INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.
SINGING THE SONGS: A QUALITATIVE STUDY OF MUSIC THERAPY WITH INDIVIDUALS HAVING PSYCHIATRIC ILLNESSES AS WELL AS HISTORIES OF CHILDHOOD SEXUAL ABUSE

Amy Hammel-Gormley

Submitted in partial fulfillment of the requirements for the degree of Doctor of Arts in the School of Education New York University 1995
I hereby guarantee that no part of the dissertation which I have submitted for publication has been heretofore published and (or) copyrighted in the United States of America, except in the case of passages quoted from other published sources; that I am the sole author and proprietor of said dissertation; that the dissertation contains no matter which, if published, will be libelous or otherwise injurious, or infringe in any way the copyright of any other party; and that I will defend, indemnify and hold harmless New York University against all suits and proceedings which may be brought and against all claims which may be made against New York University be reason of the publication of said dissertation.
Dedicated to all who have shared their songs with me.
ACKNOWLEDGMENTS

Many people have made this dissertation possible. I would like to thank them formally now.

Bess, Diane, Jack, Matt, Sally, and Tom, my participants. I wish I could give your real names and give you the credit you deserve. Thank you for teaching me about Music Therapy. Each of you touched me in ways I'll never forget. Thanks.

Barbara Hesser, my mentor. I left my simple and easy life in Texas and moved up here to New York in order to learn from you. You have been a pioneer in Music Therapy and I have had the incredible opportunity to experience you. You have taught me how to be a therapist. My heartfelt thanks!

Margot Ely, my people teacher. You have shown me how to learn about others, which permeates not just my research, but my entire way of looking at and understanding others. Thank you for your guidance and patience and for helping me to grow.

Ken Aigen, my guide. You have paved the way for us Music Therapists to share the very essence of our work with others. You have put an incredible amount of energy and thought into this task, which helps all of us. For that I am very thankful.

Joanne Loewy, my best friend. You were my first friend in New York and have been there 100% ever since. You know me inside and out and still stand by me. Thank you for your constant help throughout my entire doctoral degree. You're wonderful!
Joe Nagler, my computer savior! You have gotten me out of the depths of despair hundreds of times. For all the times you and Roanne put up with my hystericis ("I broke the computer again"), I am very, very grateful.

Gary Bedell, Todd Heyden, Bob Young, my support group. You guys are the epitome of the word ‘supportive’. For years now we have been working together in the pursuit of our degrees and for years now I have been indebted to all of you for your sensitive ways of sharing each of your brilliances with me. “Till orals do we part!”

Marty Goldray, my old friend. You persuaded me that there was life of opportunities outside of Texas and that I had a brain that could rise to these challenges and grow as a Music Therapist. You’ve always encouraged me to make the most of my ambitions and for that I will always be appreciative. Lisa Bielawa, my intelligent and patient reader, thank you for accepting me as part of your life with your husband, Marty, and for all of the days and days of help you gave me in preparing this document.

Rita Barnhart, my mother. You were my initial inspiration to become a Music Therapist. I remember you using music to help others, and always knew that was what I would also do. You have always shown me the love for learning and have supported me in all of my scholastic undertakings.

Thank you.

Dan Gormley, my husband. Thank you for your help throughout this dissertation. Your reinforcements, words of encouragement, hours of work, and putting your own music aside to allow me to write in quiet have all been appreciated. You are the kind of Music Therapist I hope to become someday.
# TABLE OF CONTENTS

**ACKNOWLEDGMENTS** iii

**PREFACE** viii

**CHAPTER**

## I INTRODUCTION

- Source of the Study 1
- Statement of Purpose and Research Questions 6

## II REVIEW OF RELATED LITERATURE

- Psychiatric Illnesses and Treatments 7
  - Psychopharmacological Therapy 8
  - Electroconvulsive Therapy 10
- Child Abuse 13
  - Prevalence of Child Abuse 14
  - Ramifications of Child Abuse 15
  - Research about Child Abuse 17
- Music Therapy 18
  - Music with Psychiatric Illnesses and Sexual Abuse 21
  - Songs in Therapy 27
- Qualitative Research 33
  - Qualitative Research in Music Therapy 34
  - Qualitative Research as a Holistic Approach 36
  - Qualitative Research with Sexual Abuse and Psychiatric Illnesses 38

## III THE RESEARCH METHOD

- Selection of Participants 40
- Setting 43
- Data Collection 43
- Data Analysis 45
- Stance of the Researcher 47
- Establishing Trustworthiness 54
- Data Presentation 57

## IV PARTICIPANTS AND THEIR SONGS

- Introduction 59
- Bess 62
  - Songs for Accessing Memories 65
- Diane 79
  - Songs for Confirming Experiences 81
- Jack 93
  - Songs for Recognizing Feelings 95
- Matt 106
  - Songs for Disclosing Self 108
BIBLIOGRAPHY

APPENDICES

A Definitions of Psychiatric Illnesses 216
B Definitions of Child Abuse 219
C Introduction and Consent Form 220
D Codings 222
E Categories 223
F Ordering Categories 228
G Trends 230
H Themes 232
PREFACE

Throughout this dissertation I will be using particular terminology to
describe parts of the therapeutic process. In order to introduce the reader to these
frequently used phrases, I will share two of my rationales for my choice of
vocabulary. First, I choose to capitalize the words Music Therapy as my
predecessors Kenny (1987) and Aigen (1991) have done in their doctoral
dissertations. Aigen explains this use of upper case letters in “distinguishing the
profession of Music Therapy from other uses of music, such as in medicine,
personal growth, new-age type healing etc.” (p. x) that might be misconstrued as
Music Therapy, which involves specific training and certifications.

Second the use of the word our in describing the Music Therapy sessions.
My therapeutic stance as a Music Therapist is to be actively engaged in
collaboration with the patient in order to help him or her feel better. Basch (1980)
tells us that it is a myth that a therapist should be a “blank screen . . . impassive,
neutral” and reminds us that the therapist needs to be actively responsive, being
careful not to disclose his/her own conflicts and problems (p.4). I feel that it is
important that I be authentically engaged with the participants and feel that an
important ingredient of Music Therapy is reciprocity. Tyson (1981), in her book
Psychiatric Music Therapy: Origins and Development, writes of the mutual journey
that the active therapist and patient embark on during the Music Therapy process. In
our Music Therapy process, collaboration was indeed an essential element, which
included the active involvement of all the participants and myself. This mutuality is
an integral component in my approach because I feel strongly that I work with
patients and do not do therapy to patients. And, although the purpose is for me
to help the patient, I feel that this is our journey, and not just their therapy (Paulina Kernberg, Personal Communication, Fall 1992).

And finally, I refer to the participants as “patients” because I feel that this term is more appropriate than “client.” Rogers (1965) defines “client” as “one who comes actively and voluntarily to gain help on a problem” (p. 7). I feel this term would aptly describe someone entering into therapy for the purpose of self-growth, but I do not feel that this term is adequate in describing persons who require hospitalization. Many persons having psychiatric illnesses are treated against their wills. Every participant in this study had been hospitalized without his or her consent at some point. Doctors, family members, or representatives of the legal system had forced psychiatric treatment upon the participants during their lives. Although the participants did not begin this study as inpatients, but as out-patients, it was likely that due to their histories of hospitalizations, they would return to being hospitalized at some point. Pavlicevic (1987) states that “patients in hospitals frequently have little choice about attending music therapy sessions” (p. 22). And, although these participants had the choice to enter into our Music Therapy sessions, many of them were required to be in a day program. Most importantly, the participants impressed upon me that their illnesses and, consequently their status in life as psychiatric patients, determined their day to day experiences and the quality of their lives more than any other single fact.
CHAPTER 1
INTRODUCTION

Source of the Study

“If you want to understand me, listen to my music,” said a 46-year-old male psychiatric patient named Al as he introduced himself. I was to be his Music Therapist and found this introduction quite powerful. Al spoke directly to me of something I have experienced often in practice as a Music Therapist. Frequently people I have worked with have shared their favorite music with me to reveal their innermost thoughts and feelings. This music, usually consisting of popular songs, has helped them long before they started receiving Music Therapy treatment. Al had endured many difficult periods in his life due to damaging effects of childhood sexual abuse and his own sexual victimization of children. Al reported that his own therapeutic use of music originated long before our sessions began, helping him cope, survive, and make sense of himself and his world. He also informed me that specific songs helped him to understand his motivations and become aware of his feelings. Songs also enabled him to connect with other people without revealing too much about himself. Music gave Al the strength to carry on through difficulties he often had to face in his life.

Many individuals can more readily communicate the nature of difficult or traumatic experiences through songs than they can through words (Bailey, 1984). For example, I have found that those who have experienced childhood sexual abuse are often able to establish intimacy and begin the healing process through songs (Hammel, unpublished master’s thesis). It has become clear to me
throughout my years of clinical work that Music Therapy interventions based on prior musical associations and/or experiences have been extremely powerful. Al demonstrated this by opening up and allowing me into his world through singing and discussing his favorite songs. From there, he went deeper into personal material by analyzing these songs and by creatively writing his own words to the music. He allowed the music to release his repressed feelings by improvising on instruments, and through these experiences he discovered new aspects of himself that were crucial to his healing. Al often told me that our therapeutic relationship was stronger because we used his own music as its basis. The fact that we developed his familiar tunes also made him more receptive to the therapy process. It is personal experiences such as these that have inspired the present study of sexually abused psychiatric patients in Music Therapy.

Songs play an important role in my life and in the lives of many others. Songs are often sought out by people to induce pleasurable feelings. Songs are listened to in almost every area of our lives—at home, at work, during travel and recreational times and, are often thought about even when not actually present (Storr, 1992). Often these songs are about relationships and seem to reflect varying reactions to important aspects of life (Ackerman, 1994). I have been interested in learning more about other people’s experiences with music because it affects me so strongly. As Ely has said, “All re-search is me-search” (Personal Communication, March, 1993).

I have been fortunate to learn about the individuals I have worked with through their songs. They used songs to communicate and to express their innermost feelings. This form of dialogue provided me a personal and direct link with their thoughts, emotions and experiences. Most of the individuals with whom I have worked have had psychiatric illnesses. This condition has made it
more difficult for them to communicate verbally with others. However, songs afforded a less intimidating way to identify and share feelings. For example, a patient could not say that he was feeling depressed and suicidal, yet he could tell me: “You know that guy in the song? Well, he’s sad and wants to end his life.” From this I could enter his world in a nonintrusive way and ask about the “guy in the song.” Soon I could ask directly; “Do you feel like that guy?” Schiller and Bennett have recently written a book entitled *The Quiet Room: Out of the Torment of Madness* (1994) in which they describe Schiller’s journey through schizophrenia. Schiller refers to the power of songs in her life more than a dozen times. Her songs help the reader to share her intensely personal experiences.

Many of the psychiatric patients I have seen in Music Therapy were sexually abused as children. This made it even more difficult for them to allow others into their lives due to the feelings of isolation caused by their traumatic past. For these individuals, songs provided an easier way to relate to others and to understand themselves. Listening to their songs helped me, as their therapist, discover their feelings and moods and see the importance of certain memories. Their chosen music or songs can provide a clear view into one’s past and present.

There is very little literature in Music Therapy research that looks at the combination of psychiatric illnesses and childhood abuse, despite the correlation that some researchers place as high as 72% (Krol, 1987). Further, in searching through the literature for writings concerning the music that a patient brings into a session, I was dismayed to find very little. In working with those having psychiatric illnesses or histories of being sexually abused, the therapists often selected the music or it was improvised in the moment between patient and therapist (Clendenon-Wallen, 1991; Den Hurk & Smeijsters, 1991).
The literature describing how patients themselves experienced music in their Music Therapy sessions is very meager. Aldridge (1994) surveyed Music Therapy research in psychiatry and found most writings to be concerned with the use of music to soothe and soften treatment. He further discovered that "most of the articles are concerned with passive music therapy and the playing of pre-recorded music" (p. 11). Amir (1992) found that "only a few researchers deal specifically with the descriptions and understandings of the experience of Music Therapy on clients' perspectives" (p. 22). This is most likely a result of the primarily quantitative nature of most Music Therapy research, which does not lend itself to evaluations of thoughts and feelings (Forinash, 1993).

The few Music Therapists who have explored the intrinsic elements of Music Therapy sessions have done so quite recently and used qualitative research approaches (Forinash, 1990; Forinash & Gonzalez, 1989; Kenny, 1982; Nagler, 1993; Pavlicevic, Mercedes, Trevarthen, Colwyn & Duncan, 1994). All of these researchers sought to describe the Music Therapy process with various individuals. For example, Forinash and Gonzalez used a phenomenological method to explore and share the experience of a Music Therapy session and included the therapist's thoughts, images, and actions in a very moving vignette of a person's death in a hospice center. Although the therapist's feelings were revealed, it was impossible to ascertain the client's feelings about the Music Therapy experience due to her level of illness. Another study included patients with psychiatric illnesses. Pavlicevic et al (1994) studied the effects of Music Therapy with individuals having schizophrenia. Their study examined the musical content but gave little insight into the actual experience of the patients.

Although all of these Music Therapy researchers studied the processes of Music Therapy, there is little reporting of the Music Therapy experience from the
patients’ perspectives. Scheiby (1991) writes, “In the Music Therapy literature we are usually only offered the therapist’s interpretations, experiences and evaluations. This allows us to get only a glimpse at the therapeutic process and the music. . . and only through the therapist’s eyes and ears” (p. 273). In addition the literature that does include patient perspectives usually employs impersonal surveys or checklists which are not especially clinically relevant to other therapists (Heaney, 1992). Aldridge summarizes this situation by stating: “Although there is a broad literature covering the applications of Music Therapy as reported in the medical press, there is a general absence of valid clinical research material from which substantive conclusions can be drawn” (1994, p. 28).

I believe that it is important to research and document the Music Therapy process focusing both on the therapist’s experience and the patient’s own experiences. We need to illuminate how our patients use music and view Music Therapy. After all, our patients are the “experts” themselves; they know themselves better than we do. In order to explore this I have employed a qualitative approach that lends itself well to a natural investigation of the therapeutic process (Aigen, 1993).

In the present study, each of the six participants entered into our sessions with music that was meaningful and important to the participant. Each participant presented his/her music in different ways. These ways included listening to, playing, creating, and analyzing music. My role was to use their music in order to help each of them. I found that music was an ideal tool that enabled me to enter into their worlds with a better, clearer understanding of them. The qualitative approach I used gave me the flexibility as both therapist and researcher, to treat them both as patients and participants.
Statement of Purpose and Research Questions

My initial formulation of the purpose and questions was broad, for as Silverman (1985) writes “Inevitably, in much mainly qualitative research, the research problem will undergo several respecifications during the period of study” (p. 22). Doyhle, Hess and LeCompte say this is because “qualitative research frequently uncovers previously unforeseen research questions that must be explored to accomplish the intended research” (LeCompte, Millroy & Preissle, 1992, p. 633).

My purpose in this study was to investigate and record on paper the essential elements of Music Therapy sessions. The initial questions that guided the study included:

1) What is the meaning of music, or how does music function, in the lives of people who have both psychiatric diagnoses and histories of childhood sexual abuse?

2) How can these meanings be used in Music Therapy treatment?

As the study progressed and I started gathering data, third and fourth questions emerged:

3) What important aspects of their lives could I, as the therapist-researcher, learn more about through the use of music?

4) How can music, specifically songs, be used to facilitate communication between the participants and therapist in Music Therapy?
CHAPTER II
REVIEW OF RELATED LITERATURE

In this section I discuss literature on psychiatric illnesses and treatments, child abuse, Music Therapy and qualitative research. I have sought additional information since I proposed the study, for as Lundy (1992) writes, "Qualitative research differs from quantitative research in that the relevant literature emerges as data analysis progresses" (p. 6). Bogdan & Biklen's (1982) advice to researchers is that "we believe that after you have been in the field for awhile, going through the substantial literature in the area you are studying will enhance analysis" (p. 153). Therefore, as the study progressed and my purpose was shaped by the data, the need for new, relevant literature emerged. For example, during this study I learned that the participants had undergone several different types of therapy that had great impact on their Music Therapy: psychopharmacological therapy, psychotherapy, and for most of them, electroconvulsive therapy. Therefore, I felt that I needed to include pertinent information about those types of therapy.

Psychiatric Illnesses and Treatment

"One basic premise of psychiatry is that there exist thoughts, feelings, and behaviors that are regarded as psychopathological, that is, abnormal" (Klerman, 1988, p. 74). These "abnormal" entities are seen as symptoms of mental disturbances. A psychiatric illness is comprised of disorders and symptoms that
impair social and personal functioning. It is usually believed that psychiatric disorders are reactions to social, psychological and biological factors (Hollander, 1990). There continues to be controversy over whether or not to diagnose, to apply a label to a person. Often clinicians are more concerned with the actual person than the category the symptoms fall into; however, the process of diagnosing allows clinicians to “benefit from the shared learning that results from being able to talk about problems with similar characteristics” (Hollander, 1990, p. 26). A diagnosis gives clinicians a common language in which to understand each other when speaking of psychiatric problems (Hollander, 1990).

Every participant in this study had received one or more diagnoses. Included in Appendix A are definitions of some of the disorders and symptoms that the participants in this study suffered and with which they were diagnosed. They are offered to introduce the reader to some of the terms that will later be used by the participants and mein descriptions of their lives. The terms defined are: bipolar disorder, borderline personality disorder, delusion, eating disorder, hallucination, psychotic, schizoaffective disorder, and schizophrenia.

**Psychopharmacological Therapy**

Every participant was taking medication for his or her psychiatric illness. Psychopharmacological therapy often influences other therapies, and during the Music Therapy sessions the participants focused a great deal on their particular medications and their effects. The use of psychotropic drugs is a widespread, publicized issue currently under much critical scrutiny. Even in popular news publications there are often arguments for and against medication for psychiatric illnesses. For example, the magazine *Time* recently presented opposing arguments about the often used medication Prozac. Two authors’ views were
detailed on the perceived positive and negative effects of this psychopharmacological treatment (Gorman, 1994). One subject of this article, Lichenstein, wrote “Medication was at the heart of my treatment” (p. 65).

Many psychiatric hospitals were previously used primarily as warehouses for the psychiatrically ill because it was often thought that unlike those with physical disorders, these patients were not curable or even effectively treatable. As medications began to be successful in treating mental symptoms, verbal, creative, and physical therapies began to be useful in helping those with psychiatric illnesses. It was found that progress could be made in other therapies when specific symptoms were controlled or eliminated through medication (Kaplan & Sadock, 1988).

The use of medications has resulted in a remarkable decrease in the average length of stay in psychiatric hospitals for many persons (Kaplan & Sadock, 1985). Medications can often treat symptoms of mental illness that inhibit other therapies from being successful. For example, a patient can be so depressed that s/he sleeps all of the time and is unable to gather up the energy to speak about what is troublesome in order to find a way to reduce or eliminate his/her worries. After taking an antidepressant, this individual may then have the energy and motivation to discuss and tackle these concerns actively.

A brief description of general categories of medication is set out below. Most of these medications are taken orally on a daily basis, but some may be ingested intravenously. Many are regulated not only by behavioral manifestations of the symptoms associated with the psychiatric illnesses, but also by specific blood levels in relation to the amount of the drug in the system (Hollister, Trevor & Way, 1988).

- antipsychotic medications help alleviate the problems in reality testing
• mood stabilizers can help control mania
• antidepressants focus on the neurotransmitters in the brain
• psychostimulants help with disorders of activity and attention levels
• sedative-hypnotics reduce anxiety

Each medication can have its own varied and complicated set of possible side effects. Some of the most prominent ones that the participants in this study complained of were the inability to concentrate, rapid heart rate, feeling of fatigue and drowsiness, tremors of the hands, dry mouth, headaches, feeling of unease, feeling of numbness, and finally, feelings of confusion.

The study participants expressed conflicting feelings about their medications’ usefulness. They all seemed to welcome the relief that they felt from many of their problematic psychiatric symptoms; however, they also seemed to mourn the loss of the benefits of some of their symptoms. Their words closely paralleled words that Sacks (1993) recorded when quoting a person about her feelings of being on an antidepressant:

Gone are the frenzied searches for the basic meaning of life. I no longer fixate on one thing since I am no longer driven. During the last 4 years I have written very few entries in my diary because the anti-depressant has taken away much of the fervor. With the passion subdued, my career and...business is going well. Since I am more relaxed, I get along better with people, and stress-related health problems, such as colitis, are gone. Yet, if medication had been prescribed for me in my early twenties, I might not have accomplished as much as I have. The “nerves” and the fixations were great motivators until they tore my body apart with stress-related health problems (p. 117).

**Electroconvulsive Therapy**

One particular therapy that most of the participants had experienced and refer to is also perhaps the most controversial, electroconvulsive therapy (ECT).
ECT is the use of electric shocks that are used to alter the turnover and metabolism of biogenic amines in the brain (Nicholi, 1978).

Electroconvulsive therapy has been used since the nineteenth century as part of a curative process for various afflictions. Since its first use, the amounts of shock has been severely lowered and refined. At one time it caused spinal fractures, but now it causes only a slight seizure lasting between five and twenty seconds, and the patient is often able to resume activity in less than 1 hour. Usually ECT is only used as a last resort treatment when all other primary therapies, such as psychotherapy, psychopharmacological therapy, and behavioral therapy, have been attempted without success, and when the depression is extremely severe, as in the case of a person who is persistently suicidal (Salzman, 1978).

Common side effects of ECT follow a continuum that ranges from an immediate headache, which generally responds to aspirin, to some reports of permanent memory loss (Salzman, 1978). Current trends involve a series of ECT sessions; for example, a patient might have one session a week for eight to twelve weeks for major depression, and sometimes for catatonic schizophrenia. Current findings rate patients’ lives much improved after ECT when it is used appropriately (Weiner & Coffey, in Frances & Hales, 1988).

The participants in this study had mixed reactions to ECT, but usually they focused on not having had a choice in the use of this particular type of treatment. Some of their specific statements about the experience of ECT can be found in Chapter IV.

Each participant had been an inpatient in psychiatric hospitals many times during his/her life. All of the participants were currently involved during the time of the study in at least one other type of therapy, such as psychoanalytic,
behavioral, or humanistic, and had been for several years. They had also previously been involved in other therapies in addition to psychopharmacological, psychotherapy and electroconvulsive therapy. They had experienced some or all of the following: physical therapy, occupational therapy, recreational therapy, rehabilitation therapy, vocational therapy, behavioral therapy, cognitive therapy, and the creative arts therapies. They all reported using music as a way of "feeling good" in their private lives, but none of them had ever experienced Music Therapy.
Child Abuse

Each participant in this study had a history of childhood sexual abuse. Some also reported having been physically abused as children. Many of the participants in this study expressed feelings that the ramifications of their families' extreme abuse contributed to the difficulties in their current lives.

Written documentation of the abuse of children has existed since the fifteenth century (Radbill, 1968) and has included physical abuse, emotional abuse, and sexual abuse. In the United States the first widely publicized case was in the 1870s, and it led to the first organization devoted to protecting children from abuse, The New York Society for the Prevention of Cruelty to Children (Lazoritz, 1990). However, the helping professions, including the medical profession, did not pay significant attention to child abuse until the 1960's, when The Battered Child was published (Helfer & Kempe, 1968). A common definition of child abuse, originally written by Helfer & Kempe, is included in Appendix B along with definitions of emotional abuse, physical abuse, and sexual abuse.
Prevalence of Child Abuse

Estimates of the exact amount of child abuse vary, but there is no dispute that the incidence of both physical and sexual abuse has been, and continues to be, extremely high. Sexual abuse occurs in every culture and socioeconomic class with similar traumatic effects to the victims (Lew, 1988; Kempe, 1978; Renvoize, 1982). An agreed upon perception is that the prevalence is much higher than most would wish to believe.

Most researchers consider that child abuse, especially sexual abuse, is often underreported, especially by the victims (Femina, Yeager & Lewis, 1990) and some research indicates that the true number is probably double the reported figures (Straus, Gelles & Steinmetz, 1980). Certain research has even hypothesized that statistics may sometimes be erroneous perhaps in an effort to falsely comfort the public (Forward & Buck, 1988). The FBI and the Justice Department write that only one in ten cases of child sexual abuse is actually reported (Poston & Lison, 1989). It has also been found that approximately one third of the victims of sexual abuse did not tell anyone at the time of their abuse and carried their secret into adulthood (Crewdson, 1988).

Researchers agrees that male victims are especially underidentified (Faller, 1988; Hunter, 1990). Weltman (1986) reports that 10% of men report they had been molested as boys, and Bass and Thorton (1983) found that percentage to be closer to 14%.

Estimates of the sexual abuse of girls range from 25% to 38% (Bass & Thornton, 1983; Engel, 1989; Lew, 1988; Russell, 1986). The highest estimate of the sexual abuse of girls comes from a study based on the highest random sample within the research, which was drawn by Russell (1986). Her study found that 38% of women had been sexually abused before the age of 18. This percentage
was higher than the only other large scale study which was done by Finkelhor in 1987; it found that 19.2% of women and 8.6% of men were sexually abused as children. The discrepancy between the figures in the two studies may be due to the fact that Finkelhor gathered his sample only from college students. This population is thought to be less fragile and includes fewer people suffering from the traumatic effects of abuse than in the general population (Faller, 1988).

Approximately 75% to 95% of the offenders, regardless of the victim’s sex, are known by and may be related to the child (Hunter, 1990). Most often these persons are the children’s uncles or fathers. Incestuous sexual abuse is often more traumatic and difficult to recover from (Russell, 1986; Sanford, 1980). Because of their history of sexual abuse, victims are generally not able to lead healthy, happy lives (Bass & Davis, 1988).

**Ramifications of Child Abuse**

Sexual abuse typically occurs at the hands of a known, trusted individual, which creates a sense of danger in what should be a safe environment. Herein lies the worst damage to the victim: the destruction of trust in one’s own feelings and instincts, resulting in a sense of foreignness to one’s own self (Bass & Thornton, 1983). Danica (1988) describes the ramifications of sexual abuse:

Sexual violence doesn’t end with the act. It occupies our thoughts and our time. It imprisons us in a space of fear, a space of shame, a space of self negation...cuts us off from joy and all those cheerful landscapes that we as children imagine lasting a lifetime. (p. 5)

Research mirrors my clinical experience that a high frequency of childhood abuse is found in the psychiatric population (Gallagher, Flye, Hurt, Stone, & Hull, 1992). Many psychiatric patients have specific histories of sexual
abuse, and there is much debate as to whether there is a causal relationship or whether the similarities are due to the high rate of sexual abuse found in the general population (Terr, 1991). Herman (1986) found that 33% of female psychiatric outpatients had histories of abuse. Beitchman, Zucker, Hood, DaCosta, Akman & Cassovia (1989) discovered that 40% of their psychiatric patients had been sexually abused as children, and Bryer, Nelson, Miller and Krol (1987) reported that 72% of their patients had histories of childhood abuse. Poston & Lison (1989) have found that, due to the accompanying depression, hallucinations and flashbacks, addictive behaviors, dissociative states, manic behavior, violent outbursts and isolation, passivity or withdrawal exhibited by individuals who were sexually abused as children, they are often diagnosed with and hospitalized for psychiatric disorders.

Many researchers have found that sexually abused people possess many attributes specific to their victimization. The literature identifies the following characteristics of those who have been sexually abused: inability to express reactions to victimization verbally and the tendency to withdraw emotionally instead; extreme affection-seeking from others; depression; self-destructive behavior; guilt; an altered body image; overly aggressive behavior; negative and hyperactive behavior with a feeling of panic; a seemingly overly compliant and accepting attitude; fleeing when the slightest hint of rejection is felt; sexualization of all situations and relationships; distancing, which is an automatic response to physical invasion in order to ward off both physical and emotional further harm; and confusion about past identities and roles (Bass & Thornton, 1983; Driver & Droisen, 1989; Faller, 1988; Finkelhor, 1979; Kempe & Kempe, 1978; Renvoize, 1982).
Kelly and Lew report that those who have been sexually abused experience the loss of the following: trust, safety, control, confidence, memories, social contact, opportunity to play and learn, and normal loving nurturing (Kelly, 1988; Lew, 1988). Research has also shown that sexually abused people are plagued with anxiety, depression, and unhappiness, believing that even ordinary events are out of their own control (Bass & Davis, 1988; Carnes, 1983; Driver & Droisen, 1989; Fraser, 1987; Renvoize, 1982; Sanford, 1980; Spring, 1987; Ward, 1984).

The primary therapeutic needs are gaining trust, coping with feelings of isolation and shame, and recovering from difficulties with intimacy (Bass & Thornton, 1983; Lew, 1988). Mrazek and Kempe (1987) describe one of the overall goals of therapy with victims of sexual abuse as being able to provide a setting which is safe, so that experiences and feelings may be dealt with in a nonthreatening manner. It is relevant that in this Music Therapy study, many participants commented on how their music offered a feeling of safety within their sessions.

**Research about Child Abuse**

Research in child abuse has been problematic for a few reasons. First, the actual definition of abuse can be vague, and it is not always perceived as abuse by the victim of child abuse (Fromuth & Burkhart, 1989; Augoustinas, 1987). Second, the population researched is often severely limited due to the consistent underreporting of incidences of child abuse (Femina, Yeager & Lewis, 1990; Straus, Gelles, & Steinmetz, 1980). Third, ethical problems emerge almost immediately if one is researching the victim directly, because it is very difficult to
maintain a participant-observer role in this type of research (Kadushin, 1981). Last, if a researcher is interviewing victims, it can be very difficult to persuade them to speak openly and then to make sure the truth is actually told (Straus, Gelles, & Steinmetz, 1980).

Moreover, most studies did not follow the abused into adulthood. The effects of child abuse on the adult survivors is an area in great need of research because as Martin and Elmer (1992) write, “There is a dearth of solid evidence concerning the long-term effects of the abuse of children” (p. 75). A significant element of this current study is in fact the effect of childhood abuse on the adult lives of the participants.

Music Therapy

Music is said to be present in all cultures as a form of communication (Radocy & Boyle, 1979). The use of music in healing has been recognized since ancient historical times, and the importance of its use as therapy has been increasingly recognized in this century (Pratt, 1987). By the nineteenth century, many physicians believed that music is essential in the treatment of emotional problems and one of the first books that dealt solely with this topic was written then The Influence of Music on Health and Life (Chomet, 1875). Altshuler, a prominent psychiatrist in the 1900’s, proposed the uniting of Music Therapy and psychiatry in treatment of the mentally ill (Pratt, 1986).

The premise that music can indeed affect emotional states is well accepted and has been documented since the late 1800’s (Alvin, 1975; Chomet, 1875; Gaston, 1968; Nordoff & Robbins, 1971; Podalsky, 1939). The positive results of music as an effective treatment has been documented throughout this century in
treatment with those having psychiatric or mental disorders (Alvin, 1966; Cook, 1981; Hall, 1982; Podolsky, 1939; Pratt, 1987; Priestly, 1975; Schullian & Schoen, 1948).

Music has been used as a therapy for the psychiatrically impaired since World War II (Schullian & Schoen, 1948), and the creative arts, including music, have been found to be valuable tools in modern-day psychotherapy (Boenheim, 1967). Training programs began in the United States in the early 1940s. Currently there are two Music Therapy professional associations, one national certifying Board, four types of credentials, and approximately seventy-five undergraduate and graduate training programs offered at various universities in the United States. Many other countries also offer Music Therapy degrees, certifications, and associations.

Music Therapy is defined by one of its pioneers as “the conscious use of the power of sound and music in therapy and healing. The Music Therapist’s work is to tap the unique potential of sound and music for the health and well-being of clients” (Hesser, 1994). She also writes: “In Music Therapy we begin by assisting each patient to express themselves fully in sound and music. . . In Music Therapy the essential aspect is the process of the music and not the product of the playing (Hesser, 1992, p.3).

Music Therapy is used in a variety of ways with individuals struggling with a variety of difficulties, disabilities, and issues (Bruscia, 1991). Hesser (1991) has classified these large areas of treatment: Music in Medicine, Music in Healing, Music in Special Education, and Music in Psychotherapy (unpublished manuscript). This study focuses on the use of Music in Psychotherapy because the participants in it have psychiatric illnesses that warrant a psychotherapeutic approach focusing on their emotions, and because I choose to work in manner
congruent with this realm of treatment. Hesser defines Music in Psychotherapy as “a form of psychotherapy which uses music in the treatment process. Music as an art offers unique opportunities for human expression, communication, and relationship and therefore can offer important possibilities for the treatment of emotional problems” (p. 8).

I share Hesser's view that “Music psychotherapy can speak to the whole person” (p. 4) and will discuss my findings of the participants' sharing many aspects of their lives. Music helped them share not only their musical interests, but also their current interpersonal difficulties, their past traumas, and their aspirations for their futures. Nagler (1989) further states that this process includes the involvement of both the patient and therapist in an “interactive musical dialogue” (p.14), and Bruscia adds that this type of Music Psychotherapy is an intense level of practice requiring specific training and supervision. He also states that this work is a process involving the patient and the therapist over time and not a one-time application of music as a treatment (1989). Although Music Psychotherapy is the exact term that best describes this study, I will use the more general term “Music Therapy” for brevity. In addition, Music Therapy is still such an unknown entity, that I do not want to diffuse it or confuse it by using a more exact term in describing it.

Music is a valuable tool in psychotherapy for several reasons. First and foremost, it is generally believed that each person has the ability to respond to and participate in, or at least enjoy, music (Hesser, 1991; Kohut & Levarie, 1950). For many, listening to music is a primary leisure activity (Bednarz & Nikkel, 1992). I have witnessed hundreds of patients, regardless of affliction, desiring and actively participating in music. At times, music was one of the few activities that many of these patients would involve themselves in.
Music with Psychiatric Illnesses and Sexual Abuse

Several persons experiencing psychiatric illnesses have shared their reflections on music in recent personal books about them and their difficulties. Stein wrote of his brother's love for music: "The only thing that gave him any pleasure was music. Music could still thrill him" (p. 243). This "thrill" of music pervaded his life even during psychotic episodes. Williams describes her attitude toward her music in the context of her life of isolation: "The guitar and I boarded the plane together. It had been a good friend and right now a friend was what I needed" (1994, p.11). Styron (1990), in his memoirs entitled Darkness Visible: A Memoir of Madness, summarized the powerful role music had in helping him choose to continue living over completing his already decided upon suicide. He described hearing a passage of music, Brahms's "Alto Rhapsody" which made him realize that he wanted to continue living (p.66-67). All of these works helped me understand the feelings about music that individuals suffering from psychiatric illnesses had. I have found that three of the main areas in need of treatment with those who have been psychologically impaired and sexually abused are: self esteem, communication, and repression (Hammel, 1990).

A lack of self-esteem is often experienced by individuals with numerous types of disabilities or illnesses. It seems that due to the stigma associated with having a psychiatric disorder (NIMH, 1980), or having been sexually abused (Fromouth, 1986), opportunities to increase self-esteem are greatly needed. Music Therapy researchers have found that music can aid in increasing self-esteem with those having both of these difficulties (Clendenon-Wallen, 1991;
Henderson, 1983; Kivland, 1986). A possible reason cited for this ability of music to help raise self esteem is that music is nonthreatening compared to other treatments (Kivland, 1986, p. 29).

It seems that many psychiatric illnesses make communication difficult because symptoms can blur reality and impair cognitive processes. For example, for someone who is experiencing auditory hallucinations, delusions, or paranoia, discerning what is actually being said to them can be impossible. Music does not arouse defenses as readily as language and therefore has the ability to serve as a vehicle for expression and communication (Noy, 1967; Verdeau-Pailles, 1987). Morely writes, “music is a form of communication analogous to speech” (Aldridge, 1989, p. 93). Communication is particularly important in therapy because “In all forms of therapy there is an emphasis with communication as a way for clients to establish connections with their inner and outer worlds” (Hesser, 1993, p.9). The ability of music to communicate is beautifully expressed by Plach (1980):

When we feel, we begin to be alive. When we express a feeling, we share with the rest of the world that we are alive. When we express a feeling through music, we invite the rest of the world to share in our experience of the feeling, and to be alive with us. (Introduction)

Music is useful in communication because it is capable of expressing many thoughts at one time (Noy, 1967). For example, the text can convey one feeling while the melody and harmony convey a different feeling. Moreno (1987) illustrates this aspect of music in his accounts of creating and singing the blues with adult psychiatric patients, in which both the expression of loneliness and the feeling of support from others could happen simultaneously.

Repression is an unconscious defense mechanism that is often seen with those who have experienced trauma such as sexual abuse (Terr, 1991). Music is good at overcoming repression, perhaps because “All music represents the deeper
sources of unconscious thinking because it is untrammeled by the limitations of language, as in poetry, or by visual imagery, as in painting” (van der Chijs, 1923, p. 379). Repression was a problem often cited by the participants in this study. Many of them attributed their repression to their sexual abuse. Moreno spoke of the use of music in the facilitation of emotional expression and illustrated the ability of music to express repressed feelings and thoughts in a safe manner for the first time (1980). Johnson (1987) detailed how the creative arts therapies, including Music Therapy, could be used as therapeutic tools in unleashing repressed thoughts and feelings. He found that these tools could be extremely useful not only in the diagnosing of particular emotional states, but also in the psychotherapeutic treatment of them.

One of the first textbooks about Music Therapy, written in 1968 by Gaston, was about Music Therapy with the adult psychiatric population, but it was about the kinds of musical activities used and not the actual therapeutic processes. It set the stage for other works about Music Therapy. Researchers seemed to be more concerned with the use of sound as a stimulus or reinforcer and less with the use of music “as a prime source of information about how to live and relate to the universe” (Ruud, 1988, p. 314). For example, many articles have been written about Music Therapy with adults in psychiatric hospitals, although many focus more on treatment as an activity rather than as a form of psychotherapy (Braswell, Brooks, Decuir, Humphrey, Jacobs, & Sutton, 1986; Carroccio & Quattlebaum, 1969; Ficken, 1976; Rajewski, Walczak, & Fellmann, 1981; Rajewski, Paterka, Fellmann, & Nalewajko, 1982; Sylwester, Barg, Frueh, Baker, Patrick & Shaffer, 1971). Numerous other articles describe the use of Music Therapy as a reinforcer in changing behaviors with the psychiatrically impaired (Cook & Freethy, 1973; Hauck & Martin, 1970; Peach, 1984).
Perhaps the rationale for all of these particular writings, which focused only on specific elements in therapy and not on the overall therapist-patient relationship or on actual musical content, was that there was a need for Music Therapy to be recognized by the scientific/medical community as a valuable therapy (Ruud, 1988). Music Therapy researcher Aigen summarizes: “Traditional research in music therapy has been limited and led astray by fundamental misconceptions regarding the locus of effect of music therapy process” (1991, p. 81).

Music can be an integral part of establishing a positive therapeutic relationship between therapist and patient. Maultsby (1977) described how music can bring forth “...strong positive emotional reactions.” This can aid the patient to become willing to even enter into the Music Therapy process. Once the patient is in process, music has been found to have a positive effect on attitudes and moods of adult psychiatric patients in psychotherapy (Kahans & Calford, 1982). Music Therapy has also been found to increase peer acceptance and group cohesiveness among adult psychiatric patients (Cassity, 1976). Perhaps this is due in part to the elements of music that allow it to be perceived as an “object” or symbol itself (Noy, 1967). A patient can therefore relate directly to the music more readily than the patient can relate to another person. The music then serves as a bridge between patient and therapist.

Two other articles that are particularly relevant describe the actual therapeutic relationships and Music Therapy treatments with other adult psychiatric patients (Aigen, 1990; Stephen, 1981). These articles clearly describe the actual importance of the Music Therapy process (Stephens, 1981) and offer vivid descriptions of the relationship as experienced by the therapist (Aigen, 1990). Both of these articles were in a case study format; and since Stephens’s
publication, other Music Therapists have begun to write more explicitly about actual session content and the therapeutic relationship. Aigen (1993) theorizes that the case study format is preferred by therapists because it "allows them to study their clinical work without subjecting it to unnatural experimental manipulations, and as a reporting form, it represents an extension of common reporting forms already used by therapists" (p. 31).

Bruscia (1991) compiled case studies illustrating various therapeutic processes within Music Therapy. His book includes many studies that illustrate the relationship between Music Therapists and their patients and clients. This book is one of the few published writings that speak to the specific uses of music with adults having psychiatric illnesses. The pertinent case studies from his compilation will be integrated in the Discussion section of this study.

There is a relatively small amount of literature available about the use of music in psychiatry (Noy, 1967). Nass (1989) attributes this to the inherent difficulties in writing about something that is not easily described with words. Much of the literature on music in psychiatry falls within three major areas: biographies of composers which are attempts to understand compositions through their creators’ lives; psychoanalytic studies of composers and musicians; and studies attempting to reveal the meaning of music (Nass, 1989). However, certain psychiatrists, psychologists, and psychotherapists have written about its effective usage as part of psychotherapy treatment (Feder, Karmel, & Pollock, 1990; Kohut & Levarie, 1950; Kohut, 1957; Nass, 1989; Noy, 1967; Reik, 1983; Winnicott, 1953).

As early as 1919, a few select psychoanalysts published writings on the importance of music, over other creative arts, in therapy. They found even then
that music could appeal directly to one's feelings without the interruption of intellectual constraints (Noy, 1967).

The various ways in which these authors found the use of music valuable with their psychiatric adult patients were: music and its relationship to thought associations, music as a transitional object, music and its relationship to original ego organization, and music as a tool for greater self-awareness in psychoanalysis (Kohut, 1951; Reik, 1983). For example, two of the most prominent psychiatrists, Kohut and Freud, each wrote of the importance of music in psychotherapy. Kohut wrote of the relationship between musical sounds and the personality, specifically the development of the personality. He also wrote of the particular use of music in releasing pent-up emotions (Kohut, 1951). Freud (1960) described one of the uses of music: "Whoever will take the trouble... to pay attention to melodies which one hums to himself aimlessly and unconsciously, will regularly discover the relation of the melody's text to a theme which occupies the person at that time" (p. 44).

The effects of abuse are often seen in the form of having psychiatric disorders. For example, the diagnosis of Multiple Personality disorder is given for extreme cases of severity of traumatic abuse, often that of a sexual nature. Other times, the symptoms that accompanies the effects of having been sexually abused and seen as psychiatric symptoms: depression, anxiety, and hyperactivity to name a few. Very little is found in the Music Therapy literature specifically about working with those who have been sexually abused. This is rather surprising for as Clendenon-Waller (1991) reports, Music Therapy is a much needed therapy for these individuals since there is widespread "acceptance that traditional forms of therapy are ineffective", and that expressive therapies are effective with this population. Perhaps this paucity of literature has to do more
with the recent emergence of individuals speaking more readily about their abuse and now, for the first time, their problems are being addressed through therapy.

One Music Therapy article (Henderson, 1991) described how music, specifically songs, offered a sexually abused individual a sense of organization. The author describes that from this structure, progress was made in releasing locked emotions. The Music Therapy in this particular study also served to allow traumatic experiences to be revealed in a nonthreatening manner. Each of the participants in this study shared his and her experience of sexual abuse through the music. Some briefly alluded to it and others shared explicit details and feelings of their past.

Duey (1991) wrote at length of his work as a Music Therapist with adults suffering the effects from abuse, usually sexual abuse. He found that

music played a significant role with this group of women because of its ability to evoke and support imagery, metaphors, and feelings. Through imagery and metaphor, the women were able to creatively and safely explore very difficult issues stemming from their abuse. Through their affective responses to songs, they were able to acknowledge and work through some very painful feelings in the safety and support of the group (p. 526).

Clenendon-Wallen (1991) also found that the use of songs was an integral part of the Music Therapy sessions she conducted with those having histories of sexual abuse. She wrote that songs offered the participant an opportunity to empathize with the character of a song and then project their personal thoughts, feelings and attributes onto the song thereby opening up a discussion about a painful topic.

Songs in Therapy
All of the participants in this study spontaneously used songs as self-expression and communication in their Music Therapy treatment; therefore, a review of this particular type of music is necessary. Their use of songs constituted the bulk of the therapeutic work that we did together in our sessions.

The specific use of songs has not been written about extensively in the literature by psychoanalysts and psychiatrists. Hannett (1964) summarizes this lack by saying "The psychological functions of music have so far attracted little attention and the field remains relatively unexplored, particularly in the area of the song lyric" (p. 226). She analyzed songs from the years 1800 to 1949, exploring meanings and themes of popular works. Ellis (1981) wrote about using songs as part of his rational-emotive therapy to explore, challenge and dispute irrational beliefs. For example, he created and used humorous songs with his patients in order to illustrate and break down their defenses.

As with other people I have met throughout my life, the participants were able to recall exact words to their songs, usually popular songs. Storr (1992) hypothesizes that this ability, which is common to many people, is a result both of the intrinsic power of music and the common place that music holds in our society. Among those suffering from emotional difficulties, Sachs found that music offered a more structured way of understanding the world (1970). Storr further hypothesized that, due to an alleged difference in the separation of the two hemispheres of the brain, persons with schizophrenia are especially in need of finding a structure or order. Music affords this opportunity and therefore helps to make life more enjoyable (Storr, 1992).

A small handful of psychiatrists have explored the functions of music in therapy. Hannett (1964) described her first realization of the role lyrics could have in therapy:
These song fragments had an insistent quality that he [the patient] did not understand. Occasionally he would recognize a link between the remembered and plaguing words and the content of a previous hour. More often the connection remained obscure. When I [the therapist] realized that the lyrics were preconscious expressions, it became clear that the patient was using them to convey emotions and feelings he could not express directly. This revealed particularly the patient’s resistance since he had until then succeeded in impressing me with his great verbal capacity. It was evident that a direct statement from him would have been too close to emotions which he was not yet ready to experience (p. 227).

Rosenbaum (1963) wrote that songs can break through rigid defenses into thoughts, feelings, and memories that otherwise cannot be reached or discussed readily. He likened the use of song lyrics to working with the manifest content of a dream, in which associations are loosened and become more available and the unconscious is made conscious. Hannett also described this process: “The manifest meaning restates the defensive surface position. The latent meaning, referring to the impulses and wishes and their genetic origin, is revealed only by analysis of the lyric” (1964, p. 237).

Rosenbaum described how in addition to accessing the difficult areas of one’s mind, the phenomena of congruence can be achieved between thought and affect through the use of the melody and the lyrics. He wrote, “there seems to be a relationship between repressed ideas and lyric on one hand and repressed affect (sexual or aggressive) and melody on the other” (Rosenbaum, 1963, p. 264). Even in conscious thought, songs lyrics can often be a less painful way to introduce painful topics (Hannett, 1964).

Songs can also serve as a means of expressing difficult, conflicting thoughts and feelings because they are capable of expressing ambivalence and concurrent feelings, unlike language (Langer, 1942). They also have the power to discharge affect and to allow fantasy-oriented thoughts via the lyrics (Rosenbaum, 1963).
Another psychiatrist, Reik also found the words of songs to be similar to the manifest content of dreams and used them in his interpretations (1953) and psychotherapist Diaz de Chumaceiro (1992) has written of songs in sessions and has also found it useful to examine their lyrical content as I did. She found that "...songs have personal meanings, not absolute ones" (p. 326); therefore, I will be sharing some of the participants’ words about their song selections after their songs in Chapter IV.

Little existing Music Therapy literature describes the therapeutic process of using songs in Music Therapy, and the writings that do focus on songs often do not discuss these in depth (Amir, 1990). The majority of Music Therapy literature about songs has to do with the technique of song-writing in sessions with groups of patients (Edgerton, 1990; Ficken, 1976; Freed, 1987; Schmidt, 1983). It has been found that this technique has helped raise low self-esteem, increase expression, and improve communication as well as to facilitate self-disclosure (Edgerton, 1990; Freed, 1987).

It is known that recalling favorite songs is simple for most, especially the recalling of lyrics (Maultsby, 1977), and Arnold found through recalling songs, feelings dating back from childhood could be accessed and thus aid in overcoming repression (1975). Song lyrics have been used specifically by Music Therapists as an external cue to urge the patients to complete a task (Gervin, 1991) and song lyric analysis has proven helpful in encouraging discussions and expressions of feelings (Clenendon-Waller, 1991; Edgerton, 1990; Freed, 1987).

Songs have been used both with those who have been abused (Duey, 1991; Clenendon-Wallen, 1991; Heal, 1989) and those having psychiatric illnesses (Edgerton, 1990; Ficken, 1976; Freed, 1987) in Music Therapy treatment. Songs provided a much needed structure in which the abused patient could begin self-
exploration and those with mental illnesses could feel better about themselves, trust others, and communicate their problems (Duey, 1991; Ficken, 1976; Heal, 1989).

Clenendon-Wallen (1991) writes of the “bridge” that songs provide those who have been abused:

Song discussion appeared to facilitate self-disclosure by creating a non-threatening environment for verbal interaction. It seems that music provides a magical bridge which permits the mind and body which is barren, expressionless, and uncommunicative to begin to identify and express through communication the feelings and thoughts which have been shut down (p. 79).

Amir looked closely at the meaning of songs in Music Therapy sessions. She utilized a phenomenological method to understand the process more clearly. Amir found that songs had specific meanings for both the therapist and the patient. Both the Clendenon-Waller (1991) and Duey (1991) studies found the use of songs to be extremely important and had important meanings for those who had been sexually abused. Duey (1991) used songs as a vital part of the therapeutic process and incorporated the techniques of listening and discussing them. In fact, he wrote that “through their affective responses to songs, they [the patients] were able to acknowledge and work through some very painful feelings...” (p. 526).

Bailey (1984) described specifically the effects of using songs in the Music Therapy process:

Songs have the potential to establish human contact and can provide a framework for enhanced communication...Song content is significant. People choose to hear and participate in songs which support their needs and which convey the mood and the messages they want to hear. Valuable information about the physical, emotional, and spiritual needs of patients and families can be gained by paying close attention to the songs they choose and the reasons for their choices. The content of song choices often reflects important wishes or memories. The music therapist can use
the verbal messages within the songs to promote enhanced exploration of inner thoughts and feelings. (p. 7)

She also described how songs help increase feelings of safety and security as well as provide a framework for processing difficult life events. She found that “one of the most important tools of the music therapist... is the use of song material” (p. 16).
Qualitative Research

In my past Music Therapy research experiences, I felt limited when using a quantitative design to investigate a specific phenomenon. On the other hand, when I used a qualitative approach I immensely enjoyed allowing the relevant material to emerge (Hammel, 1992, 1993). Aigen (1993) writes that the qualitative method is often “favored by therapists because as a research method it allows them to study their own clinical work without subjecting it to unnatural experimental manipulations” (p. 10). I chose a qualitative framework of research in which to guide my project because I believe that this framework can help the study of the whole person (Bannister & Fransella, 1986). Ely and her colleagues (1991), in their definitive book on qualitative research, included part of a publication from the General Accounting Office (1987) which states:

Many researchers who write case studies use qualitative data because they believe them to be richer, more insightful, and more flexible than quantitative data. They believe that the meaning of an event is more likely to be caught in the qualitative net than on the quantitative hook. (Ely et al., 1991, p. 55)

Qualitative research focuses on the natural environment and utilizes the researcher as the actual research tool. The primary element under investigation is the actual process of the phenomenon, and descriptions, instead of statistics, are used to present the findings. The trustworthiness of the researcher is the basis for evaluating qualitative research, and meaning, rather than truth, is what is sought in this type of approach (Bodgan & Biklen, 1982; Ely et al., 1991).
Qualitative Research in Music Therapy

Qualitative research entails many of the same overall theoretical processes as Music Therapy sessions and can often be seen as an “extension” of the actual reporting that already occurs in Music Therapy (Aigen, 1993). It focuses on understanding how the participant feels from his or her point of view (Ely et al., 1991; Lofland, 1971). For example, Bogdan and Taylor (1975) write that qualitative research is characterized by a “period of intense social interaction between the researcher and the informants” (p. 5). Lofland and Lofland (1984) describe this period as one in which the researcher listens and watches as well as questions the participants. These interactions mirror the therapeutic interactions found in many Music Therapy sessions (Bruscia, 1989). Aigen (1993) writes specifically that there are several “common grounds” that both Music Therapy interactions and qualitative research interactions share:

- centrality of human agency; equality, mutuality of process; valuing human relationships; contribution of practitioner’s unique experience; valuing the unique and individual; employing multiple perspectives to ensure integrity; valuing creativity and interactive process; honoring multiplicity of constructed realities (p. 4).

Aldridge (1991) writes that the dual tasks of Music Therapist and researcher are to “facilitate the telling” in therapy and to “understand the telling” in research (p. 119). He writes that to gain an understanding of the therapeutic process, “meanings cannot be counted or measured, but they can be expressed and analyzed.”

Aldridge cites criticisms that qualitative research is not “reliable” in the classical research sense employed by much of the medical community, and responds that “no two people are the same, and the same measure when applied to two or more people can never bring the same result. Music Therapy is a
transpersonal happening and what happens cannot be separated from the person of the therapist” (1991, p. 127). To the complaint that the research is not “objective” he answers, “It is almost impossible to seek out objective measures in creative arts therapies when subjective factors play such a predominant role” (p. 127).

Although it wasn’t until rather recently that several Music Therapists began using qualitative research, the need for such research has been acknowledged since at least 1982 (Hesser, 1982). There has been a persistent “call” over the last decade for more exploration of the actual music within Music Therapy sessions (Bonny, 1984; Bruscia, 1989; Hesser, 1982; Wheeler, 1986). Until quite recently, most Music Therapy research has been “primarily quantitative in focus” (Forinash, 1993, p. 71); however, within the past five years several doctoral dissertations have used a qualitative approach (Amir, 1992; Forinash, 1992; Gonzalez, 1992; Kenny, 1987; Loewy, 1994; Nagler, 1993), setting the stage for further qualitative research as an acceptable means of exploration in Music Therapy. Aigen (1993, 1994) has written extensively on the effectiveness of employing a qualitative research approach to the Music Therapy process as a way to view the entire treatment. Aldridge (1989) stresses the importance of studying the phenomenon of music itself without attempting to reduce the experience to a quantifiable form because, as Glynn (1986) writes, “The emotional impact of music on an individual cannot be quantified”.

One particular research study explored the phenomenon of music in the Music Therapy treatment. The researchers, Den Hurk and Smeijsters (1991), described a man with a mental illness using musical improvisation to help alleviate his psychiatric symptoms. These authors combined efforts --one as a Music Therapist, one as a Music Researcher--in order better to understand the
patient and his treatment. Their study illustrated how events in daily life can be translated into actual Music Therapy phenomena and how research can occur within the paradigm of Music Psychotherapy.

Another study entitled “A Qualitative Approach to Analytical Music Therapy” (Langenberg, Frommer, & Tress, 1993) attempted to “find and describe new aspects of an empirical field of Music Therapy” with an individual. Much attention was paid to depicting the actual music that took place within the session. The authors determined several factors they were attempting to discern more vividly: generalizability, result, variables, and validity. These priorities resulted in a drastically different form from that of the present study.

Music Therapy was used in a variety of ways with the participants in this study who each had psychiatric illnesses as well as histories of childhood sexual abuse. The existing research shows remarkably few works within the realm of Music Therapy concerning those who have psychiatric illnesses and have also been sexually abused.

Qualitative Research as a Holistic Approach

I have found that not only does the qualitative research approach allow me to look at the whole person in the Music Therapy process, but it also creates the environment necessary for both the complex areas of functioning and malfunctioning to emerge. Aldridge (1991) writes that “The advantage of the creative arts is that they allow us not only to express our pathologies, which many orthodox and unorthodox medical systems concentrate upon with their underlying moral condemnation, but they also allow the expression of potential” (p. 123). I have found a similar tendency in psychiatry and agree wholeheartedly with Sacks (1970), who observes that “Neurology’s favorite word is ‘deficit,’ denoting an
impairment or incapacity” (p. 3). He also writes that the limitation of this perspective is it yields “no inkling of anything ‘but’ the deficits, of anything, so to speak, ‘beyond’ her deficits.... They had given me no hint of her positive powers” (p. 181). Sacks illustrates the destructive effect that this concentrated view of pathologies can have on the patient by painting a familiar picture:

She had done appallingly in the testing which, in a sense, was designed like all neurological and psychological testing, not merely to uncover, to bring out deficits, but to decompose her into functions and deficits (p. 181).

Until quite recently, it was rare to discover detailed psychological research on the experiences of a small group of persons sharing a particularly difficult experience. Much more common were glossed over, brief descriptions of members of large groups of people or accounts of the singular, idiosyncratic experience of one individual. However, one recent work that describes in detail the experiences of four teenage parents was recently completed, and the author worked “to break through their resistance in telling their stories, and to emerge with more than simple explanations of their circumstances” (Sander, 1992p. xvi). She explained her rationale for working with a small group and choosing to present her findings through a qualitative approach in the hope that her accounts would “illuminate the subject in the way statistics and vignettes cannot, that it will offer a richer and more complex view of both the problem and its solutions “ (p. xvi).

Another qualitative study by Westerlund (1992), entitled “Women’s Sexuality After Childhood Incest,” set out to describe and investigate a small number of women’s experiences of sexuality after being sexually abused as children. Westerlund selected a qualitative research approach because “the need for descriptive, exploratory research was evident” and because qualitative research could “capture the complexities of the incest experience and its felt
influence” (p. 182). Throughout her research she was able to describe richly the severe and adverse effects of sexual abuse on the lives of her study participants.

Qualitative Research with Sexual Abuse and Psychiatric Illnesses

Westrulfund (1992) selected qualitative research as the most appropriate model for her study of sexually abused people because she felt this approach was able to offer a deeper understanding of the problem of sexual abuse. She describes how qualitative research was so vitally useful:

With areas of investigation as shrouded in myth as incest and sexuality, it is essential to approach the individuals to be studied as the experts. Qualitative research allows the subjects to identify the variables, thus encouraging greater discovery. (p. 182)

Kelly (1988) reports that the primary focus in most studies of childhood sexual abuse is to discover and describe the adverse effects of victimization. Much of the literature portrays only this aspect (Chase, 1987; Spring, 1987). Other writings, usually autobiographical, include descriptions of personal healing (Danica, 1991; Fraser, 1987; Petersen, 1991), but more often than not the only references to actual treatment are cited in an appendix in the back of the book (Bass & Thornton, 1983; Forward & Buck, 1988). The few authors of books that are devoted to treatment (Engel, 1989; Faller, 1988) often depict the victims of sexual abuse in depersonalized ways, as if they were subjects in a very large experiment.

The effects of psychiatric disorders are, like those of sexual abuse, also “shrouded in myth”. Some literary works help remove this veil by revealing many aspects of the actual lives of a few individuals with psychiatric disorders.
Usually these works focus on a single person's overall life experiences. Sometimes these writings are autobiographical, often written with the help of someone in the mental health profession. An example of such a work is *Nobody's Child*, by Balter and Katz (1987), about a woman struggling to overcome her psychiatric illness. Others are biographical, such as *Is There No Place on Earth for Me?* which is Sheehan's account of a woman's difficulties with schizophrenia (1982). Very rarely is this literature written about a specific portion of the life of a person with a psychiatric illness, particularly a part that is not the primary problem, disability, or deficit.

This study is shaped by much of the reasoning and ideological sentiment described in this qualitative research section. As opposed to most of the available studies and writings which focus on people's deficiencies, I aspire to deliver a more complete picture of these individuals, a view that includes their strengths and inner resources, by being open to all of music's complex meanings in their therapy. By using a qualitative approach "we attempt to make sense of how a person maintains coherence in their daily lives not in terms of discovering pathology and limitation, but in terms of potential" (Aldridge, 1991, p. 129). This study attempts to share a detailed portrait of a small number of participants, and to show how they use music as a resource both in self-awareness and in communication.
CHAPTER III
THE RESEARCH METHOD

Lincoln & Guba (1985) explain that the specific research focus in qualitative research often emerges or changes as the study progresses because "...the inquiry is being done in order to learn about complexities of which researchers are not totally aware" (p. 224-225). In this study, I examined the Music Therapy experiences of patients with psychiatric illnesses who had histories of childhood sexual abuse. I functioned both as the therapist and the researcher.

I began by investigating how the history of having been sexually abused as children affected my participant's involvement with their music. The focus shifted from sexual abuse to their psychiatric illnesses. This was because the participants related their illnesses as being more problematic than their histories of abuse, even though their histories still played a significant role. The relevance of this shift will be illustrated in the thematic analysis in Chapter V.

Selection of Participants

Participants were solicited from verbal psychotherapy support groups at a large suburban psychiatric hospital for outpatients who had been sexually abused as children. This was the first time that these participants had been in a group focusing on their histories of abuse. These groups met at least once weekly on the hospital grounds. I gained entry through the psychotherapist who led these groups
who described my proposed study to the members. This explanation was accompanied by a presentation of the consent form. This form stated that the names and places of the participants would be disguised to ensure anonymity and included the permission to tape-record sessions (refer to Appendix C).

I chose to select a small number of participants. I initially estimated that the number would range from six to eight. I accepted every volunteer for the study, six in all, three males and three females. This decision was guided by the belief that spending more time with fewer people would allow me to uncover deeper and more clinically potent aspects of these patients’ experiences. Sander (1992), in writing about the study of one family, agrees that this approach can reveal more substance than can a study with a broader focus on a larger number of persons.

The following overview is offered in order to help the reader understand the context in which the Music Therapy sessions were one part of the participants’ overall program. The six participants involved in this study were all part of a 50-member adult outpatient program at a psychiatric hospital, a new program that sought to help the participants return to the community as working members. The program that these three men and three women were involved in was staffed primarily by vocational and rehabilitative counselors. It grew out of a need to provide an alternative to lengthy day treatment programs that were no longer getting adequate funding from third party payment sources. It was geared towards planned short-term treatment. I use the word planned because treatment of the psychiatrically diagnosed often can end up to be short term, but is often not set out to be that way. For example, the dropout rate is extremely high from many outpatient programs, because people often needed to be rehospitalized in an inpatient setting.
This program was conducted five days a week from 8 to 5 PM and consisted of classes that "students" would register for each semester. These classes included, but were not limited to: Socialization Fieldwork, Relationships 101 and 102, Sexual Abuse Group, Internship Support, Asking for Help, Social Skills at Work, Responding to Anger Unit Group, Study Skills, Managing Change, and Time Management. In addition to these classes, each participant had a psychiatrist that he or she saw individually or in group sessions on a regular basis at least once a month.

Each participant was told that I would work with him or her individually for approximately six sessions over the summer using Music Therapy. These sessions fit in around their classes and were often at the end of their days in the program. Their outpatient program was intended to last about three months, with the option for some of the participants to continue in it for another semester if the members and staff felt the "students" were benefiting from it. The six participants in this particular research project attended differing numbers of sessions due to their involvement with their program:

Bess: 8  Jack: 8  Sally: 7  Diane: 5  Matt: 4  Tom: 3

Two participants, Bess and Jack, consistently attended Music Therapy sessions despite difficulties with their living situations. Two participants, Matt and Diane, were hospitalized on inpatient units at the psychiatric hospital. I saw them each twice after their hospitalizations. One participant, Sally, was hospitalized at a medical facility for a physical problem causing a prolonged absence halfway through her sessions. One participant, Tom, dropped out of his outpatient program, and although he requested to continue his Music Therapy
sessions, this was not allowed by the guidelines established from the head of the outpatient program.

**Setting**

The Music Therapy room in which the sessions took place was located in another building on the psychiatric hospital grounds and included: a wide variety of musical instruments such as guitars, keyboards, a rap machine (a keyboard that one can make rap sounds and includes a microphone with voice distortion), drums, bells, xylophones, metalaphones, rhythm instruments, a flute, an assortment of approximately 500 cassette tapes, a dual cassette player, sheet music to many of the most popular tunes of the last 90 years, a variety of drawing and writing supplies, an assortment of chairs, a table, and an audio-tape recorder.

**Data Collection**

I gathered data in each individual Music Therapy session. Each session lasted approximately one hour and was recorded by an audio recorder placed in clear view on the table adjacent to the participant and me.

I generally had between five and seven sessions with each participant over a three month period. This number of sessions has been found to be useful in exploring other people’s experiences of various phenomena within a context of a one-on-one situation (Seidman, 1991). This time frame was compatible with the general time frame of the outpatient program, which was three to four months.
I began most initial sessions with a brief clinical interview that is common with Music Therapists, clinicians, psychiatrists, and psychoanalysts (Hyman, 1954; Tyson, 1981). My aim was to ascertain interactional styles, levels of comfort, goals, and information regarding their relationships to music. Two questions that I often asked during the initial session with each participant were “Do you listen to music?” and if so, “Tell me about the kind(s) of music you listen to.” I was interested in the meanings that music may have had in their lives so that perhaps these meanings could be explored and expanded upon in our Music Therapy sessions. Based upon their initial responses, I let other questions emerge naturally from the participant’s responses. These Music Therapy sessions did not differ dramatically from those which I would conduct without using a qualitative research design except in a few areas that are described in “Methodological Considerations.”

Qualitative data usually includes detailed descriptions of interactions as well as direct quotes from participants (Patton, 1980). I began to gather my data by writing Process Notes immediately after each session that briefly described the content and interactions of the session. Then, within a 48-hour time period, I listened to the audiotape of the sessions and logged the most pertinent portions from them into my Process Notes. In addition, I later made Transcriptions of entire sessions or of meaningful portions of sessions. I selected these meaningful portions by examining content that seemed to be emotionally relevant or powerful. For example, if participants related that they found something surprising or important, or if I felt emotionally moved or sensed their affect or feelings changing, I would especially scrutinize those portions. The use of the audiotapes was essential for this scrutinization. Ely et al. (1991) write: “...both audiotapes and videotapes allow for analysis through repeated studying, as well as
checking against log notes and transcripts about the same events” (p. 82). And finally, I wrote Analytic Memos about the entire process, which included my own thoughts and observations (as well as any questions that might have arisen). Ely et al. (1991) write:

Analytic memos can be thought of as conversations with oneself about what has occurred in the research process, what has been learned, the insights this provides, and the leads these suggest for future action. (p. 80)

These Process Notes, Transcripts, and Analytic Memos served as my initial data base.

Data Analysis

Throughout these sessions I analyzed this data base in an ongoing fashion—meaning that as the data was gathered, I analyzed and reanalyzed it continuously. Ely et al. (1991) state:

To analyze is to find some way or ways to tease out what we consider to be essential meaning in the raw data; to reduce and reorganize and combine so that the readers share the researcher’s findings in the most economical, interesting fashion. The product of analysis is a creation that speaks to the heart of what was learned. (p. 140)

This work was done in a recursive manner and included the following:

coding data with descriptive side labels
comparing these codings
categorizing these codings
organizing and ordering these categories
analyzing and interpreting the material into possible emerging trends
creating themes from these trends
establishing cross-case themes across data from all participants
As I gathered my data, I first made notations in the margins that succinctly described the content of each section. These sections varied from one or two sentences to entire paragraphs. Each section differed from another by content. Codings are devices used in order to make the bulky data become more manageable (refer to Appendix D). Codings are words or phrases that describe an entire unit of material, and thus can be more efficiently used in working with large chunks of data (Ely et al., 1991). I then compared my codings to find similarities and differences.

From these codings I formed categories (refer to Appendix E for a segment of coded log entry). These categories linked similar chunks of data and differentiated singular meaning-units. Examples of such categories are: suicidality, stigma, money concerns. The use of these categories builds the framework that can help deepen the understanding, organize the material and discover meanings that connect to other categories (Ely et al., 1991). After the data has been organized into categories, it can then be ordered. This entails placing categories into organized schemas that help link several units from many places within the data (refer to Appendix F for analysis of categories that were consistent within and across cases). This ordering is then analyzed for potential emerging trends. These trends were identified within each participant’s data and as well as from person to person. Often my analytic memos served as my vehicle for identifying these trends (refer to Appendix G). From these trends I created themes.

Themes can be a way to relate the data in a condensed manner that is more personal to others. Ely (1984) defines a theme as “...a statement of meaning that (1) runs through all or most of the pertinent data, or (2) one in the minority that carries heavy emotional or factual impact” (p. ). Sometimes themes can serve to
share an experience from a participant such as “Everyone Knows When You’re a Medicaid Patient,” or to illustrate a stance one might have “Believe Me When I Speak” (refer to Appendix H). From this, I found over-arching themes that I called “Cross-Case Themes.” These themes stretched from one participant to another, connecting each of them together.

I used all of the data as an instrument for self-awareness and examination, and was careful to examine each portion of the Process Notes, Transcripts, and Analytic Memos for potential insights into my interventions. This also helped me to shape possible areas for other interactions. In addition, I consulted other qualitative researchers in my recursive analysis in the belief that other eyes could help my own eyes see clearer and stronger.

Stance of the Researcher

In order to insure that this study is trustworthy, I first began by looking at my own thoughts that might unconsciously influence my work and approach. I examined my assumptions about music and therapy. This process is part of my “practicing reflexivity,” my intentional sharing of my assumptions that caused me to select this particular study (Guba, 1981). I agree with Aigen in that: “Who the researcher is as a person is as important—if not more so—as what the researcher does” (1993; p. 28).

Throughout my life I have used music to help myself in many ways. I have played instrumental music to express my feelings, I have sung to feel better, and I have listened to songs to understand myself more fully. Although I have been a performing musician since I was a young child, listening to songs has been my musical mainstay. Perhaps this is because songs permeate my daily
activities. Like many others, I listen to music throughout my days and evenings, I awaken to music, commute to work hearing music, and listen to music during my recreational times. The music I usually listen to is popular songs.

In observing and conversing with others, I find that I am not unique in this way. I have encountered only two people in my life who did not enjoy listening to music. When I meet someone, one of the first things I find out is what kind of music s/he listens to. It seems that by doing this I am privileged to learn meaningful things about that particular person very quickly. This kind of introduction is very personal and powerful. Their music, generally their songs, provides a window into their beings.

When others tell me about the music that they listen to, they often light up and speak excitedly. The awkwardness typical of many first conversations is gone. If that person is in pain with a physical illness, the pain seems to evaporate during our conversation. For persons with psychiatric illnesses, the bizarre mannerisms disappear for a few moments as we speak about their music. I learn not just about their tastes, but about past associations to their music and often I learn intimate details of their lives. Frequently they tell me that they are surprised they have told me so much. I feel privileged to enter into their lives so quickly and meaningfully.

As a Music Therapist I have found that focusing on each individual's favored music allows me to get acquainted with that person quickly and meaningfully. My work has always been centered on the individual. I could not implement a generic schema that entailed a prearranged procedure that did not allow for individuality.

For example, as a researcher I once encountered difficulties in completing quantitative research on Music Therapy groups. The specific statistical designs I
implemented did not allow for individualized ways in working with patients through their music. I worked with individuals having psychogenic polydipsia, a severe water-drinking disorder sometimes found in persons having long-term psychiatric hospitalizations. It seemed that because of our Music Therapy sessions, these particular patients could not only curtail their own drinking, but could also be educated and made aware about the dangers of their behaviors.

Despite my excitement at these two important phenomena, I was distressed in the Music Therapy sessions. Owing to the specific research designs, I was not able to alter agendas from session to session despite the needs of members in each Music Therapy group. I had to regulate the specific verbal reinforcements given in each session to be equal among members. I had to keep exact Music Therapy activities in a preset order for a certain period of time for each group. If one member wanted to improvise a musical composition or sing a favorite song, I could not allow that to happen. I felt as if I were limiting expression. I did not feel as if I were allowing the patients to communicate freely.

These feelings attracted me to qualitative research where I am free to get to know others on their own terms, in their own ways. I do not feel constricted by having to keep all variables “equal,” but am able to attempt to be “fair” instead. It seems to me that music is very individualized and cannot be regulated or dispersed in systematic ways while expecting communication to flow freely from it. My clinical beliefs are best suited to the realm of inquiry offered within a qualitative approach. I completed another qualitative study recently and found out why I enjoy this approach when one of my participants told me, “It’s therapeutic for me to do this study with you. It shows me I’m valuable. I’m productive. I count!” In this particular study, the approach of qualitative research
sets the stage for open, direct, and free communication between the participants and me.

This study involves people with psychiatric illnesses as well as histories of childhood sexual abuse. During my training and professional experience as a Music Therapist, I have had the opportunity to work with a variety of people with different types of illnesses and disorders: physical, visual and hearing impairments, mental retardation, substance and alcohol abuse, psychiatric illnesses, cerebral palsy, autism, head traumas, comas and strokes, cardiac emergencies, forensic (criminally insane), and other less well-known disorders. I have always been intrigued by psychiatric disorders. I have found them fascinating and the possibilities of their treatment inspiring. I am convinced that those with psychiatric illnesses have untapped potential. I have always primarily focused on this population in my readings, training, and work. It is very exciting for me to realize that patients with psychiatric illnesses can, in fact, make significant gains and, at times, recover completely. I have especially been drawn to those within this population who have also been sexually abused because it seems that this trauma often goes undetected, or even neglected, as part of their therapeutic process. And although I primarily worked in psychiatric hospitals and not in sexual abuse facilities, I found a great many of my patients suffered from these traumatic effects of having been abused as children in addition to having psychiatric disorders. Because I am associated with music, many of the individuals that I have worked with shared for the first time their histories of abuse with me. I felt privileged to have been included in their disclosing. In my clinical experience I have witnessed numerous difficulties that persons suffering from both psychiatric illnesses and histories of childhood sexual abuse have had within their verbal psychotherapies. Often I was the staff member that they
chose to share this information with for the first time. I have always felt privileged to be able to use music as a tool because I was afforded easy access to what would otherwise have seemed to be barred doors. For example, I remember one of my first patients, an eight-year-old-girl, whispering to me that she was "just like Luka." She was referring to the song ‘LUKA’ by Suzanne Vega which depicts a child who is being abused and does not want anyone to find out. From her initial whisperings, we began to talk about the song and later listened to it. She was then able to have other staff members listen to the song and shared her story of abuse and then began to receive help in recovering from it.

I feel especially intrigued when music is used in treatment with those having psychiatric illnesses and histories of trauma. Music can reach the “wellness” within and bypass the sickness while speaking to the “normality” of individuals. It is something that is part of many patients’ everyday lives and something that they seek out as being pleasurable and important. When I meet a patient and I am holding a guitar instead of a stethoscope, s/he becomes eager to see me and spend some time with me.

I find that patients often use music therapeutically in their own lives. This usage can be explored and strengthened in Music Therapy sessions, so that after the treatment ends, their own growth can continue. So often in therapy the assumption is that the patient has only problems without having answers. And in other instances, therapy sessions offer techniques that are not easily replicated in the home environment and therefore have a short-lived effect. This makes the patient unable to help him or herself and is thereby dependent on others for expertise. I believe that music is already present in many persons’ lives and is already used therapeutically. My goal is to help patients use this type of personal healing more successfully.
The therapeutic interventions I employed with each of the six participants in this study can be defined as “humanistically oriented music psychotherapy” (Hesser, personal communication, October, 1994), and are congruent with a “person-centered”, originally named “client-centered”, approach. This approach is most often attributed to Rogers, a psychologist, who described the three conditions that are needed for this type of approach: congruence, unconditional positive regard, and empathic understanding (Rogers, 1980). Congruence speaks to the need of the therapist to be authentic and genuine in interactions with the patient. I feel that a musical relationship by its very nature (cooperatively creating, listening to, discussing, and analyzing music) creates a mutuality that is intrinsically genuine and authentic. Unconditional positive regard means that the therapist accepts the patient within his/her dimensions in a caring way. Again, music provides me with the opportunity to be more open and accepting by broadening my experience of a particular individual.

Empathic understanding, being empathetic rather than sympathetic with the other person, is the essential element. Empathy is defined as “the ability to share in another’s emotions or feelings” (Guralink, 1984), and Rogers (1980) describes the process of empathic understanding this way:

It means entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive, moment by moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion or whatever that he or she is experiencing. It means temporarily living in the other’s life, moving about in it delicately without making judgments; it means sensing meanings of which he or she is scarcely aware, but not trying to uncover totally unconscious feelings, since this would be too threatening (p. 142).

Hesser adds, “Empathy is a very important quality for a relationship and of the therapist’s abilities in the healing process, and the respect for the client as the total basis for the therapeutic interventions and rhythm (p. 12).
My clinical approach is that regardless of my patients’ situations, be they murderers, pedophiles, or persons struggling with serious psychiatric illnesses, they deserve my respect. I value them as individuals who each have something important to give. I also feel that within each person there is a “good” core that may not have been given an opportunity to be felt or expressed and subsequently was expressed in twisted or “bad” actions (Madsen & Madsen, 1981, p. 19). I have found throughout my life that when music was involved, the “good”, or healthy, parts of people could often shine through.

One of my basic tenets is to use the music of the patient as the foundation for our work together. This idea drew me toward the Music Therapy community at New York University from my home in Texas. This community is comprised of Music Therapists who believe, practice, and base their work on the premise that each person is a unique individual who will react with music differently and should be worked with accordingly. This community is quite different from other Music Therapy communities that I have known. For example, another community believed that music served as a sound stimulus which should be used as a reinforcer to manipulate behaviors deemed “appropriate” by groups of people. In my community in New York I have learned how to help others decide what they feel is “appropriate” for themselves—to set their own goals in therapy—and I have also grown in allowing each person to tap into his/her own music for reaching his/her own potentials.

Establishing Trustworthiness

In order to help secure the integrity of this study, I was involved in two support groups with other doctoral candidates throughout the research process.
In these groups I distributed portions of the data to gain alternative perspectives on both the data and my analysis. One support group consisted of Music Therapists, and the other of students who have completed earlier qualitative coursework as well as qualitative research. Both of these groups were comprised of doctoral students currently engaged in their own qualitative research. Guba (1990) describes a support group as a group in which

...the role of the teacher is assumed by everyone in the group and by the group as a whole. We help each other listen to the language of our interview. We read each other’s field notes. We help each other choose what we can or must study. (p. 132)

I was involved with these groups for a three-year period that began in the planning stages of the study and continued through the actual data collection, and the years of analysis and writing. We met regularly and read each others’ work in detail, and all contributed to the components of analysis--coding, categorizing, searching for themes, as well as helping each other with the writing itself. These groups served the dual purpose of peer debriefing (in part, to help me identify my biases), as well as to offer insight, support, and knowledge (Ely et al., 1991). Peer debriefing consists of making explicit what might be implicit in one’s mind by sharing one’s thoughts in detail with someone else. This process is very similar to the supervision sessions a therapist has in order to see clearly (supervision!), to maintain “good judgment” (Lincoln & Guba, 1985, p. 308). By doing so the researcher can become more aware of his or her biases. This awareness is crucial to meaningful analysis, for without the awareness of one’s bias, one cannot “control” it (Shaunnessey & Zechmeister, 1985).

The issue of biases is an important one when doing qualitative research. Shaunnessey and Zechmeister (1985) describe the problem of observer bias that researchers found in studying psychiatric illnesses:
Once patients were labeled schizophrenic, their behavior was interpreted solely in light of this label. Behaviors that might have been considered normal when performed by sane individuals were interpreted by the staff as evidence of the patients' insanity. (p. 65)

By sharing and reviewing my data with other researchers from non-psychiatric fields, I found fresh and valuable perspectives on several issues that helped me scrutinize my own biases. Watson & Watson-Franke write (1985), "The would-be interpreter can never fully eliminate his (sic) own biases even if he (sic) is aware of and reflective about some of his own starting points..." (p. 22). Music Therapist and qualitative researcher Aigen (1993) writes that the reason for studying one's own biases is to "...become more aware of them to mitigate their hidden influence" (p. 37). Aigen adds,

"...we can strive to attain a greater awareness of these reactions [biases] so that they do not unconsciously affect our perceptions of a client and thus influence the therapeutic process in a hidden and potentially destructive manner; rather they are essential components, tools to be used..."(1993, p. 29)

With the keen eye of a support group, a bias that causes disruption to the natural flow of events can be remediated. For example, my support groups helped me to see areas that I was not able to see that had to do with my combined role as therapist and researcher. I seemed to take for granted my therapeutic interactions, and would place most of the positive progress that the participants made on the power of the music and did not reflect enough on my own role as an integral part of their growth. My support groups prodded me to look for and write about my interventions, thoughts, and feelings with the participants, and this enabled me to analyze at a much deeper level the data from this study. This study shifted in large part from a "reporting-the-effects-of-music" study to an "exploration-of-communication" study because of the feedback from my support groups. I found that my role as therapist was deepened by also being a researcher, and I write
about that in the section entitled "Methodological Considerations." Other examples of my biases that I explored are illustrated in the Discussion section.

"Member-checking" entails testing conclusions from the data with the members in order to check its credibility (Lincoln & Guba, 1985). I had originally hoped to do formal member-checking which would consist of discussing actual portions of the transcripts with the participants and asking what they thought of certain ideas I had concerning the process and interactions. Some difficulties however arose. For example, a person suffering from paranoid schizophrenia may be extremely uncomfortable and may become quite agitated seeing or hearing portions of previous sessions. I found that due to similar paranoid symptoms my participants were actively experiencing, this formal member-checking would not have been a "constructive event" and could have been counter-therapeutic (Ely et al., 1991), and therefore I did not employ this formalized strategy. Instead, as part of the regular therapeutic process, I completed "informal" member-checking when I asked for clarification or offered my perceptions during our sessions in gentler verbal ways (Lincoln & Guba, 1985, p. 314). For example, I would often ask the participants "What I think I’m hearing you say is..., is that what you are indeed saying?" when I was summarizing or restating something. Other times I would offer an interpretation, such as "It seems to me that as you were playing this music you were feeling...is that true for you?"

In addition I also relied heavily on the insights of both support groups in aiding me in the interpretation of the data. Lincoln and Guba (1985) state that this use of peer debriefing is essential in helping make the research credible.
This process of including others in all aspects of the study can help develop credibility within the qualitative design. Ely et al. (1991) write that

Being trustworthy as a qualitative researcher means at the least that the processes of the research are carried out fairly, that the products represent as closely as possible the experiences of the people who are studied. The entire endeavor must be grounded in ethical principles about how data are collected and analyzed, how one's own assumptions and conclusions are checked, how participants are involved, and how results are communicated. (p. 93)

These strategies for ensuring trustworthiness were incorporated throughout this study in order to make it both believable and useful (Ely et al., 1991). I found that these vehicles helped me to examine the “truth value (credibility), applicability (transferability), consistency (dependability), and neutrality (confirmability)” that are the major concerns in the quest for trustworthiness (Guba, 1981).

**Data Presentation**

Originally I organized the most relevant portions of the data into “Stories” and “Songs”. Each participant had two sections, one that spoke of how s/he used songs in the sessions, and one that described what information s/he shared about him/herself. From these two large bins for each person, I then extrapolated and consolidated only the most pertinent aspects of their songs and stories into the next three chapters.

I am employing the use of a story, or narrative, to describe how the participants and I used songs in our Music Therapy sessions. The particular narrative style I use incorporates a device referred to as “layering” (Ely et al., 1991). Layering conveys the findings in a succinct way, allowing my voice and the participants’ voices to be heard. This style incorporates the actual words of the
participants, taken from all of our sessions, and my own words, thus interweaving our shared experiences.

Within this layering, I have "sculpted" the participants' words (Margot Ely, Personal Communication, September 1994). This consisted of pulling portions of their quotes from different sessions and joining them together in order to illustrate a singular thought or event. Some of the participants spoke in very brief phrases and returned to similar thoughts many times throughout the sessions; therefore, sculpting offers the reader a more detailed and complete portrait of each individual. I hope these devices of layering and sculpting will tell the story of how songs formed the basis of communication in our Music Therapy sessions.

The next three chapters describe in-depth the process of the Music Therapy experience for both myself as well as the participants. Chapter IV consists of illustrating how songs were used in the therapeutic relationship. Chapter V includes two primary themes of illness that the participants each shared with me. And, Chapter IV describes specific insights and reflections that each person had during the course of Music Therapy treatment.
CHAPTER IV
PARTICIPANTS AND THEIR SONGS

Introduction

As I asked my initial question about what kinds of music the participants enjoyed, several things happened almost simultaneously. The participants generally appeared excited or animated as they talked about their favorite musical artists or songs. They began to have more relaxed body postures and their words seemed to flow more easily from their lips. They often included me in their conversation directly by asking me if I was familiar with their music. I usually was familiar with their music for two reasons. The first is that I feel it is essential that I am familiar with a broad base of music so that I can “speak the language” with many different people. For 20 years I have been collecting tapes from people in an effort to learn music from Abba to Zeppelin. Hannett (1964) wrote of the usefulness of the therapist being familiar with her patients’ music so that “the therapist used the words of the songs (the patient was singing or humming) to understand what the patient was not saying directly... fortunately, the therapist was familiar with popular songs and knew their lyrics” (p. 235). I try to learn all different types of music and often find that I end up liking much of it in the process. The second reason that I knew much of the music that the participants presented to me was that many of their songs were my own favorites as well. This was perhaps due to the similarity in our ages. I found that as a Music Therapist I was allowed access into the participants’ thoughts and experiences.
quite easily and without much of the awkwardness often felt in verbal therapy sessions.

The participants’ musical introductions often served to connect us in a positive way—the recalling of pleasurable times and feelings. From this point the participants’ conversation sometimes drifted to how they came to know their favorite music. I would learn about what their lives were about and how they were feeling when they played or heard this music. I was privileged to learn a tremendous amount of extremely personal and relevant material via their sharing their musical preferences with me. Priestley (1994) found that taking a “musical history” was a “fruitful line of enquiry” for the Music Therapist (p. 23), and Tyson wrote that by using a “music-centered interview” the therapist could “elicit information of a nonmusical nature” (1965, p. 7). Instead of taking a dry “psychosocial history” as most mental health professionals do, I was given a rich biography. For example, instead of asking “do you have any siblings?” I was freely told contextually and in-depth through the music the family listened to about their siblings who abused, defended, and betrayed the participants.

This rich information the patients offered me included many areas of their lives, in particular the problematic ones. I think this was due to the fact that music is often present in so many aspects of peoples’ lives. For example, one participant, Sally, described how she listened to music. Sally couldn’t ask that her preferred radio station be left on when another person walked into the room and changed the station. From this I was able to learn not only about Sally’s musical interests, but also her level of assertiveness. Another participant, Diane, said that she knew she was able to listen to certain types of music and how they would make her feel and when she could not emotionally tolerate other types of music because she would be too fragile. She would then regulate her music
listening in order to manage her moods effectively. This glimpse at Diane’s musical choices afforded me a view of her coping strategies. A third participant, Jack, shared the difficulties he and his intimate partner had because of their different musical tastes and how the problems in their relationship were reflected and manifested by the ways in which they dealt with their musical differences. This was his way of introducing me to his primary area of concern, his relationship and the difficulty he was having being happy in it. Each participant thus shared with me through their music the problematic portions of their lives for which they sought clearer understandings of.

During our Music Therapy sessions, music served another important function. This was to link us through collaborative experiences. We would play, share, sing, analyze, and improvise music together. Through these joint ventures we grew to know and trust each other. Perhaps this was due to the mutual feelings of taking risks together by singing and/or playing together. Or perhaps it was because the focus was taken off ourselves and placed onto the music. I was not seen as some cold, distant mental health professional in a white coat and they were not seen as helpless, sick patients. Instead we were experiencing each other more as allies or comrades. Priestley (1975) writes that there exists a “…lively, emotional reciprocity between therapist and client in music that carries over into words” in Music Therapy sessions (p. 6).

The participants spontaneously requested or sang the songs used in their sessions, which they continued to listen to, play, sing, and create with me throughout our therapy. Improvisatory pieces were also referred to as “songs” by the participants. These songs enabled the participants to communicate with me. Although the songs had common uses among the participants, each participant had a primary use for his/her songs in our Music Therapy sessions that was
unique. Bess used songs to access her memories; Diane used songs to validate and confirm her difficult life events; Jack used songs to identify his feelings; Matt used songs to tell his story; Sally used songs to gain confidence; and Tom used songs to make contact, or connect, with me.

Several of their songs that seemed integral to their life, therapy sessions, and our relationship will be discussed in this chapter. I will also include important lyrics that they sang and some of the lyrics that came up in the music that we played instrumentally, because I believe that the melody alone can bring up the lyrical content which can in turn revive past associations and feelings. I also think, as Bonny (1984) does, of the need to include the textual part of the music: it is an important part of the total research data because it is an integral part of the analysis.

Within this section, I will first introduce the reader to the participants in my voice. I will include excerpts from each participant’s first Music Therapy sessions as well as relevant portions often in the form of quotations woven in from later sessions. The purpose of this is to describe each person to the reader from my vantage point. Immediately following, I will highlight other aspects of sessions to illustrate various uses of songs that enhanced communication between the participants and myself, using both the participants’ voices as well as my own.
Bess

I am walking up the stairs to my office at 3:50 in the afternoon, hurrying to get the tape recorder set up for my first session with Bess. Before reaching the top of the stairs, I hear a voice exclaim, “I got here 20 minutes early, and I heard you coming up the stairs.” At the top of the stairs, I turn in surprise toward my opened office door where Bess is standing, talking to me.

After I ask how she knew it was me, Bess replies, “By the sound of your footsteps.” I find this remarkable. Many people tread up and down these stairs throughout the day, and surely I’m not the first to have climbed them during Bess’s wait.

Inside the office, Bess plants herself heavily at the table with a loud “Ahhhhh.” She looks hot, in a closed-in, unventilated way. She’s wearing a yellow polyester pants suit and flat, plastic sandals. She carries her lunch, a loaf of bread, a jar of peanut butter, in a plastic bag. Her eyes stare out from behind fogged-up, blue-rimmed plastic glasses. Her black-and-gray hair is moist at the roots and curls up around her neck and collar. Her face, normally pale, looks flushed, as if she were wearing makeup.

As she and I begin talking about the study, Bess smiles often and laughs quick, nervous laughs. She speaks in a hurried voice that is clear and well enunciated. She tells me she didn’t bring her guitar since it was too hot to carry it and she didn’t have bus fare. She’ll bring it another day. I tell her that’s fine: she’s welcome to use one of the guitars in the office, if she would like. Bess looks directly at me with long, piercing stares, interrupted only by glances at the clock.

I ask Bess to tell me what kind of music she likes and she opens up:
I used to like to play guitar and listen to folk music: Joni Mitchell, Buffy Saint-Marie, Carole King, Judy Collins and Joan Baez. That was before I would be feeling so badly though. I don't know why I quit playing guitar. I just feel uncomfortable. If I think about, I don't want anybody to hear me playing the guitar. I used to be able to play the guitar very well. And I think when I started feeling especially uncomfortable was when I first got hospitalized and I was convinced that my hands would shake too much to play. And I didn't want to play it terrible after I've been able to play it very well before. But the truth is that these tremors don't interfere with my playing. Actually, the more relaxed I am, the less tremors I have, even though the tremors are not caused by nervousness. When I play guitar, the hand shaking actually stops!

But of course, my playing still isn't as good as it used to be because I haven't practiced. Also, I lost all of my music. Like, I used to play classical so I didn't commit all my music to memory, so I don't have any of it left. I have my folk music though so I can still play that and that's actually more practical to go back to folk music, because at my age, I'll be 42 soon, you can't suddenly become a Classical guitarist, it's considered a little too late.

Bess and I speak about the differences in playing classical and folk music on guitar. Bess speaks about losing almost all of her music books and tapes during one of her hospitalizations when she was “feeling badly”. I ask Bess to tell me about her feeling badly, and she proceeds to tell me the many diagnoses that have been applied:

Well, my diagnosis right now is, ummm, psych, no, schizo-affective disorder. Well, of course I've had other diagnoses because every time you go to the hospital you get one, and of course years ago this one wasn't a popular diagnosis at all. Well, I've been hospitalized since I was 21 years old. 20 years ago they didn't even have that diagnosis, I don't think. So I've had a schizophrenia diagnosis, a manic-depressive disorder, and a lot of other ones. Also it depends on what you're doing at that particular time. That's what the doctor explained to me. How you're doing at that particular time your illness could look like something else.

I don't usually tell people my whole diagnoses because it gives some people a bad rap, but I also have a passive-aggressive personality disorder. I know a lot of people who have other personality disorders, like borderline personality disorder, and they drive me crazy. Maybe that's because I have some traits in me.

Bess recalls previous jobs she had held as a nurses’ aide but was fired from because her supervisors felt she was too forgetful to administer medications to clients. Bess attributes her forgetfulness to having had ECT.
Unfortunately, after I was in the hospital so many times I forgot lots of things. Like how to use the computer. I used to use it a lot. I did a lot of different things before I had to be hospitalized so much. I was going to graduate school for a degree of Special Education of the Mentally Retarded, teaching guitar at night school, and substitute teaching during the day. That was before I had all these problems and needed so many medications.

Bess and I have eight sessions together in which she continues to focus on her previous life experiences.

**Songs for Accessing Memories**

Bess played guitar and sang folk songs in our sessions. She would generally play and sing just the beginning phrase of each song and then talk about what the song reminded her of. Bess used music to recall her difficult memories and to communicate her current struggles. After recalling a particular song and singing part of it, Bess talked about related painful events and often came to a deeper understanding of the significance these events had, and continue to have, in her life. Bess’s songs also helped her delve into traumatic issues such as her childhood abuse. When she spoke without a song as a point of departure, she generally focused on seemingly insignificant or trivial issues. At these times, she would giggle nervously and flit from subject to subject without any direction in conversation. However, when she would select and start a song, she immediately began to speak about issues that she stated were pressing and bothersome to her and that she wanted to clarify with me in our sessions. Starting with a song helped her access her memories and focus her emotional expression.

Bess’s songs were mainly from the folk genre and were often written and performed by female musicians. She had played guitar for many years, but had
difficulty playing more than three or four chords or beginning phrases to various songs during her initial Music Therapy sessions. Bess stated that she wanted to regain her former level of playing, which would enable her to complete an entire song without tiring or losing her concentration and needing to stop. By our last session she was able to do this successfully.

Bess sang and played almost a dozen songs throughout her sessions, speaking at great length about various topics after each playing and singing a portion of each song. Generally each song sparked comments from her that would occupy the majority of the session. The song portions quoted are the exact portions that Bess sang. Some of the songs she brought music for, other songs she remembered without any music. The songs of Bess’s that are included in this study do not comprise all of the songs that she sang, but they are the songs that seemed especially meaningful. They are presented as they arose chronologically during treatment and are given subheadings of: Childhood, Young Adulthood, Family/Abuse, Psychiatric Illness, Intimate Relationships, Symptoms, and Recognition and Growth.

Childhood

Bess’s first song brought her back to her childhood. All of the songs that she played on guitar and sang were her selections. I found it significant that without being asked about her early memories, as is the practice in many first therapy sessions, she spontaneously shared her early recollections with me in her initial session. Bess began her music by asking me if I had heard of the
songwriter Buffy Saint Marie, showed me the book of songs she had brought with her by this artist, and sang and played part of some of her songs. Bess played in a simple, folksy style, strumming a simple and an even strum on each chord. Most of her songs had uncomplicated chord progressions and she was able to play and sing without halting the tempo to change chords. Bess’s voice was clear and moderate, not strong nor soft. When she played she looked at either her music book or her hand playing the guitar chords.

‘PINEY WOOD HILLS’ (Buffy Saint Marie)

‘I’M A RAMBLER AND A ROVER AND A WAND’RER IT SEEMS
I’VE TRAVELED ALL OVER CHASING AFTER MY DREAMS
BUT A DREAM SHOULD COME TRUE AND A HEART SHOULD BE FILLED
AND A LIFE SHOULD BE LIVED ON THE PINEY WOOD HILLS

FROM OCEAN TO OCEAN I’VE RAMBLED AND ROAMED
AND NOW I’LL RETURN TO MY PINEY WOOD HOME
MAYBE SOMEDAY I’LL FIND SOMEONE WHO WILL
LOVE AS I LOVE MY PINEY WOOD HILLS

Bess told me about her childhood camp experiences and how she felt the happiest she had ever been during these times. I found it interesting that when I asked Bess, “Why did you pick this song to play?” she replied, “No reason, I just remembered it. Of course, it’s not about me. After all, I’m from the city, not the Piney Wood Hills.” But then Bess immediately began to tell me about herself and her life as a child and adolescent. She summarized her feeling about the song this way:

It reminds me of going to camp as a child and how much better I got along with people there than when I lived at home with my parents. I used to go back and visit the abandoned campsite later when I lived nearby in a commune.
Young Adulthood

As Bess continued playing and singing she shared with me this next song and spoke about her psychiatric illness in detail for the first time. She felt a great sadness about the incongruence between her employment aspirations and her impaired abilities due to her psychiatric symptoms. It seemed significant that the song which initially informed me about her illness was about working. Currently she felt bad about having lost her abilities to work.

MEN OF THE FIELDS (Buffy Saint-Marie)

MEN OF THE HILLS, MEN OF THE VALLEY
MEN OF THE SEASON AND THE SOIL
STRONG HEARTS AND HANDS WORKING THE LAND
ALL OVER EARTH THEY TOIL

DOWN IN THE FIELDS, NINE IN THE MORNING
DAY’S WORK THREE HOURS DONE
CARE FOR THE COWS, CARE FOR THE CORN
CARE FOR THE LAND WE NEED

This song reminded Bess of her times as a young adult living in a religious, vegetarian-farming commune. Bess told me that she was not sure why she remembered this particular song, but that it was in her head as our session began and she wanted to play it. After starting the opening stanza, Bess spoke at great length about various treatments and medications that she had been given in the hope of curing or minimizing her mental illness. All attempts failed with the exception of psychopharmacological interventions, which seemed to help decrease her psychotic thinking for relatively long periods of time. Bess had been sent to live in this commune by her family against her wishes in the hopes that Bess would “be cured” of her psychiatric illness.

I was taken off my medications and I was the only person there with psychiatric problems. They thought they could cure me. Eventually I was asked to leave because I kept doing bizarre things like ruining their food
supply by poking holes in their large bags of grain that they had grown
and opening up their bottled goods after the canning process had been
completed. My family was embarrassed.

As Bess continued to talk about this song and the thoughts it inspired, she
began to speak about how she needed to live her life now and deal with it as it
was, instead of awaiting a magical cure for her mental illness. Bess seemed to be
coming to this realization for the first time and seemed accepting, not despondent,
in the face of it.

Family-Abuse

Soon Bess began to delve deeper into her personal life and to speak about
her family and her history of abuse. The following song served as the stimulus for
painful memories and feelings related to growing up in her home, where her
mother physically and sexually abused her while her father turned his head away.
Bess asked me if I knew this next song. I did, and she asked me to play it with
her while she sang. We played this song from her music and I saw that the
directions from the songwriter were to play it "lyrically, nostalgic" and felt that
Bess did just that. The melody was in a lilting, almost lullaby style that Bess
picked an accompaniment to in a soft and gentle manner. She sang only the first
part to the song and then calmly spoke at length about what the song made her
remember.

‘MY FATHER’ (Judy Collins)

MY FATHER ALWAYS PROMISED US THAT WE COULD LIVE IN FRANCE
WE’D GO BOATING ON THE SEINE, AND I WOULD LEARN TO DANCE
WE LIVED IN OHIO THEN, HE WORKED IN THE MINE
ON HIS DREAMS LIKE BOATS WE KEW, WE SAILED IN TIME

69
I think I was probably sexually abused. I once told a therapist about it in 1977 or 1978 and he knew my parents (they paid for my therapy) and told me it couldn’t possibly have happened because they “were very nice people” and gave me more medication, Haldol. Then in 1989 I spoke once again about my sexual abuse with another therapist, this one I paid for out of my own funds. I got a very different reaction, but I was soon hospitalized and then no one asked me about my sexual abuse. Maybe because I was so psychotic and was only talking about my magical powers then.

And then there was this sexual thing. My mother must have known it wasn’t right. I could never bring it up with her, but maybe that’s why she feels guilty that I have a mental illness. She must have known it happened and that is wasn’t right because she’s the one who did it so she must have known she did it. I was angry but I could never bring it up with her. It happened when I was around five and went on for a long time on a regular basis. My brother was there for some of the incidents too and he would be crying and screaming. I talked to him about it once. He says I should just forget about it and that it wasn’t important and why was I making such a big deal about it. He says the childhood things are all over and done with and why should I be worrying about that now. It’s not nothing, but it’s not the end of the world, it’s not a big tragedy, but it’s not good. It was definitely not right and I remember crying and screaming, and that can’t be right.

This is going to sound weird, but later we got a dog and a cat, and she did it to them too. I was very upset and I took them to the veterinarian when I was in my 20’s to be checked over. He got really mad at me when I told him and said, “Your mother is a very nice woman and she wouldn’t do that. He gave them back to my mother and she was really angry. She said I had no right to take the dog and cat.

My mother would also hit us. She would use belts and brushes. Sometimes she would hit my head and then my head would fly back against the wall. I wish my father would have taken us away like in the song.

I still don’t think that all of this could cause a person to have a mental illness, that is my opinion. I think it is biological. Of course, I don’t think it is helpful to have your head hit against a wall. My mother goes around saying that she must have been a terrible mother, but she can’t deal with it. Like if I say to her “I used to feel...” she says “You didn’t feel that way.” She could never admit that certain things happened, but in the back of her mind she must know that they did and that’s why she keeps going around saying that she was a terrible mother.

At least I don’t think that these things cause a psychotic illness. Well, I don’t really know about my brother though to tell you the truth, he is also ill. Anyway, maybe there are other people that worse things could have happened to that don’t have a psychotic illness. I had a lot of psychotherapy, but stuff like this sexual thing never came up.
Bess spoke about not believing that her history of sexual abuse caused her psychiatric illness, but she seemed to think it contributed to her difficulties in life. I was glad that she had invited me to play with her and felt that she was inviting me to share her difficult past experiences through the music. Bess commented that she was surprised that she was speaking about these things because she thought she had forgotten them.

Psychiatric Illness

Each participant spoke at least once during their sessions about feeling “different” from other people because they have a mental illness. Bess had much to say about her feelings of being stigmatized and the next song seemed to inspire her to discuss these thoughts and feelings. She prefaced this song with saying she wanted to play one of her favorite songs for me, ‘DESPERADO’.

Bess did not invite me to sing and play with her in this song, so I did not; as I listened to the lyrics, I felt that she seemed alone and alienated. As she slowly and quietly played and sang, I realized she simplified the chords of the song and omitted any chords that were not simple minor or major or seventh chords. For example, she left out G9, cm6, Gsus and all of the chords that had a suggested inversion in the bass, Bess played without the inversion. I wondered if her life seemed complicated to her and she therefore worked on simplifying it to whatever extent she could while still living it, or musically, by still playing. She did what she could manage to do in order to still keep on going.

DESPERADO (Eagles)
DESPERADO, WHY DON'T YOU COME TO YOUR SENSES
YOU BEEN OUT RIDING FENCES FOR SO LONG NOW
OH YOU'RE A HARD ONE BUT I KNOW THAT YOU GOT YOUR
REASONS
THESE THINGS THAT ARE PLEASIN' YOU WILL HURT YOU
SOMEHOW

DESPERADO, YOU KNOW YOU AIN'T GETTIN' YOUNGER
YOUR PAIN AND YOUR HUNGER THEY'RE DRIVING YOU HOME
AND FREEDOM, OH FREEDOM, THAT'S JUST SOME PEOPLE
TALKIN'
YOUR PRISON IS WALKING THROUGH THIS WORLD ALL
ALONE

The title seemed particularly appropriate to her quest to develop relationships
again after having sworn off them for some time, as she shared through later
songs. This song helped Bess recall her feelings of alienation caused by her
psychiatric illness. After singing and playing the song she recounted a recent
incident that illustrated her perception of being “different” from others.

The residents of our halfway house went bowling the other day and I
really like bowling, but the counselor stood at the place where everyone
gets their shoes and gave the guy a form in front of everybody. It was a tax
exempt form from the Mental Health Association. This was so stupid.
Everyone automatically knew that there is something wrong with us,
otherwise we wouldn’t be tax exempt, or we’re nuns and I don’t think any
of us looked like we were nuns! Then the counselor passed out $1.75 to
each of us for snacks, which I thought was really ridiculous. I’d rather use
my own money than have it passed out to me like that. I told the counselor
later how I felt about the tax exempt form and she said “Oh, if I didn’t use
the tax exempt form I would have to pay out of my own pocket.” You can
imagine how much tax would be on $3 or $4 dollars!

It seemed that Bess’s association to this song reflected the song’s theme of
isolation. Bess often focused on her feelings of wanting to be like other people
who did not have psychiatric illnesses. She especially wanted to be in an intimate
relationship with someone out of the mental health field, but could not find
anyone.
Intimate Relationships

Bess had always selected intimate partners who also had psychiatric illnesses and was trying to understand the ramifications of her choices. She drew parallels between her former marriage and its difficulties and her problematic last relationship, and she expressed a desire to meet people outside of the mental health system. Bess asked if I wanted to hear the song they sang at her wedding and she sang it for me:

‘WEDDING SONG’ (Paul Stokey)

HE IS NOW TO BE AMONG YOU AT THE CALLING OF YOUR HEARTS
REST ASSURED THIS TROUBADOUR IS ACTING ON HIS PART THEN WHAT’S TO BE THE REASON FOR BECOMING MAN AND WIFE
IS IT LOVE THAT BRINGS YOU HERE OR LOVE THAT BRINGS YOU LIFE

Bess sang this song acapella and left her guitar untouched by her side. It was the only song that she sang without accompaniment, and this seemed to reflect her feeling of alone-ness, being without her husband or a partner. It was also significant that the words she sang were from the introduction and then the bridge of the song. Bess left out the inner parts of the song that speak of the union between and man and wife and leaving their respective homes. Instead she finished her song with a question left hanging in the air. I was curious about these thoughts and asked Bess what the song made her think of.

This song reminds me of when I was married. We were married by a Justice of the Peace and my brother took us out for hot dogs afterwards. My mother was against the marriage not because he was black and I was white, but because he had a mental illness. Six months after the wedding she gave us a reception, but she only let us invite one friend each. All of
the other guests were my mother's friends. Also, the food was of Jewish origin despite my requests to serve foods more familiar to my husband and his family. Luckily the cleaning woman brought fried chicken which my husband's family enjoyed eating.

Many people wish to have families, but for Bess this aspiration now seemed impossible. During her marriage Bess had realized that she would never have her own children and attributed this in large part to her own psychiatric illness. She said it reminded her of a song and she asked me to join her in playing and singing:

TEACH YOUR CHILDREN WELL (Crosby, Stills and Nash)

TEACH YOUR CHILDREN WELL
THEIR FATHER'S HELL DID SLOWLY GO BY
AND FEED THEM ON YOUR DREAMS
THE ONE THEY PICK'S THE ONE YOU'LL KNOW BY

AND DON'T EVER ASK THEM WHY
IF THEY TELL YOU YOU'LL JUST CRY
SO JUST LOOK AT THEM AND SIGH
AND KNOW THEY LOVE YOU

Bess sang only the chorus to this song and played it in a lively, upbeat tempo and sang strongly. She strummed in a resolute manner and seemed quite confident of herself and her playing. Bess said that for the first time she fully realized through this song that she absolutely did not want to have a partner who was unable to take care of his responsibilities and that she herself did not want to treat children as she was treated by her own mother.

My husband had two children, 8 and 10 years old, who came to live with us in our studio apartment. They were too much for someone who's never been a mother before. My husband didn't make any plans for them. Things like finding out where their mother was going to be and when she would be back. I wanted to know their doctors and where they were registered for school because if they stayed long enough after summer ended they would have to go to school. They just couldn't play Pac Man all day long and that was the only game I could think of. I wanted to take care of them properly and not get angry and frustrated at them like my mother did.
Their own mother never returned and I couldn’t take it anymore and I moved out after a couple of months. My husband’s mother took care of the kids from then on. She raised them.

It seemed that the lyrics in this song “their father’s hell” were portrayed in Bess’s description of his mental illness getting in the way of his being able to take care of his children adequately.

Recognition and Growth

During the next portion of our sessions, Bess was experiencing paranoid symptoms. Through music she shared with me her paranoid feelings so that I was able to “read her mind” (refer to Chapter VI). After this portion of our sessions where we focused on her symptoms, Bess sang a song, “Suzanne,” which seemed to mark a turning point for her, after which she was able to be more at peace with her view of herself and her reasonable hopes. Bess introduced this song by telling me that she knew how to do the picking pattern that comprised the harmonic content of the song and showed it to me. She played the arpeggiated pattern smoothly and quietly as she sang while I listened and watched. This pattern included two parts-- the lower part was comprised of a descending bass: C-B-A-G-F♯-E-D, and the upper part interspersed high G notes after each bass note. It was a nice balance of musical elements because the melody was then usually a fifth above the repeated G and held its own by most of the lyrics being sung on the note D.

Suzanne (Leonard Cohen)

Suzanne Takes You Down to Her Place By the River
You Can Hear the Boats Go By, You Can Spend the Night Forever
And You Know That She’s Half Crazy, And That’s Why You Want to Be There
And She Feeds You Tea and Oranges That Came All the Way from China
AND JUST WHEN YOU WANT TO TELL HER THAT YOU HAVE NO LOVE TO GIVE HER SHE GETS YOU ON HER WAVELENGTH AND SHE LETS THE RIVER ANSWER THAT YOU'VE ALWAYS BEEN HER LOVER

Bess played and sang the lyrics to this song alone and seemed to feel a sense that she was finally coming into her own. It seemed significant that the words "half crazy" were in this song. Perhaps Bess felt she was also half "normal" and continued in her desire for a lover. I was struck by the confidence she seemed to exude during this song. Bess was proud of her musical accomplishment in being able to play and sing this complex song. It paralleled the self satisfaction she felt about improving her living situation by being ready to live more independently. She was able to feel great pride in her move from the halfway house into a supervised apartment with roommates. When people interviewed her for the relocation process, she was able to discern which questions and statements were inappropriate.

Soon I get to move to a supportive apartment. They say I don't need much help anymore from the staff. I'll be glad when I move. I don't want to keep having other people's problems all the time because I already have my own problems.

It was strange when I was interviewing for this new housing situation. It was my former boss that I used to work for at a group home that interviewed me and all of the sudden she said "Have you got any boyfriends, because that's what you really need, that would really help you a lot." I was really shocked that she said that. I said to myself "she's getting a little senile because it is not appropriate for her to tell me that in this interview." That was my opinion, but I didn't tell her that of course and I said "Oh, that's a really good idea I hadn't thought of before, maybe I'll look into that."

Bess was able to express optimism and hope for new, healthier relationships through the following song, 'LOVE IS A ROSE'. She wanted to find friends who were not seriously afflicted with psychiatric illnesses. Bess
spoke about her desire to stay an outpatient even though it meant not being sheltered from the cruelties and injustices of others (doctors, counselors, pharmacies) due to her mental illness. It seemed that she felt solid about where she was and what she wanted, and that although she was frustrated, she did not feel hopeless.

Bess sang and played the chorus to the next song three times in a row. I had already put my guitar down and did not want to disturb her flow, so I watched instead of joining in playing and just sang along instead. Bess sang the song in a “bright country beat” as the music directed. The song was a simple one in the key of C and had only three chords: C, F, and G and had a light-hearted, easy melody.

LOVE IS A ROSE (Neil Young)

LOVE IS A ROSE BUT YOU BETTER NOT PICK IT
ONLY GROWS WHEN IT’S ON THE VINE
HANDBUF OF THORNS AND YOU’LL KNOW YOU’VE MISSED IT
LOSE YOUR LOVE WHEN YOU SAY THE WORD MINE

This song is about me right now. I have to stay on the vine to keep growing and that means I have to keep taking my medication and monitoring my symptoms and stay within the mental health system. I can’t afford individual therapy when I’m an outpatient because since I’m a Medicaid patient, I only get group therapy. That’s because of my psychological testing report. I found a summary of it that I wasn’t supposed to read and it said I have a ‘very Pollyannish view of the world, was very optimistic, and was only able to work on very superficial things, and would only need short term, very superficial work’. I wondered how they knew all these things by having me fill out a questionnaire with things like “are you constipated?”

Bess shared with me her world of being a Medicaid patient and what that membership entailed for her.

They treat you very differently when you have a Medicaid card. For instance when you’re at the drugstore, they talk real loud about your prescription, which is a certain drug and you don’t want everybody to
know that you're taking that kind. Once I had a behavioral outburst because I got upset at the pharmacy and they called the police on me and the policeman said "he doesn't have to give it to you." I had to leave. I couldn't go to another pharmacy because he took the prescription away. This kind of thing happened all the time.

I hate going to doctors. My internist is a real jerk. He takes too close a look at things. I'm pretty good with him because he wouldn't dare try any stuff with me, but he is known here in town for being sexually, well I don't know what you would call it, abusive I guess. He is known to be that way with most girls who live in halfway houses. Most of them have him since they are on Medicaid and he's the only doctor that accepts that kind of payment here. He's a real jerk. You know what he does? He puts his hand on your backside when there is no reason to, when it has nothing to do with the examination. I think he gets away with it with people from halfway houses because they don't know how to present themselves. He thinks he can get away with it because he knows you or he sees your address and knows it is a group home or a halfway house. Almost every girl there has told me things that have happened with him. They didn't know what to do. I said to them "Didn't you say 'don't do that'" and they said "Oh, I was afraid to." Anyway, that's why I hate going to doctors.

It seemed fitting that Bess's lyrical metaphor included a thorny vine that gave her the sustenance to survive. Perhaps her necessary involvement with doctors were represented by the "thorns" on the vine. Through this song Bess summarized her situation of being a psychiatric patient. It was significant that Bess sang and played this song three times through without stopping. She had set out wanting to be able to play her guitar again in our Music Therapy, and now she had actualized that goal.
Diane

I am sitting at the table in my office, waiting for Diane to arrive for our first session. It is 5:10 P.M. I am hoping Diane got the message I had left on her phone machine confirming this time. We only know one another through messages on our phone machines. Down the hall I hear the click-click-click of high heels and the sound of bubble gum popping. Suddenly Diane appears in the doorway.

Diane is dressed in a short, tight, black leather skirt with a low-cut, red silk tank top held in place at the waist by a large gold belt. Her hair is styled high above her head in front and curled loosely down her shoulders in the back. She wears eyeliner and shades of brown and green eye makeup that appear to be expertly applied. Her rouge matches her lipstick which matches her nails, which match her handbag. Her shoes are four-inch high heels, gold, seemingly made from the same design as her belt. She appears to be about 21 years old. I will later learn that she is 32.

“Wow, cool place you’ve got,” she exclaims, taking off her headphones and slipping them into her bright red, leather pocketbook as she strides into the room. Before reaching the table where I am seated, she spies a large cupboard, slightly opened. Without hesitation, she opens the doors fully and begins investigating the instruments inside.

I ask Diane how she heard about these individual Music Therapy sessions. She replies that Liz had told her group I would be running a study with people who had both psychiatric diagnoses and histories of sexual abuse in order to learn how they use music in their lives. When I ask whether she has any questions, Diane blows a large bubble, says “Nope,” and sits down at the table with me. She
pulls out a fingernail file and goes to work on one of her long, brightly painted nails. She comments on a diamond chip in that nail that is about to fall out and needs to get be replaced. Unfortunately, she just started a job, “off the books,” and doesn’t have time for a manicure this week.

I ask Diane to tell me about her music, and she tells me

I have a very wide appreciation for music. I listen to classical, or I’ll listen to rock or country, jazz or blues. The only thing I’m really not interested in is rap music. It’s not for me, it’s not my cup of tea, but I don’t limit myself to one, y’know, particular area of music. I like all different kinds of music. Depends on the mood I’m in.

If I’m feeling, say, depressed or defeated, I’ll listen to classical music. I’ll listen to either Handel or Bach. It doesn’t remind me of anything and it just makes me feel very calm and sometimes rejuvenated.

I’ve been listening to the “Savage” tape often lately by Annie Lennox and the Eurythmics. I’m going through a separation now from a person I’ve been living with for 14 years, and I think maybe she was going through a divorce or something when she did the tape. There are so many songs I can identify with, it just makes me feel not alone. It makes me feel really good. I even have the tape with me. I’m never without it. It just makes me feel validated, the words that she says I can identify with so closely that it just blows me away. Can we listen to it together in here?

Now, John’s music, that’s a different story. John is my boyfriend. He likes Lou Reed. He has every tape possible of Lou Reed: “Lou Reed in Italy”, “Lou Reed in Spain”, “Lou Reed in...”, I’m like does he have one “In the Toilet Bowl” John? I don’t care for Lou Reed, but I think that Lou Reed fits John like my Annie Lennox tape fits me. He also likes John Coltrane. I think his music is like fingernails on a chalkboard. I want to throw his music out the window! I just can’t handle hearing it. John said that Coltrane was kicking a heroin addiction when he did some of his songs and I was like “I can believe it, it sounds like someone’s kicking something really bad!”

Music depends on my mood and my mood is so complex that it depends on what it is and what it is touching at the moment. Like I’ll listen to the B-52’s if I want to dance or exercise. It’s the constant beat that I love. It doesn’t matter where I am. I try to tone it down, but, like, I was power walking in the park with my headphones on to this music and I began to move to the music. I just started dancing and women with their babies in carriages were like veering out of my way like ‘This lady’s nuts!’ But I don’t care. I just don’t care. Music really moves me and I can’t help it!
Songs for Confirming Experiences

Diane chose to listen to and speak about the lyrics from prerecorded popular songs in our Music Therapy sessions. Through listening to Diane’s music, I was afforded glimpses of her inner life, particularly her struggles in leaving her intimate relationship. Diane had been involved with a man, John, for 14 years and felt that she was no longer happy in this relationship. She wanted to be free of it but still remain friends with him.

Our first session together began with Diane’s answer when I asked what type(s) of music she listened to. Particular parts of Diane’s music were so important to her that she carried a Walkman and some of her tapes in her pocketbook with her at all times. She immediately asked if I wanted to hear her important songs and I happily agreed. It seemed that she offered up a wealth of information readily and intensely through speaking about her music.

Current Feelings on Relationship

In our first session Diane shared three recordings of songs with me that served as points of reference for describing her intimate relationship and her childhood. We listened to the tape of these songs that she had brought with her to our session. The order of her songs is chronological from the first session and seemed particularly indicative of her growth process. The first one, ‘BRAND NEW DAY’ seemed to assure Diane of her innate strength, which ensured that she would indeed survive her upcoming changes. The next one, ‘I NEED YOU,’
was a satirical song that reminded Diane of why she wanted a change in her relationship status with John. She found that her needs had changed due to her growth and that he no longer filled her new needs. Her final song in this first Music Therapy session, ‘YOU’VE PLACED A CHILL IN MY HEART,’ served to remind Diane of her traumatic past fraught with sexual abuse. This reminder led Diane to decide to make her changes slowly and carefully so that they wouldn’t overwhelm her. Following are some of Diane’s words about these songs and what they meant to her:

‘BRAND NEW DAY’ (Annie Lennox)

SIX O’CLOCK IN THE MORNING
AND I’M STEPPING THROUGH THE STREETS
THE PAVEMENT’S COLD AND EMPTY
GOT THE BLUES BENEATH MY FEET
BIG OLD SUN IS RISING UP
SO ELEGANT AND THIN
ANOTHER DAY IS OVER
SO A NEW DAY WILL BEGIN
AND THE WORD SAID HEY...
IT’S A BRAND NEW DAY

OH BABY, BABY, BABY
I DREAMED ABOUT YOU
PLEASE TELL ME, TELL ME, TELL ME
WHAT I’VE SEEN COULD NOT BE TRUE
YOU HAVE TAKEN MY EXISTENCE
YOU HAVE FILLED IT FULL OF STONES
YOU HAVE TURNED INTO A STRANGER
NOW I NEED TO WALK ALONE

BUT I WON’T BE SAD
BUT I WON’T BE DESTROYED...

AND THE WORD SAID
HEY...IT’S A BRAND NEW DAY

This song sounded strong and upbeat with a driving rhythm. Diane sang along loudly and her body seemed powerful and sturdy as she moved to the music.
This song is basically “I’ll get by, I’ll survive without you.” My associations to this song are that I’m ready now to leave this relationship. I can really believe this when I hear this song. There are times when I’m feeling afraid or scared and think ‘My God, what am I doing?’ and y’know, when I play this song, it just makes me feel strong. It instills strength like “Yeah, I can do it.” The singer is saying how she’s going to have to start over again and maybe be alone, but she’s not going to be destroyed by it. That’s like my relationship with John. It’s almost like she KNOWS my situation and can identify with it intensely.

Diane found her second favorite song on the tape and played it for me. ‘I NEED YOU’ sounded satirical and sardonic. The melody twisted around the words leaving me, the listener, on the edge of my chair. It was almost as if the singer were sarcastically speaking to someone with whom she was angry. Diane sang along to the song in a loud, clear voice and her face had an intent, almost angry expression. She then began speaking immediately after the song ended.

‘I NEED YOU’ (Annie Lennox)

I NEED YOU TO PIN ME DOWN
JUST FOR ONE FROZEN MOMENT
I NEED SOMEONE TO PIN ME DOWN
SO I CAN LIVE IN TORMENT.
I NEED YOU TO REALLY FEEL
THE TWIST OF MY BACK BREAKING
I NEED SOMEONE TO LISTEN
TO THE ECSTASY I’M FAKEING
I NEED YOU, YOU, YOU

I NEED YOU TO CATCH EACH BREATH
THAT ISSUES FROM MY LIPS
I NEED SOMEONE TO CRACK MY SKULL
I NEED SOMEONE TO KISS.
SO HOLD ME NOW
AND MAKE PRETEND
THAT I WON’T EVER FALL
OH, HOLD ME DOWN
I’M GONNA BE YOUR BABY DOLL

I NEED YOU, YOU, YOU...
IS IT YOU I REALLY NEED?
I DO, I DO, I DO
I REALLY DO
I NEED YOU...

This one makes me think of how unhappy I’ve been with John for a long, long time. For the longest time I needed him not as a woman, but as a child. And now I need him as a woman, but it’s like I’m still a child with him. But I need a man now! John is a very safe person. He’s very private, even with me. One of our problems has been our sex life. It needs a little salt and pepper, a little Tabasco sauce. Actually, it needs more like a bomb!

Diane tells me the next song on the tape is an important one to her. She says it helps her understand her own history of sexual abuse. Again, as the song played, Diane sang along and swayed to the beat while still sitting in her chair. This song, ‘YOU’VE PLACED A CHILL IN MY HEART,’ had a swinging rhythm with a simple, reassuring chord progression that was predictable. The harmony was uncluttered and seemed to place a strong support under the melody that accented each word in a clear and concise way.

‘YOU’VE PLACED A CHILL IN MY HEART’ (Annie Lennox)

TAKE ME TO THE DESERT
WHERE THERE’S GOT TO BE
A WHOLE HEAP OF NOTHING
FOR YOU AND ME
TAKE ME TO THE DESERT
TAKE ME TO THE SAND
SHOW ME THE COLOUR OF YOUR RIGHT HAND

LOVE IS A TEMPLE
LOVE IS A SHRINE
BUY SOME LOVE AT THE FIVE AND DIME
A LITTLE BIT OF LOVE
FROM THE COUNTER STORE
GET IT ON CREDIT IF YOU NEED SOME MORE.
I’LL BE THE FIGURE OF YOUR DISGRACE
A CRISS CROSS PATTERN UPON YOUR FACE
A WOMAN’S JUST TOO TIRED TO THINK
ABOUT THE DIRTY OLD DISHES IN THE KITCHEN SINK

I WISH I WAS INVISIBLE
SO I COULD CLIMB THROUGH THE TELEPHONE
WHEN IT HURTS MY EAR
AND IT HURTS MY BRAIN
AND IT MAKES ME FEEL TOO MUCH
TOO MUCH, TOO MUCH, TOO MUCH.
DON'T CUT ME DOWN
WHEN I'M TALKING TO YOU
'CAUSE I'M MUCH TOO TALL
TO FEEL THAT SMALL

LOVE IS A TEMPLE
LOVE I A SHRINE
LOVE IS PURE
AND LOVE IS BLIND
LOVE IS A RELIGIOUS SIGN
I'M GONNA LEAVE THIS LOVE BEHIND.
LOVE IS HOT AND LOVE IS COLD
I'VE BEEN BOUGHT AND I'VE BEEN SOLD
LOVE IS ROCK AND LOVE IS ROLL
I JUST WANT SOMEONE TO HOLD

There's a lot I can relate to in this song. Especially that part "I've been bought and I've been sold"--when I was younger I was used a lot and abused by my father and another man. There was one point where my father actually would pay me money just to look at me in the shower. This music helps me get in touch with all of this. And when I was a child a man who owned a dry cleaning business would rape me starting when I was six years old. I remember him enticing me behind the counter with candy and then putting his hand down my pants with his wife yelling at him from behind the curtain in a foreign language. When he did this I would feel invisible and then when I would leave the store I felt in danger. I've been having flashbacks about this lately and they are very scary. They even happen when I am busy, like when I'm doing dishes. Why didn't I remember it all before and now why am I now remembering just when I am starting to feel strong enough to leave John?

It seemed to me that this song offered Diane direct imagery that could trigger associations--"counter," "dishes," "invisible," and "bought and sold." It also spoke in general terms of "leaving a love behind." These images reflected Diane's life and offered her the view of someone else being in a similar situation. Diane reported feeling that the songwriter must have been in Diane's position and therefore her songs provided help in confirming Diane's choice to leave her boyfriend.
Throughout all of our sessions, but especially during the first ones, I found myself feeling that Diane was extremely fragile despite the fact that she presented herself as an energetic, attractive, funny young woman. I would often ask her (as if to remind her, thereby developing ego strength) how she was surviving and doing the things that she was doing such as holding down a job, going out with friends, and staying out of the hospital for more than a few weeks. During these times, Diane was able to remember her strengths and still feel her pain without the pain causing her to deteriorate. I was concerned that she was going in too deeply too quickly with me in our first therapy sessions and asked her to please keep me alerted to her feelings about our process. Diane assured me that she was all right and explained how she monitored herself with music:

I have to watch what I listen to. I’ve a good sense of what I’m in the mood to hear and what it’s going to do for me. If it’s going to make me emotional, all right if I think I can handle it. If I know I can handle it, then fine, I’ll put the tape on. I’ll listen to it. I’ll do a little crying and getting in touch with my feelings and then that’s it. But if I feel like I’m too vulnerable and can’t listen to it, then either I’ll listen to classical music or something that’s instrumental. That kind of music is safe for me because it wasn’t part of my childhood.

Feelings and Remembrances from the Past

While discussing songs, Diane also spoke about various feelings, thoughts and attitudes that she remembered from her past. For example, she recalled an artist she used to enjoy listening to--Cat Stevens, and a specific album of his--“Tea for the Tillerman.” Through my knowledge of this artist and this particular compilation of songs, we were able to discuss the intricacies of the songs. Two songs in particular were indicative of feelings and attitudes that Diane had: ‘SAD LISA’ and ‘LONGER BOATS.’ As Diane recalled ‘SAD LISA,’ I spontaneously
sung the opening lyrics and Diane joined in. After we sang the song together, slowly and mournfully as Cat Steven did in his recording, Diane spoke about what her first experiences of hospitalization on a psychiatric ward had been like. I had never been in her position as a psychiatric patient and could therefore have been seen as a “foreigner” to Diane, but because I was extremely familiar with her music and able to sing her songs without any music or tape, she was willing to “let me onto her land,” so to speak, and tell me about her feelings and her actual experiences.

That song reminds me of my hospitalizations. You know the part “She hangs her head and cries in his shirt, she must be hurt very badly, tell me what’s making you sad...she sits in her room by the door...”? Well, it was almost like he was writing about someone like me in a psychiatric hospital. I was hurting myself when I was 14 years old. I was banging my head on the wall and slit my wrists. I was going through a lot. I was mourning the death of my adopted mother. I had a lot of guilt, a lot of guilt that I had killed her. I could relate to what Cat Stevens sang about with this girl, Lisa. That’s how I felt. There was something shameful about being hospitalized. My twin and I were adopted by this family because our mother was 13 when she had us, and my father would say “You’re nuts, you’re crazy, there’s something wrong with you. You have bad blood and that’s something you got from your natural parents.”

Songs for Expressing Feelings

Diane’s upbringing was something she spoke of in our Music Therapy sessions. She had many sad memories about it. Diane was often able to express her thoughts and feelings through songs. She said that they helped her formulate her beliefs. For example, we sang and discussed the lyrics of ‘LONGER BOATS’ (also by Cat Stevens). Diane had mentioned this song as being an important one to her and again we spontaneously began singing it together. This song had a powerful rhythm underlying each word in the chorus about “Longer boats are
coming...” and the verses had a gentler feel. Through one verse Diane shared with me her attitudes concerning sexuality:

Well, there’s one line in there about ‘Mary drops her pants by the sand and lets the Parson come and take her hand, but the soul that nobody knows is where the Parson goes’. At this point in my life after my first hospitalization, I was promiscuous and I didn’t buy into any of this shit that I wasn’t entitled to have my own sexuality. Whether it was right or wrong or indifferent. I just hated the double standard that it was like a score for a man to be with a woman, it was something like a notch in his belt, or a feather in his hat. And yet it was something very shameful if a woman expressed herself in a sexual way, so I like that line.

Other songs from Diane’s past played an important role in communicating and validating her feelings about specific times. For example, as she recalled her teenage years, Diane identified a significant song that was indicative of her feelings:

Eventually I moved in with my older sister. Things were getting critical at home with my father after my mother died and a social worker from Prevention of Cruelty to Children would visit me at home and then helped me move out. I remember listening to Helen Reddy’s ‘PEACEFUL’ at my sister’s home. [Amy and Diane sing “Oh, it’s so peaceful here, there’s no one bending over my shoulder, nobody breathing in my ear.”] My father was abusive and home was not a safe place to be. My father yelled constantly. He was a very nasty drunk that would never let up. Until he finally passed out and went to sleep. It never stopped. It was so peaceful at my sister’s home. She was doing her own thing so a lot of times she would be on a business trip and I’d light candles and listen to music. It was so mellow. I stayed there until I was 18 and then I moved in with John.

Diane’s scary and sad childhood ended with this move. She lived with him for fourteen years. During our therapy she was feeling that she had outgrown him and needed to leave him. This decision was a frightening one for her to consider, and it caused her to loosen her grip on her own stability.

Speaking through Music

During the span of Diane’s Music Therapy treatment, she had to be hospitalized due to a suicide attempt. We continued our sessions in her hospital
room, but had to wait approximately one month before the first session in her room because her behaviors were too out of control and necessitated a four-point-restraint process much of the time. A four-point-restraint process entailed a patient being strapped down to a bed by four straps, one at each of her wrists and ankles. When I first saw her after our interruption in treatment, she jumped right back into speaking about John through the music again:

I'm glad you came over to my room here on the unit. This way I can relate my problems through music. Oh, good, you brought me some tapes like you said you would when we talked on the phone. Can we listen to Tracy Chapman's 'BABY, CAN I HOLD YOU TONIGHT?'

A nurse entered her room briefly and looked surprised to hear Diane speaking to me and told Diane “That music must really work, it's about time you started talking.” She then told me that Diane had not yet talked about why she was even back in the hospital and was glad that I was here with my music. After the nurse left, I handed Diane the Tracy Chapman tape and she put it in my cassette player and we began to listen to the music. ‘BABY, CAN I HOLD YOU TONIGHT?’ was a folk rock ballad in the key of D major consisting primarily of D-em-A chords with the melody being sung in a heart-wrenching manner by a woman. The song was about a woman wanting to hold her partner and needing her partner. Diane sat motionless listening to the song with her eyes looking out of the window.

Approximately halfway through this song Diane began to cry and asked me to turn off the song, telling me it was too much for her to listen to then. I immediately turned it off and Diane spoke at length. She said that what was so difficult for her during this hospitalization, it was her thirteenth or fourteenth one, was that she felt very alone for the first time since she and John weren't a couple any more. “We are just a couple trying to separate” Diane tearfully told me. This song reflected her desire to be held by him, but she knew that wasn't even a
possibility anymore since the primary reason for her attempt to kill herself was that she began seeing another man and John found out about it and ended their relationship.

After hearing this song, Diane openly talked about how her hospitalization was going. I was surprised because on the telephone (we had spoken briefly once a week) she had given no indication of how her hospitalization was going and was very superficial in our conversations. Also, the unit staff was not quite sure why she was as out of control as she was during this particular hospitalization, because she declined to speak about her feelings. As she spoke, I was surprised not only at the range of feelings she was expressing—sadness, anger, and regret but also the humor that she used to convey these thoughts to me. It seemed that the music opened her up, yet simultaneously held her together. I thought that perhaps the lyrics of ‘BABY CAN I HOLD YOU TONIGHT?’ opened her pent-up feelings, and that the relentless rhythm held her together somehow.

It’s an art, crying with mascara on that is. I’m ready for soap operas now! I’ve been having a rough time here on the unit. Jeez, rough isn’t the word. I’m into contact sports now here. They get me going with anger and then they drag me in so to speak, kicking and screaming. I’m angry with John and I’m angry at myself for ending up here. I get very angry here all the time. It’s not just anger, it’s rage. I’m angry at men. I hate men. I hate them.

Like yesterday, this mental health worker told me like a fucking drill sergeant to go into my room. So I go into my room and sit here on the window sill. He comes into my room and tells me to get off the window sill and come back out and sit in the hallway instead. I think if he had never come into my room, I would have been OK, but I tried to explain that I couldn’t hurt myself on the window sill, but he wouldn’t listen. So I went out into the hallway and sat down and tried to keep cool. You know there is a lot of crap that goes on in an acute unit, a lot of other people’s problems. I had to get back in my room for some peace. I needed my own space. I went back into my room and he followed me and I went to slam the door and said ‘get away from me, leave me alone, I don’t want to talk, why do I have to talk? just ‘cos you want me to?’” He pushed his way into my room and I moved to the window sill and started slamming the window down on my head and then picked up a chair and we struggled with that. Then I kicked him in the balls and we both fell on the bed. He
grabbed his groin yelling "Oh my God." I felt great. I would love another round with him.

Anyway, then they all came in. Even the fucking cleaning man came in. He had his rubber gloves on, he must have been cleaning the toilet or something. Everyone was getting in on the action. I was thinking "I don't believe this." They were dragging me out of my room, my fucking skirt was coming off. I'm screaming and yelling at them, and then I'm threatening the fucking cleaning man that I was going to kill him. I wasn't going to kill him, but it felt like, Jesus Christ, you know, why don't you call the fucking postman and let him come in and hold me down while you're at it!

Then they dragged me down to the quiet room and I was OK till the same guy told me to get all the way inside the room, so I kicked him. Then they locked the door and they were just looking at me through the window and I felt like I was on exhibit. Like I felt like a zoo animal. I felt like a caged animal and I started pounding on the glass with my fists and elbows. Eventually they came in and put me into four-point-restraints again.

I've been in them so much lately. I hate them. I feel like I'm going to die when I'm in them and I have to comply and not struggle to get out. That is very hard to do. I just want to keep struggling to get free. They give me an injection each time, but that just makes it worse.

Diane and I spoke about what would be happening to her now. It seemed that as she spoke, her anger began to fade and her usual good humor returned.

Last week was worse. I attacked my doctor. He came to our session one hour late. We were supposed to have our session on the unit since he won't allow me back in his office. I tried to break some glass in there to kill myself two weeks ago. Anyway, I was very upset that he was so late. It was like he didn't care and I was escalating, trying to get him to at least see how much it was affecting me. He was so callused he didn't even care that he was late. I don't remember this, but my peers were telling me that I was punching him in the face. I don't even remember. I feel like I can't control my anger or anything about being here in the hospital.

I don't know what the future holds. If I can go one week without being in four-point-restraints I'm supposed to get moved to a long term unit, but the doctor from that unit interviewed me when I was in four-point-restraints and I don't think I made a good impression!

I don't like to think about tomorrow and I try not to worry about yesterday. One thing I really try to do is to live moment to moment. Because the way I am, if I get too lost in yesterday or worry about tomorrow, I'll fucking paralyze. I won't be able to function. Let's listen to some of these other tapes you brought me. I gotta get my ass in motion and stop sitting and staring at these four walls!
As Diane spoke she became more and more animated and selected other types of music to listen to before our session ended. They were all nonlyrical songs that were upbeat in nature. Diane and I finished this session, which happened to be her last one due to her transfer to a closed unit, by listening to "house" music that had a driving beat, which seemed to motivate her to begin to ask about going to recreational activities with the other patients on the unit later that day. Diane said that she realized that she already knew how music affected her and that she was going to really try to use it to get better and to get off the unit and out of the hospital. As I left the unit for the last time, she was talking with the nurse who had entered her room when I was there and was smiling as the nurse patted her arm.
Jack

I open my office door at 1:05, thinking that perhaps Jack won’t know which office is mine. It’s his first Music Therapy session with me. I see him down the hall getting a drink of water. To my “Hello,” Jack replies, “Hi. I’ll be right there, I just need to use the bathroom first.”

Jack appears a few minutes later, enters the room, and sits down. He looks as if he is ready to compete in a triathlon. He is wearing brand new running shoes and a commercial “muscle-shirt” (like a tank top) tucked into jogging shorts. He has a tanned, athletic build. Jack comments that he has just finished lifting weights. He plops his bathing trunks down on the table, pulls a comb out of the pocket, and proceeds to comb his hair. His hair is already fashionably styled and doesn’t seem to need the combing, yet he seems to insist on getting every hair in place.

In a loud, confident voice, Jack says he’s glad to be here because he loves music. He explains that he didn’t bring his guitar because he figured he would be going to the pool after his session and didn’t want to risk overheating his instrument.

His eyes search about the room, often fixating on a spot in the upper left corner of the room. He goes on talking for long periods of time, while I only interject single words or short questions. But sometimes he stops abruptly, appearing to be lost in thought. I wonder whether he is responding to internal stimuli (i.e., hallucinating), so I ask Jack what he’s thinking. He refocuses immediately and replies, “I love music. I’m really excited to have Music Therapy sessions.”

I ask about his owning a guitar and his musical beginnings. Jack answers:
I played piano for about two years, I played trombone in high school and then I played guitar. In fact when I was in college at Harvard I used to play guitar about two hours a day. I always liked to play the blues. But then I got sick. That was about five years ago. I haven’t played for such a long time, it sounds terrible. All or most of my friends play guitar so I intend to catch up, but I’m still rusty. I can’t, my forte is still ummm, my fingers stumbled all over each other. I can’t do leads. Whenever I go to my parent’s house I sit at the piano and bang away at it.

Jack stops talking about playing music and seems to drift away in thought.

I then ask Jack about music listening--if he ever listens to music, and if so, what kind. He quickly and energetically responds:

I listen to music all the time. I listen to all kinds of music. Like the rock groups: Genesis, Foreigner, Pink Floyd, Santana. Also I listen to Classical music, my girlfriend is into that kind of music. I like Wagner.

One song I like is by Foreigner, it’s called ‘URGENT’. It’s a very hard, hard rocking song. When I listen to it, it gets me real psyched. Gets me hyperactive. Sometimes when I listen to other kinds of music I might think about things, other times I might fantasize a little. There’s another song too, Elton John’s ‘FUNERAL FOR A FRIEND,’ do you know that song? [I nod] Great! Well, it starts out more like a somber song, but it crescendos, builds up in intensity as the song progresses. And that type of song makes me go sort of WHOOOOOOOOOOOO! And other times, if I listen to the group ‘Talking Heads’, it goes DOO DUM DUM DOO DUM DUM in the drums, and that music is psych music for me. Whenever I want to get psyched, it makes me want to go out and be with friends and dance around. And with Classical music, it all depends. With Wagner, the ‘RIDE OF THE VALKYRIES,’ ever heard of that?

I am familiar with this Wagner piece and we sing the melody together using “da” sounds, and I ask Jack if this song evokes any images for him. He speaks of images that make him feel powerful. I ask him what he hopes for from our sessions and he replies:

I used to, at one point when I was playing guitar, I wrote my own music. Writing down chords and stuff like that. I didn’t stick with it. Maybe we could do that in Music Therapy. What do I want to get out of our sessions? Maybe on one hand a better understanding of myself, and fun. Yeah, work and play!

Jack told me about how his life used to be before he got sick:
I've worked before and I've been in therapy a lot. The first two years I had therapy twice a week. I've been in other outpatient programs and I was hospitalized. First I was suffering from depression and then I got psychotic and was hospitalized here at this hospital. I didn't do much. I did a lot, but I didn't do much in the way of being productive. I'm busy, but not busy enough. I used to work 60 hours a week and jog 10 miles a day and play guitar lots, but not anymore. And I'm still very leery about going back to work.

I got sick a year after I got out of college. I graduated in 1987 from Harvard. Basically I've been out of work. I was a manager at Woolworth's and I did a volunteer job working at a farm. I did varied sorts of things. Also I was a production supervisor for a major pharmaceutical company. But these didn't last. They lasted a few months at most.

I suffered throughout all my college years, suffered through depression. I hadn't been in therapy before that. But I'm lucky, I have a fairly intact intellect and my intellect was able to concen, concen, concen, what's it called? Compensate. My intellect was able to compensate for my emotional problems and I still did pretty well. I just want to get back how I was and be able to work and play guitar again, y'know? Music has always helped me to cope, and I need to get back to that again.

**Songs for Recognizing Feelings**

Jack and I spoke about various popular songs in our sessions and improvised songs on instruments. Through these two musical avenues, Jack shared his largest concern with me--his problematic relationship with his girlfriend. This was something he had been struggling with intermittently for five years in his verbal therapy sessions. Jack had great difficulty in connecting his feelings about this situation with his words, which flowed quite readily in an intellectualized, emotionless fashion. He continually spoke about the same types of problems without any apparent feelings connected to his words. But when he played music and then spoke, his face became animated, his words energetic, and he seemed to gain new insights into old problems. The progress of Jack's sessions are organized into categories: Family and Intimate Partner, Point of Departure for Music Therapy Interventions, Examination of Situation through
Music, Personal Contact through Music, Musical Role Playing, Revelations through Music, and Integration of Musical Experiences and Revelations.

As Jack introduced himself by describing the songs he enjoyed playing and listening to, we spontaneously sang bits of these songs together. Because I was familiar with his music, it was as if we spoke a common language. As we sang, I found that Jack seemed to open up. His face became expressive, and his voice broke from its usual monotone, modulating both in volume and in range of pitches. I was also struck by the effect that speaking about music had on Jack. He opened up when we spoke about music. His words and affect seemed more congruent or connected to each other during these times. For example, the music discussion caused him to speak and when he spoke about sad things, his facial expression and tone of voice also seemed sad.

Family and Intimate Partner

Through talking about his musical history, Jack told me about his family and, then, his girlfriend:

I used to play piano and trombone at home, but I stopped because nobody ever gave me positive feedback about what I was doing. My parents would walk in and say "Stop playing so loud" and then walk out of the room. I wanted approval and I didn't get it at my house, so I just kind of gave up. My parents were self-centered people. Both of them are in psychiatric care right now. Although on one hand my mother would tell me she loved me, on the other hand, before she told me she loved me, she had to abuse me. Sometimes she would physically abuse me by actually smashing me across the face with her fist. And then she would tell me hours later how much she loved me and then just repeat the whole thing again.

My whole family was split musically. They each liked different artists. Nobody would have anything to do with each other. I have two sisters. They're screwed up completely. Both of them turned out to be very emotionally disturbed. One of them is on Lithium, and another on an anti-depressant. That one saw a psychiatrist just for the medicine, but she refused to go into therapy. It was scary for me too, but I've discovered if
you face things you learn to deal with them and you don’t have skeletons in the closet all the time.

My girlfriend Jill was also sexually abused. She and I have similar histories, but mine didn’t happen very often so it wasn’t really abuse. She’s trying to remember her sexual abuse. Her psychiatrist calls it “recollections.” Apparently she blocked them out. She kept telling me “If I can remember what happened, then I’ll be feeling so much better.” I got involved in trying to help her remember. Slowly things came back to her. She was very happy, but then it all became too much for her and she became psychotic and had to be hospitalized. After she was hospitalized, everything was sort of quieted down and there wasn’t much talk about her recollections. I think the recollections were very stressful to her, extremely stressful.

As Jack focused less on his music, he often stopped speaking and would sadly, blankly stare off into space as if he were unaware of my presence in the room. During these times when I asked him what he was feeling or thinking, he would reply “nothing.” I wondered if he were responding to internal stimuli and once specifically asked him this, but he replied “no” in a noncommittal way. However, when we spoke about music, he lit up and readily spoke with much more apparent emotion.

Point of Departure: “Stuck”

Jack said that he used to play the guitar for two hours a day in college, but that since he had been living with Jill he never did. He had tried to play for her, but she was too caught up in her own problems to be able to focus on his playing, so he stopped. I spoke about the seeming correlation between his family’s lack of appreciation for his music and his girlfriend’s inattention to the same thing. Jack agreed and wondered if that was part of his attraction to her, the familiar responses and feelings she evoked in him. Jack talked about her having a manic-depressive illness with severe mood swings. It seemed that because of their problems, he could not proceed with getting a job or a career as he wanted to do,
and couldn’t focus on his own problems or heal his own history of abuse. Jack seemed to get stuck at this point. He could neither seem to understand nor talk about what went on with this relationship that was causing him distress, but would sit silently appearing very sad and lost in thought. I felt that in order to get out of this “stuck” point, we needed to get into his music.

Examination of Situation through Music

I asked what songs Jack remembered as being his favorites, and he began to speak excitedly about some of them. Jack was able to recall songs that were important to him and talk about what meaning they had for him. ‘HOTEL CALIFORNIA’ (by Don Felder, Don Henley, and Glenn Frey) spoke to him about insanity, which was reminiscent of his childhood in his home.

WELCOME TO THE HOTEL CALIFORNIA
SUCH A LOVELY PLACE, SUCH A LOVELY FACE
ANY TIME OF YEAR YOU CAN FIND IT HERE

MIRRORS ON THE CEILING, THE PINK CHAMPAGNE ON ICE
AND SHE SAID “WE ARE ALL JUST PRISONERS HERE OF OUR
OWN DEVICE”
AND IN THE MASTER’S CHAMBERS, THEY GATHERED FOR THE
FEAST
THEY STAB IT THEIR STEELY KNIVES, BUT THEY JUST CAN’T
KILL THE BEAST

LAST THING I REMEMBER I WAS RUNNING FOR THE DOOR
I HAD TO FIND THE PASSAGE BACK TO THE PLACE I WAS
BEFORE
“RELAX” SAID THE NIGHT MAN, “WE ARE PROGRAMMED TO
RECEIVE,
YOU CAN CHECK OUT ANY TIME YOU LIKE, BUT YOU CAN
NEVER LEAVE”

I have some paranoia. On the one hand I want to be with people, on the other hand I am afraid of being hurt by people. I had been hurt by many people. My parents would treat me badly, neglect me, that sort of thing. I don’t trust anyone. It stemmed from me growing up in a family where I was constantly abused. That’s why, because I came from a very dysfunctional family. I was abused in every way, mental, emotional,
physical. Nobody cared about what I was doing. I started not to trust people. And that’s where my paranoia came from.

My mother was insane, totally insane. My mother would try to destroy my most valuable possession, my stereo. I used to have to bar my door with my weights and still she’d try to break down my door. In her mind I had hurt her, so she was going to hurt me. She’d keep smashing against the door. It was scary. I would tell my father “Mom is really driving me crazy, she’s really a lunatic, she’s really hurting me,” and he would say, “just listen to your mother.” He was totally neglectful. He didn’t want to have anything to do with the family.

As Jack spoke, I found myself recalling the lyrics to his song “you can check out any time you like, but you can never leave” and thought that they perhaps reflected his experience with his family. As a child, and now as a financially dependent adult, Jack was in a sense trapped within this place of insanity.

Without music as a vehicle for communication, Jack could not describe his feelings toward his girlfriend nor guess her feelings toward him, but could only speak about enjoying activities with her. However, when I asked him what song described her, Jack could speak at great length about how he was feeling with her.

What song would describe Jill? That’s easy. ‘WISH YOU WERE HERE’ by Chicago. She’s never here in the way I would like her to be. I know one song that fits me too, ‘BACK JACK, DO IT AGAIN’ by Steely Dan, because I always think things will get better with her and I return, and then they are still the same.

Other songs also came to mind. Jack said he thought the song ‘HELPELLSSLY HOPING’ (Crosby, Stills, Nash and Young) made him think about his relationship with Jill and how he wished it could be. The song, ‘HEARTACHE TONIGHT’ (Eagles), reflected Jack’s concerns about how he would feel were he to be alone without Jill. At this point Jack spoke in great detail about his relationship with Jill, how it troubled him and how he had found no sense of relief from its problems. The main problem was that he found her very
unstable and that although she professed love for him, she often threatened to end their relationship but never did. Since this happened so often, almost seasonally, Jack said that by the time he felt solid with her again she would start to leave all over again. He knew that she would not actually end their relationship, but her threats still kept him from focusing on anything else.

Jack spoke about wrestling with this relationship over many years, not understanding why he felt as he did and why he stayed in it when it was so troublesome. During these portions of his sessions, he spoke as if he were disconnected from his feelings. His words would be redundant and seemed to offer him neither insight nor relief. He had difficulty hearing me speak and often asked me to repeat what I said. He said that he wasn’t able to focus very well with talking.

Making Contact through Music

Jack said he enjoyed playing guitar but that he didn’t want to start with it in our sessions.

I can’t play guitar nowadays because when I play guitar, it’s a reflection of my emotions and sometimes when I play guitar, it’s emotionally draining for me because my music comes out of my emotions. And the more I get into playing guitar, the stronger my emotional feelings are, and the more drained I feel, so I just have to stop.

At this point Jack asked if we could play the xylophones together and make up “songs” on them. I agreed and we played six different xylophones over three sessions. We played wooden and metal ones that were pitched from low sounds to very high sounds (bass, alto, tenor, and soprano) in diatonic as well as pentatonic scales. Sometimes we freely improvised using all of the keys on the instruments, and other times I would remove some of the keys leaving only chord
tones so that any note sounded as though it were part of a chord. Jack would request that they be set up this way if he wanted to play a blues-style song with me so that one of us could hold the chord while the other played a melody.

Jack would often name these pieces that we played and called them “songs.” I noticed that the way he played seemed to resemble how he presented himself verbally. When he began to play, he generally set a pattern that consisted of a few short melodic phrases repeated four to eight times in a rock genre that did not change in tempo or volume. His melodic phrases would be easily anticipated and would contain no surprising notes. This pattern seemed very similar to his speech: monotonous, redundant, about the same issue without noticeable change. I would place longer tones around his notes to provide a musical context and to sustain them. For example, I would play the root, third, and fifth of a chord that Jack would be playing integral melodic notes from. Sometimes we would both end at the exact same moment and we would laugh at our musical synchrony. I was listening very intently and wanted us to be together in the music, but could not have planned or directed these endings. They were a reflection of our communication in the music. During these musical interchanges I felt as if he and I were connecting more authentically than previously. I felt as if his feelings were emerging rather than being bound in rehearsed words. These were also the first times that I saw Jack smile and laugh. Sometimes Jack would make names for our improvised songs, such as “Mambo!” and would express happiness at being able to produce music, hopeful that he might feel ready to go back to his guitar someday.

Musical Role-Playing
After a session using free improvisation as described above, we began to play specific moods. I asked Jack to imagine and play a feeling on a xylophone. I listened and joined in playing and tried to guess what feeling it was that he was playing. I was hoping that he could try out new ways of playing and feeling through music. I thought that he would be willing to try out new aspects of himself through the music and then might be able to experience himself differently in other areas as well. We tried different moods and feelings with the instruments and many different ways of playing these moods and feelings. We played softly, loudly, quickly, and slowly; we played slow gliding glissandos up and down the xylophones and struck harsh single or several angry repetitive notes. After Jack began a few of these improvised songs, I started a mood improvisation. I purposefully began playing something extremely different from most of Jack’s music—an improvisation that sounded forceful and almost angry. Jack joined me, playing a melody from an earlier improvisation. This caused my playing to soften in texture very rapidly. As if by magic, we stopped together, both ending this particular improvisation by rolling on a note simultaneously. Jack called out a title to our song—“Lover’s Leap.”

It was not until I listened to our tape recording later that I realized how dramatic the effect of his playing had been on mine. It made me wonder if he had great difficulty accepting other people’s strong feelings, including anger, and generally was effective in trying to stop or reduce these feelings. Our playing made me think of his relationship with Jill and his role of trying to temper, to make more moderate, her wild mood swings and her anger. This hunch made me later ask Jack to musically role-play various people in his life. He would select two people and assign one to me and one to him to play. We played on the
xylophones the portraits of a variety of friends and family members selected by Jack. Primarily we played the roles of himself and Jill. First I was given the role of being Jack and he played Jill. His playing involved single notes jumping about, leaving a lot of space. His notes did not seem to have any relation to each other and changed rapidly in mood, tempo, and dynamics. My playing involved the systematic series of repetitive melodies that were basically unchanging, similar to Jack’s earlier melodies.

Revelations through Music

Jack looked quite surprised after we completed this musical role-playing and described the improvisation this way:

That was like me and Jill. Jack, played by you, kept the song going because you filled in the spaces. Jill, played by me, was random. That’s basically the situation I have with Jill. I’m the foundation because I’m the one who constantly wants the relationship. I smooth things over like you were doing on the bells. I just realized for the first time that the only reason that Jill and I have lasted is because I stick to the relationship regardless of its ups and downs. In the past when she’s had relationships with people who were as up and down as she was, the relationships ended quickly.

I suggested we both play the part of Jill together and we did for a brief song. When it ended Jack exclaimed, “It stopped because we were both random, there was no foundation!” He was surprised at how difficult it was for him to play her role because “it’s too disjointed...I need a pattern, my mind is too methodical.” Then we both played the part of Jack together, and he was surprised by how dull it sounded to him and said missed the “familiarity in her unsteadiness.” He began to smile and laugh as he spoke of his revelations regarding their relationship. He said that he had never really felt what it was like to be him or her in their relationship before and it surprised him to feel their roles.
During these improvised songs, Jack often spoke specifically about his struggles in his intimate relationship. I was struck by how the music helped facilitate his verbal expression of feelings and concerns. The music seemed to concretize and verbalize his thoughts for the first time. Jack also began to see connections between his relationship with Jill and his upbringing with his mother. He felt that a lack of stability was common to each.

After using the xylophones to create songs and gain understanding from them, Jack brought in his guitar for one of our last sessions. He said that he wanted to "stay creative, stay on the left side of my brain" and felt ready to play guitar again. He smiled as he improvised, playing lead guitar, for me. First he played a broken glissando type of melody on one string from the very bottom of the guitar to the very top. Jack slid his finger up the fretboard quickly and smoothly. He claimed that gave him a "rush" with the "highs and the lows" and said that it brought his mood "up." I asked Jack if he could make an interpretation of his playing. He laughed and said that he finally realized its similarity to his relationship with Jill, and that he enjoyed the ups and downs. They made him feel good.

Integration of Musical Experiences and Revelations

Then Jack played four chords: G-D-A-E7, each one going up or down dramatically in pitch (it sounded like Jill to me) and strummed the same number of times so that the next cycle could be anticipated (which seemed to represent himself). Jack called this song "Stability" and invited me to join in, playing on the guitar. I did so, and as I played I found myself wanting to hum to the song and
began to do so. The melody I hummed was a simple one that seemed to reflect
the calm and peaceful mood that Jack’s strum evoked. Soon Jack began singing
words to the melody I was humming. I joined in singing parts of his words (I sang
the first word to each line and held it out while he completed the line), and that
was how we ended our music together in our last session.

“Standing in the morning sun,
Feeling good ’cos the day has just begun.
Sipping my java, smoking on a bone,
Feeling good that the world’s ok and I’ll never be alone.”

This song seemed to summarize our sessions in signifying the beginning
of his return to music as his comfort. Jack had come to experience himself and Jill
through our music. He experienced what it felt like from both perspectives. From
these feelings he gained a new understanding of their roles in their relationship.
He realized the complementary aspects of their dynamics and found they needed
each other. Jack’s final improvisation indicated that he felt more content because
of the insights he had gained through the music.
Matt

It is a hot, humid summer day, the temperature climbing toward 100 degrees. Outside my office window, a brightly colored object catches my eye below. I peer down through a cluster of large oak trees and see a red-topped blur. He is jumping up and down, flapping his arms like wings, running in circles around a tree, and his red hair is flying out behind him.

We had met before: a brief introduction after he volunteered to participate in my study. This is Matt.

I hurry down the stairs and outside to say “Hello” and invite Matt up for his session. Spotting me, Matt stops running and jumping, walks over to me calmly, and shakes my outstretched hand. He says that he had come early for our session but was told by a staff member that I wasn’t there. The staff member appeared “hostile,” so Matt went outside to do “movement therapy” while waiting for my return. He tells me he doesn’t pick up “hostile vibes” from me, and I ask him to tell me if he ever does. I then explain to Matt that the staff often will not know my exact whereabouts and could easily make mistakes about them, but that he should always knock on my door. I assure him I will always make every effort to be there on time for our sessions.

Upstairs in the room, I ask him, “How are you doing?” He sings his response to me: “Last night, I didn’t get to sleep at all.” We both laugh at his response, with Matt adding, “I’ll tell you in music!” Matt’s face lights up when he laughs, and he looks younger than his 35 years. Almost boyish. His long, red crop of hair falls down over his eyes. He is slender. He wears a tie-dyed t-shirt, faded blue jeans, and sandals. A huge, white bandage covers one finger, with puffy white flesh oozing out from the edges. Since my hand also has a bandage on one
finger, Matt makes a joke about the two of us needing to put our two “good” hands together to play one guitar. He asks me what happened, and I explain that I closed a window on it, requiring stitches, the previous night. Matt burned his finger in his group home a week ago, trying to put out a fire in the kitchen trash can. He had seen some paper towels smoking and had reached in, but melted plastic underneath the paper towels stuck to his finger, burning it.

Matt tells me all this in a soft voice, glancing at my face periodically. His voice is so soft, and his words rush out so quickly, that I sometimes have trouble understanding him. I find myself concentrating very hard just to be able to hear him well. His eyes dart, regularly meeting mine, but only for a moment, then return to his backpack on the table. He wears a nervous smile, slightly forced. He tosses in quick, nervous laughs — “Ha-ha!” — at almost anything I say.

I ask what he would like to be called, Matt or Matthew, and he responds:

You can call me Matt instead of Matthew. There are already so many musicians with my initials, ‘M.J.’ or the reverse, “J.M.” Like Michael Jackson, Mick Jagger, Joni Mitchell, John-Cougar Melloncamp, John Mayall, and Paul McCartney’s real name was James McCartney. In addition, there is religious significance for the initial “J.” “J.” could be Jesus and “M.” could be Mary.

Opening his backpack, Matt shows me what he has brought: a torn up black folder stuffed with page after page of handwritten music. Lyrics and guitar chords have been scribbled down on the backs of pages where he’s been recording his thoughts. Matt says, “I put a big investment in my therapy,” as he shows me all his music. He also tells me he has a backpacker’s guitar, which he’ll show me when his hand is better. As Matt shows me his music, he says he does not really listen to anyone else’s music, just writes and plays his own music.

I’ve told my story to so many people that I’m sort of tired of telling it. But I would like to share my music with you instead. I write songs. A whole variety of songs: blues, blue grass, rock, folk and pop. I’ve written about 70 songs and I sing and play them on guitar by myself mostly.
Songs for Disclosing Self

Matt introduced himself in his first session by spontaneously singing a response to my question. From that point on, his primary mode of communication with me was singing. Matt had written many songs, and by choosing particular songs to play and sing for me he overcame his reluctance to tell his story again and indeed sang his story to me very willingly. The primary areas Matt focused on in his songs had to do with his auditory hallucinations, with his voice. The material within our session will be presented in the following areas: Introduction to Voices, Voices as an Aid to Composing Music, Fear of Life Without Voices, and Sense of Survival.

Matt would sing and play his songs for me and then tell me what the lyrics meant to him. I often played along on guitar and, at times, joined in singing portions of the song. Sometimes Matt needed to teach me difficult chords or complex picking styles necessary for his songs. During these times he seemed to enjoy his role as teacher/expert, and was happy that we were able to produce his music in an aesthetically pleasing way. I enjoyed getting to play his music and found it very likable and intriguing. He used a variety of styles in his songs, causing each piece to sound quite unique.

When Matt sang and played he usually looked at me or at our hands. I usually needed to watch his hands to follow his chords while I played along. He had all of his songs memorized, but after our first session he brought the lyrics so that I could sing and play with him. During the first session, he asked me if I wanted to hear a song with a specific mood, and I replied that I would be
interested in whatever he felt like playing. Matt then quickly chose his own songs
to share with me, and almost always had specific reasons for those choices.

After playing one of his first songs, Matt told me that he had made "two
mistakes on the chorus" to which I replied: "That's fine. What I think is so
wonderful about Music Therapy is how it's different from music performance--
that is, what I'm interested in here is the process--how you make music, how you
feel about it. With performance, it's how it sounds--the product. I don't care about
mistakes. So, tell me about that song." Matt never criticized his playing again, but
instead at times would comment on how it felt to play. For example, he once said
after singing a song, "I wasn't feeling too joyous when I sang it. I don't know
why I chose that one. My heart and my head must not be in sync because I
thought I was happy, but I didn't convey happiness in my singing."

Introduction to Voices

Matt first began his original music by playing and singing his song entitled
'THAT PERPLEXES ME,' which he had written about a friend of his who had
killed himself:

'THAT PERPLEXES ME'

I CAN'T FIGHT IT, I'M TOO WEAK BUT
I CAN SEE THE DANGER.
YOUR CHEAP WORDS GOT US IN A RUT--
AND OR BUT--ANGER.
I CAN SMOKE MY CIGARETTES
BUT FEEL THE ENGINE SPLUTTER
BLUNDERBUSS RUSTY BUT MISCHIEVOUS
NOW--I STUTTER.
I'VE HEARD THAT BEFORE,
AND YOU SAY YOU'RE
TOO FREE.
THAT PERPLEXES ME.

BALANCE NIL I STRUGGLE WITH IT
YOU’RE TOO POOR TO HELP ME.
SAY YOU’LL PAY FOR A LITTLE WIT;
I’M SO ANGRY.
JUMPING AROUND, ONE THEN THE NEXT,
I CAN SING A SWAN SONG,
GET OUTTA DEBT, OUTTA DEATH,
I’LL-- MOVE ALONG.
I’M TOO UNPREPARED.
AND I CAN’T DARE
INFINITY.
THAT PERPLEXES ME.

This song was slow and somber, evoking a quiet mood. Matt used dissonance very expressively throughout his song. It was in the key of b minor and included several different diminished seventh chords that provided dissonance and tension that resolved skillfully. I found it fascinating that with each lyric “perplexes” he used the chords A-flat-diminished to a G-diminished (A-flat- -diminished is the V7 of G-diminished, which in turn is the V7 of b minor). These chords seemed to reflect the quandary that the lyrical statement posed. I asked Matt how he wrote this song and he replied:

My voices helped me write that. They helped me with the lyrics. They would chime in with chords and ideas, give me suggestions, like “use a different word.” Sometimes my voices are helpful, sometimes they’re not. It depends on their mood. For a long time they hated me and wouldn’t have anything to do with my music. They say I should be a politician and not a musician. That’s part of my story.

I first got my voices when I was a senior in college. I was lonely for a very long time and then I met my music teacher who I sort of fell in love with. And the voices came and took me away from him and I went through five years of Hell. Overmedicated, no job, no support systems except for my therapist. My voices hold me accountable for my thoughts. When I was born Kennedy singled me out and called me that “redhead kid” and all the hopes and fears rested on me and that someday I would be the President.

Matt then offered to play me a song about his voices--’STOP COMIN’ DOWN ON ME’. He sang and played loudly, strumming vigorously in a
Beatlesque style and I joined in singing on the chorus. He thumped the table loudly with his hand to each syllable of each word in the chorus as he explained the song to me before playing it on guitar:

‘STOP COMIN’ DOWN ON ME’

I THINK THEY’RE JUST ALOTTA RAINDROPS
I’M STANDIN’ UNDER THIS RAIN
FEEL RIGHT BEHIND THE EIGHT-BALL
IT’S SO PLAIN

(CHORUS)
STOP COMIN’ DOWN ON ME
STOP COMIN’ DOWN ON ME
STOP COMIN’ DOWN ON ME
I THOUGHT “THE RAIN’S ALOTTA PAIN” ONCE
STILL STANDIN’ IN THE RAIN
FEELIN’ THE SHRUBS AND HERBS
WET FOOT DAYS (CHORUS)

SOMETIMES THE RAIN FEELS BLANK
DON’T SPECULATE ABOUT THE RAIN
JOE’S TOO OLD TO BANK ON
DREAMS THAT SLIP AWAY (CHORUS)

After the song Matt told me:

It’s a very assertive, anti-rage song. My voices are like bombs coming down on me, they’re the “raindrops.” This song was about “Stop killing redhead kid, stop killing redhead kid, stop raining down on me.”

The chorus contained the chords em-D-C-bm-am and matched the descending fall of the melody, which again seemed to be congruent with the lyrical content of “coming down.” The chords in the verses rambled a bit and were both in and out of the diatonic chords of D and G: G-A-C-D-G6-bm-D7-D-D. This was interesting because it seemed that the text of the choruses were more focused than that of the verses, and once again the chords reflected this difference. I wondered what impact Matt’s voices had with his music, and Matt answered my question about how his voices worked in this song:
How do my voices work? Well, it’s my own thinking. The mechanism of it is that, that’s why music is so interesting, it is auditory hallucinations. I plug words into sounds. I did that a lot more before my voices got oppressive. It is all connected in that every syllable of a voice matches some kind of pulse like a clock ticking or a hammer beating. If you and me were playing together, on drums let’s say, I’d be having a conversation with you through the beats. My voices would even take on the personality of the person creating the sound. They would reflect something you, the player, wouldn’t say out loud. And my music would reflect my core personality. What are voices caused by? I don’t know, but I think from chemistry--brain chemistry.

Matt declined to answer any other direct questions about his voices, but told me that instead he would play another song for me, ‘WALK AWAY’, and asked me to join in on guitar, showing me the chords. After we played this song he exclaimed, “Great!” in response to my playing, and then spontaneously explained the song to me.

This song is about me feeling like I have to retire from the world, like it’s all too much. I project my voices into other people. Today has been really rough and my voices are really hostile, they’re making fun of my thoughts. I think some very controversial thoughts--like I could bring the empire of America to its knees single-handedly and things like that. The words I’ve been thinking are “It only takes one hand to topple an empire.” My voices are telling me that I am evil and not patriotic and to go into politics and that “there’s freedom within the form.” I feel like there’s a war going on inside of my head. Freud said that “work, love and play” were the biggest drives for people. What’s the most important thing for me? To get relief from my mind.

I found myself thinking that this must be a most painful type of abuse--one from within. I was amazed that Matt could share with me, through his music, his extremely private perception of his inner turmoil. He seemed to enjoy playing together with me very much--he would smile and laugh as we sang and would feel freer about speaking after each song. I felt as if we were cooperatively building a relationship; our work had been collaborative, and very different from reciting his problems to another person in the mental health field.
Voices as an Aid to Composing Music

Matt once told me that he didn’t like to talk much about his voices because nobody understood them. I could play his songs about his voices and he wondered if I understood them. I told him that I wanted very much to understand him, and if his voices were part of him, then to understand them also. I thanked him for allowing me into his music. Matt grinned broadly and invited me to join in with singing and playing on his “best song,” ‘PRACTICE PATIENCE’. I played along as he sang this lively song, accompanying himself with a quick eighth-note strum.

‘PRACTICE PATIENCE’

PRACTICE PATIENCE, BE CONCERNED.
KEEP THE FIRE BURNING, BUT DON’T GET BURNED.
WHEN YOU FEEL THAT YOU HAVE HAD YOUR WAY TOO LONG
LAY YOURSELF ASIDE LET SOMEONE ELSE BE STRONG.

FIRE AN ARROW, HIT YOUR MARK.
KEEP ON TRYING THEN YOU’LL DO IT IN THE DARK.
WHEN YOU FEEL OLE LADY LUCK BEGIN TO SHINE
THEN YOU’LL KNOW THAT I AM YOURS AND YOU ARE MINE.

FEEL THE FEELINGS DEEP INSIDE
FIRST THEY FLARE WITH ENERGY AND NEXT THEY HIDE.
WHEN YOU’RE SURE YOU’VE GONE AS FAR AS YOU CAN GO
THEN YOU’LL SEE THAT FEELINGS HAVE AN EBB AND FLOW.

Matt sang his music in a rollicking, dance-like style similar to a song from the Renaissance era, and I joined in. As he sang, he bounced his legs and feet in time to the song and tossed his hair back and forth. Each line of text ended with a minor chord and I wondered if there was a relationship between the minor sounds at the end of each line and the lyrics. Immediately afterward he shared:

This song is very special to me because my voices resisted me in writing this. I got pretty far and the voices said “Oh, it’s good enough as it is, don’t try to go on, don’t go on, don’t go on kid.” I guess they thought it was too good and they were jealous, but I resisted them and wrote the next
line and kept going. Other times when I’ve resisted them, they’ve punished me. I’m not sure how, but subtly, it goes through my head now. Sometimes it’s hard to tell what’s the voices and what’s the medication and what’s myself.

The lyrics were extremely important in Matt’s music, and I was always amazed that he could remember all the words and exactly why he used them. He thought a great deal about the associations each word might have within the context of each song. An example is his song ‘HERE’. This song was again Beatlesque sounding because it used a frequent compositional technique that the Beatles and other pop writers of that era used: diatonic chords of two keys: D and G. For example, Matt played the chords bm-am-Dmaj.7-em-A7-D in every other verse and the chords bm-am-D7-G-D-D in the other verses. These chords seemed to be loosely associated to each other as did the lyrics.

‘HERE’
HERE’S A BLANK PAGE WHITE
LIKE A POOL OF SPILLED MILK
SHOULD I, SHOULD I, SHOULD I, SHOULD I CRY

TIME TO NOT BE
WAS A GOOD LINE
GO ON, GO ON, GO ON LONG

WHERE WILL I BE TOMORROW
YOU JUST HELPED ME OUT TODAY
SOMETHING, SOMETHING HAPPENED YESTERDAY

WE ARE ALRIGHT
DO ALL THAT YOU CAN
FLYING, FLYING, FLYING, SING

Matt explained his word selections to me:

This started out very literal, as a short poem about “what do you do with a blank page?” And then I made a pun about “spilled milk” and I guess I decided to cry, because I wrote the song. The part “time to not be...” was the connection that “line” and “not” have. They both have to do with string or rope. Sort of like escaping from reality, not being, another world or something—heaven or hell. And the “where will I be tomorrow” verse, well, that’s all the Beatles. “Tomorrow” is John Lennon because his song, ‘IMAGINE,’ is looking forward. “Today” is Ringo Starr just because,
“something” is George Harrison because he wrote a song about “Something”, and “yesterday” is Paul McCartney because he wrote “Yesterday.” The last part is about my friend named Al who’s a musician, that’s the “alright” part. You see, “that” means career, like the hat you wear. So, “all that” means being a professional musician. Like I can imagine schoolteachers saying “stop all that” and I can imagine saying “do all that” instead. The last part of the song, “flying...” is just to enjoy the music.

Fear of Life Without Voices

Matt continued to share his lyrics more and more with me during our last two sessions. He had missed five weeks of sessions while he was hospitalized for treatment with an experimental drug, Clozapine, targetted at reducing or eliminating his voices. When Matt returned to sessions he was so drowsy that he could barely maintain eye contact, and sometimes drifted asleep and fell out of his chair. However, when we sang or he spoke about his music, he briefly became much more animated. The medication appeared to be effective in eliminating his voices for periods of time. I asked him how it made him feel that his voices were sometimes gone. He seemed surprised at that questions and told me he was writing a new song. Matt sang and played this recent song for me--it was still untitled but he thought he might call it THE LIGHT HURTS MY EYES,’ using a straightforward, almost redundant, even-paced strum.

A BIGGER ROLE IS CALLED FOR
THE LIGHT HURTS MY EYES

THE SUN WORKS ITS WAY TO WAKING TIME
THE LIGHT HURTS MY EYES

THE NOSE ON MY FACE SAYS “BE NORMAL”
THE LIGHT HURTS MY EYES

THE VOICE OF REASON SPEAKS
THE LIGHT HURTS MY EYES

115
I TRY TO BE CHRISTLIKE IN LABOR
THE LIGHT HURTS MY EYES

I MAKE THE TRANSITION TO ANOTHER STAGE
THE LIGHT HURTS MY EYES

I LIVE WHEN I DIE
THE LIGHT HURTS MY EYES

Matt played only three different chords in this song and they were all ordinary minor chords in the key of dm. I was struck by the startling lack of chords or harmonic depth in this song. I took this song as an answer to my question. I felt that Matt was experiencing demands on him to enter a new stage of “normality” in life and that this newness, or brightness, was painful and startling. I was also struck by how this must be a very personal struggle, manifested by his playing and singing for me and not inviting me into actively sharing it musically with him. I asked if we could spend part of our last session singing about or discussing what it was like with and without his voices. Matt seemed quite exhausted, but agreed.

During the last session Matt seemed very sad at first and initiated conversation about the effectiveness of the drugs. He said that everyone else was happy that he was reporting the absence of his voices, but that although his voices “abused” him, he did in fact miss them. He was concerned about his ability to write songs without them. He said that it was too soon to tell, and that chances were the medication wouldn’t totally eliminate his voices anyway. He said that he was too tired to talk and wanted to sing two last songs with me to end our sessions. Matt said the first song, ‘DON’T EVER END UP LIKE ME,’ was “sort of an amalgam of people I met,” and the second song, ‘FIGHT DEPRESSION NOW,’ was “what I need to keep doing.”

Matt softly and slowly sang his first song for me:
DON'T EVER END UP LIKE ME

I MET HIM ON THE STREET,
IT WAS AROUND CHRISTMAS TIME.
HE WAS WAITING FOR SOME SOUP,
HE WAS STANDING THERE IN LINE.
I GAVE HIM A QUARTER,
HE GAVE ME SOME ADVICE.
HE HAD HIMSELF A GULP,
THEN HE LOOKED ME IN THE EYE AND SAID:

(REFRAIN)
WHEN YOU LOOK IN THE MIRROR
IF SCATTERED IMAGES ARE ALL YOU SEE
GET YOURSELF SOME HELP
MAKE GOOD THE HAND YOU'RE DEALT
OR YOU'LL HAVE SHATTERED DREAMS AND MEMORIES

HIS CLOTHES WERE OLD AND WORN,
AND HIS NOT-SO-PRETTY FACE
REMINDED ME OF ROCKS
WORN DOWN BY THE OCEAN'S WAVES.
THERE WERE LOSERS ALL AROUND,
AND A POSTER ON THE WALL
WITH A BRIGHT YOUNG SHINING FACE.
IT SAID "JESUS LOVES US ALL."
HE SAID: (REFRAIN)

AND AS I WALKED AWAY
I THOUGHT OF WHAT HE'D SAID
AND I STRUCK A MATCH
TO LIGHT A CIGARETTE.
I FELT KIND OF BAD
YOU SEE, I FORGOT TO SAY
"HAVE YOURSELF A MERRY CHRISTMAS
AND A HAPPY NEW YEAR'S DAY."
HE SAID: (REFRAIN)

This song was in the key of E major and Matt used his capo on the second fret.
The verse included the chords E-f#m-A-B and the refrain incorporated E-f#m-A-D-A. These chords, like the lyrics, were extremely focused and were in a straightforward medium tempo. I was struck by how "vanilla" this song sounded in comparison to Matt's other compositions and felt sad at the thought of the words "Don't Ever End Up Like Me." I wondered about the impact losing his voices was going to have on his music.
Sense of Survival

As Matt told me he had written a new song to sing for his last song in this last Music Therapy session, he told me about some of the lyrics. I commented that he was now grinning from ear to ear, which was remarkably different from the beginning of our session that day. He agreed and said that he was feeling strong right then. Matt told me that I would have to sing this song with him since we “did things together in here,” and he taught it to me. He showed me the words and chords and we sang and played this song together. I was glad to be allowed into his experience again. This song was rowdy and upbeat, with a catchy tune. It reminded me of a Monty Python parody song. We finished our sessions by singing ‘FIGHT DEPRESSION NOW’ loudly three times in a row. When Matt and I sang this song, it reminded me of the closing song from the Monty Python movie The Life of Brian: ‘ALWAYS LOOK AT THE BRIGHT SIDE OF LIFE.’ The lyrics of this movie song reiterated the title, interspersed with bright, sunny whistling to the same melody. The irony is that the characters singing and whistling this song are kicking their legs from side to side as if in a chorus line but are all hung by their hands on crosses. They all look quite happy, but their situations appear quite dismal. I still associate this song with Matt’s ‘FIGHT DEPRESSION NOW’ not only because of the musical and textural similarities but because of his situation.

‘FIGHT DEPRESSION NOW’

LOOK AT THE SUNNY SIDE OF LIFE WHEN YOU’RE DOWN PICK A DAISY, DRINK THE DEW PRETTY SOON YA’ FEEL SHINY AND NEW SO LOOK AT THE SUNNY SIDE AND YOU’LL COME AROUND
LOOK AT THE FUNNY SIDE OF LIFE WHEN YOU’RE DOWN
HIP-HOP, MOP-TOP, POP, BE-BOP
THROW A PEBBLE IT GOES KER-PLOP
SO LOOK AT THE FUNNY SIDE AND YOU’LL COME AROUND

THOUGH YOU ARE DEPRESSED RIGHT NOW MY FRIEND
HAVE HOPE THAT YOU’LL RISE TO YOUR FEET AGAIN
JUST LOOK AT THE FUNNY SIDE HONEY
AND I’LL BE YOUR CLOWN

LOOK AT THE UP-BEAT SIDE OF LIFE WHEN YOU’RE DOWN
MAKE A MIRACLE, FIND A FEAT
FEEL IT AND MOLD IT TILL IT’S COMPLETE
JUST LOOK AT THE UP-BEAT SIDE AND YOU’LL COME
AROUND

When Matt and I were playing together he spontaneously added the words after
the intended ending of the song:

“LOOK AT MY, OH, MY, MY SIDE OF THE STREET WHEN YOU’RE
DOWN.”

As we sang this last song, we burst out laughing because it was such a fun, upbeat
song to sing and play. ‘FIGHT DEPRESSION NOW’ was in a moderate tempo
and sounded like a Broadway show tune. It was in the key of C major and used a
diminished chord of G diminished going to a G chord accentuating the word
“kerplop.” Matt played major chords during the upbeat verses and the relative
minor chords during the more depressing parts of the song.

I was excited by Matt’s music and found his songs to be quite fascinating.
He exhibited knowledge of a wide range of popular music’s harmonic structures
from Broadway show tunes to the Beatlesque style. Matt was an expert in using
minor chords to evoke the feelings of heaviiness or seriousness and also was adept
at using dissonance to illustrate tension or humor (“kerplop!”). Matt incorporated
several varied strums from a slow and somber one to a bouncy medium-paced
one, to a strong driving rhythmical one. All of his songs had strong rhythm, like
my perception of his strong will to persevere. His rhythms were always suited
and congruent to his use of lyrics. Matt’s use of chord structure also seemed to
parallel his either loose or focused associations in the lyrics.
Matt shared with me his “story” though his songs. I was allowed to learn about his auditory hallucinations and how they affected his music and his life. Toward the end of our sessions, the medication was beginning to reduce the frequency of his voices, and he was struggling to adapt to this loss. His last song seemed to suggest that he would not only survive, but also force himself to be happy about it.

I felt that Matt had “shared” his story with me through his songs and had thus allowed me into his life. I felt that he had a unique relationship with me with regard to his feelings about his new medication. The only time he appreciated his voices was in his music composing. I heard his music and the influence that his voices had on it. With the beginning changes of his voices, I was still allowed into the process musically. Matt’s goal was to share his music with me, and I felt that he reached that goal in a very real and meaningful way. I hoped that after our sessions had ended he could continue sharing with others, but that seemed uncertain due to the nature of his changing voices and the influence that could have on his music.
Sally

At 3:05 I open the door, wondering whether Sally has forgotten our first Music Therapy session. She’s standing right outside. I say, “Oh, have you been here long? I didn’t hear you.” Sally whispers, “Since three o’clock. I didn’t want to disturb you.”

I welcome her saying, “Glad you’re here, c’mon in,” but Sally takes just three small steps, barely crossing the doorway. She stands with her arms hanging limply at her side, eyes cast downward. She timidly asks, “Where am I supposed to sit?” to which I respond, “Wherever you’d like.” I find it remarkable that of all the people that have come to my office for sessions, about 100 in all, no one has ever asked where to sit. The others naturally gravitated to the only seats in the room, four chairs circling a round table in the center of the room.

Sally sits down in the closest chair and pushes it close to the table. She folds her hands on the table and waits with her chin on her chest. Sally is a slender woman who appears to be in her mid-thirties. Her feet, in ragged gray sneakers, are flat on the floor pressed close to one another. Sally is wearing a light beige short-sleeve, button-down shirt (similar to a man’s shirt) tucked into worn blue jeans. Her short fingernails are squared off at the tips. She wears no makeup. Her hair is shortly cropped around her neck in a simple, no-nonsense style.

Sally glances up only briefly as I speak, quickly looking back down at her folded hands on her lap. She rarely smiles. When she speaks, it is in a very, very quiet voice, sometimes inaudible. Often I have to ask her to repeat what she said, even though I am sitting right next to her.

I ask Sally what kind of music she likes. She responds by first describing music that she does not like. This seems rather odd, as not one of the thousands of
people I have asked about musical tastes ever began their reply with what s/he
did not listen to.

Sally pauses and answers my question of her musical preferences with:

What kind of music do I listen to? [Sally looks at me expectantly, I nod in
encouragement] Well, I don’t listen to rap, reggae, or heavy metal. [in a
quiet, shy voice] I grew up with music that I like, but I don’t listen to it
much. It’s oldie stuff [sounding rather embarrassed]. Like the 50’s, or the
Big Band era. [Long pause] I feel funny saying that.

Sally rarely speaks longer than one or two short phrases at a time. All of Sally’s
following words in this chapter were gathered over the duration of all of her
sessions, and have been sculpted together in order to give the reader a more
complete sense of her.

Other people don’t listen to my music and if I have it on, they change it.
When I was little, my father listened to this kind of music and he always
had a record going. Sometimes he would read and listen, other times he
would be drunk and dance around. My mother would just kind of sit there
and sometimes dance with him. I’d laugh at them. Growing up me and my
brothers and sisters, there’s six of us in all, listened to the Beatles, but we
got into trouble with my father for listening to them. He thought they were
into drugs. They were! If my father didn’t like something we listened to,
he would throw away our records.

Over the course of our sessions, Sally shared her reactions to music:

I used to listen to music when I was depressed and sometimes it made me
more depressed. Like when I listened to Anne Murray’s music, I had every
one of her records. It was like I had problems when I listened to her music.
I would like, get the message wrong and get depressed. I would get
depressed and listen to it over and over until my doctors told me to quit
listening to it and to give them my music. I was like, “NO,” but they were
like “C’mon,” so I gave it to them. It was hard not listening to it, but I
started feeling better and then wised up. Like one of her songs, ‘BROKEN
HEARTED ME,’ I sent that in my mind to my father. I was singing it to
him. He was already gone. I said my heart was broken because he died.

Some music I used to listen to though was really uplifting. It was like Irish
or Scottish. There was no singing to it, it was just music. It was great. It
would get me going. Like Big Band music, if I’m in a bad mood to begin
with, it lifts me up a bit, but not too far. I like listening to it when I’m
already in an upbeat mood.
Sally gradually told me aspects of her life—her aspirations, background, and her psychiatric history:

I’ve been in an upbeat mood lately. I applied to volunteer and be trained as an Emergency Medical Technician. My doctor is going to go to my interview with me. I can’t believe that I get to do this. This hospital is great. I’m glad I’m here. I waited for a bed in this hospital for almost a year. The waiting list for the Eating Disorders Unit is very long. I was on the unit for four and a half months—that was a long time for me! I had Anorexia-Bulimia. I’m much better now. Now I even get hungry sometimes! Before that I had been having psychiatric problems for a long time. I got help first when I was at a sheltered workshop and they said I should start seeing someone. I first got to this workshop by volunteering in a school for special kids and they realized that I had a learning disability, the kind with reading and writing. I wasn’t going to do it, start seeing someone, until they finally convinced me and I saw a therapist. She sent me to a hospital to be evaluated and I was hospitalized right away. I was depressed and suicidal.

I’ve been in and out of hospitals so many times I can’t even count them. They would change my medications and stuff. I have mood swings, it’s a bipolar condition, and I take Pamolar and Lithium. When my mood goes up I get silly and buy lots of things that I don’t have money for, and when I get down I get suicidal.

I’ve had lots of shock treatments. I didn’t want them, but they did them anyway. The doctor said he just wanted to meet my sister and then told her I really needed shock treatments to get me out of my depression and it was like he was going to do them anyway, so I said I would sign for them. He said “No, you can’t sign” and had my sister sign. The next time I signed. I forgot stuff afterward. But not the things I wanted to.”

Songs for Building Confidence

Music served a dual purpose for Sally in our Music Therapy sessions. It helped her feel comfortable enough with me to be able to articulate her thoughts, feelings, and concerns. A book of music, held in her hands like a prop, helped her to speak. It seemed that when Sally was holding and focusing on something having to do with music, she loosened up and spoke freely, instead of remaining silent or speaking in short, clipped responses. Sally also seemed to have an
extremely low level of self-esteem, but later, when she began teaching me how to play songs on musical instruments, she seemed to grow stronger and more sure of herself. When she was teaching me I saw her smile for the first time; she sat erectly in her chair, instead of hunching over, and told me what to do instead of waiting to be told what to do.

Sally and I used songs in two ways: we talked about them, and she taught them to me. At first, she looked through song books, unable to recall any songs without them, and then asked me to sing and play some of them for her. Sally was very shy and had great difficulty maintaining eye contact and speaking audibly. However, when she spoke about music, her voice grew louder, her verbalizations were longer, and her eye contact with me increased. When Sally and I spoke about her favorite and significant songs, she generally focused on what they meant to her in a general way, rather than on specific elements such as lyrics. The areas that emerged in the course of speaking about these songs were her family conflicts, history of sexual and physical abuse, intimate relationships, and psychiatric hospitalizations. These areas are reflected in the categories of: Establishing a Musical Connection, Starting Point as Illustrated Through Music, Family, Sexual Abuse and ECT, and Growing Through Music.

Establishing a Musical Connection

Sally and I began her sessions by talking about specific songs. She said that she particularly liked the Big Band era of music and didn’t think that many other people did and therefore was embarrassed about this musical preference. I asked her about specific Big Band songs (‘STRING OF PEARLS’, ‘IN THE MOOD’ by Joe Garland) and orchestras (Glenn Miller, Tommy Dorsey) to see
how she felt about them. She was surprised to find that I was familiar with her music and commented that people usually made fun of her musical preferences. She opened up considerably more after this point, perhaps feeling that now we spoke the same language. She shared her early memories in listening to music at home with her family. Sally always conversed most easily when she was looking at and touching something tangible that had to do with music. For example, when she looked through songbooks, she was able to speak readily about her associations with specific songs.

Starting Point as Illustrated through Music

Sally began our first session sitting silently waiting for me to start. I asked her “what would you like to do?” and she said she did not know. I suggested we do something with music and she said she did not want to sing or play, but wanted me to play songs for her on the flute or guitar and sing. She didn’t know what songs she wanted, so I suggested that she look through a songbook and pick out songs. Sally thumbed through a songbook and almost fearfully selected the song often referred to as the national anthem, ‘AMERICA THE BEAUTIFUL’ (by Katharine Lee Bates), for me play for her on my flute. Her jaw and voice shook as she told me that it was difficult asking me to play for her even though she wanted to hear this song. Later, she explained that she always had trouble asking anyone to do anything for her, that she wasn’t assertive. When I asked for an example, Sally mentioned that when she was in her outpatient program listening to the radio in the day room, and someone changed station without asking her, she would not be able to ask them to leave it alone. Even if she hated their choice, she would remain silent. I was surprised to hear Sally speak so much, because I had never
heard her say more than two or three words in a row before. As I played ‘America’ on the flute she closed her eyes and looked relaxed. Even her shoulders that were usually rigidly set dropped, and her hands that were tightly locked on her lap loosened. Then, after I finished, Sally opened up and told me:

I remember when I was a kid, I had a 22-note keyboard and much to my father’s amazement I played this song by ear. He said “You have a horrible voice and you can play the friggin’ national anthem?” in surprise.

I asked Sally how she interpreted that comment from him—if that was a compliment or a put-down, and she replied it was a compliment.

AMERICA THE BEAUTIFUL (Katharine Lee Bates)

OH BEAUTIFUL FOR SPACIOUS SKIES
FOR AMBER WAVES OF GRAIN
FOR PURPLE MOUNTAIN MAJESTIES
ABOVE THE FRUITED PLAIN
AMERICA! AMERICA! GOD SHED HIS GRACE ON THEE
AND CROWN THY GOOD WITH BROTHERHOOD
FROM SEA TO SHINING SEA

Family

As we spoke about Sally’s favorite music, she came to realize that I not only knew most of her favorite songs but that I also shared her enthusiasm for them. She became more assertive and began to more readily select songs from books for me to play either on my flute or on the guitar. Sally would tell me what the songs made her think of after I had finished. Once Sally asked me to play on guitar and sing the song ‘PUFF THE MAGIC DRAGON’ by Peter, Paul and
Mary. I softly played and sang this song, using the original key in which it was
written. Sally then introduced her family to me through that song:

Oh, yeah, I remember the words ‘PUFF THE MAGIC DRAGON, LIVED
BY THE SEA.’ We could not listen to that song in my house when I was
a kid because my father thought it was about drugs--marijuana. My father
died 13 years ago, a heart attack they said. My father got mad at my
mother the day before he died. We had a fight in the basement, all three of
us. He was beating her and he was going to kill her. He was going to shoot
her with his pistol, he was a policeman. Somehow I got between them and
pushed him up against the wall as hard as I could. It was self defense,
everyone says that. He slid down the wall and then went upstairs. My
mom and I spent the night down there and the next morning we went
upstairs and he was passed out in bed. My mom called 911, but he died a
few minutes later. No matter what happened he was my father and no
matter how bad things got, I loved him. He was always there for me even
though it doesn’t sound like that. If something happened, he sobered up
fast even though he was an alcoholic. I remember when I was a kid and
we’d beg him not to drink and tell him we couldn’t live like this.
Sometimes he would stop for awhile or lighten up and other times he
would blow us off.

PUFF THE MAGIC DRAGON (Peter, Paul & Mary)

PUFF THE MAGIC DRAGON, LIVED BY THE SEA
AND FROLICKED IN THE AUTUMN MIST IN A LAND CALLED
HONALEE
LITTLE JACKIE PAPER LOVED THAT RASCAL PUFF;
AND BROUGHT HIM STRINGS AND SEALING WAX AND OTHER
FANCY STUFF

Sexual Abuse and ECT

Sally would sit silently when she had no music books to look at, but just
looking at song titles reminded her of family events, and she would ask me to sing
them for her. Afterward, looking at the music to these songs, she would tell me
the associations she had with them. One of these songs that Sally asked me to
play guitar and sing was ‘BAD, BAD, LEROY BROWN.’ This song I played in
the “moderate boogie-rock tempo” the music suggested. The rhythm was a
dotted-eighth one in the key of G major. The melody was a sung/spoken one in a
bluesy style that I sang in a strong, forceful tone of voice. When I finished the song, Sally looked directly at me and spoke with passion in her voice, almost angrily, and told me what the song made her think of.

‘BAD, BAD, LEROY BROWN’ (by Jim Croce)

HE’S BAD, BAD, LEROY BROWN  
BADDEST MAN IN THE WHOLE DAMNED TOWN  
BADDER THAN OLD KING KONG  
AND MEANER THAN A JUNKYARD DOG

Remember when I told you that my shock treatments made me forget some things, but not the things I wanted to forget? Well, that song ‘BAD, BAD LEROY BROWN,’ makes me remember being sexually abused and beat up by my brother. He was older than me and started doing this when I was 7 until I was 13. I told my mother about it a few years ago when I was first hospitalized—it was a big mistake—she called me a liar. She confronted my brother even though I asked her not to and he said “She really is crazy and belongs in that mental hospital.” The last time I was sick my doctor brought it up again with her and my mother said, “Why do you keep bringing that up? If it did happen, it’s over.”

I didn’t feel too good about this. One of my sisters had also been raped by another brother of mine and my mother walked in and saw it and beat the hell out of my sister. I don’t want to ever go home. It’s very hard to see my mother and I don’t want to be near my family. My brother that sexually abused me would also threaten me with a gun, he’s a cop. He would hold his gun to my head when he was drunk. He would hit me, punch me, he broke my arm once. He also once hung me on the wall by my throat with his hands.

Sally then asked me to sing and play:

‘WHERE HAVE ALL THE FLOWERS GONE’ (by Pete Seeger)

WHERE HAVE ALL THE FLOWERS GONE? LONG TIME PASSING  
WHERE HAVE ALL THE FLOWERS GONE? LONG TIME AGO  
WHERE HAVE ALL THE FLOWERS GONE? GIRLS HAVE PICKED THEM EVERY ONE  
WHEN WILL THEY EVER LEARN? WHEN WILL THEY EVER LEARN?

I played and sang this song with the four repetitive chords written for it: C-am-F-G and sang it evenly and calmly. I remembered thinking that this song originated from an old Ukrainian folksong and thought how it fit many cultures, peoples, and
times. This version of the song then has repetitive verses about the girls going to husbands who in turn become soldiers and die, then about graveyards and back to flowers again. I wondered if this related to the seeming cyclical pattern of abuse in Sally’s family by powerful male figures armed with guns. Sally spoke after the entire song had ended:

That reminds me of last year at this time. It was the anniversary of my father’s death and I was locked up in the hospital. I wasn’t doing too good. I was in the quiet room. I wanted to be with him. I wanted to be dead. I’ve tried to kill myself a lot of times. Once I went down to the basement to try to kill myself and found a crowbar and began to hit my head with it. I hit it four times, but I only fractured the bone all the way down. What? You asked me “What keeps me alive?” I’ve never been asked that before! I guess I’m just a chickenshit. I can’t go through with it.

While Sally spoke she often held onto the songbook with one hand and sometimes held it in her arms against her chest. When she spoke about particularly painful songs and their significance in her life, she would at times speak to me through the page of music. It seemed that the book itself served as an object of safety, power, or comfort for Sally. She also seemed to feel better about herself as she recalled these painful memories and realized that previously she could not even think about them without becoming suicidal. She said that she was now able to talk about these memories and realized how much stronger she was than before.

Growing through Music

The second way of relating that Sally and I had in our Music Therapy sessions consisted of Sally figuring out and teaching me her favorite songs on the piano and xylophone. When Sally taught me songs on the piano and xylophones, she grew much stronger and more assertive.
The way that Sally started teaching me to play songs was quite accidental. I remembered her telling me that she enjoyed instrumental songs and asked her if she wanted to play some music with me without words. We decided to play the bass xylophones together during our third session, and as we were setting them up I hit four notes (G-F-C-C) to show her how one of these instruments sounded. Sally told me that those four notes were the beginning of a song and immediately began to figure out the song. After about five minutes of experimenting on her xylophone, she realized that the song was SEND IN THE CLOWNS’ by Steven Sondheim. She was able to pick out the entire melody bit by bit and taught it to me as she discovered phrase after phrase. The melody to this song was primarily comprised of one short phrase repeated twice, one longer phrase, then one short phrase. Although the original song is in the key of Eb, Sally adapted it to the key of C.

Sally seemed extremely pleased that she was able to do this and kept grinning and happily repeating “I can’t believe I can figure out this song and teach it to you!” We spent an entire hour-long session with her teaching me this song bit by bit in a slow, patient manner. I usually play by reading music, and Sally tried to learn how to read music as a child, but her learning disability made this an impossible activity for her. However, Sally’s ability to play by ear greatly excited her and I was genuinely interested in learning from her.

The next sessions were also spent in large part with Sally teaching me other songs on the xylophone. She would generally remark on her ability to play by ear by commenting “I can’t believe I can play this good without even reading music,” and then taught me the songs ‘HEART AND SOUL’ and later on, ‘YOU NEEDED ME’ (by Anne Murray). Sally commented on how good she felt to be able to do this. She explained that these two songs had been extremely important
during most of her hospitalizations and that she would play it when she was upset. She told me,

I still can’t believe I could play that ‘SEND IN THE CLOWNS’ by ear. I never had played it before! I recognized the notes you played when you were messing around and you didn’t even know what you did! I had to teach you!

Sally was the most animated I had ever seen her when she was teaching me songs. She would grin, smile, laugh, speak freely and energetically and even joke with me as she taught me her “important” songs, as she called them.

Later, during one of our last sessions, Sally asked if I would like to hear her play the song, ‘AMERICA,’ on the keyboard. After she played it for me she told me, “You know when you asked me if what my father said was a compliment? Well, I think it was really a put-down. It was definitely a put-down.” Sally then spoke about how any attention from him was seen by her as positive until quite recently. It seemed to me remarkable that Sally was now able to look at this incident so differently after such a relatively short period of time. I felt her growth in self-esteem had to do with the types of things we did in our Music Therapy sessions.

I was very struck by Sally’s need for safety, structure, and tangible objects. Without any of these she was not able to voice her thoughts. Holding songbooks enabled her to tell me a great deal about her life. It also seemed that throughout her experiences in hospitals and programs as an adult, and probably in schools long before that, she was always in the position of being the recipient of help, never the helper or teacher herself. Sally’s ability to teach me music seemed to be extremely important to her increased feelings of self-esteem. Although we never discussed the lyrics themselves in any of the songs that Sally taught me, I
often wondered if the song ‘YOU NEEDED ME’ was her way of telling me that I
needed her to teach me; in other words, that she was important.
Tom

Tom is a middle-aged male who is dressed in a golf shirt, khaki pants, and tennis shoes. His stomach hangs over his pants, stretching his shirt tightly across his waistline and chest. His face is slightly flushed, and perspiration mats some of his hair from the sides of his head to his forehead. His brown hair is thin and covers the sides of his head in a simple, straight style. Behind wire-rimmed glasses, his facial expression vacillates back and forth between sullenness (with a down-turned mouth) to a frown (with wrinkles creasing his forehead).

Approximately 10 minutes prior to our scheduled time, Tom steps into the Music Therapy room without knocking. He has his guitar in hand. As I introduce myself, he sits down in a chair and looks at me expectantly. He slumps back slightly into the chair, his legs spread apart and his hands resting on his lap. He seems a bit nervous. His hands and knees shake slightly, and his eyes dart around the room.

I am not quite ready, since he is early. Hoping to involve him and give him a feeling of more control and comfort in this session, I ask Tom if he will unwrap a cassette tape while I set up the tape player. He willingly completes the task. Then, without a word, he puts the tape in the recorder, turns it on, takes out his guitar, and begins to play. He strums several chords softly. His hands and knees have stopped shaking. The chords aren’t from any song I recognize, but they fit easily into a rock-and-roll progression.

Tom continues playing and motions toward my guitar, telling me I can join in if I would like. I quickly tune my guitar to his, and Tom returns to his chord progression. I try to imitate his chords and his strumming. While playing, I
thank Tom for unwrapping the tape. Over the next five minutes of playing, Tom speaks to me in snatches.

I like it when people tell me “thank you.” They do that at my volunteer job at the Medical Center... I translate Spanish and wheel patients about... I learned Spanish and French at college where I was a language major... I like being a good person and treating other people like I like to be treated. I try to be a good friend and reciprocate and let others educate me when I need it.

When Tom stops playing, I do too and we begin to speak about the study that Tom has agreed to participate in. Tom tells me that he doesn’t know how long he will be in the hospital because he is angry at all of the staff and is only “hanging on” so that he can have Music Therapy. He tells me about himself:

There’s been a lot of hospitalizations. I have lots of illnesses, they are called “Schizo-affective, Bipolar, and Personality Disorder.” You name it, I’ve got it. I don’t really listen to labels, except the Bipolar one. I keep that in mind ‘cos I have a chemical imbalance and without medication I lose it. I used to take Lithium, but I just started a new medication, Depico.

His voice is rather subdued and he speaks within a very limited pitch range, almost in a monotone. Tom’s vocabulary is quite large, as large as one might expect from one who attended college. He listens to what I say, pauses, and then usually replies in short, one-phrase sentences. Tom’s eye contact makes me feel somewhat ill at ease because he stares into my face almost all of the time. He rarely glances away and blinks infrequently. I find myself acutely aware of where my own gaze falls. Tom rarely laughs, and when he does, it is a short grunt of laughter without much change of facial expression.

Tom begins to play a song by Billy Joel titled ‘MY BABY GRAND’ and offers up comments as he plays:

That’s a great song--how his instrument is his best friend. It’s always there, always comes through for him. That’s how I feel about my guitar. My guitar always makes me feel good and rarely complains--except when
it goes out of tune or needs new strings! You can trust your instrument, but not your woman. Yep, you can trust an instrument all right. I had a piano once, but my mother sold it on me. It didn’t go along with her decor. I’ll get another one someday, it wasn’t worth arguing about this one.

**Songs for Making Contact**

Tom played guitar and sang many songs, all of them by popular songwriters primarily from the 1960’s and 1970’s. They were of the folk rock and classic rock variety usually. His guitar-playing was quite advanced, utilizing all of the common chords as well as some more complex chords, including bar chords. The shaking of his hands and legs seemed to stop when he started playing guitar, and he was able to strum and pick without faltering. Tom’s singing voice, as opposed to his speaking voice, had a large range and he seemed quite at ease singing out in an audible and clear tone. Many of his songs were originally performed by singers singing with a folksy, raspy twang that Tom imitated well.

His way of staring at me intensely made me think he was uneasy with me. Before he played his first song, Tom invited me to follow along in playing and singing with him. I did so, hoping to form an alliance with him. The fact that I had to learn the chords of the songs from him provided him with the role of “teacher.” I followed his chord changes by watching his hands. Luckily, I was familiar with many of his songs, and was therefore was able to “speak his language” by singing them with him. When I asked questions such as “What was that song about?” Tom usually responded, “The words,” perhaps adding a short, descriptive phrase from the song, and would then immediately begin another song.

As he continued playing and singing one song after another, I found myself thinking that one way to understand Tom was through his choice of songs.
Another way was by paying close attention to how he described the songwriters. It seemed to me that he projected his own thoughts and feelings onto these artists. These realizations did not come easily to me, because I also felt that he used his music as a shield to prevent his thoughts and feelings from being too readily apparent. Tom seemed to treat me as an appreciative audience member, rarely pausing between songs and hardly ever speaking spontaneously. I was surprised how many meaningful connections I was finding between the songs but did not feel comfortable discussing these insights with Tom. I found him too vulnerable and defensive in all three Music Therapy sessions. Instead, I felt that it was more important to forge a trusting and comfortable relationship with him.

The following are the most significant songs that Tom sang and played over the course of our three sessions.

Musical Introduction

Tom began our first session with this song and it seemed to me that it was his way of introducing himself to me verbally much as one might say “I was born to a family that...” Tom played guitar and sang in a raspy voice that was pitched well for the first part of the song ‘FOUR AND TWENTY’:

‘FOUR AND TWENTY’ (Steven Stills)

FOUR AND TWENTY YEARS AGO I CAME INTO THIS LIFE
THE SON OF A WOMAN AND A MAN WHO LIVED IN STRIFE
HE WAS TIRED OF BEING POOR
AND HE WASN’T IN TO SELLING DOOR TO DOOR
AND HE WORKED LIKE THE DEVIL TO BE MORE

This song, in the key of D, sounded a bit depressing, and after the song ended I asked, “Can you tell me a little about that song? I don’t know it,” to which Tom
replied, "It's about the words." I then responded, "Oh, I was so busy watching your hands to learn how to play it that I didn't get to listen much to the lyrics, so tell me about the words." Tom told me, "It began when he first made it big in music and he didn't know what was going on. He was making all this money and he was breaking up with women, a lot of sex and no love and all that kind of stuff."

Tom then began another song. The incessant stare of his unblinking eyes made me uncomfortable. He rarely glanced away except to look quickly at his hands or mine on our guitars, but those glances were so brief that they offered little relief. His eyes just seemed to fixate on my face.

Intimacy

Tom played his next song with a delicate, quiet strum on his guitar and sang softly and slowly. This song was free flowing and evoked a romantic scenario through the lyrics:

'LADY OF THE ISLE' (Graham Nash)

HOLDING YOU CLOSE, UNDISTURBED BEFORE A FIRE
THE PRESSURE IN MY CHEST WHEN YOU BREATHE IN MY EAR
I KNEW THIS WOULD HAPPEN WHEN YOU FIRST APPEARED
MY LADY OF THE ISLE

My acute awareness of his gaze as he sang this song led me to think that I needed to ask Tom about how he was perceiving our time together, but I did not want to ask too personal a question yet, so I asked about the songwriter. Tom told me that in this song the songwriter had "fallen in love," and when I said, "I wonder how he felt about having fallen in love in that song," Tom did not speak but immediately began his next song. He strummed strongly and sang out in a
confident voice. I followed along in playing the chords on my guitar and listened to Tom's voice.

'WOUNDED BIRD' (Graham Nash)

I'VE WATCHED YOU GO THROUGH CHANGES THAT NO MAN SHOULD FACE ALONE
TAKE TO HEEL OR TAME THE HORSE THE CHOICE IS STILL YOUR OWN
BUT ARM YOURSELF AGAINST THE PAIN THE WOUNDED BIRD CAN GIVE
BUT IN THE END REMEMBER, IT'S WITH YOU YOU HAVE TO LIVE
AND IN THE END REMEMBER, IT'S WITH YOU YOU HAVE TO LIVE

STAND YOUR GROUND I THINK YOU'VE GOT THE GUTS IT TAKES TO WIN
BUT YOU MUST LEARN TO TURN THE KEYS BEFORE SHE'LL LET YOU IN
AND UNDERSTAND THE PROBLEMS OF THE GIRL YOU WANT SO NEAR
OR YOU'LL WEAR THE COAT OF QUESTIONS TILL THE ANSWER HAT IS HERE
BUT IN THE END REMEMBER...

SERENADE YOUR ANGEL WITH THE LOVE SONG FROM YOUR EYES
AND GROW A LITTLE TALLER EVEN THOUGH YOUR AGE DEFIES
FEEL A LITTLE SMALLER AND IN STATURE YOU WILL RISE
A HOBO OR A POET MUST KILL DRAGONS FOR A BRIDE
AND HUMBLE PIE IS ALWAYS HARD TO SWALLOW WITH YOUR PRIDE
BUT IN THE END REMEMBER...

This song was again in the key of D, and Tom played it with soft, pretty and simple strums. It sounded philosophical as though an older man was explaining love to a younger man. After we played this song, I asked Tom what the most important words were and he replied without hesitation, "Serenade your angel with a love song from your eyes." I inwardly reflected on how uneasy his gaze made me feel, but before I could comment he immediately played his first, and only, classical piece. It had no lyrics and he couldn't remember anything
about it, other than that he liked it. Looking back on this classical piece, I wondered if it was a distancing kind of musical statement. The piece he selected could not directly reflect his feelings on a textual level and therefore perhaps felt safer to play. Then Tom began another popular song still in the key of D. This song seemed like Tom was longing for something that he no longer had.

'LONG AGO AND FAR AWAY' (James Taylor)

LONG AGO A YOUNG MAN SITS AND PLAYS HIS WAITING
GAME
BUT THINGS ARE NOT THE SAME IT SEEMS
AS IN SUCH TENDER DREAMS
SLOWLY PASSING SAILING SHIPS AND SUNDAY AFTERNOONS
LIKE PEOPLE ON THE MOON I SEE
ARE THINGS NOT MEANT TO BE

(chorus)
WHERE DO THESE GOLDEN RAINBOWS END?
WHY IS THIS SONG I SING SO SAD?
DREAMING THE DREAMS I'VE DREADED MY FRIEND
LOVING THE LOVE I LOVE TO LOVE

LOVING THE LOVE I LOVE TO LOVE
IS JUST A WORD I HEARD
WHEN THINGS ARE BEING SAID
STORIES MY POOR HEAD HAS TOLD ONCE
CANNOT STAND THE COLD
AND IN-BETWEEN WHAT MIGHT HAVE BEEN
AND WHAT HAS TO COME TO PASS
A MISBEGOTTEN GUESS ALAS
AND BITS OF BROKEN GLASS (chorus)

This song had a complex picking pattern, so I watched without playing. This was the first song since we began that I didn’t play and I was struck by the feelings of loneliness and isolation in the lyrics. I also wondered at the fact that Tom chose a very difficult way of playing this song that was not conducive to our playing together, and thought that this might be his way of still keeping me at a distance. I was also curious if Tom was making statements in the music about romantic feelings for me but at the same time trying to keep himself safe since he
had been hurt before. Perhaps he wanted to be able to love again, but did not feel that this would ever again be a real and safe possibility for him. To make him feel safe while hopefully checking my hunches, I asked Tom about the songwriter and not about himself and his selection. Tom told me that this songwriter was "A very nice guy. He was screwed up in the past, but he got through it. Music helped him get through it." I commented that I enjoyed hearing Tom play and sing, to which he responded, "Well, most people say I don't sing well, so I don't sing usually. Professional musicians have told me that my voice is lousy." I then asked, "Well, I wonder how it makes you feel to hear me say that I enjoy your music?" Tom immediately began another song:

Trust

Tom began 'YOU’VE GOT A FRIEND,’ and I joined in playing and singing with him. We sang this song in a peaceful, calm style matching our strums together in very similar rhythms. I was familiar with the chords (am-E-am-E-am-F-G-C-E-am-E-am-F-em-dm-G-dm-G) and focused on our singing. Tom sang the first verse and chorus to this song and left out the last two verses that are about loyalty during cold and stormy difficult times.

'YOU’VE GOT A FRIEND' (Carole King)

WHEN YOU’RE DOWN AND TROUBLED, AND YOU NEED SOMETHIN’ CARE
AND NOTHIN’, NOTHIN’ IS GOING RIGHT
CLOSE YOUR EYES AND THINK OF ME AND SOON I WILL BE THERE.
TO BRIGHTEN UP EVEN YOUR DARKEST NIGHT

YOU JUST CALL OUT MY NAME, AND YOU KNOW WHEREVER I AM
I’LL COME RUNNING TO SEE YOU AGAIN
WINTER, SPRING, SUMMER OR FALL, ALL YOU HAVE TO DO IS CALL
AND I’LL BE THERE; YOU’VE GOT A FRIEND
Again, I found myself reflecting on our previous verbal interchange and it seemed that his song was in response to my supportive comments, but before I could say anything, Tom commented that our singing seemed off-tempo or not “in-synch” and then began yet another song. I was surprised at his comment because at the time, and later as I listened to the tape recording, I noticed no evidence of any rhythmical instability in our singing. I wondered if it was his way of protecting himself from too much intimacy by judging our interaction negatively. Tom mentioned all his “scars from the bars” he had played in when people were disrespectful of his music, and said that his self-esteem was low from being a “mediocre” performer. He said that his goal was to build his “self-confidence” in our Music Therapy sessions. Tom then immediately began to play in a stronger and more dynamic way:

‘YOU MUST HAVE’ (Emmet Rhodes)

YOU MUST HAVE FOR EVERY RAINDROP, A RAY OF SUN
YOU MUST HAVE FOR EVERY TEARDROP, A SMILE FOR SOMEONE

(chorus)
TO GET BY
TO LIVE YOUR LIFE
YOU MUST HAVE FOR EVERY RAINDROP A RAY OF SUN

YOU MUST HAVE FOR EVERY GREY SKY
A SKY OF BLUE
YOU MUST HAVE FOR EVERY LOVE LOST
A LOVE THAT’S NEW (chorus)

I’VE BEEN ALONE TOO LONG TO FEEL RIGHT
I’VE BEEN ALONE TOO LONG TO SAY GOODNIGHT
SOMEBODY HELP ME SEE THE LIGHT
JUST SPREAD A LITTLE SUNSHINE ON ME (chorus)

AND I KNOW YOU KNOW THE WAY
AND I FEEL YOU FEEL THE SAME
JUST SPREAD A LITTLE SUNSHINE
EVERYTHING WILL BE FINE
SPREAD A LITTLE SUNSHINE ON ME
As Tom sang this song and I found myself wondering if my comment about enjoying his music had been the “smile” for the “teardrops” brought about by the comments from the professional musicians. I asked Tom to tell me about this song. He quickly answered, “It’s another love song,” and went on to his next song.

Painful Past Relationships

Tom began the next song in the key of D major and used a light but sad sound in his strumming. I found myself thinking that the song was about being respected.

‘RIGHT BETWEEN THE EYES’ (Graham Nash)

MY HEAD IS HANGIN’ HEAVY WITH THE THOUGHTS OF YOU IN MIND
DECIDE THE NATURE OF THE DAY
ADVANTAGE OF THE BLIND
SO TELL BEFORE YOU COME TO ME
FROM OUT OF YONDER SKIES
A MAN’ A MAN WHO LOOKS A MAN
RIGHT BETWEEN THE EYES

THE THING THAT WE COULD BRING TO HEAVEN
I DON’T THINK WE COULD BEAT
PLEASE DON’T ASK ME HOW I KNOW
I’VE JUST BEEN UP THAT STREET
AND IF THE PEOPLE LIVING THERE
HAVING BEEN SILENCED BY THEIR OWN LIVES
A MAN’S A MAN WHO LOOKS A MAN
RIGHT BETWEEN THE EYES

This mournful song ended strangely, as if it weren’t really ending (on a Gmaj-7 #11 Lydian chord), and Tom told me, “I don’t know if I got the words right, but this one was about the breakup of a marriage or a long affair. He really got hurt by his wife or lover, and he didn’t know what to do, so he got along somehow till he met somebody else. Relationships are weird like that.” I asked
Tom to tell me a little about his experience with relationships and he pulled out his lower guitar string loudly and laughed and continued:

Oh God! I've been dry for a long time. I have occasional dates, nothing much. I had a lot in the late 60's and 70's, and since the 80's it's been downhill all the way. That was when I got sick, I had a lot of hospitalizations.

His song selections were usually from the 60's and 70's, and at this point I remembered research showing that musical preferences with the elderly usually stemmed from their courtship years. This seemed the case with Tom. I was also thinking how glad I was that he was finally able to talk to me about himself directly. Tom continued:

Wrong women. Either I was right or they were wro...right. Y'know what I mean? Unrequited love and all that stuff I was going through. Just thinking about that is a bummer. I'd rather play. It calms me down.

Pleasure in Music

Tom began playing and singing again:

ROCKY RACCOON' (John Lennon and Paul McCartney)

ROCKY RACCOON CHECKED INTO HIS ROOM
ONLY TO FIND GIDEON'S BIBLE
ROCKY HAD COME EQUIPPED WITH A GUN
TO SHOOT OFF THE LEGS OF HIS RIVAL
HIS RIVAL IT SEEMS HAD BROKEN HIS DREAMS
BY STEALING THE GIRL OF HIS FANCY
HER NAME WAS MAGILL AND SHE CALLED HERSELF LIL
BUT EVERYONE KNEW HER AS NANCY

This was the first song that Tom sang that was upbeat, and he said it was just for fun. He sang loudly and quickly and smiled throughout the song. Tom played it in two as called for by the music and in the key of C. He was quite adept at this song and even gave the eighth notes a triplet feel toward the end of the
song, playing and singing this portion in the “barrelhouse” style. I joined in and reflected his happy mood. After we sang and played it together, we burst out laughing. Tom commented, “I think about music when I get upset. When the world gets me down, I listen to music” and went on to another song:

Search for Acceptance

Tom began the next song and was able to imitate the complex introduction with glissando chords on his guitar. He included even the most difficult of the specified chords such as E9, and A9sus. Tom sang this song in almost a winsome, plaintiff voice as if he were pleading with someone. I joined in singing and playing but could not complete all of the chords that Tom did and had to watch his hands intently to learn them.

‘JUST THE WAY YOU ARE’ (Billy Joel)

DON’T GO CHANGING TO TRY AND PLEASE ME
YOU NEVER LET ME DOWN BEFORE
MMM, MMM, DON’T IMAGINE
YOU’RE TOO FAMILIAR
AND I DON’T SEE YOU ANYMORE

I WOULD NOT LEAVE YOU
IN TIMES OF TROUBLE
WE NEVER COULD HAVE COME THIS FAR
MMM, MMM, I TOOK THE GOOD TIMES
I’LL TAKE THE BAD TIMES
I’LL TAKE YOU JUST THE WAY YOU ARE

I felt that this was Tom’s way of asking me to accept him exactly how he was. Tom abruptly stopped this song halfway through, bitterly complaining, “I forgot it.” I explained to Tom that in Music Therapy I was interested in the process of his music and not the product. Tom looked relieved and then spoke in musical terms about the song: “The best part was coming up, the part that said ‘I
love you and that’s forever, and this I promise from the heart.’ That’s the strongest part of the song for me.” I had a hunch that this was Tom’s way of telling me that he heard me and felt accepted by me.

Sharing Self

As Tom began the following song, it seemed that he had gathered his strength and sang out strongly and in a definite manner. I joined in playing only since I did not know the words.

‘EVERY WOMAN’ (Dave Mason)

DON'T MISUNDERSTAND ME THOUGH I KNOW THAT I'VE BEEN MEAN
WOMAN CAN'T YOU SEE I'M IN NEED
ALTHOUGH WE MAY BE FAR APART
IN HEART AND SOUL WE'RE NEAR
MY BODY ACHES FOR YOU TO BE NEAR

YOU ARE EVERY WOMAN IN THE WORLD TO ME
ANY EVERY SEASON I GO THROUGH
YOU ARE EVERY WOMAN IN THE WORLD TO ME
ESPECIALLY WHEN I'M MAKING LOVE TO YOU

LIKE A FALLING TEARDROP
YOU CAN WIPE AWAY MY BLUES
LIKE THE HONEY YOU CAN MAKE THE BITTER SWEET
YOU ARE A GIRL, CHILD, A WOMAN
YOU ARE EVERYTHING I CHOOSE
THAT'S WHY I SING THIS SONG, SONG OF LOVE TO YOU

Again Tom stopped playing after these phrases and abruptly said:

Forgot the rest of the words. Someone stole my album. A house I lived in was filled with drugs and everything. There was noise all the time, people blasting their music at full volume all the time. There were fights, it was in a poor part of town. I couldn’t stand it. I’d go crazy. I’d get sick or something. I’d have to go live at my mother’s house for like nine months out of the year.
He then went directly into the next song, singing and playing almost in a comical, haphazard way in an upbeat fashion sounding rebellious:

‘COMIN’ IN FROM LA.’ (Arlo Guthrie)

COMIN’ IN FROM LONDON FROM OVER THE POLE FLYING IN A BIG AIRLINER
CHICKENS FLYING EVERYWHERE AROUND THE PLANE, MAN, I COULDN’T FEEL MUCH FINER
COMIN’ IN FROM LOS ANGELES, BRINGING IN A COUPLE OF KEYS-
DON’T TOUCH MY BAGS, IF YOU PLEASE, MR. CUSTOM MAN

THERE’S A GUY WITH A TICKET TO MEXICO
EVEN THOUGH HE COULDN’T LOOK MUCH STRANGER
WALKING IN THE HALL WITH HIS THINGS AND ALL
SMILES AND SAY HE WAS THE LONE RANGER

HIP WOMAN WALKING ON THE MOVING FLOOR
TRIPPING ON THE ESCALATOR
THERE’S A MAN IN LINE AND SHE’S BLOWIN’ HIS MIND
THinking THAT HE’S ALREADY MADE HER

Tom sang this song right after talking about getting sick where he used to live. I had an image of a big airplane zooming up and down that seemed to represent Tom’s bipolar illness. The crazy scenario in the song seemed to illustrate either having a “flight” of ideas or being on a psychiatric unit. Again, it seemed to me he was sharing himself, his illness with me. After playing and singing this song with Tom, I indicated that our time had come to an end and asked how he wanted to finish up our session. Without replying, Tom began another song.

Sharing Feelings for Therapist

It was ‘MAKE IT WITH YOU,’ and Tom sang it one-half step lower (D) than the key it was originally written in (Eb). I believe this was for the sake of
simplicity because the original chords are rather difficult. Tom sang in a timid voice, with lots of pauses between phrases. His tempo was slower than the recording, and was almost like a slow, strolling pace.

‘MAKE IT WITH YOU’ (David Gates)

HEY, HAVE YOUR EVER TRIED
REALLY REACHING OUT FOR THE OTHER SIDE
I MAYBE CLIMBING ON RAINBOWS
BUT BABY, HERE GOES

DREAMS ARE FOR THOSE WHO SLEEP
LIFE IT’S FOR US TO KEEP
AND IF YOU’RE WONDERING WHAT THIS IS ALL LEADING TO,
I WANT TO MAKE IT WITH YOU

As Tom sang and played this song, he for the first time did not stare at my face, but instead looked out the window to his side. Although I felt a sense of relief at his change in focal point, I felt the lyrical content of the song unsettling. Tom stopped in the middle of song and said, “I can’t play this one.” I asked why he picked that one, and he answered that it was the only song by the group Bread that he knew. As I began to ask why he could not finish it, he once again went directly to the next song:

‘YOUR SONG’ (Elton John and Bernie Taupin)

IT’S A LITTLE BIT FUNNY THIS FEELING INSIDE
I’M NOT ONE OF THOSE WHO CAN EASILY HIDE
I DON’T HAVE MUCH MONEY BUT, BOY, IF I DID
I’D BUY A BIG HOUSE WHERE WE BOTH COULD LIVE

IF I WAS A SCULPTOR, BUT THEN AGAIN, NO,
OR A MAN WHO MAKES POTIONS IN A TRAVELIN’ SHOW
I KNOW IT’S NOT MUCH BUT IT’S THE BEST I CAN DO
MY GIFT IS MY SONG AND THIS ONE’S FOR YOU

AND YOU CAN TELL EVERYBODY THIS IS YOUR SONG
IT MAY BE QUITE SIMPLE BUT NOW THAT IT’S DONE
I HOPE YOU DON'T MIND, I HOPE YOU DON'T MIND-
THAT I PUT DOWN IN WORDS
HOW WONDERFUL LIFE IS WHILE YOU'RE IN THE WORLD

This song was sung and played slowly with a strong beat as heard in the recordings, and Tom sang it with confidence. He strummed each chord with identical strums so that the entire song felt extremely structured. Although the chords changed rather frequently, approximately 20 chord changes a verse, Tom never lost track of them. He even accentuated the downward descent of the bass line within these chords with his bass string of the guitar. Tom's mood seemed to be that of hope and happiness while he sang and played.

Tom then spontaneously began to tell me how he felt about the songwriter and said, "He's a good musician. He thinks he's God though. He's been through a lot and I think he's got a big ego. He needed it I guess to survive." I wondered if this was how Tom perceived himself and noticed that I also perceived him as being rather egotistical, which I thought probably stemmed from his insecurities. Without another word, Tom began to play in a moderate tempo and sing with confidence and I followed similarly with my playing:

'LOVE SONG' (Elton John)

THE WORDS I HAVE TO SAY, THEY MAY BE SIMPLE BUT THEY'RE TRUE
BEFORE I GIVE MY LOVE THERE'S SOMETHING MORE YOU MUST DO
LOVE IS THE OPENING DOOR
LOVE IS WHAT WE CAME HERE FOR
COULD ANYONE OFFER YOU MORE
DO YOU KNOW WHAT I MEAN?
HAVE YOUR EYES REALLY SEEN?

YOU SAY IT'S VERY HARD TO LEAVE BEHIND THE LIFE YOU KNEW
BUT THERE'S NO OTHER WAY AND NOW IT'S REALLY UP TO YOU
LOVE IS THE KEY WE MUST TURN

148
TRUTH IS THE FLAME WE MUST BURN
FREEDOM, THE LESSON WE MUST LEARN
DO YOU KNOW WHAT I MEAN?
HAVE YOUR EYES REALLY SEEN?

This song, in the key of G-major-7, seemed to reflect the idea I had that Tom hoped that by finding love he could find a new way to live. I wondered if he felt that I personally could offer this kind of love for him. As Tom finished this song, he began to stand up and put his guitar away without stopping to comment or hear my comment about the song. I was extremely curious about the connections between these last two songs, and his feelings about me, but he seemed as protected as one could possibly be, standing up and turning his back to me in order to begin putting away his instrument. I asked if there were a musical theme linking the songs together and he replied “love.” Then suddenly he sat back down and asked if he could play “just one last song.” Without waiting for my reply, he began:

Hope for Healing

Tom began his final song with one simple strum on his guitar to set the harmonic content, then looked at me and sang in an upbeat manner giving the song a joyous, ragtime feel:

‘GABRIEL MOTHER’S #16 BLUES’ (Arlo Guthrie)

WOKE UP THIS MORNING WITH MY HEAD IN MY HANDS
C’MON CHILDREN, C’MON. JESUS IS GOING TO MAKE YOU WELL
I’M GOING TO MAKE YOU WELL

Tom did not sing any other words to this song but these. He said that he could not remember others, but that these were the most important ones anyway.
I found it interesting that Tom selected this song to be his last one, and that even though I had said his time had ended, he insisted on playing this “one last song.” I asked “Did that song have significance since it was the last song we got to do today?” Tom replied that he liked the song because his father used to ask him to play it, since, “it is a good song” and, because he had figured it out by himself. Tom also happily informed me, “I think that it is the best song that I play. I hadn’t played it in years though. I heard that song the other day and I’m lucky I remembered the music and how to play it.”

I wondered if there was not also some sort of reference in this final song to his therapy and his hopes that it would help him. It seemed to me that this last song also summed up his journey from feeling only pain and isolation in searching for someone else to heal him, and finally finding his own ability to heal himself. Tom offered me communication through his song selections. He shared with me his experiences, vulnerabilities and hopes through his music.

Summary

Each participant allowed me into his or her experience through the medium of music in our sessions. Each had already used music in his or her own life, for a variety of reasons. They entered the Music Therapy sessions with a sense of what their music meant to them and why. We shared their music and their songs as a common ground upon which our relationships were built. I use the term “common ground” because this music was mutually experienced. We each played, sang, listened, created, and talked about their songs together. Our relationships were built securely on this musical ground, and trust sprang forth from the common ground that we shared. Because of this musical common
ground, trust developed in our relationships, and I was permitted access to their “lands of living” with psychiatric illnesses. I was allowed to hear about their experiences in living with such disabilities. Their songs were the bridge that connected our lands of therapist and patient together, and this bridge was built strongly and quickly by both of us. The incredible part to me was that the actual process of building musical bridges was filled with such joy and was so full of meaning, and although the work was exhausting, it was never tiresome. It was an extremely rewarding experience!
CHAPTER V
THEMES OF ILLNESS AS COMMUNICATED THROUGH SONGS

A handful of Music Therapists have recently begun to focus on patients with psychiatric illnesses and their lives and struggles outside of the Music Therapy session. Langdon, Pearson, Stastney & Thorne (1989) purposefully set out to describe their patients' lives in the community. Although I didn't request it, the participants in this particular study all spoke of their lives and struggles in the community during their sessions. As previously seen, the participants had unique ways of using songs that enabled them to speak about their lives. Every participant spontaneously spoke about two common areas of their lives in detail through their music. These two areas had to do with their psychiatric illnesses and their perceptions of themselves and others. The participants spoke often during the course of their sessions about having low self-esteem and also focused on having difficulties in their intimate relationships. I will be sharing their thoughts in these two themes: "I'M A BROKEN SELF" and "WE WERE FALLING APART TOGETHER."

During the recursive analysis, I found these two themes that linked all of the participants' experiences. A theme is defined by Ely et al. (1991) as a "statement of meaning that runs through all or most" of the data (p. 150). These two themes initially surfaced and captured my interest as direct quotes from two participants. Then, during the recursive analysis of the data, these two thoughts continued to reappear through every participant's songs and discussions over and over. It intrigued me that each participant spoke about these two areas in different
ways, but expressed similar thoughts. These themes seem to me to encapsulate the primary issues that each of the participants struggled with on a day-to-day basis. Both of these themes are very painful to experience, and it seems that the songs helped make these issues easier to first identify and then to share with me.
"I'm a Broken Self"

All of the participants spoke about not feeling "whole," "complete," or "normal," due to their psychiatric illnesses. This seemed to me to be an extremely private and sensitive view for them to share with me. I felt they were able to self disclose such emotionally laden material because I had been able to feel what they might feel, be empathetic, through sharing their songs. Hesser (1992) writes "Empathy can dissolve alienation. The client feels he is not alone and that someone understands how he feels" (p. 1).

I believe that my empathy was essential to being allowed to see and feel my participants' struggles with their psychiatric illnesses. It seemed that they felt a sense of being stigmatized due to their illnesses. Unfortunately, this stigma seems to be pervasive from person to person and has existed throughout time. The National Institute of Mental Health (1980) has been addressing this very concern:

People who are identified as "mentally ill" are faced with a special set of concerns. They are 'ill' in a way that many people do not understand and also fear...negative attitudes toward the mentally ill are often perpetuated in both subtle and blatant ways by mental health professionals themselves...in the process of treating patients, mental health professionals often fail to treat people...those who enter 'mental health' facilities are branded 'sick' in a unique way—a way that sets them apart from all others who are in need of health treatment. (p.1)

Stigma was experienced and shared with me by all of the participants. The first manifestation of the participants' feelings of being different from others was in making and keeping friends. The second was about the severity of their sadness and subsequently their feelings and actions about staying alive.
**Friendships**

Making friends was an issue that all the participants struggled with in relation to feeling uncomfortable about their psychiatric illnesses. Tom poignantly told me after singing the song ‘YOU’VE GOT A FRIEND’:

It’s hard meeting new friends. I don’t know what to disclose, what to talk about. So I let them talk and if I have something to say in relation to what they talk about, I say it. Otherwise I stay silent. This feels uncomfortable to do, but I’m scared of turning off people and then they would stay away from me. I’m nervous here at the hospital because I see people walking around stoned out of their minds on medication. And I see friends of mine after five, seven years and longer, and I don’t think they’re ever going to get out of here. I think people look at me like that. Where am I? I’m nowhere. I’m a mental patient.

As he improvised alone on his guitar, Jack also related his thoughts about being friendless and an “outcast”:

It’s been very lonely. I tend to have relationships with fellow mental patients. I really have no friends outside of here. Since I got sick I haven’t trusted anybody except for my girlfriend. I’m afraid to. I felt like an outcast. I felt sick, unworthy, drugged up. I changed a lot. I lost a lot of friends...they didn’t like me anymore. You find out who your real friends are. If I had had a physical illness instead of a mental illness, they would have had empathy for me. It’s not fair. Instead I got a cold shoulder. My closest friend talked to me for five minutes, but didn’t say anything really.

After singing a song and talking about the songwriter going through a breakup in his marriage, Tom described a conversation he once had with an activities therapist a few years ago at the hospital. He fantasized that she was interested in him romantically, but he felt that he could only be a friend to her and not anything more than that. He had meant to say to her “I’m going through a lot of things right now and I don’t know if you can put up with me,” but instead the words “I’m a broken self” had popped out. He said that the therapist ‘got turned
off’ and replied, “You just want a girl to take care of you.” That was the end of their relationship. Tom attempted to console himself with the thought that “patients and staff don’t mix.”

Bess spoke about how her life had changed in relation to having friends, specifically in this area of staff and patient relationships. She was applying to live in a supervised living situation where, ironically enough, she had once worked as a staff member.

I interviewed for this housing situation I told you about that I want to live in, and it was kind of odd because the woman who interviewed me used to be my boss when I worked there. It will be strange to go to this independent apartment since it is where I used to work. The clients I used to work with aren’t there anymore anyway, but some of the staff still are. They used to be people I would go out for coffee with. Could you imagine having them now be your counselor? And now to not be friends?

**Suicide**

Most of the participants spoke of being “healthier” when they were younger and being able to have friends. Through their songs, the participants shared their feelings of not being “whole,” “normal,” or “complete” due to their illnesses. Sometimes these feelings had been overwhelming and suicide was considered as an alternative.

Jack felt he didn’t have much going for him anymore:

I had my heart set on a career that I don’t think I can do, it’s too hard for me, and a relationship that I don’t think I can do. It’s like building, building, and building and then having everything knocked out from underneath you, and then everything falling.

Matt often spoke, through and after his songs, about how problematic his psychiatric illness was, which included his hearing voices, and how difficult it
was living with these voices (refer to his song ‘Stop Coming Down on Me’). He felt as if his voices were ripping him apart.

The most important thing for me is to get relief from my mind. My voices are abusing me. Once I tried to kill myself. I wanted to drive off a cliff like Leo Buscaglia’s friend, but I couldn’t find a good place to drive off the parkway, so I gave up. I would like to get some relief and it seems that suicide would give me some relief.

Sally also spoke about her feeling so bad and how she had often wished she were dead. She had often felt that her life was beyond repair.

Last year I was locked up in the hospital. I wasn’t doing too good. It was the anniversary of my father’s death. I was in the quiet room. I wanted to be with him. I wanted to be dead. I’ve tried to kill myself a lot of times.

Diane too had tried to kill herself. During a recollection of a particular song, ‘SAD LISA’, Diane related her thoughts about having wanted to end her life since it seemed unlikely to get any better.

There was something shameful about being hospitalized. It was like, “You’re nuts, you’re crazy, there’s something wrong with you.” I’ve been in this mental health system for years. I’ve been falling apart, twice I’ve tried to kill myself. I came close and it wasn’t for lack of trying, believe me. The second time I was in a coma, but it didn’t work either.

It seemed that all of the participants viewed themselves as individuals who were not as “put-together” as others who did not have psychiatric illnesses. At one time they had all felt better, more “whole,” but now felt “broken.” They also had similar perceptions of the partners with whom they had intimate relationships.
"We Were Falling Apart Together"

The participants spoke of their relationships through songs. Many times these songs were popular songs about love. Popular songs about love permeate our culture, even our popular literature. For example, one airline magazine recently wrote about popular music that “Popular songs vivisect relationships. They are the primary source of love education...we share our myths and ideals about love. In a tough mercantile way, they warn us what love may cost. But they also alert us to what grandeur it may bring” (Ackerman, 1994).

Every participant spoke about the intimate relationships that they were either currently in or had been in before. Not one of the participants reported currently being in or ever having been in a long term, happy relationship. One participant, Sally, had just begun a relationship that she was happy with, but their relationship did not last as long as her participation in this study. Each participant spoke about their partners also having emotional problems that compounded their own problems, thereby causing the relationships to fail or to be extremely difficult.

It is not unusual that the participants all had relationships with others who also had psychiatric illnesses. Gelb (1980) shared the thoughts of a mental patient who had formerly been a psychiatrist-in-training. This individual wrote about “resisting and resenting” her forced group identity within the genre of psychiatric patients. She found that as a patient, she was able to have access only to those similarly diagnosed and was not accepted into other groups, and even that the treatment staff forced her into socializing with mental patients. She wanted to build “supportive relationships with others,” but found this was not a viable
possibility, and so had to seek out support from those already seeking their own support, those who were also struggling with their psychiatric illnesses.

**Past Relationships**

Matt described his ex-girlfriend through a song he had written, and then said:

We have a plan that if neither of us has anyone else when we get old, that we will get back together. She is very troubled, she is manic-depressive and lithium keeps her from getting too troubled. But she gets really depressed and they tried every medication and shock treatments and now she is in the hospital. Now she doesn’t even remember who I am because of her treatments. We were together for three years and broke up one year and three months ago. We were falling apart together.

After speaking about a songwriter’s girlfriend, Tom spoke about his own girlfriend, and how she made him feel sicker. He also shared his feelings of embarrassment at hearing what his former girlfriend from the psychiatric hospital had to say in a crowded restaurant:

She gave me a compliment which I thought was lousy, but she meant it to be good. She called out from another table “Eat ‘em out Tommy, you used to drive me crazy.” She also told me to “Kiss them a lot. I didn’t like it when I was with you, but now I like it.” I didn’t know this when I was with her, because she never brought it up. I was with friends when she yelled this out and they told me that it was a good thing that we had broken up because she was ‘flighty and fucked up,’” but I didn’t believe them because I was in love with her. Later I agreed and was glad we had broken up, because she was making me go crazier.

Sally also spoke of past boyfriends through music:

That song, ‘UNFORGETTABLE’ by Natalie Cole reminds me of my first boyfriend. That was going to be our wedding song. I loved him so much, but the staff in our program and my family would tell me all the time that he was gay. I didn’t believe them. Then right before the wedding, he took me into his therapist’s office and told me that he was gay. How did I take
it? All right. Well, I didn’t take it all right, I ended up in the hospital. I became very depressed and wanted to kill myself and I gave up on life.

My relationships didn’t get much better than that. One man I lived with, Brett, wouldn’t make much sense to me. He had problems, especially when he stopped taking his medication for his schizophrenia. He would do things like apply for a job, be accepted, and then not show up to work. He was difficult to live with because he would hit me. When I was admitted to the hospital he was tricked into seeing my doctor. She was not impressed with him. She is up front with me and told me that he was too sick with his schizophrenia. After this we spoke less and less on the telephone and he never visited again. I got letters from his aunt saying that he was in the state hospital and that it was my fault that he was there. They were upset that I was getting help instead of helping him.

That guitar over there reminds me of Dave. He spent money like it was going out of business. For example, one time when I was in the hospital I wanted a guitar. He got a loan and spent $500.00 on a guitar for me. A few months later he sold it to buy food and only got $75.00 for it. I tried to get it back, but we couldn’t afford to buy it back. And even though we were on public assistance, he would get loans for all kinds of things. And another thing, if his clothes were dirty, he wouldn’t wash them, but would buy new ones instead. I tried his way with clothes for awhile, but it didn’t make sense to me. And that messed me up because I went broke and then had to live with my family again. Then my brother, he’s an alcoholic cop, beat me up and threatened to shoot me. I ended up back in the hospital again.

Matt played and sang another original song of his, ‘Talkin’ One Bad Case of the Blues’ and described the situation that inspired him to write it:

I did something to that girl in the song that was pretty horrible. I got drunk one day, very drunk, like blacked out, like I was unconscious but moving around, talking and walking and everything. I went over to my girlfriend’s house with a buddy of mine and we had a parade in her father’s liquor cabinet. She tried to take a bottle of vodka away from me because she was afraid it was poisoned or inhabited or something. I hit her over the head with it. So, this song came after that. It’s kind of an apology for that.

By first singing her wedding song and then other songs. She began speaking about what they made her think of, Bess described her relationships with partners who had mental illnesses, and how it exacerbated her own psychiatric symptoms.
There were a lot of different reasons for why my ex-husband and I had to get divorced. It had more to do with our illnesses. He had a very severe manic-depression illness with psychotic problems and I was depressed a lot of the time. Maybe I was psychotic at the time too, but of course at the time I wouldn’t think so. Once we got into an argument about the T.V. We each thought it was emitting voices to us individually and he got angry at me and punched me in the eye.

My husband was very sick. He would get very depressed and would stay in a fetal position under the covers for many weeks. The doctor from the Crisis Team would have to come and give him a shot of Haldol and that would snap him out of it. One time he told me Jesus Christ was coming to tea. I made tea. I had to make two different kinds, Irish Breakfast and Earl Grey.

That line in that song ‘last night in sweet slumber I dreamed I did see, my own precious jewel sat smiling by me,’ that line reminds me of my last boyfriend. I was involved with him for two years after my marriage. I met him an Alchoholics Anonymous group. I really liked him a lot, but he also had a manic-depressive illness. It was under better control than my husband’s. He didn’t do as many public things as my husband, but he used to say very weird things to me and friends of ours. Like he told our friends that he saw a cat setting fires. Our friends told him ‘that can’t be true’ and that made him very angry and upset.

It seemed his illness set off my illness. He told me that I was better than other people because I had magical powers. I used to think, maybe I knew, that something was going to happen, and then it did happen. He’d encourage me a lot and got me involved in a religious group. It was kind of a cult. I’d never talk about this with other patients, they might get interested and involved in it. This group had a leader and they believed this leader could be present everywhere. He’s a living person, but they believed he could appear to all. I used to see him do things like sit on my chair. My boyfriend thought I was really special because I had hallucinations like that. That song, ‘Desparado’ also reminds of of that cult. We believed in traveling outside of your body—soul traveling. I think that’s called dissociation in psychiatry, and it’s not considered a wonderful thing that everybody should aspire to do! I had a strong feeling when I read the founder’s autobiography that he had been sexually abused when he was a child and that’s why he dissociated. In this cult everybody tried to do this soul-traveling. We had different spiritual exercises to practice getting out of our bodies. I was really good at it, that’s why people thought I was a very spiritual person. We both ended up in the hospital after one seminar with this cult because we thought we could control the Middle East.

After listening to Diane’s song ‘BRAND NEW DAY,’ Diane said she felt validated in her feelings of needing to leave her current relationship, Diane
recognized the dangers of being with someone who is ill, and spoke about an intimate relationship she had once been in. She described it first with a poem she had written and then with her words:

I carry a torch for you,
it's miles high.
It reaches the heavens,
but it burns like hell.

This poem was about a very abusive relationship I was in. I could see the sick progression this relationship took after I was out of it and could look at all the poetry I had written during it. He was a sick man, a really disturbed man. I'm not saying this out of malice or like he was wrong and I was right, but we were both very sick. I think we were like two sick people feeding off of each other's problems and we compounded our problems.

He was psychotic and physically abusive, violent. He wouldn't allow me to wear makeup and would make me speak in a low voice so that it wouldn't sound feminine. I was masochistic at that time and he was sadistic and although it was just a sexual thing at first, it started encompassing my whole lifestyle...it's almost like brainwashing. I would have to sit and hear him lecture me for hours. I would have to repeat certain phrases over and over, and there were certain words I would have to say over and over. It was a very sick relationship. He had to control almost everything about me. One of the last times I saw him he was banging my head up against the wall because I was seeing a therapist and talking about my situation. He would get enraged and say that he was going to kill me. I put up with a lot of abuse, but I really felt that he was going to kill me. I actually feared for my life because he would hurt me so badly.

He wanted me to commit suicide with him. We were going to overdose on pills together. For some reason or another, I was always doing well when he was really low, or vice versa. We would never get on the same wave length.

Current Relationships

Jack was involved with a woman during his participation in the study. Much of his session time focused on problems due to the psychiatric illnesses that were manifested in their relationship.
Now I’ve been with Jill and we’ve been together for almost five years. She is manic-depressive and she has a lot of mood swings and is extremely symptomatic. And I also have schizo-affective disorder, but I’m fairly asymptomatic. Sometimes she loves being with me, other times she doesn’t want to be with me, and other times she just plain wants to kill me! I’m having trouble deciding whether or not I want to stay with her because she’s so unstable and yet I really love her.

She’s on so much medication it’s incredible: Loxitane, Lithium, Tegretol. She’s been on them for a long time. I’m on Lithium too. I really want a family and my girlfriend’s on too much medication which she’ll never come off of and she can never have a child. It’s like having a triple whammy since Jill is very unstable. She cannot maintain an even mood, she is depressed or elated, or this or that. It’s a problem and it seriously affects our relationship. At one point she wanted more freedom and at another time, she complained of feeling abandoned when I spent more time with my friends. Now I expect her to say ‘Give me more space, keep away from me’. She is so unpredictable. It’s like that song ‘Tell me it’s black when I know that it’s white, tell me I’m wrong when I know that I’m right, it’s just the same that’s all.’

I’m not an expert on normal people, but normal people don’t play the games Jill is playing. I can’t stop though and say to myself “Hmmm, what’s she got up her sleeve, what game is she playing?” I can’t do that, instead I take verbatim everything she says. See, my doctor says that, and I believe him, he says that as long as I stay with Jill there’s going to be a lot of instability because she’s unstable. It’s like when I try to play guitar at home for her. The first and last time I tried to play for her she did not respond. I realize that her illness keeps her from being able to pay attention, but I want her to be able to speak positively about my playing. I just wish I had a relationship with someone that was more stable, less phobic, less psychotic and more affectionate. Someone that I could be able to not worry about the relationship all the time and get on with my own life and career and job.

Sally had also been involved with men with various emotional problems, and was currently getting involved with the first partner who did not have a psychiatric diagnosis. As she taught me how to play the xylophones she began to smile and laugh and giggle and told me:

I’m dating a guy who is really nice! He has a job, pays his bills and has his own car. He took me out to dinner and I ordered steak! It was the first time I ever ordered steak, I’ve never been able to afford it before! This guy opens the door for me, he’s a gentleman! I never dated anyone like that. Before I always had boyfriends that in addition to being ill, would be drinking or doing drugs and would hurt me. One raped me. I thought they loved me.
Hopes for Future Relationships

After singing a song that reminded Bess of her previous marriage, Bess spoke of wanting a relationship with a man who did not have a psychiatric illness.

I have a goal of meeting people who are not part of the mental health system. I don’t want to get rid of my friends, but make new ones in addition. I was told by that lady who interviewed me that it was an indication of low self-esteem, but I don’t feel that way. She said that people with diabetes might have other friends with diabetes. I said “But people with diabetes don’t have their friends with diabetes sit around talking about their doctors and their insulin levels and their blood sugar levels and how many shots they take a day, and we tend to do that.

Mentally ill people tend to spend a lot of time talking about their day programs, their psychiatrists, their medications. That’s what I don’t want to do anymore. I recently went to a party where everybody at the whole party was part of the mental health system. Everybody was saying “my psychiatrist...” or “my medication... .” There were three people off in the corner trying to convert each other to religion because they were having manic episodes. And there was one guy who was acting really manic and was taking money out of his wallet and having all the girls count it, and was behaving very strangely. Of course, you could have a mental illness under control and be functioning well, but it is really not so much fun to be around people who are not doing too well.

These two cross-case themes, “I'M A BROKEN SELF” AND “WE WERE FALLING APART TOGETHER,” illustrated the areas that were of most concern to all of the participants. Although they all had histories of being sexually abused as children, these two areas were the ones that they were the most troubled by. There could be several possible reasons for this focus on their illnesses. The first is that their illnesses presented pervasive problems that influenced their lives in every sphere, whereas their histories of abuse strongly impacted only a few areas of their lives. It could also be that the emphasis of their psychological and psychiatric treatment centered around current issues and behaviors, and not historical elements. Another possibility is that the planned
short-term nature of this particular study determined that the participants did not have the time to delve deeply into their sexual abuse histories, although each participant did speak about it at some point in his/her Music Therapy sessions. But for whatever reason, all of the participants used their songs as communicative vehicles to share their thoughts and feelings with me about these particular two very painful areas in their lives. I feel that music afforded me access in an immediate and direct way into their lives. By sharing music together, intimate details of their lives were able to be brought to the foreground in a nonthreatening way. It seems that the participants’ songs helped cut through defenses and enabled them to explore important issues through a safe, fulfilling process in the Music Therapy sessions.
CHAPTER VI

THE PERSPECTIVES ON MUSIC THERAPY

In this chapter I will discuss the findings of this study from my own perspective as therapist and from the participants’ perspectives as patients. In qualitative research an essential element is the “researcher-as-instrument” role (Ely et al., 1991). I believe it is important for me to illustrate how I understood and experienced our Music Therapy sessions. Current Music Therapy research is beginning to consider “subjective information” to be relevant and important data (Aigen, 1990, p. 44). I will now share with the reader some of my thoughts during the therapeutic process in order to illuminate my feelings, actions, and intentions. It is my hope that I can articulate my own “common sense” impulses here.

With each participant I found myself utilizing different interventions and discovering new insights about myself and the participants. My interventions were guided by my insights, knowledge, and experiences and were dependent on my perception of the patient’s needs at that moment. All of these interventions enabled me to understand myself, the participants, and our journey in a deeper fashion.

In this chapter I will also share with the reader examples of each participant’s exact words in order to present his/her personal thoughts more directly. Yalom (1974) wrote about a course of therapy with his patient in a unique way in his book Every Day Gets a Little Closer: A Twice-Told Therapy. In this book he shared both his thoughts as well as the patient’s thoughts through
the written logs of their sessions. This was a fascinating and unique account of a therapeutic journey because it included both of the participants’ experiences. This type of dual reporting is not commonly found within the psychiatric or Music Therapy research. Much Music Therapy literature uses statistical results or therapists’ views to evaluate the Music Therapy experience. Until quite recently, it was rare to find patients’ own words in actual research. Even when similar patients are requested to evaluate their Music Therapy experiences, their thoughts are often recorded in checklists or surveys (Heaney, 1992) and not in their actual words.

In this particular study, though I never asked, all of the participants reported positive experiences in their Music Therapy sessions. All of them spoke spontaneously at some point during the study about what they experienced in Music Therapy and in their lives with music.

This chapter includes interwoven reflections containing “Therapist’s Insights and Experiences” and “Participant Reflections.” Within the first subsections of “Insights,” I will identify one key insight that I had for each participant. Within the “Experiences” subsections, I will share overall thoughts from myself and the participants. Relevant theory will be incorporated as well as spontaneous quotations from the participants and myself.
Therapist’s Insights and Experiences

I addressed Bess’s paranoid thoughts about me metaphorically rather than directly, as a way to help her trust me a little bit more. Guralink (1984) defines metaphor as “a figure of speech containing an implied comparison, in which a word or phrase ordinarily and primarily used of one thing is applied to another” (p. 893). Through the metaphor of song lyrics written by someone else, Bess shared her feelings with me. I felt that indirectly, through these song lyrics, she shared her paranoid thoughts with me. Williams (1994), a patient with a psychiatric illness, describes how she was able to share herself with another person when words were too threatening: “I recited the lyrics to a song I’d written” (1994, p. 208).

Bess began a session by playing the song ‘Helpless’ (by Neil Young).

She told me about her song selection:

That song reminds me of how I feel with my illness. Like I never know what’s real or what’s my symptoms. Did you know that I was thinking about you last week? Did you read my mind? Sometimes I think that other people can read my mind. I want to play more of this song, but I get tired and my eyes get confused. I think Music Therapy is really fun, but last week my doctor said that I was getting paranoid due to my parent’s visit. I’ve been experiencing symptoms again lately and this makes it difficult to hear others speak. I can’t really tell anyone about it, but that’s what the song reminds me of. I’m glad I know that you can’t really read my mind.

During this same session Bess said she had been feeling very fearful of others. She had had a tumultuous family visit and had been experiencing paranoid symptoms. She sang ‘HELPLESS’ in our session and was only then
able to ask me if I was “reading her mind.” She had been worried that I had this power, but was afraid to ask until she sang this song.

I used the song 'TAPESTRY' (by Carole King) as an indirect way of addressing Bess’s feelings. In an earlier session Bess had mentioned this was a favorite song of hers and now I asked if we could sing and play it together. I felt that this song might be calming and offer her a sense of cohesion since the lyrics were about different colors being woven together in harmony. I had hoped that this could represent a safe image to her, almost like a tangible blanket to comfort her. Bess readily agreed and we sang and played it together a few times. Some of the words are:

MY LIFE HAS BEEN A TAPESTRY OF RICH AND ROYAL HUE
AN EVERLASTING VISION OF THE EVERCHANGING VIEW
A WONDROUS WOVEN MAGIC IN BITS OF BLUE AND GOLD
A TAPESTRY TO FEEL AND SEE IMPOSSIBLE TO HOLD

After we sang, Bess asked me if I could help her fix her guitar case handle. It consisted of an open wire that hurt her hand to carry. Together we sewed a thick cloth handle around the wire with some upholstery material. This song seemed to “weave” her together as did our cooperative handle-sewing together. Metaphorically and realistically, it seemed that Bess left with a stronger “handle” on reality. She was able to speak about ordinary sensations and feelings that seemed perfectly relevant to the situation.

In summary, Bess had very different behaviors with and without her songs. For example, she seemed more able to deal with issues that were extremely important when she was speaking about a song and its associations. Without the presence of a song, she talked about things that seemed superficial, things like the weather, what she had for lunch, what clothing styles she liked. Not that these weren’t meaningful to her, but they didn’t seem as useful in our
therapy sessions. But when a song sparked her mind, she lit up. She had illuminating thoughts about many aspects of herself that not only enabled me to see and understand her better, but enabled her to shed new light on darker, more troubled areas for herself. One instance of this was by Bess recalling troublesome events of her past relationships, she was then able to make decisions about the kinds of healthy relationships she was going to try to find. A dramatic shift took place between her statement about her initial song, “It isn’t about me at all,” and the metaphor she offered as an interpretation of her final song. I felt honored that she allowed me into her world in such a personal way.

Bess’s Reflections

I like coming to Music Therapy better than going to my doctor here at the hospital. I like talking about different things, that’s what I noticed the most. The music made it more interesting. And the songs always seemed to correlate to me and I thought that was interesting. Like it reminded me of things. That’s what I noticed.

My brother asked me about it. I told him that I had Music Therapy and he was surprised and asked what that meant. I told him that you talk about issues similar to therapy issues and you also play the guitar and sing. I didn’t tell him about the kinds of things, like the sexual stuff, that we’ve talked about. He’d be really mad if I told him that.

I like Music Therapy better than regular therapy. I get more attention, I’m probably not supposed to say that! The things we talk about are more intense in here too. I think the music brings me more deeply into certain issues and into talking about things. Now I can play my guitar again and listen to music. Before I couldn’t do that. I even can do it with my new roommate too!
Diane

Therapist’s Insights and Experiences

With Diane I often found myself making validating interventions, saying supportive statements to remind her that she was doing well in several areas of her life: “Somehow you keep going—you’re looking for a job, you’re making strides in your life, you’re strong enough to let go of a relationship that has been an important part of your life for 14 years...” As I realized that my primary interventions were of this nature, I evaluated their role and shared them with Diane in musical terms through the context of a song that had been running through my head:

I was just thinking of this song by the Grateful Dead called ‘Touch of Gray’, do you know it? Some of the words are something like ‘I will survive, I will get by.’ As you were speaking, I was feeling that there is a sense of resiliency within you like in that song.

I felt that by sharing my perception through music, Diane would be more willing to hear my feedback and perhaps more able to keep it as a musical memory as someone else’s picture of her.

During my first sessions with Diane I wondered why I kept making verbal statements like this because she seemed to be functioning at such a high level in comparison with the other participants. She was the only one holding down a job, not showing symptoms of her illness, and initiating change within her own relationships. I remember questioning why I felt the need to make such statements, and it wasn’t until she was hospitalized that I felt I had been doing the therapeutically appropriate thing. I had been trying to remind her that she was
able to manage and that she could hold onto that knowledge even when things became overwhelming.

Overall, it seemed that Music Therapy afforded Diane the opportunity to reflect on her current situation in a safe way. She told me, "One thing I really try to do is to live moment to moment. Because if I get lost in yesterday or worry about tomorrow, I'll fucking paralyze. I won't be able to function." Through the music Diane could explore her intimate relationship in the moment without getting caught up in the past or anxious about the future. I shared with her the image I had that symbolized her seemingly stagnant relationship with John. A large table top was wobbling on a skinny table base. The top had grown too large, and the base, which hadn't changed, was no longer strong enough to support it. I shared my metaphor with Diane and illustrated it with my hands. Diane nodded emphatically and said that was exactly what it would look like. She added that it was not secure because the top wobbled too much now and took too much energy to stay on the base. It seemed to me that music afforded Diane the opportunity to imagine being this table top without having to analyze the composition of the ground below the table, or having to think about how to get off the base and find a new base. Music gave her the opportunity to feel what the moment was like without thinking of context or consequence.

Diane's Reflections

Music makes me feel free. It's getting out of myself-pure freedom. It helps me get apart from myself. When I hear music that moves me, it helps me move out of myself, carries me along or carries me away. It calms me down. It's almost like a Lithium. Or if I'm feeling bad about myself, it can help me rejuvenate. Music with lyrics, like Tracy Chapman that we listened to, helps me get in touch with what maybe I don't pay attention to, or I suppress if I don't really want to think about it or deal with it. So if I listen to a song like that, then I know it's right for it to surface and it will pull it right out. It gives it a chance.
Just talking about music is really important. It’s given me a chance to talk about my issues with having some structure to it so I’m not, it’s not like regular therapy sessions where you flesh everything out—it’s more structured. It holds me together. You have to plan it out too. You have to know your customers. With me, ending with a real gut-wrenching song is going to make me feel hysterical. And I think you’ve respected that and have been able to help me. Not that you’ve manipulated it and said “OK, this is a song you have to leave listening to,” but that I don’t think I’ve left your office never feeling OK. Maybe I went to a better song, a more lively song, but I’ve never left your office with a song that’s too upsetting to me.
Jack

Therapist’s Insights and Experiences

In attempting to understand my reactions, or biases, to the participants, I analyzed not only our interactions, but also carefully examined aspects of the research approach. The following is a portion of an Analytic Memo I wrote to myself during my sessions with Jack:

I found myself pondering “why did I choose the pseudonyms that I did for my participants”? Especially, why did I select “Jack” before meeting him and later on in sessions as he began to speak of his girlfriend, select “Jill”? When I assigned her pseudonym, it never crossed my conscious mind that there was a childhood rhyme with those two names until almost the end of “our eighth Music Therapy sessions. Now when I reflect on this rhyme (“Jack and Jill went up the hill to fetch a pail of water. Jack fell down and broke his crown, and Jill came tumbling after.”), it seems quite significant. It seems that they are each in an uphill battle, trying to make a relationship work while having significant problems of their own, and that when one falls, so does the other.

This insight first led me to give more importance to the idea of pervasive themes, especially the one “WE WERE FALLING APART TOGETHER” because this rhyme so clearly spells out the mutual falling down of Jack and Jill. But more importantly, it showed me how even the subtleties of how I think of others can and do affect my interactions with them.

Another unconscious association that came while thinking of Jack and Jill’s relationship led to my suddenly recalling a song. This song, ‘Sometimes You Have to Make Up Your Mind’, by the Lovin’ Spoonful, habitually ran through my mind. I could never understand why this happened because I had always understood the lyrics to mean literally choosing between one partner or
another. Jack did not seem to be attempting to choose between two people in his life. At first, since I could not understand why this song kept reemerging, I often tried to ignore its presence in my thoughts, but I could not. Then, as I listened to Jack play his guitar at the end of our last session, depicting both himself and Jill, I thought it seemed that he had finally made up his mind. He had to choose between living with her, caught up in the day-to-day adventures of her instability, and dealing with other concerns, such as his own history of abuse and difficulty getting a job or selecting a career. It seemed to me that he chose Jill and felt good about that choice because although it was difficult to be with her, he would not be alone.

In summarizing Jack's sessions, it seemed to me that Jack musically portrayed himself and Jill in separate yet integral roles in a complete musical statement. He provided the stable base, rhythmically and harmonically, and she lent the interesting and exciting melody. Together they formed a complete duet in their day-to-day relationship expressed metaphorically in the music. Without her, his "music," or his life, would have been lonely and without excitement. Furthermore, he would have had to face the possibility of failure in a career. By staying with Jill, he ensured that he would have no energy to look for a job, and was therefore safe from that risk of possible failure.

Jack's Reflections

In here I'm able to express a more creative part of my mind and my emotions, whereas when I'm just talking to my doctor, it's more cerebral. The way music makes me feel, the music can actually have the effect of making me feel better. It's almost like the music can trigger endorphins or something. It creates a very pleasant sensation.
Matt

**Therapist’s Insights and Experiences**

Matt also often spoke of experiencing paranoid thoughts. He would usually sing original songs and then explain them. After talking about his song and what it was about, he would be able to talk about our relationship.

This song is about me feeling like I have to retire from the world, like it’s all too much. I project my voices into other people. Like I have this fantasy that I’m made reference to in movies, T.V. shows, the radio. Only I take that bait and act on this perceived desire for me to be a public person. You’re asking me how do I know it’s a fantasy? I don’t. I’m convinced that when I hear things on the radio or T.V. they’re really about me. I find that sometimes the song on the radio is appropriate to my current mood and I think that the D.J. is playing it just for me.

You were so nice to me outside two days ago when I saw you that I thought of dating you and then you started coughing and I thought that was a reaction to my thought. A way of saying “That’s not the relationship, I’m establishing boundaries” by coughing.

At this point I told Matt that I didn’t know his thoughts and that I didn’t remember coughing, but perhaps I had something stuck in my throat. He replied “I can’t believe you. That’s one of my problems in therapy, I think everyone can read my mind...I’m abused by my mind.” I thanked Matt for being so brave by sharing this thought with me and explained that we couldn’t date because our relationship was a therapeutic one. At this point Matt coughed and I commented “now *you* coughed.” He explained that he had “phlegm in [his] throat” and I said that perhaps something similar and happened to me. Matt replied, “Sometimes I think that my voices can make phlegm come into my throat...it’s a diversion to confuse me so that I don’t know if it’s a communicative cough or a natural one...it’s very complicated.” The more we spoke of his suspicions that I
could read his mind, the more it seems he was able to open up and share his experience of life with me.

In conclusion, it seemed that Matt was able to speak about his largest concern--hearing voices--very clearly through music. I was able, through singing and playing his music, to participate as an active ally in learning to feel what his life might be like. I was struck by his ability to cope with his ‘inner abuse’ and felt that he had a will to persevere that was fed by his music-making. It made me reflect on how he has tremendous difficulties in everyday situations discerning what is real and accurate and what is not, and who or what to believe. Yet, through all of this, he continues creating and trying to communicate and reach out to others.

Matt’s Reflections

I wanted to share my favorite music with you because I didn’t want to hustle you and pretend I didn’t know anything about music. I wanted to do my best for you. I didn’t want to continue playing in isolation just for myself, but that playing for other people gave me too much attention and my delusion gives me enough attention. I want to play for only you in Music Therapy. It gratifies my ego. I’m feeling better than when I walked in. That’s ‘cause I like your attention. I like your paying attention to my music. I don’t get a lot of praise for my music. I get some, but not a lot. I guess I don’t go out to try to win praise. Music is a way of expressing myself, of communicating.
Sally

Therapist’s Insights and Experiences

I analyzed the songs that came up in Sally’s sessions in three ways. Songs that arose spontaneously, perhaps unconsciously, were scrutinized for potential connections to the participant’s situation, such as ‘SEND IN THE CLOWNS’. Songs chosen by the participant that gave me general associations, ‘HEART AND SOUL’ were reflected upon. And songs that lent themselves to an analysis of the lyrics, ‘YOU NEEDED ME’ were pondered for aspect of growth or change.

I described in Chapter IV how I played the first four notes of ‘SEND IN THE CLOWNS’ without realizing it. I still am not sure why I played this song, but felt that it was necessary to try to interpret possible motivations I might have had. I pondered these lyrics to see if there was something to the song that made me play the first four notes without realizing it, but I found no connections. My interpretation of this song is that someone is feeling foolish and heartbroken for having fallen in love. This protagonist had always been the one in “control” in past relationships and had never been hurt before. The title describes a circus practice that I became aware of only after flying on a trapeze in a circus for a couple of years: sending the clowns out to distract the crowd after a performer has had an accident.

I wondered if it was simply a coincidence as the first three notes are the fourth, fifth, and root of a major chord and not too uncommon. Sally later played the song ‘HEART AND SOUL’ and spoke about it a great deal as a song that made her feel better when she was upset. This is a song about falling in love that
most people think of as a beginner’s piano duet. Children often enjoy playing it without ever knowing the words. It has a very simple bass line and harmony and a cute melody that can be easily mastered and made fancy. I found this song to be congruent with Sally’s simple childlike way of being.

Sally’s final song, ‘YOU NEEDED ME’, is about someone feeling needed by a loved one. The helper in this song provided light, growth, and direction for a partner. Feeling “needed” in this song seemed to make the helper feel especially happy and important. I found this song to encapsulate Sally’s major gain in our sessions together—that she was actually needed by another person, me, and that she was important and strong. I do not think Sally had ever experienced being needed before and instead always needed other people’s help. The look of glee and feeling of self-sufficiency that Sally seemed to have while teaching me seemed to state that she enjoyed this role immensely.

In general, sessions with Sally always reminded me that music can feel good, safe, and calming. She could hug a music book like a teddy bear or speak through a piece of music like a girl talking through a doll. Sally used music initially to feel more comfortable, and then through playing and teaching, to feel stronger on her own.

Sally’s Reflections

Music has always played a large role in my life. I’ve always listened to music and used to play piano a lot, and still do. When I was in the hospital whenever I would get upset they would let me go and play the piano in the back room. It wasn’t fair to others, because they weren’t allowed to go into that back room unless they had reached target weight, but they let me do it since they saw that playing music would calm me down. I would play the one song I know over and over, ‘Heart and Soul’. I even taught you that song! You also learned ‘You Needed Me’!
Kelly (1988) was completing an intense study on sexual violence and felt vulnerable during her "reflexive experiential analysis" (p. 14). She wrote about the fact that research texts “recommend this immersion in the topic, but they seldom reflect on the impact this might have on the researcher” (p. 15). She shared her own vulnerability in her study. I also experienced my own vulnerabilities with one of the participants, Tom. As I mentioned in his Songs, I felt uncomfortable with his stares. I felt that these stares invaded my personal space even more after he related the following description of a relationship he had been in:

She dumped me because I put my fist through her door, but a few days before that I stuck my penis into her. She freaked out...it was an accident. I knew she wanted to be a virgin and that's why I had never done it before...but this time it just slipped in. She called me a bastard, but she liked it. Then after she dumped me she had sex with everyone on campus. My friends went out with her and told me about it.

I felt angry at him for what I felt was “date-raping” his girlfriend. I do not think that I would have been able to work through my anger as quickly as I did had it not been for a “musical countertransference” that I experienced.

In Psychoanalytic Aspects of Fieldwork, a qualitative handbook, Searles broadly defines countertransference as the therapist’s reactions to the patient which in turn influence the therapist’s thoughts or actions (Hunt, 1989). Priestley (1994) writes, “The [music] therapist relates to the patient in an inner way through intuition and in an outer way through the eyes and ears” (p. 99). An example of an “inner” way of relating to a patient would be my tendency to think
in song form in order to understand my patients. Sometimes this phenomenon is externalized, and I find myself humming a particular song over and over when I think about a certain patient. Other times it is more subtle and I have repeated vague remembrances of a certain song which I must ponder in order to discover why that particular song is on my mind. In both cases the genesis of the song is spontaneous. I refer to this phenomenon of inner songs as a "musical countertransference" because it is induced by my thoughts about a patient and it brings forth my own sets of associated thoughts and feelings. Reik (1983) explored the use of song lyrics in countertransference from his own perspective as the therapist. He found that by listening intently to the song melodies and lyrics that cropped up in his mind, then he, as the therapist, could understand and help his/her patients more fully.

One particularly strong example of musical countertransference" occurred during this particular study. The following excerpt is from an analytic memo I wrote after my second session with Tom:

I found myself thinking of a song as I said goodbye to Tom after our second session. This song was 'Mr. Tanner' by Harry Chapin. It was a song about a dry cleaner who loves to sing and is encouraged by his friends to sing professionally. He sings a debut recital in New York City which is negatively reviewed by the critics, and returns to his small hometown where he never sings in public again, and never speaks of his recital or review. He sings only late at night while working alone in his empty shop.

Somehow this song fits Tom so well. I'm not exactly sure why. He's not humble, as Mr. Tanner appears to be, but it seems to me that something similar has happened to Tom. I remember he mentioned auditioning in bars and having scars that lasted from this experience and that 'they cut them deep.'

I'm a bit surprised at my linking Tom with this song because my heart always went out to 'Mr. Tanner' and Tom is a person that my heart doesn't reach out to in that way. I think he doesn't allow it to. He seems so guarded and defensive. Maybe this "musical countertransference" will help my heart reach out and to see past Tom's blockades? Hmmm.
This "musical countertransference" changed how I felt about Tom. It gave me access to my own feelings of empathy for him that had previously been blocked by his defensiveness and mannerisms. When I allow myself to reflect upon and explore the meaning of an inner song brought about in such circumstances, I am usually able to gain additional insight into my own thoughts about the patient, and how I perceive their own points of view. The insights or perceptions I gain from acknowledging my inner songs usually deepen my understanding and empathy for the particular patient, and therefore help me to be a better therapist for that patient.

In reflecting over all of the sessions Tom and I had, it seemed that I had such difficulty feeling comfortable and empathetic around Tom that I found myself obsessively rehashing bits of each session throughout the following weeks. I hated how he stared at me. It made me feel uncomfortable. I do not think this alone would have unnerved me because in the past I had often been the only female therapist on all-male maximum security units, and I was accustomed to patients who stared and had strong feelings for me. It wasn’t until my experience of my "musical countertransference" with the song 'MR. TANNER' that I felt I could understand how Tom might feel. At that point I began to enjoy our sessions together and felt much more comfortable with him. He never said anything that demonstrated a need for the empathy which my "musical countertransference" evoked until his parting words to me in our last session:

Toms' Reflections

I like our Music Therapy sessions. I get to play songs that are very dear to me. Without music, my life is a drag. Music Therapy helps me to build my self-confidence.
CHAPTER VII
SUMMARY, DISCUSSION AND RECOMMENDATIONS

Summary: Therapeutic Progress of the Participants

Each participant seemed to grow during our sessions and I often witnessed a parallel process between their music and their lives. Hesser (unpublished manuscript) writes, "We cannot change another. A conscious desire or motivation for self-growth and awareness must be present for transformation" (p. 3). In this particular study, I felt that the use of participants’ songs as communicative and therapeutic devices enabled each of them and myself to explore the areas which they liked and disliked about themselves and their lives.

In Bess’ case, music provided what Clenendon-Wallen (1991) described as a “common starting place for discussion of personal issues” (p. 79). Bess was able to recall and review past experiences, the impact they had on her present life and the choices she was making now. Smith (1991) wrote about a person with a mental illness who had also been sexually abused. This woman used songwriting to share feelings and thoughts and, like Bess, she recalled events of her sexual abuse through singing. Through the process of singing, recalling and sharing, Bess began to understand her past more clearly and thus feel confident in her current life. There was evidence of this confidence both in her music and in her living environment. Bess was able to sustain longer sessions of guitar playing and began to complete songs as she was also in the process of moving to a more independent living situation. Bess had gained strength and endurance.
Diane was in a difficult period of her life: she was trying to extract herself from the only safe relationship she had. This was a relationship she had been in for fourteen years, one she had entered into as she left her family. Clenendon-Wallen writes, “members enjoyed bringing tapes of certain songs to the sessions which both provided an opportunity for them to share their feelings, and allowed a concrete way to invest in the group” (1991, p. 78). Diane too brought in tapes of significant songs that helped her understand her life. Like Diane, Perilli’s patient (1991), also a woman suffering from a psychiatric illness, listened to pre-recorded music to gain insight into her own thoughts and actions. Diane used her songs to help her understand her own motivations for leaving the relationship. Although Diane was hospitalized due to a suicide attempt in response to the demise of her relationship during the time of the study, it seemed that she regretted not her actual decision to leave the relationship, but the way that she had done it. The insights and validation she had gotten from her songs offered her strength in the knowledge that she had done what she needed to do despite the consequences.

Jack seemed locked into his intellectualizations and rarely showed his feelings. Boone (1991) described a patient with a psychiatric illness who had a similar difficulty; just like Jack, he used music to “unfreeze” his emotions. Also, similarly to the individual Boone depicted, Jack tapped into his own feelings by exploring sounds. For example, he tried out new ways of representing and understanding himself through musical role-playing. Clenendon-Wallen (1991) hypothesizes that “music therapy activities may provide the opportunity to risk trying new experiences which can be transferred to other areas of [the patients’] lives” (p. 79). Jack’s experience of creating the musical portrayal of himself and
Jill made him finally realize that he wanted to stay in his relationship because of the balance it offered him.

Matt and I primarily sang his original songs and I learned about him through them. At one point we attempted an improvisation that Matt requested. We each played hand drums for a few minutes, but then stopped because Matt looked uneasy and seemed to be having uncomfortable hallucinations. As Pavlicevic (1987) also found while improvising with his adult psychiatric patient, “pursuing this, at that time, was clearly not right for either of us” (p. 23) because with that individual it was not serving a therapeutic purpose. Matt said that he thought that I was playing “evil” words on my drum during our improvisation, and I felt that Matt was beginning to unravel psychologically. However, when we stayed within the structure of his songs he seemed stable, and we were able to communicate effectively. Through our sessions Matt was able to share his thoughts and concerns about the impact his voices had on his music. For example, like Matt, the patient in an article by Boone (1991) used his delusional material in his songwriting. Boone wrote that this helped this particular individual share his thoughts and feelings. Matt’s songs taught me about the experience of hearing voices. One of my original biases had been my assumption that hallucinations were not pleasant or helpful and that anyone suffering from them would welcome their absence. Through my research with Matt I learned that it is not that simple. Matt’s voices were terribly distressing to him but were also a source of inspiration and help in his musical creations. Matt reported that everyone was delighted that his auditory hallucinations were diminishing. However, through Music Therapy, Matt was able to share with me how difficult it was to lose his voices, and this process of sharing helped him feel less isolated in this change.
As Sally grew more confident in our Music Therapy sessions, she was able to tolerate her first positive intimate relationship with a healthy, non-abusive partner. Clenendon-Wallen (1991) found that sexually abused individuals in her study showed positive changes in self-confidence through Music Therapy, as in Sally’s case. Clenendon-Wallen reported that “song discussion and listening were important, safe and non-confrontive tools,” and Sally began her Music Therapy sessions this way. An important difference is that Sally selected her own songs, as did all of the participants. Clenendon-Wallen often made the selections for her patients. Her study also states that “gaining musical skill is often related to an increase in self-esteem and confidence,” (p. 79) which I observed as Sally played and taught me songs on instruments toward the end of our sessions. Sally grew from a passive listener into an active teacher.

Tom communicated with me through his music, and demonstrated that, as Clenendon-Wallen discovered, “music can often temper anxiety reactions of clients and set the stage for open communication” (p. 79). Tom used music of a “familiar medium” and therefore was able to relate to me (Clenendon-Wallen, 1991). Nolan (1991) described how a resistant woman with a bipolar illness was able to use music as a “bridge” into an active participatory role in her own treatment, just as Tom does in this study. It seemed that Tom’s ability to connect favorably with anyone, especially a therapist, was an important event. It could set the groundwork for him to return to therapy and perhaps to establish a trusting relationship with a professional who could help him live a happier life.
Discussion of Findings

Songs as an Inner Resource

Songs have been used therapeutically by people suffering from psychiatric illnesses as well as by those who have been sexually abused (Clenendon-Wallen, 1991; Duey, 1991, Schiller & Bennett, 1991). Schiller describes dozens of ways in which she herself used songs in her life and often found correlations between the songs and the symptoms she suffered because of her illness. She used songs in a variety of ways: writing songs to express her sad feelings, playing songs to reflect her moods and behaviors, recalling songs that reminded her of previous events, and listening to songs to help her understand her experiences. Schiller considered music one of her “primary possessions” (p. 191). Like the participants in this study, Schiller used songs independently as a way to stay mentally healthy (Personal Communication, February, 1995).

The participants in this study communicated directly with me through their songs quite quickly. I first analyzed each song by looking closely at the content of the song, the participant’s words about what feelings or memories the song evoked, and the clinical context which brought forth the song. My analysis of their songs suggested a framework for the therapeutic process. I then thought about the possible uses that their songs seemed to have in our sessions. My findings indicate that we used songs from the participants’ lives in a variety of ways for differing therapeutic uses. Songs were used as a:

1) stimulus to gain access to memories. Bess recalled and played favorite songs from her past.
2) means of gaining insight and validation. Diane listened to, analyzed and interpreted lyrics from pre-recorded songs.

3) vehicle to recognize feelings. Jack improvised songs which clarified troublesome relationship issues.

4) way to disclose feelings and experiences. Matt played and sang original songs which told his story.

5) method of building confidence. Sally progressed from a passive listening role to an active teaching role.

6) direct expression of feelings about the therapeutic relationship. Tom often sang and played pre-recorded songs in order to make emotional contact with me.

It is interesting that each of the six participants brought music into their sessions in very dissimilar ways as demonstrated in their diverse uses of songs. Many of the participants used pre-recorded music: Bess and Tom played guitar and sang, Diane listened to recordings and then analyzed their content, and Sally first listened to me play her requests and then taught me other songs. Other participants used non-popular songs. Matt played guitar and sang his original music, and Jack improvised on the xylophones and guitar.

Music, specifically songs, permeated the participants’ lives. It already functioned to make them feel better on a day-to-day basis. Although not always intentionally, the participants used songs as inner resources of strength which helped them to cope with their difficult lives. The songs already provided avenues of safety and growth before the participants brought them into our sessions. In these sessions we first increased their awareness of the existing therapeutic use of songs in their lives, then explored and expanded these uses. The participants came to understand more clearly the potential that music had to
improve and maintain their mental health, then took these insights back into their everyday lives for continued growth. Thus, what already functioned as an unconscious inner resource could be purposefully and intentionally used towards better health and happiness.

The Influence of Music on the Therapeutic Relationship

As our sessions began I was struck by the positive relationships we formed and the amount of trust that the participants seemed to have in me, as demonstrated by their willingness to speak about private and painful feelings. One particular work of Music Therapy research found that other adult psychiatric patients also had formed positive attitudes towards their Music Therapist, and the researcher attributed this attitude to the presence of music in their relationships (Kahans & Calford, 1982). Other research (Cassity, 1976) revealed that a significant contributor to this positive relationship was the participation in musical activity inherent in Music Therapy. Anshel & Kipper (1988) discovered that singing in particular positively influenced trust. Singing did seem to dissolve barriers between myself and the participants, and to create great intimacy and an atmosphere of trust. I found, as Amir did in her qualitative Music Therapy study, that "...trust can be gained sometimes more immediately and effectively through the nonverbal process of music making" (1992; p. 22), specifically through singing with each participant.

Within the positive framework of a trusting therapeutic relationship, the participants shared a great deal about their lives. While examining and analyzing the data from all six of the participants I discovered that they all shared similar feelings in two specific areas. These two cross-case themes that emerge from
their songs, "I'm A Broken Self" and "We Were Falling Apart Together," represented primary foci in each participant's sessions. The participants often expressed feelings of low self-worth due to their psychiatric illnesses and their troublesome relationships with others who were also struggling with similar difficulties. As early as 1965, Music Therapist Tyson mentioned that she had observed similar feelings in the adult psychiatric out-patients with whom she worked. She found that they did not involve themselves in activities and "craved" meaningful vocations and relationships (p. 1).

**Stigma**

Often employment and healthy relationships were not possible for the participants in this study due not only to their problematic symptoms, but also to the stigmatization accompanying their illnesses. The sense of stigma that all of the participants felt because of their psychiatric illnesses was revealed in these two themes, "I'm a Broken Self" and "We Were Falling Apart Together". Other studies have also found that individuals were "being herded together administratively against their will on the basis of a common stigma" by mental health organizations (Goffman, 1963, p.81) and that finding a job was extremely difficult because "official entree would necessitate the employer knowing about their stigma" (p. 94). Gibson (1992) writes that this "stigma against mentally ill persons seems to have been present from the beginning of recorded history" (p. 185). Gelb (1980) states that:

The mentally ill have always had to cope with discrimination stemming from negative perceptions of mental illness. This discrimination has a pervasive influence on the lives of the mentally ill (p. v) ... people who are identified as 'mentally ill' are faced with a special set of concerns. They are 'ill' in a way that may people do not understand and also fear...
it is no wonder that negative stereotyped views toward mental illness are common” (p. 1). Those who enter ‘mental health’ facilities are branded ‘sick’ in a unique way—a way that sets them apart from all others who are in need of health treatment (p. 12).

Fink and Tasman (1992) assert in their recent book *Stigma and Mental Illness* that it is now time to ask how we can overcome stigma (p. 95). I believe that one way to begin to do this is to explore and utilize the inner strengths that persons suffering from psychiatric illnesses have. By doing so, these individuals begin to be empowered to help themselves. For example, in this particular study each of the participants attended every scheduled session. None of them missed a session and very few were even a few minutes late. Their Music Therapy sessions were something that they had a choice about and that they were motivated to attend. Only one participant had to drop out of the study despite his request to continue, but since he had quit his membership in the outpatient program he was no longer permitted to participate. This involvement in Music Therapy seemed important to the participants. During their sessions, the participants spontaneously shared their perspectives on their Music Therapy experiences. Perilli (1991) found, as I did in my study, that her patient reacted more favorably to Music Therapy than to verbal psychotherapy. She believed this response was due to the less threatening contact with reality in her Music Therapy sessions. Each of the participants in this study spoke positively about their Music Therapy experiences. In this study I included direct quotations from participants, because I believe that, as Scheiby (1991) explains, for a patient to articulate his/her experience in Music Therapy is essential to both the therapist’s understanding and to the therapeutic process.
Sexual Abuse and Psychiatric Illnesses

My initial belief, or bias, prior to the study was that the impact of childhood sexual abuse would play an extremely significant role in the lives of the participants. However, it rapidly became evident that coping from day to day with a psychiatric illness took precedence over dealing with the ramifications of the abuse that each of the participants had encountered. The impact of their abuse certainly caused immense difficulties, but the complications of the psychiatric illnesses were much more pervasive in their lives. More significant was the fact that talking about their histories of abuse was often not part of their usual therapies, and they wished it were. The participants expressed concern that their histories were indeed causing problems in their lives, especially in their relationships, but that when they spoke about their abuse in other therapies it was considered a psychiatric symptom, not a problem of its own. For example, when Bess spoke of her childhood sexual abuse, her dosage of medication was increased because it was thought that she was becoming more psychotic. Although the literature does not confirm causality between childhood sexual abuse and psychiatric illness, one rare long-term study of psychiatric patients who had been sexually abused did show increased factors of anxiety, depression, suicidality, and personality disorders (Beitchman, Zuicker, Hood, DaCoasta, Granville, Akman & Cassavia, 1989). In the past, the participants’ families, and often their therapists, were not able to respond therapeutically to their concerns about their sexual abuse. Therefore, they had learned to keep their thoughts to themselves until they became involved first in a Sexual Abuse group and then in their individual Music Therapy sessions.
Therapeutic issues that the sexually abused need help to address are: disturbed self-esteem, trust, isolation, shame, and intimacy (Bass & Thornton, 1983; Clendenon-Wallen, 1991; Lew, 1988). Although the participants gave priority to their psychiatric illnesses, it is significant that their primary themes were also sexual abuse issues: low self-esteem, which include shame and isolation, and difficulties with intimacy, which encompass violations of trust.

I found that songs provided a safety net for the participants, enabling them to recognize and then discuss their concerns without falling too far into despair. Songs also seemed to provide a safe distance, a "hands-off" way of addressing distressing problems. The underlying structure of popular music, with its stable and consistent rhythm, framed their exploration with a secure beginning, middle and end.

Reflections on the Method

The qualitative research method that I used provided another level of understanding, due to the combined roles of therapist and researcher, that I had not encountered previously. Through the intense scrutiny and study of the Music Therapy sessions, I explored the content and process of each session more deeply than I would have ordinarily. For example, process notes were taken and each session was tape recorded and 35 transcripts were made, each approximately 30 pages long. These transcripts enabled me to clearly analyze songs, words, and interactions. I wrote Analytic Memos throughout my work--before, during and after my sessions with participants--which helped me to recognize my own feelings and reactions.
I found each of the participants’ sessions to be fascinating in many ways. There were two general aspects that captivated me. The first was the way the participants used music as a way to build bridges over which I could cross onto their lands. The second was my own experience of what it was like to live on these lands of psychiatric illness. I was also struck by the potency of the experience and depth of the understanding I gained from the participants. Although I have worked with people with psychiatric illnesses for over a decade, I had never realized the depth of the participants’ experiences of illness. I came to know much more about how having such an illness kept the participants from being able to have ordinary conversations, take a trip, walk to the bus, and other aspects of day-to-day life. I found that another of my biases was in my assumption that any illness, whether physical or psychological, would be treated openly and with dignity in the patients’ communities. I had no idea of the extent to which demoralizing events happened to individuals merely because their illnesses were psychiatric ones. For example, something as simple as picking up a prescription could become a painful and embarrassing event when the pharmacist would loudly call out the name of the medication and insist that the patient return after two days since she had not yet run out of the drug. During my involvement in this study my own work with patients on my unit changed. I became more involved in their lives outside of the institution. I accompanied them into the community when asked. I advocated for them with other medical professionals when needed. I was more aware of their struggles in the community. I attribute this richer understanding to the research method I implemented within the framework of the Music Therapy sessions.

Also, my research groups gave me fresh insights that I ordinarily wouldn’t have gotten. Many of them were in nonpsychiatric fields and were reading about
psychiatrically ill persons for the first time. For example, I am so used to seeing the effects that psychotropic medications and electroconvulsive therapy have on people that I often forget the huge impact these "treatments" have on people coping with illness. Through the eyes of my research groups I saw more clearly what had become faded. I saw anew how large doses of certain medications change a patient's physical aspects, and how even one's gait changes. I became reacquainted with not only the debilitating memory loss from ECT, but also the feeling of powerlessness which accompanies being subjected to this treatment. Because of this qualitative research approach, I learned new things about a population I have worked with for a long time and have consequently grown as a therapist and a person. A qualitative research approach particularly lends itself to Music Therapy in that much of its practice is identical to many aspects of therapy in general. Therefore, it is not necessary for the therapist-researcher to sacrifice optimal therapeutic processes in order to research the treatment.

The ethical considerations involved in this particular type of research are also congruent with those in standard Music Therapy practice. The primary goals of this study, the exploration and understanding of the participants' experiences with music, allowed for research to take place without compromising the therapeutic focus inherent in the Music Therapy sessions. There was no need for 'control' groups or the use of 'placebos' which often present ethical dilemmas to the researcher because they do not provide treatment for those in need of it. Instead, all willing participants (6) were included in the study. The standard confidentiality practices which apply to studies of people with psychiatric illnesses were implemented in the research method: using pseudonyms, keeping locked files, changing certain identifying data, and erasing tape-recordings of
sessions after transcriptions were completed. I found that neither the research aspect nor the therapeutic aspect was significantly altered by combining the two.

The effects of this study on the participants and myself, the therapist-researcher, were quite similar to the effects of non-researched Music Therapy sessions. The length of the sessions within this study was not different from the usual session length. Like the sessions in this study, most of the sessions I conduct ordinarily are within the framework of planned short-term treatment. This is due to shortened hospital stays as dictated by insurance reimbursements. Also, as in ordinary sessions, the types of interventions I incorporated were client-centered. My way of working with these participants was no different from my approach without a research design, although the process was influenced by the deeper impact of these sessions, as discussed below. It seemed significant that I used the words ‘patient’ and ‘participant’ interchangeably within this study, probably because I felt that the combined roles of researcher and therapist fit together smoothly. The participants had been patients at a large teaching/research hospital for years and were used to being video- or audio-taped throughout their sessions, so they were quite accustomed to the presence of recording devices.

The area in which I felt a difference was the impact the research had on me and the participants. One contributing factor was the extent to which I used the tape recorder. Often in my ordinary sessions, I use a tape recorder for my own instruction, but what distinguished this study from my previous work was the amount of effort I put into understanding the recordings of the sessions. Therefore, my therapist-researcher role was more informed and I was more invested in it than would have been the case without the research method. For example, I remembered aspects, details and musical elements of previous sessions with more accuracy than in my non-researched Music Therapy sessions. This
phenomenon stimulated me to delve more deeply into the inter-relationship between the participants and myself, as detailed in the chapter "Therapist and Patient Perspectives". I believe that being part of a research project did not have a negative impact on the participants’ therapeutic process. On the contrary, I believe that they were offered a richer therapy because I was more informed and attuned to their experiences. As therapist-researcher, I felt more deeply affected by my participants due to my intense analysis of and in-depth focus on our Music Therapy sessions. I believe that they felt this intensity too, and that it enhanced both the therapeutic process and their trust in me, enabling them to open up and share deeply personal thoughts and feelings.

Suggestions for Further Study

Future mental health treatment will most likely be in the form of planned short-term interventions due to financial constraints. This reality necessitates a different type of treatment focus than we have seen previously. As early as the 1970’s the Music Therapy literature had been documenting that the length of stay during psychiatric hospitalizations was being decreased (Tyson, 1973). There has been an outgrowth of outpatient clinics and services. I believe that a unique need for the Music Therapist arises from the predicament of the out-patient as described by Tyson:

There is the patient’s tenuous hold upon reality, which results in a precarious, unstable day-to-day life situation; the inability to formulate goals or to apply oneself with sustained energy; low self-concept which perpetuates destructive and self-defeating tendencies; lack of satisfying experiences; denial of angry feelings; immobilization because of overwhelming anxieties and fears; profound misunderstandings and distortions of events and responses. Above all, there is the terrifying isolation which results from the inability to relate to others (p. 120).
I believe there are strong indications for Music Therapy within the short-term framework, due to the ability of music to dissolve barriers between two strangers, enabling meaningful, therapeutic communication in a relatively short period of time. The expedient way to gain entry into people’s inner lives is the use of familiar, and already-therapeutic, elements in one’s own environment. Since music is often an intrinsic part of people’s lives prior to entering treatment, it is rich with associations which have great therapeutic potential. Tyson (1973) stresses the importance of music as a bridge to the inner lives of her patients:

it is important that the music therapist’s sphere of interest be the inner life, the inner reality of the patient. The therapist is not so much concerned with the form or refinements of his medium, as with its use as a vehicle by which inner reality can come to the surface, be heard and experienced and examined in the light of day (p. 121).

It is equally important to recognize the parameters set by the duration and depth of planned short-term therapy within the realm of out-patient services. The therapist and patient must realize what kind of progress can be made and what types of interventions are feasible within that framework. In this study, I felt it was essential that each participant gauge and control how deeply he or she went into the experience of abuse to insure that s/he would be able to function after leaving the session. I told the participants that I would rely on them to alert me if they felt they were “unraveling” and to let me know if they needed to change the focus at any point. I made sure that as each session ended the participant felt ready to leave. It seems that the participants’ music also served as a buffer and a stabilizer for them. Their music offered them safety and support which they could take with them when they left.

I believe that it is important for Music Therapists to use the authentic music of their patients as part of the therapeutic process. This way, the patient has
the opportunity to retain certain therapeutic aspects in a concrete manner. For example, these participants continue to have the music of their choice in their environments and can utilize that music in their own continued healing.

It is also important for verbal psychotherapists to consider utilizing music as at least part of the introductory part of the therapeutic process. Because music is such an integral part of most person’s lives, speaking about it can disclose valuable information about many facets of an individual. A therapist can learn much about a patient quickly by inquiring about music in their lives. Learning much about a patient in a short period of time is essential in meeting the challenges of planned, short-term therapy.

Furthermore, as previously discussed, the use of a qualitative approach lends itself well to the exploration of the therapeutic experience, and it is my hope that researchers will increasingly utilize this approach. It allows participants to retain their identities as individuals and to benefit from more powerful therapeutic experiences. It allowed me to learn more about my participants and to understand them better. As Dr. Martin Luther King wrote (in Sander, 1992, p. xi):

That’s why I say we’ve got to understand people, first, and then analyze their problems. If we really pay attention to those we want to help; if we listen to them; if we let them tell us about themselves--how they live, what they want out of life--we’ll be on much more solid ground when we start ‘planning’ our ‘action’, our ‘program,’ than if we march ahead, to our own music, and treat ‘them’ as if they’re only meant to pay attention to us, anyway!

And finally, it is my wish that, as researchers investigating people with psychiatric illnesses, we will become increasingly inclined to look not just at their ‘illness’. For all therapists, the positive role of music in patients’ lives provides the opportunity to look also at their ‘wellness’.
EPILOGUE: ONE YEAR LATER

The following epilogue is offered out of my desire to show the reader a glimpse of the participants' lives one year later. These glimpses do not indicate long-term predicaments or positions, but allow us to see seven slices of life at one particular moment in time. This information comes either from the participants themselves or, if I never saw them again, the staff member who conducted their original "Sexual Abuse Group" from which they were introduced to our study.

Bess has been working as a secretary in a local business and living in her supervised apartment since our study. Considering that she, as with each of the other participants, had been hospitalized for a great portion of her adult life, this ability of hers to stay in the community is a remarkable one. She sees her psychiatrist once a month and her therapy group once a week. I see Bess approximately once a month when she is at the hospital. She always greets me with the question "When can I have Music Therapy from you again?" and tells me what songs she is learning on her guitar. She has continued to play her guitar often at home and sometimes plays with others. She tells me that she enjoyed our time together and is glad that she can play guitar again.

Diane has been on a long-term unit for the entire year. She continues to have enormous difficulties on the unit and often has to be restrained. When she does earn passes for intervals of time off the unit, they are fraught with incidents of trying to hurt herself, after which she must start all over again when she returns to the hospital.

Jack was out of the hospital for the first half of the year but he has been hospitalized since then. I am struck by how different he looks, since he has
gained at least 40 pounds. He looks disheveled, his hair is often unruly, and his sweatshirt and pants are usually dirty and torn. I am amazed when I remember how he used to appear as if he were on the cover of a sports magazine. Both Jack and Jill were hospitalized at around the same time but on different units. Looking drugged, eyes glazed over, Jack happily said that both he and Jill were soon to be discharged and that they were looking forward to living together again.

Matt has been out of the hospital for over half a year. His medication trial that began toward the end of our study was finally complete and he is now regularly on a full dose of the new drug Clozapine. I often see Matt sitting motionless on the stoop of his outpatient building. Where he always used to carry his backpack’s guitar and a backpack stuffed with music, he now carries a pipe. He usually looks forlorn. Matt tells me that he no longer writes music. He says that his voices, which used to help him write his songs, have left. He misses his voices.

Sally had a breast removed due to previously undetected cancer, and she spiraled downhill into a deep depression over her loss. Her boyfriend left her when she went in for the surgery. Sally has been on various units and is hoping to be discharged after the holidays. She says the staff will not allow her to leave earlier than that because her depression gets worse during that time of the year. I see Sally only during hospital activities when she is accompanied by a staff member. Sally says she has lost the hope of fulfilling her dream of becoming an EMS worker. She looks sad but brightens up when we bump into each other in the hospital. She usually grins and tells whoever is near us that she taught me how to play the xylophone. She sometimes asks me if I can still play ‘YOU NEEDED ME.’
Tom has been readmitted to the hospital several times. Each time I see him he is wandering around, alone. Tom initiates conversation and always says “hello” and that we should play guitar and sing together again. He usually remarks that “we sounded good together,” asks me if I’ve been practicing, and comments that I was a “quick start” in learning from him. He still stares at me without looking away, but it doesn’t seem to bother me anymore.

I have continued working with children and their families on my unit at the psychiatric hospital. I have a much greater awareness of the impact that their illnesses have on their lives and try to be more attuned to their everyday situations. As a result of my increased awareness of the stigmatization that people with psychiatric illnesses suffer, I no longer identify myself as “the child’s therapist” to inquiring neighbors. Instead I simply reply, “I’m a friend.” Although I continue to work with these families as a therapist, I am more sensitive to how others might perceive this type of work and do not call attention to it.
BIBLIOGRAPHY


Hammel, Amy (1992). But you won't be able to see my voice. Unpublished paper.


APPENDIX A: DEFINITIONS OF PSYCHIATRIC ILLNESSES

These definitions of psychiatric conditions are taken from the DSM III-R.-A.P.A., 1987:

**Bipolar Disorder**--a Mood Disorder that involves the full symptomatic picture of both Manic and Major Depressive Episodes” (p. 226). A Manic Episode includes: a distinct period of abnormally and persistently elevated, expansive or irritable mood; an inflated self-esteem; a decreased need for sleep; an increase in talking; a flight of ideas (rapid uninterrupted talking about several unconnected topics); a distractibility, and an increase in activity with excessive involvement in pleasurable activities which have a high potential for painful consequences (p. 217). A Major Depressive Episode includes (on an almost daily basis): depressed mood, markedly diminished interest or pleasure in activities, significant weight gain or loss, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or excessive guilt, diminished ability to think or concentrate, and recurrent thoughts about death (p. 222).

**Borderline Personality Disorder**--a pervasive pattern of instability in the following areas: mood, interpersonal relationships, and self-image. This begins by early adulthood and has some of the following traits: a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of overidealization and devaluation; impulsiveness in areas that are self-damaging; affective instability; inappropriate intense anger; recurrent suicidal threats, gestures, or behavior; marked and persistent identity disturbance; chronic feelings of emptiness or boredom, and frantic efforts to avoid real or imagined abandonment (p. 346).
**Delusion**--a false personal belief based on incorrect inferences about external reality which is firmly sustained in spite of what almost everyone else believes is true and in spite of what constitutes incontrovertible and obvious proof or evidence to the contrary (p. 395).

**Eating Disorder**--characterized by gross disturbances in eating behavior, including Anorexia Nervosa and Bulimia among other disturbances. These two disorders typically begin in adolescence and are apparently related to each other. Anorexia Nervosa is a refusal to maintain normal body weight. This is usually accomplished by a reduction in total food intake, often with intensive exercising (p. 65). Bulimia includes: recurrent episodes of binge eating, a feeling of a lack of control over eating, self-induced vomiting or the use of laxatives or diuretics, strict dieting or fasting or vigorous exercise in order to prevent weight gain, and persistent overconcern with body shape and weight (p. 67).

**Hallucination**--a sensory perception without external stimulation of the relevant sensory organ. A hallucination has the immediate sense of reality of a true perception, although in some instances the source of the hallucination may be perceived as coming from within the body (p. 398).

**Psychotic**--a gross impairment in reality testing and the creation of a new reality. When a person is psychotic, he or she incorrectly evaluates the accuracy of his or her perceptions and thought, and makes incorrect inferences about external reality, even in the face of contrary evidence (p. 404).

**Schizoaffective Disorder**--includes conditions that do not meet the criteria for either Schizophrenia or a Mood Disorder, but that at one time an individual exhibits the criteria of both disorders (p. 208).

**Schizophrenia**--includes the presence of some of these symptoms: delusions, prominent hallucinations, incoherence or marked loosening of
associations (unrelated thoughts as expressed by speech), catatonic behavior, flat or grossly inappropriate affect ("...the feeling tone, pleasurable or unpleasurable, that accompanies an idea," Kaplan & Sadock, 1985, p. 165) (p. 194).
APPENDIX B: DEFINITIONS OF CHILD ABUSE

Below I set forth the traditionally accepted and most widely used definitions that have served as cornerstones in ascertaining instances of abuse.

Child abuse damages immature members of our species in such a way as to interfere with their optimum development and to impair their adaptive survival abilities. Abuse involves children of all ages, from infancy through adolescence, and caretakers of both sexes, all ages, and with various kinds of relationships to the child (Helfer & Kempe, 1968, p. 81).

Emotional abuse plays some role in all abuse and neglect but because the scars are not physical ones, they may go unnoticed. Although it is difficult to document, its effects can be crippling. Sometimes the abuse is primarily verbal and other times it takes the form of neglect, or an absence of adequate parenting. (Kempe & Kempe, 1978, p. 12-13).

Physical abuse of children is the intentional, nonaccidental use of physical force, or intentional, nonaccidental acts of omissions, on the part of a parent or other caretaker interacting with a child in his care, aimed at hurting, injuring, or destroying that child (Gil, 1970, p. 6).

Sexual abuse is the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend and to which they are unable to give informed consent, or that violate the social taboos of family roles (Schechter & Roberge, in Mzarek and Kempe, 1978, p. 11).
APPENDIX C: INTRODUCTION AND CONSENT FORM

(introduction)

Amy Hammel is a Music Therapist who is interested in exploring the meanings that music may have for you. If you wish to be involved in her study, she will have a few individual Music Therapy sessions with you in a nearby building here on campus. Her proposed project does not have any potentially dangerous or harmful physical risks. Due to the nature of any therapeutic relationship, issues of emotional content may be present and may cause a wide spectrum of feelings. Should you feel any overwhelming stress, or for any other reason, you will be able to withdraw your participation at any time without negative ramifications. However, most people involved in similar participant studies have reported feeling good about the process.

(consent form)
Dear ____________.

I am a Music Therapist and a graduate Music Therapy student who is conducting doctoral research at New York University. I am interested in the experiences and feelings about music of people who have been sexually abused. I feel this will help me to better serve future clients in my work as a Music Therapist. If you permit, my project will involve your participation in a few individual Music Therapy sessions.
We will have the sessions in a private room on the hospital grounds. All of the information you give me will be confidential. I will refer to you and the hospital in my records with pseudonyms. All participation will be voluntary. You have the right to withdraw at any time without any negative impact. As part of this project I will need to audio-tape our sessions to help me study what took place. These tapes will be kept in a locked file and then destroyed after the project is completed. Please sign below if this is agreeable to you.

Sincerely yours,

Amy Hammel, MMT, RMT-BC

I may be reached during the day at: (914) 997-4371

__________________________
(signature)

__________________________
(date)
APPENDIX D: CODINGS (Diane)

(adoption)
My twin and I were put into an orphanage after we were born and then into a foster home 1 and 1/2 years later. We were eventually adopted when we were 9 years old. We were always told that our biological mother was ‘sick in the hospital’ and we didn’t realize until later that she lived in our neighborhood and had other children. We think that we met her at our adopted mother’s funeral because she didn’t look like anyone our mother’s age but was introduced as a woman who ‘was in your mother’s class at school and was a friend of hers’. We both felt like we looked like her and that she had been our biological mother.

(children having children, stigma)
Donna, my twin, followed in our real mother’s footsteps and also became pregnant when she was 13 years old. Our Catholic school forced her to go through the pregnancy and wouldn’t allow her to get an abortion and then kicked her out of school and wouldn’t let her go to any of the special functions. The whole neighborhood made fun of her and her life was miserable.

(alcohol, father-daughter relationship)
When it was time for her to deliver, the hospital needed our father’s permission because the baby was over 9 pounds. He was drunk and refused to give it, but the hospital took the risk and did it anyway. Then she wanted to live at a home for unwed mothers with her baby and finish school and learn how to take care of him, but our father’s permission was needed and he said “no”. He said that she had to raise him at home, so she gave him up for adoption even though she didn’t want to.

(adult coping with adoption)
She knows his phone number and still calls him up to hear his voice say “Hello”. He is 18 years old now and she plans to contact his parents sometime to ask to meet him as an adult if he is willing.
Jack - Session #6 - 7/27/93

Amy: So when you got admitted, you didn't know who you were and where your were?

Jack: Right.

Amy: So what happened, how did you get here?

Jack: I got here... I thought I was John F. Kennedy and I thought my doctor told me to take a large dose of medicine. It was too much for me obviously. I started feeling really sick, I was at home, I was in the hospital, she was psychotic too. I called the ambulance, which is the same number as the police and they came over and they saw what the situation was.

Amy: What did they see?

Jack: Well, I was ordering them around, I thought I was the President. (They laugh)

Amy: I guess if you thought you were the President, you could order anyone you want around.

Jack: Right, so they told me they were taking me to my house in the country. I believed them and they put me in the car and they took me over to ...

Amy: Sure, quite a house in the country, huh?

Jack: Yeah, and I got there and I passed out. I woke up on a stretcher. They were putting this liquid through me, to get the medicine out, I was on an IV.

Amy: Wow! How much did you take?

Jack: 300 milligrams of Thorazine.

Amy: That's a lot.

Jack: Yeah, that's a lot. But I was psychotic before this ever happened, I was psychotic for about 4 days.

Amy: How did you get psychotic for so long?

Jack: Well, I was psychotic and she made me psychotic. I had the illness but it was latent and she brought it out in me.

Amy: How?
Jack: By talking to me about psychotic things that were very disturbing and I was in poor mental attitude before that. We had a fight and we weren’t talking to each other and it was extremely stressful. I was going out every day and I didn’t have any place to go to. I walked to different places but I was under a lot of stress. So anyway, I woke up on the stretcher and I had an IV in me and I really thought I was going to die. Cause I had so much medicine in me that they could barely keep me conscience.

Amy: It sounds really scary.

Jack: Yeah, it was.

Amy: So then what happened? They flushed the Thorazine out of you?

Jack: Yes, and then they told me I was going to the hospital. I got to the hospital and I thought I was in a hotel.

Amy: (Laughs) Compared to than right? I can understand that. So were you still psychotic when you came to this hospital?

Jack: Yeah.

Amy: How long ago was this?

Jack: About 6 years ago.

Amy: Okay, so what happened being here in the hospital?

Jack: Well, I was having a really good time, I was manic.

Amy: So, it felt great?

Jack: I felt great, and then they hit me with the medicine, and I totally crashed and I went into a deep depression.

Amy: You mean you went down? So then what? Did you come back and realize who you were?

Jack: I was psychotic...I was in the hospital for about 3 months, I was psychotic for about 2 months.

Amy: What’s it like to be psychotic?

Jack: I thought I was God. I just kept it to myself and I stayed away from everybody.

Amy: Why did you keep it to yourself?
Jack: Cause I thought they were evil. I thought the other were different people.

Amy: So you just kept real quiet and kept to yourself?

Jack: Right.

Amy: Okay, then what happened?

Jack: Actually, I didn't come out of the psychosis until I spoke to had just gotten out of the hospital, she called me.

Amy: Was she in this hospital too or a different hospital?

Jack: She was

Amy: So she was

Jack: Right, so she got out of the hospital and she called me. We hadn't spoken to each other since we were hospitalized. I started talking in a psychotic way and she told me to cut the shit. I guess then I realized that I was talking...so psychotic. So little by little I got rid of all my psychotic thoughts.

Amy: By her saying that?

Jack: Yes.

Amy: Her saying, "cut the shit?"

Jack: Yes.

Amy: That's incredible. I had no idea something like that would help.

Jack: Well, it was that plus the medicine.

Amy: Then what happened?

Jack: So I was in the hospital for 3 months and I got out.
Jack - Session #7 - 8/26/93

Amy: Like some conspiracy, putting a bunch of obstacles in your way?

Jack: Yeah.

Amy: Is that what's happening to you now? Tell me a little bit about that?

Jack: It's almost like there's some mysterious force that is bent on giving me a hard time.

Amy: Why? What would this force be thinking? Something like, "John's life has been too good, let's mess it up?"

Jack: Let's make John's life as bad as I can get.

Amy: That's what it feels like? It's hard to think these things happen by chance isn't it?

Jack: No, it doesn't seem like chance.

Amy: That it was put there purposefully?

Jack: Yeah. (LONG PAUSE)

Amy: Have you ever had that feeling before, that things were put there purposefully?

Jack: Let me put it this way, it's going to sound a little weird. But I consider myself a good force and I feel like I have to battle evil forces.

Amy: And what's going through right now...

Jack: I'm battling evil forces.

Amy: Have you done this before?

Jack: Yes, when I was psychotic.

Amy: Help me compare those two times, then and now. Were you battling an evil force?

Jack: I felt like it. It wanted me to give in, like go crazy and go to the hospital.

Amy: Who won out then?

Jack: I did.
Jack: Then I asked if I could stay at the hospital. He said, he refused to let me. He said he would see me the next day. I went outside and I was terrified of the dark, I thought there was something lurking in the dark. So I came back inside and I said please take me to a hospital. He refused to take me to a hospital. He called me a cab and I rode back home. This happened before the police came and took me to Hospital.

Amy: How much before would you say?

Jack: About a few days before. I went home and I got totally psychotic and more psychotic. Like I was terrified that someone was trying to kill me. So I didn’t answer the phone, the phone kept ringing all day. I didn’t sleep all that night, up all night, guarding the door, making sure no one came in. I tried to sleep but I was still manic and I ended up sitting up all night. The next day, I forgot about the doctors appointment, I forgot about all sorts of things and I was getting phone calls and I wouldn’t answer the phone, cause I was afraid that if someone knew I was there, they would try and kill me.

Amy: So people were trying to get a hold of you? Then what happened?

Jack: That’s when...that leads into the other story I first told you.

Amy: So when did the doctor tell you to take all the Thorazine?

Jack: Well, I called him. I missed my session with him but I still had enough common sense, I called him. I told him things like I couldn’t read newspapers because the words were upside down, things like that. That’s about it.

Amy: Wow, that’s incredible.
SESSION #2 - 6/15/93

Bess: And another thing is, the medication the other doctor would give me was making me gain weight. So it was really ridiculous. The other doctor had me on very high doses of anti-psychotic medication.

Amy: I remember you said you take an anti-seizure medication, it’s not called Dilantin, it’s called (INAUDIBLE). Do you take other medications with that?

Bess: Actually, the seizure medication that I take is also mood stabilizing medication.

Amy: Oh, which one is it?

Bess: Tegrital and Depicode. I take both of those, because the doctor felt that since I have trouble with my moods that it would be a good idea.

Amy: How do you like it?

Bess: I love it. When I started taking the Tegrital, I slowly got out of the depression and I could feel an instant improvement in my mood. It was the combination maybe. I also take Narbene which I started taking only recently, only a couple of years ago. I had taken it once before but not on a consistent basis.

Amy: How does it help you?

Bess: It decreases my delusions and hallucinations, things like that.

Amy: So you can tell the difference?

Bess: Yeah, and it flares up but it doesn’t lower my seizures. My Thorazine lowers my seizure threshold.

Amy: So, you really have to balance this out?

Bess: Narbene helps me. I missed one day since I’ve started taking it.

Amy: How long ago was that?

Bess: About 2 or 3 years ago.

Amy: And you just missed one day, that’s incredible.

Bess: Yeah, that’s pretty good.
Jack: I hear about people changing doctors all the time. Or complaining that their doctors aren’t doing anything that they want them to do. The doctor doesn’t listen, or isn’t helpful. I haven’t had that. I had an incompetent doctor once.

Amy: What happened?

Jack: I would just sit there and talk and talk and talk and he would just nod his head. Then after he nodded his head, he gave me the wrong medication.

Amy: How did you know it was wrong?

Jack: I was suffering from depression and he gave me the medication that was a dosage that would make me more depressed. Then he put me on an anti-depressant that had all sorts of side effects. Like I would pass out, black out, I couldn’t walk sometimes, I would loose all ability to walk. It was a horrible medication.

Amy: How did you leave that doctor?

Jack: Well, I got psychotic. I was getting manic and psychotic and he didn’t catch it in time and he kept me on a high dose of Noradil and Noradil can send a manic person into a state of psychosis. So, I went into psychosis.

Amy: So, you left him when you were hospitalized?

Jack: That’s when I got my new doctor.

Amy: And you were happy then?

Jack: I was very happy then. This guy is great and he’ll be with me for the rest of my life. I’ll just call him on the phone. If he even moves away.
APPENDIX G: TRENDS

ANALYTIC MEMO #1--7/5/93

It seems like a perfect time to do my first memo to myself. I have 6 participants in my study. 2 I have seen 3 times, 2 I have seen 2 times and 2 I have seen 1 time! I'm learning so much about myself, them and how do continue with this study.

First, about the study. I have been trying to write my logs the day of the session but find that I'm not going as in depth as I like due to how late it is when I get home from running the sessions after each work day so I'm ending up with less rich logs than I would like even though I've listened to the tape after each session. Then I'm still having to listen to the tapes again later to do partial transcriptions. I'm finding that I'm not getting as much feeling oriented information down as I would like, nor my own feelings and reactions, or details about appearances and affect. So I tried something new on 4 of my last sessions and now have a slightly altered game plan that I'll try out for the next batch of sessions and then re-evaluate. I'll write short process logs the night of each session that have to do with feelings of myself and the participant, descriptions of things that aren't readily apparent on tape, and my reactions and thoughts. Then over the weekends I will listen to the tapes as I type out chronological, content-oriented logs to get the gist of the session including quotes. At this point I will notate portions that I want to transcribe. I have a hunch that the transcriptions won't be so huge as I had originally planned because when I was trying out this method I found that by incorporating quotes into logs there was little that a transcription would add. All along I had planned to only transcribe pertinent portions and not entire sessions and that still feels right to me now.

I'm learning so much about what it is like to have a psychiatric illness and how isolating and humiliating that can be. I'm really struck strongly by this and am amazed because for 14 years I've been working as a Music Therapist or student with people having psychiatric disorders as well as having read works about and by people having this problem since I was a young teenager and never felt the impact in such strong, immense way. So far it seems that the
sexual abuse portion is overshadowed by the nature of the psychiatric disorders because they are so severe.

As for what I'm learning about myself I find myself much more naturally engaged than I would have imagined. I seem to respond very naturally to the participants and am not aware of stringent boundaries that keep me from expressing many of my own thoughts as they relate to the music. I've never been traditionally psychoanalytically inclined and have always found it therapeutically helpful to be engaged in the session actively and this reaffirms this method for me.

I have to try at times though not to be too enthusiastic about their musical selections which is difficult at times when I really do like their pieces! But I don’t want to sway their own likes and dislikes by showing too much favoritism to certain selections.

I'm so glad that I picked this particular topic and that I'm doing sessions and not just interviewing because I wouldn't be able to separate the two at all. It seems like the processes are intertwined with my way of being.

Soon I will begin to organize the codings that are forming on my readovers of logs into another Analytic Memo. Some of the things that I am struck with include Uses of Music (relax, gain insight, pretend) and Perspectives of Living with a Psychiatric Illness (humiliation, outcast, lonely, changes life) and Relationships with Having a Psychiatric Illness (difficulties in finding one, having one that is problematic).

I also want to write up profiles on each individual that include detailed descriptions about what they each seem like in their sessions so that the reader can get a real feel for each participant.
APPENDIX H: THEMES (Bess)

If A Person Says “I Have To Go”...

I wish I were moving right away to that independent-living apartment. I'm so tired of living in this halfway house. I'm angry, really angry at my counselor at my current place and that's why I want to move. I'm angry because I had to go to the bathroom the other day. This is a stupid reason, but I had to go to the bathroom the other day and I have a problem that I wet my pants and I have to wear protective undergarments and everything. She knows about it, and I had just come back from a trip with the halfway house and it was a long way in the car. I had to go to the bathroom and I couldn't wait, so I went in the office where the staff has their bathroom. It was just the closest bathroom, that's the only reason I used it. I asked first and told her that it was a real emergency and that I have to go and I can't climb up a flight of stairs to the other one. She got very upset and said that it has to be the last time I ever do it and they don't normally allow this to happen and this just can't happen ever again. She went on and on about it and I said it was ridiculous because they know that I have this problem and even if I didn't have a special problem, if a person says they have to go to the bathroom, they probably have to go. One other time I had to use that bathroom and the director of the house told me “oh, don't be silly, go ahead”.

I Want to Remember

You remember when I was telling you about that old woman who interviewed me for my new living situation? Well, at least she was older than me. It's so frustrating to have counselors who are supposed to be helping me, being younger than my stepchildren! Like last week, I forgot one step in how to cook a turkey so I asked the counselor about that little step. She said “Oh, I've never cooked a turkey”. Well, I've cooked about a million turkeys, but I forgot this one step. I'm not at this special living environment to learn things I never knew, but to remember things I knew already. Like, I forgot how to clean a floor. I asked my counselors and they would act like it was clean enough and didn't tell me the different steps in cleaning a floor when it was filthy. Luckily my roommate at the time had an obsessive-compulsive disorder and she told me the different steps to
clean a floor. I found out that you don’t just wash the floor with the same bucket of water, you rinse off the mop in another bucket. And that you can use ammonia which is very good. And that you move all the chairs out of the way, which was one of the things I didn’t remember. Unfortunately, after I was in the hospital so many times I forgot lots of things. Like how to use the computer.
THEMES COMMON TO MANY OF THE PARTICIPANTS:

I know this is going to sound funny, but I still think it anyway...

My diagnosis can give me a bad rap!

I don't want to keep having other people's problems all the time because I already have my own.

They told me my sexual abuse couldn't have happened, and gave me more medication.

His illness set off my illness.

I want to meet people who are not in the mental health system.

Unfortunately, after I was in the hospital so many times, I forgot lots of things.

THEMES UNIQUE TO BESS:

Believe Me (If a person says they have to go to the bathroom, they have to go.)

I Used to Be Better (Could you imagine people that you used to work with and go out to coffee with, now be your counselors?)

What Works for Others Might Not Work for Me (This religion thing wasn't too good for me, it encouraged me to hallucinate and dissociate.)

How Are You Supposed to Help Me? (It's so frustrating having counselors who are supposed to be helping me-- being younger than my stepchildren.)

They Treat You Differently when You Have a Medicaid Card.

He Thinks He Can Get Away With It because You Live in a Halfway House.