric image of Angela as the blue Mother Mary recurred, and her closing remark as she left the session further reinforced it, "I've done well, haven't I?" although this time it was a rhetorical statement rather than a question that required reassurance.

4.1.2.2 Songs 9-14

In session 55 Angela's magnanimity extended Song 3 to *"Hello to Everyone"* and the whole group played handbells. Gracie had moved forwards in dealing with her own personal issues and was standing up to the *Drunken Sailor* that was a metaphor for her abusive husband (see Appendix A1: Case Histories and

Appendix A2: Initial Song Choices), lifting her bell high above her head as, for the first time, she sang the chorus, "Hooray and up she rises Early in the morning." Angela interrupted to ask for "My Fine Lady" but struggled to explain what this song was. After a while it occurred to me that the musical sequences in *Drunken Sailor* were reminiscent of *London Bridge* and that this could have triggered thoughts of not 'Fine' but 'My Fair Lady'. Angela agreed that this was what she meant, and this became Song 9:

> London Bridge is falling down, falling down, falling down,
>
> London Bridge is falling down, My Fair Lady.
>
> Build it up with iron and steel, iron and steel, iron and steel,
>
> Build it up with iron and steel, My Fair Lady. (Traditional, s.l:s.n)

As we sang, in this session and in the following weeks, I felt strongly that we were dealing at last with the incidents of Angela's physical 'falling down' from before her multiple sclerosis diagnosis, and later her 'building up' with 'iron and steel' in the form of her wheelchair. The metaphoric image is not that of the Bridge itself but, reflecting Angela's song title, it is the Fine Lady, and the extracted construct:

                    falling down : building up

This song was the start of a short period of intense sessions with new musical material making transparent Angela's increasing assurance in addressing issues previously kept silent, including her physical difficulties and her emotional

dealings with clothes. The climax of this subject development came in session 60. Prior to this Angela had applauded after Song 10 (a farewell song I occasionally used to signify the ending of a session) in session 57 and been absent in session 58.

Session 59 saw Angela in active mood, confident and talkative, back on the woodblock, and competing with Clare in making requests. After a brief return to *Edelweiss,* Clare, looking through a song book, began to sing *Oh Soldier* (Song 11) and Angela responded with agitated excitement, shouting, "Soldier! Soldier!" and trying to sing the rest of the words:

> "Oh soldier, soldier, won't you marry me
>
> With your musket, fife and drum?"
>
> "Oh no, sweet maid, I cannot marry thee,
>
> For I have no coat to put on."
>
> Then up she went to her grandfather's chest
>
> And got him a coat of the very, very best,
>
> She got him a coat of the very, very best,
>
> And the soldier put it on. (Traditional, see Anon 1985, 2)

I could think of nothing in Angela's life history relating to soldiers or marriage but 'I have no coat to put on' struck a chord, reminding me of session 41 when Angela had had no clothes to put on after ripping them all. Clothes were certainly on her mind now as I had arrived wearing a red jumper and she had shouted at me that she didn't like red, she only liked blue. She wanted a repeat

of the song and, in each verse, she suggested clothes for the soldier to put on, "Hat….coat." The metaphoric image, though, is not the clothes. It is, in Angela's words, the "Soldier" and the extracted constructs are:

blue : red

dressed : naked

This was too close for comfort, and Angela asked for "different music", choosing:

> I hear footsteps slowly walking,
>
> As they gently walk across a lonely floor.
>
> And a voice is softly saying:
>
> "Darling, this will be goodbye for evermore."
>
> There goes my reason for living, There goes the one of my dreams,
>
> There goes my only possession, There Goes My Ev'rything.
>
> (Frazier 1965)

This, Song 12, instead of being 'different', seemed to me to portray Angela's sense of loss at the destruction of her precious blue clothes, her 'only possession'. I felt she was acknowledging her emotional and behavioural issues around clothes and colours and that we were moving nearer to a breakthrough realization of the underlying reasons why this meant 'Ev'rything' to her. Almost as if Angela was thinking the same, she immediately chose *Love Story* (Song 13) and the lyrics appeared to express her struggle, especially in the song's alternate title *Where Do I Begin?*:

Where Do I Begin to tell the story of how great a love can be,

The sweet love story that is older than the sea,

The simple truth about the love she brings to me?

Where do I start?......

She fills my heart with very special things,

With angel songs, with wild imaginings.

She fills my soul with so much love

That anywhere I go I'm never lonely.

With her along, who could be lonely?

I reach for her hand, it's always there. (Sigman 1970)

The constructs from both Songs 12 and 13 are the same:

losing : keeping

loneliness : companionship

Looking back with the benefit of hindsight I can surmise that both Songs 12 and 13 provide another clue to where Angela's problems may 'Begin': being abandoned by her mother at a very young age and losing the love of this major female figure. But I didn't know this in session 59 and it was to be another few months before this event came to prominence.

The Soldier returned several times in session 60 and, with some degree of effort in concentrating and thinking, Angela dressed him in a new hat, coat and, finally, a "Smile". With this aspiration accomplished she was confident enough

to improvise and a laughing song began with woodblock-scraping glissandi. She began to talk about going swimming and I turned my vocalised "Angela is laughing" into "Angela is swimming" and she added, "In the water in [place name]." After some repetitions of this song she put down her woodblock and clapped.

 swimming : sinking

This improvised Song 14 occurred only once more, in session 65, but it was instrumental in bringing out the importance of water for Angela, something that would become vital during the Recapitulation. It also set up a chain of songs, in the same session 60, like a looped tape, that ran through the laughing improvisation, *London Bridge* (Song 9) and *Oh Soldier* (Song 11).

Back on the clothes issues, Angela gave the soldier some trousers and struggled to express her insight, "I been here years…coming here long time." This comment could have referred to her presence in the unit itself but I interpreted it as a response to the issues implicit in the words of the song: her emotional state of being stuck 'here' with her clothes problem. We moved back through *Love Story* and to *Adios* (Song 10) to end the session and Angela clapped again. She had moved through an emotional loop too, one that began with marching in Song 9, then progressed through imaginative flying and a more pragmatic buoyant swimming, and now, with clearly acknowledged insight she stated simply, "I can't walk, Carol."

Such an influx of songs suitably matched the complexity of issues being raised and Angela's increasingly determined struggle to deal with her emotions and her continued physical decline. After reaching a peak of insight, and verbal and musical expression, in session 60, she retreated for a couple of weeks. There were no songs; some shouting at Gracie; talk of the dentist; and a return to the early security of the wind chimes. Within her own protective chrysalis she absorbed her earlier personal insights, and after this small metamorphosis she reappeared in session 63 ready to do battle again.

4.1.2.3   Songs 15-17

In session 63 Gracie was manic, talking constantly, singing rude limericks, and arguing with Jackie, who played up and down every black key on the keyboard; Linda refused to touch any instrument and Angela kept to her wind chimes. From the xylophone, I tried to pull all this together into a cohesive group. Jackie began to quietly sing as she played. It sounded like *Tulips from Amsterdam* but she said it was, "Sailor turning on the tide, sailor go home across the sea." At the mention of sailors, Gracie began to talk of her husband and his drinking, and Angela loudly said, "The war." The music changed, following Gracie's thoughts but Angela insisted, "Other music again…War" and we improvised around, "The sailor went to war one day." Angela was satisfied and carried on playing. This, Song 15, developed over sessions 65 and 68 into, "Angela's war music…marching to the War." It always seemed prompted by arguments between the other women but, in addition, it reflected both her personal battle and her growing assertiveness in demanding attention within the group.

This became the theme for the weeks between sessions 63 and 67: brief improvised songs using Angela's own suggestions as she struggled to express what she felt. 'War' was a good starting point in which she could work through strong emotions in an acceptable and supported way. How different from our first months of Nun-like aspirations and denial of bad experiences. Goodness was still high on her agenda, though, for she wanted *Wuthering Heights* (Song 16) which she haltingly developed over several weeks to her own words, "Wuthering Heights, Wuthering Heights, to…be…come, to…be…nice," and Song 17, a single occurrence but significant in that she improvised and sang by herself for the first time: a quiet repetition of, "Hallelujah, Hallelujah."

Full integration of these dichotomous aspects of herself was a major obstacle for Angela. She had explored the presentation of difficult or negative emotions through songs and experienced acceptance of these by myself and the group but had yet to make the breakthrough of open acknowledgment of the root causes of her problems and acceptance of these as part of herself. Songs 15-17 acted as a bridge, leading to a phase of development on a far deeper level, where these issues began to be addressed, in Songs 18-20.

4.1.2.4   Songs 18-20

Song 18 is *Sweet Red Roses*, a surprising choice for someone who hates Red, it would seem, yet this selection is not random and, in the context of Angela's

behaviour in sessions 68 and 69, it brings together several previous songs and issues and finally exposes the reasons that compel them. In session 68 Gracie wandered in and out, swearing and asking for drinks or cigarettes, leaving Angela and me alone for much of the time. After an early interruption Angela responded with *War* music then quietened with *Wuthering Heights*, before returning to dress the *Soldier* in coat, hat, gloves and scarf. She talked through each verse, telling me more about the dentist, her white handbag, buying new shoes, and, "I hate that Linda." Eventually, she declared the soldier, "All ready." She clapped for a long time, and then improvised on the woodblock, as I played the xylophone, until the end of the session. As I began to pack away she asked for *Sweet Red Roses* and explained it was, "Who will buy my sweet red roses, one or two for a penny." (This is possibly from a musical version of the story of Oliver Twist.)

At the start of the next session, Angela asked for one of her drawings to be taken off the wall. It was blue paper with a blue felt pen outline of a simple square house with pointed roof and two windows symmetrically placed either side of the central door, and a stick figure of a woman wearing a triangular skirt. She tore it into large pieces and then searched through these to tear each into smaller pieces. I accompanied this with improvised 'ripping' music, but made no comment. Gracie entered the room and sang *Drunken Sailor*.

Gracie: "What shall we do with the Drunken Sailor….?"

Carol: "What shall we do with him?"

Angela: "Send him to the dentist."

We talked for several minutes about what would happen at the dentist. Angela was to have a filling and we improvised music using trills to make drilling sounds as we removed the "bad" bits of teeth and filled up the holes to make them "as good as new". Angela knew she had a choice of black or white fillings and, to my surprise, chose black. Immediately, she wanted *Sweet Red Roses* and started tearing her picture even smaller. She then moved to *Wuthering Heights*, "To be-come, to be nice," with the blue bell and followed this with a short improvisation. To end the session I played the farewell song *Adios Amigo* (Song 10). In previous sessions she had clapped at this song but now she picked up the small remains of her picture and tore them again as I sang:

Adios, Amigo, Adios, my friend,

The road we have travelled has come to an end.

When two love the same love one love has to lose,

And it's you that she longs for, it's you she will choose.

Adios, Compadre, what must be must be,

Remember to name one muchacha for me.

I ride to the Rio where my life I must spend,

Adios, Amigo, Adios, my friend.

Adios, Compadre, let us shed no tears,

May all your mananas bring joy thru' the years.

Away from these mem'ries my life I must spend,

Adios, Amigo, Adios, my friend. (Livingston and Fredd 1962)

At the final words, 'Away from these mem'ries my life I must spend', Angela picked up the tiny pieces of her blue picture and calmly ate them.

Carol:	"The blue picture's gone now. What was on it?"
Angela:	"It was a lady and a house."
Carol:	"I wonder who the lady was."
Angela:	"I wonder…(pause)….Will you wear a skirt next week?"
Carol:	"I might………will you?"
Angela:	"In my wheelchair?"

We discussed which colours we might wear….

Carol:	"Now blue's gone, will you have a sweet red rose one?"
Angela (laughing):	"Yes……brown."

The voicing of the one word 'brown' here was my eureka-moment, when all the events, songs and issues slotted together and formed a significant pattern (here again, the emergent insight and the production of meaning). I had asked if she would wear red, the colour she always avoided, and she had replied 'yes' – but this was not just 'yes' to the colour red, for she added 'brown', hinting that red and brown were in some way connected (otherwise, she would have replied "No…brown" has she been arguing *against* wearing red). My image of Angela had been associated, since the early sessions, with the Virgin Mary; she presented herself dressed totally in blue, she had blue and white possessions, used blue instruments, and aspired towards goodness. But now the blue had gone; she had (as it were) consumed it, taken it into herself. It seemed to me that this internalisation of colour also acknowledged and expressed the

underlying personal significance, and I realised, at that moment, that the colours red and blue were pointing towards a racial issue: they represent, respectively, black (or 'brown', as Angela herself had said) and white skin. Angela as a Black woman was struggling with her own sense of identity and self-esteem; she had suffered racial abuse and even been abandoned by her own mother, and she had a violent past. In contrast, the goodness of the blue Virgin Mary and the Nun-like snow-white Edelweiss were acceptable. She had adopted blue and white clothes to try to fit in, as a disguise that projected a persona of acceptability and hid the trauma not only of her self-identity but also, perhaps, of her life experiences. Hating the colour red, a contrast to the perfect image of blueness, can therefore be seen as a way of denying herself and her own emotions. The physical tearing of her clothes could have two meanings: either a symbolic removal of her own skin, a denial of her true self, or a throwing off of her disguise, a plea to be accepted as she is. I now read back through Angela's large archived case file. It was not clear whether she had been brought up by a white or a black family but it was noted that, as a child, she had indeed denied being Black and had tried to straighten her hair, altering her image in order to fit in with a certain range of societal expectations. Was the blue picture an idolised image of her mother and early home? Were these the 'mem'ries' (*Adios*) she has spent her life 'away from'? Or is Angela the blue lady, trying to put her past behind her? In either case, eating the picture is a symbolic and yet very practical act of integration: the memory is indeed part of her in the most immediate sense imaginable.

Sweet Red Roses: black : white

Adios Amigo: past : future

Now the Soldier was dressed and "all ready", was Angela armed and ready to face the world in her own true (red) identity? I decided to assist by actively promoting her acceptance and use of other colours during the music therapy sessions. This proved to be another long campaign in Angela's personal War. She had a break in session 70 and went out on the bus instead, but returned in session 71. I wore a cream dress covered entirely in large red roses. Angela made no comment but played quietly as I concentrated on Jackie's keyboard improvisation and Clare talking of her fears. She had noticed, though, and her shrewd acknowledgement came in the title of her sudden request for *Knowing Me, Knowing You* (Song 19) and Jackie and I helped her sing the lyrics:

No more carefree laughter, silence ever after.

Walking through an empty house, tears in my eyes.

This is where the story ends, this is goodbye.

Knowing me, knowing you, there is nothing we can do.

Knowing me, knowing you, we just have to face it,

This time we're through.

Breaking up is never easy I know, but I have to go.

Knowing me, knowing you, it's the best I can do.

Mem'ries, good days, bad days, they'll be with me always,

In these old familiar rooms children would play.

Now there's only emptiness, nothing to say,

Knowing me…..(Andersson, Anderson and Ulvaeus 1976)

In this 'Abba' song (as Angela called it) I felt that she was letting me know that she knew I understood about the red roses and their true meaning. Perhaps she also felt that 'knowing' was 'the best [we] could do', recognising that her

memories would 'be with [her] always', especially if it was a childhood memory of an empty house, connected with her blue picture.

However, this is not 'where the story ends'. On the contrary, some of her real story was just beginning to be told. She may have said goodbye to certain issues, as signified by the picture obliteration, but the battle with others was not yet through.

knowing : denying

In the next few weeks Angela continued to assert herself in the group. She spoke about the dentist every week until session 79, when she had had her filling done, and black and white became a more open issue as Jackie was racially abusive and threatened her during sessions. Angela shouted back, following up this personal war with the motivating reassurance of *Onward Christian Soldiers* and *Edelweiss* and a reaffirmation of dressing the *Soldier*; and the blue bell became more prominent than the woodblock.

This was a difficult time, as Angela's emotions came out in her music and in her behaviour, with open expressions of anger and impatience, and, to add to the struggle, her physical health continued to decline. I was concerned about her apparent acceptance of her increasing loss of mobility and co-ordination. She no longer walked; needed a special armchair as her wheelchair did not provide enough support in sitting; had difficulty holding and manipulating the instruments; struggled to speak. Her deterioration seemed too rapid. Had she

given in? Did she believe 'there is nothing we can do…we just have to face it…I have to go' (Song 19)? I wondered if she would cope with her new level of insight and hoped that, unlike the sentiment of Song 19, we would not 'break up' and the therapy stop, as it had with some of the original ten women when faced with the reality of their lives during sessions. But Angela had been built up 'with iron and steel' (Song 9) and was determined to persevere. Again, she seemed to answer my unspoken thought in her next song, which first appeared in session 76. Staff had removed Jackie from the room for blocking the door and being abusive, and Gracie had wandered out saying she was going to bed to die as no-one cared, and Angela and I were alone. Straightaway, she asked for "Gloria Estefan" and told me it was "quiet". I could not identify a song so quietly sang "Gloria" repeatedly in rising patterns, then added in "Angela" and she smiled. This worked on two levels, being reminiscent of Angela's own song 17, *Hallelujah*, in tone and the use of the praise word 'Gloria', and also being a positive image association with a black woman performer.

On my next visit, a member of staff was able to tell me which Gloria Estefan song Angela had been singing. It was *Can't Stay Away From You.* This became Song 20 and was the main focus of sessions for almost three months:

> Time flies when you're having fun, I heard somebody say.
>
> But if all I've been is fun, then baby, let me go.
>
> Don't wanna be in your way, and I don't wanna be your second choice;
>
> Don't wanna be just your friend.

You keep telling me that you're not in love;

you wanna throw it all away.

But I can't stay away from you; I don't wanna let you go.

Though it's killing me, that's true,

there's just some things I can't control.

Your love is slipping through my hands, though I've heard it all before.

I know you're telling me the truth, I know it's just no use.

But I can't stay away from you. (Estefan 1987)

This reinforced my thoughts: that Angela needs music therapy and our relationship within it. It is not just 'fun' and she wants to be taken seriously as a person in the group and as a Black woman. She 'can't stay away' and recognises that we are dealing with 'the truth' about her life, even though this is difficult and she feels 'it's killing me'. On a deeper level, this last hyperbolic statement is of more concern. Does Angela feel that this is not an exaggeration: that her illness is actually killing her? Is it 'some things I can't control' and battling against it is 'just no use'? This aspect of therapeutic interpretation stayed with me, and took on greater significance during the Recapitulation phase.

serious : fun

truth : lies

4.1.2.5 Development Discussion

The second question which I raised in section 4.1 was whether the Development

section really explores and expands on the material presented in the Exposition. The answer, undoubtedly, is that it does: it gets behind Angela's positive aspiration to be recognised as a good person, and provides opportunities for her to explore some of the more difficult aspects of her life, such as her deteriorating health, her aggressive behaviour and tearing of clothes, her relationships with other women and feelings about racial abuse, the abandonment by her mother and her own sense of self-identity. Through the music of mainly pre-composed songs she could present, represent, and retell these issues, express her emotions, and begin to reflect on and absorb their effects. This process is fully integrated music therapy in action.

Narrating these stories and having them accepted and reconstructed by the group gave her strength to try out new ways of approaching her problems, and her experimentation with self-composed songs and instrumental improvisation developed. What she now needs to achieve is McLeod's (1997) 'satisfactory-enough alignment' between her individual experience and her actual life that will enable her to create a 'narrative truth' that she can live with (see Chapter Three, section 3.3.2). But Angela has a growing dilemma: she is exploring her past, getting to the root of the problems which culminated in her being in a secure forensic unit but, in the present time, she has a progressive neurological disorder which is impinging on her physical abilities. Does one have to take precedence or can she address both at the same time?

My concern over the impact of her physical decline on her psychological state was triggered by Song 20 and it continued through the last weeks of the

Development. During this period of sessions two seemingly new topics arose. Both were to continue on into the Recapitulation and unite into one song which combined both past and present issues and defined the raison d'etre of the music therapy process.

The first new subject started in session 74, two weeks before the arrival of Song 20. Something unknown to me prompted Angela to ask:

A: "How's 'Jennifer'?"

C: "I don't know 'Jennifer'. Who is she?"

A: "Staff at [previous hospital]…in a room…washing me…

cold water."

I expressed concern but Angela said she liked cold water. We improvised music with "brrr" trills and she was amused. References to 'Jennifer' and to cold water baths continued in conversations over the next few months.

The second new material arrived in session 78. During Song 19, *Knowing Me*, Angela began to speak of going to Barbados and Egypt. We improvised a calypso then played 'Egyptian' music with E minor chords interspersed with a melody using F natural and G sharp. A few weeks later we went to Holland, a syncopated improvisation in compound duple time with a pentatonic harmony based around the 'A' of her "navy" blue bell. She said we would "fly" there and I was reminded of her earlier marching, swimming and flying around the time of Song 14. Over the next few weeks we visited Norway, Belgium (with slow

alternating chords of C and D flat major), Turkey and Mexico, California (which was "snowy" and cold, like her water), Greece and Israel, but Holland remained the destination of choice and was revisited many times.

In similar structure to the end of the Exposition, the Development has a three-week codetta with no songs. In sessions 91 and 92 we visited several countries and in session 93 Angela was absent, visiting a physiotherapist. Again, this represents a period of silent struggle. Musically roaming around the world seems to be significant but Angela has no words in which to express its relevance, or perhaps, at this point, no insight herself into why this tourism is so important. I returned to her archived case file to search for clues from her past that would assist me in supporting her now. Three events were strikingly apparent: soon after Angela was born her father had been deported to another country; within a year her mother had put Angela in the care of someone else and left for a different country; and, as a teenager in psychiatric care, Angela had absconded, boarded a plane and been found in yet another country. It is no surprise that 'flying' and foreign countries are part of her vital memories, and that exploring different countries through music enables her to actively search for her roots, her identity, her family, and the sense of belonging for which she yearns.

She had to find the words to express this, as best she could, in a self-composed song that came to dominate the next period of music therapy, the Recapitulation, where music, events, and emotions combined, and past, present and future life was determined.

4.1.3 Recapitulation

Recapitulation: Sessions 94-136
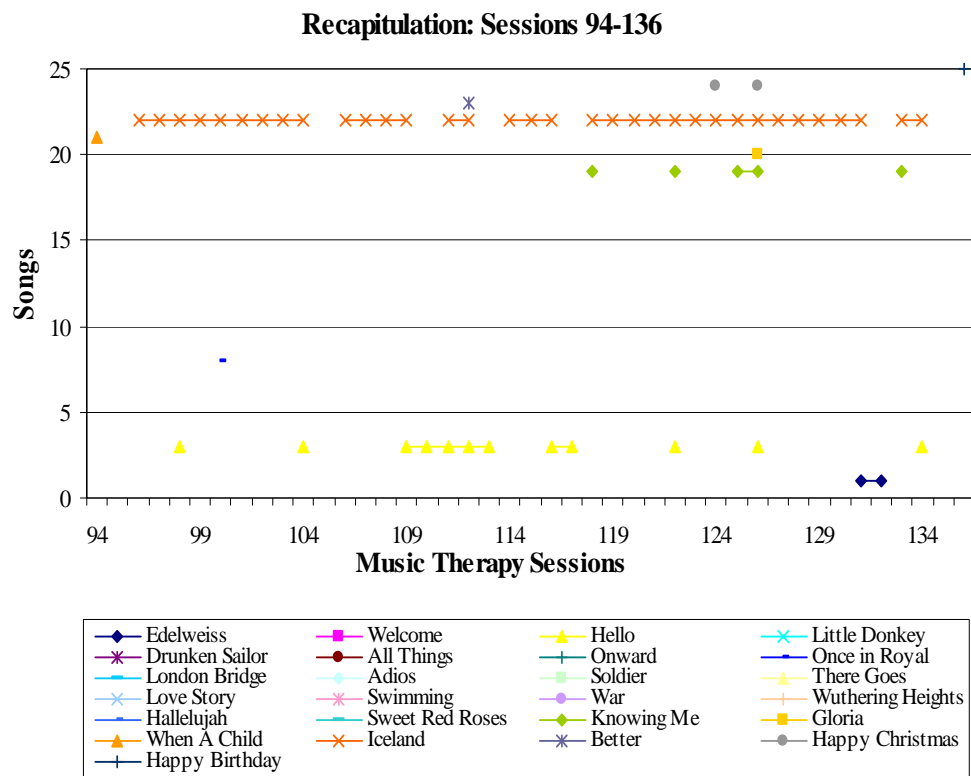
The rapid exploration of new songs that characterized the Development has diminished. In the 43 sessions of the Recapitulation a total of only ten songs are used and a mere five of these are new. Some occur just once or twice and the entire period is dominated by the repeated performance of the new Song 22. Is this a recapitulation of the first subject from the Exposition, the unusually absent *Edelweiss*, which now occurs only twice, towards the end of this period? Is it a narration of Angela's Goodness story that has been reconstructed to include the therapeutic insights gained during the Development?

4.1.3.1 Songs 21-22

Session 94 took place three days before Christmas. As ever, Gracie was singing

carols, but we were discussing how some were slow in tempo and that Christmastime could be sad with no family around. Angela had been oscillating between Holland and Belgium, or talking about 'Jennifer', but as soon as Gracie started *When A Child Is Born* (Song 21) she joined in with interest:

> A ray of hope flickers in the sky
>
> A tiny star lights up way up high
>
> All across the land dawns a brand new morn',
>
> This comes to pass when a child is born.
>
> > A silent dawn settles all around
> >
> > You got the feel you're on solid ground
> >
> > For a spell or two no-one seems forlorn,
> >
> > This comes to pass when a child is born. (Jay 1974)

Unexpectedly, Angela told me she had a daughter who was nineteen. Did she really have a child, the memory of whom had been prompted by the Child of the song title? There was no evidence to support this in her case history so possibly she was just making conversation, attempting to regain my attention from Gracie. But, though the truth of her statement was in itself improbable and could not be verified, it did show that mothers and babies were still at the forefront of her thinking as she travelled 'all across the land' of her imaginary globe of countries. Did this relate to the image of the Virgin and Child, or to Angela and her own mother – or perhaps to both, with a symbolic connection existing between the two. This was certainly the 'dawn' of a new assertiveness for Angela. With a feel of being 'on solid ground' she began confidently to set

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her own boundaries in the sessions. For example, when new staff stayed in the room in session 95 Angela said, "Tell them to go, Carol…I don't want them here." Our relationship in music therapy was a very personal exploration for Angela; it was still separate from her everyday life in the unit and her newly constructed persona was not yet ready to face the world fulltime.

beginning : ending

Song 22 had its compositional origins in session 96. Angela was playing the blue bell; she was tempted by the harmonica but it was red and, "I don't like red." We visited Amsterdam, Cyprus, New Zealand and eventually happened upon *Iceland*. At this request, turn-taking began between her blue bell and my keyboard trills. I described "cold frosty sounds" and Angela was pleased. She began to sing, "Iceland…Iceland…" (pitched C - A…C - A…). I imitated and added, "Cold…hard…water," (A flat - G - A flat - F) making my discordant A-flat emphasise the coldness of her 'A' bell. As I paused, Angela joined in singing "water" and began to play more continuously, muttering about Jennifer and cold baths. The atmosphere seemed clouded with anger, though she said again that she liked cold water.

Iceland, in this same form, was repeated in the two sessions that followed. Angela told me she had dreamt of Iceland but it was impossible to explore this further as Jackie was confrontational, throwing tea cups, swearing and shouting at both Angela and me, and Angela turned back to the security of *Hello*. She continued to talk of Jennifer and cold baths, and was able to improvise a piece

of music using the names 'Jennifer', 'Angela', and 'Gracie'.

Session 100 had an equally chaotic start as a new resident threw something at Clare. Everyone seemed nervous and each played their own music, oblivious to the rest of the group. For weeks Angela had been asking me to wear a skirt and, today, I did. The request for a skirt had reminded me of her blue picture of a house, and a lady in a triangular skirt, the image which had ultimately led to my recognition of blue and red as an issue (in fact, a racial issue) of identity. And so I wore a skirt which was navy blue with a pattern of large red roses, and I wondered if she would notice. Of course she did; she commented several times and pointed it out to Gracie. It was now February but Gracie, in her positive religious mode, was back on Christmas music. She held the guitar across her knees, twanged the strings and sang *Once In Royal* (Song 8). In a flashback to session 54, from almost a year earlier, Angela sang again, "Mary was that Mother mild, Jesus Christ her little Child," but, when I asked if she was singing too, she replied, "Yes, Carol…Iceland…Iceland…" But why Iceland? The colour connection here seems to be both reinforced and expanded: the song words are about Mary (usually depicted and associated with blue), yet Angela changes the words to sing of Iceland (water which is cold and blue). From the perspective of an association between mothers and children we can connect, through the category of blueness, the good Mother Mary to Angela's own 'bad' mother, the stick figure in a skirt in her picture, who has coldly abandoned her for another country. And so, colour appears to relate not just to race but to motherhood, and to the relative warmth or coldness of emotion and relationship within a given human context.

I spent some time with the Art Therapist after this session, discussing Angela's progress, interested in his views on the images she was presenting. We both felt that Angela's multiple sclerosis was progressing too rapidly and that it might be psycho-somatic, that is, her psychological feelings of being shut in, trapped in the unit and unable to escape, were leading to an actual physical shutting in, a closing down of her own body. This is projected in the metaphoric image of *Iceland* in which she is frozen, numb, unable to move, trapped in the cold hard water.

cold : hot

trapped : free

Song 22, therefore, is a synthesis, bringing together in one image several co-existing elements of Angela's life issues. From the present day it reflects her entrapment in the secure unit, the physical frozenness of her multiple sclerosis, and the coldness of her relationships with some of the other women. From her past it appropriates relationships with other people, from the previous staff's cold baths to the abandonment by her mother and the unattainableness of contact from other countries. In colour terms the blue Mother figure, and the blue – red racial identities, combine and conform with the habitual custom of representing blue as cold and red as hot, and Angela's use of the blue bell serves both to express her feelings and to further ensnare her in the immobility and impotence of the ice-realm.

My aim as Angela's music therapist became clear: I must meet her in the Iceland music and support her in defrosting, warming up the music, changing

the colours, and empowering her to recharge herself and diffuse some positive energy back into her future life. Over the next few weeks this aim became imperative. Angela had been released from the Section of the Mental Health Act that required her to be detained in a secure forensic psychiatric unit, but this was a mixed blessing: although it gave her more freedom, it was allowed precisely because her physical condition had deteriorated to such an extent that she could no longer be deemed to be a danger to the public or to herself. She would be moved to a nursing home and the music therapy would end, so, if she was to find a way out of her imposed ice-cage, it had to be done soon.

My immediate problem was that we knew each other too well and making obvious changes felt almost disloyal. Angela could see through such trickery and would resist. In the words of Song 19 "Knowing me, knowing you, there is nothing we can do". Salvation came from an unexpected source, a *deus ex machina* in the form of 'Adam', a music therapy student who joined us in session 102. He innocently did something that would have been unforgivable if I had done it: he played the red bell. It prompted an explosion of muttered swearing from Angela but she settled when he changed to a green bell and, with the increased attention from two therapists that enhanced interactions within the group, Angela began to try new instruments, first the tambourine, then the cabasa, and in session 103, the claves, glockenspiel and sleigh bell.

Staff said Angela had not been told that she would be moving home but she seemed to have some idea. "People coming to see me…away…away," she told Adam. Perhaps this gave her a measure of hope to fuel her musical reaching

out. The following week she asked for the blue bell again. "Light blue or dark blue?" I offered and, unusually, she chose the light blue, but she kept on asking me what colour it was until eventually I told her, "Turquoise." We were still singing *Iceland* but our conversation had returned to clothes shopping. She was going to buy trousers and a T-shirt, she said, "Green ones".

Carol: "They'll be nice when it's hotter in the summer."

Angela: "When will that be?"

Carol: "July."

Angela: "How long away?"

We repeated this conversation several times before I suggested that we play 'hot' music. Angela said it would be 'lively', and I brought out the drum, without her usual objections, and the group improvised. Later on, Angela looked inside her bell, "How does it work…up or down?" "Both ways," I replied, and she tried to copy my arm movements up and down. I felt the ice beginning to melt: Angela was looking forward to the hot weather, positive about buying new clothes. Perhaps 'up and down' indicated her feelings and she was really asking how she 'works' and if she had permission to change and try out new ways of functioning.

In the next week, session 105, I was angry. Staff had forgotten the music therapy session and taken Angela out shopping; the group had to run without her. But she returned later in the afternoon and my frustration turned to joy: along with some navy trousers she had bought a light blue and a pale green top.

4.1.3.2   Songs 22-23

Colour persisted as a dominant theme over the next few sessions leading up to Song 23. Angela now wore her new paler clothes and she also used the light blue bell more often. This had a subtle effect on our musical improvisations as the tonal centre moved from the 'A' of the dark blue bell down to 'G'. But although the tonal level lay a whole tone lower in pitch, this actually lightened the character of the music, since I now tended to play in G or C major rather than in A or D minor, unless I elected instead to use pentatonic scale-forms and harmonies. These major keys leant towards a brighter overall sound.

Iceland continued every week, as before, but the other women were clearly now becoming rather tired of it. "Her and her Iceland," complained Gracie; but Clare found a compromise: "Iceland in the summer." Angela was initially not at all keen on this, so it was necessary for me to adapt her song and take it in this new direction gradually. To begin with, I retained the original words but made additions, giving the paradoxical lyrics "Iceland…cold hard water…in the summer". Gradually, over the course of several weeks, I altered them to "Angela in Iceland, in Iceland in summer".

After this physical change in the use of coloured bells, a further observable instance of the practical embracement of colour began in session 109. Angela now knew she was soon to be moving home and she was beginning to get ready to go on a visit. She had been measured for a new wheelchair and excitedly told me it was going to be "black". Although this colour is not normally associated with positive thoughts, this was indeed a significant step forward for Angela, an

inward adoption and outward statement of the idea of being 'Black' and proud, in contrast to her usual white accessories. This in turn seemed to prompt memories of an earlier colour connection, the black and white teeth filling dilemma, and The Dentist made a few brief reappearances. Overall, however, Angela was keen to move on and in session 111, dressed in her new light green top, she asked, as I set up the room: "What've you got different?...I'll have a green bell." This was a sign, initiated by her, of a clear desire and intention on her part to change and transform both her attitudes, her behaviour and her underlying mode of operating.

Sadly, however, her physical decline continued: she struggled to sit upright, her head had to be propped up, and her speech became increasingly confused. She lost the word 'bell' and started to request instead the "green…peg". This bodily decline contrasted strongly with her improved mood and self-belief. In session 112, she asked me to sing "Getting better" (Song 23) and so I went on to improvise "Angela is getting better, better, better, Angela is getting better every day", something which amused her and prompted further discussion about the idea of clothes-shopping.

This bright expansion of psychological horizons through the medium of colour, mood and music ran on for a few weeks. By the time of session 119 Angela had her black wheelchair and was dressed in green top and black trousers. One week later, she told me she wanted to buy two green T-shirts and some green or grey trousers. The green bell had evidently served its purpose, and she now moved on to try the tambourine and the sleigh bell: these then predominated throughout

the remaining sessions until the end of the music therapy.

The 'greening' of the musical environment also progressed, and we regularly visited 'Iceland in summer', yet 'Jennifer' and cold water still continued to surface at times. The two eventually assembled together in session 120. I asked Angela what she would do in Iceland. "Swimming," was her reply and from here the song developed even further. Over a couple of months it turned into variations on "Summertime in Iceland…Angela is swimming in the water". The frozen waters of Iceland were warming up, releasing the held memories of the cold baths and thereby freeing Angela to allow movement, in the form of swimming, back into her life. As with her *Swimming* in Song 14, this supported movement was clearly both psychological and physical, representing a new and positive unity of mind and body.

4.1.3.3   Songs 22, 24-25

Angela's generally buoyant mood continued, though it was sometimes a struggle as weakness in her hands made her drop instruments, and mental concentration and choice-making were clearly an effort for her. There had been as yet little progress towards her move from the unit, things were thus inconclusive, and the waiting was undoubtedly difficult. Possibly this situation, and the anxiety it caused, lay behind her request - in session 124, a hot day in August - for "Happy Christmas" (i.e. *We Wish You a Merry Christmas*, Song 24), since at the same time she asked how long it then was until Christmas. Did she really mean how long it was until she moved, until she would be 'happy'?

"I don't like it hot," she said in session 126, now worrying about leaving, and asking for "winter" instead of summer in *Iceland*.

Thankfully, we worked through a short bleak month of winter and then, by the time of session 132, we were improvising "hot" music at her request. But some insecurity remained nevertheless. Angela was wearing green and playing the tambourine: "No-one's taking this away from me, are they?...It's my favourite."

We then moved on to "Iceland where it's hot, hot, hot", and spoke over quiet guitar music about the likelihood of her moving home in the near future. Gracie was talking of where she used to live as a child but Angela interrupted:

Angela: "Abba."

Carol: "Which Abba song?"

Angela: "Knowing Me."

We sang this, Song 19, several times and the lyrics were very poignant. It became instantly clear why, deep down, she had chosen them: 'breaking up is never easy I know, but I have to go.'

We had one final outing to a hot *Iceland*, a week of absence when she was taken out to lunch instead, in session 135, then our final 'Coda'. In session 136 Angela arrived telling me she would be leaving at the weekend. She chose the "round hoop" (tambourine) and played quietly while Gracie and Clare vied with each other for their song choices. I asked Angela what she would like and she

chose *Happy Birthday* (Song 25). Our trips to Iceland were now finished and, instead, she had a positive swan-song in which she was openly identified as the centre of attention: "Happy Birthday to Angela, Happy Birthday to You". Of course, it was not her actual birthday but, in a way, I am quite sure that we were wishing her happiness for her future life. We talked about her moving on, and about this being our last music therapy session. I tried to find an appropriate song to end with, but she went so far as to interrupt *Adios*. Songs, it would seem, were apparently no longer necessary, and she would control our goodbyes in her own way:

> Carol: "Would you like to choose a song to finish, Angela…?"
>
> "What would you like?"
>
> Angela: "I'd like a cigarette, Carol."

So ended Angela's journey of music therapy and so ends our retelling of it here. Our relationship as client and therapist was over but, as an individual with new-found self-confidence and a generous spirit, Angela invited me to stay for tea, and, no longer as therapist but as guest in her home, I did; we had fish and chips together before I left the unit.

4.1.3.4 Recapitulation Discussion

So, was this truly a recapitulation of the theme of our first subject? Is *Iceland* in any sense a reconstruction or a transformation of *Edelweiss*? I propose that it is: that the Goodness aspiration and Angela's search for acknowledgment of her true self-identity were encapsulated in embryonic form in *Edelweiss*, took shape

and grew within the Development period, and were brought to full maturity in *Iceland*. This self-composed song may be seen to have synthesized in one complex image Angela's past, present and future life. Activated by her current problems with relationships and declining health, it brought together the earlier issues of race and familial abandonment, clarifying the importance of colours and the Mother figure as behavioural agencies for the expression and exploration of emotional dilemmas.

Iceland also brought together song and musical improvisation, for its composition was ever-changing. This, I suggest, is the process of music therapy in action, for it influenced and allowed similar transformative changes to take place in Angela. It was a slow gradual reconstruction, as the defrosting process released inner feelings, expanded the colour range and presented possibilities for behavioural and physical improvements. Of course, Angela's move to a nursing home finally cut short the therapy process. It can hardly be claimed that further sessions would have halted or reversed some part of her physical immobility, but it was abundantly clear that her emotional strength had been invigorated. I felt certain that she now had a far stronger sense of self-identity, of belief in herself as a Black woman, and a new self-acceptance, not only of her 'goodness' but also of the 'bad' parts of her life; and also that she was now equipped with alternative practical means for expressing her feelings around these issues, as well as more socially acceptable behaviours with which to face difficulties in the future. Her legal and physical release from the secure unit was now matched by her emotional release from the inner core of ice that held her; from her persistent need to control the chaos around her has arisen an ability for

controlled self-expression, for a more self-aware and self-possessed negotiation of her surroundings, and hence for the construction of new social relationships.

In structure, other material motifs from the Exposition have been reworked and reformed in the Recapitulation too. Impressions and images have been modified and re-presented, and unspoken questions answered. The 'white, clean and bright…blossom of snow' of the Edelweiss has been transformed into the clear ice of Iceland; the good Nun replaced by the bad Mother. More intriguingly, a link now appears with the second subject (*Welcome to My World*) of which I was, at the time, completely ignorant: 'seek and you will find…the key to this world of mine.' Angela not only introduced us to her inner world of emotion but took us on a tour of her virtual globe as we searched through the countries of the Development to find her roots in the Recapitulation of a metaphoric Iceland. Her aspiration came to fruition as she explored her early home life and prepared to be released to a new home. It was all, in a sense, foretold in Song 1:

Bless [her] homeland forever.

4.2   Discussion

Chapter Four has presented a narration of Angela's entire period of music therapy and, in so doing, has retold the story of Angela's life and the personal experiences, events and relationships that matter most to her. The original raw data of transcribed session notes obviously represent an abstraction from which the lived reality of music is inevitably removed; and the timeline of songs is even further distanced, being a mere chronological list of song occurrences - but

its decontextualization revealed an overarching musical structure, a sonata form archetype, which guided the reconstruction, on a new interpretative level, of the full narrative account.

Detailed consideration of each song, from the initial statements of the Exposition, through a complex and sometimes puzzling musical-and-personal Development, to the transformed unification and closure of the Recapitulation, contributed to the therapeutic interpretation. And the additional embedded description of Angela's musical involvement and improvisational progress places the music, and the shared musical experience within our relationship, firmly at the centre of the therapeutic process: it is the mutual construction of these songs which lies at the heart of the therapy, and it is their re-performance and sustained musical development over time which empowers emotional and relational expression, exploration and growth in a way that words alone could not do. Angela had neither the language skills nor the motivation to discuss how she was feeling. Indeed, with the progress of her multiple sclerosis she lost some of her physical ability to speak - but music gave her a voice, a real auditory presence, and a new means of communication. Pre-composed songs gave her a starting point, articulating shared codes and images, and embodying cultural terms of reference that every member of the group understood and which thereby, to begin with, negated any need for personal emotional disclosure of a dangerous or declarative kind.

Working musically within the confines of the song format allowed for a controlled, appropriately paced exploration of the experience of chaos, and out

of this grew Angela's ability to improvise and to compose her own songs. Without doubt, her persistent involvement and sustained commitment over three years gives authenticity to this narrative as a true account, a story that she herself could not tell. This adds weight to the establishment of verification for this research study by increasing its credibility and dependability, as I put forward in Chapter Two, section 2.4. It also begins to clarify my thoughts on the significance of the personal need to tell individual stories in one's own voice, and the role that song may play in making this possible. These ideas will be developed further in Chapter Five.

But, as yet, we have completed only one stage of the narrative analysis. From the songs we have explicated a series of sense-impressions, constructs in images and bi-polar dimensions that are the focal points of meaning for Angela at the time of construction, taken from her own words, her song-names, in combination with the experiences surrounding each performance. Now the cycle can begin again, decontextualizing these image-impressions to another level of abstraction, searching for further patterns or regrouping into themes for meta-analysis.

Some significant themes have already been identified, such as colour and race, understood both in terms of racism and of self-identity. These will be discussed in Chapter Six. This emergence of important features and categories now shows the true colours of our butterfly after its long period of transformation within the chrysalis of music therapy sessions, and the real nature of Angela's difficulties reaching right back to their germination at the time of abandonment by her

mother. But there are other things as yet unrevealed that still lie hidden, things my auditory brain has not heard but my visual brain has sensed in our glimpses of images; there is something about the images themselves which will tell us more about song as a process in music therapy. Therefore, Chapter Five will begin with a closer examination of the colourful visual appearance of our newly emerged 'research butterfly'.

Chapter Five: Butterfly

As Angela embarks on a new life, released from the legal, physical and psychological restraints of the secure forensic unit, so too does our research butterfly, newly freed from the confines of the chrysalis. In its fully-fledged form its true colours are revealed, much as Angela's true identity has been asserted and her life history disclosed. But, as the newly emerged butterfly flies off to explore its territory, vastly widening its available perceptions from its original caterpillar ramblings, we also continue to explore the process of music therapy that lies within the territory of Angela's narrative account, this time from another unique perspective. In Chapter Four I extricated a series of images and constructs from the songs, using Angela's voice as a focus whenever possible. Now, in Chapter Five, the metaphoric cycle turns again and these images, these impressions, will themselves be decontextualized from the songs and the narrative account, and analysed for further patterns or themes, then recontextualized, in the light of Angela's experience, to provide and provoke meaningful theoretical insight into music therapy and its wider cultural domain, according to the second stage of therapeutic narrative analysis as first described in Chapter Two, section 2.3.6.

5.1   The Song Images

Figure 5 presents the entire collection of metaphoric images that were crystallized as focal sense-impressions from the songs in Chapter Four. The 12 images from the 25 songs are displayed, from top to bottom and from left to

Figure 5: The Song Images
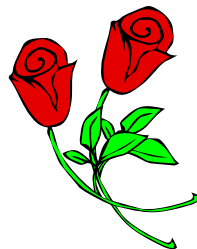
right, in the order in which they appeared. Here they are decontextualized from the songs and appear simply as visual images in order that patterns or episodes within them may be more clearly seen. When removed from their ecology of songs, events and experiences do these images still contain the essence of their creation? Can they distil and impart further confidences that will enhance our interpretative understanding?

Indisputably, they can, for in their simplicity of presentation lies a clarity of reality, and even a brief perusal of this artistic exhibition immediately reveals the intelligence that my visual brain had already recognised but been unable to cement:

The images are overwhelmingly of human figures.

Perhaps this should not be surprising as the images arise from song material and lyrics are written by people, for people, and frequently portray human emotions and experiences. However, in many of these songs the human figure is not the central character in the narrative and an uninitiated observer, asked to pick an image to represent each song, may have chosen alternative objects or symbols. For example, it would seem relevant to choose a flower for *Edelweiss*, a donkey on its own for *Little Donkey*, a bridge for *London Bridge* and, perhaps, a cross for *Onward Christian Soldiers*. But what is important about the images in Figure 5 is that they were created according to Angela's voice and my interpretation of her experience based on activities in and around the music therapy sessions. She called *Edelweiss* "Nun music", she sang about "Mary" in

Little Donkey, and she asked for "My Fine Lady" not *London Bridge*. In effect, these images are social products, manufactured, negotiated through our participation in the song performances and, as such, they adhere to the conceptual paradigms both of symbolic interactionism and of social constructionism, as presented in Chapter Three, sections 3.3.1 and 3.3.2.

Even in cases where the central activity involved in the song performance contains a meaning seemingly unconnected to the image, it is the human figure which remains. For example, the Soldier defined Angela's issues with clothes but she always called the song "Soldier!" Perhaps it is the very humanity of emotion which it is vital to represent, even if the actual human figure associated with the song is irrelevant. So, rather than anthropomorphize clothes, Angela's feelings around self-identity and exposure of her true self are projected into the character of the soldier, and her emotions surrounding falling down and losing her ability to walk become those of the Fine Lady, rather than of the bridge. Even here, though, there is some connection at a deeper emotional level, for the Soldier speaks of Angela's personal war and the Fine Lady of her aspiration for goodness and acceptability. It appears that the images have been *humanized,* the stories contained in the words of the songs and their associated (or connoted) emotions being transformed and contained within the image of a person, a single human figure, irrespective of the characters or objects which may actually dominate the lyrics or the context in which the song was used. This is a kind of 'condensation', not perhaps in the Freudian sense, but in a way that allows the human figure to 'stand for' and somehow embody all the relevant and desired content of the song in question.

In all of these examples, the songs form an associative narrative, Angela's personal soundtrack for her life, and the images, as focal points, briefly halt the passage of time and enable us to see a visual representation of this vocal recitative. But the images and the songs are far more than a mere representation for, in their therapeutic construction, they have a clear function: they enable the expression, experience and adaptation of associated human emotion without any need for personal identification of its ownership. Mary can be carried on the donkey, the soldier dressed by a maiden, and the sailor sent to the dentist, and Angela can flesh out the characters, give depth to their experiences, feel their emotions and change their behaviour, without ever needing to openly acknowledge that these are her feelings. Distress, fear, sadness, uncertainty, anger, embarrassment, shame and guilt can be voiced in personally and socially acceptable ways. The images have been *depersonalized,* separated from Angela by the construction of their own independent human figure, yet still connected to her by the transference of aspects of her emotions and personality characteristics. By mutually using the images through an active-creative process of song and music both therapist and client are working with feelings that are too strong or too deeply hidden to be openly addressed but, through the use of such human characters, the emotions are kept alive and can be experienced and actively transformed. And it is the genre of song, with its strong musical current, that allows this to happen. We may be dressing a metaphoric Soldier but Angela can construct this process according to her current therapeutic need, be it for acceptable new clothes or a reassuring "smile".

This leads to a fundamental realization concerning the use of metaphoric imagery in song, and one of the most significant assertions of this thesis: it is a process of Music Therapy by Proxy, wherein transformative attention is focused on a condensed 'third person' in the form of an image of a human figure, a depersonalized yet still humanly connected figure which contains and utilises the associated needs of the client.

For this process of Proxy to be effective it is vital that both client and therapist have a mutual understanding of the image and its humanized personality. Both must be able to relate to the associated emotion in order to interpret and transform the character's actions and the music that supports and drives such change. This accounts for the use of songs rather than improvisation, as songs already contain a wealth of recognisable figures suitable for appropriation, together with accompanying text that may serve to spell out, or at least hint at, the underlying emotional need of the client. It also contributes to an explanation of the somewhat surprising choice of songs. With the exception of Abba and Gloria Estefan, Angela's choices, and those of the other women, are simple, well-known pieces, often folk tunes, hymns, Christmas music or children's songs. It is the music of a mutual, culturally shared childhood, with songs and characters we all know and can instantly relate to without resort to complicated explanations. And, of course, the music of our youth is pre-recorded onto our personal soundtracks, so these songs contain the associative emotion of our life events. Thus, the seemingly innocuous choice of a simple tune to pass the time is just the tip of Angela's metaphoric iceberg and the exact size and strength of its emotional importance lies hidden below the surface image. This truth is

revealed when we nudge the image, disturbing the reflection and the depths of water that surround it. Such a psychological nudging frequently seemed to occur through the actual present day events in Angela's life, often in the music therapy sessions themselves. For example, it was Clare who first chose *Edelweiss*, prompting Angela's Goodness aspiration to be expressed through the Nun, and it was Gracie who initially introduced *Onward Christian Soldiers*, inciting the link with arguments between residents into Angela's association with War music. *Onward* also pushed to the fore the 'marching' connection with Angela's current loss of walking ability.

This connection between current events, the auditory stimulation of a song, and past emotional experiences rests easily within my personal alignment as a music therapist with the epistemology of a behaviourist approach, as described in Chapter Two, sections 2.1.1 and 2.3.3. In believing that connections between songs and emotions are made throughout our lives by virtue of learnt associations formed by particularly strong or repeated personal experiences, resulting in a life soundtrack, then it is natural, in later life, that a new pertinent presentation of either song, event or emotion, will act as a stimulus to elicit a conditioned response of the evocation of the other associations. Such interconnections prompt a return to Angela's timeline of songs, to recontextualize our images into a life soundtrack; but this must wait until section 5.2 as we are digressing from this section's prime emphasis on decontextualization, the separation of images from the songs.

Having established the relevance of the images as human figures, with projected

human feelings, it can be noted that some are not merely ordinary people but are distinctive iconic or archetypal figures. Clearly, these prototypes have the added advantage of communicating further cultural conventions, inherited understandings instilled in us from an early age which, like the songs, need no introduction. Or, do they? For Nyborg (in Brun 1993b, p.5) stresses that archetypes have a 'bipolar, conflicting character'. This can be seen in Angela's iconic figure of the Nun. Throughout this thesis, I have described the Nun as a representation of Angela's Goodness aspiration but the image also has an opposing character, a shadow side, for it encompasses the negativity of a woman set apart, removed from the real world. Both the nun in a convent and the female patient in a secure psychiatric unit are women subject to some degree of isolation, loss of freedom, and institutionalism, be this voluntarily chosen or imposed upon them. Also, our metaphoric Nun is eventually exposed to reveal not only the archetypal guiding principle of positive motherly goodness but also the negative aspect, the cruelty of a mother who abandons her child. How appropriate, it now appears, is *The Sound of Music* where Maria, the postulant Nun, becomes stepmother to so many children. Of course, all good fairy tales contain a wicked stepmother, and, perhaps, Angela's experience, or her perception, of being fostered was no different.

Coincidentally, the Edelweiss, as a flower, is a symbol of wholeness, according to Brun (1993a, p.124) and so would have been an inappropriate choice as an image representing Angela's scattered emotions at the beginning of therapy. But the rose, too, is a flower and we later have the image of *Sweet Red Roses*. This begs the question, why a rose and not a human figure? The same can be asked

of *Iceland*. If human images are so vital, why do we have two songs with non-human symbols, and what do these divulge about the process of music therapy for Angela?
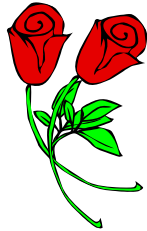
Brun (1993a, p.125) provides an answer for the choice of roses, a nature symbol which she lists as 'a symbol of the self'. This certainly fits with my interpretation of the use of this song, for in asking, "Who will buy my Sweet Red Roses?" I had felt that Angela was asking who would accept her, her true self, the real Angela just as she was. And so a personified figure is unnecessary as, for the first time, Angela comes close to identifying herself as the owner of the song's associated emotion. It is still an abstraction but it relates directly to the first person, bypassing the constructional utilization of the metaphoric third person.

In addition, the artist Locke (1998) writes of the pervasive use of the rose image by Hispanic inmates of New Mexico State Penitentiary, particularly its use surrounding depictions of Our Lady of Guadalupe, a reapplication of the Black Madonna. This image has a long religious tradition and recedes into pre-history, appearing as the archetypal Earth Mother. Guadalupe is a protectress, viewed by the prisoners as someone who looks out for them and knows they are there, important issues for the unseen, undervalued Hispanic men in a dominant white culture. Locke (1998, p.305) also lists complex meanings for the symbol of the rose itself. In its beauty of perfection, the growing rose indicates the bipolar mystery of life and death and, in its vivid red colour, passion and erotica and the duality of blood: the blood-red of virginity and fertility. I am reminded again of

Angela: the virginity of the pure Nun and the life-giving fertility of the Mother figure. These images combined early in therapy into my image of Angela as the blue Virgin Mary. Could the Roses really assert her right to align herself with the 'red' Black Madonna, a more inclusive support for an ostracized, unseen black woman in an all-white forensic unit? Supportively, we later have the image of a black mother and child, chosen to represent Angela and her response to the song *When A Child Is Born*. It is unlikely that Angela would have consciously known about the significance of roses and any connection with, or existence of, the Black Madonna. But, after all, a true archetypal figure is a primordial image, retained in the mind as a remnant of an ancestral experience (Jung, in Locke 1998, p.289).

It is interesting, also, that *Sweet Red Roses* is followed two songs later by *Gloria Estefan,* not only a positive image of a black woman (which, incidentally, is a constructed image and not intended as a depiction of the real person) but one of Hispanic connections, being born in Cuba. Though Angela is not of Latin-American origin some influence appears, in imagery if not in music.

What is more certain is that Angela's apparent hatred of the colour red and love of blue seemed to be both an attempt at integration and an initial denial of her own racial identity, resulting in our long period of work on colour-transformation and acceptance which culminated in the greening of Iceland.

Our image of Iceland is clearly symbolic: it is not an actual depiction of the real country itself. It was construed from the cold, hard water of which we sang in Angela's improvised song about swimming in Iceland. Water actually appears in two images, both in the sea around Iceland and in the 'Swimming' image. Water, as a symbol of feminine character, is often associated with women (Holbeck, in Brun 1993b, p.10) and Brun (1993a, p.124) lists going into water as being symbolic of a descent into the unconscious. Personally, I am reminded of the tradition of water as a trial, particularly for women, such as the medieval dunking-stool punishments and the witch trials by immersion. Water may thus represent Angela's struggles with life issues. But Angela is not sinking in the water; she is swimming and this, according to Dream-land (2006) is a symbol of cleansing and renewal. Moreover, they claim, swimming outdoors foretells future success, being a sign that you are gaining strength and endurance. However, Angela's dreams of success are tempered by the ice which indicates coldness and loneliness, so perhaps her inner emotional strength is growing whilst her physical capabilities remain limited by her disability. Additionally, or alternatively, it could be her emotional issues which remain blocked or frozen but her willingness to address them which is being renewed. In this case, the clearness of the ice should at least afford her an unrestricted view, providing an elemental clarity to her investigations.

This may be the reason why Iceland needs no human figure. Angela finally acknowledges this as her music, and states clearly (in words and in transparency of ice-image) her ownership of action and feelings: it is "Angela" who "is

swimming in the cold, hard water in Iceland", and so no third person Proxy is needed to act on her behalf. One gains a sense of Iceland as a meta-image, a compound crystallization of all previous images, all past issues, and all hopes for the future. It becomes a temporary stopping point on Angela's journey of self-discovery. It was the final destination of our world tour during music therapy but may not be the end of her search for enlightenment and acceptance. In this respect it is also an archetypal image symbolising the overarching experience of our heroine's journey through life.

On returning to the images in Figure 5, a further examination shows such 'journeying' to be a common theme. We have the iconic figures of a sailor and a soldier, modern-day Warriors who undertake epic travels around the world, often bravely fighting battles to protect or rescue people in need. We also have Mary carried on a donkey, journeying with Joseph from Galilee back to Bethlehem in Judea to be registered in his homeland. And Angela, too, journeyed around the world, transported through the imagery of marching and swimming, and elsewhere in the narrative, by flying.

Wanderers are a symbol of longing, the restless urge of nostalgia for the lost mother (Brun 1993a, p.125). As such, they have a bipolar impetus where the hero desires both to connect to the mother figure and to become independent of her, and so follows an oscillating path which can never achieve its objective. So Angela searched not only for her past roots, for her mother and father in two different countries, but also for a place of acceptance in the present that she could call home.

5.2   The Life Soundtrack

Analysis of the perceived patterns and themes from the decontextualization of the 12 song images revealed a sense of 'journeying'. This interconnects both the processional journey through the music therapy sessions and the experiential life journey through which Angela has passed, and it was this historical aspect which began to unravel the early roots of her emotional issues, present almost at the time of her birth.

In this section of the thesis it is 'time' itself which becomes the most relevant and revealing feature of the analysis. Back in Chapter Two, section 2.3.6, I detailed the reasoning behind my choice of therapeutic narrative analysis and my decision to focus on the temporal aspects of data presentation because of the three-year length of the case study over the entire course of Angela's music therapy. This linear nature now seems even more vital. In Chapter Four the song occurrences were abstracted and analysed, not according to quantitative hierarchical components but to chronological episodes over the passage of time, culminating in the production of the song timeline. Recontextualization back into the narrative account of music therapy, using qualitative association of relationships with life events, generated the song images. The subsequent decontextualization of these images, in section 5.1, led to the concept of journeying, and extended our chronological timeline. Now we have experiences relating far back in Angela's biography, before the narrative of music therapy began.
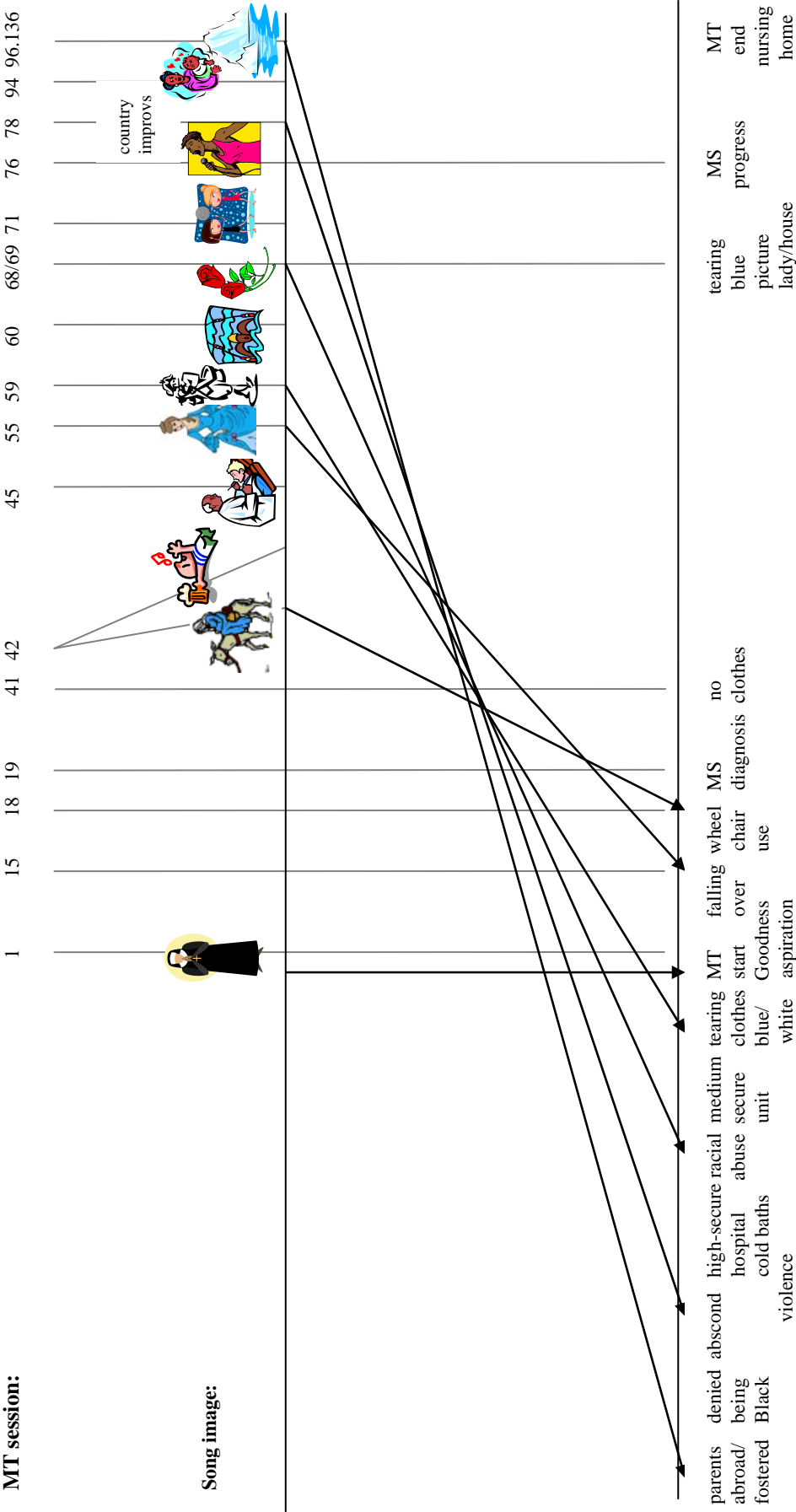
And so, the next phase of recontextualization will return the song images into a life soundtrack: a new linear representation which visually places, and reconnects, images in the context of associated events and experiences, demonstrating how the chronology of time and the biography of life are linked together in the songs.

Figure 6 reconstructs the timeline of songs and music therapy sessions from Figure 4 in Chapter Four. It summarises the song occurrences by the simplified presentation of their extracted metaphorical images, taken from Figure 5, and aligns this chronological display with a brief biographical account of Angela's experiences in life prior to, and during, music therapy (as revealed and interpreted in Chapter Four and Chapter Five, section 5.1). It should be noted that this graphic presentation is shown in order of time and events, but not to scale. That is, no attempt has been made to indicate by any temporal scale the actual duration of the passing of years or weeks. The order is real, but the visual spatialization arbitrary.

The vertical grey lines indicate the music therapy sessions in which events first occurred or songs were initially presented, as recorded in my therapist session notes in the narrative account. The black arrows visually connect the song images with the biographical details to which they relate. These connections were evoked in Chapter Four but left singularly unattended in the continuing detail of analysis. In this section, now, they will be extricated and briefly restated for the purpose of clarity before assertions of their significance are presented.

Figure 6: The Life Soundtrack

MT session: 1 15 18 19 41 42 45 55 59 60 68/69 71 76 78 94 96.136

Song image:

country improvs

Angela's Biography

parents abroad/ fostered Black — denied being — abscond — high-secure hospital cold baths violence — racial abuse — medium secure unit — tearing clothes blue/ white — MT start Goodness aspiration — falling over — wheel chair use — MS diagnosis — no clothes — tearing blue picture lady/house — MS progress — MT end nursing home

The Nun appeared in the first music therapy session with the song *Edelweiss*. It represents Angela's aspiration towards Goodness and indicates how she was feeling at that moment in time, her current hopes, and her behavioural attempts at social interactions; hence the parallelism of the grey line and the black arrow, both relating to session 1 and current events.

Over the course of the next few months events in Angela's life changed more rapidly than did her songs. Session 15 saw the beginnings of her failing strength, with episodes of falling over and being unable to stand, closely followed, in sessions 18 and 19, by the necessity of using a wheelchair and her diagnosis of multiple sclerosis. The Exposition section ended in session 41 when a combination of Angela's growing distress and her blue clothes obsession released emotional expression hitherto unseen in music therapy, culminating in the aggressive behaviour of ripping her clothes and having to borrow some in order to attend the group.

The image of Mary appeared in the following session, as Angela sang of Mary being carried on the *Little Donkey*. Although this again may represent her feelings at the time, the index event in her biography is the appearance of the wheelchair in which she has to be 'carried', hence the black arrow from session 42 points back slightly, to 24 weeks earlier and the time of session 18.

The Sailor and the Dentist appeared in sessions 42 and 45, and seemed to represent the confusion and uncertainty in Angela's life. She was beginning to acknowledge the bad in her life as well as the good but she wanted a quick fix, especially in relation to her ongoing concerns about her teeth and her inability to walk. These two images arise again out of current issues and a gradual change in attitude. I could find no obvious link to past events and so there are no black arrows leading from them.

In contrast, the Fine Lady had a clear connection with the 'falling down' of *London Bridge* and Angela's earlier episodes of actual physical falling. The black arrow from session 55, therefore, points backwards 40 weeks to connect to the index events that began in session 15.

Whilst the Fine Lady reflected Angela's ever present aspiration towards Goodness, it was the next image, the Soldier, which began to express how much of a struggle this was. Her personal battle for self-identity and self-expression, which was made manifest in her emotional investment in blue clothes and belongings, began to come to the fore. Angela's present-day exploration and acknowledgement of her feelings connected directly back to her aggressive behaviour, characterized by the tearing of clothes, for which she was infamous in the unit, and which had contributed to her referral for music therapy. Thus, the arrow returns session 59 back over a year to a time prior to the start of music therapy.

Angela's personal insight grew and the Swimming image reflected this as she came to terms with her physical decline. I could identify no clear events in her past life that would have acted as a trigger for this. Perhaps the cold baths in the high security hospital may have focused her attention on water but this seems too tenuous to be linked by arrow in Figure 6.

The arrival of Sweet Red Roses in session 68 coincided, in session 69, with Angela tearing and eating her blue picture of a lady and a house. This was the moment when I realised that red and blue were racial issues and that, symbolically and practically, Angela was integrating her memories, establishing her own true self-identity as a Black woman, and acknowledging her past abuse. Linked by the grey line, the song and events of session 69 connect back to Angela's earlier experiences, notably the racial abuse she suffered in the hospital, but also, perhaps, to her childhood when she had denied being Black: almost a lifetime of personal and social rejection.

Session 71 represented Angela's acknowledgement through Abba that both she and I understood this true meaning: that now we 'know' her memories. Although the lyrics may hint at childhood memories I could not relate this directly to one event in her early life, so no black arrow is given.

Similarly, Gloria, beginning in session 76, seemed to deal more closely with current issues than past life experiences. Angela's multiple sclerosis was progressing rapidly and, as she asserted herself as a positive, serious Black woman, her physical decline also became more obvious. Music

therapy, and our relationship within it, became vital as, at some deeper level, we explored the difficult relationships from her early life.

Two weeks later, in session 78, our musical improvisatory exploration of countries around the world began. No songs, no third-person images, but a musical tourism in her own identity: Angela herself searching for her roots as she had actually done in reality as a teenager when she absconded from care and flew abroad. Although there is no song image, I felt this to be significant enough to warrant a black arrow of its own, connecting the later sessions of music therapy with the early years of Angela's biography.

 In session 94 the Mother and Baby materialised briefly, indicating her thoughts were still in her early family relationships as we continued to search around the world.

 Finally, we settled in Iceland, where we stayed for several months, until the end of music therapy. In the present day, it represented her physical and psychological frozenness of body, entrapment in the secure unit, and cold relationships with other residents. From the past, it synthesized the blue colour of the Mother figure with the coldness of abandonment as a baby and the inaccessibility of contact from another country. In practice, Iceland was the focal point from which we worked on changing and accepting colours, moving from cold blue to hot summer green, melting and releasing positive feelings as we altered and expanded the music. But, for the purposes of this section and Figure 6, the image links most clearly back to the

beginning of Angela's life and her experience of being fostered while her parents separated to different countries, and so this is where the arrow connects, from the end of therapy to her birth and the very start of life's journey.

What Figure 6 constructs, therefore, is a soundtrack of the whole of Angela's life. When examined in conjunction with the narrative of Chapter Four, it illustrates how events in the present day give rise to songs, and their respective metaphoric images, which have a direct association with previous life experiences. As a behaviourist, my theoretical understanding of this process is one of conditioned responses whereby significant life events or strong feelings have become associated with the music of the time and either musical or emotional memories can then be resurrected at a later date as a direct response to a current stimulus of the same or similar music or feelings.

This relates very clearly to the theoretical literature presented in Chapter Three, section 3.4. Music therapy for Angela became a 'soundtrack process' (Rolla 1993, p.83), an inner musical score, a synopsis of life that both reveals and integrates emotion, actions and experiences. This soundtrack is, as Ruud (1998, p.82) described, 'a map that helps organise a sense of identity' and, therefore, a musical structuring that has a function in constructing personal meaning, locating incidents in time and space.

In Chapter Four the framework of Sonata Form was used to guide the reconstruction of the full narrative account and demonstrate the phases through which the music therapy process passed. To continue this musical analogy now,

to remove the images and events from the framework and present them as a chronological 'map' gives, in effect, what I term a Coded Recitative, a personal declamation where the musical metaphoric images characterize and give depth to the life events, fleshing out the potted history of experience. Musical recitatives exist to provide the listener with a wealth of background information. They explain prior events and relationships and set the scene for what is to occur next, and so they must be presented in easily understandable language, within which a cultural understanding of signs and symbols, be they verbal or musical, within a social context is vital. This is true also in the musical structuring of a soundtrack, as asserted by Ruud (see section 3.4). Of course, I can not ascertain, or even presume, that Angela's song associations were causally linked at the time of her early experiences. But what is noticeable is the predominance of images from childhood nursery rhymes, folk songs, Christmas carols, and popular musicals, all of which have accessible cultural understanding and possibilities for further mutual interpretative and constructive relevance. And, as described in Chapter Four, many songs were adopted by Angela after initiation by other women in the group: in effect they were the stimulus that prompted the conditioned emotional associations and behavioural responses to recur. Indeed, this adaptive structural function is made evident by the fact that the vast majority of images from the soundtrack in Figure 6 occur during the sonata form Development section (sessions 42-93) and the only two images linked to events by black arrows outside of the Development are the Nun and Iceland, and these may be seen rather as all-encompassing alter-images representing Angela's journey in search of the Good Mother figure.

So, Figure 6 clearly sets out the links between songs, current and past events, and emotions, encapsulated in the metaphoric images. But this coded recitative is more than a mere representation for it provides further information of a model of a structural process. It chronicles two series of events: the course of music therapy and the biography of Angela's life. By necessity, these two are greatly simplified, listing only the main basic experiences of which I became aware and could chart. As such they are the result of my personal therapeutic interpretations and other subtler or more ongoing experiences remain in the background. Nevertheless, the seven identified associative black arrows present an unexpected yet striking pattern, one which I term 'Reverse Chronology'.

As the music therapy progresses each consecutive image is linked by arrow back to an event in Angela's life. However, the process is not a direct correlation of ongoing events, as would be indicated by the model shown below. Instead, this model is represented more by the vertical grey lines from Figure 6.
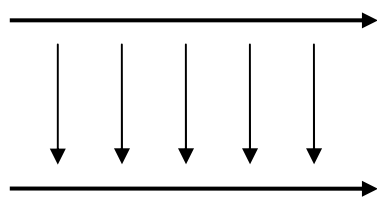
Nor is the process a direct reversal back through time from the same starting point of the first session, as might be indicated by the model shown below.
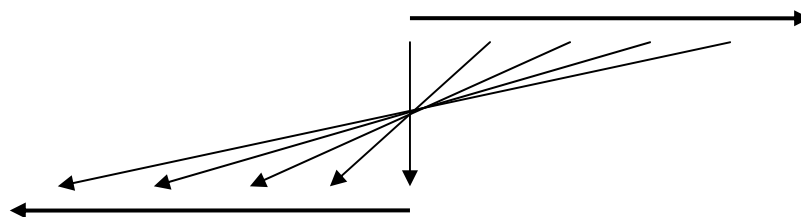
What must be factored into this model is the importance of the ongoing passage of time, the lived experience which continues during the provision of music therapy sessions. The initial image in Figure 6, the Nun, relates to the same session, the here-and-now, but each successive image, moving along the chronological line, links slightly further back in actual time rather than in biographical event. So, the Donkey from session 47 links back 24 weeks to session 18, and the Fine Lady from session 55 links back 40 weeks to session 15. It is only when we reach the Soldier in session 59 that we begin to link back to index events occurring over a year previously, and prior to the start of music therapy. Figure 6 can then be seen as a 2-dimensional diagram of a 3-dimensional process, where time exists chronologically, biographically, and temporally, causally linking in a looped tape of associated sounds and images. Of course, all three actually relate to the same fourth dimension of time, so plotting the seven images and seven events (the black arrow connections) in order along one continuous line produces a more grammatically correct model of an ever widening spiral:
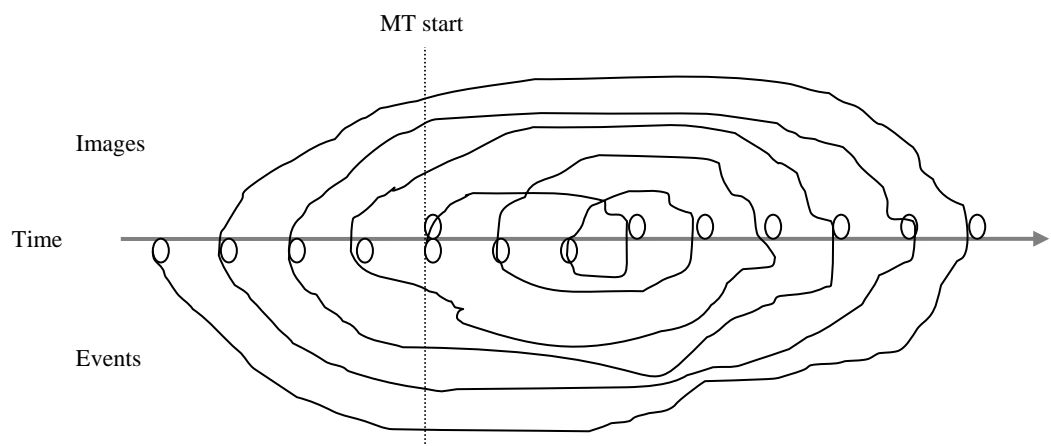
However, even this does not produce a satisfactory enough model of Reverse Chronology, for the initial loop at the start of music therapy appears to be an anomaly that does not conform, and yet this lies at the heart of the process. The problem with it as a model is that it focuses on the passage of time from start to finish, left to right across the page, and considers the spiralling link from image back to event. What we really need to ask is how past events link to the present and the effect of 'here-and-now' moving on with the passing of time. Past memories only exist in our awareness when we reconstruct or re-experience them and, at that moment, they are in our here-and-now. In the above model the dotted line representing the start of music therapy and Angela's immediate link between image and current event must also move along the line of time, as each past memory becomes a present experience and each new event links through to the past.

The model must take on an imaginary moving 3-dimensional form, as depicted in Figure 7. Here, the key part is the Here-And-Now, in the form of a portal, or gateway, through which the constant soundtrack of life incessantly moves. It acts as a speaker or viewfinder, allowing us to magnify and re-experience what is recorded on the soundtrack. The soundtrack itself remains in the analogous form of a tape, in which loops take on the spiral qualities of Reverse Chronology and expand in size all the time, as new present stimuli associate with what is currently in our awareness as it passes through the portal.

The fact that Angela's songs and images linked steadily further back in time as the sessions moved forward suggest that the way in which memories are

structured and recorded onto this looped soundtrack forms some sort of track, a path which is easier to follow, retracing our steps in order, with one stimulus prompting another, rather than reliving events in haphazard fashion. In order to do this we must sift through the trail that we created as we lived those events the first time around and sort and understand how, and why, that path was brought into being. Only then can we learn from our experiences and our mistakes and build up positive choices of new paths to take in our present and future lives, new ways of behaving and new patterns of social interactions to form. The concept of journeying returns, as any journey forwards through life inevitably becomes one of a linked parallel journey in reverse.

Figure 7: A Model of Reverse Chronology over Time
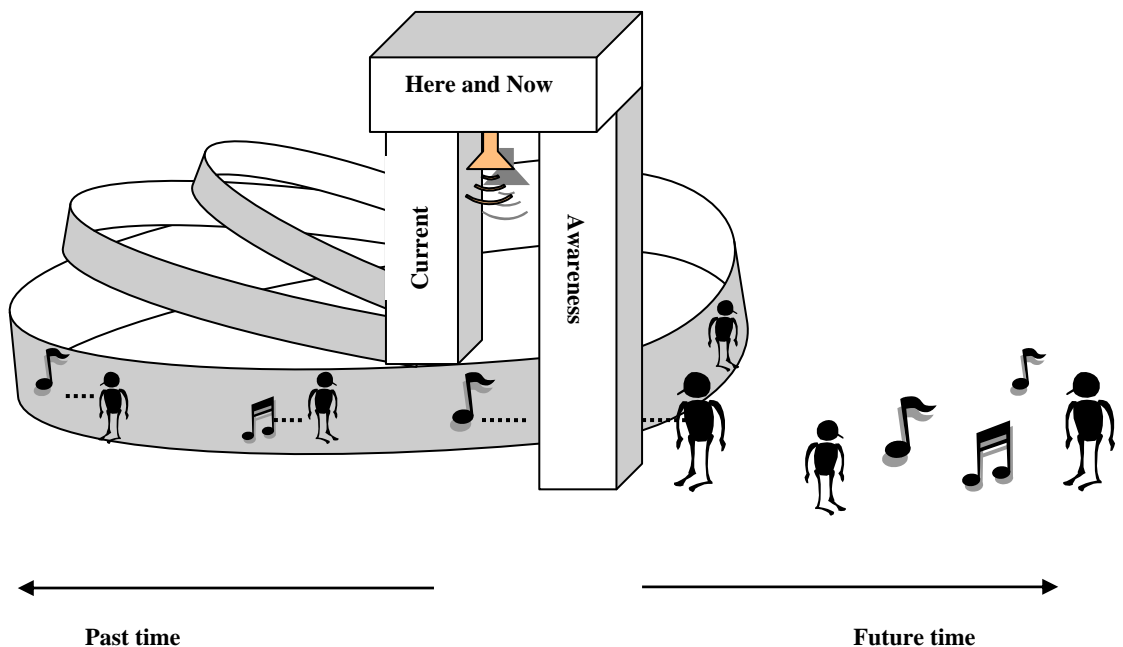
It is as described by the 19th century existentialist philosopher and Christian writer Soren Kierkegaard, under the pseudonym Johannes Climacus (see McDonald 2006): a performance of 'recollection forwards' where the realization of eternal (future) truth is captured in time through the task of individual repetition.

Life can only be understood backwards; but it must be lived forwards.

(Kierkegaard, in Moncur 2007)

In summary, analysis of the song images has led to two major assertions. Firstly, decontextualization from the song episodes revealed a process of 'Music Therapy by Proxy', using humanized yet depersonalized figures as metaphors for Angela and the transformation of her emotions and behaviours. Secondly, the recontextualization of these images produced a life soundtrack and revealed the process of 'Reverse Chronology' whereby current events associate with past life experiences through the medium of songs.

The concepts of journeying and time have been central to both of these analytical procedures. So, too, has been the transformation of these concepts along the bi-polar dimensions of past-future and good-bad (in the metaphoric guise of Nun-Iceland). In the next section we return to the constructs extracted in Chapter Four, the verbal rather than visual sense-impressions, in order to sort and compare, search for further patterns, and regroup into categories or themes of personal or contextual importance for examination in Chapter Six.

5.3   The Bi-polar Constructs

Figure 8 provides a list of the entire collection of thirty bi-polar constructs, extracted during analysis in Chapter Four, in the order in which they occurred. These bi-polar constructs were elicited from musical-therapeutic episodes according to the narrative analysis approach of Aldridge and Aldridge (2002) as described in this thesis Chapter Two, section 2.3.6. Such verbal labelling assists in establishing the credibility of the research by forcing the researcher-therapist to define meanings in his or her own words, based on experiential practice.

Aldridge and Aldridge's (2002) approach goes on to present such data in the form of either a hierarchical focus analysis or a spatial principal components analysis, both of which then demand further interpretation. My approach has some similarity with focus analysis but combines this with Rolla's (1993) soundtrack concept and the presentation of associated musical impulses that cluster around a 'center of meaning' from which patterns tend to radiate in 'dynamic core groups', as described in Chapter Three, section 3.4.

Figure 8: The Bi-polar Constructs

1	greeting :	ignoring
2	recognition :	denial
3	white :	black
4	purity :	pollution
5	growth :	decline
6	open :	closed
7	carry :	abandon
8	heavy :	light
9	onward :	backward
10	follow :	leave
11	questioning :	stating
12	acceptance :	rejection
13	war :	peace
14	broken :	mended
15	travelling :	stationary
16	falling down :	building up
17	blue :	red
18	dressed :	naked
19	losing :	keeping
20	loneliness :	companionship
21	swimming :	sinking
22	war :	peace
23	black :	white
24	past :	future
25	knowing :	denying
26	serious :	fun
27	truth :	lies
28	beginning :	ending
29	cold :	hot
30	trapped :	free

What I have done in Figure 9 is to search the constructs from Figure 8 for focal groups, collections of patterns around a core concept or theme. Essentially, these are abstractions at a deeper level, which are presented as Centres of Meaning, with new verbal labels, with the thirty constructs radiating from them. Inevitably, these are my immediate subjective categorisations, not externally validated but internally influenced by my own participant experience and, therefore, strengthened by the deeper focus. It is important to emphasise, however, that these are not summaries of the constructs but centres around which they revolve. The radial arms in Figure 9 move out from the focal centres to connect to the smaller numbered constructs, not the other way around.

> Understanding the significance of the collective patterns may reveal
> the modus operandi of the center or offer insight into resolution of an
> inner conflict which may be at the center itself (Rolla 1993, p.41).

Or, in my own terminology, the centres of meaning have a generative function: they contain and determine the basis of Angela's personal condition, her emotional and psychological conflicts and her motivational and behavioural processes in dealing with these conflicts. The constructs, and the songs from which they arose, are outward manifestations of these inner states, generated by association in the context of life experience.

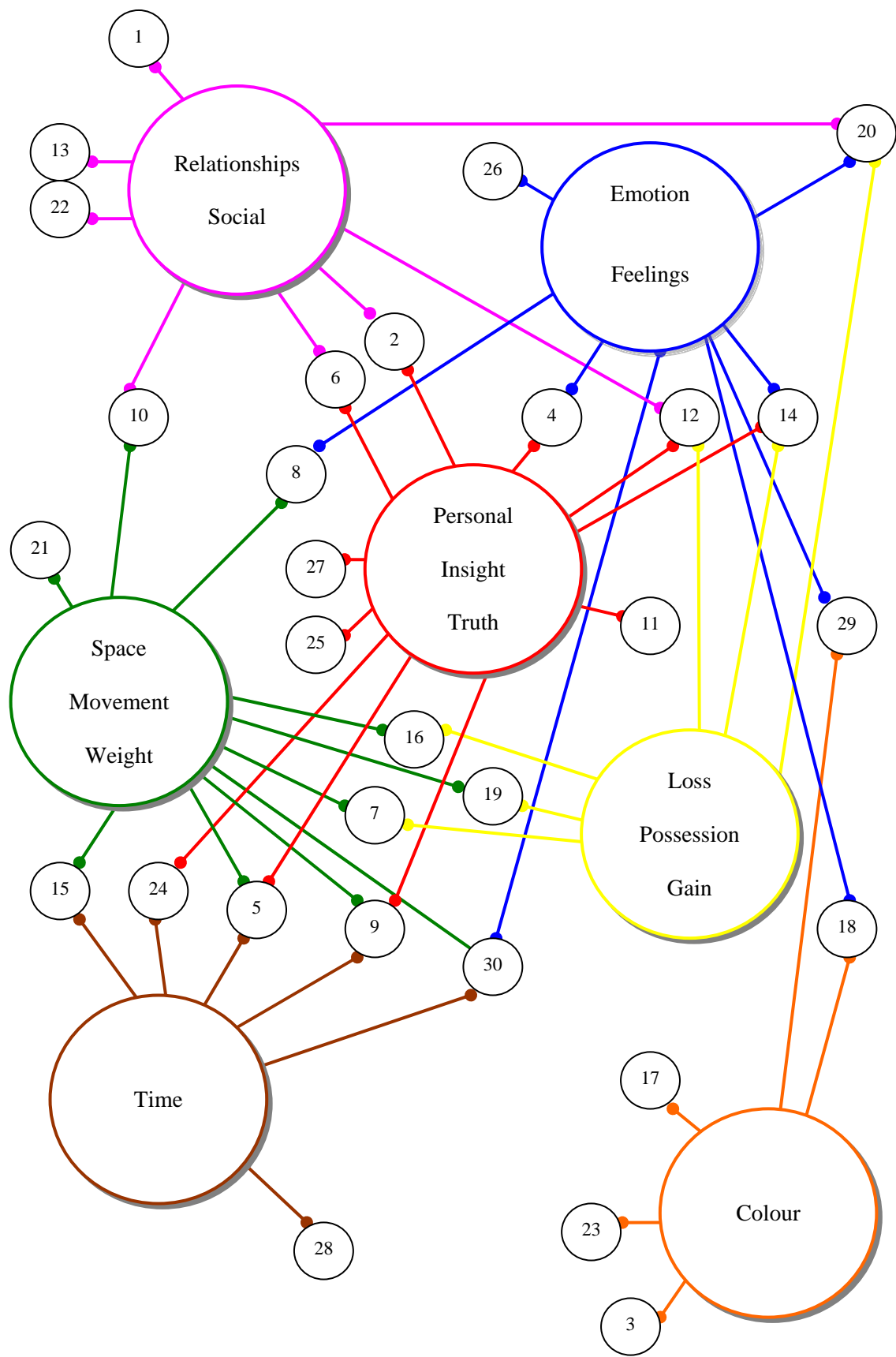**Figure 9: Constructs and Centres of Meaning**

Figure 9 reveals seven centres of meaning, seven broad core themes which may be the source of inner conflict for Angela. These are listed in Figure 10:

Figure 10: List of Seven Core Themes

Social /Relationships

Colour

Movement / Space / Weight

Time

Personal / Insight /Truth

Emotion / Feelings

Possession / Loss / Gain

These issues, or themes, now become the basis for contemplation in Chapter Six. In the final recontextualization they will be examined again in the narrative of Angela's account in order to search for further insights and to come to a broader and more fine-grained definition of what the meaning of the music therapy experience was, and represented, for her.

5.4   Discussion

Chapter Five has presented an analysis of our metaphorical research butterfly in its fully formed state. We can determine the true nature of a living butterfly through the design of its colourful appearance and so, too, can we examine the nature of Angela's identity, her understanding and ways of operating, from the

crystallization of her emotions and experiences that have been presented in the form of song images and constructs. Although these were both extracted as sense-impressions from episodes of songs and experiences in the original narrative account, the undertaking of Chapter Five has revealed slight differences in their structure and usage.

The images are clearly defined visual pictures in succinct form, condensations of states of being, subtle representations of cultural meanings. They exist in the nebulous world of good and bad, and function precisely because, through the socially understood and socially acceptable medium of song, human emotion in all its forms can be presented in an idealised impersonal manner. By using the metaphoric, often iconic, figure of a recognised third person, difficult feelings can be re-experienced, examined and restructured, allowing new patterns of behaviour to be developed.

In contrast, the great strength of the verbal constructs lies in their clarity of description. They are clearly defined by the bi-polar nature of their definitions, and function precisely because of their contrast of expression. Cortazzi (1993) found such polarities in teachers' perceptions of their work. He concluded that these opposite poles are both necessary to understanding, with the relationship between them being one of dynamic tension rather than choice between opposites. In music therapy, and in this thesis, such antithesis can also be beneficial if used not to indicate a choice or dilemma, but rather to give insight into the central foci of underlying emotional conflicts and patterns of behaviour caused by the need for individual resolution.

However, the whole range of abstractions, both visual and verbal, are reunited in their function within this thesis, and indeed in the therapy process itself. On one level, they are both descriptive, giving an extracted summary of what has taken place in the songs and in the music therapy sessions. But, on another level, they have become tools with a transformative capacity. During the music therapy sessions the song images were used, by Angela as client and by me as therapist, to explore and develop the music and its associated feelings and relationships. The constructs were also available for interpretative insight into the causative process, although I was, of course, unaware of the majority of them at the time. But, perhaps most importantly at this point, they have both become research tools. Throughout Chapter Two, I stated the position of my research within a naturalistic tradition, emphasising the importance of an emergent design which would grow out of the narrative account of the actual clinical realities of the practice of music therapy. The images and constructs are both outputs of this process, contributing to the body of data for analysis, and, more prominently, tools in the very process, being used flexibly and subtly to examine the material, and the patterns that become evident within it, and to interpret the outcomes of the therapy, the clinical practice itself, within a more structured, and to that extent reasoned and rational, framework.

This central positioning of detailed subjective analysis that emerges from, and shapes, the whole cycle of research serves, therefore, to illustrate and justify the choice of methodology put forward in Chapter Two, by contributing to the intensity of its trustworthiness, as proposed in section 2.4. It also supports my early proposition, back in Chapter 1, section 1.5, of a Generative Metaphor of

Metamorphosis which works on three levels: the songs, the therapy process and the research methodology (as depicted in Figure 2). This was the point at which my Elusive Butterfly came into being and the germ of an idea, an egg, was laid.

The research has subsequently moved through its metamorphic journey from egg to caterpillar, from chrysalis to emerged butterfly, from the germ of an idea to a fully formed design and almost complete analysis. Angela has experienced a journey forwards through the therapy sessions and, in Reverse Chronology, backwards through her life history. And I, too, have journeyed from my initial position as therapist-participant to one of researcher, from being actively involved in the sessions, the music and the emotional experience, to observing and analysing the data and interpreting the emergent patterns and assessing their significance, converting the practice base of music therapy into mature research.

This all combines to make a real, live process, a practical application of the art of music therapy within the time and space of the lived world, and one which furthermore can generate its own insights into human existence and experience in a supremely practical and productive way. It gives support to the ongoing debate within the arts therapies professions that research methodology can, and must, be based around clinical practice and the use of the arts to examine the nature of the artistic therapeutic process. Research design does not always have to be borrowed and applied from other scientific professions but can be found in the nature of the arts themselves. Music therapy research can emerge from music therapy and reveal its own truths, for music and life are inextricably linked.

Now we journey onwards, into the final Chapter Six, in order to investigate more deeply into the themes and issues raised in Chapter Five, to examine their possible meanings for Angela, and to consider further the relationship between real life and the practice of art.

Chapter Six: New Pastures

It is clear that the metaphoric butterfly is now reaching the final stages of its life cycle. As a mature adult it has explored and expanded its territory, and has sensed and responded to the manifold impressions, as well as the difficulties, of its environment. Now it has one task to fulfil which represents the culmination of its life's purpose: it must find a safe haven in which to reproduce. The butterfly lays eggs that contain the genetic blueprint for the next generation, and, as they hatch, the generative cycle begins again.

This picture of the cyclical process of growth and regeneration may stand as an emblematic representation of the scope and trajectory of the research study in its broader aspect – for, in this concluding chapter, I aim to generate a new cycle of thought and interpretation, based on what has been discovered during the course of the project, and thereby to sow the seeds of further practice and further exploratory research. The broader purpose of this is, then, as I see it, to encourage the opening up of new areas of critical interest and new paths of development, and thus to help stimulate research into unfamiliar or remoter aspects of music therapy and related fields – in such diverse ecological pastures as musicology, psychotherapy, gender studies, linguistics, and sociology.

Yet, as the butterfly now alights momentarily on a leaf, to rest and gather strength for its longer journey, we can also perhaps take a moment to pause and reflect on its accomplishments hitherto. We may consider the metamorphosis it has undergone to achieve its present form and also, perhaps, admire the multitude of coloured patterns in its wings which both construct and proclaim

its identity. As we do so we may reflect upon, and appraise with new intellectual clarity, the trajectory of metamorphosis described over the course of the research project, remarking on the details of its construction, on its modes of thought and investigation, and on the themes which have emerged from it, as well as on the important musical and therapeutic experiences that have been an intrinsic part of it – which (we might say) are embodied within it, and form its core.

From my original clinical work with ten women in medium secure forensic psychiatric units I developed two main ideas. Firstly, the concept of a Generative Metaphor of Metamorphosis: a cyclical representation of progressive stages in the evolving path of song use, therapeutic process, and research (with its core element of reflective/interpretative thought), structured by analogy with the life cycle of a butterfly. This representation served both to illustrate and to (actively) inform the successive stages of my thinking and understanding. As each stage came to fruition it evolved and transformed itself, in turn generating new related metaphors – until, finally, it could be seen to have played a key role in structuring the path of the research itself. Secondly, this journey of research focused on the concept of metaphoric images, constructed out of the words of songs chosen by the women during music therapy sessions, and which came to be seen as closely associated with their current emotional states, or past life experiences. The actual (experiential) work within the sessions, and the subsequent (reflective) thought and interpretative scrutiny which took place afterwards, were linked through the common factor

of the musical and textual (and also visual) elements which provided the substance of the therapy.

Here, then, the role of music was determining, functional, and irreplaceable. Not only did the music 'carry' the words, and (so to speak) make them available to the women from their own associative experiences in memory (both individual and shared), but it was also an active agent, exercising a strong therapeutic influence of its own. It structured the space within which the therapy occurred and acted as the all-important non-verbal medium of communication between therapist and client (also between clients). Thus by its very nature it facilitated, perhaps even prompted, the confrontation – and, eventually, the voicing – of underlying issues and areas of inner conflict. This process of voicing (I have argued) made all the women clients intensely vulnerable, and so it could take place only gradually, over an extended period of time, within a humanized yet also safely depersonalized environment. During this time they were sustained by the ongoing presence of music in the sessions (music's agency), not just by the repetitions of the familiar song texts (and the condensed images). This then helped – again over time – to give them the confidence they needed to be able to confront and (indirectly) voice their issues and their fears.

In every sense, then, the therapy can be seen to have been strongly processive and cumulative – something which hence needed to be clearly reflected in the design, analysis and presentation of the research in its final written and narrative form. Both music (as the pervasive non-verbal expressive medium) and text (with its words and images) played an important role in this overall progression.

By this combined means, the experiences and issues could be gradually exposed, powerfully but indirectly, through being encoded within the song material, while all the time the sessions were sustained and emotionally structured by the underlying presence of the musical element in its range of song forms.

Music was thus an essential medium throughout the whole process (music's agency): it was not just 'conveying' the song lyrics, acting simply as a functional vehicle for the words and their associated images, but rather was acting as the – for the most part invisible – missing link between the texts and images, on the one hand, and the women's deeply rooted (often hidden) personal responses, on the other. Through its role in structuring the sessions, it was what brought the images close to them, into the world of ideas and of personal interiority. In this way, music was able to function powerfully yet indirectly, as a way of giving depth and cohesion to the experience of the figures and images of the songs, and endowing them with emotional force, yet at the same time keeping them safely distant from the conscious experience of shame and fear. Thus it may be argued that the words could never have functioned in quite the way they did, had it not been for these therapeutic properties of music, and its status as an emotionally powerful yet morally depersonalized medium.

The words and images derived from the songs were initially understood as being located within three different levels of meaning (Explicit-Stated, Implicit-Contained and Implicit-Construed), according to the degree of interpretation

required in each case for their construal and elucidation. Such interpretations are fundamentally personal and reflexive, being grounded in my dual experience as therapist and researcher. More specifically, they are based on my having constructed, out of this dual role, a strong and vivid sense of the meaning produced from my knowledge of the women and their situation(s), set in relation to my (participatory) understanding of – and interaction with – the context within which the songs appeared, were used, and transformed.

Other interpretations may of course be possible. The whole point about the strength and significance of the act of interpretation, understood in this way, is that it is concerned not with identifying definitive, self-sufficient meanings in the absolute, but with the *production of meaning* as a category, from within a given context. Indeed it is surely a fundamental strength of this kind of approach that other interpretations may be able shed further light on mine, as well as on the material itself and what it has to tell us. Yet this is not, in the end, the most significant point at issue here. Rather, it is the depth and consistency of my own activity within this dual process, my full immersion in both the therapy and the research, that will serve to give the reader a sense, consistent with the chosen qualitative and naturalistic paradigm (with its strong temporal-longitudinal dimension), of the richness and immediacy of the data and the material – and will also, in the final analysis, ensure its integrity and credibility.

This approach was greatly strengthened by the adoption of a case study design (after Cresswell 1998), and by a gradual narrowing of focus onto one woman only. I was thereby able to follow (as researcher) the entire course of music

therapy in an evolutionary and cumulative way, conducted (as therapist) in a sustained, in-depth clinical relationship with her over a period of three years. Such delimitation was entirely deliberate, and was chosen precisely in order to provide more manageable, yet at the same time richly detailed, data, and to strengthen the element of in-depth interpretation within the case study (as discussed in Chapter Two, sections 2.2.1.1 and 2.3.2). Angela was chosen both for reasons of practicality and because of my own personal interest in her and her situation. The strength of my observations and theoretical assertions stems ultimately, then, from the uniqueness and the intrinsic qualities of her case. My approach in this sense brings the question of qualitative research design and analysis to a new (and, I hope, significant) point. Angela may doubtless 'represent' other women and their issues in some way; but any results obtained are not necessarily generalizable in any obvious or realistic way, though they may well indicate further areas of interest for future research in other contexts.

Angela's songs were examined and images extracted from them and analysed, in the light of relevant life experiences, in order to explicate something of the meaning and utility which the experience of music therapy has had for her. During the design and conduct of the research over time, three key philosophical perspectives and theoretical frameworks proved to be invaluable as guiding principles, and also, within the limits of my chosen approach, effective in practice – behaviourism, therapeutic narrative analysis, and the dynamic archetype of sonata form.

The paradigm of behaviourism, considered both as an underlying philosophical orientation and also as a framework and methodology for research, brought about a concentration on the collection and analysis of observable behaviour(s) (which for me includes language and all similarly declarative acts); a focus on searching for regularities, patterns or associations between events which are indicated over time; and a central consideration of both the internal and the contextual circumstances in which such behaviours occur – these behaviours being viewed from the perspective of a stimulus-and-response understanding of conditioned associations, built up through the reinforcement of the given functions of the human organism, encompassing both mind and body, and working on a holistic, physiological basis.

However, as is by now (I hope) abundantly clear, my research design was sharply distanced from more traditional behaviourist forms of experimentation (with their controlled environment, prestructured approach to observation, and measurement-based findings), as I adhered to the naturalistic principles (Lincoln and Guba, 1985) of observation within the natural setting. The use of therapeutic narrative analysis (Aldridge and Aldridge, 2002) effectively enabled me to observe and analyse patterns of behaviour within the natural course of the music therapy, while still applying a rigorous structure of inquiry. It was also eminently adaptable to the needs of a personal and individualised case study, for I applied its cycles of decontextualization and recontextualization of the available observed patterns on a longitudinal, temporal basis which not only utilised the three-year course of therapy as a natural set of structural boundaries for the case, but also emphasised and expanded the concept of a journey (as

metamorphic process) over time, as well as providing a system within which data could be examined, cyclically and progressively, at different levels of abstraction or meaning. It was this form of analysis that was influential in the production of a narrative account, a retelling of Angela's story that related as closely as possible to her own voice, by linking together the observed episodes, events or patterns of imagery from her songs and her experiences.

It was the graphical depiction of the timeline of Angela's songs, produced in the first stage of decontextualization, which led to my initiation of a sonata form archetype as an aid, or tool, in the research process. This provided a visualised and spatialised – yet at the same time unfolding – three-part framework of Exposition, Development and Recapitulation which helped to focus the whole process of questioning, guiding it by reference to the processive and cumulative structures of a given musical form of wide acceptance. It may be that the dynamic archetype underpinning the detailed unfoldings and symmetries of sonata form (with its presentation of conflictual and resolving phases) has an underlying relationship of some kind to the realities of human therapeutic process. But it is at present scarcely possible to verify such a proposal, and in practice I used the sonata form analogy simply as a useful tool of research that allowed me to inspect the material in implicitly dynamic, thematic and ultimately resolving ways.

It was not so much the songs themselves, as musical pieces, that formed the material for this analytical inspection, but rather the ideas and themes from 'beyond the songs' – the elements which they yielded or gave rise to, and more generally what they signified or symbolised to the women. Just as real sonata

forms show considerable freedom in their treatment of the archetype, treating existing themes developmentally but also frequently introducing new ideas where the extension of old ones might otherwise have been expected, so too the course of the therapy turned out to have a trajectory which included the orderly along with the unexpected – so in this way, too, the analogy proved fruitful.

This type of musically governed analysis was not applied to the musical processes operating within the sessions, however, nor to the individual song forms, nor indeed to any specific evolution of musical themes leading from one song to another or connecting across sessions. Rather, it was geared towards an examination of the broader longitudinal effect, at the same time both psychological and therapeutic, of the musically structured sessions and interactions. Its power of significance in interpreting the available material lay *beyond*, rather than *in*, the songs as musical items – in what they stood for and accomplished, therapeutically, rather than in what they were, stylistically and musically (hugely important though this had been to the running and continuity of the sessions themselves). Thus the sonata form analogy was used to frame, to inform and to guide the analysis of the 'thematic development' of therapy issues, thereby assisting in the organisation and interrogation of the data, and, once again, underscoring the temporal and processive nature of the research.

The combination of the structure of therapeutic narrative analysis and the application of a sonata form archetype to the timeline enabled me to extract from the narrative account two types of focal impressions - personally constructed foci which provided condensed summaries of the quality or range of

meanings inferred from each song: the visual metaphorical images and the verbal bi-polar constructs. I do not mean to suggest that these were actually in existence, in one form or other, during the music therapy sessions themselves (though some images and personified figures were indeed clearly apparent and 'present' at that time) but, rather, that they are abstracted representational impressions which in some sense condense and depict the core aspects of the experience in as close a way as possible to the original, being created from the words and actions of Angela herself during our explorations of the songs and their meaning(s) for her. They serve to give definition to the data, making subjective (or intersubjective) experiences recordable in a concentrated form which may be sourced from, and at the same time related to, the context of the therapy sessions and also to Angela's past and present-day life history. Thus, these images or foci became the foundation for the detailed work of analysis and interpretation which occurred throughout Chapters Four and Five.

My concluding assertions at the end of these chapters illustrated the proposed relationship between life and art, the centrality of the role of our mutual and always participatory song-construction in the therapeutic process, and the relevance and range of meaning of metaphoric images. Two specific concepts were evolved and were foregrounded during the research and have been presented as the most significant findings. These are Music Therapy by Proxy and Reverse Chronology.

In the process of Music Therapy by Proxy I propose that the client utilises the appropriation of a third-person or proxy. This takes the form of a metaphoric

image which is personified or humanized, being a human figure of a conventional, culturally received and understood, and perhaps even archetypal nature – a figure which is thus able to depict human life experiences and emotions without difficulty. It is also, essentially, decentred and depersonalized, in the sense of being separated from the client so that difficult emotions or experiences can be distanced by being transferred onto the figure, presented through music and song in a socially and personally acceptable manner, experimented with, modified and adapted, before being finally re-accepted and integrated into the client's functioning patterns of behaviour.

It might seem strange, at first, for a behaviourist to focus on such seemingly ethereal and insubstantial images, constructed as they are from words and impressions, rather than on any more obviously externalised – hence observable and recordable – aspects of behaviour. However, it was precisely the women's *avoidance* of expressive musical improvisation and their preference for the routine of pre-composed songs which had originally provoked my interest, and I wanted to understand the relevance of these songs and the images they seemed to contain for the therapeutic process as a whole. Watson (1931) for example *included* linguistic representation and indeed the whole realm of language in his holistic view of conditioned reflexes, or habits which are learned and retained, stressing that such things do indeed serve a useful purpose:

> Language, when fully developed, really gives us a
>
> manipulable replica of the world we live in. (Watson 1931, p.302)

Proxies, in the form of metaphoric images, may also be seen in this sense as 'manipulable replicas', and it is precisely this function, when combined with the adaptive and developmental capacities of music, which make the songs significant. Direct replication, through self-expression in musical improvisation, of the tortuous world in which some of these women lived would be too harsh, too personally, emotionally intrusive. But indirect replication through a third person is approachable – the emotions can be contained within the life of the character. And, perhaps, the use of metaphors in images becomes even more relevant if the client's language use is not fully developed and so pictures or images, particularly those culturally conditioned since childhood, can simplify the process. Once this separation of replication onto the proxy has been achieved it is music which comes to the fore, bringing the emotion to life, and the character's music can divert the therapist's attention, allowing the client to participate or observe and absorb only to the extent which is manageable for her. Participation in the music, through active listening, singing, instrumental accompaniment or improvisation can be used to try out new ways of expression, constantly being modified and adapted until it can be successfully experienced, relearned and reintegrated. In effect, the transformative capacity of music gives alternate ways of responding or strength of character to the fragile or chaotic world of the psychiatric patient in the same way that all humans learn and relearn from their experiences:

> Individuals can and do change their personalities. Friends,
>
> teachers, theatres, the movies all help to make, to remake and
>
> to unmake our personalities. (Watson 1931, pp.302-303)

But, even when considered from a behavioural perspective, this cycle of learning is not merely a set of conditioned responses for it is affected by each individual's life history and the unique build up of a repertoire of behaviour, an antecedent or 'environmental history' (Skinner 1974, p.82). Skinner stresses the importance of reminiscence and remembering, in their original meanings of being mindful of something again, and he discusses the central place of imaging and metaphors in these formulations. And yet, crucially, he stresses that responses are not simply transferred from one situation to another but that they occur because of similarities in the surrounding stimuli. Meaning, then, is found 'not in the current setting but in a history of exposure to contingencies in which similar settings have played a part' (Skinner 1974, p.90). It is, therefore, the functions of behaviour which are crucial and it is the environmental conditions in which they occur rather than their associated subjective feelings (which are acknowledged as part of a holistic bodily state) which allow us to analyse and explain the meaning.

It is in my second significant proposed finding that the importance of environmental history becomes even more prominent: in the existence of a soundtrack of life-and-song associations which can be traversed according to a pattern (perhaps a model) of Reverse Chronology. This concept arose when I began to notice that current events in the music therapy sessions or in Angela's present day life acted as stimuli for the initiation of, or response to, a song which in turn gave rise to a metaphoric image or figure. But the underlying theme or issue on which this figure was based often related to an experience from an *earlier* period in Angela's life. Such occurrences did not appear in

random order but apparently in reverse, moving progressively back in time through Angela's previous life history as the music therapy progressed forwards. And yet this was not a direct correlation in reverse, for the model itself is not static – it is complicated by the need to account for the ongoing progress of current time and so it is from this moving point of reference that the images appear to go backwards. In so doing, they are positioned progressively further back (in chronological time) from the vantage point of each new session, as well as appearing in reverse biographical order. This gives an overlap in the early sessions (as was shown in diagrammatic form in Chapter Five) making the cycle seem distorted, somewhat like a spiral in the centre, rather similar to a coiled spring which at the start gives impetus to the beginning of the cycle, but then radiates from it in ever increasing circles.

This reminds me strongly of a statement by Ruud (2005, p.36) concerning the hermeneutic circle, the cycle of 'evolutionary' understanding and interpretation based on the making of connections between a whole text and the sum of its parts, which has more recently been described as a spiral. This implication of an onward progression through time of an interactive process connects closely with my sense of the associative and unfolding stages of a metamorphic journey.

The concepts of life associations being constructed over an individual's lifetime, in the form of links between music or songs and experiences, which can then be evoked at a later date (that is, the Life Soundtrack, as I have called it) fits well within the behavioural/behaviourist paradigm. What remains less clear is the exact nature of this process for Skinner refutes the existence of such

a timeline or internal map and, indeed, of any internal representations at all which are stored in memory. Instead Skinner is keen to argue for the importance of reinforcements which simply change our ways of behaving in response to future stimuli:

> A person is changed by the contingencies of reinforcement under which he behaves; he does not store the contingencies. In particular, he does not store copies of the stimuli which have played a part in the contingencies. There are no "iconic representations" in his mind; there are no "data structures stored in his memory"; he has no "cognitive map" of the world in which he has lived. He has simply been changed in such a way that stimuli now control particular kinds of perceptual behaviour. (Skinner 1974, p.84)

This well-argued view is an extreme one, which may usefully caution us against any too-easy presumption that changes in behaviour may be grounded in changed attitudes at a self-aware cognitive (and thus 'map reading') level. But it does not detract from my assertions of metaphoric images as proxy, of the reality of a timeline of songs, and of a model of reverse chronology - for these are perceptions and constructions of my own, and they have served their specific purpose in facilitating and illustrating understanding of the meaning of Angela's use of songs within her therapy. Questions concerning the nature of their underlying existence, or the contextual stimuli which give rise to them, will remain, as they must, open to debate. There is in this approach (I suggest) no essentialist form of truth; but rather a sense of truthful cohesion and a kind of

grounded integrity, arising out of my own dual role within the project, and out of the equally important fact that the project was in the deepest sense a participatory one, rooted in relationship and trust, between myself and my women clients.

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However, my own task as therapist-researcher is not yet quite complete, for, in exploring the landscape of Angela's narrative, I have so far neglected to develop and nurture one of my early research foci – one, indeed, which was an important instrumental question in the initial visualisation, composition and orchestration of this thesis. The final assertions of the appropriation of song images in Music Therapy by Proxy, and of an emergent pattern of Reverse Chronology have profound implications for my personal understanding of clinical practice (as a therapist), and also for my view of the active-creative nature of music (as a practising musician). Their contribution as parts in the whole generative metamorphic process deepens my understanding of Angela as a person, as well as a client in music therapy, and may lead to wider enlightenment in aspects of music therapy in general. And yet this basic mystery remains: if such a process of song and imagery is so profoundly significant, as I believe it is, why is it not more prevalent in standard music therapy practice? Or, to return to the 'egg' of an initial research question that I asked myself in Chapter One, why have I only experienced such extensive use of pre-composed songs with women in forensic psychiatric units and precisely *not* with other client groups? In behavioural terms, is there some specific significant factor or stimulus in the context of women's lives in secure forensic

psychiatric institutions which might have facilitated, or necessitated, a conditioned response in the particular form of pre-composed song constructions and appropriations?

There is one potentially revealing part of the abstracted data which has yet to be analysed: the seven core themes which were listed in Chapter Five, Figure 10. On initial inspection these themes will without doubt appear broad and generalised, perhaps even rather vague, being applicable without difficulty to almost any person. But this is precisely what makes them of particular interest, when considered from a behavioural perspective. Behaviourism in its broadest sense espouses a strong holistic belief in the somatic basis of the human organism, with behaviour and its effects being driven by internal physiological states. These seven themes are the core centres of meaning, what I described (in Chapter Five) as the inner issues and sources of conflict for Angela, which appear to underlie and determine the creation of the bi-polar constructs which are manifested, or materialized, in her chosen songs. If such inner drives and functions are generally applicable to all humans, then we must look in part to the external conditions of a person's life or experience in order to analyse and understand why they should have surfaced in a particular way at a particular time. In the remainder of Chapter Six, therefore, I will return to these seven themes in order to search for further insights which may be articulated explicitly in terms of Angela's own experience, and implicitly in terms of wider contextual possibilities and forensic relevance to the broader field.

Each of these themes will now be presented and discussed separately, for the sake of ease and clarity, though it must be stressed at once that they are not meant in any sense to represent discrete and defined parts of Angela's personality, but are intertwined threads of a rich thematic complex constituting an overall interactive state of mind and being. Angela's narrative will again be used for illustrative purposes, but the scope of Chapter Six widens once more, and will include examples from some of the other nine women introduced in Chapter One. In Chapters Four and Five the literature field was largely absent, this being a deliberate policy in order to promote Angela's voice as the main focus of the narrative, and as the locus of prime data importance. This central focus now expands again, being recontextualized into further relevant areas across a broader spectrum, once more relating this case study to the wider field of theory, exploring the implications for current practice, and finally (by way of conclusion) introducing a range of potential ideas for subsequent research.

6.1   Theme One: Social / Relationships

Six women living in the same house with one communal lounge and dining room does not sound like a recipe for success. Add in to that mix varying degrees of mental health issues, personality disorders, learning disabilities and the fact that the women have no autonomous choice of leaving or remaining there. Inevitably, the concoction takes on combustible characteristics. Women's relationships within the medium-secure unit were varied and tentative. Angela had a fragile friendship with Gracie but Gracie's cycles of depression due to her bipolar disorder made continuity difficult and unpredictable. Relationships with the remaining residents were even less forthcoming, with Jackie being racially

verbally abusive and Clare often antagonistic as she was unable to understand Angela's increasing physical frailty. Even within the close confines of the unit individual women were isolated by their own and each other's behaviour and, when solitary paths crossed, acts of verbal or physical aggression were common. This was one of the prime reasons for establishing group music therapy rather than individual sessions: it was a basis for exploring and promoting positive relationships for the women who had no choice but to deal with each other on a daily basis.

What soon became apparent was the uniting factor of the women's love-hate relationship with the unit staff. The women's perceptions of their treatment by nursing and care staff was a revealing glimpse of their self-views, and the need to speak openly about such issues was the main reason I chose to work alone in the group, without the added complication of staff presence. Of course, this was possible only because I was a visiting therapist, not part of the full-time staff, and so could be seen by the women, perhaps, as a connection with the real world 'outside' and not an internal threat from the system itself. This benefit also had an opposing side, and as a therapist I was acutely aware of the possibility of collusion with the women in their beliefs of victimisation. At times this was difficult to resist, as my reflective session notes record my own feelings of marginalisation from the workings of the rest of the unit.

On the whole I had positive interactions with the staff. I was welcomed into the house each week, kept up to date on events in the women's lives, and I fed back information on progress or problems within music therapy. However, there

remained a persistent feeling that the role and status of music therapy was not entirely accepted; it was given token respect when necessary in order to maintain the status quo. As an example, for several members of staff, music therapy could not be named. Despite my best efforts at explanation, promotional information, and weekly announcements along the lines of "Hello everyone, I'm just setting up the room for the music therapy group…", my arrival would often be met by staff with "The music teacher's here…are you going for your lesson now?"

Education, it would seem, is more socially acceptable, or less threatening, than therapy. It became a personal goal for me to reach the residents' lounge before any member of staff did – the paranoid and compulsive behaviour of institutionalism can indeed affect even the most dedicated therapist.

Staff resistance is certainly neither rare nor restricted to music therapy. Thompson (2003, in McKean 2006) writes of prison staff fearing disruption to routine, chaos and undermining of a system which is committed to reform and rehabilitation but dominated by an agenda of punishment and discipline:

> Being a visitor as opposed to being a staff member has certain advantages as it enables one to take on the role of the outsider and ask for and sometimes achieve results that would otherwise not be deemed possible. In turn this can and does create suspicion in the minds of those in charge within the institution. (Thompson, in McKean 2006, p.317)

McKean (2006) writes of the use of theatre in a women's prison and questions the nature of personal transformation as underpinned by institutional transformation. Prisoners who wanted to use drama as advocacy were concerned about the responses of prison staff:

> Self-censorship mitigates against the creation of the 'voice' that this
>
> kind of theatre is supposed to 'empower'. (McKean 2006, p.318)

With this in mind, perhaps it is no surprise that women in forensic institutions, who may have additional tendencies to operate at a higher than normal level of paranoid delusion, turn to the socially acceptable use of 'innocent' songs and the security of a third-person Proxy in order to voice their concerns. It is worthy of note, too, that children's songs make such a strong representation. In previous Chapters I addressed the notion that this links to associations with biographical events in early life, as part of a constructed musical soundtrack, but there may be an additional factor influencing this usage for women in secure units: a return to childhood that is subtly enforced by the system. The prison system was built mainly for men. Women placed within it, the 'girls' within 'the Doll's House', are 'infantilised' (McKean 2006, p.320), disempowered to a greater extent than men by the loss of decision-making and opportunities to deal with their complex social responsibilities in their everyday roles as wives or mothers.

I found such infantilisation to be clearly evident in the forensic unit staff's insistence on 'music lessons' and pleas to the women to 'play nicely'. Angela's

response was to ask me to tell them after sessions that she had 'been good', a measure not only of her personal striving for Goodness away from her past bad life experiences but also an indication of her compliant institutionalism. This in itself may be why it took one year to creatively undo the safe acceptability of *Edelweiss* and move into voicing more personally revealing musical constructions.

Institutionally entrenched views of gendered music were very noticeable in my therapy practice. In the women's medium secure unit staff expected 'nice' music and, in early sessions at least, loud emotional outbursts of sound would bring staff into the room, "Just to check everything's OK". In contrast, in another setting - a high-secure ward for men - loud chaotic improvisations on drums and cymbals were the norm. I distinctly remember the first sudden silence, a rare intermission when for a brief moment the heightened expression of a group of distinct individuals converged into a moment of satiation. We collectively exhaled and smiled at each other but within seconds two nursing staff burst into the room, concerned for my safety in the unexpected calm.

Female psychiatric patients, and their music therapists, therefore have a dual task: they must legitimate and assert both their particular choice of therapeutic activity and their rights to freedom of participation and expression in that activity. The concept of legitimation is presented by Ruud (2001, paraphrasing Horden 1997) in a discussion on the history and cultural context of music therapy where historical practices of using music as medicine have been used as a tool for legitimising current practice. As Ruud argues, whilst a bio-medical

model of musical healing is becoming increasingly claimed by and through the authority of medical doctors, the discipline of music 'as' therapy as opposed to music 'in' therapy continues to require negotiation for the acceptance of its efficacy as a separate intervention. I certainly found that this negotiation demanded careful consideration of the culture and community of the institutions in which I was operating. As a visiting therapist, I had to negotiate for physical space in which to work; for uninterrupted confidentiality for the women; and for consistent timing of attendance without other activities taking precedence. And with the women, too, I had to negotiate a mutual manner of working that fulfilled their need for a creative therapy yet did not compromise their very real expectation of institutional reprisal.

The required construction of an almost game-like process of manipulated legitimation serves to corroborate the use of songs rather than of free musical improvisation. Frith (1987, pp.101-2) suggests that the meaning of songs lies in their social 'use', and that songs have words to provide 'access' where '…songs don't reflect emotions…but give people the…terms in which to articulate and so experience their emotions'. In effect, they are popular legitimised cultural products which can be used to build social relationships. Above all, such popular music can offer:

> An affirmation of personal identity and a sense of membership
> in a larger collectivity. From this point of view, the phenomenon
> is more sociological than musical… (Martin 1995, p.274)

The struggle of psychiatric patients to build meaningful social relationships within institutions built on the boundaries of bureaucratic management is not a new idea. It was a focus of concern for Goffman as early as 1961. In his essays on the social situation in 'Asylums', he details the power differences of false relationships between psychiatrists and patients when the patient is not a voluntary client (Goffman 1961, p.319). He goes on to claim that doctors should take patients' statements on face value as reports of symptoms or useable information but, instead, expressions of disgruntlement or denial are more likely to be seen as signs of illness and are therefore discounted. From the perspective of music therapy though, such expression, be it direct or metaphorically placed through a song image, can be used as a focus for an interactive relationship based on equality, and music thus becomes a self-preserving adaptation within an institutional organisation. The patient is thereby enabled to maintain her individual identity and assume responsibility for constructing her own recovery, rather than having a pre-defined treatment imposed upon her.

Bostock (2002, p.10) reviews similar issues in presenting the difference between people who are 'well' and 'ill' and the stigmatising effect of society's perception of not-relating to someone who is different yet still a normal individual. As she says, 'Ill people don't always have to be nice, they just need to be human.' Expressions of confusion or anger at being detained in a secure hospital involuntarily can thus be seen as perfectly rational, human and emotional responses, and not necessarily as symptomatic of an illness itself. And so, as a practising therapist, I need to listen to the unheard voice of the patient seeking to describe, beyond the immediate concerns of 'our' texts and

contexts, the underlying problems or priorities she feels she *does* need help in confronting.

The division in society between ill and well is a culture clash which also exists within our special hospitals in terms of their use. Spillius (1990, pp.586-587) describes the conflict inherent in hospitals which provide services and care for the benefit of patients but that need also to 'manage' them when relatives and society can not. She claims that, as hospitals serve the conflicting interests of patient and society, such institutional contradiction gives rise to personal and collective anxieties. These result in organisational attitudes and techniques that turn the institutions themselves into functioning social defence systems for those working inside them. Hinshelwood (2000, pp.468-472) illustrates clearly the denigration of psychotherapy in prisons that may result from such a culture-dominant system, and the difficulties of integrating change without providing support against 'unconscious collective defensiveness' (Hinshelwood 2000, p.472).

The power struggle continues as modern-day prisons try to reconcile the public desire for criminal recompense and punishment with a societal need for rehabilitation and resettlement. Mackie (1994, p.247), writing about art therapy in prisons, describes crime as 'essentially the solution of personal problems at a childish level of conduct' and suggests that the institutionalised punitive rituals of the past which linger in the prisons of today only serve to foster ever more ingenious routes through which inmates channel maladaptive behaviour. Both art and music therapy allow clients to test out alternative solutions to their

problems, with particular sensitivity to the central role of non-verbal communication. The process is more important than the product but in order to transform prisons into humanitarian communities with an ethos of personal growth resources must also, Mackie states, be made available to the staff in those organisations to allow staff to address their issues in adapting to a changing cultural context.

This, I agree, is needed within the forensic psychiatric system too. Patients can only change if staff members allow them to, and staff members need knowledge and understanding that this can be achieved through a variety of processes. Flexibility can be hard to maintain for nursing and care staff working in volatile environments and they, too, need support to deal with issues and emotions aroused in them. Many, many times staff in both of the medium secure units told me they wished there was a music therapy group for them to attend. On occasions I, too, felt I could have achieved results quicker for my women clients by not working with them, but working instead with the staff and assisting them in allowing and supporting the residents to re-assume responsibility and regain control over their own paths of progress.

This dilemma of choosing the best working practice is one aspect of changing world-views, of increasingly diverse social communities, and of growing ethical considerations. As Brown (2002, p.2) states, 'It could be argued that a culturally-centred music therapy practice is unnecessary if music therapists practice empathically and sensitively.' But in so doing we must examine our

own world-views and those of our clients and 'become aware of the preconceptions that we use everyday in our practice' (Brown 2000, p.8).

I would add that it is not just our preconceptions of cultural issues and contexts that must be reviewed. Angela and the other women have changed my world-view of music therapy itself. My horizons have expanded vastly from the definitions I gave in section 1.1 of this thesis. Musical improvisation, as I first viewed it, can be achieved very creatively through the medium of a pre-composed song for it is in the mutual, social act of co-reconstruction and re-expression that therapeutic relationships are built and a voice given to the hidden emotional issues and conflicts of the individual client. It is in the depth of practice, a highly active creative process, which, for women in forensic units, can be an accessible and appropriate means of addressing the tension of institutional power struggles, and social and cultural constraints.

For Angela, the core theme, or centre of meaning, of Social / Relationships may therefore be seen as an inner force which strives to balance such tension: addressing the conflicting demands of Angela's needs for self-expression and those of others within the group; the administrative requirements of an institutional system and her desire for autonomy; and her changing recognition, presentation and adaptation to her own and cultural preconceptions of her state(s) of illness or health. Thus there is a need for the researcher, also, to balance his or her interpretative view of such tensions and diagnostic factors within a given social and institutional framework.

6.2   Theme Two: Colour

The presentation and use of colour was a multi-faceted phenomenon throughout the course of Angela's music therapy. It is impossible to define exactly how much, or in what ways, her preoccupation arose out of her personal emotional needs or was a racial issue, a response to cultural or institutional constraints imposed upon her. Certainly, some aspects of Angela's obsessive behaviour may be seen as part of the institutional power struggle: her insistence on blue or white clothing could be one way of re-asserting self-control and striving to exert some level of personal influence in the otherwise over-controlled environment of her daily life. My session notes record many other instances of colour-related events, most notably our repeated conversations about black and white teeth fillings and her actual physical destruction of red objects. This thesis has concentrated on only those most musical manifestations of colour as they appeared in the music therapy sessions, so the dentist and his drill make several appearances in musical improvisations and song. Chapter Five, section 5.1 examined the possible associations between the blue Virgin Mary and the red roses of the Black Madonna, and how imagery in song and my own clothing was combined to elicit understanding of parts of Angela's early life history and the connection with her absent mother. Chapter Four, section 4.1.3 explored in some detail the use of the blue bell, its connection with frozen *Iceland* and the warming, defrosting process of greening that led to emotional expression, the green bell and change to other coloured clothes. This demonstrates a positive and successful use of behavioural shaping techniques – gradually manipulating metaphoric images and actual coloured objects in the immediate environment so as to alter conditioned responses. Much of this process related to Angela's

physical decline and psychological, and actual, entrapment in the unit, but there also seemed to be a cultural undertone in her search around the countries of the world.

It is difficult to assess, or even to imagine, Angela's understanding of her own racial identity, and this was not something of which she spoke. Her case notes did not detail whether she had been brought up by a black or a white family after being abandoned by her mother, only noting that, as a teenager, she had denied being black. Within the unit there was no apparent cultural upbringing or Black identification that set her apart from the other all-white residents and staff, yet she was clearly labelled as such by other members of the group and was said to have been a victim of racial abuse in her previous hospital. Section 6.1 has introduced the idea that society labels some people as 'ill', especially those with psychiatric problems, and then treats them according to the prejudices of that label rather than as individuals with distinct needs. So, too, the label 'black' can obviously be applied to someone, irrespective of their self-identified racial or cultural alignment or sense of self:

> One is not born 'black' but rather one becomes 'black' either by
>
> self-identification or through social maneuver. (Annoual 1998, p.20)

Annoual (1998) addresses the concepts of racism, race and blackness, and art therapy. She differentiates between objective characteristics, such as skin colour, and subjective identities. She presents 'blackness as an identity construct', not a static concept but a process of construction 'that may change

depending on situation and context' (p.20). Racism is based on prejudicial preconceptions of differences that lead to the actual practice of discrimination, and such practice can be systematically embedded in an institution. Of course, in today's ethnically diverse society it is not simply a matter of black or white, and identification of self or other groups is highly complex. Annoual (1998, p.17) noted the use of shades and textures in clients' self-portraits and how this related to the group dynamics of what is now sometimes referred to as 'shadism'. She states that within art therapy the use of colours for the expression of shades can be contained but notes that 'this requires precaution since all characteristics pertaining to blackness have long been dehumanized' (p.17). Exploring the hidden connotations is a 'touchy subject' (p.17) which could be divisive in a constructed group that may already struggle with issues of unity and acceptance.

Katz (1996) takes this notion further in examining the 'mixed metaphors' (title page) in the construction of racial identity for children within inter-racial families. Postmodern philosophy, he argues, denies the structural developmental view of personal identity as posited, for example, by Piaget or Winnicott, where a fixed set of beliefs and dispositions develops over time into a stable structure based on fixed causal links between past and future events. Postmodernism focuses instead on an individual's, or group's, construction of an unstable reality, a 'conflicting set of meanings and emotions held together by narratives which cover the cracks of contradiction and discontinuity' (Katz 1996, p.186). These narratives vary in different circumstances in order to maintain a 'fantasy of coherence' in a multiplicitous notion of 'difference' and 'otherness' (p.186).

Katz adopts Narrative Identity as a model of development of personal identity, based on the concepts of Ricoeur (as mentioned at the end of Chapter Three), where narrative acts as a mediator (a force for mediation), enabling us to construct and reconstruct our identities, changing our interpretation of self-knowledge over time and in different contexts. Accompanying meta-narratives of theories or cultural or societal norms legitimise the individual narratives and provide the frameworks in which they exist. Institutions exist to regulate society and make it meaningful. They do not exist separately from human action but do need to be explained and justified. According to Katz (1996, p.29), 'Legitimation is the set of values, beliefs and norms surrounding all institutions'. It strengthens their power and shapes social action through defining the relationships of our institutional roles, and 'the major legitimising factor in all institutions is language' (Katz 1996, p.29).

In this model, (Katz 1996, pp.187-189) legitimating forces operate to keep narratives within an acceptable framework. These may be internal, such as feelings of guilt, or external, such as a threat. Therefore, to rise to maturity, above a childish level of operation, requires individuals to face the contradictions in their lives, to live with uncertainty, and to confront the forces involved in shaping their narrative.

Thus, in postmodern racial identity issues, primary biological assumptions should give way to biographic notions. For Angela, this does not present any easier solutions, for the early biography of her family background is peppered with uncertainty, rejection and confusion, and her present-day social

interactions are limited to an enforced grouping which labels her as an outsider based on prejudicial views that may not match her own beliefs. She also lacks the speech and language skills necessary to negotiate and legitimate her own identity within the framework of institutional roles. Ricoeur's 'privileged mediation' (in Katz 1996, p.187) comes to the fore in the form of the narrative song and the use of the third-person Proxy. The threatening forces of internal identity and external racial conflict can be presented and manipulated into a more acceptable story, and one which can provide unity of action in its performance in a divisive group.

To some extent the Proxy, the metaphoric song image, acts as a mask, an act of 'creative transcendence' (Pattison 2000, p.162) that metamorphosizes the hidden reality of the individual into a powerful universal symbol, allowing one to act shamelessly, facing and reducing one's fears. But some masks may also be stifling and Pattison (2000, p.173) notes a book by Fanon, *Black Skin, White Masks,* that points out the mental disorders which arise when Black people have to live in a society ideologically constructed around White assumptions.

However, as Condliffe (2001) explains, racism is an inevitable part of the nursing curriculum because the framework on which it is built, and the ways student nurses are socialised into the profession, are based on an invisible white ethnicity: an identity which is not labelled 'white' because this is set as an unquestioned standard against which others are measured.

Preconceived ideas, including fear of the 'otherness' of black people, has produced stereotypes in white staff that damage and alienate black patients and contribute to the inequalities in healthcare that they experience (Webbe, 1998). Their emotional distress is more likely to be medicalised or criminalised as nurses perceive their behaviour to be threatening. This has resulted in an over-representation of black patients detained in psychiatric hospitals, and a disempowering label which obscures their real issues and prolongs their detention.

What is needed is culturally appropriate health care which goes beyond anti-discrimination policies and includes cultural awareness, knowledge, and sensitivity. This leads to a practice of cultural competence that acknowledges both individual differences and a shared humanity (Papadopoulos et al 2001).

This is also addressed by Lago (1996) in terms of counselling or therapy. He stresses the need to take into account the whole being of the patient and her past and present life experience. In particular, a white therapist must be aware that the inner being of a black client may be rooted in the same culture as the therapist and the inner similarities of social beliefs and attitudes may be more relevant than the outer visible biological differences of racial characteristics.

Aitken (2000) takes this further by examining the power relationships of white women therapists working with black women clients in forensic mental health contexts, where it is possible that the commonality of gender can mask or evade differences in structural power. She applies feminist principles of transparency,

collaboration and honesty in her work to renegotiate trust and power relations, viewing it as her 'responsibility' to explicitly raise 'visible differences' in race or culture 'if the client herself has not' (Aitken 2000, p.257), in order to acknowledge issues that may arise for either client or therapist.

In my own music therapy practice, by contrast, I take the opposite approach, believing that true issues will be revealed in the music and that explicit naming may act instead as a suggestive determinant, notwithstanding any additional problems caused by the power issues of institutional language itself. Again, I return to what I believe is the advantage of a non-verbal therapy: individual clients' emotional issues can be explored, negotiated and reconstructed through the abstracted musical process, once trust has been established. This trust can be constructed through the same shared musical experience as the therapist listens to, accepts, supports and enhances the musical contribution of the client, at whatever level of self-expression or musical ability, so that power is transferable and fear of failure or further shame is negated.

Perhaps it is the balance of power which lies at the heart of the core theme of Colour, relating more to the ability to accept and proclaim a personal self-identity irrespective of perceived individual differences. It took Angela almost three years to work through her colour issues. We may well not have stopped the racism she was experiencing (we could hardly have hoped to), nor altered the painful experiences of her early family life, but I am convinced she ended therapy with a stronger sense of self-identity, greater acceptance of her inner conflicts and, above all, a more positive attitude and outlook, coupled with

increasing ability to negotiate successful social relationships, thereby making her voice heard. And let us not forget one of the prime sources of a woman's confidence and power – a new fashionable colourful wardrobe in which to face the world.

6.3   Theme Three: Movement / Space / Weight

For a moment, let us continue the exploration of colour issues concerning racial or cultural awareness. In an examination of the appropriateness of complementary therapies to the needs of Black mental health users, Jennings (1995, p.12) notes that 'generally speaking, Black cultures stress the importance of communalism, the group and family', and that 'the effectiveness of an individual is judged by their interrelationship with their community'. This leads me to question the relative appropriateness of group or individual music therapy for Angela. As the sole black woman in the group this may put extra pressure on her to form relationships but individual sessions would deny her the opportunity to nurture and develop such relationships. At first the group sessions were obviously difficult for Angela, for whatever reasons, and her coping mechanism seemed to be significantly related to the negotiation of space.

As I described in section 6.1, as the music therapist I had to negotiate and legitimate a physical, professional and personal space for sessions to take place.

Working under the prevailing bio-medical model in medicine gives

only marginal space to enact any therapy which claims to influence

the body through a musically altered frame of mind…music

therapists have to negotiate this space of intervention…a lot of effort

has to be spent upon securing boundaries and identities, aiming

towards some sort of credibility. (Ruud 2001, p.4)

In the same way, the women also negotiated their spaces within the group. They had favourite chairs or particular places to sit, and establishing and adhering to these mini-territories was an important ritual at the start of each music therapy session. I asked everyone to sit in a circle so that we all had access to the instruments in the centre; even so, in initial sessions, Angela had to push her chair to the edge of the room, touching the wall, behind the door. This was not a problem for music travels well and permeates all spaces within a room. Angela could respond and I could musically acknowledge and support her instrumental playing or body language and, therefore, still involve her in the group activities, as well as venturing into her territory occasionally to directly improvise with her or to share instruments.

Perhaps it was this emotional acceptance, combined with a certain sense of reassurance derived from the security of her spatial vantage point, that enabled her to relax sufficiently to fall asleep in early sessions, a rarity which was observed by the staff. Later on, she would physically move further into the circle and finally, when in her wheelchair, would confidently sit in the centre of the room, even with the door behind her. This view of music therapy reminds me of Jennings' (1995, p.vi) description of the 'sanctuary model' of

community-based crisis services for African-Caribbean communities where both the type of service and the atmosphere in which it is provided offer a place of safety and time out.

The idea of music therapy as a protected place, a sanctuary, in both physical and emotional space, may have given Angela important periods of time away from her prejudged, labelled roles. Here, she could retreat from the visible difference of her skin colour and have space to be unseen for a time. And the music itself focused on what she could do, on her wellness and not her illness; it thereby empowered her as an individual person rather than addressing a diagnosed and thus codified problem that had to receive treatment in specified ways. Therefore, it may be said that a judicious process of music therapy can reverse at least some of the infantilisation that takes place in institutions for women, as discussed in section 6.1: the old adage 'children should be seen but not heard' can become 'women can be heard, even if not seen'. Here, too, the envoicing of the woman client is the crucial factor in this balanced liberation of the inward and unheard.

But therapy, some would argue, also necessitates engaging with certain aspects of care that in the normal course of events are more suitable for children than independent adults. Vaillant (quoted by BAPSCAN 1999), in discussing the defence mechanisms (and consequent management requirements) for women with personality disorders, states that they 'often need care similar to the care required by adolescents…':

Indeed adolescents do not need therapy at all; they need a social

group that offers them the time, space and safety to internalise the

valuable facets of their parents and their society and to extrude

the chaff. (Vaillant, in BAPSCAN 1999)

Music therapy provides, or may provide when judiciously used, the necessary boundaries for such a group to function in just such a way. It is able to contain the emotions and behaviours in its virtual space, which is musically as well as socially constructed; and within this space it allows each individual to explore and internalise according to his or her own needs.

Space, therefore, can be seen from several inter-related perspectives. Indeed, Ruud (1997, p.4) defines four major categories of space and suggests how music and musical experiences may be seen to 'inhabit' them:

1. music and personal space

2. music and social space

3. the space of time and place

4. transpersonal space.

Ruud generated these categories through the analysis of close to one thousand musical experiences or short narratives of musical incidences. He found that all related to one or more of these four categories or 'dimensions'. Ruud proposes a theory of music and identity in which 'identity' is understood as a 'metaphor for self-in- context' and 'music… positions people in relation to time and place,

other persons or transcendental values' (Ruud 1992, p.3). Music plays an important role in the construction of identity within the 'mediascape' or 'personal soundtrack' of our lives (Ruud 1992, p.11).

In music therapy it is the construction of the musical relationships between players which becomes significant, more so than the construction of the organised sounds of the actual music. For, as Bunt and Pavlicevic (2001, p.183) state, 'the musical relationship… has direct links with patients' lives outside the therapeutic space' and offers opportunities 'to make connections between their individual and social lives'.

Frederiksen (1999) analysed musical clinical improvisation in her music therapy work in order to try to understand her client's resistance to interpersonal dynamic interaction. Part of her methodology was to apply Simpkins' observational questions which, as Frederiksen (1999, p.214) describes, originate from Laban's system of observation of bodily movement. In this, physical effort, or the set of inner physiological impulses from which movement originates, is mirrored in the actions of the body. The three elements of space, weight and time relate to attention, intention and decision, being stages of preparation for the fourth, the flow of movement which finds concrete expression in outer bodily action. Frederiksen analysed these elements as they appear in musical improvisations, and found this approach fruitful in introducing a bodily perspective to the psychic dynamics of the anorexic client.

Several aspects of Frederiksen's work strike me as particularly interesting in relation to the present thesis. Firstly, the four elements of space, weight, time and flow correspond completely with two of my seven core themes – Theme 3: Movement / Space / Weight, and Theme 4: Time. Secondly, the bodily perspective of outward movement relates closely to Angela's physical decline and steadily decreasing ability to move. This, I had always felt, was worsened by her physical and psychological restriction of movement from the secure unit.

Forensic psychiatric patients must find limitation of space and lack of movement to be a contentious and painful conditioning influence, for the authoritative boundaries are imposed upon them, usually without their agreement. Time spent without purpose can then increase the weight of tension and this, in turn, seeks an outlet, any outlet, in bodily form. I once asked Ruth what she was going to do after her music therapy session: "I've got nothing to do," she said, "but pace up and down or sit and rock." It may be that such repetitive movements assisted her sense of being properly oriented in the space allowed, for as Hall (1966, quoted in Lago 1996, p.41) states 'such knowledge is ultimately linked to survival and sanity. To be disoriented in space is to be psychotic', which, according to her clinical diagnosis, Ruth was.

Although these elements may apply to all patients in forensic units, space may be especially relevant for female clients, if its negotiation mirrors that of relationships outside therapy and in women's social lives. Heidensohn (1985) critiques the debate on women and crime and dedicates an entire chapter of her book to the issues of women and social control. Women's behaviour, she

argues, is socially controlled both internally and externally. The internal mechanisms of a woman's accepted role as wife or mother contributes to domestic containment and the potential for isolation within the circumscribed space of the home. And external threats, in the form of actual violence or of perceived fears, may have a conditioning effect outside the home, particularly in cities where 'urban space for women is compartmentalised, [and] to deviate from women's allotted space is to run the risk of attack by men' (Hanmer, in Heidersohn 1985, p.183).

I am entirely confident that 'a woman's place' is not as set now as it was when Heidersohn was writing some twenty years ago. But the biographies of many of my female clients, and the abuse they have experienced, shows that a large degree of social control through violence still persists. It is not unreasonable to consider that some part or measure of their mental health problems must relate to these women's difficulties in negotiating and reconciling such internal and external identity crises and power struggles. And so, the core theme of Movement / Space / Weight seems to be particularly pertinent to women in a forensic psychiatric unit and what music therapy can offer is un-imposed space created within the shared experience of music, the freedom to improvise ('making' and 'expressing' in music) without restriction, and the potential to follow a different path. The essential need for movement can be transformed from restricted bodily action into the flow of a broader emotional journey, where the woman defines her own acceptable boundaries and creates her own choices.

6.4   Theme Four: Time

Initial choices, then, may be created by the client in music therapy, but the act of deciding which path to follow, which action to take, then presents a further dilemma. As mentioned in section 6.3, Laban's (see Frederiksen 1999, p.214) system of bodily movement claims that a person has 'decision' only when he has mastered or adjusted his relationship to the dimension of Time. If we apply this concept at a broader level to include psychological, emotional or perceptual movement as well as physical action, then we can begin to see more clearly why decision-making can be such an issue for forensic psychiatric patients.

Most prisoners have a fixed set of boundaries when engaged in the proverbial act of 'doing time'. They are given strict conditions and strict limits – and they have to work within them. They know the length of their sentences and can create their own systems of measurement to help in structuring their path, even as simply as counting the succession of days, weeks or months. But two specific groups of incarcerated people do not enjoy even so simple a human privilege: those on a life sentence, and psychiatric patients detained under the provisions of a Section of the Mental Health Act. Both of these groups are subject to the uncertainty and the anxiety of indeterminacy: they have no idea when they will be released.

Walker, a life licensee, and Worral (2000) argue that the entirely rational despair which indeterminate imprisonment produces cannot be managed by the complex implementation of the rules and regulations of the penal system.

Moreover, much of the human pain of this experience is specific and gendered, concerning losses experienced by women lifers above those common to all prisoners such as loss of autonomy or privacy. To understand women's experiences one 'must take account of the relationship between time and the reconstruction of 'womanhood' under conditions of intensive and prolonged surveillance' (Walker and Worral 2000, p.27). As Walker and Worral discuss, losing control over time affects a woman's self-identity. It is more than mere restriction of liberty, for in losing responsibility for her children she may lose her socially-constructed views not just of what she does, but of what she is. This may be further compounded by the ticking of the biological clock, resulting in loss of fertility and future reproductive prospects, a punishment which nature does not inflict on many male lifers, who may still be able to father children on their release.

In such circumstances it would be perfectly normal to feel and express anger or despair and to grieve for what has been lost. But, according to Walker and Worral (2000, pp.28-34), the penal system is not in any sense geared towards this psychological bereavement process, but instead requires prisoners to engage or 'collude' (p.29) with their own management through addressing their offending behaviour and conforming to recognised levels of 'safe' (p.28) and acceptable behaviour, as judged on approved scales of risk assessment

Similar processes also apply to women in secure forensic psychiatric units where the indeterminate detainment of patients can be altered only by their presentation of compliant attitudes and behaviours to medical professionals.

Goffman (1961, p.41) suggests that this creates a defensive response known as 'looping'. An individual may comply, deferring to circumstances, but may at the same time protect herself and maintain her own sense of dignity and self by expressing complaint or contempt. This is then seen as insolence or as evidence of rebelliousness, a situation which is then fed back to the patient as another 'problem' which needs to be addressed by more intervention. Institutions therefore create and target natural patterns of self-preservation which serve to perpetuate their own diagnoses, thereby justifying the reasons for someone to be kept there and prolonging their detention over time.

It is, then, perhaps no wonder that my female clients needed a third-person Proxy through which to express their views and positions in music therapy. Such a strategy is able to provide an innocuous assertion of normal negative emotions, expressed through the seemingly compliant behaviour of attendance at therapy sessions and participation in songs and music.

However, the fear of institutional retribution and the power struggle of constructing or maintaining self-identity also showed themselves in time-related acts throughout my work in forensic units – and although many of these acts were not directly connected to the music, they still affected the dynamic of the sessions. Angela, initially, and Clare, always, were obsessive clock-watchers, wanting the session to end promptly at 3pm, irrespective of our start time. Eventually, I discovered that the reason for this was the regulation one cigarette every hour, which they were afraid they would miss, even though this was a policy designed for their benefit to help them spread their own purchased

supplies out throughout the day. Similar problems also came to light regarding cups of tea, when Health and Safety regulations forbade them from entering the kitchen: another prime example of infantalising women who were supposed to be being rehabilitated towards independent living. Ever practical, I extended the boundaries of therapeutic space, made the tea myself and took it into the session. This extended the duration of sessions, took away the need to clock-watch and eventually, when the women trusted me enough to believe that it really would happen, we moved tea to a social event after the end of the session. Empowerment of decision-making was established and tea-time became a moveable feast instead of a fixed requirement. Of course, control of the flow of tea was also emotionally and socially negotiated and I was on the receiving end of so many flying cups of tea, courtesy of Jackie, that staff changed their verbal label of me from 'music teacher' to 'tea lady', and I took to wearing beige.

Moira also used time to assert some level of control within our relationship. Sometimes, she would refuse to attend for a few weeks, but would also claim that she still wanted the sessions and no-one else could have them. During these weeks I stayed in the therapy room, 'holding' the space for her return. In my metaphoric cycle of metamorphosis, as described in section 1.5.2, this is the stage of therapy hibernation or chrysalis (as I have termed it). This often occurs after a particularly emotive session: the client then withdraws for a time, internalising and balancing out what has happened, before returning to continue with further sessions. This absence was difficult for other staff to accept, and two women were told, against my wishes, that they could no longer have music therapy if they did not attend.

Similarly, length of therapy cannot be predetermined but music therapy is often in a position of having to prove itself over a short set timescale. In some institutions I was frequently hired on a self-employed basis to initiate projects of six to eight weeks. If this had been the case in these forensic units, Angela would have been left stuck on the repetitive cycle of *Edelweiss* and so much potential for therapeutic growth would have been missed.

It would appear that a flexible approach to the use of time is needed, both in long-term provision and in daily scheduling. A considered process of listening to, and believing in, the choices of the women concerned would provide an initial set of guidelines for this. The core theme of Time appears to be relevant to women in forensic units as a holistic process or dimension operating both internally, to structure the process of psychological adjustment and movement, and outwardly, in resulting adaptive behaviours which take place over time, but are also related to time-based perceptions and routines. The concept of internal personal change and development over time, both during therapy sessions and outside of them, in avoidance responses, could therefore be a potentially revealing and informative aspect of future research.

6.5   Theme Five: Personal / Insight

Listening to women in prisons and secure psychiatric units raises issues far beyond those of personal choice at a localised, institutional level. It seems to be that there is a fundamental dilemma encountered in defining what constitutes 'voice' as an acceptable means of communication and expression – for there exists, in my experience, a prejudicial and territorial hierarchy of professional

disciplines which still places the declarative value of the spoken word, and therefore verbal psychotherapies, at the top of the value tree. This, in turn, discriminates against those for whom verbal expression is difficult, and who cannot therefore find the words to articulate or adequately define their experiences and insight.

Player (1996) introduces a debate on the legal, ethical dilemmas of incorporating psychotherapeutic treatments into the criminal justice system and, in particular, she notes with disquiet the curious lack of open discourse and debate, the limited level of communication, and the lack of joint enterprise between the two separate disciplines of criminology and forensic psychotherapy. She states that 'therapeutic programmes within the criminal justice system can only operate ethically with the consent of the offender', but also recognises the pressures towards conformity on such voluntary consent which exist within a system of indeterminate sentences and discretionary parole (Player 1996, p.91).

In any forensic psychiatric unit, treatment is required by the Mental Health Act 1983, and responsibility for this passes into the hands of the health services. Although voluntary participation is no longer required, I strongly believe that ethical issues remain in the nature and delivery of some programmes of intervention. In the units where I worked, participation in music therapy was voluntary. Some women attended music therapy, art therapy and psychotherapy, in addition to being under the care and responsibility of a psychiatrist and a Medical Director. Ultimately, the women's release from the unit was dependent,

in this medical model of care, upon their ability and willingness to acknowledge and address their offences and thus almost to 'prove' their suitability for safe rehabilitation back into the community. Many procedures exist to assist women in this gradual process of increasing clarity of verbalization, including mentors, advocates, interpreters, and simplified printed materials. Yet all of these are explicitly based on words, on the use of language – and if we, as professionals in different disciplines, sometimes fail to communicate to each other exactly what we are doing or have set out to do, how much harder must it be for clients to express something as intangible as their experiences during a session or a period of non-verbal therapy? I have no doubt whatever that music therapy can affect change and growth, and that insight can be achieved through a reconstructive process of doing and feeling. The higher abstracted level of verbalization seems to me to be somewhat unnecessary in such cases; and, therefore, it is not only practically and ethically dubious but also functions, perhaps, as an additional pressure leading women to fail, thereby perpetuating the cycle of power struggles within the system.

Loth (1994) clearly discusses these issues of validity and feasibility of music therapy in the forensic psychiatric setting. She presents the themes of choice and denial as patients' progress on 'an individual journey through the legal and forensic system' (Loth 1994, p.17). Music therapy, as Loth describes in a much focused way, can allow a client to become aware of, and accept, their feelings and have these acknowledged and supported without the ever-present offence or crime being directly raised as a symptom of their illness. Externalising feelings

in music links their inner and outer worlds and is valid 'regardless of whether patients show insight into their offence and remorse for it' (Loth 1994, p.17).

Any therapist who operates to a greater or lesser extent from the moral stance of the judicial or psychiatric systems is in real danger of bringing meaningful therapy to an end, for these cultural narratives rely on personal memory and a chronicle of events (McLeod 1997, p.153). Instead, from a social constructionist perspective, therapy must be deployed so as to offer a framework for making sense of the truth, while clearly acknowledging that what is believable or 'what can be talked about' (p.152) depends on the placement of an individual narrative within a wider context. If personal experiences are too disturbing, when no alignment can be found, the stories remain untold. McLeod (1997, pp.151-2) reviews Danieli's description of a 'conspiracy of silence' between society and survivors of the Holocaust, with 'one not hearing, one not saying'. For some people, some experiences are simply indescribable; words are inadequate, and powerful cultural forces act in a variety of ways to distance or deny such stories. Interestingly, McLeod notes the tendency for survivors to return to engage in testimony-giving and personal reconstruction later in life, observing that immediately after the war their energies were devoted to getting on with the practicalities of survival and the pursuance of life, work and family.

It seems plausible to suggest that similar factors could be in operation in the silencing of women in secure units. Dealing with the confines and constraints of their new enforced way of life is initially of prime importance, rather than recounting the events that led them to be placed there, especially when many of

these experiences are unbelievable by normal societal standards. WISH (Women In Secure Hospitals 2001, p.18) cites statistics from various research studies showing that between 50% and 70% of women in prison or secure psychiatric hospitals had experienced physical or sexual abuse, many of them in childhood.

For these women, it may well be that silence has become a deep-rooted survival mechanism, yet one which is 'unwittingly perpetuating a male-voiced civilization that is founded on disconnection from women' (Gilligan 1993, p.xi). In this study, Gilligan examines the perspective of 'voice' as it links psychological theory and women's development. She views the concept of voice as a relational exchange, and indeed as a 'litmus test of relationships and a measure of psychological health' (p.xvi). But psychological health, in more extreme cases, may depend precisely on *not* voicing in situations where compliance is required, for, as Aldridge (1997, p.207) observes in his examination of women and suicidal behaviour, 'once a system labels one of its members as illegitimate and deviant as a person, rather than a person exhibiting deviant behaviour, then distress escalates' and self-harming or suicidal behaviours can increase.

Patients who are reluctant or unable to speak in therapy or who are unable to choose a topic for discussion traditionally have such behaviour negatively labelled as 'resistance' or 'self-sabotaging' (Hassenfeld 1999, p.497, 495). It is often accepted that this may be a result of a fear of recovering unacceptable memories or a wish to avoid change and maintain the stability and apparent

security of predictability. Hassenfeld (1999, p.495) suggests a third explanation: 'an acting out of a fundamental existential dilemma… to be or not to be an adult'. He proposes a treatment of 'Generative Caring Psychotherapy' in which patients are listened to and affirmed but where the psychotherapist does not ask questions, making patients responsible for their own behaviour and promoting their emotional transition from childish dependence to adulthood.

However, such empowerment is difficult for women in high secure environments that are 'mainly designed along a patriarchal model with security procedures being established to safely manage the most dangerous male offender' (Murdock 2000, p.25). Here, women's offences are usually rather different to those of men, and more serious incidents are in a minority. In 1999 only 38% of the index offences of women in high security hospitals involved violence against the person compared to 78% of those of men (WISH 2001, p.17); arson, damage, disturbed behaviour and self-harm are more common for women. Murdock (2000, p.25) reports the increasing provision of gender-specific health care at Rampton high secure hospital to meet the differing priorities of women's needs, with particular reference to the fact that, in a recent survey, 83% of the women had tragic histories of abuse. She notes the urgent need to hear the voices and insights of women's lived experience, and especially to acknowledge the point of view of those who, like Angela, have a learning disability; and she anticipates progress in providing alternatives to hospital admission. But there is also a cautionary note of the professional anxiety and resistance that comes with the realities of partnership working in a closed institution (Murdock 2000, p.26).

It seems, then, that voicing women's personal experiences and insights can be a contentious issue on all sides, involving not only the maintenance of the psychological health of the patient but the role of the therapist and the context of the medical institution. New presentations of client testimony must focus on present constructions, rather than on past reconstructions, unless the woman herself chooses to take this path. If she does, then her experiences must be given a framework within the cultural community in which they can be supported, rather than being localized within the individual herself. The structural process of creating music together with a therapist can be pro-active in allowing such narratives to come into being, and the mutuality of known cultural songs provides a clear framework for their truths to be examined and accepted.

Here, the needs of the individual and the collective environment, both social and psychological, can be reconciled for the good. And music is central to this process, precisely because it bridges the gap between inner and outer, between the personal and the shared, between feeling and reason. This is its therapeutic force, and it is one that may help to produce insight – to enable and indeed to generate the production of meaning in this larger sense. The core theme of Personal / Insight is thus vital as a force which drives us towards understanding ourselves, balancing this awareness with knowledge of our place in the environmental and social context in which we operate. Such insight, I propose, may be constructed internally, through the assimilation and awareness of newly acquired responses and perspectives, and may be expressed or voiced in many different ways, not all of which will necessarily require speech. Here, the presence and function of music, as just such a vital force, is crucial. And for

women in particular there are two specific cultural issues which make alternative presentations of such (unvoiced) expression particularly pertinent. These coincide with, and will be presented as, the final two core themes in sections 6.6 and 6.7.

6.6   Theme Six: Emotion

The concept of 'voice' was introduced in Chapter Three, section 3.3.1, when examining Cortazzi's (1993) notion of narrative as a model of disclosure and enquiry. In this process of enquiry it is reflection, knowledge and voice which combine to enable human experiences to be reconstructed in a clear and psychologically realistic way, and to that extent explained or at least understood and illuminated.Voice concerns empowerment, and I proposed that music, in the form of pre-composed songs, enables personal experiences to be emotionally reconstructed in a manner which overrides language difficulties and personal and social inhibitions. Some previous life experiences, though, will inevitably produce emotions so strong and painful that inhibiting factors affect an individual's present life and relationships and, to a greater or lesser extent, their journey through the therapeutic process. And some of these factors are specifically known to be gendered.

White (1994, p.14) writes of his experiences of theatre as a prison 'lifer', when therapeutic qualities of recognition and expression liberated 'potentially violent and destructive emotions'. He details the feelings of frustration and anger that are seen as 'disruptive' within the imposed penal structures and the prison sub-

culture that will not tolerate grief and sensitivity, effectively trapping individuals and censoring their emotions. Such prolonged repression, he claims, fuels outbursts of violence and suicide – but the arts represent 'one of the few positive channels for such potentially destructive emotions' (White 1994, p.18).

Women often, but not exclusively, tend to turn their destructive feelings inwards, inflicting self-harm. To enable women in the criminal justice system to better communicate their anger and reduce the likelihood of harm to themselves and others, the 'Clean Break' theatre company initiated a group work project entitled the 'Women and Anger Programme' in 1998. This led to 'understanding their own behaviours in a new way' and 'exploring new ways of relating to people' ('Joining The Dots' 2007), and suggested that improved communication could assist in better management of anger.

Management of expressions of anger, and other strong emotions, are of course part of the everyday work of therapists; but the extent to which we can, or should, contend with this is an ongoing debate. The art therapist Karban (see Teasdale 1995, p.3) outlines the stance of being 'fully there' for offenders as this 'helps them to see me as another human being… remaining vulnerable and open in the presence of potential violence [is a] powerful therapeutic tool'.

This is precisely the approach that I chose, working alone with individuals and small groups in both medium and high secure hospitals in order to encourage freedom of expression. Yes, it is true that I was frequently on the receiving end of small acts of violence, and I therefore also understand the views of Teasdale

(1995, p.3) that in larger groups, on a more permanent rather than sessional basis, 'such vulnerability would make professional life 'intolerable''. Teasdale illustrates the therapist's dilemma of idealized but also emotionally taxing work with violent offenders through the metaphorical terms 'reforming zeal' and 'fatal attraction'. He also uses these terms to apply to inmates, who may desire reform and use art therapy for purposeful self-appraisal or else use it as 'an extension of controlled…pathological or reactionary behaviour', masking the treatment by 'seduction and skilful, or naïve, exposing rather than exploring through image making' (Teasdale 1995, p.4).

Therapists must constantly evaluate and interrogate their own practice, peeling away the layers of action and expression in order to guard against being drawn into collusion and reinforcement of such avoidance tactics. This is, to be sure, much easier said than done in any secure psychiatric unit, for psychopathic individuals not only exhibit 'emotional difficulties such as lack of guilt and empathy' but also usually have affective and interpersonal characteristics including 'superficial charm, pathological lying [and] manipulation', all of which contribute to their high risk of anti-social behaviour (Mitchell and Blair 2000, p.6).

So far, the present discussion has related primarily to the dilemmas faced by the therapist. What, however, is the nature of 'emotion' considered as one of Angela's underlying core themes? How does it function as a source of inner conflict for women in forensic units? This is precisely where gendered differences begin to take effect, showing up in the women's life histories and

the beliefs which they bring with them into the already turbulent and (inwardly if not outwardly) violent, yet also over-controlled, world of secure care.

Central to this examination is the consummate volume by Gilligan (2000) on the current epidemic of violence. He makes a compelling conceptual leap away from the Western cultural notions of the morality of violence, with its focus on guilt and criminality leading to imprisonment or hospitalization: 'legal' punishments which, in their moral use of violence, have identical ends and means to crime itself (Gilligan 2000, p.19). Rather, he approaches violence from a diametrically opposing angle:

> … as a symptom of life-threatening… pathology, which, like all forms
>
> of illness, has an aetiology or cause, a pathogen. (Gilligan 2000, p.92)

This pathogen is the 'emotion of shame' (Gilligan 2000, p.110), and can be spread along social, economic and cultural vectors, making violence a social and psychological contagious disease (Gilligan 2000, p.105). From this viewpoint, violence, however horrific it may be, is not an irrational act but is 'psychologically meaningful' (Gilligan 2000, p.9) to the perpetrator. If it can be viewed as a rational response to overwhelming but deeply hidden feelings of humiliation and shame, then to understand the crime requires interpretation of the actions as 'symbolic representations of thoughts… [and thus as a form of] symbolic language – with a 'symbolic logic' of its own' (Gilligan 2000, p.61).

Here, again, I see the logic and value of using music therapy in working with offenders whose orientation is towards behavioural actions rather than verbal articulation in the expression of their thoughts and feelings. The process of deconstructing and reconstructing humiliating emotional experiences can be achieved through musical improvisation, and through the depersonalized, yet also humanized, third-person Proxy of an image in a known song, without necessarily involving verbal discussion of actual offending behaviours (which would obviously imply a requirement for the explicit individual acknowledgement of guilt). Music, both with and without words, is by contrast able to create a space where such factors can be approached and addressed, internally and externally, without the need for 'incriminating' verbalisation. Music may in this sense be a proxy, and a uniquely powerful one. Music therapy may therefore avoid the potential for increasing the level of personal shame felt by the patient, and avoids contributing to a causal cycle of offending responses.

It is the clarification and separation of guilt and shame which will be of vital importance in understanding and responding to the inner conflicts of offender patients. McLeod (1997, pp.41-42) examines studies that have constructed descriptions of these emotions, and he notes that it is virtually impossible to do so comprehensively without recounting a narrative of the experience itself, in order to account for it. Shame is a relational emotion, evoked by the presence or thought of other persons, and the acute (indeed pathological) embarrassment it causes can induce a state of psychological paralysis, undermining the sense of self (McLeod 1997, p.97). This is a clear reminder of Angela's state of

'frozenness', psychologically, physically and musically stuck in her cold song of *Iceland.*

Living in a society which labels, and judges, individual differences can cause additional overwhelming problems for ethnic minorities, survivors of abuse, or people with mental health problems. They are all stigmatized in various ways by virtue of their 'otherness', and have to overcome the 'stigma that can surround an identity shaped by shaming experiences [and] assert their basic acceptability and goodness to themselves and others' (Pattison 2000, p.173). Angela's solution was to associate herself with the goodness contained in the identity of the Nun in order to work through acceptability within the group and, finally, reassert her own identity. Here, we can observe the associative power of such ideas, the depersonalized status of pre-existent images, and music's ability to bring them close to the patient without fear of shame or guilt.

Overcoming the social determinants of shame may be particularly difficult for violent women offenders. Gilligan (2000) discusses both the biological and the cultural determinants which may combine to stimulate acts of violence. In spite of societal condemnation of violent behaviour, there is still a tendency for many patriarchal cultures to view it as more expected and somehow accepted for men: it is a youthful display of force, or a proof of manhood and machismo, a justifiable act when fighting for your honour or that of your country. Gilligan notes gender differences concerning the notion of honour, where men are defined by a value system of activity and power and women by inactivity or passivity. To deviate from such codes or roles brings dishonour, and so, in our

society, shame is apportioned unequally and in distinctly gendered fashion. The violent female then has to overcome both societal condemnation and her own internal, individual sense of shame, which is also influenced by culturally shaped beliefs and value systems. Shame, however, can be a driving force which stimulates responses situated along a broad bi-polar continuum:

> Shame not only motivates destructive behaviour, it also motivates constructive behaviour… the ambition and the need for achievement that in turn motivates the invention of civilization. (Gilligan 2000, p.234)

So, we encounter here an inner conflict, a paradoxical dilemma of maintaining an equilibrium of shame, and also the management and expression of shame, both personal and societal, which may be seen as the defining forces in the core theme of Emotion. Just such a dilemma, I suggest, may lie at the heart of Angela's struggles with self-identity, family and race, mental health and violence. It helps to explain her aspiration to present herself as a good person, and, at its most basic level, its roots perhaps lie in the traumatic experience of humiliating abandonment by her mother in early life.

6.7   Theme Seven: Possessions / Loss / Gain

The James Nayler Foundation (2001) believes that personality disorders arise because some adults continue to rely on using infantile life support strategies. In this model, if children grow up with a sound parental attachment, then damage from childhood trauma is (or may be) ephemeral. But without a robust

attachment the effects of trauma will be long-term, and the individual becomes 'frozen' at an infantile stage, lacking the adult reasoning and behavioural mechanisms necessary to cope with new everyday realities. The original fear may now be obsolete, but anger – and resulting violence – still remains as a defence against the terror of facing the truth(s) of adult life. To become mature and thus responsible, in a state of adult emotional health, may even require a profound grieving process for the lost childhood. . (In such a process both the use of narrative and the experience of music – in the form of traditional music therapy based on improvisation, or, as I have suggested in this study, of music therapy by Proxy – can be effective and beneficial.)

Bergman and Hewish (in Hughes 2005, pp.58-59) draw upon both attachment theory and neurological research to suggest that early trauma or abuse can affect memory by specifically limiting the ability to 'map' experiences. 'Mapping' refers to the representation of something physically, in pictures, or in memory. Lacking an ability to internally represent other people makes it hard to 'attach' or connect with them and to understand their behaviour (as a sympatic or empathic cognitive function). If the mind develops more general memories, blocking the more specific representations, both of painful feelings and of positive experiences, then self-esteem may be limited and the flow of creative imagination interrupted and drastically curtailed.

I can not with confidence define the extent to which Angela may have been affected by the loss of both parents at an early age, nor can I determine her strength of attachment to those newly entrusted with her care. It does seem

pertinent, though, to conjecture that the strongly emotive nature of music, coupled with simple, clear personified images presented in structured, repetitive songs, may well have provided a means to counter the detrimental effects of trauma on memory, self-image and construction of personal relationships. Even more so if these songs hold strong associations with the music of childhood. But assisting a client to recover such lost memories will inevitably present further dilemmas, for grief may be complex and unresolved, and the process of its expression – of its 'declaration' if you like – correspondingly complicated and painful.

Killick (2001, pp.248-9) writes of experiences of bereavement and grief for people with dementia, whose losses are compounded by their memory problems. In adjusting to their present circumstances, he notes their use of metaphorical language and particular types of non-verbal expression such as crying and rocking. He comments, too, that when recall of people to whom they were closely attached is disrupted by dementia, patients may regress and become attached to external symbols such as soft toys or particular members of staff, thereby providing themselves with a degree of comfort and security.

It is easy to see that such normal processes of grieving can lead to behaviours which, in a psychiatric hospital, might well be seen as irrational, infantile or obsessive – symptomatic of mental disorder rather than of a process in recovery. I am reminded of Jackie, mourning for her lost child by rocking and quietly singing to the sounds of lullabies; and of Linda singing *Strangers in the Night,* unable to come to terms with the loss of her relationship with another patient in

a previous hospital. And, of course, Gracie, still caught in the perpetual conflict of *Drunken Sailor,* mourning the loss of a husband who abused her. It may also be true that Angela's apparent obsession with blue clothes could represent another form of attachment, standing in for the security of her lost mother. And perhaps, too, other feelings could be hidden away, safely concealed (and thereby psychologically 'contained') in her ever-present white handbag – for, as is so often said, we all carry 'baggage' with us.

Enforced imprisonment, or hospitalization, adds considerably to the weight of this baggage, for bereavement does not relate only to the death of a loved one. Women speak of the worst thing about prison as being 'loss of freedom… loss of liberty' (McKean 2006, p.313), but it is equally true that they also lose their responsibilities. Over 40% of women in prison are primary carers, and they may also lose their children and their homes (Wilkinson in McKean 2006, p.318). This in itself may contribute to 'the conflicts of shame, guilt and failed motherhood' (Walker and Worral 2000, p.34) which women prisoners need to work through in order to achieve any state of acceptance and emotional growth.

The core theme of Loss may thus be particularly relevant for women in forensic units, for it relates both to practical (physical) and psychological (emotional) losses. Current possessions may adopt greater significance within a process of bereavement and adaptation to new circumstances, and changes in language and active behavioural responses which reflect earlier associations may become prominent. In this we may again observe how the song material may have brought such reconciliatory developments closer to the individual client in

therapy. Songs are tokens – tokens of past associations, of past experience and past human relationships – which are personally, intimately significant to those who continue to remember then. Yet they are also held in common with other people. They are socially grounded and contextualised, yet may also have deep personal significance.

6.8   Summary and Discussion

In summary, it appears that Angela's journey has been not only a search for her lost mother but, in a broader and perhaps even more essential sense, a search for the roots and ground of her lost self-identity. The bi-polar construct of 'goodness : badness' which became apparent in her music therapy sessions can be seen as an internal force which drives her to restore a degree of consonance or balance in her life by addressing her issues of personal and societal shame and guilt. The fundamental issue, which I suggest lies at the root of all seven core themes, is that of a power struggle playing itself out within internal forces, while also expressing itself through external relationships – thus existing, as I have repeatedly observed, *between* the internal and external worlds. It is this meta-conflict in establishing and maintaining a personally acceptable self-identity within the cultural constraints of societal (particularly institutional) life which has a degree of commonality and, I would argue, supreme relevance for women living in forensic psychiatric units. This in turn serves to generate another major bi-polar construct around the dilemma of 'voice', where the unheard voice of women's experience may lead to a lack of understanding and/or appropriate care, but where, too, the forced requirement of voicing such

experiences in explicit verbal terms may also contribute to the ongoing conflict of underlying issues, thereby perpetuating women's isolation, and intensifying their predicament. It is my belief that the partial resolution of such a nexus of dilemmas has been the therapeutic core of 'our' song experiences in therapy, as shared between myself, Angela, and my other women clients.

unheard voice : forced voice

It may be said that music therapy is in the first place an essentially non-verbal approach, based on the creative use of music and sounds within a therapeutic relationship. This thesis has sought to examine and explain the nature of the application of music therapy for women in forensic psychiatric units through the detailed experiences of one woman over a long period. Essentially, it asks how her voice can be heard and supported, or empowered, through the unusual, and at first seemingly inappropriate and uncreative, choice of pre-composed songs. The presentation of the whole unfolding process of Angela's songs as a case study has been an unusual journey. Their reconstruction as a narrative from my double perspective as both therapist-participant and researcher (as 'inside researcher', therefore) has led to results which are both highly distinctive and deeply personal, while nevertheless also containing (I believe) the seeds of wider contextual application. Therefore, instead of presenting general conclusions I shall here put forward a series of linked assertions. It is my hope that these will in turn become metaphorical 'butterfly eggs', able to generate further research into the metamorphic and transformative power of song, in both its verbal/visual and its musical dimension, within the field of music therapy.

6.8.1 Concluding Assertions

The assertions which follow are all based on two underlying beliefs, condensed from the writings of many authors working in different disciplines, which this thesis has introduced and examined in preceding chapters. They are, firstly, that we each construct our own 'life soundtrack' of associations between music and life experiences, a process which offers a wide range of available meanings and potentially meaningful correspondences; and secondly, that self-identity is a constantly changing narrative process which is socially constructed, and profoundly influenced by our cultural knowledge and heritage (the enactment of self-identity within a social and also, where appropriate, a musical context). From the basis of this understanding I propose the following assertions, which have been presented in detail within this thesis and are now given here, by way of conclusion, in summary form:

- The distinctive issues and conflicts which are part of an individual's process of identity-construction and personal relationship-formation can be expressed within music therapy through a range of metaphorical images contained in the words of well-known pre-composed songs.

- These images are abstractions which are specifically depersonalized in order to present painful or difficult memories safely, as it were from an oblique angle; but they are also, crucially, humanized figures precisely in order that they should enable the exploration of human, social relationships. This is what I call a process of Music Therapy by Proxy.

- Such a process may work progressively further and further back in time, through a person's life experience and emotional/psychological history, as the music therapy moves forwards. This I call Reverse Chronology.

- This type of music therapy, using pre-composed song within an active and participatory therapeutic context, is pertinent to individuals in forensic psychiatric units, and to women in particular, as a result of a combination of factors including traumatic life histories, the structure and nature of institutional care, emotional and communicative diversity due to psychopathology, and social and cultural expectations of conformity which may be prevalent. Music therapy through song provides a cultural framework in which relationships based on equality of power and choice of decision-making can be successfully constructed and negotiated.

- Using song creates and recreates a narrative of an individual's changing identity in which their story, their voice, and hence their experience and insight, can be heard – in this way their views and issues may be expressed and explored. It is song as a constructive relational process which is important, not the product of the songs themselves in any direct sense. For this reason, the title of this thesis refers to 'Song' rather than 'songs'.

- This is a distinctive type of music therapy which yields distinctive and, in that sense, original results. The construction of a narrative, using Proxy in song, becomes not only the means of therapy but also the method of analysis in research. Understanding of the case is consequent upon this matching of materials with methodology, as insight is gained

through a cycle of decontextualizing and recontextualizing within a clear structural framework. This is a model of therapy-as-process, arising as a form of mutual interaction between practice and research, and one which enlightens both fields. In its predominant use of imagery and its cyclical nature it may be termed a Generative Metaphor of Metamorphosis.

- When matching materials and methods in music therapy research, the use of particular musical genres, forms and structures can be advantageous. In this case study pre-composed songs established the basis for the therapeutic interactions, and a sonata form archetype provided a meta-framework for their longitudinal analysis. I believe this to be of profound significance in helping to re-establish the specifically musical focus of music therapy research: using music itself as an application in its own examination, instead of often borrowing credence and models from other disciplines. Further research could trial the trustworthiness of the 'narrative-dramatic' archetype of sonata form as a tool for application in other fields of music therapy research.

6.8.2 New Fields, New Pastures: Directions for Future Research

Further research could usefully take our metaphorical butterfly into new fields within a greatly expanded territory, generating new ideas in music therapy theory and practice, and perhaps in related areas of musicology, forensic psychiatry, psychotherapy or sociology, as well as in linguistics and neurology. These could include such diverse ideas as the significance of non-verbal imagery and memory in gender studies; the nature of voice and differentiation

of the process of expression and communication within differing models of therapeutic institutional care and treatment; the issues of power conflicts and choice in society and their relevance in maintaining health and preventing illness and violence, perhaps through an application of music therapy as 'preventative medicine', or else, in more appropriate non-medical terms, the pro-active maintenance of 'cultural health' (or a social and psychological balance of health), rather than subsequent treatment after problems have arisen. Neurologically one could investigate what a more detailed knowledge of the nature of music and musical experience might tell us about cognition and mental functioning, and about the experience of self and consciousness. Musically, one might ask far-reaching questions about the effectual power of music *per se* on the human individual, and about the way words and music interact in song not so much on an aesthetic as on a more general psychological and (inter)personal level.

More specific musical and music therapy research ideas arising from this thesis might include:

- A more detailed investigation of the definition of improvisation and the specific examination of its creative use, as well as its operative structures. For example, in using pre-composed songs, how are changes or transitions between songs reciprocally introduced and negotiated by client or therapist?

- How do changes to melodies or harmonies, or rhythm, influence or alter the process of Song? Do they prompt or cue changes of image or transitions between songs? How do these contribute to the expression of emotion inherent in the song words or contained in the metaphoric image?

- What, within the clinical therapist-client relationship, are the modalities of interaction between text and imagery, on the one hand, and the expressive-therapeutic force of the musical continuum, on the other, when pre-composed songs are used?

- How much of the song's potential for meaning is contained, respectively, in either the words or the tune, and what is the perceptual/cognitive balance of qualities or the overall imaginative dynamic existing between them?

- Is there an emotional by-product, within the client, of associations brought out by song melodies 'borrowed' by a therapist but in fact used for another purpose, e.g. in adapting a well-known tune to use as a greeting song in a group session?

- Do other therapists working in other contexts confirm my ideas of gender differences in the use of, and response to, songs and images?

Furthermore, when does a narrative end? Are there such things as 'real' or definitive conclusions in such cases? Angela's music therapy sessions have finished and she, like our metaphorical butterfly, has moved on to new pastures. My own journey as researcher in this case study has also (provisionally, and for the present at least) come to an end. But it will never truly be finished, for, as Angela and Abba would say:

Mem'ries, good days, bad days, they'll be with me always.

(Andersson, Anderson and Ulvaeus 1976)

* * *

Like a circle in a spiral, like a wheel within a wheel,

Never ending or beginning on an ever spinning reel,

As the images unwind

Like the circles that you find

In The Windmills of Your Mind.

(Bergman and Bergman [and Legrand] 1968)

Adios, Amigo.

Appendix A1: Summarised Case Histories of 10 Women

Client A   'Clare'

Diagnosis:
Learning disabilities.
Chronic paranoid schizophrenia.
Auditory hallucinations.
Obsessions, depression, epilepsy,
osteo-arthritis, over-eating.
Life history:
Early disturbed behaviour, age 10
mother died, placed in care, frequent
moves, possible sexual abuse, several
years in high security hospital.
Music Therapy Issues:
Lack of self-confidence/motivation.
Intolerance/inability to listen to others.
Lack of identity within the group.
Distrust of nurses/sexual
issues/personal 'safety'/cleanliness.
Need to be reassured she is 'doing it
right'.

Client B   'Angela'

Diagnosis:
Learning disabilities.
Mental illness.
Visual and auditory hallucinations.
Facial dyskinesia, multiple sclerosis.
Life history:
Fostered age 9 months, mother
moved abroad, behavioural problems,
physical violence, psychiatric care
aged 13, absconsion, many years in
high-security hospital.
Music Therapy Issues:
Insecurity. Social isolation. Insistence
on 'favourite' instrument. Need to be
reassured that she has been 'good'.
'Irrelevant' conversation – wanting
everything blue, wanting teeth
removed.

Client C   'Gracie'

Diagnosis:
Psychopathic disorder.
Registered blind.
Anxiety, mood swings.
Mobility problems.
Breast cancer (treated).
Life history:
Age 3 father died, mother remarried,
normal schooling, several jobs, married
(husband in Navy, possible physical
abuse), had a child (taken into care
aged 4), divorced, several psychiatric
admissions. Many years in high-
security hospital.
Music Therapy Issues:
Changeable attitude, memory lapses,
need to talk and be listened to.

Client D   'Linda'

Diagnosis:
Chronic schizophrenia.
Psychotic symptoms.
Auditory hallucinations.
Physical violence, self-harm, arson.
Renal function abnormalities.
Life history:
Normal early milestones, aged 6
parents divorced, various jobs,
admitted to high secure hospital, one
long relationship with another patient,
J, who committed suicide.
Music Therapy Issues:
Anxiety, resistance, use of
instruments as a barrier, deluded
speech, consistent belief that she is
marrying J or that I have stolen him.

Client E　'Jackie'

Diagnosis:
Paranoid schizophrenia. Persecutory delusions, auditory hallucinations, jealousy. Partially sighted/breast cancer (both due for surgery). No use of right arm. Rheumatoid arthritis, deep vein thrombosis, diabetes. Mild learning disability.

Life history:
Meningitis at 18 months, temper tantrums, psychiatric services aged 14, married, 2 children, daughter adopted, attacked father with knife, had abortion, admitted to high-secure hospital for 3 years.

Music Therapy Issues:
Paranoia of persecution. Verbal accusations or abuse. Sudden violence. Child-like mannerisms and speech.

Client F　'Ruth'

Diagnosis:
Personality disorder. Paranoid psychosis. Depression/hypomania. Aggression. Auditory hallucinations/delusions. Emphysema. Self-harm. Arson. Absconsion.

Life history:
Normal school and jobs, married, 4 children and grand-children. No index offence. Admitted as risk to self and others.

Music Therapy Issues:
Sporadic attendance. Belief that she has been kidnapped. Issues of loss (home, family, work). Belief that I control her mind through music. Alternation between denial/recognition of problems and between aggressive / 'catatonic' behaviour.

Client G　'Moira'

Diagnosis:
Psychopathic, severe personality disorder. Self-harm by burning, gouging eyes (severe impaired vision). Destructive aggressive behaviour. Verbally abusive. Obesity. Depression.

Life history:
One of a large family, later claimed sexual abuse resulting in birth of child by brother, rift with family, death of mother, some reconciliation, not invited to father's funeral. Many years in high-security hospital.

Music Therapy Issues:
Clear descriptive imagery, often concerning 'servants'. Need to perform to nursing staff.

Client H　'Felicity'

Diagnosis:
Mental illness. Psychopathic disorder. Bipolar mood disorder. Auditory hallucinations. Persecutory and sexual delusions. Mood fluctuation. Pressured speech. Verbal aggression.

Life history:
Normal schooling, job, partner, children and grand-children, repeated movement between community psychiatric services.

Music Therapy Issues:
Delusions and resulting anger, verbal aggression, avoidance. Needs immediate attention when requested or takes offence. Feelings of being patronised – talks of previous family and work.

## Client I	## Client J 'Brenda'
Diagnosis: Mental illness. Bipolar affective disorder. Self-harm (hanging/poisoning). Arson. *Life history:* Normal schooling and work, musical family background, married with children and new grandchild, some abuse. *Music Therapy Issues:* Insecurity, lack of self-esteem. Lack of concentration. Difficulty making choices and keeping to them. Expressing anger at loss of freedom, home, family etc.	*Diagnosis:* Psychopathic disorder. Breast cancer (treated). Pre-occupation with physical problems. Obsessional behaviours. *Life history:* Adopted, treated as 'little girl', early sexual abuse outside of home, sexual self-harm, difficult school years, attacked grandmother (died). Many years high-security hospital. *Music Therapy Issues:* Demanding, obsessional behaviour. Complaining of 'dead' hand. Feelings of 'not being heard'.

Appendix A2: Initial Song Choices of 10 Women

Song 1 *Frosty the Snowman*	**Song 2** *Drunken Sailor*
Frosty the snowman was a jolly happy soul With a corncob pipe and a button nose And two eyes made out of coal. Frosty the snowman is a fairy tale, they say He was made of snow But the children know How he came to life one day.	What shall we do with the drunken sailor What shall we do with the drunken sailor What shall we do with the drunken sailor Early in the morning?

Song 3 *O Little Town of Bethlehem* O little town of Bethlehem, how still we see thee lie. Above thy deep and dreamless sleep the silent stars go by: Yet in thy dark streets shineth the everlasting Light; The hopes and fears of all the years are met in thee tonight.	**Song 4** *Strangers in the Night* Strangers in the night exchanging glances, Wondering in the night what were the chances We'd be sharing love before the night was through. Something in your eyes was so inviting Something in your smile was so exciting Something in my heart told me I must have you.
Song 5 *Edelweiss* Edelweiss, Edelweiss, Every morning you greet me. Small and white, clean and bright, You look happy to meet me. Blossom of snow may you bloom and grow, Bloom and grow for ever Edelweiss, Edelweiss, Bless my homeland for ever.	**Song 6** *Elusive Butterfly* Don't be concerned, it will not harm you It's only me pursuing something I'm not sure of in the night. Across my dreams with nets of wonder I chase the bright elusive butterfly of love.
Song 7 *When the Saints* I am just a lonely traveller Through this big wide world of sin, Want to join that grand procession When the saints go marching in.	**Song 8** *Tennessee Waltz* I remember the night And the Tennessee Waltz Now I know just how much I have lost. Yes I lost my little darling The night they were playing The beautiful Tennessee Waltz.
Song 9 *If* If a picture paints a thousand words Then why can't I paint you…. (played without words)	**Song 10** *No song*

Client/song matches:
A:7   B:5   C:2   D:4   E:10   F:3   G:6   H:8   I:9   J:1

Appendix B1:   Letter of Assent from Secure Unit

Pastoral Homes
responsible care

26 June 2000

Carol Chambers
Music Therapist
Nottingham MusicSpace
Harpenden House
Edwards Lane
Nottingham   NG5 3JA

Dear Carol

Thank you for your letter of the 29th May 2000.

Following discussion at ward round, your request to use examples from your past and continuing work with patients at Pastoral Homes as material for your research, was agreed.

As noted in your letter all material should remain confidential.

Yours sincerely

Chandra

Dr Chandra Ghosh
MEDICAL DIRECTOR

Pastoral Homes Limited
Registered No. 3233164

Appendix B2: Letter of Assent from Research Director

(My home address removed)

KNEESWORTH HOUSE
PSYCHIATRIC HOSPITAL

INVESTOR IN PEOPLE
Please contact direct on:
Tel: 01763 255605
Fax: 01763 246115

Bassingbourn-cum-Kneesworth
Royston
Hertfordshire SG8 5JP
Telephone (01763) 255700
Fax (01763) 255718

Carol Chambers

13th July 2001

Dear Carol

Thank you very much for your letter and copy of your research protocol.

I think that as you have already obtained agreement from Dr Ghosh and are well into the work that it would be pointless putting it through an Ethics Committee. I would just emphasise the need for patient information to be anonymised so that no individual can be identified. This is particularly important for presentations at meetings as well as in the written material.

I would be most grateful if, when you have finished the project that you could send me a copy of your work.

If you have any further projects I would be grateful if you could send me a protocol. I wish you well with this project.

Yours sincerely

Dr John Taylor FRCPsych
Medical Director

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Appendix C: Sample of Narrative Account from Session Notes

Session 59　　**7/04/00**　　　　**50 minutes**
Present:　　**'Angela', 'Gracie', 'Jackie', 'Clare'**

Welcome To My World

❊❊

Very unsettled start. **Gracie** wandering around the room, seemed confused, asking for an instrument when she already held the sleigh bells, constantly requesting drinks, came in and out of the room all session. **Angela** chose the woodblock and kept it for entire session, was very talkative and seemed confident, making clear requests. She stated that she didn't like my red jumper, she liked blue, which she was wearing as usual. **Jackie** was out in the patio area, came in as I began to play keyboard and sing *Welcome* but was very verbally abusive towards me. **Clare** was upset and got up to leave but I persuaded her to stay and ignore it, saying I was not upset by Jackie. (Unsure if Clare was worried for me, frightened of Jackie or just disturbed by conflict in the session?).

Edelweiss

Scarborough Fair

Clare alternated loudly between tambour and xylophone (reflecting conflict or unable to choose?), effectively overpowering the *Welcome* music, then asked to look through song books. **Angela** immediately requested *Edelweiss* by name (as if competing with Clare to have her choice first). **Jackie** left the room but returned quietly later. **Angela** confidently tapped and scraped the woodblock, watching me as I began to play and sing *Edelweiss.* **Clare** interrupted, trying to sing *Scarborough Fair* from the book but frustrated when she couldn't get the tune right. Needed reassurance. I began to play the tune but she continued to flick through the book looking for something she could get 'right'.

Soldier Soldier

❊❊

Clare began to sing *Soldier, soldier, won't you marry me?* and I joined in. **Angela** became very animated, seemed excited, loudly shouting "soldier, soldier" repeatedly and trying to copy some of the other lyrics.
Clare was taken out by staff (trip out to buy new shoes). **Angela** continued to request *Soldier.* I repeated it several times and Angela began to suggest clothes when I left pauses "hat….coat". Still held woodblock and occasionally played with energy, voice was stronger than usual.
(Although Angela was shouting "soldier", and this was what first grabbed her attention, is the relevance something to do with a soldier in her past life, or is the connection to her ripping of her own clothes and 'for I have no coat to put on' etc?)

There Goes My Everything

Angela suddenly asked for "different music" (*Soldier* too personal?) but was reluctant to improvise. Seemed to need something more defined so I offered a choice of songs from the songbook. She chose *There Goes My Everything* (her clothes?). **Gracie** had been wandering as if not paying attention but now seemed upset (by the song?) and left the room. **Angela** listened quietly then chose *Love Story,* didn't sing but at 'how much she means to me', began to talk about 'Dee'…….

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