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THE RESTORATION OF COMMUNAL EXPERIENCES DURING
THE GROUP MUSIC THERAPY PROCESS WITH NON-FLUENT
APHASIC PATIENTS

David W. Ramsey

Music Therapy Department
Department of Music and Performing Arts Professions

Submitted in partial fulfillment
of the requirement for the degree of
Doctor of Arts in
The Steinhardt School of Education
New York University
2002
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[Signature]
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CHAPTER I

INTRODUCTION

For over twenty years, first as a substance abuse counselor and then as a music therapist, I worked with cognitively intact, verbally proficient adults. My approach to therapy was best characterized as client-centered. The concept of client-centered therapy is most closely associated with the works of Carl Rogers (1951), who proposed a foundational belief that therapy is most effective when focused on the supportive process of therapist and client discovering the client’s needs together. When working with verbal, cognitively intact adults determining the client’s needs is often direct. I ask them what it is that they feel they need and they tell me. If this is not clear to the client at first, it usually becomes clear with time and support. After the need is determined the course of therapy is easily constructed around discovering psychological blocks that prevent the meeting of these expressed needs and the provision of options related to these needs.

In 1996 I began work at a skilled nursing facility with adult patients who, although cognitively intact, could not speak because of neurological damage. Patients coming into therapy with non-fluent aphasia could not verbalize their needs to me, and yet their primary need appeared obvious. They wanted to be able to speak. It was my assumption that speech and the fluent use of language allowed for all other needs, social and personal, to be met. So equipped with this assumption, my client-centered approach, and the power of music to
instantaneously facilitate articulate vocalizations, I tended to fundamental things first: the improvement of speech.

While tending to the improvement of speech with aphasic patients, I noticed that many nonverbal communications were being employed. Gestures were used in conjunction with inarticulate speech in what seemed like an attempt to clarify or emphasize messages. Head nods were constantly employed to signal agreement or disagreement. I began to suspect that eye contact was not just an indicator of listening focus, but it also reflected a multitude of cognitive processes related to communication. I began to wonder how these nonverbal behaviors, demonstrated both in the music making and outside of it, might be related to one another. I wondered what purpose these nonverbal behaviors might serve persons who had lost their voice due to a cerebral vascular accident. I also noticed that during the music making extraordinary displays of social contact and personal expression were demonstrated. These observations during music therapy with aphasic patients stimulated my interest and ultimately led me to this research project.

In the course of this study I re-examined the function of speech and language, the nature of communication, my role as a client-centered therapist, and the role of music in the process of speech rehabilitation. This dissertation began as a search for significant nonverbal indications of communication in music therapy with non-fluent aphasic patients and led to a discovery of significant communal experiences during music making. The findings shed light on the communication dynamics of aphasic patients and how music therapy can provide
unique support in critical areas of their need. In the course of doing this research I also discovered that client-centered music therapy sometimes means actively directing the client towards essential human experiences.

Source of the Study

In the Spring of 1997 I was invited by the Head of the Speech Department at my facility to join her speech therapy group of stroke patients with aphasia. I had worked with several stroke patients individually at the hospital and had noticed to my amazement that despite their inability to speak, they could sing familiar songs. This phenomenon was related to the fact that music was processed in the undamaged right hemisphere and singing involved the bypassing of the impaired language centers in the left cortex. The participant’s singing certainly stood in stark contrast to their normal ability to speak and reflected observations from other speech therapists (Sparks & Deck, 1982). I was excited with the belief that there must be a way to utilize this phenomenon to help such patients regain their speech. By joining the group I hoped to learn how a trained speech therapist approached the needs of non-fluent aphasic patients and to gain some insight into how I could use music to rehabilitate speech.

When I entered the room for the first meeting, I greeted the five patients sitting around a large table. Unable to vocalize a greeting, the patients smiled and gestured their hellos. The speech therapist also greeted the patients and began the group by announcing that the topic of the day was the zoo. The speech therapist asked the patients a series of questions related to things at a zoo. Then she passed
around prepared posters with multiple choice answers so that each patient could point to the answer that most agreed with their preferences. After about five questions the speech therapist asked me to sing a song related to the topic. I sang “Old Macdonald Had a Farm.” I feared that my selection might have given the patients the impression that I saw them as children, but I also knew from experience with several stroke patients that familiar songs engaged them. The patients sang along. Some were more articulate than others. Some tapped their hands on the table. During the music the group dynamics changed dramatically. Through the introduction of music the patients were now not only able to use their voices successfully, articulating lyrics in a way they could not articulate spoken words, but they were able to enter into a form of expression that was characterized by fluidity as the time of the music brought much more movement to their interactions. The patients were now looking at one another, displaying emotional facial expressions, looking at me and responding to the shared musical events related to tempo and rhythm, lyrics and melody. We started and ended together and for the most part sang in synchrony. During the singing, from moment to moment, we shared the same time as dictated by the music.

At one point in the song where a new animal was to be introduced, I slowed down to allow a pause. The cadence of the music prompted vocal responses. Sometimes several patients responded at one time. This in turn evoked laughter. It seemed to me that the laughter was not based so much on the content of which animal was chosen, but in the collision of two responses at the same time. During the chorus of the song the patients sang in unity. This unity seemed
based on a common knowledge of the familiar lyrics and familiar melody. The unity and the collision of the two responses was lived out in “real time” (Ramsey, 1999), an experience of time that is normally exhibited when people converse and have to not only present their thoughts but negotiate the placement of responses in relation to one another in a shared knowledge of “proper” time management. During the singing, the group members were involved in a collective form of expression much different from the multiple choice exercises introduced by the speech therapist, where they were involved in a static form of communication time or “step time” (Ramsey, 1999). These exchanges were characterized by long periods of waiting while physically challenged patients struggled to manage the exchange of the posters and to point at written responses. One at a time and separated from the fluidity of real time, a whole dimension of communication seemed to be lacking in the multiple-choice exercises.

As I observed the patients outside of the group, in the hallways and in the dinning rooms of the hospital, I realized that this form of step time was a part of their daily existence. In the music they were sharing time together and this shared time afforded some of the rich dynamics and interplay that allowed for certain forms of self-expression and communication. Outside of the music they were faced with the struggle to convey simple pieces of information related to basic needs. Any other communication was too demanding.

After several months with this group I became more and more aware of the differences between their life in the music and their life outside of the music. Although I could not fully explain the difference, I knew that something subtle,
natural, and essential was missing from their interactions with others and it was not entirely dependent upon the exchange of specific ideas. Speech is the vehicle for language: Language existed in the context of an immense dance and interplay with gestures and tempo changes that conveyed as much if not more than the words themselves.

Researcher’s Music Therapy Foundations

I was not a speech therapist and I did not know all of the mechanics involved in speech production, the usual means to rehabilitation, or the prognosis of aphasic patients. Although concerned about this lack of knowledge, I realized that a good deal of my focus would be on the psychosocial aspects of the therapy. I planned to conduct sessions that utilized the power of music to facilitate articulate vocal productions, and at the same time to focus on those aspects related to psychosocial expressions. What role the limited use of words would play in these sessions I did not know. Therapy without words was rather new for me.

My music therapy foundations were primarily psychotherapeutic in nature. I worked from the premise that music could symbolically reflect personality structures and coping patterns. I noticed that music making with clients could establish an unusual level of rapport and that this rapport was conducive to psychotherapeutic processes. Once the rapport was established, issues that caused the client reoccurring anguish, or prevented the client from breaking self destructive habits could be musically reinacted and expressed. This process brought the “hidden” into the open and helped the client develop awareness into
reoccurring behavioral patterns that prevented progress. Alternative choices were discussed and the client experimented with these new options through improvisational musical explorations that aimed at symbolic reinactment of the issues. In this therapeutic format words were important because they were the principle avenue of insight development and insight development seemed the most effective way to discover alternative behavioral options.

Speech Rehabilitation Verses Music Centered Therapy

Pavlicevic (1997) states that “music therapists who use words in sessions are often perceived as working psychodynamically rather than purely music-therapeutically, and this bias is seen as compromising the validity of the musical act” (p.12). The bias that Pavlicevic refers to is certainly not one that I ascribed to previous to this study. I saw the verbal processing of musical expressions as enhancing the therapeutic process. As a part of my music psychotherapy training at New York University, groups were designed to reflect “a miniature society … whereby the uses of music for healing and therapy were organically discovered by the group members.” (Hesser, 1995). Verbal processing was an intricate part of this discovery. Psychodynamic oriented music therapy generally utilizes verbal presentations as significant materials for reconstructive levels of therapy, especially if the patients are cognitively and verbally intact.

The standard format of my earlier music therapy sessions was to play music with my client and then verbally process the music in order to uncover material related to psychic conflict. I believed that music, because of its capacity
to express emotive elements and symbolically represent the personality, was a
viable therapeutic tool to access cognitive material. This uncovering process was
sorted out verbally and in most cases "the conflict was sustained by cognitions or
events in the stream of consciousness that were verbal in nature" (Beck, Rush,
Shaw & Emery, 1979, p.3). An underlying principle of my humanistic, client-
centered approach was the belief that "an individual's affect and behavior are
largely determined by the way in which he structures his world and his cognitions
are based on attitudes and assumptions (schemas), developed from previous
experiences." (Beck et al.) In order to facilitate change I assumed a change in
cognitions was essential.

As I began to work with verbally challenged adults in a skilled nursing
facility, I found myself working almost exclusively in the music. Although I
would struggle with some form of cognitive reflection on the music experience by
asking the patients closed-ended questions about the music making, I found it
more practical and more rewarding to remain music centered. Verbalizations led
to difficult and frustrating experiences for the patients while music led to easily
managed and enjoyable experiences. During this time of transition from working
with words to a more music-based approach, I began re-evaluating my position as
to the value of words. I was observing startling transformations and interactions
in the music making that indicated to me that somehow the music making itself
was therapeutically enough. I was aware of music centered music therapies
before, but I had never fully considered their implications until my work with
language deficit patients. The principles underlying music-centered approaches
became fuel to my own journey away from words and into the therapeutic musical experience.

The Nordoff and Robbins music therapy approach was the first model of music therapy I studied during my training at New York University. Nordoff and Robbins (1977) created a music therapy approach that centered exclusively on the music making process. Working with handicapped children they created an approach that allowed the child to engage in significant musical relationships that addressed developmental delays. Inherent in the Nordoff and Robbins approach was the idea that music was an “agent for change” (Aigen, 1998) and that music allowed for “archetypal experiences to affect the patient” (Marcus, 2000) so as to facilitate psychological development and healing.

Since I was not working with developmentally delayed patients, and because I did not observe music to have independent healing properties, certain aspects of the approach did not provide a supportive rationale for my new observations of my music centered music therapy. Aigen’s (1998) expanded description of the Nordoff and Robbins approach did, however, resonate with my evolving awareness of the value of musical experiences. Concepts related to “communicative experiences,” “altered states of being in the music,” and “communal experiences” supported observations I was having with nonverbal adults.

Aigen (Aigen, unpublished manuscript) notes that many music therapists define their goals along non-musical lines. He states that by limiting music
therapy goals to social skills, psychological conflict, and cognitive development we render “actual musical experiences dispensable.” He suggests a music-centered framework to explain the therapy in music therapy. I found academic support in such ideas.

Pavlicevic (1997) believes that musical encounters can be therapy in and of themselves because they provide for an essential human need. She explains this need as a need to “be part of the pleasurable and unpleasurable effects of communication” (p. 99). This “being a part of” is experienced musically in all forms of communication because there is a shared human knowledge regarding rhythm, tempo, intensity, contours, and patterns that carry universally understood messages.

Ansdell (1995) explains that music therapy works in much the same way that music works. He states that the qualities of speed, force, attack, and intensity are musical and emotional at the same time. All humans share a common makeup that is characteristically musical. These shared characteristics allow all humans the capacity to recognize the intentional use of sound to reflect expressions.

As a person who loves music and who has always found music to be a source of strength, personal stimulation, an outlet for creative inclinations, and means for social connections, I was very excited to find a way to see music as “good enough” therapeutically.

During this research project I made a transition from music therapy that was dependent upon cognitive insight to music-centered therapy. My initial
dissertation proposal reflected concern with discrete communication displays (nonverbal behaviors that could be directly translated into verbal statements). These nonverbal behaviors reflected cognitions, and thus were reminiscent of my need to verbally process material. By the end of the research project my view of music making events had changed dramatically.

Research Questions

In designing the study, I knew that I wanted to look at nonverbal communications. I choose a qualitative research method that would allow for new questions to evolve if the data swayed the inquiry into unforeseen directions (Ely, Anzul, Friedman, Gardner, & McCormack, 1991). I remained open to the process and in the course of the study I did find my research focus changing.

The initial research questions gave me a framework from which to begin analyzing the data. As the data analysis progressed I noticed that my active introduction of familiar songs was necessary to keep the patients engaged, but did not facilitate individual expressiveness. My focus changed entirely from individual forms of nonverbal kinesthetic communication efforts to group musical responses. The following questions evolved as a result:

- What function does singing provide for patients who have lost their ability to speak?
- What function does the use of familiar songs serve non-fluent aphasic patients?
• What role does the music therapist play in the group process?

• What is the significance of responses to the manipulation of familiar songs by the introduction of various musical dynamics?

• What is an appropriate model of music therapy intervention consistent with humanistic principles for aphasic patients?

These questions provided the foundation for the following study and allowed me to further investigate the process of music therapy with non-fluent aphasic patients.
CHAPTER II
RESEARCH METHOD

Naturalistic Inquiry

In this study I used a qualitative research approach based on naturalistic inquiry (Lincoln & Guba, 1985). The qualitative method was characterized by the use of (a) a natural setting, (b) a human instrument as the means of gathering and analyzing data, (c) tacit knowledge as valued information, (d) case study reporting, and (e) developing theoretical concepts of the work that were grounded in the data and reflected the relationship of observed phenomena (Glasser & Strauss, 1967, Strauss & Corbin, 1998, Lincoln & Guba, 1985).

"For the naturalistic inquirer the design can be given in advance only incompletely: to specify it in detail would place constraints on either antecedent conditions or outputs or both" (Guba, 1990, p. 12). Thus one of the hallmarks of naturalistic inquiry is a design that emerges and varies according to data gathered and data analyzed. Such a research model allowed me to examine my own clinical work and illuminate essential elements related to communication in the music therapy process.

As indicated by the originally proposed research topic, the concern was with the examination of what constitutes communication during music making and during the entire music therapy process. Through immersion in observationally derived data, I was able to develop conclusions regarding
communications in the music therapy process, while at the same time shifting the focus from sub-problems revolving around micro-kinetic behaviors as indicators of communication efforts to a focus on responses relating to the group’s singing of familiar songs.

The research procedures followed guidelines posed by Lincoln and Guba (1985) and Aigen (1995) and were characterized by a comprehensive gathering of information from many sources and a recursive handling of data whereby data was gathered, analyzed and conceptualized repeatedly.

Although the focus of the research revealed unforeseen avenues of examination, certain mechanisms and procedures regarding data analysis remained constant. Mechanisms to ensure trustworthiness were employed (peer debriefing, member checking, triangulation and prolonged engagement) according to the guidelines posed by Lincoln & Guba (1985), and maintained throughout the entire research project.

The Setting

The study was conducted at a 520 bed skilled nursing facility where I work. Although this facility has offered long term care for severely disabled patients for over 75 years, services have been expanded during the last seven years to include short-term rehabilitation and outpatient care.

I have been employed as a music therapist at the facility for over five years and am currently the Assistant Director of the Music Therapy Department.
The sessions took place in the music therapy studio next to my office. The studio is a 16’ by 13’ room with many music instruments including drums, xylophones, guitars and a studio piano. The windows of the studio overlook the trees of the Botanical Gardens. The room is bright and inviting and creates an atmosphere that welcomes musical expression.

The sessions took place from September 6, 1999 – December 20, 1999. Sometimes internship students helped me gather the patients from the units but often I gathered them myself. During these times I became familiar with the patients’ living situations and with the dynamics of relationships on their floor. I often whistled, hummed and sang tunes while pushing their wheelchairs towards the studio. It was common that the participants would join in by humming or tapping their hand to the whistling that I initiated. During those times when the students gathered the participants, I had a chance to observe the arriving patients as they waited for me to set up the room before the sessions. Thus, in some respects, the sessions started long before the first note played in the studio. The internship students sometimes observed the sessions and they interacted with the patients when the participants initiated contact.

Selection of the Participants

Four participants were selected and seemed optimal for this study. More participants might disrupt group cohesion and focus, fewer members would not have allowed for multiple dynamics to evolve and demonstrate themselves. These dynamics were essential to this study on communication manifestations. The four
patients were selected from the skilled nursing facility where I presently work. Participants were selected based on a pre-admission diagnosis of either cerebrovascular accident (CVA) or traumatic brain injury (TBI). Each participant was assessed and treated by a speech pathologist and discontinued from speech therapy after reaching a rehabilitation plateau. I intentionally chose patients who the speech pathologist had given up on because I felt like my approach could provide therapeutic benefits to patients faced with termination from further rehabilitation attempts. I believe that the musically assisted speech could in fact help improve the neurological organization process involved in speech, improve motor functions connected the vocal production, and address psychological issues related to impaired speech. This belief affected my finding in that I looked at psychosocial demonstrations as much as improved vocal articulations.

The subjects selected were diagnosed with non-fluent aphasia. All participants were assessed as capable of processing receptive information and were capable of understanding information presented to them. This ability was assessed during sessions prior to the research where I talked to the clients about their relationship to music and possible interest in music therapy. During this assessment interview I based my conclusions on unequivocal nonverbal communications such as head nods and hand signals that at a minimum reflect definitive affirmations and negations.

I selected this particular group of patients for several reasons. Because managed care guidelines prohibit patients to continue in speech therapy if they are unable to show continued progress, people with non-fluent aphasia are left
without treatment. In previous experience with aphasic patients, I had noticed that they received discharge from speech therapy as a verdict of no hope. I knew music could provide successful vocal experiences, I hoped music therapy could improve speech, and I saw patients willing and wanting to continue attempts to rehabilitate.

The participants were invited to participate in the study because they expressed an affinity towards music and they seemed to enjoy the music making activities and the group support. I selected patients with these inclinations because previous experience had shown me that they were more likely to sustain interest in music therapy and not drop out early in the research process. This method of selection is referred to by Lincoln and Guba (1985) as “purposive sampling”.

Participants were given assurances of confidentiality. Pseudonyms were used to protect the identity of the participants in all written reports, including the final dissertation. To further assure confidentiality, all records including videotapes were locked in a file in the music therapy office with access to this file by the researcher only. Logs and videotapes were reviewed by my peer support group who were aware and committed to the established code of ethics in the field of music therapy. (See the Letter of Informed Consent in Appendix A.)
Data Collection

The music therapy group was comprised of four participants and sessions were conducted twice weekly. Sessions lasted for one hour. Data collection continued until the data recorded ceased to provide new information about the process. Data collection ceased shortly after the fourth month. Techniques such as vocal improvisations, singing familiar songs, and dialogue singing were employed to facilitate confidence in vocal production, encourage self expression, and develop group rapport and support.

The data base was comprised of video tapes of each session, transcriptions of video taped sessions, session notes reflecting my impressions of the group, session notes reflecting the observations and impressions of the viewed video taped sessions (often at altered speeds) and verbal reports from caregivers. Caregivers include family members and hospital staff that tended to the patient and who provide information regarding the patient.

Immediately following each session, I reflected on the form, structure and content of the music therapy. This log reflected my ideas regarding themes, methodology, initial belief and biases. Videotapes were transcribed to reflect verbal, nonverbal and music based interactions.

Because the music therapy groups reflected aspect of the researcher’s current clinical work, the session format was one I had employed previously. The introduction of a video camera, however was unusual. As a part of the intake procedures and consent reviews, videotaping was explained and all participants
were aware of the presence of the video camera. I presented some of my observations from videotape reviews to the clients as the research progressed. It was not uncommon for me to present observations of client’s behavior during the course of music therapy, it was however unusual that those observation were based on my review of videotapes in between sessions. Thus the feedback that I provided was based on more detailed observations and contemplation. The nature of the feedback was not different, only more informed. This more informed feedback might have influenced the music therapy process in matters of details but not in overall format.

Because the research group was so similar to the ongoing work of the researcher, because group rapport had already been established, and because I thought that the participants could continue to benefit from the group I decided to continue the group after completion of the research.

Data Analysis

Data analysis started after the conclusion of the first session and proceeded throughout the entire research process. The purpose behind analyzing data from the beginning was to help guide my observations of the sessions and to inform me when data collection was to end. Although data collection ceased after new data failed to appear, data analysis continued until the completion of the written dissertation.
Analyzing data during the research process influenced the sessions slightly. Although I did not change any particular forms of interventions, I did give more time to events that related to evolving research interests. For example, when noticing the differences between the nonverbal behaviors of the participants when responding to questions, I began to give the participant more time to answer. Previously I might rescue them from the struggle involved in difficult verbal responses. Other such areas of interest occurred and likewise I would give the event more time to display itself. I was not aware of introducing any new interventions during the research process.

Procedures regarding the analysis of the data followed the guidelines posed by Strauss & Corbin (1998) in that data was coded, categorized and analyzed according to a paradigm that subjects data to examinations regarding (a) the conditions of the phenomena, (b) the interaction among the participants in the phenomena, (c) the strategies necessary to sustain or diminish the phenomena, and (d) the consequences of the strategies to the phenomena. This four dimensioned coding paradigm posed by Strauss & Corbin (1998) was employed both to process the data and to guide the analysis toward conclusions.

All data including the researcher’s session notes, logs, transcriptions of the viewed videotapes, and notes regarding information from caregivers were included in my research log. A qualitative analysis of the data was undertaken by following several steps.
1. Video taped session were transcribed. Transcriptions reflected the researcher's observations of verbal, nonverbal, and musical components of the interactions of the participants.

2. Session notes were recorded before viewing the video tapes and reflected the researcher's impression of the client's responses. Many entries reflected psychological interpretation of motives as to the behaviors demonstrated. The researcher's personal reactions were recorded as well.

3. All data was subjected to an open coding system. Open coding (Strauss & Corbin, 1998) is a process of "providing conceptual labels on discrete happenings, events and other instances of phenomena" (p.61).

3. Coded data were grouped in categories. These categories reflected a homogeneous relationship among the coded segments and begin to provide a conceptual framework. (See Appendix B).

4. Categories were subjected to techniques for enhancing theoretical sensitivity (Strauss & Corbin, 1998), by posing questions that challenge basic assumptions of words, phrases and entire sentence concepts.

5. Data was subjected to axial coding: "a set of procedures whereby data are put back together following open coding, by
making connections between categories. This is done by utilizing a coding paradigm involving conditions, context, action/interactional strategies and consequences” (Strauss & Corbin, 1998, p.96).

6. Interpretations emerged from the coding procedures (including memoing: interpretive notes from the researcher) and were grounded in the data.

7. A central concept theme was developed that characterized all data. Interpretations regarding the relationship of categorical data were presented and grounded in the data (Strauss and Corbin, 1998).

Trustworthiness

Because I was in the dual role of researcher and clinician, establishing trustworthiness was a major concern. Trustworthiness is best established by open disclosure of personal biases and by the implementation of mechanisms to check biases against evolving conclusions.

Five mechanisms described by Lincoln and Guba (1985) were employed to ensure trustworthiness. They were prolonged engagement, persistent observation, peer debriefing, triangulation, and member checking.
Trustworthy Mechanisms

Prolonged engagement in the research process allowed all relevant elements of the group process to be examined. I continued the collection and analysis of data until data became redundant and I had examined all relevant aspect to nonverbal communications in my music therapy groups. Persistent observation, or intense emersion into the data, allowed the emergence of concepts that capture the essence of the observed process.

I am currently involved in a support group with other doctoral candidates doing qualitative research. I continued with this support group in order to expose my conclusions to the scrutiny of disinterested peers (Lincoln & Guba, 1985), disinterested in the sense that they are not intimately involved in the data, and they provide a perspective to the process that I may have never considered. This support group checked my method and provided multiple perspectives on data analysis. Peer debriefing occurred in these groups on a bi-monthly basis.

As an example of how the support group helped me gain a new perspective I offer this story. At one point in the research analysis I commented to the support group that I joked around a lot with the participants. I called myself a buffoon and characterized the behavior as a distraction to the therapy. Members of the support group reframed my perceptions by characterizing my behavior as a way to create rapport.

Triangulation was employed by collecting data from a variety of sources
(researcher’s log, video tapes, session notes, session transcriptions including verbal, nonverbal and music behavior). The data from these various records were utilized to verify emerging conclusions.

I presented my ongoing findings to the group members during the research period. After the data collection had ceased, I conducted interviews with the participants. I did this so as to check my conclusions with them. Participant checking was employed to enhance trustworthiness. Despite the verbal handicaps of the research participants, they were cognitively able to respond to questions with gestures and noticeable communications of affirmation or negation. Analysis was presented to the participants in an attempt to confirm or deny emerging deductions/conclusions. (See Appendix D). Pam, for example, was very dramatic in answering question regarding my observations. She would move her head vigorously up and down and sway her hand in the same direction when I asked her if singing with others was a positive experience for her.

Stance of the Researcher

I came to this study as an experienced music therapist and researcher. This research resulted from the accumulation of twenty-three years of experience in health related fields, seventeen of those in the field of music therapy.

Prior to this study I had developed a music therapy approach that emphasizes the importance of meeting the unique needs of each individual client and fosters the expression and understanding of those needs. Heavily influenced
by the works of Bandler and Grinder (1975), and Carl Rogers (1951). I acknowledge the difficulties in understanding another's perspective and the subtle ways in which a person communicates his or her needs and perceptions. Before undertaking this study I already professed a belief that nonverbal communications comprise a large portion of material in the music therapy session and that this material is significant.

I acknowledge that a unique rapport is developed and lived out in the music making between a therapist and the client and that the therapeutic musical relationship can help restore a client's capacity to have fundamental human experiences that are otherwise lost due to mental and physical illnesses.

I presented at the American Music Therapy Association's national music therapy conference on my ideas and developing philosophy of treatment with patients who were unable to talk or mobilize (Ramsey, 1998). I proposed that music making provided such patients with experiences that extended beyond the obvious value of becoming active and engaged. I suspected that for such patients who were deprived of social, creative and personal forms of expression, music provided experiences that were essential. The following year I coined the term "essential human experiences" (Ramsey, 1999) while writing an article on the use of adaptive music equipment with verbal and physically handicapped individuals. I referred to the unique aspects of communication that were afforded by the manipulation of time and generalized three categories of essential human experiences in music making related to community, creativity, and expressions of control. Upon entering this study I acknowledged an inclination to the belief that
musical interactions provided exchanges that restored, on an experiential level, expressive events and social contact that were similar to those reflected in most human contact.

I have presented my ideas regarding these concepts at national conferences and have recently completed a two-year research project noting some conclusion related to nonverbal communications. I feel that these predispositions placed me in the position of genuine desire to discover more about my life's work. I was excited about conducting research into my own work and felt that I gained a tremendous amount of information about my music therapy work with aphasic patients, information that I could have never gotten from reading another's work and observing it to be true. This study was an attempt to further clarify or disqualify any concepts that I already owned and to illuminate the meaning of nonverbal communications in my work through a more rigorous research format.

The Scope of the Study

Since this study was directed to a particular patient population, neurologically impaired patients with language deficits who had been discontinued from speech therapy, the scope of the conclusion may only apply to such populations. Furthermore, because the methods employed in this study are unique to this practitioner, conclusion from this study may not be relevant to music therapy with this population when using other music therapy approaches.

The group studied was originally designed as a speech rehabilitation
group. The group was called the “Musically Assisted Speech” group for this reason. Techniques unique to this group include exercises that I created and revolved around the practicing of familiar conversational phrases that are sung to the melody of traditional songs. My use of nonverbal cues may have been unique especially in that I overemphasized certain movements in order to model correct articulations. Specifically, the use of my hands to conduct the correct formation of the mouth during certain articulations may have been distinctive to this group. Additionally, the way that I used familiar songs to reenact conversational dynamics may have contained unique features that demonstrated my personal relationship to the clients. In these regards the results of this research project may not pertain to other music related speech groups.

Finally because the study was limited to the observations of one group with only four participants, the conclusions may not be relevant to music therapy speech groups with larger groups.
CHAPTER III

STATES OF SPEECHLESSNESS: PARTICIPANT PROFILES

Left Speechless

No more mumblings under my breath
A casual jest to a friend
No more twists or inflections
A jolt, a slap, a fend.
Living on time that is stilted
As moments are frozen away,
The needs of my meager existence
Are held silent, the sway of the day.
Oh how I yearn to conjure and call
On the flash of a moment
Where nothing does last,
To wield with assurance
A simple catch phrase
That joins us in union
Comrades of the say.
Yes only a moment
Where nothing does last
But oh in that moment
My soul free and vast.

d w ramsey (1997)
The music therapy intern brought Ross in to the music therapy studio for the first session as I was setting up the video camera. The session was scheduled for 10:00 am, it was 9:40. It was impossible to coordinate the arrival of the participants for the sessions as the gathering process involved different volunteers going to different floors and negotiating crowded elevators. When Ross arrived I could not attend to him due to his early arrival and my scheduled routine. I looked over to Ross and said, “Hello Ross.” He turned in my direction but did not reply. I repeated my hello this time with a musical quality to my voice that brought emphasis to my intentions to draw him out.

This time Ross looked over to me and stuttered, “Heelllllooo.” Short and to the point. No further greetings were offered. He turned his head to the side, and I returned to my duties.

Moments later a volunteer brought in Greta. I was still administratively involved, my back turned away from the center of the room. I instructed the volunteer to place Greta’s wheelchair next to Ross. I looked over to Greta and greeted her with a spirited, “Hello Greta.” She looked over at Ross and then to the volunteer. I repeat my hello in order to focus her attention in my direction. She seemed unable to locate my voice.

Finally she looked over to me and said, “Thannnkukuubaba.” There was a slight pulsing sound to her vocalizations that insinuated joviality or laughter. She quickly exited the greeting by focusing on her left hand and seemed to withdraw.
into a state of contemplation.

When Mary and Pam arrived I greeted them briefly, then spent the several minutes before the scheduled start of the session moving around the studio, gathering sheet music, checking the camera angle, the television monitor and instructing the internship students. The participants remained silent. Greta still gazed at her slightly waving left hand. Pam, head down, occasionally sipped her coffee. Ross completely disengaged, looked down at the wall to his right. Mary was the only one watching my movements with any degree of intent. She looked at me several times and smiled as I looked at my watch and whispered, “Just a few more minutes.”

At 10 O’clock I grabbed my guitar, I played a D major chord with exaggerated vibrato. I paused for a moment looking down at the floor before playing the vibrating chord again. “I would like to welcome you all to the Music Therapy Group”, I said. Mary was already laughing as a result of the vibrato guitar chords which seemed to announce in a whimsical way the start of the group. Ross’ eye contact indicated that he was watching me but no other responses let me know what he might be thinking. Pam raised her left arm briefly; I interpreted the palm turned up gesture as saying, “Well, what’s next?” Greta looked over at this gesture ever so briefly and then turned her focus to me as I began to explain the research project.
Aphasia and Speechlessness

All of the participants in my study had non-fluent transcortical aphasia. Birket (1996) describes 7 types of aphasia according to language abilities. Three of them result in impaired speech production: Global, Boca’s, and Transcortical motor aphasia. Broca’s or expressive aphasia is characterized by the inability to process auditory material from the posterior end of the Sylvian fissure (Wernick’s area) to the primary motor cortex because of damage in the Broca’s area, the area thought to regulate the transfer of this information. “The Broca’s area of the brain is the best example of localization of a mental function in the brain” (Birket, 1996, p. 82) and both Trancortical motor aphasia and Brocca’s aphasia can be traced to damage to this area or the areas surrounding it. Expressive aphasics can comprehend and process external stimuli but cannot organize speech to respond. All of the aphasic patients in my study were assessed by the speech therapy department as having receptive language abilities and could often present either one-word phrase in response to verbal initiations or use gestures to convey their responses. All could occasionally name objects when presented to them. Birket would classify these aphasic patients as having Transcortical motor aphasia.

The effects of a stroke and traumatic brain injury are multifaceted and can affect every aspect of a person’s ability to organize perceptions and to communicate their ideas, feelings and needs to others. Neurologically impaired
individuals with accompanying speech deficits are often left without the
communication skills necessary to respond to a simple greeting from a family
member. The communication of basic needs for food, drink and toilet use can be
insurmountable tasks. Sometimes aphasia can affect a person’s ability to
comprehend, read, tell time, calculate, write and a multitude of functions related
to cognition and the initiation of social contact. Although expressive aphasic
patients primarily demonstrate diminished capacities to express verbal material,
certain elements of language receptivity may also be compromised. Ultimately,
damage to the speech centers of the left hemisphere leave the aphasic patients
speechless and unable to communicate easily whatever cognitive processes they
do possess.

Even if certain cognitive abilities are diminished most aphasic patients
seem to be able to comprehend social interactions according to their emotive
characteristics. Sacks (1998) speaks of how neurologically damaged patients can
often determine the emotive intent and authenticity of speakers through the
prosody or musical tones to the speakers voice. Since the processing of such
information resides as a function of the right hemisphere, these receptive abilities
certainly demonstrate themselves with aphasic patients. The fact that transcortical
aphasic patients are often equipped with communication boards to improve
communication responses suggests that alternative avenues can facilitate
cognitions into forms of expression.

I found that aphasic patients demonstrate multifaceted levels of
comprehension during communication exchanges and can communicate if a
medium of exchange is provided. The lack of a communication medium leaves the aphasic patient with a multitude of ideas, and feelings cognitively processed but no means for expression. In a recent documentary film about stroke, Ram Dass (2002) describes the process of aphasic communication as “having an idea that needs clothes to wear. You go to the closet to find some appropriate clothes to wrap the idea around and the closet is empty.” Such is the situation of the speechless aphasic patient. The cognitive life is full of things to be expressed but there is no way to communicate them to the outside world.

The Participants

Greta

Greta is a 74-year-old black female who grew up in rural South Carolina. One of five siblings she received a minimal education finishing only junior high school. She worked briefly several years prior to her hospitalization. She had four children out of wedlock and placed all four children in the same foster family. The foster family has encouraged the children to maintain a relationship with Greta and prior to Greta’s hospitalization she was living with her eldest daughter in Jamaica, New York.

Greta has a history of hypertension and following a severe headache in 1986 was admitted to the hospital where they discovered a brain tumor. She was admitted for surgery. During surgery she suffered a subarachnoid hemorrhage and went into a coma for three weeks. Thereafter her mental status was described as
disoriented in regards to time, place and identity. While in the hospital, her family noticed that she was most responsive to music, tapping her left hand to the beat of favored tunes.

At the time of the research Greta had been in the hospital for thirteen years, her mental status much improved. She has been assessed as having expressive aphasia. She is able to mobilize herself and enjoys getting up early and going to the canteen on the first floor of the hospital. She is unable to respond verbally to questions with organized speech instead she repeats the same phrase to all contact: “thanannkuuubaba.” The only time this response changes is when she is singing. Which she does in a soft, melodic, soulful voice - - or when someone tells a joke or dramatic story when she manages a response of “goddamn.”

Greta locates herself in the same spot almost everyday: just around the corner in the hallway where all staff, residents and visitors pass before getting to the elevators. Most of the staff know Greta and they usually greet her in passing by first tapping her arm and giving her a quick hello and a smile. She smiles often, replies “thanannkuubaba” to all greetings and has a personality that draws many to these brief personal contacts. She attends any group or special activity that involves music and waves her left hand expressively to the music and sings along if she is familiar with the lyrics.

She often becomes frustrated by her inability to speak, but quickly recovers from her frustration and smiles and gestures in a way to say “I can’t give you a good response, but hello anyway.” Greta is a soft gentle person whose
personality comes through expressively in the music. Singing seems to be the only activity that allows her to vocalize successfully and engage in interactive social connections.

**Ross**

Ross is a 45-year-old Hispanic male who grew up New York City. One of five siblings, Ross feels a close connection to his four older brothers. He has limited contact with his family, including his eleven-year-old daughter. He is divorced and has been residing at the facility for six years.

While managing a convenient store in the Bronx, Ross was the victim of a robbery. He received traumatic brain injury from a gun shot wound and was given a frontal craniotomy to help with seizures and other complications from the injuries. He has a secondary diagnosis of depression as a result of his injuries, the separation from his family, and his current living situation. He is alert; and, despite aphasia due to left hemispheric injury, he can mumble responses to inquiries. He is receptive to communications and understands all presentations; he is capable of clearly stating affirmations and negations. His few articulate statements are presented in a stuttering fashion.

Although Ross was diagnosed by the Speech Pathologist’s department as having aphasia, I note a difference in his aphasia from those participants who are aphasic due to stroke. He seems to have more of a sense of what he wants to say, with little difficulty in retrieving the information that he wants to present. The
process of retrieving information seems more unimpaired than that of the other participants. Where Ross is similar to the other participants is that he is unable to coordinate the motor functions necessary to execute speech and the pronunciation of the words.

Ross loves to sings and remembers the lyrics to standards and songs from the 1960s. He often laughs during the singing of songs, especially if the lyrics are funny or speaking of an unusual situation. He seems to identify greatly with the lyrical aspects of the music. Because of Ross's responses to lyrics it was easy to engage him in lyrical improvisational moments.

Pam

Pam is a 72-year-old white female who was born in Canada. She moved to New York City to pursue an art career at the age of 28. She is widowed and has two daughters. One daughter lives in Japan and the other lives within two hours of the facility, and visits on weekends. Pam and her daughters exchange mail whenever visits are not possible. Pam is ever ready to show her picture book which she carries with her everywhere she goes. Inside are pictures of her grandchildren.

Pam suffered a cerebrovascular accident (CVA) in her left cerebral hemisphere in 1991. This left the right side of her body hemiplegic. Comprehension is not compromised for Pam, but her expressive language is very limited. Her speech is inarticulate, and she stutters even on the inarticulate words
that she can speak. Affirmations of yes, and negations of no, are easily demonstrated with head movements and the use of hand gestures. She has a speech booklet that has numbers, dates, schedules, and other symbols. She can point to symbols to convey basic information. Sometimes she attempts to present complicated ideas by using her booklet in combination with gestures. She often becomes frustrated when she is not understood. When communication fails, she lifts her left arm up in a gesture that insinuates a state of frustration.

Pam loves to sings and often sways in her chair and taps her feet on the floor while singing. She uses her arms to conduct and emphasize the musical elements as a way of adding expression to her garbled voice. Sometimes Pam will unexpectedly struggle to her feet and sway to the music. Pam is demonstrative with her artistic expressions.

Pam dresses fashionably and is proud of her artistic accomplishments. Her room is filled with pictures of famous acquaintances from the art and political world. She displays her artwork on the walls in her room along with family photographs. Her pre-stroke artwork is impressionistic in nature and depicts mostly scenery. Her post-stroke art is childlike and depicts more family-oriented images. The post trauma art is done with her non-dominant hand and accounts for some of the childlike qualities of the art.

I have noticed that Pam is a loner in the health facility. Pam rarely initiates contact with other patients and avoids social contact with others at the facility. Her brief contacts constitute greetings, mostly with staff.
Mary

Mary is a 54-year-old Hispanic woman from Puerto Rico. She is married and has seven children and twelve grandchildren. She lives in the Bronx, New York and has been married for 31 years.

Mary suffered a left hemispheric CVA in 1997. She is right hemiplegic and was unable to walk at the start of the research study, but as a result of Physical Therapy and determination she was able to walk with a walker during the last month of the project. She was very proud of this accomplishment and at one point she and Pam stood and danced to the music during one of the groups.

Mary is demonstratively outgoing and friendly as manifested by her smiles and attempts to say “hello” whenever greeting a person. Her warmth is immediately disarming to others, and she developed a strong connection with Pam instantly. Mary’s outgoing, nonjudgmental, inviting personality brings others into what ever she is initiating. These characteristics allowed for a unique bond to form between Mary and Pam.

Discovering States of Speechlessness

Gathering the participants from their floors and bringing them down to the music therapy studio was something that involved time and planning. As they arrived, some as early as a half hour before the sessions, I was often involved in the previously scheduled activities. I would say hello briefly and then return to my duties. The participant’s arrival time usually went on for about 15 minutes. In
some regards the studio became an active “waiting room” whereby the patients arriving early had to wait while the regular activities of the music therapy studio unfolded. Most of this waiting period was captured on tape as I had no remote control and often turned the camera on manually before the room became crowded.

For the first two months of data analysis, I focused only on events following a formal verbal or musical introduction. I found myself fast-forwarding the videotapes to avoid the first fifteen minutes of inactivity, as I perceived it as unimportant at the time. One time during video analysis I was watching the fast-forwarded images of the pre-session events. I saw myself moving all about the room at high-speed, occasionally nodding to the group members and then moving on. My movements stood in blunt contrast to their lack of movement. Their inactivity was not entirely due to being in a wheelchair or being hemiplegics, even my brief greetings were met mostly with lack of facial expressions and upper body motionlessness. Yes they were without speech, but more than this, they were withdrawn. I never once noticed the participants initiate any contact with me. These observations drew my attention to areas related to “withdrawn” and “initiation”.

For two months prior to this observation, my research focus had centered on my role as a music therapist and specific participant responses to musical dynamics employed while singing familiar songs. These observations consistently revealed my directive use of music to engage the participants. I was concerned with being so directive while claiming adherence to a non-directive
client centered approach. These concerns overshadowed a closer look at what was prompting my directiveness and prevented me from focusing on a fundamental piece of data: their condition. In retrospect I feel that the observations related to the participant’s withdrawn and inactive states should have reflected the research starting point, as it seemed to be the participant’s starting point upon entry to the research.

The following descriptions are drawn from data related to the various states of speechlessness, the usual condition of the participants when not actively engaged. I use the term states of speechlessness, as I came to relate all of these states to their inability to initiate and sustain speech.

Although the actual sessions revolved around the singing of familiar songs and the practicing of musical exercises to facilitate articulations, many times the participants attempted to verbalize their thoughts. I often supported verbal expressions by giving them extra time and by repeating what I thought they were saying. If I failed to understand them I would give more time and try again. Sometimes despite considerable efforts, I could not understand their verbal communications. Noting the patients reactions to failed communication attempts led me to a greater understanding of their tendency to withdraw, and I also came to discern other related states. In this chapter I describe three States of Speechlessness.

The following description of the three states of speechlessness implies a progression from complete withdrawal and inactivity to a state of vicarious
participation whereby a state of alert, involved observations are demonstrated. These states, the state of mute, the state of waiting, and the state of vicarious participation, indicate the states at which I began my music therapy sessions, and ultimately determined my interventions and influenced my overall approach.

State of Mute

The state of mute is a term I coined to help me organize and conceptualize my observations regarding the result of unsuccessful verbal communications. The behavior of all participants regarding activity level and expressiveness was remarkably different from when they were in the music and when they experienced non-musical, verbal encounters. While participating in musical activities they were fluid and expressive, whereas verbal encounters were characterized by struggle and failure leading the participants sometimes to become withdrawn.

Verbal communications for all participants appeared to follow a cycle: communication efforts led to failure, failure led to frustration and self-criticism, and finally a withdrawal from others. While closed off to outside contact the participants would often avoid eye contact, or any activity that demanded verbal engagement. This state of mute was dependent upon the factors preceding it and constituted a complex process. The process consisted of three stages: verbal failure, frustration and self-criticism, and the state of mute. Once the participants reached stage three, the state of mute, it required an intervention characterized by concern, support, and the provision for a successful interaction in order to engage
them.

During the first research session, I facilitated introductions by asking the members to state their names. Ross was first. He stuttered his name getting caught on the first syllable (his real name has three syllables) before completing a second syllable. I helped him out by completing his name. He smiled and repeated "yeah, yeah, yeah." I asked him where he grew up. He was able to articulate "hereere." I proceeded by asking him if he knew the other members. He then began to look over at Greta and mumble repetitive inarticulate sounds. I tried to discern words, and guessed what he was trying to say. He was able to grunt an articulate, sharp, "no" at my failed attempts to understand him. Giving up he looked to the wall on his right and ceased to speak. I welcomed Ross formally to the group and moved on.

I leaned forward to catch Greta's attention and announced her name, she responded with a smile and uttered, "Thannnnkuuubaba." I asked her where she was born. She repeated "Thannnnkuuubaba" several times before getting a puzzled look on her face. She ceased further attempts, swaying her head in a half circle dip of defeat, palm up questioning and apologizing. Ross stuttered several phrases, in what seemed to be an attempt to help Greta. He repeated these attempts three times, then stopped.

Pam's attempts at a verbal introduction were completely unintelligible. She started to use illustrative gestures to emphasize her communication attempts. I could not understand any of her verbal expressions. She threw her left arm up
high, pursed her lip and dramatically dropped her arm to slap her thigh in what seemed like defeat. She got so frustrated that she began to gather her purse and coffee preparing to leave. I introduced her to the group as an artist and as someone who I knew from other music related events. I described her to the group as "very artistic." She smiled at the acknowledgement and put her coffee down as an indication that she would stay.

Mary was the most articulate member of the group. She was able to state her name somewhat clearly. She dipped her head, took in a deep breath, swung her head up, chest out and with a big smile announced, "Mary." Her articulations were slurred, but understandable. Her mannerism conveyed a certain sense of confidence, enjoyment and openness. She drew the attention of the others who instantly smiled at her display. Her verbal presentation was accompanied by such enthusiasm and joy it made me laugh. Her nonverbal communication conveyed an attitude of "here I am, glad to met you, let’s get going," attitude that caused me to proceed. I welcomed her without further information exchange.

Although Mary’s articulation skills were limited, she was markedly more outgoing and persistent than the other members. It took communications demanding more than greeting exchanges to frustrate her and lead her to a state of communication withdrawal. During the initial sessions I observed all participants expressing nonverbal responses to failed attempts at communication. What was evident from the start was that the participants usually ceased their verbal presentations after two or three failed attempts.
During one of the earlier groups I introduced the idea of vocal improvisations. I asked Ross if he knew what scat singing was. He began to make vocal staccato sounds using the syllables “ssoooo” and “siiiii.” Eventually he managed an elongated “soooooooooolllll” sound. I guessed he meant soul music. He articulated a “yeeeeeaa” affirmatively. I asked if he was thinking of any particular singer. He struggled with rapid, stuttering sounds for about twenty seconds. I resisted the urge to rescue him with a speculation, as I was curious as to his verbal skills. He tried for a bit longer and terminated his attempts. He executed the same head movements that I had witnessed before, by looking to his right, towards the wall and a bit lower than his eye level.

I went around the room asking Pam, Greta and Mary if they knew anything about scat singing. Greta re-enacted in character and duration the verbal attempts I had seen in the four previous sessions. Two “thannnkkuuuubaba’s,” a look of puzzlement and then a head movement that dipped in a low half-circle swing which gave me the impression of defeat. Her attempts ceased. Pam struggled with what I believed to be the name of a singer. She was completely inarticulate. I did not attempt to liberate her from the struggle with a speculation. She became frustrated and stopped trying.

My early conclusions about these observations were simple. The participants ceased verbal communication because they could not succeed. People get frustrated when they cannot accomplish what they set out to do. Withdrawal is the natural result of this frustration. I was willing to accept this as self-evident until I began to compare the early verbal attempts with those later in
the research. As the sessions progressed I noticed that the participants were beginning to prolong their attempts at verbal communication despite continued failure. Sometimes the exchanges lasted for long periods of time even in the midst of complete verbal failure. What then accounted for the early cessation of attempts during the first months? What accounted for the sustained attempts in the latter session?

**Communication Regulators**

I broadened my focus in order to explain the cessation of verbal attempts that occurred early in the research. I wondered if the early cessation of verbal attempts reflected norms established in their everyday encounters, since most caregivers do not have the time to engage in lengthy discernment of inarticulate speech. I was familiar with the efforts required to engage in verbal exchanges with aphasic patients and knew first hand the time requirements for such encounters. Sometimes the only reasonable means of contact in an environment with work demands is to limit contact to concise, defined exchanges that are courteous, polite and sometimes jovial. Nonverbal messages that limit or conclude conversations are what Mehrabian (1972) calls communication regulators and indicate that it is time to end the contact. Nonverbal cues such as looking toward the clock, turning toward the door or shifting body weight as if to walk, give messages that are acknowledged almost unconsciously. In the hospital setting, they evolve out of necessity and the patient seemed to know to expect them.
I suspected that another reason communication regulators were employed by caregivers was to avoid discomfort when unable to understand someone’s desperate attempts to convey messages. Again, I knew these emotional reactions firsthand, as I had felt helpless and guilty at not being able to understand inarticulate speech. I sensed the patient’s frustration at being inarticulate, and I wanted to spare him or her the struggle. I also wanted to spare myself from the helpless caregiver role. These feelings sometimes prompted me to utilize communication regulators in order to end difficult communications.

The more I observed these communication regulators and the more I discussed with coworkers about the possible role of these regulators with the non-fluent patients, it became abundantly clear that they were employed extensively. Staff members began to tell me stories about floor clerks who started shuffling papers when certain patients approached the front desk. One coworker told me of how the “crisp delivery of responses” often gave the patients the message that there was no time to chat. The crispness was somehow interpreted as an indication that time was limited. I collected stories from co-workers about communication regulators and the mechanisms employed seemed endless. Some reported the use of downcast eyes to avoid eye contact as a way of regulating communications. Conveying a “busy” exterior limited communications, and direct statements to patients, such as “I don’t have time,” limited communication opportunities. These stories made me aware of the ever-present nature of these communication regulators. Communications toward the aphasic patients were laced with restrictions and limitations that said, “If you can’t get your message
across in a reasonable amount of time, please don't try.”. I began to see how the early cessation of verbal attempts related to the regulated conversations in the patients’ everyday encounters.

**Sustained Communication Efforts**

The session after the Thanksgiving Holidays, three months into the research, I greeted Mary and asked her how her Thanksgiving had been. She replied with a hearty head shake indicating “very good” as she spoke an understandable yet garbled version of the phrase. I then asked her if she cooked. She shook her head as she answered “yes”. She then began to describe what she cooked for the dinner. I heard “turkey,” I repeated, “turkey” she nodded her head and articulated, “Yeeaas.” I heard “Bean and Rice” and repeated it. She nodded her head and articulated, “Yeeees.”

She then said something I could not understand. It was a three-syllable word that sounded to me like “potatoes.” I repeated “potatoes” several times. She shook her head no and grunted dissatisfaction as she tried again to articulate the word. She continued over and over again. I continued with her, always attempting a guess at what she was trying to communicate. She was getting frustrated, and the other members joined in the struggle. Pam at one point nodded her head “yes” and mumbled a sound of affirmation at my guess of sweet potatoes, but Mary indicated “no” with a headshake. Pam presented another guess which was unrecognizable, but Ross affirmed Pam’s suggestion with “Yeeaaaa.” Greta added “Thannnnkuuuubaba.”
We were engaged in a sustained guessing game, very little content was exchanged, but many communication dynamics were demonstrated by gestures, increased vocal volume and tempo manipulations. Everyone seemed attentive. Everyone exhibited some identification with the struggle and tried to help Mary. The conversation was failing in terms of verbal exchange, but lasted for a fairly long time anyway.

Mary did not give up easily. She tried to write the letters of the dish on her thigh and then in the air. I still could not get it and tried to guess the texture, or type of food. I asked her some closed ended questions and narrowed it down to a traditional Spanish vegetable dish. The attempts reached an impasse, I was not familiar with this particular dish, and I gave up. Mary threw her hands up in defeat. I said, “I’m sure it was very good.” She agreed with a smile of consolation, though she seemed not quite over the disappointment of the communication failure. I acknowledged the failure and said that I would bring in some names of traditional Spanish dishes and present them to her later in an attempt to find out the missing dish. Again she smiled a half smile - I had come to know her full smile from previous encounters. We did not reach an understanding, and yet many aspects of our communication reflected success.

Mary’s attempt to describe her Thanksgiving dinner demonstrated two characteristics that were often missing from what I had come to characterize as typical hospital conversations involving aphasic patients. The two distinguishing characteristics were time and encouragement. I gave her time. I did not employ communication regulators to end the struggle; instead I leaned forward indicating
that I was available. When I did not understand what the participants were saying I asked them to try to speak the word again. If I still failed to understand I guessed. When I failed to understand, I tried again. I encouraged them to continue. I sustained curiosity and provided support and encouragement. These elements allowed for longer more sustained attempts at communication.

As the sessions progressed, I noticed a marked difference in the time allotted difficult verbal encounters. The participants demonstrated an increased persistence in their attempts at verbal communication even if they were not understood. I attributed this increased persistence to their perception of my willingness to endure difficult verbal transactions and to our developing relationship.

Pam, for example, began to use her assisted speech book that contained names of places, people and events important in her life. She spent more time attempting to communicate, and, despite special difficulties in trying to relate complex concepts, she persisted longer than in the initial sessions. Greta, although making absolutely no progress in her ability to convey verbal information did maintain eye contact with me longer and repeated her signature “thanannnnkkkkkkuubababa” longer and with more sustained contact. To the end of the study, Ross continued his inarticulate stutters until I had to directly impose limits to his verbalizations. I told him that we would have to move on despite my inability to understand him.

By the end of this study I rarely saw the participants shutdown or
withdraw into the state of mute as a result of failed communications.

State of Waiting

Although I felt as though the state of mute exhibited itself often, it would not be completely true to say that participants automatically slipped into a withdrawn state of non-responsiveness if not constantly activated. There were many times when the patients, once engaged, entered what I called a state of waiting. This state was characterized by a more alert quality with more openness to interaction. The state of waiting entailed openness to outside events as well as receptivity to sensory and social information. Once the participants were engaged, there seemed to be a particular level of anticipation that something else was to follow. Thus the state of waiting involved a hopeful, watchful, alert quality.

After I initiated contact or strummed a wake up chord on the guitar, the participants entered the state of waiting. Their attention level increased as eye contact and focus became particular to me. As was the case during the music therapy sessions, this state of waiting did not last long, because it was so closely followed by my initiated activities. Where I noticed a more prolonged state of waiting was during my visits to the floor either prior to sessions or during regular floor visits.

Once on the floor I would sometimes stop short of the participant's view and would watch them interact with caregivers. If I caught them as the nurse was ready to administer their medication, or to serve them a snack, they were more
alert to what was happening around them in anticipation of the service. Usually if caregivers or other patients actively engaged the participants, the participants would respond to the greeting with some nonverbal display of attentiveness. They then entered a communication stance that indicated receptiveness to communication while at the same time conveying the message that the communication control would have to be in the hands of the initiator as nonverbal responses were all that were available in return.

State of Vicarious Participant

Another state that I became cognizant of was when the participants observed others. During these times when they would watch others interact, there was a certain amount of passive involvement in their viewings of what was happening on the floor. It was as if they were vicariously experiencing the exchanges of others and responding internally to these experiences. Sometimes they would respond externally with a laugh, or a smile, or a sign of disapproval, such as a grimace. These expressions did not always seem intended as social exchanges as much as personal emotive and cognitive reactions. I refer to these moments as being in the state of a vicarious participant.

These observations aroused my curiosity as to what role vicarious participation might play in the lives of the participants. I sometimes came into the television room and sat in the back in order to watch Ross or Greta viewing some morning talk show. I rarely saw Ross in any sort of interaction with caregivers, and yet he displayed an unusual responsiveness to the Jerry Springer Show. Once
while a particularly intense, sexually charged exchange between a man and woman occurred, Ross exploded in laughter. He seemed to be resonating with the ridicule of the television studio audience, and yet the reaction seemed fully his own. Greta also watched the morning television programs, and I often saw her shaking her head in disgust over some conflict on the screen. Greta and I would look over at each other sometimes and shake our heads together and share our disgust. In the moment of our acknowledged nods to one another we were in some way exchanging a shared knowledge of the incident and an identification of a shared response to the incident: disgust mixed with amusement.

I saw distinct differences among the state of waiting, the state of mute, and the state of vicarious participant. During these moments of the vicarious participation, the patients’ involvement seemed to move more toward a self-initiated demonstration of intentional participation, if only vicarious and from a distance. The state of vicarious participation demonstrated to me the participants’ motivation to get outside of themselves and take in events, to enjoy, to be entertained, to expand beyond the self. When they were in the state of mute they were dependent upon another person to initiate contact that would disengage them from the mute state. The state of waiting was dependent upon some future event. The vicarious participant was more active and self-initiated. None of these state involved a demonstrative element of active initiation despite some responses reflecting willful intent.

The completely self-initiated communication was rare. The only fully self-initiated behavior I ever saw was the hello gestures and greeting mumbles from
Pam and Mary as they entered the room. No participants ever started a communication transaction, asked me to change something in the session or requested a particular type of music. I suspected that their lack of initiation might have reflected a combination of psychological and neurological factors.

Lauria (1963) speaks of the inhibition of global cortex functions whenever any portion of the cortex is damaged. He describes the structure of the cortex as a “functional mosaic,” whereby damage in one specific area can inhibit function in another. He states that the functional constellation of centers in the cortex work in concert to facilitate all executive activity. Thus the initiation of social contact and the expression of self (which are certainly executive functions) could be affected by a localized injury anywhere in the cortex. He believes that some of the global inhibitions exhibited after brain injury can be restored through alternative forms of treatment that recognize the holistic nature of the brain and the intentional activation of the entire constellation. I felt that music provided such a holistic intervention in that it addressed the neurological component demonstrated in difficult initiation.

As the study progressed and our relationships became stronger, I did find that the participants could respond to topics that I introduced. They would respond with personal reactions that attempted to convey ideas, feelings and specific information related to events. Certainly Mary’s description of her Thanksgiving dinner conveyed personal communication choices, and yet no participant ever started a communication. I found myself questioning the
distinctions that I was making between self-initiated and responsive, and asked myself if there were any truly self-initiated communications. On one level, communication and responses to communications appeared seamless components of a complex communication process. On another level, most initiated presentations seemed independent from external stimuli and reflected expressions of internal processes. The participants' responses during topical discussions, and nonverbal exchanges seemed to be lacking in the sort of self-initiation that was independent of external prompting.
CHAPTER IV

MUSIC THERAPY FOR APHASIA

In the previous chapter I described the participants’ condition as it related to their inability to speak. I described how their inability to successfully verbalize led them into a state of withdrawal. I talked about how the participants found it difficult to initiate communications because of their verbal inabilities and their fears that others would regulate their attempts. In this chapter I will discuss my approach to the participants’ condition. The chapter is divided into three sections: the session context, the session format, and the techniques employed.

The Session Context

The description of the session context entails the characteristics of my approach. For many years I ascribed to the guiding principles of the client-centered approach of Carl Rogers. Rogers (1951) describes this approach as non-directive. The essence of this client-centered, non-directive approach is to provide unconditional acceptance. A therapeutic rapport is established as a result. This rapport is foundational to the therapeutic process in that it allows clients to explore the inner world of thoughts and emotions. Through the experience of a relationship that accepts all expressions unconditionally clients begins to grow into personhood. The therapist is rather passive, allowing clients to unfold at their own pace and on their own terms. The therapist provides an ever-present
backdrop of support responding to the presentations of the clients.

As I began to review the research tapes one thing became obvious above all else: I was directing all events throughout the sessions. Because of my adherence to a non-directive, client-centered approach, the idea of becoming the focal point of a therapy session was confusing and upsetting. I felt as though I had to come to terms with these conflicting emotions and thoughts before fully understanding the directed nature of the sessions. At one point in my research log I described myself as a music therapy dictator and,

a force to be reckoned with. No longer the sweet non-directive, client-centered, give them space to be themselves kind of therapist who takes what they offer me and facilitates a therapeutic transformation through the gentle art of cognitive and emotional exploration, I now present my beautifully organized healthy world of music and try to make them “live” in it (Personal Log, 11-3-99).

My log reflected not only my struggle with the directive stance but a sarcastic anger at the part of myself that automatically excluded “directiveness” as a possible way of centering on the client.

As I contemplated the functional role of direction for these clients, I came to realize that the only self-initiated act I had ever witnessed from the participants was a brief “hello” from Pam or Mary. No participant had ever suggested a song, asked me a question or even actively objected to the selection of an activity.

During my previous twenty years as a therapist I had always supported a patient’s initiations. I sensed the participants perceived me as receptive and supportive. I knew that I had given them many opportunities to assert direction in the sessions, yet they did not. I suspected their inability to initiate was profound and although
psychosocial in demonstration, it had some neurological etiologies (Lauria, 1963). On a somewhat intuitive level I had realized long before this study that the patients could not initiate or sustain most communication exchanges and that the construction of my music therapy sessions with aphasic patients would have to involve direct support.

**Meeting Patients’ Needs**

The session format and the techniques employed during the research project reflected session designs I had constructed based on my previous experience with aphasic patients. As the study progressed, my reasons for these earlier decisions became clearer. I came to realize that the session design and interventions reflected a focus on meeting the needs of aphasic patients: the need for support, psychologically and neurologically; the need for clear direction; the desire for rehabilitative improvement; and the need for community. Thus the session context was characterized by support, direction and goal setting in a community-based atmosphere. An underlying principle to my approach included the belief that the provision of “essential human experiences” (Ramsey, 1999) during the music making would on some level address all of these needs. This research concludes with findings that support the provision of experiences related to community, which was something the patients lost along with the ability to reach others through speech.

Throughout the music therapy sessions, an atmosphere of support, encouragement, and acceptance prevailed. Perhaps the most obvious provision of
support came in the form of successful vocal experiences. When working with aphasic patients in the past I had often seen them moved to tears as the first fluid vocal sounds passed their lips. Sometimes the patients were a year or more past their stroke, and they did not know that singing could allow them coordinated, articulate vocal production. They were surprised and suddenly filled with an experience that obviously touched them deeply. I suspected that these experiences were related to a reconnection with a sense of the normal and a rekindling of hope. I interpreted the reaction to these successful vocal experiences as a reflection of the patients' needs to feel expressive, whole, and moving toward the goal of normal speech. The music activities in our group sessions supported these experiences neurologically as well as psychologically. Affirmation of the experiences was demonstrated nonverbally through smiles and "yes" head nods, indicating satisfaction and enjoyment. Thus support was experienced fundamentally and profoundly in the music as it actually held, organized and guided the patient's most intimate instrument of expression, the voice, and provided a bridge to the outside world.

**Directing Participants**

Another characteristic of the session context was that of direction. I provided continuous leadership cues during the vocal exercises and the singing of familiar songs. I augmented my verbal instructions with visual gestures and used charts or pictures to support my guidance. Every instruction was calculated to elicit some response and designed to clarify the specific makeup of the response.
desired. By being so directive I felt that I was providing the guidance that the participants could not provide for themselves.

While initiating and directing exercises I knew that I was demonstrating myself as a teacher, or a speech rehabilitation specialist, or a vocal coach. Although I did not see these exercises as exclusively rehabilitative in nature, I intentionally introduced vocal exercises as a way of acknowledging their vocal difficulties, establishing my role as the leader and as someone who would initiate for them. I wanted to inspire trust by demonstrating a certain level of professionalism related to vocal production. Although I was not a trained speech therapist, I did understand vocal coaching. Like Tyson (1981), I believed that the role of teacher could be employed in the therapeutic process as long as the focus remains on the client’s needs.

Although verbal responses were common, especially as the research progressed, I tried to stay with activities that revolved around music, as I thought music the most immediate medium of support. I considered the sessions music-centered while at the same time I realized that the design of the sessions focused on speech improvement and thus, by its very design, promoted verbal explorations.

**Verbal Presentations**

I considered support for verbal expressions a necessity in order to convey a truly responsive environment. Whenever a participant wanted to verbally
respond to one of my stories or to an interaction within the music, I gave space for such attempts. It was obvious that they wanted to respond and to verbally communicate as demonstrated by the consistency with which these presentations occurred. A safe, supportive environment was provided for the participants to explore these communications. I gave them time and permission to fail, and encouragement to try again if they did fail. During the course of this research I isolated three elements that seemed to characterize all of my response to verbal attempts. I made sure that some form of either acknowledgement, understanding or affirmation prevailed. I came to adopt an approach so that every verbal presentation was supported by at least one of these three fundamental characteristics. Verbal presentation either concluded with an understanding whereby it became clear that the message was actually comprehended or an acknowledgement of the presenter’s desire and courageous efforts. I acknowledged their frustration if communication failed, and I usually promised to try again with some other methods to aid in the understanding. I believed that by approaching verbal presentations in this manner that personal affirmation was conveyed despite the success or failure of information transfer. In this regard I considered my approach reflective of “unconditional positive regard” (Rogers, 1951), a principle that I ascribed to throughout my clinical career. Through the investment of time and demonstrated desire on my part to understand, I hoped to convey the idea that they were worth my time, that their ideas and feelings were worth the effort. I wanted to convey to the participants that they were more important to me than the details of the message itself, I hoped that this was
experienced on some level just by the attention and time extended and shared.

Verbal exchanges involved intensity even if the subject seemed casual.
Topics about food, baseball, and movies took on an intensity similar to that which I had experienced with patients relating significant life issues. The participants wanted to be heard, even if it was just the expression of their favorite food. The need to be heard was at issue during these exchanges, not the exact exchange of details. In this regard, I understood why the participants displayed such intensity, for at the core of the verbal exchanges was the issue of not just understanding but the essential need to be listened to and to be heard.

When the participants were trying to verbalize I often moved my swivel chair closer to the speaker and leaned forward, repeating verbal presentations frequently and guessing what words were being presented. Often I filled in the blanks as a way of speculating as to the specific content of the communication. I constantly kept a close eye on the speaker for nonverbal cues as to my accuracy and adjusted my responses to facilitate more communication efforts. The entire process was characterized by the mirroring back of understood articulations and speculations when misunderstood. Filling in incomplete phrases was a frequent task. I filled in the unspoken, incomplete, half portions of their communications.

The concept of "half" and "incomplete" seemed to characterize more than just our communication fragments. These patients were hemiplegics. Half of their bodies were frozen. Their right arms were immobile and flaccid, their right
legs were weak and mostly useless. The right side of Pam’s tongue was even compromised. Damasio (2000) claims that a significant component of self-identity revolves around our concept of the body. He describes the perception of motion and emotions in the body as our “neuro-self” and contends that all other component of self-evaluation stem from these perceptions. I suspected that a fundamental psychological issue for the participants revolved around their identification with limited bodies. If their pre-stroke identity was connected to a whole body, a whole language and whole sentences, then their identity was now challenged by the “half-ness” of their bodies and the incompleteness of their sentences. In my attempts to fill in their missing words, I wanted to fill in their missing half. Although completing incomplete verbal presentations was a reoccurring necessity, I came to sense that the process of being in the struggle together provided a more fundamental connection, a more profound sense of communion than the eventual transfer of the correct words. Ultimately the only real restoration of wholeness that I perceived came during the flow of musical encounters with the other group members.

**Experiencing Community**

The singing of the familiar song was much easier to execute and more successful than all of the other activities in the session. During these times we became involved in a common pursuit: the production of the simple pop song. These events were characterized as dynamic and fun. Underlying the singing and the laughter, the participants were engaged in a complex neurological process that
addressed speech rehabilitation and cognitive restoration issues while at the same time provided for connection with the other members. A sense of community was established and the group became a psychological, social support group.

One of the most fundamental findings in this study was that the restoration of community seemed to demonstrate itself during the process of singing together and working together on speech improvement. Experiences with other aphasic patients that involved communication struggles, as well as successful musical productions, created a unique sense of rapport and community among the group members. During the verbal struggles the participants identified with one another’s difficulties. In the music they shared each other’s competent, creative expressions. Together these experiences infused a sense of togetherness and community.

**Vocal Exercises**

Vocal exercises were incorporated into the singing of familiar songs. Whenever a participant had difficulty in articulating a specific phrase, I would slow the tempo down, repeat the phrase slowly many times while demonstrating some visual cue to aid the formation of the mouth. These articulation exercises remained integrated into the fabric of the song and thus remained music-centered. Musically assisted phrases followed the singing of familiar songs. These drills were music based and revolved around the singing of typical conversational phrases over familiar pop song melodies. The sessions concluded with a rendition of either “Bye Bye Love” whereby I would insert the names of the participants.
and improvise my goodbyes to them or “Goodnight Irene.” As the participants were leaving I always repeated the musically assisted phrase “Goodbye, I’ll see you later” to the melody of “Swing Low, Sweet Chariot.”

The Session Format

The session format followed a usual structure including (a) vocal warm-ups, (b) the singing of familiar songs, (c) vocal exercises (d) more familiar songs (e) musically assisted phrases, and (f) farewell songs and the musically assisted “goodbye” phrase.

Before leading groups with aphasic patients I had never considered working with such a defined format. I had always objected to such structure because I thought it inhibited freedom of expression and was in this sense anti-therapeutic. I preferred a loosely structured improvisational feel to music therapy sessions. When working with an aphasic population such a structure was impossible, impractical, and to my newly informed way of thinking, anti-therapeutic. Structure was lacking in their way of perceiving the world. Structure was lacking in their way of responding; structure was an essential experience that they sought to achieve in what endeavors they did attempt. Thus every session followed the six sections outlined above.

A typical session started with an original “hello” song utilizing what I perceived to be the usual prosody of “hello.” A three-note phrase cued the start of the hello song, and I had hoped to use this cue to prompt the participants to say
the word "hello" in future greeting situations.

Following the hello song I usually lead the group through some vocal warm-ups. These exercises were similar to those employed by vocal coaches and involved the singing of vowel sounds up and down the major scales. We then sang about five familiar songs. Ross and Greta liked gospel songs. Pam liked old standards from the 1940s and the 1950s. Mary knew most of the familiar pop songs from the 1940’s and the 1950’s and some of the gospel songs. The singing of familiar songs was the most prominent feature of the sessions.

The Familiar Song

The familiar song constituted an ever present, supportive influence in the sessions. During the course of the music therapy groups, I used familiar pop songs from the 1930s, 1940s and 1950s. The more familiar and enjoyable the songs, the more potential for musical contact. The same 10-15 songs were used for every group. (See Appendix C for copyright information).

1. This Little Light Of Mine
2. You Are My Sunshine
3. Side by Side
4. Yes, We Have No Bananas
5. Amazing Grace
6. Swing Low, Sweet Chariot
7. Home On the Range
8. When the Saints Go Marching In
9. If I Were a Rich Man
10. Day O

65
11. Goodnite Irene
12. Bye, Bye Love

I was not interested in expanding the musical repertoire. Songs were not selected due to their lyrical significance or personal preference. I was interested in utilizing the engagement displayed by singing songs that were easily produced.

Tomaino (1997, 1998) claims that the use of familiar songs plays an essential role in therapy with neurologically impaired patients. Speaking of neurological reasons for using music with cortically damaged patients, she notes the bilateral representation of sound in the brain. With bilateral representation, auditory signals can be processed by circumventing the damaged areas. This is especially important for aphasic clients with left hemispheric damage. Another reason for the use of familiar songs is because of the multidimensional levels of memory that remained preserved in the context of familiar songs (Tomaino, 1997).

Musical Expressions

In the first session during the singing of “You Are My Sunshine” Pam waved her left arm in the air and swayed in her wheelchair. Her body movements were exaggerated and lively despite the noticeable effort needed to sway. She was unable to articulate clearly and could not produce the melodic intonations of the melody, but she did manage the rhythm of the melodic phrases, to move in time with the music, and it was obvious that she knew the song and that she was
enjoying herself. She smiled often.

Mary demonstrated similar expressive displays; especially during “When The Saints Go Marching In” and “Take Me Out To The Ballgame” Mary’s voice was very loud and full of intent and enthusiasm. Mary’s legs were short and did not touch the ground when she sat in a chair. She often swung her legs musically to the rhythm of the songs. She smiled while singing and I got the impression that she was proud of her ability to sing the words despite their muffled texture. She would look over to the others occasionally to make eye contact and smiled as she sang.

Ross sang all of the songs with a loud, harsh voice. He sang in distinct phrases taking in deep breaths between each section. Ross wore a neck brace and had poor posture due to scoliosis. It was obvious that his physical condition made singing difficult. Ross often complained of having neck pain and of feeling uncomfortable. He sometimes grunted in discomfort. While singing he sometimes incorporated these sounds into his singing.

He loved gospel songs. His favorite was “Amazing Grace.” I had only to sing the first word of the song before Ross would explode with a loud, harsh presentation of the song. Sometimes I would briefly drop out and ask Ross to help me with the song. He always remembered the next lyric. Occasionally he would laugh while singing certain songs. This reaction seemed to be related to the whimsical lyrical events of the pop song. He knew them well.

Greta, on the other hand, sang softly with a tender, sweet, soulful voice.
Greta was most remarkable in her contrast between singing and speaking. She sang more clearly, more melodically, and with more expression than the others, and yet her ability to speak was the most severely blocked. She loved to sing the old gospel songs and was able to sing most pop songs from the 1950s. All participants demonstrated a familiarity with the songs we sang and an immediate enjoyment in the participation and production of the song.

_Sustaining Musical Memory._

The memory of familiar songs provided unique moments of connection for the music therapy group. Once, while transporting Greta to a session, I started to whistle “This Little Light of Mine.” Greta started to hum along with me. Upon entering an occupied elevator, I ceased my whistling, and Greta ceased her humming. The song however lived on as I tapped the melodic rhythm on her shoulder, and she continued to tap her hand on her armrest. We were not producing audible sounds during this moment, but we were both continuing to display a rhythmic connection to the melody. Upon leaving the elevator we resumed our humming and whistling, rejoining the song still in progress. I sensed that this experience demonstrated something about the independent nature of the familiar song and its ability to connect us.

After sharing this experience with Greta I tried to duplicate the same thing in the group. I leaned forward and started to sing, “You Are My Sunshine,” conducting the tempo and the volume, and giving nonverbal indications of the direction of the music. The volume started to decrease; I placed my right
forefinger to my lips to indicate a “hush.” The volume decreased until there was silence as I continued to swing my right hand in time to the unheard music. All eyes were on me. I kept swinging my hand as I leaned down and pretended to adjust the cuff of my left pant leg. I pretended distraction though my hand held high continued the tempo. After returning to full sitting position, I leaned forward and started to whisper the lyrics at the place where it would have been if not silenced. All participants whispered with me in time.

It would be difficult to determine what cognitive processes the participants actually experienced during the absence of the audible music. Associative memory theories (Rudy & Sutherland, 1994) would claim that memories reside in a network. When any part of the network is presented as stimuli the memory of the entire network is activated. With this in mind auditory cognitions of the melody and lyrics could have been played out in the minds of the participants in tempo as I suspected. Another possible explanation would be that the music between us was a synchronizing affinity to the “physiognomic quality” (Pavlicevic, 1997, p. 108) of my waving hand and that the resumption of singing was cued by my indications to start singing again. If this were the case, the physical movements observed during the silence would be in response to my swaying hand, and the song coming back at just the right moment was the result of the participants following my cue. This certainly could have been the case. However I interpreted certain behaviors as indications that the participants cognitions were related to the silent music remembered.
Common Experiences of the Familiar Song

Greta and Pam swayed their hands with me during the silent portions of “Your Are My Sunshine” in the seventh session. Greta occasionally grunted a sound that was intermittent but on pitch with the music we had been singing. Mary’s foot moved in tempo. Increased eye contact and pulsing sounds let me know something musical was still alive. I’m not sure if we were all listening to the continuing song exactly the same, but we were engaged in some semi-silent experience together that was initiated by that familiar song.

Mary was a Hispanic woman from Puerto Rico. Greta was a black woman from Georgia. Ross was a Hispanic from the Bronx, New York, and Pam was a Jewish woman from Canada. None of the participants shared a similar cultural background. Even Mary and Ross, though both were Hispanic, did not share similar cultural experiences, because Ross was a native New Yorker and Mary was an immigrant. What bound the group together were the familiar songs. These were not necessarily the songs of their particular preference, but they were songs that seemed to engage them and songs that they seemed to enjoy. They were songs that were so familiar that they did not have to struggle to remember them. They were songs that allowed for successful individual and group production.

Scheiby (personal communication, February 16, 2002) states that the familiar song although not personally significant becomes the greatest common denominator for some groups. Discovering the greatest common denominator
reflects the process of discovering our common humanity, and such songs become significant through sharing and group identification with the lyrics. Tomaino (1997) states that familiar songs elicits past significant memories along with the remembered lyrics and melody. These personal memories, obviously, would not be the same for all participants, but the emotional connection to the songs could account for a heightened level of responsiveness to the familiar songs. Oliver Sacks (1998) states that music is essentially emotional in nature and that the more connected a memory is to emotions, the greater its recall and reproduction.

Some of the songs selected could have been family sing-a-long songs or used as lullabies for children in the family. Certainly these songs were heard during some portions of the participants' lives and provided some sort of backdrop to life situations. I did not focus on memories as significant therapeutic elements, but rather as possible underlying characteristics that motivated the participants to engage musically. This musical engagement provided the foundation for group cohesion.

The familiar song became our common language. The lyrics became our words, the rhythm became our speaking tempo, and the dynamic flow became the emotive character. In order for us to sing the familiar songs together, all members had to access the memory of the lyrics and the melody. After accessing the same memory we demonstrated our shared knowledge in an activity that required a group submission to the music. Expressions of this shared knowledge were communal, not individualistic in nature. Accessing shared memories and expressing those memories together in a group seemed to me to be similar to the
mechanics or substructures of any community event that bound people culturally. Thus, the familiar songs became our agreed upon medium of sharing. In the recognition and living out of these familiar songs we developed rapport and our own culture.

Clinical Techniques

During the course of the research I employed five noticeable techniques. These techniques were (a) articulation exercises (b) improvisation (c) musically assisted phrases (d) cueing and (e) storytelling. These techniques addressed the participants' conditions as detailed in Chapter Three.

Articulation Exercises

I often led the group in vocal warm-ups and vocal exercises. Using vowel sounds, I led the participants through the singing of the first five notes of major scales. These exercises are common exercises employed by singing instructors and are designed to prepare the voice for future work. (I had learned these techniques while studying voice years earlier.) Utilizing the vowel sound "ah" and a five-note ascending/descending scale exercise, I moved the key up in half steps until I sensed someone becoming uncomfortable. Then I changed the vowel sound and repeated the process. Once the vocal warm ups returned to the "ah" sound I would segueing into the gospel song "Amen."

Many times I would introduce a vocal exercise by explaining the
mechanisms of the vocal chords. Once I even brought in a picture of the vocal chords to illustrate their construction in order to emphasize the need to exercise the muscles surrounding the chords and the breath support system. I instructed the group to “take in a deep breath” and to “let out” vowel sounds. Everyone watched and followed intently. Pam and Mary became very serious and focused as they watched me. They followed my breathing demonstrations, mimicking my breathing tempo and exhaling mannerisms. I often instructed them by giving suggestions to relax, to breathe into their diaphragm, and to open their mouths. They followed my instructions with intent.

Pam was quick to exercise. Several times during vocal exercises, Pam would start moving her left leg up and down or grab her hemiplegic right arm and stretch it with her left arm. When I asked her if she was exercising she nodded yes and began to stand in order to demonstrate her overall rehabilitation progress. Mary also was quick to demonstrate her rehabilitation progress and joined Pam by standing. Once they started to sway together and dance expressively. Sometimes Pam would hold her throat during exercises and lean her head back, dropping her jaw rhythmically. Again I asked her if she was exercising, and she claimed that she was. I interpreted these displays as an important part of the sessions, and a reflection of her desire to reconnect with the hope of rehabilitation. When asked if she were still in speech or occupational therapy, she once thrust her left hand in the air, shook her head no with a grimace. I sensed that she longed for the opportunity to try again.

Ross seemed to demonstrate this desire every time he struggled through a
difficult breathing exercise. His breathing was labored, and he had to physically adjust his body to take in deeper breaths. He often made eye contact with other members in an attempt to check the correct way to vocalize. Sometimes he seemed to be eliciting positive feedback for his efforts.

As I observed the vocal coaching aspects of the sessions, I realized that I was always more concerned with encouraging participation than in correcting participants. As a trained music psychotherapist, I supported exploration over success, and prompted expressiveness and social contact over precise vocal production. Even when I gave direct feedback, I was more focused on the process of support over the product of correct articulation. It seemed important to the participants to reconnect with a sense of hope related to taking charge of their health. Their dedication and focus during the exercises demonstrated to me their desire for rehabilitation. I wanted to acknowledge this desire and provide for a rehabilitation focus while at the same time providing for other psychosocial needs.

Improvisation

The manipulation of musical dynamics was probably the most noticeable features of the group singing activities. Although I had not planned the manipulation of tempo and volume as specific interventions, upon observation of the videotapes, it became obvious that I employed them often.

I knew from previous experience as a musician that the more a musical piece is performed by rote the less likely it is to be expressive. I was by nature an
improvisational musician and used unplanned musical elements to bring expressive life to my own music. I knew that I needed to use "over learned" (Rogers & Fleming, 1981) musical pieces so as to activate successful vocal production in patients with non-fluent aphasia. In retrospect I see that I approached the singing of familiar musical pieces improvisationally as I instinctively wanted to facilitate expressive communication experiences.

The Unexpected as Stimulation

Nordoff and Robbins (1977) encourage the music therapist to intentionally use musical elements that create a sense of unpredictability, especially those elements related to tempo and phrasing. Taylor (1997) speaks of a P3 phenomena, a biochemical reaction in the brain whenever one is confronted with an unexpected situation. A flood of neuro-chemicals puts the brain on alert and prepares it for new learning when such unexpected events occur. By manipulating portions of an over-learned musical piece, I felt as though I was initiating a P3 moment, not for the purposes of learning something new, but because I suspected that these experiences happened during fully alive conversations. I supposed that many communication interactions demanded a person to think spontaneously, negotiate the timing of responses and assert opinions and emotions, and that all of these elements involved to some degree the unexpected.

Improvisational music making is the hallmark of many music therapy approaches (Nordoff & Robbins, 1977; Lee, 1996). Implied in the concept of
most improvisational music in music therapy is the concept of creating unique and original music to reflect the individuality of the patient. I did not use musical improvisation to reflect individual personal dynamics as much as to reflect universal communication dynamics that reflected spontaneity and expressiveness. I came to equate the manipulation of musical time with the conversational dynamic that Knapp (1980) spoke of regarding nonverbally embedded messages reflected in the management of space, time and tone. I came to compare the manipulation of the musical volume to experiences of assertion of self. As I made these comparisons I came to see the provision of these dynamics as a way of providing the simulation of normal conversations.

Facilitating Interactions

A consistent observation throughout the research is how I intentionally changed the musical elements of tempo, volume and even lyrics to facilitate interactive moments. I interpreted the management of these musical dynamics as a way to create anticipation and a state of attentiveness. I used my entire body to cue such changes and accompanied any musical change that I initiated with somewhat grand arm, head and leg movements. These manipulations of the musical dynamics certainly indicated my leadership role, a role that, on some level, I hoped the participants would challenge as an indication of self-initiation.

For example in session number eight while playing "When The Saints Go Marching In" Mary started to sing with assurance. I attempted to slow down the tempo, but she waved her hand. "Come on, Keep up with me." I stopped playing,
and she sang alone for a moment. I gave her the lead, singing quietly in the
background during the second verse. She became unsure of the lyrics. I left
space in the music by dropping my rhythmic guitar chords. She jumped in
demonstratively with the wrong lyric, laughed, and instantly tried to correct
herself. She could not and ceased her singing. She waved her hand indicating to
me that she wanted me to start playing the guitar again. She granted the
leadership back to me. Although she had initiated the leader role, she could not
sustain it. I started playing the guitar and the group resumed the song.

In this example Mary took charge of the musical time. Although it was
rare that one of the participants would initiate such control and be able to maintain
it for any period of time, this incident demonstrated Mary's knowledge of the
"moment" involved in negotiating the control of time. She understood the
negotiations and the mechanisms of such exchanges.

Pam and Mary used volume to assert themselves in the music. They
would look over at each other while increasing their volume and smile seemingly
in acknowledgement of their exerted power. Once while singing "Swing Low,
Sweet Chariot" I slowly diminished the volume until we were whispering. As we
were increasing the volume Ross and Mary started to sing loudly. Both voices
became harsh with the increased volume. We were repeating the final phrase,
"coming for to carry me..." when Ross exploded with a very loud "home" to
complete the phrase. All the other participants looked at Ross and laughed. I
interpreted the laughter as acknowledgement of Ross' "taking control." I saw this
explosion of sound as a sonic manifestation of Ross' assertive self and read the
humor displayed as a celebration of the emergence of this self.

**Cueing**

Cueing refers to the initiation of stimuli that are associated with an entire network of memories in order to effect neurological, psychological and social functions (Thaut, 2000; Tomaino, 1998). My use of initiated stimuli came in the form of changes in musical dynamics, verbal presentations, and non-verbal gestures. These cues became evident as I manipulated the music. I changed tempo so as to facilitate a response of slower or faster. I increased or decreased volume so as to facilitate a response of increased or decreased volume. I left musical and verbal phrases incomplete so as to prompt completeness.

The term “cueing” has been used in various bodies of literature to refer to these types of stimuli (Thaut, 2000; Tomaino, 1998). The efficacy of cues to initiate responses can be explained neurologically if the focus is on the stimuli’s ability to affect brain functions. Benefits of cueing can be explained socially if the response provides communicative value.

There is implied in the concept of neurological cueing the notion that musical memories are imprinted holistically in the brain (Tomaino, 1998). Whenever a portion of any imprinted memory is omitted the organism seeks, on a neurological level, to complete it. Implied also in this notion of cueing is the concept that the reflex to complete a network when once learned is automatic. This reflex represents the intricate, natural temporal functions of the brain (Thaut
2000; Taylor 1997), a process that entails the precise rhythmic transfer of neurological information. Thaut, Kenyon, Schauer and McIntosh (1999) state that "auditory rhythmic patterns exert a strong magnet effect on the timing of motor responses in the brain" (p. 101). Thus the rhythmic nature of this transfer of information may account for music’s ability to organize and elicit certain responses.

**Cueing for Interpersonal and Social Expression**

I found that the stimuli that I presented fostered personal and social expressions in addition to organizing certain neurological functions. I found that I could not separate the restoration of neurological function from the restoration of personal and social functions, especially since these responses were done within a group context that was supportive and responsive. For example, whenever I would present an incomplete well known musical phrase to Mary, she would be able to articulate phrases that she could not do outside of the neurological organization provided by the music. But also in the process of producing the sound she would be demonstrating pleasure, and pride over her successful articulation. The other participants would smile and even clap when she completed the phrase. They were responding to her display of pride and acknowledging her accomplishment. Thus, the stimuli (the cue) that helped initiate, and support certain neurological functions became the pivotal element of support for social contact.
I used the term acute cue to refer to stimuli that involved easily recognizable musical or verbal phrases that were intentionally left incomplete. I found that I needed to devise a term to distinguish these cues from less obvious forms of prompting or conducting. One of the first music therapy techniques that I learned as a student was to use incomplete musical phrases to encourage responses from patients. Music therapists often employ the use of incomplete musical phrases to prompt responses (Nordoff & Robbins, 1977). I thought of the rhythmic, musical phrase as a "statement of presence" requiring a musical response (p.88). I found that if the phrase was familiar enough there seemed to be an instinctual inclination to finish the incomplete phrase. These sorts of acute cues were frequently employed throughout the sessions.

While singing "Side by Side" during session 14, I noticed that we were all singing in synchronicity. I leaned forward as if I were going to say something important or initiate a change. I sang the phrase "we ain't got a barrel of-" slowing the deliverance of the phrase in increments so as to create a tension that reflected the feel of a question. All of the members filled in the blank with "money," and then I followed by singing in like fashion "we may be ragged and-." They filled in the word "funny," the next word in the song. The singing was full, and loud, Mary was especially expressive and laughing with Ross. There was an atmosphere of anticipation that was based on the incomplete phrase and my hesitations. The participants paid attention, they had a memory of the missing lyric, and they were able to negotiate the timing of the response based on my manipulation of the time changes. In the process of completing the phrase we
were acting in concert. In the process of completing the phrase the participants were completing my incompleteness as opposed to their usual conversational format whereby others completed for them. I came to view these experiences as restorations of essential human experiences (Ramsey, 1999) related to the normal flow of conversations.

**Rhythmic Cueing**

I further noticed that the rhythms embedded in familiar melodies created a distinct pattern that was instantly recognizable. In session 16, sometime around the winter holidays, I tapped out the rhythm of the melody to "Jingle Bells." Pam immediately started to sing the opening lyrics, repeating "jingle bell, jingle bells." She could not remember any other lyrics, but the rhythmic pattern I played by tapping on the side of the guitar was enough to bring back the entire melody of the song. Even songs that did not evoke immediate lyrical memory did often evoke immediate melodic recognition. This recognition in turn prompted participation in the familiar melodies and melodic rhythms. After initiating a familiar rhythmic pattern created by the melody, Pam, Mary and Greta were often able to pronounce vowel and consonant sounds that they could not outside of the rhythm.

During session 5, I tapped out the melodic rhythm to "You Are My Sunshine." Mary started to laugh and sing simultaneously. This was one song Mary articulated easily. As she swung her head back and forth she had an expression that said to me, "This is too easy, almost childish." If she did
perceived the song as childish, it didn’t seem to matter; Mary appeared to be captivated by the rhythmic and melodic aspects of the song. She sang with enthusiasm.

Sometimes the participants were able to use the rhythm of familiar melodies to support vocal phrases. In session 4, Greta sang “Swing Low, Sweet Chariot.” I leaned forward and stopped the music. “Greta, can you just say those words without singing them?” I asked. I tapped the guitar with my right hand and played just the rhythm of the melody while repeating the words. Greta watched me closely and said the words in time with the melodic rhythm without the melody itself.

Another example of rhythmic cueing occurred when I placed the guitar face down and started to slow the pace of the music. I accompanied my singing with taps on top of the guitar and used the soles of my feet to slap out the pulse of the familiar pop song. Pam raised her left leg, extending it out completely and dramatically dropped it so as to slap the floor. Mary looked at her and followed suite. At one point we all stopped singing and just stomped out the rhythm of the song, not the melody, but the rhythmic pulse of the piece.

The Musical Gavel

One of the first cues I noticed during the research came in the form of my use of particular guitar chords played out of context of any structured song. Isolated and full of vibrato these chords marked the beginning of the music
therapy sessions. The sound made by the vibrating chord or melodic line (riff) on the guitar, broke the silence and ushered in a completely different atmosphere to the room. Something about the quality of this vibrating chord seemed to command attention and brought order to the sessions. In my log I referred to this particular cue as the “musical gavel”.

Prior to the musical gavel there was no one focal point to the group. After the musical gavel, I became the focal point as evidenced by the shift in eye contact. The musical gavel seemed to speak, saying, “Okay, now it’s time to get to work.” The event was almost always accompanied by a spontaneous burst of laughter.

During the first session I played a chord on the guitar and leaned forward to get Ross and Mary’s attention. I looked down to the floor, I pause, and then I played a vibrato chord on the guitar and accompanied it with a vocal “ahhh?” There was a sustained pause; all previous distractions ceased. This created a focus and a quiet moment. I had taken the floor and announced a new direction that let them know that I would be the director. Later in the session Pam arrived. Her late arrival was disruptive as the group was continuously engaged in one musical section or another before her arrival. As Pam settled in, I used this “guitar vibrato announcement” again to regain the floor.

As I reflected upon these observations of the musical gavel, I realized that I was initiating a State of Waiting. I was introducing an element into the environment that called for attention to some future event. This particular cue did
not lead the participants into overt action as did other cues, but it did prepare the way and move those who were withdrawn into an anticipated awareness. Something about the sound of my vibrating guitar chords, or those sounds in combination with my body posture, cued a state of alertness, of anticipation.

**Conducting Cues**

I use the term conducting cues to distinguish musical stimuli that created, organized and facilitated a musical flow, as opposed to cues to prompt discrete musical completions. Conducting cues were more covert and involved the impulse to adjust musical elements so as to match a musical presentation. These cues and adjustments happened on a micro time level. Thaut (2000) talks about the speed at which the auditory system processes information. His research suggests that a tempo can be initiated and interpreted by the listener in as few as three beats of the presented rhythm. Keil’s (1995) concept of “participatory discrepancies” explains the process occurring during group music making as one that involves the coordination of individual presentations into a unified groove. The established rhythmic unity is dependent upon the negotiations of time in that each member must make adjustments that fit rhythmically into a greater rhythmic whole.

Both concepts speak of the immediacy with which the music makers perceive changes. As I observed my research group I noticed that I provided a strong rhythmic foundation to the music. I further noticed that the group members rarely challenged or initiated musical elements. This is not to say that
group members never influenced the music dynamics. It is just that most of the
musical responses from a group member were in some way a response to previous
cues. With these concepts in mind, conducting cues saturated almost every aspect
of my directive music therapy approach.

When initiating a particular song I did so with a strong rhythmic intensity.
I usually started each song with this intensity in order to stimulate participation
and to musically “hold” the members. The rhythm that I presented did not reflect
so much the original style of the piece as much as my intentional intervention to
support the participants. If I ceased to provide some indication of conducting, the
music died. Even during the times that I diminished my rhythmic support or
ceased my strong guitar rhythms, I felt as though the music would have
eventually died without my waving, conducting hand to sustain its life.

In my description of the state of mute, I mentioned that I observed a
tendency to homeostatic withdrawal. I sensed that on some level the participants’
inability to initiate and sustain expressions demonstrated itself on many levels,
even during the flow of dynamic music. In session 13, while singing “Swing
Low, Sweet Chariot” I raised my leg slowly and slapped it to the floor with the
execution of the lyric. I then kept the time with my tapping foot. As I leaned
forward and slowly started to whisper the lyrics all participants followed suit. It
was an intimate moment that became more and more silent as the volume
decreased. At one point the only audible sound was the tapping of my foot. I
turned in my chair to adjust the table behind me. I wanted to see if the music
would be sustain without the conductor. It was not. I wondered if the members
entered into my distraction with the table or if they were simply unable to sustain the music without me. I don’t really know the answer. Observations of self-initiated musical presentations were non-existent. I was the strongest musical force in the room, and I intentionally drew the patients into my musical flow. The rhythmic feel held them in a musical flow that allowed for “musicing” (Elliot, 1995), a complete emersion in the music making experience.

Cueing for Articulation

I often led the participants in articulation exercises. Even though these were almost always within the context of songs, it was apparent that I was bringing focus to articulation. I would sometimes point to my mouth, or give instructions for them to form their mouth like mine. Sometimes I would grand hand gestures to mimic the way the mouth should be formed while exercising articulation; the participants became focused on these visual events.

The patients looked to me as if they needed guidance when trying to accomplish certain goals. I noticed that they watched me very closely, observing how I formed my mouth to articulate certain sounds and at times mimicking body movements that I unconsciously used to accompany my music making. They seemed at times like children trying to mimic their parents, but the intention and focus was so strong that I realized their observations of me and mimicking of me were specific and goal directed. I interpreted their intense focus as a desire to improve their vocalizations, their speech. They saw me as a role model to follow. They seemed to need visual modeling in order to accomplish certain tasks. For
instance, Pam and Mary would focus on my mouth and lips to see how to create an “ooooohhh” sound. Pam and Mary would focus on my mouth and lips. I sang, “Whaaaaaa ooooooohh.” In between phrases I talked quickly, giving instructions. “There are two different sounds; you have to form your mouth differently for each one.” I wheeled my chair around to Ross and Greta, pointing to my mouth. They looked intently and following my “mouth gestures.” I returned to center. I formed the letters “w” and “o” with my arms. I exaggerated my mouth movements which all watched intently. These visual cues seemed significant for the accomplishment of certain articulations.

Musically Assisted Phrases

I constructed musically assisted phrases to assist the participants in the production of common conversational phrases. By taking the melody of well known songs and supporting them with over-learned musical phrases, I found that the participants were able to articulate phrases successfully. I constructed four such musical phrases, and we practiced them during every session.

Sparks and Deck (1974) warns the speech therapist against the use of familiar melodies to assist speech production. Their fear is that the aphasic patient will confuse the original lyrics with newly introduced conversational phrases. I found this to be unfounded. As I practiced the same conversational phrases repeatedly with over-learned melodic phrases the participants eventually connected the new phrase with the old melody.
During every session, we practiced articulating, “Yes, I would like to do that. I would like to do that today” to the tune of “Yes, We Have No Bananas.” During one of the last sessions I was whistling the tune “Yes, We have No Bananas” while preparing the room for the session. Greta and Pam were the only group members in the room. Greta started singing, “Yes, I would like to do that, I would like to do that today.” I was pleasantly surprised by Greta’s musically assisted phrase and awakened to the fact that, if practiced, it was possible to cue conversational phrases imbedded in well-known musical hooks.

The music therapy-speech program by Rogers and Fleming (1981) used a “carrier melody” to support common conversational phrases. They used a melody that was “over learned” and “automatic”: the tune to “Yankee Doodle.” All phrases were sung over this “carrier melody,” while individual words were practiced over a two-note pattern. During my sessions I used a variety of phrases and sang them over familiar chorus-style melody lines. With practice I found that the participants could sing the newly introduced phrases over familiar melodies.

**Storytelling**

I realized that Mary, Pam, Ross and Greta listened intently whenever I spoke. They demonstrated increased eye contact and displayed nonverbal reactions to the dramatic aspects of stories that I told. I realized that through storytelling, I could intentionally utilize the state of vicarious participation in service of addressing a variety of psychosocial issues related to their neurological condition.
Prior to session 3, I went to get Ross. I found him in the television room watching a talk show that featured a young man who had lost an extraordinarily large portion of his brain from a gunshot wound. The young man had not only survived but was now attending college. Having been robbed and shot in the head himself, Ross watched intently. After the segment was over, I asked Ross what he thought about the story. He repeated, “Thank God” several times. “Thank God for what I asked? “ I’m alive” he replied.

When Ross and I entered the music therapy studio we were about ten minutes late. I explained to the others that we were late because of the television show that Ross and I had watched. I began to tell the group the story about the young man with the head injury. I leaned forward and told the whole story from start to finish. I took my time, and I employed vocal dynamics and timing to emphasize dramatic segments of the story. My storytelling style seemed very much like my music conducting style in that I intentionally used pauses and tempo to create tension and dynamics. Greta, who usually can only manage a “Thanannkuubaba” in response to a question or a greeting, now articulated very clearly, “Gooddammmnn.” Pam and Mary were also intent on the story. Pam shook her head back in forth in disgust over the violence. Mary followed suit. I asked Ross if I could tell the group about his injury and he indicated I could. I told the group about Ross’ identification with being shot, and I told them his reaction of “Thank God I’m alive.” I acknowledge that everyone in the group had faced great loss because of their injuries. Everyone responded to my acknowledgement with a head nod of identification. Ross could not move his
head up and down but grunted a concise repetitive “yeea, yeasss, yeaaa.”

The Healing Power of Stories

Everyone in the group had undergone significant life trauma. I believed that to ignore this overtly would be to limit the scope of therapy. During the presentation of stories I was aware of the imagery that I was providing. Zeig (1980) cites Milton Erickson’s employment of anecdotes to embed messages to the subconscious and to create psychological support through “reframing” (an alternative perspective with which to understand an experience). According to guided imagery theories (Bandler & Grinder, 1979), when verbal images are presented, the listeners search their personal memory for similar experiences and retrieve images and sensory information that simulate the original event. I was interested in creating shared images as a way of creating group rapport.

In 1978 while working as a substance abuse counselor, I became aware of the significant healing power involved when patients shared similar traumatic experiences. I witnessed firsthand the transformations that could occur when patients found support from those who personally understood their situation. Self-disclosure was a key component in those processes. With verbally intact adults the process of self-disclosure could be facilitated in group discussions. For the verbally challenged patients the difficult process of communication itself might supersede any cathartic experience had during verbal processing. Thus my intent was not to process individual feelings or reactions. My intent was to join the group in what I considered a shared state of vicarious participation in order to
facilitate group support of shared traumas. I offered no solutions. I offered no insight. I offered group identification in service of support and consolation.

**Buffoonery and Role Reversal**

Other stories that I presented revolved around my mishaps in the kitchen over the weekend, or around an event at work where I forgot something, or around how I mismanaged some electronic device. During my stories I tended to over dramatize events in much the same way that I over-dramatized musical dynamics. I did this intentionally to facilitate responses of laughter, negations and affirmations. In stories that revolved around my mismanagement, I intended to reverse roles for the participants. They were usually the ones seen as incapable but in the stories I was incapable. Where they were usually the ones needing help, now they would have to help me. Many times I was able to devise situations that created similar role reversals.

I found that I often presented myself as confused, clumsy and a buffoon. There was something in my mannerisms at times that conveyed to the clients that I could not quiet manage things. Sometimes they took advantage of me or laughed at me because of this mismanagement. Sometimes they offered to help me. I was very much aware of them taking advantage of my disability. I was also aware that I set things up for them to take advantage of me. I knew that they were the ones usually unable to manage, the ones who were disabled, and I suspected that they got feedback from others that made them feel like a weak or disabled person. I intended to reverse these roles to allow them once again
experience the role of the capable ones who needed to help the poor buffoon.

They seemed eager to help me.

Sometimes the participants laughed at my mismanagement. I compared their laughter to the way I laughed at most comedy sketches. I was reminded of the slapstick antics of Laurel and Hardy or the Three Stooges which derived it’s laughter from clumsy negotiators. Laughter at another’s ineptness seemed to be part of our human heritage. As I reflected on this I couldn’t imagine that Mary, Pam, Greta and Ross hadn’t at one point in their lives laughed at someone’s inability. But I sensed that people shied away from laughing with disabled patients when the humor was centered on someone’s inability to manage. It seemed that there was some fear that such humor would either remind patient’s of their misfortunes or convey a disrespect of their condition. I began to think that perhaps more disrespect was being shown by not allowing disabled patient’s to laugh once again at a buffoon.

In session 10 during vocal exercises, Mary took in a deep breath. She was following my every move as she let out a loud but constrained “ahhh” sound followed by a burst of laughter. I asked her to drop her jaw a bit, which she did. Pam and Ross followed suit by experimenting with various levels of jaw positions. I led them through the first five-note scale in the key of C using the vowel sound “ahhh.” As we reached the top note, Mary laughed and set off a chain reaction. Pam and Ross begin to laugh along with Mary. I tried to bring the group back to the exercise. Every time I started to lead the exercise someone either laughed or yawned. They were disrupting my attempts to facilitate the
exercises. I attempt to regain focus. I tried using the yawn, emphasizing the "aw" sound as something we could practice. Again, half way through, Ross and Mary start laughing. Upon video review, it is obvious, in my nonverbal behavior, that I recognize and welcome the chaos and the challenge to my role as the leader and the teacher. There is something in my mannerism that invites the challenge. Again I tried to set up situations that drew the participants into another role besides that of the helpless aphasic patient.

Creating an Atmosphere of Alertness

I often told stories with obvious inaccuracies. During these times the participants were quick to negate me and to assert their command of the correct data. During the Holiday Season, I started to tell the story of the Pilgrim’s first Thanksgiving. I said that all of the Pilgrims were from Puerto Rico and they cooked rice and beans. Mary cackled a definite "nooooo." One time I started to tell the group that I was not a baseball fan, but that I was saddened by the news that the Yankees could not seem to win any games. Pam and Mary exploded with negations asserting not only their allegiance to the Yankees, but putting me in my place. During the musically assisted phrases exercises I would ask the participants questions that required an obvious "no" reply. In story fashion with dramatics I would ask, "Would you like to fly to the north pole for dinner and have some delicious whale blubber and chocolate covered penguins legs?" The group exploded with a musical "No thank you, I don’t want to do that."

I often told stories or jokes to the participants during the sessions. I
observed a great similarity in the way I presented stories and conducted music.
Through the use of dramatic elements and the use of presentational dynamics I
created anticipation, expectations, and suspense. On some level these stories
forced the participants to relive previous experiences or to recall the usual way
that such dramas conclude. I would intentionally insert unusual elements so as to
challenge expectations and put participants in a position to guess what would
follow. In this regard I was reversing the roles. Instead of my guessing in order to
fill in their presentations, they were now guessing the conclusions to my stories

Occasionally songs, jokes, singing and exercises would intermingle with
the storytelling musical elements. On one occasion I was singing, “He’s got the
Whole World.” I initiated a strong rhythm on the guitar and vigorously kept time
with my right foot. Mary leaned forward and pointed at my foot. Pam quickly
joined in. They both pointed and declared, “shhhooeee.” I glanced down briefly
but continued the song. My shoelace was untied.

I strengthened my conductor’s stance to bring order to the music, increasing the
volume and foot slapping intensity. This only ignited louder cries from Pam, and
Mary. Ross began to laugh. I stayed oblivious until Mary’s commanding voice
cut through with unusual intensity. I stopped and looked down at the shoe. “Oh,
my shoes. I just bought them last weekend, do you like them?”

Mary and Pam exploded, “Tiiiee daaat  shhhooeeee!”

I replied, “Oh you’re right, my shoe is untied.” I resumed the song without
tying the shoe.

There was an explosive command from Mary to me. “Tie dat Shoe!”
“I’d better tie my shoe, or else I’ll...” I paused, lost for words. In chorus Pam and Mary shouted, “Fall!!!”

I tried to make the storytelling as musical as possible and the music as communicative as a story. I tried to make the jokes serious experiences and the serious exercises fun. I tried to create an atmosphere of expectancy and alertness where every moment possessed an element of acknowledgement and support.
CHAPTER V
TRANSFORMATIONS

In chapter three I described how I had observed the participants as withdrawn and not open to social contact. I explained these observations as the result of their feelings of frustration related to their inability to produce articulations and because of restricted opportunities for attempted communications. I suggested that social norms did not allow sustained social exchanges for the verbally inarticulate. I described how the participants seemed to demonstrate levels of withdrawal in the three states of speechlessness. All three of these states were characterized by an inability to initiate communications. I suspected that neurological factors combined with psychosocial factors to create the states of speechlessness.

During the course of describing my approach in chapter four, I detailed how I specifically designed certain interventions to activate the participants and how they responded by singing, moving, laughing, and frowning. I noted how they increased their verbalizations, and their eye contact. They displayed frustration and joy. They were creative and social. All of the efforts that I exerted in a directive way were designed to engage the participants in self-expression and social exchange.

Comparing the Three States of Speechlessness to participants’ responses in the music therapy I found it evident that,

* Where they were once inactive and withdrawn they became active and
engaged.

* Where they were once mute they became vocal.
* Where they were once failed they became competent.
* Where they were once isolated they became social.

In short, I observed dramatic transformations during the music therapy process.

The present study included observations from the actual sessions as well as observations of the participants while encountering them outside of the session. I found myself drawn to balance the observations of the participants in the State of Speechlessness, wherever displayed, with active responses in music therapy. Therefore, I have arranged this chapter to reflect these comparisons as outlined in the four previous statements.

**Active Verses Inactive**

I often saw Pam in the hallway and in the cafeteria drinking coffee. Pam usually situated herself in the corner of the cafeteria in the mornings and thumbed through the daily newspaper while drinking coffee. I never observed her in sustained social contact with others. I sensed her as somewhat anti-social in addition to her problems related to aphasia. Sometimes staff members would initiate a greeting. The most demonstrative I ever saw her was during the times that she smiled and raised her hand briefly in response to these staff greetings. She was isolated from the other residents despite being mobile. Reading the newspaper was the most self-initiated, active thing I observed her engaged in. I did not observe Pam to be as active as Mary or Ross in her ability or desire to
engage in activities that might take her focus outside of herself. Activities such as watching television or musical performances or even recreational based activities did not provide Pam with opportunities for interactive exchanges.

In the music therapy sessions, Pam came alive. She was immediately transformed through the music. In the music making she used her body expressively, swaying her entire upper body to the music. She even struggled to her feet at times to sway and dance. She often moved her arms assertively to conduct the music and smiled during the execution of the conducting. During the music she was physically active, always tapping her hand, swaying her entire body, and swinging her legs in time to the music. Her verbalizations were extremely slurried and inarticulate. But in the music her voice demonstrated impassioned inflections while maintaining melodic accuracies.

I suspected that Pam was very much in control of various life situations before her stroke. She was eager to show me the photo album of her artistic accomplishments and of her famous acquaintances. She demonstrated much thought and intention in her selection of dress and in her room arrangements. She had a private room, which is somewhat rare in the hospital, and I suspected that this was at her insistence. Many behaviors in the sessions indicated to me that she was prepared to leave if things did not go her way. Although she never requested a song, or changed any noticeable portion of the musical events, she did demonstrate an inclination to take control by responding in a self-assertive manner. She would raise her arms to conduct the music in very dramatic, over-emphasized ways. Although she was in a sense following the music, these
conducting displays completely activated her. She smiled and swayed her body as if she was in control and wanted every one to know it.

Greta sat in the hallway outside of the cafeteria daily. She oftentimes seemed withdrawn and unaware, but she never failed to respond with a smile and a “Thananuubaba” when actively greeted. Greta vacillated between the State of Mute and the State of Waiting while outside of the music therapy. During the music therapy sessions she tended towards a withdrawn state if there were long pauses in-between the musical activities.

In the music she became musically, physically and socially active. Greta was so very musical. Her soft melodic voice was full of passion and involvement. She loved gospel music, and when singing “Amazing Grace,” she moved her hand in soft fluid motions that matched her gentle expressive tones. Greta was naturally musical, and in addition to activating her vocally, socially and, physically, music seemed to connect her to her spiritual or religious inclinations. Greta had a capacity and an inclination to use music on many levels. She smiled and made intentional eye contact while singing. She often concluded her vocal connections with others with a pulsating ‘laughing’ sound. I interpreted these sounds which were always connected to direct eye contact towards me, as a nonverbal affirmation of our shared experiences of the music. I felt connected to Greta during the singing, and although she seemed emotionally flat most of the time, her sweet soulful voice reflected an expansive capacity toward creativity and social contact.
Mary did not seem to be especially musical by nature. She enjoyed singing and she enjoyed people. She seemed to enjoy any activity that allowed successful social involvement. Music was the perfect medium for Mary’s outgoing social personality. It provided active social contact and a channel for her highly developed sense of humor. During the music therapy she worked diligently on the exercises, and she played joyfully. She laughed often and her sense of humor was a constant source of energy in the sessions. The music therapy sessions allowed for her to engage in playful and sometimes challenging exchanges. She was always the first to notice when I made a mistake and the first to correct me.

During the singing of some songs, she appeared to be “speaking” or connected to the lyrics in an unusual way. This connection did not seem literal; that is she did not seem to be using the lyrics to convey a specific message. Instead her connection to these lyrics appeared rooted in a matrix of playful, lighthearted sarcasm. The lyrics were not particularly meaningful to her, yet she could enter into a jocular presentation of the song based on the whimsical nature of the melody. The combination of musical playfulness and blithe sarcasm conveyed a nonjudgmental atmosphere. She seemed to be able to make any song a platform for her expressiveness. She would sometimes over-dramatize the melody and the rhythm, and use gestures to mock the exercise, while at the same time endear the others to her display of joy. The music allowed her access to multifaceted aspects of her humor, creativity, and fundamentally outgoing personality.
Ross was the most isolated. He stayed all day in the television room on his floor. I never saw him initiate contact with others while on the floor. He apparently was so withdrawn that when I would approach him in the television room it would take several greetings to get his attention. After I got to know Ross better, I sensed that he desperately desired contact. His severe stuttering speech seemed to startle some caregivers, and I never observed anyone approach Ross to attempt contact for exclusively social reasons. The caregiver tended to him, gave him his medications and positioned him for breakfast, lunch and dinner, but for the most part he seemed very isolated.

In the supportive atmosphere of the music therapy sessions, Ross exploded with musical expressions and increased verbalizations. Whenever Pam would attempt to speak of her family, Ross would respond by stuttering the name of his daughter. He smiled and laughed whenever he spoke of her and it was obvious that he was proud of her.

In the music he was capable and expressive. He loved gospel music and seemed to be praying when singing gospel songs. During songs like “Side By Side” and “Take Me Out To The Ballgame,” he seemed to adopt an identification with the cheerful attitude of the songs. He was easily amused when given the opportunity, but I sensed that he had few opportunities to express his sense of humor outside of the music therapy.
Vocal Verses Mute

The most outstanding response in the music therapy sessions was that every participant had successful vocal experiences. The phenomenon of being able to articulate certain vocalizations exclusively during singing was extraordinary. I came to see the music as a rehabilitation device much like a wheelchair or a pair of glasses. Music was instantaneously able to support and facilitate successful articulations. While singing the participants were able to execute physical functions that were completely unmanageable outside of the musical experience.

Without music, Greta could not say one single word except an occasional “godddddammmmn” when excited during a storytelling event. Even these exclamations mimicked music making in the way she extended the one word statement into a multi-note prosody. I noticed that Greta needed only the conductor’s support to keep the music flowing; she also could easily recover from forgotten lyrics if everyone was singing. During the vocal exercises she mirrored my modeling with intent and was able to begin making “-L-” sounds where she could not before. These successes were not sustained beyond the exercises, but she did demonstrate improvement in the physical mechanics of vocal production while exercising. Greta was so completely musical, and since I saw such personal transformations during her singing, I tended to focus more on her musical expressiveness than on her articulations. Greta seemed to enjoy the music so completely that I suspected that she was the least interested in these vocal exercises.
Pam was mechanically impaired by muscular paralysis related to her vocal production apparatus, and was physically unable to produce "-L-", "-S-" and "-P-" sounds. These were sounds that we worked on as a group from time to time. Despite Pam's physical limitations, she joined the others in working on these articulations. Since these sounds were often practiced in the context of two and three-syllable words, other sound productions accompanied the exercises. In the process she would complete the rhythmic prosody of the three-syllable word, overcoming the slurred management of the first syllable. Pam was courageous and proud. She was able to articulate successfully a few vowel sounds that were understandable.

Pam became very expressive while singing "You are My Sunshine." I suspected that because this song was so well known to her, and because it had some personal associations, it was able to exert extra support due to emotion-based connections (Sacks, 1998). Pam's garbled voice belied the enthusiasm and artistic expressions that she seemed to experience, and which I could catch a glimpse of, but which she could not produce through tone or melody.

The rhythm of the music seemed to organize Ross's stuttering. Outside of the music his voice was harsh, guttural and repetitive. He would get stuck on the opening syllables of words and stutter endlessly. The music provided a supportive brace that allowed a flow to these articulations. This is not to say that the music allowed Ross a pleasant, smooth, fluid production. His voice still remained rough in texture. The music however did allow for a bypassing of the stuttering impasse. He sang in an arduous, labored manner, one that reflected
musicality despite these difficulties. He was able to complete phrases only within the context of the music. Ross’s favorite song was “Amazing Grace.” He could remember all of the words, and he was able to lead the group lyrically whenever I forgot the lyrics. With my guitar rhythmically supporting him, he enjoyed taking the lyrical lead. He was able and successful in the music despite his occasional need to pause for breath. He exploded vocally at times and his presence was unmistakable during these explosions.

Mary’s vocalizations were difficult for several reasons. First she had some disarthric components to her disability that restricted the mechanical processing of sounds. The stroke had affected the musculature of her vocal apparatus and this made it difficult for her to produce open vowel sounds. Secondly she had difficulty in processing the correct words because of the aphasia. During the exercises she worked diligently. After singing for a period of time Mary’s vocal chords would become irritated and she would grab her throat. Sometimes she would cough and cease singing.

Despite the harsh labored quality of her voice she exhibited a fully involved personal investment in her vocalizations. She sang with conviction and often demonstrated a nonverbal display of pride and enthusiasm while singing. At times she would straighten up her posture in the wheelchair, extend her chest, take in a deep breath, look at the others to make sure they attended to these displays, and then proceed to explode with a voice that although constrained was loud and vital.
Competency Verses Failure

The improvement of speech was a prominent focus of the music therapy group. The ability to physically produce sounds reflected not only active participation by the participants but a level of competency as well. The participants' expressions related to this display of competency stood in stark contrast to the displays related to failure that led them into a state of withdrawal.

When I observed Mary and Pam dance together they were outwardly demonstrating their excitement over becoming competent "standers." When they looked at each other and laughed while singing they seemed to be demonstrating a similar excitement over their achievement in singing the words. Closely connected to Pam's demonstrated need to control was her need to feel competent. Pam's swaying shoulder movement when speaking of her theater experiences and when showing her artwork conveyed the same pride exhibited when she expressively sang, "You Are My Sunshine." Her nonverbal displays of pride seemed to invite praise and acknowledgement. I felt that her identification was profoundly associated with the competent artist, mother, wife, and socialite. In the music she became competent not so much in the precision of her articulations, but in her overall expressiveness and artistry.

Greta, on the other hand, showed no visible signs of gratitude regarding her ability to sing; she seemed to take it for granted that she could sing. Singing and music were so integrated into her personality that music flowed from her effortlessly. I don't know if she was capable of such reflections or if she connected the transformations from "mute" to "vocally fluid songster" to a feeling
of competency. She appeared to become totally involved in the music while singing.

With this in mind I challenged myself over my need for Greta to recognize her competency. For me to want some visible signs from Greta that she recognized her competency was, in a sense, a feeling that such insight would verify the significance of the therapy. I had relied on this validation for years while working with highly verbal patients. I had to remind myself that Greta’s musicing was enough and exactly what I was coming to believe as the essence of this therapy.

Ross corrected me several times whenever I missed lyrics to his favorite gospel songs. He would look over to Greta, who also loved the gospel songs, in what I perceived as a sign of pleasure in demonstrating that he could correct the “teacher.” Greta usually responded with her “thannnkuuubaba.” He seemed to appreciate the acknowledgement from her. He seemed to beam with pride as these demonstrations that gave him the chance to be the competent one. Being so vocally and physically challenged, Ross had few opportunities to experience competency. I felt that these experiences provided a restoration of self-esteem that could only be achieved through some form of successful endeavor.

The Chorus Effect

The research of small group dynamics has traditionally focused on two major issues (Gibbard, Hartman & Mann, 1988). The first pertains to changes in group structure and process over time and the second concerns itself with the
direction of social change due to the role of individual leaders or role specialists. During the early years of small-group research the methods employed relied on techniques that recorded verbal presentations and analyzed them according to social intent and function. The verbally inactive group members were not factored in as significant components of the group process. Later analytic techniques considered multi-dimensional aspects of “interpersonal space” that were determined verbally and nonverbally. These behaviors reflected status, power, likeability, and task commitment. Current small group analysis revolves around the social and psychological significance of group process. Determining the roles and the significance of individual roles are the usual means for this analysis.

While analyzing my group I was aware of the various individual personalities demonstrated during the group process. Greta seemed to be the compliant one, while Mary was the challenger. Ross would agitate the group at times, and Pam could demand attention and divert group activities. I was the demonstrated leader. The traditional way of observing each member as to role function however did not take into consideration the “personality” and “role” of the music. The task commitment on one level was the production of the familiar song. On another level the song exerted a power and leadership of its own that ultimately determined group process.

I came to view the group from a perspective that focused on unified group responses rather than individual differences. The traditional view of group dynamics whereby individuals interact to determine process was replaced with an
overview of the "chorus effect" whereby individuals, rather than demonstrate personal preferences, submit to the musical experience. The musical experience in this case provided for them, held them, and restored essentials that no other element could provide. Through the group engagement and unified production of the well-known song, the participants could immerse themselves in expressive presentations that reflected the shared human necessity related to need for community.

As I came to consider the music the "leader" and the "provider" it also became apparent to me that the music also reflected the "good enough mother" (Winnicott, 1971). The submission to the "good enough" musical experience was not to restrict or imprison individual will but to restore individual needs that existed beyond individual personality and reflected what I assumed to be essential human need rooted in the experience of being a part of the group.
CHAPTER VI.

COMMUNAL EXPERIENCES

We are all Speechless, We all survived
We are all people, and so we all strive
I hear your voice, strong and clear
Blending sounds, blending fears
Blending humanity, blending as one
A chorus of pedals to soften my tears

d w ramsey

“What father would give his child a stone when he asked for a loaf of bread” (Mathew 7:9 Revised Standard Version). At the start of this research I noted that I considered myself a client-centered therapist whose focus was on meeting the client’s needs. As non-fluent patients in a rehabilitation facility, the participants in my music therapy group were asking, on some level for the rehabilitation of speech and words. As I look back on my work and studied the results, I asked myself questions related to my ability to meet their needs. How well did I provide for them? Did I resemble the inadequate father in that I gave them a stone, something they didn’t need or want? Was my music a diversion from their woes or did I in some way address their need? Does the father who offers his child a cake because he has no bread display a dismissal of the child’s expressed needs? Some might argue that the child is asking for basic healthy sustenance, and that by giving the child cake the father would be overindulgent.
and promoting an unhealthy condition. He might be pacifying the expressed need instead of meeting it in some substantial way. But others might note that in addition to the cake’s sweetness, and pleasurable qualities, it has enough calories to stave of starvation and it is something usually associated with the times of our life that are worth celebrating. It is what we wish we could eat every day and still remain healthy. Was I the good father or the inadequate father? Did I give my patients bread, stone, or cake?

My clients came to speech therapy for words. Speech therapy could not give them words. They came to me for speech improvement as well, but instead I gave them group musical experiences. As I contemplated my music therapy sessions with Ross, Mary, Pam and Greta, I constantly asked myself what specifically had I provided for them, what was the function of the music therapy process and my role as a music therapist.

Toward the Restoration of Community: Conditions & Consequences

Aigen (Aigen, unpublished manuscript) expanding upon the concept of communitas notes that the unique sense of community experienced in group music making can address “essential human needs and ….can constitute a legitimate clinical focus in and of itself.” Upon review of all research data, I found the “Restoration of Community” emerging as a core category in that all observations seem to point to the fact that underlying all interactions was the developing of relationships and a sense of a shared culture. Determining the
restoration of community as a core category came about through a process of looking at all data from a broad perspective.

Max Weber (1964) discovered unexpected relationships between organizations, events, religion and philosophies by questioning the “function” of phenomena. He realized that the intention behind the construction of structures is not always in line with their verified function. By subjecting structures (organizational, social or therapeutic in this case) to scrutiny as to their demonstrated function, fundamental relationships emerge.

I thought that a similar approach might help me discover not only a deeper understanding of my intentions, but reveal relationships within my data. I started with a look at the function of speech therapy because speech improvement was a predominant focus. I proceeded to an inspection of the use of music and specifically the familiar song. Finally I questioned the functional implications of my direct manipulation of the musical components of the familiar song. Three elements resulted from a “chunking up” categorization process, as all data could be assumed under one of these three major categorical abstractions.

Functional Relationships

1. Speech Therapy

   * The function of speech therapy is to improve articulation of words.

   * The function of the articulation of words is to employ language.

   * The function of language is to communicate our experience of the world.
* The function of the communication of our experiences is to commune.
* The function of communing is to make communal; to share the same thing.
* The function of communion is to "realize" (to make real) a shared body of knowledge.
* When we realize a shared body of knowledge we come to a sense that we are not separate, not alone, and not different. We experience not-aloneness when we experience the group, the community.
* Thus the function of speech therapy is to provide the experience of community for people.

2. The Familiar Song

* The function of the familiar song in my group was to provide the greatest common medium of communication.
* The function of the greatest common medium of communication was to provide a means to activate the participants into a group event.
* The function of participation in a group event was to promote intercourse and communion based on a shared body of knowledge.
* The function of communion through the sharing of a common body of knowledge is to experience the community.
* Thus the function of the familiar song was to provide a means for experiences of the community.

* The reason to use pop songs was to start with something familiar. Starting with the familiar allows for experiences of familiarity and novelty.

* Novelty allows for tension and release.

* The function of initiating variation on well-known songs was to create tension, expectations and release of tension.

* The function of promoting events related to tension, expectations and release of tension was to activate expressive experiences.

* The function of promoting expressive experiences was to provide interpersonal realizations of the shared experiences.

* The function of realizing the same experiences interpersonally is to become part of the community.

* Thus the function of song improvisation was to experience the community.

If in fact the function of my groups was to provide experiences of community, how did my music therapy groups demonstrate the provision for these experiences? Did community experiences happen? How did they happen? What were they made of? How did I know that the participants actually experienced them? What allowed these experiences to happen and what allowed them to continue?
Prerequisites for Communal Experiences

I would like to address these questions by starting with the last, as the answer of this question will help explain the nature of these experiences and their significance. In order to proceed with this conceptual development of my findings, I will briefly define “experiences of community” as any activity where the members participate in a group musical activity together.

Two people from completely different cultures could watch a man straining to push a piano up a hill, look at each other, wink and smile at the poor man’s struggle. In the instant of the smiling wink, they would share an experience together, a moment in time, and they would communicate a common body of knowledge without having the same language. What would make this moment possible would be a medium of communication (the wink), the ability to utilize the medium (enabled), a time share as they were at the same place at the same time, involvement in an event as it progressed in time (multi-dimensional time share), and a shared body of knowledge concerning the event (they both understood struggling).

I observed that in my research group, community experiences occurred as a result of six prerequisite elements.

1. There had to be the provision of a communal event.

2. There had to be the provision of a medium of engagement and exchange (medium).

3. The participants had to be able to control the medium (enabled).

4. The participants had to experience the event together, at the same time,
and had to engage in some time-based interactions (multi-dimensional time-share).

5. There had to be a shared knowledge regarding the experiences contained in the communal event process (shared body of knowledge).

6. The shared experiences had to be realized interpersonally (interpersonal realization).

In determining the conditions that allowed for the communal experience to occur, I realized that the elements that provided for the phenomena to occur also entailed a description of the event itself. In order to describe the conditions of a tornado, for example, one must speak of the need for air currents to mix in a certain way at a certain velocity, with certain levels of humidity. In describing the conditions for the tornado to occur, in essence you describe the tornado. With this in mind I realize that my description of the six provisional conditions constitutes a portion of the description of the communal experience. I will describe the six prerequisite elements in a general sense while providing observations to augment the description of significant components of the communal experience.

Communal Event

The communal event observed in my music therapy groups centered on singing. In many regards the music therapy groups resembled a campfire sing-a-long with underlying fundamental features that augmented the focus to include instructional and rehabilitation elements. The communal event was music based and included vocal exercises and vocal improvisations.
In the groups, the participants became involved in a collaborative process whereby the group joined to produce something: the familiar song. Within the focus on producing the song was the concentration on producing articulate sounds. In the process of producing articulate sounds and the familiar song the members combined voices to create a unified chorus. Thus the music therapy group process was directed towards production on many different levels.

The product orientation bound the members together under a defined, common goal. This common focus allowed four very different people a common meeting ground, it allowed for the development of rapport and the successful accomplishment of a goal. In the pursuit of this product many other psychosocial processes demonstrated themselves.

The Medium and The Enabler

The music itself functioned on many different levels. On one level it provided the greatest common communication denominator for the group. In the form of the familiar song, music became our common language. It was something that we did not have to struggle to remember or to produce. The familiar song was a recognized body of knowledge that all members knew well enough to share and adopt as their foundational meeting ground. On the most basic level, as a familiar song, the only information exchanged was that we all knew the lyrics and melody of the song and that we could sing it.

Because the familiar song was actively sung in time together and various musical elements were intentionally manipulated for expressive purposes, certain
aspects of the familiar song transcended the traditional concept of language and became our shared experiential event. A traditional view of communication might describe the origins of a message in a "source" who "encoded" it, entrusted it to a "transmitter" that delivered it to a "receiver" who "decoded it" (SMCR Model) (Gibbard, Hartman & Mann, 1988). In this process, cognition is processed into verbal data and presented as such. The person receiving the verbal presentation processes the information through their "model of the world" or personal associations (Bandler and Grinder, 1975). The communication process is very much an oscillating event whereby information is transferred in a back and forth, feedback fashion. The singing of the familiar song was not a language or vehicle that facilitated a dualistic transfer of thoughts, but rather it was the vehicle for shared experiences to be lived together.

In the process of conceptualizing the music based activities, I found that I had to abandon the notion of information transfer altogether. The intimacy with which music-based experiences and shared communications occurred could not be described in a dualistic fashion. In the music, there seemed to be an interlocking matrix of conversational elements and shared experiences both at the same time.

Some communication events shared traditional communication norms and could be described as exchanges but those that occurred within the music itself could not.
The singing of the familiar song was the enabler. The neurological process that allowed for these non-fluent patients to experience the fluid production of vocal expression was a necessary component. Music as an assistive device allowed all other processes to happen.

I liken music’s ability in these groups to a medical device that enabled the intake of sensory input and then organized and supported responses to the input. Music was crucial to our communal process. If the two strangers watching the man pushing the piano up the hill were blind, the exchange could not be perceived, if they could not wink because of facial paralysis, then the communion could not be completed. There had to be a medium of exchange and there had to be control over that medium. The singing of familiar songs was especially important for this population because of its ability to affect the neurological system in a way to support their vocalization.

At one point in the music therapy group, I had considered the use of instrumental improvisation. It is true that improvisational instrumental music making could have been employed to facilitate a communal event, but because the central deficit being addressed was vocal, and because the singing of familiar songs was easily accomplished, singing was the most appropriate way to utilize music. I assumed vocal production to be an essential component of the communal event based on the assessed need of the participants.
Multi-dimensional time-share

In order for the communal event to happen there had to be a sharing of interactive time. There had to be a time when all participants gathered together in the same room, and there had to be an event that allowed for a multilevel phenomenon of time (Forinash & Robbins, 1991).

In many regards, it seemed like the participants had all the time in the world. Their life was free from the demands of work, family obligation, or any other time-demanding activities. And yet they had no time at all, or more precisely, no power over time. They did not choose what time to eat, what time to bathe, what time to go to bed. People did not spend time with them because conversations were so difficult. When they did engage in conversational events the participants did not have control of the conversational element of time as one might in most conversations. Forinash and Robbins (1991) speak of four levels of time in music therapy, now (creative) time, emotional time, growth time, and physical time. I observed now time and emotional time as consistent components of my music therapy sessions which were scheduled twice a week at 10:00 am in physical time.

The musical interactions demonstrated in my music therapy groups reflected certain time-related characteristics that denoted emotive distinctiveness. Whenever the tempo slowed down at the end of a phrase, a certain kind of excitement was created in anticipation of the precise moment of conclusion. As Mary and Pam joined in the singing of “This Little Light of Mine” and emphasized, through staccato presentations of the lyrics, “let it shine, let it shine,
let it shine,” they seemed to be using the timing of the melody to make a proclamation whose power was dependent upon dramatic time. The shared musical time reflected each individual’s involvement in the creative and emotional expressiveness of the musical dynamics. Forinash and Robbins (1991) describe some such characteristics as the “quickness of time in excitement, intense interest, ardent pleasure, enraptured absorption; the slowness of time in boredom, displeasure, suffering and waiting” (p. 52).

In the course of all interactions the participants also experienced the time of awareness associated with recognizing that you are with others, creating with others, interacting with other in the present moment. The sharing of time together was itself a significant component of these communal events. Time-sharing was something that was limited in the everyday lives of the participants because communication regulators were often employed to restrict the participant’s communication efforts. It was a rare occurrence that people gave Ross, Mary, Pam or Greta time. People did not sit and talk with them. People seldom engaged in activities with them, and even recreational activities such as craft making, bingo and video viewing did not involve interactive elements that depended upon the management of time. The provision of time together was essential for the communal experience. Being in the same room for one hour together provided an essential time-share. Involvement in the tempo and time changes in the music provided another dimension of time-sharing.
Shared Bodies of Knowledge

Noam Chomsky’s (1965) studies of language lead to the linguist model of transformation grammar. Inherent in this model is the belief that the structure of language conveys a certain body of knowledge that is shared among native speakers of that language. It also proposes that the “surface structure” attempts to convey the speaker’s “deeper structure” or full linguistic representation of his experience of the world. Whenever a native speaker breaks one of the rules governing “well formed” surface structure the other native speakers instantly notice this breach. Implied in these acknowledged breaches is that there is a great body of shared knowledge among the native speakers.

Bandler and Grinder (1975) speak of how we use the structure of language to globalize experiences in order make the communication of complex experiences manageable. These globally expressed experiences are often received and acknowledged with concise verbal cues that let the speaker know that we identify and understand his or her communication based on our associative experiences.

The idea that structures and structural levels could convey shared bodies of knowledge interested me, especially when seeking meaning in my use of structured familiar songs and my intentional manipulation of these well known structures.

I observed three structural levels of musical activities in my group. Each structural level demonstrated different kinds of shared knowledge. The confirmation that these bodies of knowledge existed and were acknowledged
among group members was demonstrated mostly through nonverbal communications and will be explained in each sectional detail of the particular level.

The structural levels serve similar functions in that they support experiences that convey shared bodies of knowledge. The structural levels differ in their makeup and in the particular type of knowledge exchanged through the structure. Structural level one (the surface structure) reflects the medium of exchange: the familiar song and the common knowledge shared within this structure. Structural level two (the mid-structures) supports the exchange of knowledge related to our shared human nature and is demonstrated during the flow of essential human experiences. Structural level three (deep structures) reflects the nonverbal dimensions of communication intercourse whereby we exchange fundamental knowledge regarding conversational time.

**Surface Structures: The Familiar Song**

I use the term surface structures to refer to the most obvious structure employed in my music therapy sessions: the familiar song. The familiar song was pre-composed and had specific lyrics and melody. The song followed a format that usually involved the singing of verses followed by a chorus. The chorus always repeated itself.

The participants’ knowledge of this structure was demonstrated in various ways. The most obvious way was in the successful group singing of the lyrics and melodies. Whenever a musical form was completed, as I knew it to be
original to the composition, I assumed the participants knew that element of the song. Other demonstrations of this shared knowledge came in the form of communications from the participants that let me know something was wrong with some part of the song, that something was untrue to the original composition.

Aigen (Kenneth Aigen, unpublished manuscript) states that music making that is spontaneous and not mechanically bound by structure can allow for experiences that are richly charged with affects. Implied in these concepts is the notion that spontaneity and richly charged music making is an important component to the facilitation of communitas.

When using structured familiar songs I found that I had to bring spontaneity into the way these songs were sung in order to facilitate these rich experiences. I did this by intentionally changing portions of the original composition. In the process of bringing spontaneity to the structure of the familiar song, I began to realize that this type of spontaneity was dependent upon the shared knowledge of the correct structure. There seemed to be a kind of meaning and experience which depended on a departure from the predictable itself, and of course this depended on everyone first having familiarity with the song and knowing what was predictable.

The richly charged moments of our group happened whenever the known structure of the song was intentionally played with. Whenever I broke the well-formed structure of the song, the participants knew that I was doing this on purpose. They usually laughed immediately or negated my presentations in some way. Without a knowledge of the structure, of the way the song was suppose to
be sung, a particular type of spontaneity could not exist. The intentional mishandling of the known structure is what gave the communitas in our group its most unique, significant, and personal characteristics.

A person at a formal dinner party could intentionally select a fork to eat his soup in an attempt to playfully challenge the correct, well-known rule governing the formal setting. He may wink over at someone who recognizes his intentional faux pas. In the acknowledgement of the intentional faux pas an extraordinary level of rapport is sometimes demonstrated. The intentional breaks in a well known, acceptable structure - that is recognized as intentional can demonstrate rapport that transcends the obligatory acceptance into a group just because you know the rules. I interpreted the acknowledgement of an intentional musical faux pas as reflections of such rapport.

In addition to singing the songs correctly, I knew that the participants shared the knowledge of the songs with me when they reacted to my real mistakes while leading the song. One time as I was singing “Amazing Grace” I reversed the order of several phrases. Ross let me instantly know that I was wrong with a sharp loud, “Nnooooo.” When I asked if I did it wrong, Greta shook her head yes and mumbled “yyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyyy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started to point their shaking fingers at me to remind me of my broken promise. This display was executed while singing the incorrect lyrics "pumpkin pie."

Ross's response was dependent upon the knowledge of the familiar song and reflected almost a reflexive negation, possibly slight frustration at the wrong lyric. Mary and Pam's response reflected a quality of humor designed to make me feel guilty. Humor, guilt and frustration (connected to the wrong lyrics) combined to create a moment of rapport based on multiple layers of shared knowledge.

When the usual lyrics were incorrect, the participants responded either by trying to correct me or by criticizing me. When I intentionally missed a lyric, the participants usually picked up on my intentions and responded in a way that let me know that they knew of my intentions. Something about the intentional mismatching of lyrics created an atmosphere that made available unusual qualities of interactions. Certainly the unexpected nature or the wrong lyric created attentiveness. I interpreted these moments as more than just attentive moments as a result of the unexpected but as moments that conveyed specific and unique communications based on the intentional mismanagement of the well-known.

Mid-Structures: Essential Human Experiences

While Mary and Pam joined together in their chiding, finger pointing behavior when I neglected to tie my shoes, they were identifying with each other in the knowledge of my neglect. When they smiled and gave each other a high-five slap they were joined in an awareness of something that I was not. I seemed
oblivious to an impending concern; they were well joined in awareness. Although only a high-five gesture, in the moment of its execution, of its sharing, Mary and Pam demonstrated that they assumed something together, they both recognized and knew of my "neglect" and the "impending danger" of my falling from untied shoes, they were also aware of my buffoonery.

Many times during the music therapy sessions the participants would recognize more significant and fundamental exchanges, expressions and endeavors that reflected more their sense of personal identity than a response to something outside of themselves. In the course of recognizing the endeavors of others as experiences that constituted a fundamental portion of their personal life, they wanted to convey that they identified with these experiences. The way that participants conveyed their identification with another’s demonstrated experiences was sometimes overt and direct, even if nonverbal, and sometimes it was communicated through a communication matrix of merged musical expressions and experiences. This matrix of shared expression and experiences that reflected overall shared experiences is what constituted the second structural level in the music therapy activities.

In that I assumed certain behaviors to convey meanings related to the identification of a specific experience, I realized myself as an instrument of measurement of the reality of these experiences. In noting certain responses as indications of identification I displayed a bias as to the meaning of such communications. Although I employed member-checking interviews after the
completion of the research, these interpretations remained my main source of validation as to this data.

Charlesworth and Kreutzer (1973) state that innate factors "seem to be mainly responsible for the morphological characteristics of expressive behaviors (and hence the fact that they occur at all as such) and for the connections such behaviors have to the emotional states associated with them" (p. 31). Eibl-Eibesfeldt (1975) has concluded that neurological factors account for the origins of facial expressive behaviors, but that gradation in expressiveness and development of variations to express specific personality traits are determined by the environment and culture. Still, these variations have their root in universal neurological structures. Multicultural studies (Ekman & Friesen, 1969, Eibl-Eibesfeldt, 1975) have noted that some facial expressions reflect universal connotations and that the emotions of happiness, surprise, sadness, anger and disgust\contempt are easily recognized by many cultures.

That people easily recognize the emotions of others by facial and other nonverbal displays is an assumption that I acknowledge. Emotive displays of frustration, enjoyment, humor, compassion, and affinity were assumed by me to have universal meaning. Many nonverbal displays of frustration were demonstrated. When Greta dipped her head in defeat because she could not remember something or when Pam slapped her knee if I misunderstood her, I understood these behaviors to be signs of frustration. Eye contact almost always shifted to Greta or Pam these events. Nonverbal indications of sympathy and support from other participants were common and usually were accompanied with
a "yeeass" or "uuhhhhhuu" sound of affirmation and identification. I assume emotive displays as a part of our human heritage and the acknowledgement of them is instinctual; to share them is a part of the human experience.

In determining the demonstration of an experience or the acknowledgement from one participant of another's experience I utilized affective displays (facial expressions), nonverbal affirmations (head nods and gestures) and participatory affirmations (full musical involvement) as indications of the reality of these experiences' expressions.

During the research sessions I observed reactions from the participants that reflected consistent identifications with certain events. In the course of the study several experiences seem to recur. Since the participants were struggling to improve their vocal mechanics I termed one of these experiences as striving. There were many times when the participants successfully completed articulation or expressive presentations. I came to term these expressive experiences as "competency." In the process of striving towards competency the participants displayed "frustration" and thus another experience was identified. There were many experiences related to laughter and humor. The participants asserted themselves by affirming or negating certain situations and thus another identified experience I labeled "self-assertion." The participants displayed affection towards one another and camaraderie at times, and finally the experience of community was indicated by the sum total of all other experiences.
Thus I identified seven reoccurring experiences: Striving, Competency, Frustration, Humor, Camaraderie, Self-assertion, and Community. I assessed these experiences as essential to meeting the needs of my clients who could not communicate. If they could communicate, I assumed that these experiences would be sought and available through verbal communications. Implied in my use of the term “essential” I am referring to these experience as essential to the fully functioning human. These expression or experiences demonstrated themselves in the music when musical structures reflected certain characteristics, and they demonstrated themselves outside of, or in response to, the music. I came to equate certain nonverbal behaviors with defining characteristics associated with one of the labeled seven essential human experiences. For example I assessed laughter as an experience of humor. I assessed certain nonverbal expressions such as frowns, as signs of frustration.

**Striving**

During the music therapy groups there were many times when the participants struggled to verbally communicate, to improve articulations or to remember lyrics to songs. Even with the assistance of music that allowed fluid movements and clearer articulations, there was always an underlying quality to the sessions that conveyed a certain level of striving. Ross could sing lyrics to his favorite song “Amazing Grace” and yet it was with a labored breathing and a need to pause occasionally. During a time when Ross tried to sing solo and he needed to pause, the group instinctively hesitated with him. When Mary struggled to describe her Thanksgiving dinner, everyone tried to help by guessing the name of the missing
dish. In this offered aid they were acknowledging her striving and their compassion for the struggle.

I heard Greta’s “gooooooodddddaaaaammnn” in identification with the tragic loss of function portrayed in my storytelling of the brain injured boy. I heard all participants laugh at situations where I was clumsy. I came to see these responses as acknowledgements of experiences that they could identify with on a personal level; experiences related to striving.

There were numerous nonverbal acknowledgements of fellow members while they strove to accomplish something. Pam would wave her arms to conduct and assist Ross and Greta when they paused too long. Head nods that indicated “yes, keep trying” were ever present. Attempts to rescue or assist showed a response of compassion that was dependent upon a previous knowledge that something in need of compassion was occurring.

Pam’s leaning forward, nodding her head yes to Mary’s struggle to articulate “casaba,” indicated her identification with the experience of struggling. Her attempts to guide me to a better understanding not only showed her desire to rescue Mary, but to end a difficult situation or to provide a successful, competent completion to the struggle. Greta’s shaking her head and frowning when Ross struggled to form certain vowel sounds indicated that she understood his striving.

During the vocal exercises Mary would look at Pam to see how she was forming her mouth and, Pam would display the correct formation. In this music therapy group members adjusted their breathing, their posture and the formation
of their mouths in order to produce more articulate sounds. They adjusted musical elements until they achieved the tone and rhythm of the musical piece. Their striving was demonstrated in many subtle forms from the obvious filling in of a correct lyric to the micro-adjustments of musical responses to tempo changes. Acknowledgements ranged from overt moments of laughter and strong vocal affirmations, to the soft musical changes indicating the effort involved in making things more musical or making things right, in synchrony.

On one level we were exercising with the intent of rehabilitation, and on another level we were making music. In the music, there were moments when the participants endeavored to produce musical contributions. Elliot (1995) describes "musicing" as "one of the most consequential, dynamic and practical pursuits in the human repertoire" (p. 120), because it addresses central human values of self-growth, self-knowledge, and optimal experiences. Basic human actions that reflect "intention" toward these values can be noticed easily in the intricate pursuit of making music.

Improved articulations were more than a means to better speech, they were purely musical contributions. The clearer, smoother vocal sounds that the participants strove for constituted the intentional manipulation of vocal chords in order to create music. At its most fundamental level these adjustments reflected the ability to monitor, "adjust, balance, manage, oversee and otherwise regulate ones musical thinking" (Elliot, 1995, p. 123).
These intentional manipulations while reflecting usual conversational, and social actions became musical actions. Elliot refers to various forms of musical knowledge one of which is termed “informal musical knowledge” (p. 222). This form of knowledge refers to the natural understanding of musical form. None of the participants had formal musical training that I was aware of, but all participants demonstrated some natural tendencies towards music. In the pursuit of the chorus effect many musical decisions had to be executed, many efforts were executed to make things musical.

Competency

The purpose of striving is to achieve. To achieve is to control. To control is to bring pleasure. Whenever Mary sat a little straighter in her chair and pushed her chest forward in a display of confidence, it was always associated with her demonstrated ability to sing something. When Pam stood to dance and show off her ability to stand on her own, she was displaying pleasure at being competent. Mary clapped and joined Pam in her display thus identifying with her competency. It was identification with being normal or able bodied that everyone in the room understood. This understanding was demonstrated through smiles when Pam formed her “-L-” sound, when Greta said “yeeeeeaaaaa’ to Ross’ remembered arrangement of “Amazing Grace” and it was demonstrated through the laughter at Mary’s hearty rendition of “When the Saints Go Marching In.” Whenever moments of struggle were followed by successful executions of tasks, the other members noticed it, eye contact shifted to the accomplishment, and
some nonverbal forms of acknowledgement almost always followed.

A significant component of competency is the act of completion.
Something left incomplete is not considered competent. By finishing an entire
song the experience of competency was had. These moments of completion as
separate experiences were not so readily acknowledged as moments to be
celebrated or acknowledged, because they were incorporated by the whole task.
It’s almost as if the completion in some regards went unnoticed and taken for

I bring attention to this component of the competent act only because there
were so many experiences of “not complete” in the participants’ lives. There was
an occasional smile after experiencing the pleasure of singing a song, although the
smile was not directly associated with “completion” as a significant experience, I
do believe it was felt as complete. Completion was absorbed into the grander
experience of competent.

Whenever competency was displayed everyone seemed to recognize it
instantly. It wasn’t something that anyone had to explain formally as an
accomplishment or as a demonstration of competency. Whenever someone failed,
acknowledgements and offered support followed, indicating recognition of what
was not competent. Competency demonstrated itself as a body of knowledge that
we all seem to share immediately.
Frustration

Greta could not remember the name of her favorite singer. All other members are focused intently on her attempt to remember. She gave up and dropped her head in defeat. There was a groan from the others in acknowledgment of her failure. Pam could not articulate the name of her new grandson. She became agitated, slapped her knee, frowned, and shook her head in disgust. Mary lifted her shoulders in a shrug. She cannot articulate the name of her favorite Thanksgiving dish so that everyone could understand her. We all shrugged in unwilling acceptance and shared the frustration of her difficulties.

Almost all of the frustration experienced in the group revolved around verbal attempts. During failed verbal attempts the participants demonstrated what I had come to know as vicarious participation. By leaning forward, eyes focused intently focused on the failing speaker, moving their lips to model and support some inarticulation, the other participants not only demonstrated their desire to help out but their connection to the experience of failing and feeling frustrated.

There were times that musical execution was difficult or even unsuccessful, but in the music we always managed to overcome the impasse in order to provide a flowing musical expression. Even in the music it was always the lyrical component that caused the breakdown and consequent frustration. I never emphasized the correct lyrics and in fact encouraged the wrong ones if we didn’t know the original lyrics. In this manner music allowed for a successful segue out of frustration and provided an alternative experience: success and
competency. For this reason I tried to stay in the music as much as possible. Those times that I allowed for verbal interactions to sustain and fail, I did so to demonstrate and promote experiences of compassion and comfort as a way of balancing out the usual experience of being regulated.

**Humor**

We laughed often in the group. We laughed at jokes, we laughed at unexpected events in the music and during non-musical interactions. Sometimes there was laughter even when someone failed to verbally succeed. Verbal struggles were a constant source of frustration, but sometimes, especially in musical exchanges, verbal failures could be reframed and set in the context of an overall successful communication. When Mary and Pam failed to articulate “pumpkin pie” in the context of our song about my forgetfulness it was a way of laughing at me while at the same time not taking the failed verbalizations seriously. In the context of fluid musical exchange, multiple layers and meaning were demonstrated. In this way it allowed the participants an overriding experience of success despite inarticulations. Laughing at failed verbal attempts was not interpreted as cruel because it did not occur during sensitive topics. Instead it occurred during light, casual topics, and there was always a provision for some sort of successful experience, usually musical, connected with the difficult exchanges.
The group laughed at my jokes, stories and buffoonery. Everyone understood the nature of the humor in the situations and demonstrated this understanding through the laughter. A joke is not functional if you have to go back and explain it. The joke laughed at in unison demonstrated that everyone understood the unexpected twist, the humor in directing serious effort towards a silly endeavor, the pleasure of laughing at our shared inadequacies. Every element of humor expressed in jokes, stories and buffoonery were also demonstrated musically and acknowledged just as easily.

For example in session 12, I struck the dominant chord of “Amen” on the final chorus. I pause. We were suspended in the expectation of the final chord. I sang an incomplete “a...” I waited and dropped my head. Mary and Pam shout, “...men.” I ignored their plea to end and struck the five chord with increasing volume and dissonant tension. Laughing erupted. They were ready to end but at the same time were enjoying the suspense.

Camaraderie

Pam and Mary developed a special bond during the music therapy sessions. They often held hands and several times they stood and danced together. They looked over at each other and laughed in concert together. They increased eye contact toward one another during individual demonstrations, greeted each other with excitement and blew kisses to each other upon departing. Greta and Ross shared a love of gospel music and looked over at each other at the start of “Amazing Grace” and “Swing Low, Sweet Chariot.” The group was
united in the singing of the familiar song and shared a bond based on the
production of the music. There seem to be a unique and lasting bond developing
between the members based on their shared experiences of music making. They
shared the experience of identifying with being an aphasic patient on one level,
but on another level they were members of the music club, they were music
makers.

Self-assertion

Self-assertion came in the form of filling in the blanks to incomplete
musical phrases. Every time we sang “Side by Side” the participants came to
expect me to leave phrases incomplete. As the group progressed the completed
words “money” and “funny” became louder and louder. The participants looked
to each other as they exploded the responses. In concert, these assertions of self
were presented, and as a group they were acknowledged. Self-assertion was
assertion of individual will but because it was in the context of a chorus that did
not create separation.

At the start of the research I expected more displays of self-assertion. A
foundational therapeutic principal of my long-standing client-centered approach
was to foster expressions of self. Through this research I came to realize that self-
assertion did not have to necessarily entail the separate, distinct and the
contrasting. The individual self-expressing its will could be united in a chorus or
a group in its unified expression. The two were not mutually exclusive. I became
the music therapy director because the participants could not initiate. I did not
determine whether this was due to neurological factors or psychosocial factors, but nonetheless, self initiated, distinct displays of self-assertion were rare. While the music provided a means for self-assertion, each individual experienced self-assertion at the same time others were asserting similar forms of expressions.

Community

In the shared experiences of striving, competency, frustration, humor, camaraderie, and self-assertion an experience of community was had. In my description of the chorus effect, I talked about how individual expression was subsumed into the unified group singing. The participants almost always sang together. The focus was on group production of the familiar song. Condon and Ogston (1980) wrote about the tendency for those that experience rapport to demonstrate synchronicity in body movement when talking to one another. They claims that the physical or sonic synchronicity can demonstrate affinity and well being and should be considered an essential component for the assessment of health. The music therapy group demonstrated synchronicity in voice and in movement. This constituted a group form of nonverbal acknowledgement of the shared communal experience.

Deep Structures: Time Management

The essence of the experience of community for the music therapy groups was the real-time communication exchanges that conveyed shared bodies of knowledge that let the participants know, from group acknowledgement, that they
were alike, and not alone in their struggles, in their perceptions, in their world.

The management of time was perhaps the subtlest structure of the sessions that conveyed a shared body of knowledge: the time dictates of the hour-long session; the time dictates of the scheduled 10:00 am start time; the time dictates inherent in the flow of the music itself; and the time dictates of the verbal exchanges. Each event had its own time “norms” and knowledge of these various norms demonstrated that the participants were aware of their demands or expectations.

In a previous publication (Ramsey, 1999) the present author referred to the concept of real time. In that publication I describe how patients with language disabilities are often equipped with assistive speech boards that allow for the exchange of specific words and phrases. Missing from the format of these speech-board conversational exchanges was the flow or usual fluid time. Inherent in the management of time are experiences that reflect shared knowledge of the intentional use of time to add meaning to specific data. Kendon and Ferber (1980) categorized four time sharing components usual to normal conversations: (a) turn requesting, (b) turn yielding, (c) turn denying, and (d) turn maintaining. Mehrabian (1972) states that time is negotiated through kinesthetic communications in a way that lets the communicating parties know when someone wants to speak, when someone is ready to relinquish the speaking floor and when someone wants to maintain their conversational dominance.

In the music I observed that there was the time of the familiar song. It
called for its turn, and a certain known management of time. Whenever we
mismanaged the normal time of the song, we were denying, in a sense, the
request of the music itself to maintain time. We denied the music its time as we
asserted our own time. All participants responded to these time manipulations by
laughing. I suspect that on one level the laughter was related to the suspense
created by the manipulation of the phrases, but on another level I think it had to
do with the restoration of an experience of “taking control of time.” The
participants were not able to articulate words in conversations much less enjoy the
normal experience of time management. In the music a sense of control over
some elements of time were restored.

The concept of time management as an experience in and of itself is a
difficult one to observe, and I admit a bias to the realization of these experiences.
I came to interpret the quality of laughter and joy in time manipulations as
something beyond the suspense and humor of following an indecisive leader. I
suspect that real-time experiences were restored whenever time was manipulated
to convey a sense of intentional control.

Synchronistic use of time seemed to imply a sense of unity. Whenever we
got out of synchronicity with one another it was immediately noticed through
laughter or rhythmic adjustment to get back in synchrony. Implied in these
responses and adjustments was the notion that the participants knew the right
time.
Interpersonal Realization

In order for the experience of community to happen each member must realize a personal connection to the event and to the shared experiences of the communal event. Throughout the study I referred to the verbal and nonverbal acknowledgements of such realizations. As a final method of confirming that the participants found the music therapy sessions significant, I conducted an interview to directly check the participant’s interpretation of the group experiences (See Appendix D).

In the concluding interviews I asked Pam and Mary a series of questions related to the group process. I choose closed ended questions that could be answered with a headshake of yes or no. I asked them if the singing sessions felt similar to a discussion around the family dinner table. I asked them if they thought singing together felt like a substitute for conversations in some way. I asked them if they felt connected to the other members because of the group experiences. I asked them if they thought singing together would be a good thing to do everyday. Both Mary and Pam indicated that they valued the group experiences, that they liked being with the others and involved in active singing. They indicated to me that singing did provide a substitute for “conversational experiences” and that they felt a sense of fellowship with the other members.

During the interviews I did not expect them to indicate to me that they hated the group, that they did not like the other members, or that they did not experience a sense of community. I think that in some regards they felt drawn to
agree with me because they sensed that I wanted them to agree with me. On another level I sensed that verbal confirmation of a shared nonverbal experience somehow diminished its value.

Pam laughed at one point when I asked her if singing together with the others felt like a conversational substitute. She threw her head back, put her arm in the air and let out a mock operatic tonal gesture. I threw back my head and let out a mirrored Pavarotti-like sound. She grabbed my arm as we laughed together. It seemed obvious to me that we really didn’t need to talk about the value of realized experiences.

It is not what we share, it’s that we share at all. Entering into a shared experience directly, each person knowing and demonstrating his or her knowledge of the structures of the activity or the exchange creates the experience of being together. When a group of people join in these sorts of events and various levels of shared knowledge are demonstrated through the normal fluid management of the musical structures a sense of unity seems to occur. When a group of aphasic patients join in the fluid production of singing familiar songs, music-based communal experiences are provided. Through these experiences a restoration of the self’s identification with the whole, the group, the heritage of being human is activated.
CHAPTER VII

CONCLUSIONS

In this study I was able to utilize a research approach that combined features of Naturalistic Inquiry with Grounded Theory. This method of research allowed me to look at my own work and develop a language to describe underlying principles, techniques and findings related to what I perceived as essential provisions for these aphasic patients.

Throughout the study I found that the participants' condition restricted their access to communication avenues and to the multifaceted social experiences related to communication. I determined that music not only supported and facilitated the restoration of successful vocal experiences but created a bridge from their withdrawn state into expressive, socially active exchanges.

This dissertation involved a personal journey whereby I was challenged to question deeply held principles regarding the use of "active direction" as a therapeutic tool. I found that this journey took me through stages of denial - whereby I ignored the strong influence that I was exerting in the sessions because I viewed the strong presence of the therapist as intrusive - to a welcomed acceptance of my directive interventions. I came to see "direction" as the only way to ultimately meet the needs of the patients.

The study brought me to a profound respect for the musical experience itself. It validated something very essential about the nature of music making
with others and provided me, as a music therapist, with a new, substantiated reason for pursuing music therapy as a career; as my life’s mission.

I came to a greater understanding of what I believed to be the substructure of communication. The study influenced my observations of the conversational act, and helped me see beyond the exterior context of words exchanged. I caught a glimpse of the personal exchange: a transaction dependent upon a spiritual bonding that needed no words. I came to view the human exchange as a dance of souls combining rather than passing pieces of information from one separate mind to another separate mind.

Summary of Findings

The key concepts summarizing the dissertation can be condensed into eight statements that reflect the condition of the aphasic patient, their responses during music making and the restoration of communal experiences.

1. **Caregivers tend to avoid social interactions that depend upon complicated exchanges of information with aphasic patients.** My observations of participants while engaged with hospital staff revealed the initiation of certain communication regulators. These regulators from the staff limited the amount of time allotted communication exchanges. I suspected that these regulators were employed to avoid uncomfortable communication struggles and because of limited staff availability.

2. **Aphasic patients become frustrated during unsuccessful verbal presentations and tended to withdraw from social interactions that depend**
upon complex exchanges of information. I noticed that failed verbal presentations lead to frustration and finally to a state of withdrawal. This withdrawn state, which I called the “State of Mute,” seemed to become pervasive in the participants’ daily interactive mannerisms.

3). Aphasic patients will withstand the frustration of failed verbalizations and continue to try to communicate if the listener remains attentive, encouraging and provides alternative communication means. During the course of the research project I noticed that the participants increased their attempts at verbal communications despite repeated in articulations and my inability to understand them. I attributed this increase in communication efforts to the successful musical exchanges provided and to my attentive, encouraging manner during difficult verbal exchanges.

4). Music (Singing) can provide an alternative medium for communication and expressive experiences. The participants displayed a desire to sing and an involvement in the communal singing process. Based on nonverbal communications such as laughing, affirmative head nods, gestures of negation, etc. all of which were connected to initiated musical events, I summarized that music was providing a means of connection with the other participants. This connections was based on personal preferences and certain knowledge of musical and communication dynamics.

5). Music (singing) can provide a medium for immediate transformation of inarticulate verbalizations. The participants could articulate certain
vocalizations during the music that they could not articulate outside of the singing.

6). The familiar song provided the greatest common denominator for this group of aphasic patient who were from different cultural backgrounds. All four of the participants came from different cultural backgrounds. The common element upon which they could meet was the familiar pop song. It allowed for not only successful, fluid vocalizations, but a common foundation that revolved around a shared knowledge of the song and the expressive elements of music.

7). The structures of musical dynamics and musical exchanges reflected foundational communication dynamics that in turn convey a shared knowledge of essential human experiences. Through the successful management of the structures of the musical dynamics the participants displayed a shared knowledge of time management, of social norms related to time sharing, as well as the essence of experiences related to a) striving, b) competency c) frustration d) humor e) camaraderie f) self-assertion and g) community.

8). Group singing for aphasic patients provides the restoration of community through the shared knowledge of these essential human experiences during music making. I observed a certain sense of community, or camaraderie developing among the participants as a result of sharing the musical process together.
Implications for Research

I found that the qualitative research format that I employed allowed me to become more cognizant of communication exchange patterns within the music making group. Along with the discovery of certain repetitive patterns, I began to affix some meaning as to what allowed the exchange processes to continue and what inhibited these processes. This is the beginning of the development of a theory related to music therapy and communication for aphasic patients. I feel that similar research could further the search for a theory of such practice which in turn could provide a foundation for further research. Future research could either validate or negate theoretical assertions for this work, with this population and would probably center around quality of life issues related to the need for improved communication means.

Implications for Practice

In my experience as a clinician who works under a rehabilitation, medical model of treatment, it is important to remain aware of clinical benefits that are not easily measured. It is my hope that this research will validate the improvement of the quality of life obtained by providing expressive, communal experiences for patients who are deprived of such encounters due to their loss of speech. In this document I present my key concepts, principles and the guidelines to my work with aphasic patients. These findings are in the context of a small group format, and most of the findings are related to the restoration of essential human experiences in a communal milieu. Since there is very little published in the field
of music therapy in regards to this population, it is my hope that some of the principles and techniques will be utilized by other music therapists. As others incorporate such techniques it may become clearer to the music therapy profession which are of value and which are not.

Closing Story

Several years ago I was working with a group of dementia patients. One of the patients refused to join the group and would leave every time I started to play an old standard pop song from the 1940s. She was a trained classical pianist, and although she could not organize her speech her nonverbal behavior told me that she thought the music beneath her. Once just the two of us were sitting in the small dinner room area looking out the window. We sat in silence for about ten minutes. All at once she exclaimed with enthusiasm, “Look ta backmo to, OOOH OHH so freshly the dress ov maaaaa ta loowwly.”

I leaned forward looking out the window in the direction of the weeping willow tree flowing so beautifully in the wind. I replied with matched excitement, “oohhh so beautiful, so beautiful, the way they dance. They move, so sweetly, so beautiful.”

She looked over at me and smiled, but quickly returned to the dance of the weeping willow tree. She began to verbally respond with words unrecognizable as far as specific content was concerned. But her voice was so full of music, so full of expression. I matched her prosody, the musical excitement in
her voice and eventually experimented with nonsensical words to match hers. We had a five minute conversation without any clearly understandable words and yet the conversation was so fully alive, as alive as any conversation I have ever had.

During my music therapy groups with Greta, Mary, Pam and Ross we laughed, we sang, we danced and we sometimes we even talked. We communed.
REFERENCES


Aigen, K. Music-centered music therapy. Unpublished manuscript.


APPENDIX A

LETTER OF INFORMED CONSENT

I would like to take this opportunity to explain a new project being implemented by the Music Therapy Department at the Health Services. This project will investigate the effects of a music therapy intervention on communications with patients having difficulties with speech. The study will focus on all forms of communication (gestures, eye contact, body movements) demonstrated during the music therapy groups, determine their meaning and usefulness in helping patients with speech problems. The Investigator is conducting this research project as a part of his doctoral dissertation program for the department of Music and Performing Arts, Tisch School of Arts at New York University.

We are asking you if you would be interested in participating in the project. Each participant in the project will receive music therapy two times per week, in a small group setting, for about four months. The music therapy groups themselves will involve singing familiar songs and playing percussion instruments in the small group. No prior musical skills are necessary to participate. The music therapy session will consist of: singing popular songs with other patients, playing percussion instruments and vocal exercises where the patient will be encouraged to sing spontaneously, using words and phrases that reflect happenings in the group at that time. These musical exercises will be assessed and analyzed by the investigator as to social meaning and communication significance. What the investigator will be looking for is interactions that occur during music making that indicate social contact, expressive involvement and communication of preferences and needs.

We will be asking you questions about your past musical interest and your possible interest in joining music therapy. The questions will be presented in a manner that allows you to indicate yes (affirmation) or no (negation) by either shaking your head or arm up and down for yes or side to side for no.

We understand that it is difficult for you to speak and that you have been discontinued from speech therapy at present. We further understand that although you are unable to speak that you understand what people say to you. It is important that you understand that your treatment at the hospital will in no way be effected by whether you participate in answering our questions. In fact, if you would like to agree to participate now and then change your mind later on, you can easily do this. Again, this will not effect the treatment you receive here at the hospital.
The following information answers questions that people have about participating in projects such as this:

1. Your treatment will not be effected in any way by choosing not to participate or to participate. Further, the discharge planning including the date of discharge will in no way change by your decision to participate in this project.

2. The risks of participation are minimal. It has been our experience that most people enjoy participating in music therapy. However, there may be times when you may become restless or agitated. In these circumstances, the music therapist will provide comfort and reassurance to you and allow you to leave the session at any time. On days that you are not feeling well or choose not join, the music therapist will affirm your right to decline participation on that day.

3. You may benefit from regular involvement in the weekly music therapy sessions and your participation in this project will help us develop better programs for people with language deficits.

4. Your sessions will be video taped. The tapes will be reviewed by the music therapist to assess progress. You have a right to review these tapes. A review of tapes can be arranged with the music therapist. You may request that any or all portions be destroyed at any time during the study.

5. You may change your mind about participation in this project at any time. This will in no way effect your current treatment or discharge. Further, this decision will be fully respected.

6. All information from you, the staff nurse, medical records and any family members will be kept confidential. Only the researcher and the research support team will have access to these records. Some of the information will be put on a computer using a number code for identification. Records will be locked in a file cabinet in the research area, and the music therapy studio of the hospital. Pseudonyms will be used in all written reports, including the final dissertation.

7. Nonparticipation or withdrawal from the study will not affect the services you receive at the hospital or discharge date.

8. For information about your rights as a research participant, you may contact the University Committee on Activities Involving Human Subjects, office of Sponsored Programs, New York University. Ph # (***)* ***-****.
I thank you for allowing me to talk to you. If you decide to sign this letter, I will give you a copy for your files. If you have any questions now or in the future, please feel free to contact me:

David W. Ramsey, MA, ACMT
Health Services
Music Therapy Supervisor
Principal Investigator Ph #

I would like to participate in the music therapy research project on communications. I understand that my participation in no way effects my current treatment here at the hospital or my future discharge. I also understand that I can withdraw from the project at any time.

----------------------------------------
Signature

Date ----------------------------------

----------------------------------------
Witness Signature

Date ----------------------------------
### APPENDIX B

#### DATA ANALYSIS CHART

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CONDITION</th>
<th>INTER\ACTIONS</th>
<th>CONSEQUENCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1). state of mute</td>
<td>Inability to speak</td>
<td>Inarticulate communications are regulated</td>
<td>Withdrawal and cessation of verbalizations</td>
</tr>
<tr>
<td>2). state of waiting</td>
<td>Inability to initiate</td>
<td>Someone offers future engagement</td>
<td>Becomes Attentive</td>
</tr>
<tr>
<td>3). state of vicarious participation</td>
<td>Inability to initiate engagement</td>
<td>Outside event elicits personal interest 🐥 🐥</td>
<td>Affected intra/ personally</td>
</tr>
</tbody>
</table>

\[ \downarrow \) Their response category \[ \downarrow \)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CONDITIONS</th>
<th>INTER\ACTIONS</th>
<th>CONSEQUENCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>directive mt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercises</td>
<td>Mt initiates (MUSIC)</td>
<td>Mt coaches Pt vocalizes &amp; Exerts.</td>
<td>Articulate, laughing,</td>
</tr>
<tr>
<td>Cueing</td>
<td>Mt initiates (MUSIC)</td>
<td>Mt creates tension, pt completes</td>
<td>Articulate, musical</td>
</tr>
<tr>
<td>Storytelling</td>
<td>Mt initiates relatable drama</td>
<td>Mt creates tension, pts identifies intrapersonally</td>
<td>Pts Laugh, affirm, &amp; negate.</td>
</tr>
<tr>
<td>Singing songs</td>
<td>mt initiate (MUSIC)</td>
<td>Mt conducts, chorus effect</td>
<td>Musically artistically expressive</td>
</tr>
<tr>
<td>Song improvisation</td>
<td>Mt conducts (MUSIC)</td>
<td>Mt manipulates dynamics, pts become dynamic</td>
<td>Musically artistically expressive</td>
</tr>
<tr>
<td>Verbal Communications</td>
<td>Mt elicits &amp; supports Pt desires communication</td>
<td>Pt struggles Mt speculates group supports</td>
<td>Understood acknowledged or affirmed</td>
</tr>
</tbody>
</table>
APPENDIX C

FAMILIAR SONGS
COPYRIGHTS

Side by Side, @ (1927) by Shapiro, Bernstein & Co, Inc. New York, Copyright renewed. Words and Music by Harry Woods. ==


Amazing Grace, Newton John (1725-1807) m: traditional (in Virginia Harmony)


Day-O (The Banana Boat Song) @ 1957 Edward B. Marks Music Co. Copyrights renewed. International copyright secured. Made in USA. All rights reserved. Based on traditional Trinidad material & popularized by Harry Belafonte.

Home on the Range. Authors unconfirmed due to unsettled 19th century disputes and lawsuits. Probable authors are Brewster Higley and Dan Kelly. On Pete Seeger “American’s Favorites Ballads V2.

Yes! We Have No Bananas. @ 1923 Skidmore Music Co. New York. Silver, Frank and Cohn, Irvin.

When the Saints Go Marching In. @ 1951 & renewed Folkways Music Publishers, Inc. NY, NY. Intro and Bridge by the Weavers.


He’s Got the Whole World. Traditional Gospel. 1st collected by Frank Warner from Sue Thomas in 1933. In Marion Kirby’s “Collection of Negro Exultations”.

You Are My Sunshine. @ 1940 (renewed) by Peer International Corp., 1740 Broadway, NY, NY 10019. International copyright secured.
APPENDIX D

MEMBER CHECKING INTERVIEW QUESTIONS and GUIDELINES:

1). During the research study, there were times when I was able to understand you, sometimes I could not. Sometimes we spent a long time trying to communicate and I still did not understand you. Was this disappointing for you? Do you think it was more disappointing to be misunderstood after spending such long periods of time at trying, than when people usually only tried for a short time?

2). Was it enjoyable for you to make music in the group?

3). Would you say it was important?

4). Was it alright even if the music was bad?

5). I saw that sometimes you displayed frustration and were upset when unable to talk like you used to, like normal speech.?

6). Did the extra attempts at trying to understand help with this frustration?

7). Did you think that the times with me guessing, filling in blanks and speculating were profitable or a good idea?

8). Did the music making feel at all like the feelings you had when in a normal conversation?

Remember when -(example specific to participant------, did you feel like this replaced in some way the feeling of regular speech, regular social activities, regular living?
During these interviews I got univocal affirmations from Pam and Mary that the music making, the verbalization attempts, the non-verbal group interactions were important and provided a substitute for normal activities. After the interviews I realized that I used the word “replaced regular” (substituted for normal), so these adjectives may have not completely confirmed the assumption of “normalcy.” But I felt uncomfortable in using the word normal and instead substituted “regular.” I also felt that they would understand the concept of “replaced regular” better than “substituted normal”.

Pam and Mary were quiet demonstrative in their responses to these questions, Pam with exaggerated head nods, long and extended range of motion to emphasize her strong affirmation that they were important and that they did replace regular forms of social and personal expressions. Mary accompanied her responses with inarticulate sounds and attempts to verbally explain yes while nodding yes all along. When I asked her if her contact with Pam constituted a close personal exchange, even though they could not exchange words, she became adamant that I was correct.

Greta was less demonstrative, and was only able to understand simple concepts. I think that this is due to Greta lack of education and of natural introspective tendencies. She is able to answer definitively about what she likes and what she doesn’t like, and could confirm objective observations that I had presented in the past, but when I asked her to hypothesize about how these experiences might substitute for normal exchanges, she could not answer. She did express a appreciation to me for giving her extra time to try to explain, and affirmed that music making was important to her.
Ross became ill after the research study and was unavailable for the interview.

My assumptions confirmed by member checking and from own personal interpretation of responses, I felt ready to elaborate more fully on my theory of the value of “experiences” in the research group.