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THE IMPORTANCE OF LOVE

IN MUSIC THERAPY

A Thesis
Presented to New York University
New York, NY

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in Music Therapy

by Charles S. Gourgey
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THE IMPORTANCE OF LOVE IN MUSIC THERAPY

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Abstract

While psychotherapy offers many theories of love, most are inadequate to describe the role of love in the process of healing. The premise of this work is that love is the most potent healing factor in therapy. An existential definition of love in terms of awareness of the individuality of others can help greatly in clarifying love's proper role and distinguishing it from countertransference.

Music therapy extends the range of verbal therapy, making it possible to reach people whose illnesses or disabilities preclude verbal communication. Music also allows the direct expression of love as a healing influence. This thesis contains detailed descriptions of specific examples from group and individual work, showing how music therapy can benefit people with severe disabilities and demonstrating the central role of love in the therapeutic process.

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CHAPTER 1

IDEAS OF LOVE IN PSYCHOTHERAPY

I used to feel uncomfortable sitting through some of the courses I took when training to become a psychotherapist. I remember in particular the clinical case presentations. The focus would always be on psychopathology: what is the diagnosis, the underlying dynamics, the family system, and so forth. Of course, in a clinical case presentation, one can hardly leave this information out. But I often felt that something important was left out. I almost always felt a great sense of distance between the therapist and the client, as if the two represented different orders of being. The client was the one with the problem, the pathology, the personality defect. The therapist was the healthy one, in some sense the superior one, inhabiting a completely different world. In spite of whatever useful information the client's diagnostic label contained, I felt it served another purpose besides informing the therapist about the client: it stamped the client as "different," as "not-me," and thus kept the client at a safe emotional distance.

The question of how useful a diagnostic system based on a medical model can be in psychotherapy is complex and could be the subject of its own thesis. I do not wish to address it here. I am only stating my own personal impression that such a system often serves a purpose beyond the diagnosis itself. In psychotherapy, meanings that can be safely neglected in physical medicine become important. A medical doctor need not be too concerned about his personal feelings toward a patient, as long as they do not interfere with his treatment. If the patient has a kidney stone, he removes it; whether he feels repelled by or attracted to the patient is immaterial, as long as he does not act on these feelings. Of course a good "bedside manner" is much to be desired, but better a skilled surgeon with a cold attitude than an affectionate hack.

In psychotherapy, on the other hand, the personal feelings of the therapist are part of the process itself, and cannot be separated from it. Any label we place on a client affects the way we perceive that person, and on some level the client will react to this perception. If we call a client "borderline," we place the client in a category to which we already carry many associations. Most likely very few of these associations are positive. But one thing the label does is place the client in a world qualitatively

different from our own. I would guess that not many therapists think of themselves as "borderline." The label itself creates a disconnection between the therapist and the client: the client exemplifies a category to which the therapist does not belong. I have said that I do not wish to comment on how appropriate it is to use such labels; I wish only to observe that a psychotherapist who does use these labels needs to be fully aware of their implications.

I noticed something else interesting while I sat through those case conferences. I usually became extremely bored, and had difficulty keeping my eyes open. Most of the presentations seemed very dry to me, like dissection reports from biology class. Something important was missing. I almost never failed to hear the therapist's desire to help--this was always evident. But what I often did miss was a true sense of compassion. Compassion--literally, "suffering with"--to me meant a deep feeling for the client, and a desire to join the client in his own world, to walk with her on her own ground. Of course, we were all students then, and this may have been a lot to ask of us. But there was something in the self-conscious distance between client and therapist that always made me uncomfortable.

Decreasing this distance, however, can be tricky. There is a reason that psychotherapists are taught to practice it. To try to approach the client too closely can become a violation. One cannot practice effective therapy without a clear sense of boundaries, a sense of where one leaves off and the client begins, a respect for the client's world. To become too enmeshed with the client can confuse the relationship and undermine the therapy; even Freud occasionally made this mistake. Therapists who love their clients too much may even end up facing prison sentences.

Nevertheless, in my own experience working with clients I have come to believe that love is the most essential and powerful ingredient of good therapy. I believe that while therapeutic results may be obtained without love, they will be much less deep and far more limited. Yet psychological theorists rarely speak about the importance of loving one's clients. And it is also true that to talk only about "loving" one's clients is meaningless. One needs to have a clear sense of what love is, or if this is asking too much, at least how love becomes involved in the process of therapy in a constructive and growth-enhancing way.

As a practicing psychotherapist and now music therapist, I am concerned about understanding my own responsibilities. This thesis will therefore deal

primarily (but not exclusively) with what it means for therapists to love their clients, and how this can occur in a healthy way that enhances therapeutic progress. A related issue is the client's self-love: how the therapist's love can enable clients to accept and love themselves in healthy ways. Another question that may arise is whether this healthy love can flow in both directions: do clients love their therapists in ways that are more than projections of their primitive needs and dependency wishes, that is, in ways that enhance their own (and their therapist's) growth?

I will describe my own understanding of love in the therapy process in the next chapter. Right now I would like to discuss and contrast two very important ways of understanding the role of love in therapy, a psychoanalytic way (as represented by Sigmund Freud) and a humanistic way (as represented by Carl Rogers). While an attempt to trace the concept of love throughout the history of psychotherapy would be far too ambitious a project, these two approaches have influenced many others, and viewing them together will cover at least one significant portion of the field of psychotherapy. The contributions of both these approaches are seminal, and have much to offer any psychotherapist, whether or not she considers herself belonging to either of these two schools. In addition,

they complement each other remarkably. My own view, which I hope this comparison will illustrate, is that while each approach has made a singularly important contribution, each also contains a serious flaw that the other does much to correct.

Love in Freudian Psychoanalysis

Ideas of love in psychotherapy have changed greatly as psychotherapy has developed and grown from its psychoanalytic roots. Freud had some definite ideas about love, and while I find them unsatisfactory for my own approach to therapy, they are still important and deserve consideration. It may hardly be an exaggeration to say that every form of psychotherapy currently practiced in this country has been influenced by Freud to some extent, including those therapies that have consciously reacted against him. Many of Freud's ideas endure, and I believe that no therapist, regardless of orientation, can afford to ignore them.

For Freud, love is an emotional investment that one person makes in another. (The technical term for this emotional investment is cathexis.) One makes this investment by directing a certain amount of energy toward the image one has of the person who is loved. This image, or "mental representative," of the loved person consists of all the thoughts, feelings, and fantasies one directs toward that person. The energy

that one directs toward this image comes ultimately from the sexual drive, and is called libido. The person who is loved is called the object of the cathexis. Thus to say that "the mental representative of the infant's mother is cathected with a large quantity of libidinal energy" is roughly equivalent to saying that a child has a great emotional investment in its mother. (For an introductory treatment of these ideas, see Brenner, 1973. For a more advanced treatment, see Fenichel, 1945.)

The nature of the emotional investment that we call love can be either of two types, described by Freud (1914). We may love someone for taking care of us, or for reminding us of someone who did take care of us--this is called "anaclitic object choice." Or we may love someone because we find that person similar to ourselves--this is called "narcissistic object choice." ("Anaclitic" comes from the Greek ἀνακλίνειν, meaning "to recline." The idea is that in this type of love the sexual drive "reclines upon" or is supported by the drive for self-preservation.) The terminology may seem complicated, but basically it reflects the human tendency to become drawn to people who fulfill our needs or with whom we share similar characteristics.

Freud does not seem to consider other possibilities. He puts it this way:

> A person may love:
> (1) According to the narcissistic type:
> (a) What he is himself (actually himself).
> (b) What he once was.
> (c) What he would like to be.
> (d) Someone who was once part of himself.
> (2) According to the anaclitic type:
> (a) The woman who tends.
> (b) The man who protects.
> (Freud, 1914/1963, p. 71)

When Freud considers love in the context of therapy, he has in mind mainly the emotional attachment that the patient forms toward the analyst. The analyst tries to maintain an attitude of emotional "abstinence" toward the patient, becoming a neutral "mirror" reflecting only what the patient produces (Freud, 1912b). There are two important reasons for this. First, such an attitude protects the analyst from inappropriate emotional involvement with the patient. Second, by revealing nothing of his own personal reactions, the analyst becomes a "blank slate" upon which the patient may freely project wishes and fantasies, making them accessible to the analytic process. The patient comes to experience the analyst as a powerful caretaking figure, often a parental surrogate. The result is an emotionally charged, though one-sided, relationship between patient and analyst known as the <u>transference</u>.

It is important to look carefully at this concept of the transference, since most of what Freud has to say about love in the process of therapy falls under this heading. Greenson (1967) defines the transference as follows:

> Transference is the experiencing of feelings, drives, attitudes, fantasies, and defenses toward a person in the present which are inappropriate to that person and are a repetition, a displacement of reactions originating in regard to significant persons of early childhood. (p. 33)

Transference contains the element of projection, but it is more than that. It is actually a relationship between two people, although one that is not reality-based (Greenson, 1967, p. 151). It is a replay in the present of a relationship that actually existed in the past (or that one wishes might have existed). It is vitally important that the therapist become aware of transference reactions in the client. These reactions provide important information about how the client's past affects relationships in the present, and how the client views and meets the world. Any therapist who fails to recognize the transference risks misunderstanding the relationship with the client and undermining the therapy.

A strong part of the transference relationship is love, at least love as the client has first grown to experience and understand it. Freud himself was at

first greatly confused about his patients' expressions of love towards him, especially his women patients. In the famous "Dora" case (Freud, 1905) he first came to understand these expressions as transference reactions, and to value them as providing the very substance of what the analyst must work with. These experiences helped Freud refine his theory of love, and led him to offer much advice to practitioners on how to deal with transference reactions in their patients.

Freud's concrete suggestions grew from his most basic assumption about love, that all love is primarily sexual.

> We have to conclude that all the feelings of sympathy, friendship, trust, and so forth which we expend in life are genetically connected with sexuality and have developed out of purely sexual desires by an enfeebling of their sexual aim, however pure and non-sensual they may appear in the forms they take on to our conscious self-perception. To begin with we knew none but sexual objects; psychoanalysis shows us that those persons whom in real life we merely respect or are fond of may be sexual objects to us in our unconscious minds still. (Freud, 1912a/1963, p. 112)

Combining these observations with Freud's comments about "anaclitic" love, that we tend to fall in love with people who take care of us, we can see that the temptation for a patient to fall in love with the therapist can indeed be tremendous. For Freud, love in the therapy process itself is exclusively transference

love. The analyst (or "physician") ignores this at the risk of endangering the analysis:

> He must recognize that the patient's falling in love is induced by the analytic situation and is not to be ascribed to the charms of his person, that he has no reason whatever therefore to be proud of such a "conquest," as it would be called outside analysis. And it is always well to be reminded of this. (Freud, 1915/1963, p. 169)

This is very practical advice. Once I had a client who developed a strong infatuation with me. In her dreams, she associated me with Paul Newman. I might have reacted, for example, by feeling flattered, or guilty for leading her on. Neither reaction would have been appropriate. An obvious clue to the situation was that, as anyone who knows me can tell, I bear no resemblance to Paul Newman. Rather, I became a symbol to this client of something she needed to confront in her process of trying to straighten out her relationships with men. My task was to meet her transference with respect and compassion, helping her work through it to achieve greater self-understanding. As she did so, her attachment to me gradually began to relax.

Even if our theoretical orientation is not psychoanalytic, we need to take Freud's warnings on these matters quite seriously. As therapists, we may easily underemphasize the impact that the therapeutic situation itself can have on a client. The therapist

gives the client undivided attention, is caring and supportive, always ready to understand the client. The effect on the client can be powerful indeed. No matter one's specific approach, every therapist needs to be trained in understanding and working with the transference. This may hold especially true for music therapists, since music can often be such a powerful stimulus to regression.

Freud's basic assumptions, that all love is primarily sexual and that the patient's experience of love toward the analyst is based on an illusion, an attempt to recreate a past relationship in the present, lead him to his conclusion: the proper response of the analyst toward the patient's expressions of love is indifference (Freud, 1915/1963, p. 173). There are a number of reasons for this. First, if the analyst allows himself an emotional response he may lose his objectivity, and in the worst possible case he may lose control of his own feelings for the patient, compromising the integrity of the therapeutic relationship. Second, the frustration of the patient's transference wishes is a driving force for change and a major incentive for the patient to engage in analytic work. Gratifying these wishes removes this incentive and will ruin the analysis. Freud is very clear on this point:

> It is therefore just as disastrous for the analysis if the patient's craving for love prevails as if it is suppressed. The way the analyst must take is neither of these; it is one for which there is no prototype in real life. He must guard against ignoring the transference-love, scaring it away or making the patient disgusted with it; and just as resolutely must he withhold any response to it. He must face the transference love boldly but treat it like something unreal, as a condition which must be gone through during the treatment and traced back to its unconscious origins, so that it shall assist in bringing to light all that is most hidden in the development of the patient's erotic life, and help her to learn to control it. (Freud, 1915/1963, p. 173)

Freud's considerations of transference love, the love the patient feels for the analyst, lead to conclusions about the feelings the analyst may have for the patient. These feelings are generally described under the heading of countertransference. Freud first introduced the term to describe the analyst's reactions to the patient that arise "as a result of the patient's influence on his unconscious feelings" (Freud, 1910/1963, p. 80). Freud emphasized the importance of the analyst's own self-analysis in identifying the countertransference and keeping it in check. Like transference, it cannot be ignored, and like transference, it must not be indulged.

Freud's observations and assumptions lead inevitably to the conclusion that expressions of love by the analyst towards the patient are inconsistent

with the goals of therapy. This is in fact his recommendation to practitioners:

> And yet the analyst is absolutely debarred from giving way. However highly he may prize love, he must prize even more highly the opportunity to help his patient over a decisive moment in her life. (Freud, 1915/1963, p. 178)

It would seem that Freud sees no place for love in the therapeutic process, except as a displaced reaction of the patient that itself provides material for analysis. Freud's theoretical position follows from his view of the nature of love, which he sees as highly self-serving. If all love is essentially erotic, if the impulse to love is driven by the perception of our own image or the image of a caretaker in the one we love, then love is the most extreme form of self-interest. It is thus no surprise that Freud sharply criticizes and dismisses the kind of nonerotic, compassionate love exemplified in the biblical injunction to "love thy neighbor as thyself." After a lengthy discussion intended to demonstrate the foolishness of this kind of love, Freud concludes that "nothing else runs so strongly counter to the original nature of man" (Freud, 1930/1961, p. 59).

While Freud himself was often not as cold and remote toward his patients as his theories might suggest, many of his followers practice an attitude of emotional distance toward their patients. Other

approaches, especially the "humanistic" school, have reacted strongly against this.

Love in Rogerian Psychotherapy

For Freud all love is basically an erotic attachment, expressed either directly or symbolically. Therefore all expressions of love in the clinical situation must fall under the headings of transference and countertransference, since there can be no appropriate and "real" love relationship between analyst and patient. Carl Rogers takes a sharply contrasting view. Love is not only possible in the therapeutic situation, it is necessary in order for healing and growth to occur.

In therapy that is "client centered" (or "person centered," as Rogers called it later) clients learn to accept themselves largely by experiencing the love and acceptance of the therapist.

> One hypothesis is that the client moves from the experiencing of himself as an unworthy, unacceptable, and unlovable person to the realization that he is accepted, respected, and loved, in this limited relationship with the therapist. "Loved" has here perhaps its deepest and most general meaning--that of being deeply understood and deeply accepted. (Rogers, 1951, p. 159)

This love is nonerotic, "nonpossessive" love; it is a type of love not discussed in classical psychoanalytic theory. This love is like fertile soil that makes growth possible. This viewpoint becomes

clear in the way Rogers sums up the essence of his "person-centered approach":

> Individuals have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behavior; these resources can be tapped if a definable climate of facilitative psychological attitudes can be provided. (Rogers, 1980, p. 115)

Rogers is very specific about what these "facilitative attitudes" include. He has outlined three essential qualities of a client-centered therapist:

1. Congruence.
2. Unconditional positive regard.
3. Empathic understanding.

"Congruence" means that there is a match between what the therapist inwardly experiences and what he or she presents to the client. The therapist is "authentic," "genuine," not putting up pretenses. There is an essential honesty in the relationship.

> The more the therapist is himself or herself in the relationship, putting up no professional front or personal façade, the greater is the likelihood that the client will change and grow in a constructive manner. This means that the therapist is openly being the feelings and attitudes that are flowing within at the moment. The term "transparent" catches the flavor of this condition: the therapist makes himself or herself transparent to the client; the client can see right through what the therapist <u>is</u> in the relationship; the client experiences no holding back on the part of the therapist. (Rogers, 1980, p. 115)

While congruence has to do with communicating what the therapist experiences, "unconditional positive regard" has to do with the content of that experience. Ideally, the therapist will experience a warmth and acceptance toward the client, which promotes the client's own self-acceptance:

> When the therapist is experiencing a warm, positive and acceptant attitude toward what <u>is</u> in the client, this facilitates change. It involves the therapist's genuine willingness for the client to be whatever feeling is going on in him at that moment,--fear, confusion, pain, pride, anger, hatred, love, courage, or awe. It means that the therapist cares for the client, in a nonpossessive way. It means that he prizes the client in a total rather than a conditional way. . . . It means an outgoing positive feeling without reservations, without evaluations. (Rogers, 1961, p. 62)

Feeling positively toward the client is essential, but this affective response must be supported by understanding. In the presence of the therapist's empathic understanding, clients best learn to understand and accept themselves.

> [Empathic understanding] means that the therapist senses accurately the feelings and personal meanings that the client is experiencing and communicates this understanding to the client. When functioning best, the therapist is so much inside the private world of the other that he or she can clarify not only the meanings of which the client is aware but even those just below the level of awareness. (Rogers, 1980, p. 116)

Rogers (1951, pp. 32, 34) speaks of adopting the client's internal "frame of reference," of learning to

perceive the world the way the client perceives it, to see "through the client's eyes."

> The counselor says in effect, "To be of assistance to you I will put aside myself--the self of ordinary interaction--and enter into your world of perception as completely as I am able. I will become, in a sense, another self for you--an alter ego of your own attitudes and feelings--a safe opportunity for you to discern yourself more clearly, to experience yourself more truly and deeply, to choose more significantly." (Rogers, 1951, p. 35)

The therapeutic attitudes of which Rogers speaks constitute his understanding of what love means in the psychotherapeutic relationship. Rogers leaves no doubt that love is an important ingredient of successful therapy: "I feel enriched when I can truly prize or care for or love another person and when I can let that feeling flow out to that person" (Rogers, 1980, p. 20). As an illustration Rogers cites an experience in an encounter group. A seriously depressed woman with a troubled marriage came to the group and experienced a transformation, due largely to the therapist's expression of love. Rogers quotes her in some detail:

> The real turning point for me was a simple gesture on your part of putting your arm around my shoulder, one afternoon when I'd made some crack about you not really being a member of the group--that no one could cry on <u>your</u> shoulder. In my notes I had written, the night before, "My God, there's no man in the world who loves me." You seemed so genuinely concerned the day I fell apart, I was overwhelmed. . . . I received the gesture as one of the first feelings of acceptance--of me, just the dumb way I am, prickles and all--that I had ever experienced. I

> have felt needed, loving, competent, furious, frantic, anything and everything but just plain loved. You can imagine the flood of gratitude, humility, almost release, that swept over me. I wrote, with considerable joy, "I actually felt love." I doubt that I shall soon forget it. (Rogers, 1980, pp. 20-21 [also reported in Rogers, 1970, pp. 33-34])

The question naturally arises: If a genuine loving relationship is not only admissible but necessary in the process of therapy, then what about transference and countertransference? Are they still relevant concepts? Rogers answers with a qualified "Yes," but the qualification is huge indeed. While he does recognize that transference cannot be ignored, his inclination is to minimize its importance (Rogers, 1961, p. 81). Rogers' basic position is that while transference "attitudes" may arise in any type of therapy, in client-centered therapy transference-based relationships generally do not develop (Rogers, 1951, pp. 200-201). Rogers expresses optimism that even "transference attitudes," projections of inappropriate affect onto the therapist, can be resolved fairly quickly in client-centered therapy. This is because the client-centered therapist, whose own attitude is nonjudgmental understanding and acceptance, gives the client nothing on which to base a projection. The client must therefore come to own the emotional reaction as arising from within (Rogers, 1951, pp. 203,

205). Because the therapist accepts the client fully and never puts the client on the defensive, the client becomes able to recognize the projection and take responsibility for it. Then transference attitudes "simply disappear" (Rogers, 1951, p. 210).

Critique

To have written a comprehensive history of love in psychotherapy would clearly have been far too ambitious an endeavor. I have chosen Freud and Rogers because they represent two almost diametric points of view, yet each has made a vital contribution to the practice of psychotherapy and, ultimately, to many forms of music therapy as well. Freud is a central influence in the work of music therapists such as Mary Priestley, Juliette Alvin, and Evelyn Heimlich, while Rogers is similarly influential in the work of Edith Boxill, Clive Robbins, and many others. And each has greatly influenced me in my work both as a psychotherapist and music therapist.

Earlier I mentioned that each of these perspectives seems to correct a shortcoming in the other. I prefer to view these two approaches in a nondogmatic way, as complementary, rather than as irreconcilably opposed. In its "pure" form, either of these approaches may suffer from a lack of balance. Rogers (1951) rightly points out that classical

psychoanalysis may foster excessive dependence on the therapist, partly because of the aloof, authoritarian manner of the "pure" psychoanalytic practitioner. It may also be also true that the analytic attitude of abstinence and neutrality (above, p. 8), when taken literally, produces an emotional distance that can make any kind of trust other than unquestioning dependence difficult if not impossible to achieve. Greenson (1967, pp. 219-220) cites the example of an analyst who was treating a young mother whose infant son suffered a sudden serious illness. The analyst greeted her tearful story with silence. The following week the patient announced she was quitting therapy. When the analyst asked why, she replied that he was sicker than she was.

Most psychotherapists since Freud, particularly those influenced by humanism, view the relationship between client and therapist as a vital part of the therapy itself. Even Greenson speaks of the "real" relationship between an analyst and patient, advising that the patient's realistic perceptions of the analyst be respectfully acknowledged. Rogers' humanistic approach would therefore seem to be the perfect corrective to the awkwardness and artificiality of the classical analytic situation.

Rogers' approach, however, has problems of its own. As Rogers has formulated it, the quality of "unconditional positive regard" may be an unattainable ideal, and perhaps not desirable even if it could be attained. Rogers (1961, p. 47) calls unconditional positive regard a "positive affective attitude." It is not realistic to expect that a therapist will always experience positive affect towards the client. Even Rogers would ostensibly not hold such an expectation, since he does speak about therapists needing to accept their own negative feelings. However, Rogers does repeatedly emphasize "unconditional" positive regard as a necessary condition for growth, and the word "unconditional" does not easily admit to exceptions. What is missing in Rogers is a full discussion of how a therapist's negative reaction toward a client can sometimes actually serve a therapeutic purpose. A further complication is that "unconditional" acceptance of whatever the client feels, says, or does might imply that one can conduct therapy without a set of values of one's own. A full analysis of this question is beyond the scope of this thesis, but it is an important issue in psychotherapy theory, and in my view, a genuine difficulty for Rogers.

Rogers' formulation originates in a valid concern, the need to make the client feel accepted and

understood. However, "unconditional positive regard" puts the emphasis on the wrong place: on the feelings of the therapist. An alternative is to emphasize not the therapist's feelings but the therapist's awareness, both of self and of the client. While positive feelings cannot always be realistically or honestly maintained, a therapist can always try to remain aware of the client's unique world. The following chapter will explore this alternative more fully.

There is indeed a delicate balance. The emotional distance of the psychoanalyst can seem cold and unloving. The analyst maintains this distance partly out of respect for the interpersonal dynamics of the analytic encounter. The question arises as to how a more humanistically oriented therapist can allow the experience of caring and love toward the client to enter the therapeutic process while still maintaining a full respect for these dynamics. My own view is that Rogers' emphasis on the therapist's feelings, rather than on the therapist's awareness, leads him into error in this regard.

It will be helpful to consider a specific example. Rogers (1965) conducted a psychotherapeutic session on film, as part of a series of filmed sessions of famous psychotherapists. It is always refreshing to see a film of an actual session, as opposed to reading a

therapist's written account. When one can see the session itself, one is free to draw one's own conclusions, rather than having to accept the written account at face value. A psychotherapeutic encounter between two human beings is full of nuances, and one cannot usually say with dogmatic authority what is right and what is wrong. Nevertheless, an analysis of this session from an existentialist point of view might call into question some aspects of Rogers' technique.

The client is Gloria, a young woman, recently divorced, with a nine-year-old daughter. Her daughter presented her with a dilemma by asking, "Did you ever make love to a man since Daddy left?" Gloria lied and said no. Now she feels guilty for having lied to her daughter. She wants to be honest, to follow her "true feelings." What should she do?

Rogers' demeanor throughout the session is kindly and paternal. He pointedly refrains from giving her advice or telling her what to do, but other than that, he is very supportive. When she says "I feel like you are backing me up--telling me, 'You know what you want to do--Go do it!'" he says "You've been telling me you know what you want to do--and I believe in backing up people in what they want to do." At one point she tells him, "I'd like you for my father." He responds: "You look to me like a pretty nice daughter."

Rogers refers to this moment in his comments after the session. With a tint of anger in his voice, he says that to talk of it in terms of transference would only be "playing with the real world of relationships," from a "highly intellectualized framework" that misses the "immediate encounter" of the experience. If the therapist supports and "prizes" the client, she will be motivated to prize herself more and explore herself more deeply.

Analysis. An existentially oriented therapist might say that Rogers, in being unconditionally supportive, has failed to help the client recognize and confront her "mode of being in the world." Gloria is quite seductive, and in a way quite manipulative. She is facing an "existential crisis": her life seems to be heading in a direction of which she does not quite approve. She approaches the therapist with flattery and almost flirtatious requests for reassurance. While the therapist does not actually tell her what to do, he does give her the approval that she craves, which helps her evade facing her own moral dilemma and her disapproval of herself.

Gloria's conflict over what to tell her daughter is not the real problem; it is a symptom. Gloria feels guilty and ashamed at what she has told her daughter because she does not approve of her own conduct. We

are missing many important details that the therapist might have considered: Since her divorce, what have Gloria's relationships with men meant to her? Was there love in these relationships? (It would seem not.) Were the men married? How does Gloria feel about them in retrospect? The meaning these experiences had for Gloria was never investigated. A hypothesis arises that needs to be explored: perhaps Gloria is struggling with a clash between her deepest values and loveless sex. The therapist cannot resolve this clash, but if it is there and she is in fact trying to evade it, he can help her recognize it. This may mean withholding immediate gratification of the client's desire for affection, refraining from either approval or disapproval, while still remaining with her as a nonjudgmental presence and companion on her journey.

Gloria is seeking a type of support that will silence her own inquietude. She wants to hear the words, "You know what you want to do--Go do it!" She wants the approval of an external authority, so that she need not face the meaning of her own self-disapproval. Rogers does gratify this wish, becoming an approving father.

It seems that Rogers dismisses the concept of transference a little too quickly. It is likely that

Gloria's attempts to manipulate him are not totally conscious, and that they do contain an element of transference. Rogers' own response is an example of what Mary Priestley (1994) calls "c-counter-transference." The client pushes him into a certain role, and he accepts that role.

These observations may draw some support from Gloria's own feedback. After having had sessions with two other therapists, she concluded that the one who helped her the most was the one who most prodded her to confront herself, perhaps reflecting her own realization that she needed such a push.[1]

Confronting the client in this way does not preclude the presence of warmth and caring in the relationship. Strong support of the client may be present, but it is not the type of support implied by "unconditional positive regard." It is support for the inward struggle the client needs to face, even if it means having to introduce the client to the pain it necessarily involves.

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[1]Was this realization temporary? Defending their approach, Raskin and Rogers (1995) report that Gloria subsequently changed her mind. However, their own analysis provides compelling evidence that Gloria's reaction to Rogers was indeed strongly influenced by transference.

Conclusion

Spending this much time on psychological theories and case analysis may perhaps seem excessive in a music therapy thesis. I have chosen to do so because I believe these considerations are important for music therapy. The two theorists I have chosen make indispensable contributions to the process of both psychotherapy and music therapy. Rogers tells us to consider the importance of love as a healing factor in the therapeutic relationship, while Freud cautions us never to lose sight of the unconscious dynamics. Each does so with a degree of depth and detail not yet available in the music therapy literature alone.

I have provided a lengthy analysis of the session with Gloria because I believe that whether or not the reader agrees with my critique, it is important for music therapists to work with psychological issues. All the dynamics of the psychotherapeutic encounter may be present in a music therapy session, and the music therapist/clinician needs to recognize and consider them.

I also wanted to show how an existentialist analysis might pinpoint some weaknesses in a humanistic approach, even though that approach supplies an important corrective to the emotional dryness of classical psychoanalytic therapy. Rogers' theories

themselves contain the seeds of an existentialist approach, particularly his discussions of how a therapist needs to enter the client's "frame of reference" or "world of perception." Existentialist psychotherapy theory takes these ideas and develops them in a little more detail.

CHAPTER 2

LOVE: AN EXISTENTIALIST PERSPECTIVE

Freud and Rogers were both very important to me in my own development as a psychotherapist. I could not easily do without either one of them; nevertheless, I do not call myself either a psychoanalyst or a humanist. My theoretical point of view is "existentialist." Since no one definition of this term is universally accepted, it is important to clarify its meaning.

The Meaning of Existentialism

"Existentialism" is a term borrowed from philosophy. Unfortunately, philosophical discussions of existentialism are usually far from clear, and the term has even been applied to positions that are almost contradictory. There does, however, appear to be a common concern among points of view that call themselves existentialist. This is the idea that the starting point of philosophical speculation or psychological theorizing must be human existence itself, rather than some theory or theology that we might wish to impose on that existence. We may have an idea of how the world "should" be, how people ought to

react in certain situations, or how God presumably governs the world. If, however, these ideas run counter to the evidence of our experience, an existentialist would find them of little value. (This does not mean existentialists must be godless. I would, in fact, describe myself as a "theistic existentialist," but a full exposition of this viewpoint is beyond the scope of this thesis.)

Perhaps an example will help clarify the existentialist approach to human experience. The major turning point in my life, the event that set in motion the changes that brought me to music therapy, was the sudden, violent death of my first wife after four years of a happy marriage. My first wife was also my sister's best friend. Eventually, my sister entered group therapy for help in sorting out and resolving her grief and her pain. The therapist kept trying to do "therapy" on this experience: she kept asking my sister about her past, trying to get her to relate her present pain to ways she had reacted to similar situations in the past. But there were no similar situations in my sister's past. This was a unique tragedy, a horrifying trauma for which she was totally unprepared and to which she didn't know how to respond. It was not a psychological conflict.

Not every human crisis is a conflict to be resolved or an illness to be treated with medicine or with psychology based on a medical model. While traditional psychotherapy has its place, it can seem impotent when confronted by certain troubling aspects of life, things that are inevitable and not the result of emotional conflict. The core of existentialism is graphically represented by the story of the Buddha. It is said that the Buddha began his spiritual search when he left the shelter of his princely palace and for the first time saw an old man, a sick man, and a dead man. After that experience he could not remain complacent in his place of privilege. He devoted his life to the search for a way to ease this suffering, or at least for a noble way of confronting it. Old age, death, and even much sickness cannot be "cured." They belong to human existence and cannot be removed. What the Buddha sought could therefore be found neither in medicine nor in psychotherapy.

An existential approach to therapy seeks to address problems whose source does not necessarily lie in internal conflict, or in "disturbances" of healthy patterns of living. The anxiety aroused by the contemplation of death, or the trauma and difficulty of adjusting to a physical illness or disability, are not "symptoms"; they are normal reactions to life's

inevitabilities. It would be misleading to view them as deviations from some idealized normality and therefore as conditions to be "treated." A particular illness can be treated, but the fact of illness itself, with its consequent pain and anxiety, cannot be eliminated. To an existentialist, it is not necessarily some pathological process but life itself that creates the need for healing.

Traditional psychotherapy therefore has one basic limitation: based on a model of diagnosis, treatment, and modifying symptoms, there is little it can do when faced with the pain that arises from life itself and not from any particular disease. There is an "existential barrier," a line defining a painful part of existence that psychotherapy cannot cross because life itself is not a disease or a deviation from "something else" that we call normal. Life itself is limitation. Freud was the first to recognize this, and his hopes for psychoanalytic treatment were not too ambitious:

> When I have promised my patients help or improvement by means of a cathartic treatment I have often been faced by this objection: "Why, you tell me yourself that my illness is probably connected with my circumstances and the events of my life. You cannot alter these in any way. How do you propose to help me, then?" And I have been able to make this reply: "No doubt fate would find it easier than I do to relieve you of your illness. But you will be able to convince yourself that much will be gained if we succeed in

> transforming your hysterical misery into common unhappiness." (Breuer & Freud, 1895/1974, pp. 392-393)

Traditional psychotherapy has one other basic limitation: it relies on words. We sometimes call it the "talking cure": by its very nature, it cannot exist without words. The ideal client for psychotherapy is intelligent and verbal, and preferably also young and affluent. So many people in need of healing have none of those qualities. How does one treat a demented patient, who can only scream at or kick the therapist, with verbal psychotherapy? How does one treat a patient in a coma, or one who is dying and cannot speak? These are all conditions out of reach of psychotherapy, but that still call desperately for compassionate intervention by a caring and skilled human presence. These situations belong inseparably to our existence as human beings, and so an existentialist approach to therapy leads naturally to the urge to break through the limitations of traditional psychotherapy based on words alone. Existentialism, therefore, leads almost inevitably to music therapy--but that will be the concern of the next chapter.

Existentialism is not really a philosophy but an attitude, a point of view. "Existential" means beginning where we actually "exist," in the suffering, pain, and despair, as well as in the joy and the hope,

that we experience right now. It means standing on the same ground on which the client stands, not on a remote mountaintop hoping somehow to pull the client up to that same lofty height. It is this "existential attitude" that unites the various philosophies, very different and often contradictory, that have come to be called "existentialism."

Existentialism is an attitude, but it requires a methodology. It was mentioned earlier that existentialism begins with the raw material of our experience, not with theories or philosophies we might wish to impose on our experience. Therefore existentialism is closely allied with another branch of thought, phenomenology. Like existentialism phenomenology is usually included under philosophy, but is not really a philosophy. Phenomenology is a method, a way of understanding the world, that tries to put the existentialist attitude into practice: meeting our experience the way it comes to us, without trying to impose upon it any predetermined categories of meaning.

This is not the place to trace the development of phenomenology since Brentano and Husserl. I would just like to discuss briefly its relevance to therapy. In essence, phenomenology presents an alternative to what Husserl called the "natural attitude," the view that the world we observe is independent of the

consciousness of the observer. This view works (at least most of the time) for the natural scientist, who assumes it when investigating natural or physical phenomena. In psychology, however, it creates problems and distortions, since in the realm of human interaction we deal not with one "objective" reality "out there," but with many diverse, individual personal "realities," or rather, modes of perception.

An example may help to clarify this point. A botanist can investigate a tree and discover much useful information, without worrying too much about her own reactions, feelings, or perceptions regarding the tree. But all this material relating to "subjective" experience, which the scientist wishes to discard, is precisely what psychology deals with. To a phenomenologist, there is no such thing as a "tree" out there in the world, separate from the consciousness of the perceiver. When you and I look at a tree, we may perceive two entirely different objects. You may see and experience it as an object of beauty; I may want to chop it down for firewood. The two perceptual objects, which we each call "tree," are entirely different. One might say that what we see is determined largely by our intentions toward it. Thus existentialists use the term <u>intentionality</u> to describe how our own needs,

desires, and experiences color our perceptions of the world.

In a very real sense, then, each of us inhabits a different perceptual world. This presents a formidable problem for interpersonal communication. How can we understand each other if the world as each of us experiences it is not even the same world? Phenomenology provides a response to this problem, called the phenomenological reduction. Husserl conceived it as a method of studying the content of our experience in the hope of attaining some form of objective knowledge. In essence, it consists of bracketing (suspending, setting aside) every belief, bias, or preconceived notion we may have, and describing our experiences exactly as they first appear to our consciousness. The phenomenological method is essentially descriptive, abstaining from reaction, judgment, or abstract theorizing. It is an attempt to recognize and overcome the limitations and distortions of our own intentionality.

This method and the attitude it represents have important implications for psychotherapy. I begin with the assumption that the world in which my client lives is not the world I inhabit and that is familiar to me. Clients have their own perceptual worlds, which the therapist must learn how to enter. By appreciating

that my client does not perceive the world the same way I do, I show respect for the individuality of the client and the world in which he or she lives. Adopting the phenomenological attitude, I try to "bracket" my own preconceptions, my predisposition to judge, the assumptions I make in my own perceptual world. This is extremely difficult, and requires ongoing self-examination and self-questioning by the therapist. The therapist is willing to pay this price for the privilege of understanding the client.

An Existentialist View of Love

The idea that we each live in a different perceptual world has far-reaching implications. It can explain much of human conflict, from petty arguments even to war. Even well-meaning people can clash violently, because the worlds they see, and hence the assumptions they make about themselves and others, are different. It is hard to separate our perceptions of "what is" from our feelings about "what should be." If someone else, inhabiting a different perceptual world, has very different needs, or does things differently, it can seem like an intentional violation of the norms that keep our own world orderly. This is clearly evident in cross-cultural conflict. As anyone who has done business with people from other countries knows,

an expression or gesture that is expected in one setting can seem offensive in another.

This is just as true, though perhaps less evident, among people of similar background. Without realizing it, we often violate the norms and expectations of others, while at the same time we project our own expectations onto them. We have seen in the example of the tree how need can determine perception. The world we perceive is based upon our needs and experiences, which are directly available to us while the experiences of others are not. Needs often conflict, and it is not surprising that different perceptual worlds often collide.

This existential separation, the fact that I cannot perceive your experiences nearly as well as I do my own, and that consequently we see the same world in totally different ways, is the greatest obstacle to love. Paradoxically, it is also what makes love possible. Love is so difficult because the separations between people are so deep. But the essence of love is the bridging of separation: if we felt completely identified with others, if there were no differences to bridge, then love would not bring us out of ourselves and beyond ourselves; it would not contribute to our growth. It would hardly be love at all; it would simply be the rediscovery of ourselves everywhere we

looked. Love wants to reach out to that which is different, which is not the self and is not like oneself. Freud's "narcissistic" love, though it describes a truth about human nature, is a limited and superficial idea of what love is, what it brings and how it transforms. This is not a new observation; while Freud provides a critique of the Bible, the Bible can also be read as a critique of Freud: "For if you love those who love you, what reward do you have? . . . And if you greet only your brothers and sisters, what more are you doing than others?" (Matthew 5:46,47).

The separation of ourselves into separate bodies, selves, and worlds is the root of misunderstanding and conflict. Love bridges this separation. How? It is helpful to begin with a definition of love that expresses this quality. I have found the following definition increasingly helpful, both in the work I do and for life in general:

Love is the awareness of another's individuality.

This definition rests on two basic ideas: "individuality" and "awareness."

Awareness is an elusive quality. The differences between one's own perceptual world and that of another are largely unconscious. This is true in two senses. Some of these differences are "unconscious" in the Freudian sense, because they are repressed. The ego's

defense mechanisms, which Anna Freud (1966) described so well, play a major role in keeping our worlds separate. The most important of these is projection. We may project onto others things we do not like about ourselves, to avoid seeing them in ourselves and taking responsibility for them. We may project our needs onto others, believing it is the other person's responsibility to fulfill them. We may project onto others our whole perceptual world, believing they do or should perceive things as we do, and resenting them when they do not act according to our perceptions. The mechanism of projection is usually unconscious: we have an interest in keeping it unconscious so that we may continue to believe the responsibility for our conflicts lies outside ourselves.

In situations like this, awareness takes the form of self-examination. On our own or with the help of a therapist, we can become aware of what we project and begin to take responsibility for it. We may become surprised to discover how constant and continuous the habit of projection can be. As we become more aware of our projections, we become able to see others more clearly, which increases our capacity for love.

We may be unaware of differences between our own perceptual world and that of another not only because we have repressed them, but because we have never dealt

with them to begin with. Since we do not have direct access to others' experience, certain differences never come to our attention unless we consciously choose to attend to them. We may not have tried to shut them out of our awareness; we have simply not encountered them before. In this situation awareness takes the form of observation, of becoming interested in others, in learning about them and understanding them. As we become more motivated to understand others as different from ourselves, our capacity for love also increases.

Observation begins with self-observation. To help them become more aware of the differences between their own perceptual worlds and those of others, I have found it useful to introduce interested clients to a particular form of meditation. This meditation is based upon the "insight" meditation traditions of the East, and its essence is detached observation. The client who undertakes the practice of this meditation, who adopts what may be called a "meditative attitude," learns to insert a pause in the crucial space between thought and reaction. Learning to observe one's thoughts and feelings greatly increases self-awareness, and also gives one freedom: the freedom to choose how to respond to situations, rather than react automatically often without understanding what drives one to react. This is putting the phenomenological

reduction into practice: "bracketing" or setting aside one's own preconceptions and interpretations of one's experiences to become more open to other ways of seeing.

This leads to another important aspect of the "meditative attitude": the consistent willingness to practice self-questioning and self-confrontation. This is another application of "bracketing": using one's capacity for self-observation to question one's own perspective, prejudices, and opinions. It is the use of observation rather than brute force to counter the natural human tendency to hold fast to one's own point of view without reflection. This tendency is a cause of tremendous suffering both to self and others. It is also a formidable obstacle to love. Love is not possible when one's own particular world view, one's intentionality, so strongly influences one's perceptions and reactions that it becomes impossible to see others clearly. The power of meditative observation to soften this tendency shows more clearly the connection between awareness and love.

At first glance this emphasis on meditation and detached observation may seem contrary to most forms of modern psychotherapy, which stress the importance of emotions, "getting in touch with one's feelings," and becoming less inhibited in self-expression and

emotional reaction. This may in fact be an important difference between the present approach and many others, and so it is worth trying to clarify its meaning.

The "meditative attitude" does insert a crucial pause between thought and emotional reaction. The idea is not to analyze one's reactions intellectually, but to become aware of them. According to this perspective, we become cut off not from our emotions themselves, but from our awareness of them. Far more often than we may realize, our feelings determine how we react, but usually not consciously. How often, for example, do we react strongly to a provocative situation, only to regret it later and to feel we did not know what we were doing or "were not ourselves"? Recently newspapers reported that some therapists want to include "Road Rage" in the next edition of the Diagnostic and Statistical Manual of Mental Disorders. This urge to invent a new disease may mask the more general implications of the problem: that most of us already do tend to react on our emotions, perhaps far too easily, and that meditation may be of more help than psychiatry in alleviating the harmful and even disastrous effects of this tendency.

One implication of Freud's theory that makes people most uncomfortable is his "psychic determinism"

(Brenner, 1973), the view that our behavior is not normally a product of our free will, as we might wish to think, but determined by unconscious mental processes. Even trained psychoanalysts may become upset with this idea, because it is so contrary to the way we like to think about ourselves. I remember creating an uproar in one of my psychotherapy training classes when I suggested that it followed logically from everything we had been studying that most of our actions are not really free.

My own views are not as absolutist as Freud's. I believe we do possess the capacity to make free choices and decisions; however, I also believe that Freud's view bears more than a grain of truth and that the freedom we possess is often severely compromised. The more our thoughts and feelings remain below the level of our awareness, the less freedom we have in choosing responses and behaviors that express our highest values rather than the reaction of the moment. From an existentialist point of view, it is the task of psychotherapy to restore to the individual the freedom that he or she may have lost in becoming captive to emotional reactions. The key to this restoration is awareness: not becoming intellectually removed from one's feelings, but seeing and owning them, so that new choices become possible.

The other basic idea in the definition of love is "individuality." In religious terms, individuality is called the "image of God" (Genesis 1:27) or "soul" (Psalm 103), the unique reflection of the divine within each of us. In psychological terms, it is called the "true self" (Winnicott, 1960b). In music therapy, it is called the "music child" (Nordoff and Robbins, 1977; Robbins and Robbins, 1991). The idea of the unique, authentic individual, with great incentive and potential for growth, is central in humanistic psychology. It is one important aspect of what I mean by "individuality." What I would like to describe by the word "individuality," however, is not really a psychological concept and cannot be defined precisely. As the word itself implies, it is the core of the person that makes him or her absolutely unique, which one can recognize and appreciate but never fully comprehend, when one approaches another in a spirit of love. Above all, it is the person's capacity to express goodness in uniquely distinctive and often creative ways. It is a person's desire for life, for healing, for reclaiming and integrating fragmented parts of oneself. "Individuality" has also a loving quality, wanting to embrace the world and others.

A basic assumption of my own psychology is that while one's individuality may be masked, it is always

present. People may hide their individuality, sometimes quite aggressively, but it is still accessible to a compassionate awareness willing to see beyond the surface. Awareness leads to love because it includes awareness of the projections and defenses, the pretenses that mask our individuality, from ourselves as well as from others. Compassionate awareness invests the energy and the time to know someone until that person's individuality becomes visible. The result may be as much a revelation to the one who is known as to the one who wishes to know. As Paul says at the end of his famous tribute to love: "Now I know only in part; then I will know fully, even as I have been fully known" (1 Corinthians 13:12).

Awareness of another's individuality <u>in its deepest sense</u> naturally engenders love. This is not the erotic love of which Freud speaks, nor even necessarily the love of which Rogers speaks, based on constant positive feeling. This love is based on nonintrusive, compassionate awareness rather than feeling, although it may be frequently accompanied by deep feeling. It is the kind of love the Greeks called ἀγάπη, and which may also be called <u>non-self-interested love</u> (Gourgey, 1990, 1994b).

Trying to bridge the existential gap, to become aware of the client's world as different from my own, is therefore an act of respect and love towards the client. The next task is to try to become sufficiently aware of the client's world that I become able to join him or her within it. I become a bridge, hopefully a healing bridge, between the client's world and the world of others. I believe that in its deepest sense, maintaining a respect for the client's separateness while joining the client in his or her world is an act of love, and to the extent that I am able to achieve this, I find myself building the type of good will toward the client that we naturally associate with love. In this sense therapists might not only be permitted to love their clients, they should be encouraged to do so.

This type of love, "non-self-interested" love, may require some clarification. "Non-self-interested" does not mean self-negating or self-denying. "Non-self-interested love" is not anti-self. It is love that, unlike the types of love Freud described, brings one beyond the limits of self ("For if you love those who love you, what reward do you have?"). Stated abstractly, it may seem unattainable, perhaps not even desirable. This is why defining love in terms of <u>awareness</u> makes it more practical, more accessible. It

is hard to know how to try to be loving, but one can always try to be more aware.

How Love Heals

A client needs the experience of being known, seen, understood, to feel capable of receiving love and of giving it as well, for this is love's essence. Hopefully the client experiences this understanding and acceptance in the therapeutic relationship. In this sense my approach has much in common with humanistic psychotherapy. Even psychoanalysis seeks to increase levels of awareness, by making conscious that which was formerly unconscious. But there is a need not to stop at this point. To be able to grasp the essence of another individual, the awareness won in psychotherapy needs to be refined. It is the difference between simply becoming aware of one's boundaries, where "I" leave off and "you" begin, and the "bracketing" of prejudices and preconceptions that the phenomenologist believes is needed to lead us to the "essence" of things.

The therapist or caregiver does much more than feel kindly toward the client. The therapist's compassionate awareness becomes a light by which the client can see his or her own individuality more clearly. By being seen through the eyes of someone who has no personal agenda, no specific intentionality

other than awareness, no wish to use the relationship to fill a personal need, one can experience what it is like to see oneself in this same appreciative light. Being truly seen helps one to see oneself; being truly heard helps one to hear oneself. One may then become aware of hidden or neglected strengths. One may become more willing to see and accept disowned parts of oneself, thoughts or feelings that may have been repressed because they seemed unacceptable. One may become more aware of one's own distorted prism, how one's own personal judgments misshape the views one has of oneself as well as of others. One may learn to love oneself in a way that is compassionate rather than narcissistic.

I have seen this demonstrated most clearly in hospice, where I worked for five years before beginning my formal study of music therapy. Having worked with many nurses and volunteers, I noticed that while many are dedicated to the work, a small few have a special quality. They do what they do very quietly, almost unobtrusively, but there is something different in the kindness they show the patients. It is not the sort of kindness motivated by a desire to feel good about oneself by giving; rather, it seems to come from a simple awareness of the patient's needs and an inward response to those needs. And patients know the

difference. They will often experience condescension when visited by those who do it for their own self-esteem, and I have seen patients refuse such visitors. When, however, I found myself in the presence of those nurses or volunteers who were free of this motivation, I would feel uplifted, inspired through their example to learn about this special quality of compassion. They have helped me to see the difference between being attached to one's patients and loving them.

I have tried to describe how being aware of the individuality of others does in fact lead to the quality we experience as love. One may nevertheless question the hidden assumption, that awareness of the essence of another person will draw a compassionate response. So often we only grow to dislike some people when we get to know them better. "Familiarity breeds contempt"--but familiarity is not awareness. Familiarity is knowledge on a superficial level, knowledge of another person through our own intentionality, our own set of likes and dislikes and idiosyncratic perceptions. We may get to know another person well enough to discover that his perceptual world clashes irrevocably with our own; the natural reaction to this is dislike. But we can attend through our own reaction of dislike, to become aware of the needs, beliefs, and perceptions of the other person

that may lead him to behave in ways that strike us as offensive. Sometimes this will result in a dramatic change in our emotional reaction toward the person, but this is not always so. Awareness does not imply either fondness or approval. It does not mean becoming naive about another person's intentions; in fact, it means seeing them more clearly. But it also means seeing that there is more to people than their conscious intentions and the way they affect us personally. Love in this sense, as has been said, does not mean constant positive feeling. The biblical injunction to "love one's enemies" does not mean to feel affectionate toward them, or even to pretend that they are not really enemies. It means look more deeply into people, past the qualities you may notice first because you feel most personally affected by them.

A person's individuality draws forth a compassionate response because it is that person's capacity to express goodness, which may be seen even if hidden beneath layers of fear, self-centered thinking, or physical or mental illness. Individuality is essentially a spiritual quality. Individuality is a person's spiritual core, the undefinable, unique aspect of another that one grasps in a moment of love. I have learned my deepest lessons about this in my work in hospice. I have often seen patients who were at first

fearful and agitated but who were able to reach a state of transcendent peacefulness just before their deaths. At first these people may have been unapproachable through their fear, but their time in hospice gave them a chance to work through many unresolved conflicts as the end of their lives drew closer. Later on, although their bodies became weaker, a peacefulness would settle over them that would make them almost radiant. It would be as if these people had shed a mask, revealing a part of their nature that was previously unseen.

> How can I possibly express what I have learned from these experiences? I believe there is a mask we all wear, the mask of the controlling, grasping intellect that tries to impose order on our experiences and will accept things only a certain way. In many people who are terminally ill, the mask begins to slip. Something else rises to the surface, a consciousness that when fully present is deeply peaceful. It is as though the individual, who once was completely a citizen of earth, begins to be aware of another home. This awareness can deeply affect one who is receptive to it and who has the opportunity to be with the dying person. To be this close to death can be a profoundly comforting experience--if one is able to see behind the mask. (Gourgey, 1995, p. 168)

Conclusion

Awareness, the central idea within the present definition of love, exists on a continuum. Even Freud, who denied the existence of non-self-interested love, was very much interested in awareness. His psychoanalytic method, whose purpose was "to make the unconscious conscious," is a way of promoting

awareness. An existentialist response to Freud might recognize this as a very good place to begin, but say that it needs to be taken farther. We are not interested only in becoming aware of repressed thoughts and feelings; we wish also to be aware of hidden talents and strengths, the capability of growth, the capacity for goodness, that exists potentially in everyone.

Humanistic psychology has tried to expand the frontiers of psychology in this direction, but in its tendency to focus on growth rather than conflict, it has occasionally neglected examining the deeper dynamics that often complicate human relationships. (We have seen one example in the previous chapter, in the discussion of the "Gloria" case.) "Awareness," however, is such a comprehensive and flexible idea that it can encompass all those aspects of the human being to which both psychoanalysis and humanism wish to call our attention.

It cannot be emphasized strongly enough that understanding love as awareness means that love is more than positive affect. The humanistic principle of "unconditional positive regard" confuses love with affect, and is not always attainable or desirable (chapter 1, p. 22). For healing to take place, it is not enough for the therapist to feel positively, kindly

or affectionate, towards the client. What the client needs most is the therapist's awareness, and once this is established, positive affect usually follows. One of the examples in the following chapter (the case of Miriam) will show quite clearly that positive affect alone is not sufficient to form a therapeutic alliance. The therapist needs to recognize and enter the client's individual world.

Awareness of one's "individuality," one's unique capacity to express goodness, takes us from the psychoanalytic awareness of inner conflict almost to what religion would call the "soul." To continue the discussion from this point would take us into issues of spirituality. While I believe these issues have important implications for music therapy, I will not touch upon them here in any detail.

There is much that I might have said about existentialism, spirituality, and love, but I have chosen instead to try to show the general applicability of this way of understanding love, whether or not one prefers a spiritual orientation. It is time now finally to turn to music, to consider the unique role music can play in extending the availability of this love to those for whom it might otherwise remain inaccessible.

CHAPTER 3

LOVE AND MUSIC THERAPY

When I worked as a volunteer music therapist at Beth Israel Hospital, I visited a woman rendered completely aphasic by stroke. Her children, a son and a daughter, came dutifully every day to visit her. They would tentatively approach her bed, as if trying to get close but stopping at an invisible wall. Their words were endearments, but they were uttered roughly, as if trying to force a response the old woman was incapable of producing. Her children needed her to speak, and when she wouldn't, they raised their voices. The old woman protected herself from the harsh sounds by slumping back into her bed, pulling her blanket up around her.

I began to play my recorder, and it was as if she finally heard a voice she understood. She sat up in bed, opened her eyes wide, broke into a smile, and began to hum to the music. She swayed back and forth in perfect time, then waved her hand to conduct me as I played.

This was music crossing the "existential barrier," the line defining the inevitable and painful part of

existence that is inaccessible to words. How could I have approached the situation as a trained psychotherapist, using the "talking cure"? The woman could neither understand words nor produce them. And words alone had no power to bring the mother back to her children. Psychoanalysis, psychotherapy, even family therapy, seem to hold little promise in such circumstances. But music seems to have a power, quite mysterious, to visit places words cannot go.

Sometimes I wish I could explain the source of this power; sometimes I'm glad it remains a mystery. I believe that the power of music to heal cannot be analyzed or explained, because it is fundamentally spiritual. A discussion of precisely what this means is beyond the scope of this thesis. Nevertheless, since music therapists do use this power in their work, either consciously or unconsciously, it might be useful to cite a couple of anecdotes illustrating the spiritual qualities of music in a direct, experiential way.

The first is from a sermon recently delivered in a church in rural Vermont.

> A few days ago as Joan and I walked along
> the East Craftsbury Road,
> we heard a strange sound coming from the Simpson
> Library.
> I suppose it wasn't that the sound was so strange
> in itself;

what was strange was that the sound came from the library.
Ordinarily, libraries discourage sounds.
Shhh. Quiet please.
In libraries, sound is disturbing,
unless it is the quiet sound of a page turning,
or the soft shuffle of sorting through the card catalog,
or voices lowered to a whisper to inquire about a book.

But as we walked, we heard something quite out of the ordinary
coming from inside the library.
Even more odd: the library was closed at the time.
We detoured from the shoulder of the road
up to the porch and listened.
The sound was just muffled enough
that we couldn't be exactly certain,
but we think it may have been the sound of ...
a viola!

We walked a little further,
and from a quiet white house on the left,
we heard a piano.
And as we approached the church, this church,
ordinarily quiet as a church mouse on a summer afternoon,
we heard a human voice singing Schubert,
a clear, wondrous soprano voice echoing through the empty halls of this building.

East Hill was alive with the sound of music.
Some would say it always is.
On a summer evening, crickets and peepers sing.
On a cool autumn night, we might hear the cry of the coyote.
As we sit on our back porch, the downy woodpecker peeps,
the mourning dove coos, and the goldfinch chirps.
Can any of us say for sure which of these sounds is "sacred"?
Which of these songs was offered to God,
the library's viola? the church's voice? the coyote's?
Which sound expressed thanksgiving?
Which music would the Spirit of God use
to inspire faith, hope, love?

(Kellam, 1977)

Music has power partly because it evokes so many basic things, all at the same time: the sounds and beauty of nature, powerful memories from the past, even religious faith. Music works on many levels at once: physical, mental, emotional, aesthetic, and spiritual. The strength and depth of our response to music is partly a result of this effect of music on our entire being, bringing together all these channels of response simultaneously.

The evocative power of music can awaken and enliven the human spirit when other forms of communication have failed. A man describes visits to his 87-year-old mother, whose memory has been badly deteriorating from dementia. She does not remember the stories he has told her, or the Christmas tree they used to have in the back yard, or even who he is. She becomes agitated; their visits turn very brief and very strained. But then one day he sings to her songs from an old songbook from which she used to play when he was little. He begins to sing "Loch Lomond"; she sings along, remembering the words. She takes his hand, looks into his eyes, and says, "I never knew there could be such sweetness in a human relationship" (Carter, 1996, p. 14).

Music has awakened more than this mother's memory. It has awakened her spirit. It has elevated her mood.

It has brought back to her the love in her relationship. Before he started using music, her son would tell her that he loved her in words, but the words didn't register. It was only after he started singing, sharing the music that once connected them, that she could feel the love once again.

Of course, not all music is supportive and loving. Sometimes music can even be harsh and threatening. But when love is present between two people, or among members of a group, music can make this love felt in a uniquely powerful way. Music extends the range of verbal therapy in at least two significant ways:

1. It can touch people who are beyond the reach of verbal communication: people suffering from stroke, from dementia, from severe debilitating depression, even people who are terminally ill or in comas. I have found that once I began to incorporate music into my practice, possibilities of becoming available to people in a beneficial way dramatically increased.

2. Music allows the direct expression of love as a healing influence. In any encounter between people, love can be present. In verbal therapy, however, it is not often possible or appropriate for the therapist to express love directly to the client. The man who sang for his mother discovered that she could respond to the love he expressed in this music, while the love he

expressed in his words failed to awaken her. Perhaps because music engages all levels of our experience at once, perhaps for some more mysterious reason, the messages that music conveys penetrate our awareness more deeply than do messages expressed in words alone.

To understand with greater clarity how music can be a healing influence specifically through the expression of love, let us return to the definition of love. Love is awareness of the individuality of others. One way in which music promotes love is through expanding our awareness. Music expands our awareness by developing it on intuitive levels.

Music as an Intuitive Process

I became drawn to music therapy out of a growing frustration with the limitations of verbal psychotherapy. It seemed to me that in order to benefit from verbal psychotherapy, one must already be pretty functional. The best candidates for psychotherapy have sometimes been described by the acronym "Y.A.V.I.S.": young, affluent, verbal, intelligent, and single. What about people who are old, poor, nonverbal, or demented? I wanted to be able to reach them too.

I soon found music to be a ticket to the bedside of people who are severely ill and isolated, people whom I would not be able to approach if words were my

only resource. I found myself near people who were extremely compromised, who could not speak, even people in comas. What could I possibly do for them? Words were clearly of very limited value.

Since such people lack an intact capacity for speech, music becomes much more crucial as a way of reaching them. However, since music lacks the denotative quality of speech, one cannot communicate through music the way one can through words. With words one can point to very concrete, specific things; one can focus on an issue and present it in a way that will be understood hopefully with some degree of accuracy. But how does one communicate through music? And how can love play a role in this communication?

If the essence of love is awareness, music must play a role in promoting awareness, both the therapist's awareness of the client, and the client's awareness of the therapist. If words are not available to provide information, to help one understand, to make one more aware, then one must acquire this awareness in other ways. One important way is through intuition. The immediate task is twofold: to understand what intuition is and how we might exercise our intuitive faculties to become more sensitive to others, and to explore how music can provide a means of supporting the intuitive process.

It is not always easy to recognize our intuitive capacity and to differentiate it from personal prejudice or preconception. If we have a "gut feeling" or a "hunch," how do we know we are not simply projecting something of ourselves onto someone else? Often we make these projections because there is something, inside ourselves or in the situation itself, that we wish to avoid seeing. In working with these issues in my private group practice, we have repeatedly confronted the idea that we possess much greater intuitive powers than we normally imagine. When a member would describe a confusing situation, it often became apparent that she actually did have an accurate sense of it, but screened the information out of her consciousness because it was too threatening or uncomfortable to face. We see much more than we know, and often prevent ourselves from knowing it, in order to protect ourselves.

The task, then, is to recognize this intuitive capacity and to develop it. This is important in any kind of therapy, and particularly important in working with patients when verbal information is unavailable. Assagioli (1965) maintains that every successful therapist must carefully develop the use of the intuition. He also states that intuition is often underdeveloped and repressed, largely because we fail

to recognize its importance and value. (To this I would add that intuition is often repressed because the information it brings threatens the picture we would like to have of ourselves or of the world.)

For Assagioli, intuition "apprehends the totality of a given situation"; "it does not work from the part to the whole--as the analytical mind does" (Assagioli, 1965, p. 217). It is therefore difficult to describe intuition discursively, to defend it in the court of logic. Nevertheless, its information is important, and we cannot afford to ignore it. We still need to be careful to discriminate the results of true intuition from projection or wishful thinking. For this reason Assagioli counsels balancing intuition with use of the intellect--the two must function together. He offers some suggestions for developing intuition:

1. Eliminate from the field of consciousness thoughts and sensations that might clutter and obscure one's awareness of more subtle information.

2. Quietly wait for the emergence of intuitive realizations (Assagioli, 1965, p. 219).

Eliminating the clutter of intrusive thoughts is surely more easily said than done. As a method of practicing this, I have often suggested to my clients the practice of certain forms of meditation based on detached observation, as described in the previous

chapter (see, for example, Thera, 1962). The basic idea is that, by simply observing one's thoughts before reacting to them, one acquires more awareness of influences that tend to distort one's perceptions, as well as greater freedom in choosing one's responses.

Because music elicits many layers of nonverbal as well as verbal response, it is a good medium for the transmission of intuitive information. Karlheinz Stockhausen (1989) has made intuition an integral part of his idea of music making. He calls music both an "intuitive" and a "spiritual" activity. Stockhausen suggests that musicians prepare themselves with "spiritual exercises" before they play, to place themselves in a state of concentration and receptivity to higher sources of inspiration. Without this preparation their playing will be mechanical--the same notes may come out, but they will not move the audience. That which music expresses is more than just the notes.

Stockhausen recognizes the multi-layered appeal of music. He says that different kinds of music energize us in different ways. Some kinds of music merely entertain us; other kinds arouse our sensuous nature; some appeal to the erotic, and others appeal to the intellect. Music affects us on many levels, including

one that can be called healing, and intuition is an important part of the way music does this.

Stockhausen has proposed an intuitive model of music making, applied mainly in a group setting. He has written a collection of meditative texts, Aus den Sieben Tagen ("From the Seven Days"), which do not tell the musicians what to perform but are intended to guide them toward a state where they can allow intuition to take over, so that they may participate in a flowing process of listening and communicating with each other. Here is one example:

Begin with yourself:
you are a musician.
You can transform all the vibrations of the world into sounds.
If you firmly believe this and from now on never doubt it,
begin with the simplest exercises.

Become quite still, until you no longer think, want, feel anything.
Sense your soul, a little below your chest.
Let its radiance slowly permeate your whole body
both upwards and downwards at the same time.
Open your head on top in the center, a little towards the back,
and let the current that hovers about you there,
like a dense sphere,
enter into you.
Let the current slowly fill you from head to foot
and continue flowing.
Quietly take your instrument and play, at first single sounds.
Let the current flow through the whole instrument.
Whatever you want to play, even written
music of any sort, begin only
when you have done what I have recommended.
(Stockhausen, 1989, p. 42)

One might well use this as a meditation to aid in tapping one's intuitive capacities and expressing them through music.

One performs "intuitive music" by responding to the other players through one's own intuitive sense; in this way the players can establish close communication with each other. Hamel (1978) tells what it is like to participate in a Stockhausen "Intuitive Music" Group:

> A further important factor here is the personal relationship of the players to each other, for in improvisation there is a direct meeting of minds, a question and answer situation, a love-hate relationship. No one can keep his skeletons of prejudice or aversion in their private cupboards. (p. 31)

And so music can convey much information, sometimes very intimate, without a word being spoken.

If intuition is difficult to describe conceptually, can one offer an "intuitive grasp" of it? An example recently came to my mind that represents to me in a simple way what intuition feels like. I am listening to some Spanish language learning tapes. These tapes contain stories in conversational Spanish, with no English translation. There are instructions on the tape directing the listener <u>not</u> to try to understand every word, but to go for the general sense. One is even encouraged to listen to the tapes while doing something else, so that one will not try to decipher them too deliberately.

If I try to understand the tape by starting and stopping it until I can identify every word, I get one kind of experience. Eventually, I will get every word, but the process is mechanical and time-consuming, and I may even end up with only a string of words devoid of any larger meaning. If, however, I allow myself to wait in my confusion until the general sense occurs to me, I get a totally different experience. I won't understand all of it; my sense of the whole may be quite vague, but when my grasp of it does occur, it will be lightning-fast, like a light effortlessly clicking on in my mind with no conscious control on my part. In Assagioli's language, this is apprehending the "totality" of the situation, rather than working "from the part to the whole." This is kind of what my intuition feels like when I am using it clinically. I believe the process is very similar.

Understanding intuition this way makes clearer just how music can support the intuitive process. While words refer to specific things, music conveys the general sense, the "totality," of a complex feeling state. Improvisatory music in particular, created in a moment of encounter with another human being, may carry information about everything the creator of the music is thinking and feeling, consciously and unconsciously, in reaction to the other person and to the situation.

To discuss music's capacity to represent specific emotions, sadness, grief, joy, and the like, tells only a small part of the story. Words in their own way can also represent those emotions. Music works on a more intuitive level: it represents many different, complex cognitive and emotional states at the same moment, states of being and feeling that do not translate easily into words. It therefore represents far more than can be put into words, but with far less specificity. The information that music conveys is more comprehensive than verbal information, but much less definite. It is like trying to grasp the meaning of the Spanish tape without looking up each word: one grasps the totality rather than just separate pieces, but there are gaps in one's knowledge, fuzzy spots of uncertainty, that words can sometimes supplement and help clarify. Intuitive knowledge may therefore fail to pass standards of scientific rigor, but it is still vitally necessary for clinical work.

Music as Communication

Previously in this chapter I have referred to music as "communication." It is worth saying a little more about this, since it is a controversial area, and since it also has to do with how love is expressed in music therapy.

It is easy to say that music is "communication," but what and how does music communicate? Philosophers of music have rightly pointed out that we are not entitled to assume that music expresses the feelings of the person who created it (Budd, 1985; Kivy, 1989). It is no contradiction, however, to observe that music arising spontaneously in a clinical situation can often be understood as a response to everything that the person making the music experiences in the moment. Clinical improvisation is a process in which the participants interact and respond to each other on many simultaneous levels, conscious and unconscious.

A demonstration of how music can communicate in this way occurred one day in Internship Seminar. Each student was instructed to play an improvisatory portrait of a client at the piano, while saying nothing in advance about the client. Other class members had to offer brief phrases describing the client, based only on what they heard in the music. There was remarkable agreement among class members for most of these musical portraits. The same descriptive phrases often appeared in the responses of several members to a given portrait. It seemed clear that the music was communicating something about each client, even, in some cases, information that may have been unconscious to the person playing.

From an existential point of view, communication may involve not only ideas, concepts, or feelings but states of being. Hora (1957) speaks of "existential communication" as the unconscious communication of a person's "mode of being in the world": "How the patient experiences his life and how he is related, or how he communicates or fails to communicate with his environment" (p. 40). Existential communication is the mostly unconscious communication of a person's total cognitive and affective state at a given moment. The direction of this communication may be from patient to therapist (for example, "c-countertransference," Priestley, 1994, p. 85) or from therapist to patient (for example, "doctrinal compliance," Ehrenwald, 1966, p. 51). Since this mode of communication is mostly unconscious, it is picked up intuitively, rather than conceptually. The use of music as an assessment tool is one example in music therapy of seeking to open ourselves to this form of communication, to learn what we need to know about the client and what the client may not be able to tell us in words.

If music can communicate inner thoughts and feelings, it can also communicate a healing state of mind. Precisely because music can be a carrier of intuitive information, it is an especially effective channel for such communication on a deep level. Music

affects the participant on levels beneath conscious verbalization. Music arising spontaneously in the clinical context can represent a person's inner state on all the levels we have mentioned: physical, mental, emotional, and spiritual. Through music, more effectively than through words, one can communicate even to a coma patient one's compassionate presence, a sense that the patient is not alone. I have often seen the relaxing effect that music can have on these patients, visibly decreasing their fear, most likely their fears of abandonment. To dementia patients, music can convey the message that someone still takes them seriously, still respects and dignifies them. To depressed patients, music can convey a message of hope, and can help them renew their ties to internal resources and positive memories that can support and sustain them. To all clients, music can convey the therapist's attention and awareness, and thus the sense that she loves them. Especially as the therapist becomes more practiced in self-observation and "bracketing" (above, p. 37), including seeing one's own limitations and boundaries and respecting the client's separateness, it becomes more possible to use music to communicate a healing message.

Love in Music Therapy

Because music is a carrier of intuition, it can also be a carrier of love. Intuitive receptivity leads to love: intuition is a form of receptive, nonjudgmental listening to another human being. When one encounters another with intuitiveness rather than judgment, the other person will feel seen, heard, and understood--and will thus be more likely to experience the presence of love.

While it may be implicit in many descriptions of music therapy, the importance of love in the process of healing is not often discussed in the music therapy literature. A notable exception is Mary Priestley's brief but significant essay "Music Therapy and Love" (Priestley, 1994, pp. 119-125). Priestley begins her essay by saying that it is important not to forget the "heart" qualities, compassion and empathy. While this may seem obvious to some, a modern, medicalized, even technologized approach to therapy can easily neglect a most potent therapeutic agent, the warmth of the human heart. Priestley is not embarrassed about discussing this in a book on "analytical" music therapy.

"Greater love, of self and life and others, is the ultimate aim of all analytical music therapy" (p. 121). This is quite a statement. One may describe in copious detail the various techniques available to the music

therapist, but if one leaves out the importance of love, one omits the most essential detail, in fact the very reason for the process itself. Priestley is careful to point out that emphasizing the importance of love does not mean denying the existence of hate, or all the negative feelings that may arise in therapy. These are all part of a unified process. Sometimes hatred must be recognized and worked through for love to become possible. Not running away from hatred, staying patiently with it, understanding it and working through it, is in fact an act of love.

"In the dyadic improvisation there can be a loving that allows the client to be, that enfolds her with appropriate sound or challenges her to be herself and show her real feelings. There can be warm, reciprocal sharing of feelings--no cold Freudian mirror here" (p. 123). What a remarkable statement from a "psychoanalytic" music therapist! The full potential of music, including its power to heal, cannot be tapped in the remote, nonrelating atmosphere of classical analysis. Music lives and breathes in the context of relationship, the connection between performer and listener, or between therapist and client. In fact, in the clinical situation, music becomes most intimate, a "reciprocal sharing of feelings."

Priestley addresses explicitly both sides of this reciprocity: the client's love for the therapist, and the therapist's love for the client. These are both essential aspects of the therapy process:

> As the therapist I find that love is an essential ingredient in the therapy. The client's transference love for the therapist enables her to struggle to overcome her weaknesses and eventually to find substitute love objects in the world outside, where the boundaries do not preclude the physical development of expression. The therapist's love for the client aims at being not a sentimental or smothering love but a true empathy, enabling him to see life as much from the point of view of the client as possible; but at the same time not to lose his own orientation. It is very difficult to work with a client effectively before this balance of love is established. (p. 123)

While Priestley's orientation is analytic rather than existential, she also describes a love that sees and respects the world of the client, that recognizes the boundaries, that allows the client to be separate while still trying to see from the client's point of view. Priestley's description is highly consistent with our definition, that love is the awareness of the individuality of others.

I find particular beauty in Priestley's description of music therapy providing "subverbal communication with loving meetings via sound patterns" (p. 119). This is an apt summary: music therapy can reach people unreachable with words, because it goes beyond words. Elsewhere in her book she describes in

more detail how music therapy can facilitate the nonverbal communication of love. Her "holding" technique is an example, which she sees as a "maternal" holding that provides through sound what Winnicott has described as a "holding environment" (Winnicott, 1960a). Priestley also describes what some might call the spiritual power of music: the intrinsic power of music to evoke a joyful, healing state of being, a power not available to words:

> Love can be compared with a spring of water. Music therapy, like most other therapies, is used to clear away the blockages to the spring; but unlike them, it is also used to express the joy of the spring itself. . . . A psychotherapist friend said he could do this with his clients too, but I am sure there is not the immediacy and internationally understood mutual joyous expression that we can experience in musical improvisation. (p. 122)

As I began to understand more about combining music with psychotherapy, this point became particularly important. Music therapy is not simply verbal therapy with music. Music therapy incorporates an additional force: the power of music itself, which is different from the power of words, and must be carefully coordinated with it.

Putting love into practice in the clinical situation requires inner discipline. Scheiby (1997) speaks of being "present" with the client. Therapeutic presence requires a high level of awareness, both of

one's own feelings and reactions and those of the client. Thus Scheiby strongly stresses the importance of monitoring one's countertransference, using this introspective process to learn more about the client and the process of therapy, as well as about oneself. Scheiby points out that when undetected, countertransference can become an impediment to successful therapy, but when recognized it can provide useful insights about the client. If the therapist can succeed in setting aside her own personal feelings and projections, she can then discover in her reactions clues to what the client feels and experiences (Priestley's "empathic countertransference"). This "setting aside" is crucial--it is akin to what the phenomenologist calls "bracketing."

> What does it mean for a music therapist to be present? Making a commitment to music therapy means making a profound personal commitment because one's personal feelings, life philosophy and values are transparent in the session, especially in the musical contact with the client. By its nature, music cannot be sanitized or neutral--it is a mirror of what is going on inside and is consequently a highly subjective medium in which to work. One learns to listen not only to the outer and inner music of the client, but also to a deep place within oneself, where thoughts and feelings are acknowledged as they arise. Yet one must also learn to put these reactions aside in order to maintain attention to and contact with the client. (Scheiby, 1997)

Thus in order to achieve the awareness of the client that is a prerequisite for love, one must pay

close attention to the dynamics of the encounter, and learn to observe one's own inner state very carefully. Scheiby also understands music as a carrier of intuitive information--"a mirror of what is going on inside." The inner life of both client and therapist will be revealed in the music. The therapist must learn how to receive this information and use it.

While Scheiby does not speak explicitly in terms of love, she does describe a "supportive" model of group music therapy. One group, which I observed on several occasions, contained four members all suffering from varying degrees of dementia and depression. M was a 92-year-old woman suffering from severe senile dementia. She was often extremely agitated, depressed and anxious. At the beginning of one session she was crying and singing, "Where did they all go? I am so lonely. They did not come back again." The therapist took these words and expanded them into a song: "Where did they all go, M, where did they all go? They went away so fast. But now you have your friends again in this group. You have G and H and J and Benedikte. Where did they all go? They disappeared so quickly. Where did they all go? Here you have some new friends." M stopped crying and became much calmer. The other members of the group addressed her, saying "Hello" (Scheiby, in press, pp. 22-23).

The purpose of the improvised song was twofold: to mirror M's feelings, thus making them more accessible to her and visible to the group, and also to encourage the other members to make a supportive connection with M. Scheiby describes how the music--its melodic and harmonic structure, and also the therapist's voice--provides a "holding function." It becomes a "container" for the client's feelings, and supports her by acknowledging her and letting her know she is understood. The harmony of the song fluctuates between major and minor, reflecting both the client's sadness and the hope of still finding positive human contact.

In terms of the present discussion we might say that the client encounters a healing moment through the experience of being loved. Love is present in the form of the therapist's awareness of M's needs and feelings, and her encouragement of the other members of the group also to become aware of M. Love is also expressed directly in the music, which "holds" the client much as a caring parent would hold a child. The therapist herself cannot be M's parent, but the music can express something beyond the personal feelings of the therapist, and perhaps even help the client make a connection to her own capacity for self-nurturing.

Conclusion

Because music conveys so much information on so many levels at once, it can bring to the client a sense of the therapist's awareness and understanding in a very immediate way. It can also communicate the therapist's countertransferential feelings in an especially powerful way. Scheiby's insistence on monitoring countertransference and using it constructively is crucial. Without constant self-monitoring, it may be difficult for the therapist to distinguish feelings of inappropriate attachment, possessiveness, narcissistic gratification, or excessive identification from a genuine sense of non-self-interested love. What may seem like love may often be a use of the client to fill an unarticulated need in the therapist. It is common, for example, for therapists to identify strongly with clients who have suffered traumas similar to their own, and to project their own responses and wishes onto the client. A therapist may unconsciously try to maneuver the client into completing the therapist's own unresolved process, which may not be what the client actually needs. Self-observation and competent supervision are safeguards against such unfortunate occurrences.

There is nevertheless another side to countertransference. Therapists who are committed to

this self-monitoring process and who respect the client's boundaries can use their countertransference, even their identification with the client, to help them form a compassionate bond. The key is always awareness: awareness of what the client needs, which is usually different from what the therapist needs. Maintaining this awareness, therapists can use even their own personal experiences to enhance the quality of love that may pervade the session.

Bringing these two themes together, compassion for the client and respect for the underlying dynamics, unites the best of what psychoanalysis and humanistic psychology have to offer. The use of music can fine-tune both these aspects of therapy. Music expresses much that cannot be said in words, including thoughts and feelings that may not be consciously available, and so, like dreams, it can provide insights about what is happening beneath the surface of consciousness. Music also expresses feeling directly, and so it can, as in the "holding" exercise, give the client a sense of being in the presence of compassion, being understood, on a level far deeper than words alone can reach.

Music therefore greatly expands the scope of verbal therapy, both in the variety of clients that therapy can reach and the depth at which it can reach them. The client M in Scheiby's group could not be

reached with words alone. I have often seen how aggressive and perseverative she can be, completely tuning out any attempt to make contact with her. Yet when she would hear a song that she knew, she would interrupt her repetitive speaking and begin to sing. Music strengthens therapy because it touches people in ways words cannot; it brings into therapy the "heart" qualities of which Priestley spoke.

Music therapy is therefore a natural, almost inevitable extension of the existential approach to love. It crosses the "existential barrier," offering healing to those whose problems may be physical as well as psychological in origin. And it can bring into awareness not only what is conscious, what is easily expressed in words, but also our most hidden responses, hidden from ourselves as well as from our clients. Non-self-interested love is an ideal, perhaps never completely realized. It is nevertheless the most potent healing factor in therapy, and whatever contributes to our awareness makes it more approachable.

CHAPTER 4

EXAMPLES FROM INDIVIDUAL WORK

The need for loving contact is perhaps nowhere as deep as it is in large institutions. People are at once extremely dependent and extremely isolated. Staff members are preoccupied with caring for their patients' physical needs, and often lack both the time and the training to care for their patients' emotional and spiritual needs as well.

I have done my internship at a large long-term care hospital in New York City. The hospital serves people with various chronic disabilities, mostly neurological. As a large institution, it is probably much better than most. It offers a full program in both music and recreational therapy, in addition to the other standard rehabilitative services. Nevertheless, its residents are often isolated and needy, and must struggle with the large, impersonal nature of the institution in addition to the effects of their own individual illnesses. There is an "institutional depression" that threatens patients who are thrust into a strange and sometimes unfriendly environment, in a state of helplessness, unable to come and go as they

please, constantly dependent on others who may or may not be available to minister to their needs.

A large institution is often a place of conflict. Patients suffer conflicts in three areas: conflicts with other people, conflicts with themselves, and conflicts with their own reality.

Interpersonal conflict is common between patients and staff, and between patients themselves. Patients often feel ignored, neglected, disrespected. The fear and anxiety can be tremendous: Will the nurse give me a drink of water when I am thirsty? Will she help me to the bathroom when I need to go? Do these people care about me? The sense of isolation that accompanies these fears can lead to expressions of anger, which sometimes alienate the staff, or it can lead to depression, if the patient gives up. The situation is inherently difficult: too few people are caring for too many people with tremendous needs, and the caregivers themselves can be insensitive, either because they are not sufficiently trained, or because they need to protect themselves from the emotional impact of what they see. Patients themselves live in very close quarters with others who are strangers, very different in personality and background. Privacy is limited. One does not always receive the respect one was used to when healthy and independent. Patients sometimes

inflict on each other the effects of this stress, and occasionally the confrontations become violent.

Nonacceptance of self can become acutely intensified when one is hospitalized and severely disabled. One becomes frustrated with oneself at not being able to perform simple tasks one used to take for granted. One turns against oneself the anger one feels toward staff and toward one's own condition. One may hate oneself for being sick and helpless, for becoming at times an object of humiliation. Sometimes blaming oneself seems like the only source of power available to someone who feels totally powerless.

Nonacceptance of reality is a common reaction to a debilitating condition for which one was not prepared. Who is ever prepared? One fights it, denies it, resigns oneself to living with it. The futility of one's anger can become unbearable, and so this anger turns to depression. There is a way patients look that is very common when they reach this stage. They sit in their chairs with their eyes closed and their heads slumped over, as if in a catatonic stupor, even though nothing may be wrong with their minds. It is a sign of their having given up.

While music can do little to change the external conditions that give rise to these conflicts, it can do much to mitigate their effects, to help a person heal

from within. I would like to begin with the story of one patient who suffered from severe depression, originally a reactive depression to her disabled state, but greatly exacerbated by what she experienced as the depressive nature of her environment.

Annette: Music and the Treatment of Depression

An important aspect of the experience of love in therapy is the discovery of self-love. Patients with severe depression are often profoundly self-rejecting. They blame themselves for their illness and incapacitation, and see themselves only as a burden to others. The understanding of love as awareness is no less relevant for self-love than for love of others. This depressed patient needed to become aware of her own individual world, to come to know it, feel it, accept it, and respect it. She needed to learn to live comfortably within her own world, to make it her home. Expressing her world in music made this something possible for her to attain.

Annette, a 66-year-old former schoolteacher, was the first patient assigned to me at the hospital. When I first saw her, she appeared to be suffering from some form of severe dementia. She sat in her wheelchair, her head drooping over her chest, her eyes closed, her expression distant. She was completely withdrawn and silent. I expected very little response, and was

surprised to find she could carry on a lucid conversation. She was suffering the effects of a stroke, which greatly impaired her ability to walk but affected her mind hardly at all. What affected her ability to express herself far more than the stroke was her severe reactive depression.

In the hospital Annette was isolated and frightened. She was terribly homesick; she missed her husband, on whom she depended greatly. She would break down in tears at the slightest provocation. Because extraordinary patience was required in dealing with her, she became known as difficult. She was not always treated kindly. I had to report one nurse's aide for verbally abusing her; the aide was subsequently transferred.

Annette often exhibited feelings of self-hatred. She said she felt powerless and out of control, having to lie in her bed all the time, depending on others to move her or take her to the bathroom. If a nurse failed to handle her gently when turning her over in bed she would cry or scream, as much from fear as from actual pain. Annette berated herself constantly. The lack of love she felt living in the institution became translated into a lack of love for herself.

At first it was difficult to know how to establish a rapport with Annette musically. No matter what song

I played, whether the words expressed hope, confidence, or even joy, whether the tune was in a major or minor key, the rhythm slow or animated, Annette would say the music was "sad." Annette displayed great resistance to participating actively in the music. She would always refuse to take an instrument, and would try the keyboard, which she used to play well, very reluctantly and only after much coaxing. She constantly judged her playing, always beating herself for failing to get the notes right, even though I tried to explain that we were just improvising and that there was no "right." I soon realized that I had to take a different approach with her.

I began to spend the sessions just singing to her. I sang many different songs, folk songs and popular songs. She always would say that she loved to hear me sing. Occasionally I would ask her why she did not wish to participate more actively. I said, "You want me to do all the work, don't you?" She said "Yes," and we both laughed. But then she made a good point: "Listening is also participating."

Although I consciously had some doubts about the value of just singing to her while she seemed so passive, I continued to follow my instincts. I realized later that this was exactly what she needed. Annette was depressed, emotionally starved. She needed

to be fed, and the music was feeding her. My singing to her created a "holding environment." It let her be, just as she was, almost as if it were a womb in which she could both rest and grow.

After a while, I began to notice certain changes. At first her favorite song was "Bridge Over Troubled Water," and she requested it repeatedly. But then she tired of this song--while at first it uplifted her, as her mood began to change she no longer wanted to remain in the "troubled waters." She began to request songs that more openly expressed happiness, like "What a Wonderful World" and "Oh What a Beautiful Morning." But the biggest change of all is that she spontaneously began to sing with me. She became conscious of an impulse within herself that wanted to sing. Sometimes she couldn't get enough--when we finished a song, she would keep singing the words anyway, making us do it again. She let me know both the form and the timing that her own participation would take, and then she was very consistent, singing with me all the time.

As she became more comfortable singing, I tried to stimulate her creativity. I had her write her own song about how she felt, and what she felt could give her strength. She began to improvise words over a simple melody. I supported her with guitar, and supplied some

simple chords. This became our Contact Song (see Appendix):

To Ease Your Mind

Go on as best you can,
Go on as best you can,
It will ease your mind,
It will ease your mind,
And you will feel better.

Oh I need a family,
Right behind me,
All the time,
All the time,
And I will feel better.

And if I need a friend,
If I ever need a friend,
Bob is right behind,
Bob is right behind,
To ease my mind.

A very simple song, in a major key but with just a little minor flavoring, whose repetitive structure seemed to suggest reassurance. The refrain, "And you will feel better/To ease my mind" seemed to be Annette's own inner voice speaking to her to comfort her. Bob was Annette's husband, a great source of strength for her.

I printed out the music to this song on my computer, added Annette's name to it, and gave her a copy. She was very proud of it, and liked to sing it often.

Annette's gradual mood change was also reflected in the other songs she liked to sing and improvise with. Her favorite was "What a Wonderful World." She

loved it so much that I had her compose her own words, making the song express her world, the things that made her happy:

(To the tune of "What a Wonderful World")

When I'm not in pain and I'm feeling good,
Things are going my way, just like they should,
I think to myself, What a wonderful world!

I see lands of green and flowing rain,
It makes things seem like spring again,
And I think to myself, What a wonderful world.

The colors of the earth are pretty down below,
And on the people's faces I see a happy glow.
I see happy people, and friends going by,
With smiles on their faces, a shine in their eyes.

I hear children's voices as they play,
They make me feel so peaceful today,
And I think to myself, What a wonderful world,
Yes I think to myself, What a wonderful world!

I noticed other changes as well. While doing some guided imagery work with her, I found that she could now associate sad feelings with pieces in minor keys, and happier feelings with pieces in major keys. She no longer labeled everything sad regardless of the quality of the music. I began to sing to other patients the songs that she had written, and I told Annette she was helping people she didn't even know. She loved to hear that and seemed to derive a sense of accomplishment from it.

When I shared my observation that Annette's mood had greatly improved, she said, "You bet!" Eventually the time came when she could look forward to discharge,

and we were able to go through a termination process, reviewing her journey and her progress and helping her appreciate how far she had come. Annette repeatedly expressed deep gratitude for music therapy, telling me that it did just what it was supposed to do.

Music therapy was just one component of a comprehensive rehabilitation program that aided Annette's recovery. While other aspects of the program helped Annette heal physically, music therapy helped her heal emotionally. She entered the hospital full of fear and self-hate. The music enveloped her, allowed her to be who she was, to progress at her own pace with absolute freedom from judgment. It also gave expression to her fears and aspirations. It helped her contact these different parts of herself, the fearful part, the depressed part, the hopeful part, and even the joyful part, and accept and integrate them. In short, it taught her self-acceptance and self-love, a form of love she had been desperately lacking.

Stephanie: Music and the Use of Intuition

The previous chapter mentioned the importance of intuition in bringing love into the therapeutic process. The use of one's intuition helps bring love's presence into the therapeutic situation, since it helps the patient feel understood without having to work too hard to make the therapist understand.

Some patients test our intuition more than others, and those who do have something important to teach us about love. It is hard to imagine a greater test of one's intuition than working with a coma patient: with so little overt response to work with, intuition becomes exceedingly important. I have had some experience using music in work with coma patients (Gourgey, 1994a), and this experience proved invaluable in working with Stephanie. Still, Stephanie presented me with some special challenges.

Stephanie is a 19-year-old woman suffering the consequences of gestational diabetes. She has been in a deep coma for about two years. Stephanie has one son, but her family does not visit. I am told that formerly she loved to go to parties and listen to popular music.

I would typically find Stephanie sitting in a wheelchair, her head down and turned to one side. Her body, especially her arms, would be very rigid, her fists tightly clenched around two pieces of foam rubber. She would make no sound, except for an occasional fit of coughing. And, of course, her breathing.

As with any patient, therapy proceeded in stages. In the beginning stage of therapy we became acquainted. I chose songs I was told might be familiar to her:

"Jamaica Farewell," "Day-O," "I Can See Clearly Now." I noticed a pattern to her response: Stephanie would open her eyes while I sang, close them in between songs, then open them when I started again.

Expressiveness in a coma patient is often concentrated in the eyes. In many coma patients I have worked with in hospice, I would notice the eyes open unnaturally wide, dilated, frozen in what looked like an expression of fear. In almost all cases I found that, after playing some soft, soothing music for them, their eyes would gradually relax and close. Sometimes I observed this response in Stephanie. But Stephanie's eyes were more expressive than the eyes of a terminally ill coma patient. Sometimes she would actually hold eye contact with me. I noticed a difference between times when her eyes were directed towards me but unfocused, and other times when she seemed to possess a sharp gaze. And very often I noticed that as I walked around the room, Stephanie's eyes would track my movements.

Her eyes were expressive in other ways. Once in the middle of a session two orderlies came in and began straightening the bed next to Stephanie's, making a lot of noise. This annoyed and distracted me, and it took me several minutes to tune it out. Stephanie seemed not to react to it at all. She did, however, seem to

react to my reaction: when I felt myself tensing because of the intrusion, I would notice agitated eye movements in Stephanie. Without verbal corroboration, I cannot be absolutely certain of their meaning. But the timing seemed significant. I felt a match between her eye movements and changes in my own internal state: when I felt agitated, her eyes became agitated. The timing of little things can contribute greatly to one's intuitive sense of what is happening.

Other incidences of timing gave me an eerie sense of how Stephanie was aware of my presence. Quite often by the end of a session, when she seemed totally at rest with her eyes completely closed, when I got up to leave she would suddenly open her eyes wide, begin to groan, and go into a coughing fit. This happened too many times for me simply to have dismissed it as coincidental--sometimes I could almost anticipate the reaction. I would then spend a few extra moments with her, until she became calm once again.

I noticed great variations in the music to which Stephanie would respond. In the initial stages she seemed to respond to familiar songs, folk, calypso. She also seemed to care about the way I played them. If my playing was too loud or too fast, she would tense her arms even more than normally and begin to raise them. Her body would quiver, as if she were going into

seizure. Music toc loud or too fast seemed to overstimulate her. I usually found that slowing the tempo, softening the dynamics, brought her back to a restful state.

After several weeks she stopped responding to songs at all. To get her attention, I had to improvise. In this regard, Stephanie was very different from my hospice coma patients. Those patients seem to respond best to soft, gentle music played on a tenor or bass recorder, the mellower members of the recorder family. This had no effect on Stephanie. However, when I played on my alto recorder a vigorous jazz or bluesy improvisation, Stephanie would open her eyes wide, turn her head toward me, and follow me with her eyes. After a while she would close her eyes and turn away again; as if to tell me when she had had enough.

Stephanie responded not only with her eyes, but also with her voice. It sounded like random groans and grunts, but I didn't think they were random. They seemed to occur when she was either excited or distressed about something. During one week, over three consecutive sessions, something remarkable happened. For some reason I felt prompted to ask Stephanie, after just having sung a few songs, if she liked them. I asked her to let me know by making a

sound--and she did so. It would be a low sustained groan, "unnnnhhhh," as if she were trying to speak. Once again, it was the timing: she made these sounds whenever I asked her this question. The pattern did not continue, and I cannot explain why, except that these responses seemed extremely difficult for her, requiring tremendous effort. But during that week, the timing seemed far from coincidental--she gave me that vocalization only after I specifically asked her whether she liked something she had just heard.

Sometimes I tried to incorporate her sounds into musical responses. I would groan or yawn along with her, or use my own voice to try to feed back to her the melody I heard in the sounds she made. Sometimes, for just a couple of seconds, she would seem to hum along with me. Using this musical dialogue as a starting point, and trying to respond to what I sensed might be her feelings, I made up a contact song for her, "Stephanie's Song" (see Appendix). The song is repetitive in both music and words; in particular, Stephanie's name is repeated a lot, a reaching out for contact. I wanted to provide a safe structure for her in the music, in which she might even feel a sense of recognition.

Stephanie frequently responded to touch as much as to sound. If I would gently hold her hand or rub her

back, she would turn her head toward me and open her eyes. After the first few weeks of therapy, when she stopped responding directly to songs, she seemed to want to be touched. During one session, while I was singing to her, she began to cough vigorously, discharging a huge volume of mucus from her mouth and nose, and she turned her face away from me. I sat still for a moment, then got some paper towels and started cleaning her face. Only then did she turn her face toward me and make eye contact. She seemed to be saying, "No, I don't want music today; I want to be touched and cared for."

I tried to combine music with her wish to be touched. I would gently touch her fingers, which tightly gripped a foam rubber ball, and sing to her in a soft, improvised lullaby: "Stephanie, relax, relax your fingers." I would sing to her the spiritual, "Give me your hand, give me your hand, all I want is the love of God," while trying to place my hand gently in hers. The melody of that spiritual revolves around a single chord, and it was easy to be flexible with the tempo, slow it down, as if I were speaking directly to her as I sang. After about half an hour of my singing and gently touching her rigidly closed hand, she would relax her thumb and let it drop. Then her other fingers would follow, and I could put my hand in hers.

Before concluding Stephanie's story, I would like to say a little more about the role of intuition in working with patients like her. Through my years in hospice, as well as in my work with Stephanie, I have been developing a sense that seems to tell me when I am communicating with the patient. It is admittedly difficult to be objective, but sometimes the impression I receive is as strong, if not stronger, than those of my other senses. If something is not working, if I feel we are not connecting, I experience kind of a "sour" feeling, almost in my stomach--something that tells me nothing is really happening. But if I feel the patient is responding, even if visible cues are minimal, then something within me responds to the patient in turn. It might be an urge to hold the patient's hand, to look into her eyes, to sing with more energy. And when I feel this connection, I can often sense specific emotion in the patient: fear, grief, or peacefulness.

Intuition is not psychic, "extrasensory" perception. It is guided by sensory information. I did have sensory cues to direct me: movements of her eyes and head, changes in breathing and muscle tone, some crude vocalizations. But often I had to respond to Stephanie before getting these cues. I felt a relationship between us, that on some level she knew

me, and that on some largely unconscious level I was responding to her. Without words (or at least without words from her), we had to rely upon nonverbal, intuitive channels of communication that captured many levels of meaning, conscious and unconscious, at once. The senses play a role, but there is something else besides, something I cannot describe.

When I do feel this connection with a "nonresponsive" patient, what I also feel is love. I feel my attention fixed intensely on the patient, and something opening inside of me, expanding, in a desire to give something to her through my presence. What I wish to convey is reassurance to calm the fear I sense so often in patients who are in comas. I think this fear is so common because people in contact with coma patients often do not treat them as fully human. When I feel connected to such a person, I see a full human being, and I want the person to know that this is what I see.

My work with Stephanie had a strange, anti-climactic ending. The nurses on her floor began enforcing a policy of keeping Stephanie seated in the middle of the corridor, where they could easily watch her. I no longer had the luxury of working with her inside the ward, which was always quiet, often with no other patients present. From the day Stephanie was

moved to the corridor, I could no longer do any meaningful work with her. The corridor was noisy, and there was the constant traffic of nurses and other wheelchair patients moving by. I felt Stephanie withdraw into a protective shell. I felt that under such circumstances music therapy might even be a disservice, removing a needed protection from a threatening environment. The contrast between this withdrawn, unresponsive Stephanie and the Stephanie I had known before reinforced my sense that we had once experienced a deep connection.

The nurses were strict about the new rule, and my tenure as an intern was coming to an end, so it was not worth trying to fight them. I stood beside Stephanie in the busy corridor, and said a gentle good-bye.

Miriam: Music and the Inner World of Dementia

The wish to do good for others is not synonymous with love. One's good will, if one cannot see the other's individual world, can easily become destructive. Perhaps more than any other patient I have worked with, Miriam taught me what it means really to enter another person's world, and not to mistake the wish to change someone, even for the better, for a truly loving awareness.

I had just begun my internship. I was passing through the fourth floor of the old wing of the

hospital when I heard screams coming from the dining room. "Miss Inez! Miss Inez!" It went on without stopping. I wondered about the fear that must have produced that screaming. I entered the dining room and found a very heavy-set woman in her seventies sitting in her wheelchair at the far end of the room, continuing to scream. Her chart indicated a diagnosis of "organic mental syndrome," or stroke-induced dementia. I introduced myself and gently asked her what the matter was. I got no intelligible response. I had my recorder with me, so I began playing for a few minutes, a soft improvisation on a Christmas tune I had heard a long time ago and that suddenly came to me. She turned toward me and said it was beautiful.

I thought she would be a good candidate for music therapy; someone in distress, with an obvious need, who also responds well to music. Someone who also caused a great deal of stress to the staff on her floor. So I chose her to work with individually. I remember the laughter of a couple of the nurses when I told them I wanted to work with her.

Since this was the beginning of my internship, I hardly knew what to expect. The first contact encouraged me. I had hopes of visiting Miriam and soothing her with sweet music on my recorder. I never again received from her the unambiguously positive

response to music that she gave me during our initial contact.

When I first started to work with her, I played some soft classical music on my recorder, hoping she would continue to respond the way she did at first. She listened for a short while, then started screaming. I used the recorder to try to enter into dialogue with her, mirroring her exclamations and improvising responses to them. She quickly lost patience with this. "Miss Inez!" she would scream over and over, interspersed with incomprehensible phrases. I would sing to her on my ukelele (I did not yet play the guitar), with no greater success. Her screaming or crying seemed to express disapproval of everything I did. Whenever I asked her if she enjoyed the session, she would answer with a very direct "No!"

I desperately wanted to understand Miriam. I started making assumptions, which I realized only much later were counterproductive. I thought "Miss Inez" was someone Miriam had once known, perhaps a nurse at the hospital, who had been kind to her. I began asking everyone who had contact with Miriam if they knew who Miss Inez might be. When Miriam would perseverate on that name, I would improvise to it. I asked Miriam if Miss Inez was a nurse whom she used to know, and she responded positively. I made up a song, "Where Is Miss

Inez?" to a melody in major based on a descending minor third, something a little like "It's Raining, It's Pouring." I thought maybe injecting a childlike playfulness into the session might lighten the mood a little.

Still, over time, I felt Miriam becoming angry with me. I asked her if she was angry, and she said yes. I asked her why, and she said "Because I want Miss Inez." Again, I assumed (wrongly, as it turned out) that this meant she wanted to find someone named Miss Inez. I told Miriam I didn't know where Miss Inez was, but would inform her if I found out anything. Her response: "You're full of baloney!"

The process of therapy seemed to deteriorate. Miriam would quickly lose patience with me. She would often cut sessions short, ordering me out of her room, crying, telling me to take her back to the dining room ("I want to go out!"). When I sang to try to soothe her, she would drown me out with her screams.

One session that occurred at that time, about two months after I started working with Miriam, typified my confusion and my clumsy attempts to understand her. I asked her many questions: How are you today? What song would you like? (no response). Can you help me understand you? Do you know anyone named Inez? (no). Do you like the name Inez? (no). Then do you just like

to say Inez? (no). Her answers seemed to make no sense: If she does not know any Inez and doesn't even like the name, why does she keep saying it? I responded by doing musical improvisations on the name "Inez," weaving the name into melodies that I made up and supported on my baritone ukelele. I thought I was trying to reach her where she was. It was exactly the wrong thing to do. Finally she screamed: "What do you want from me!? I don't sing anything!! What do you you want?? What do you want from me!!"

Listening to the tape of that session, I am amazed at how little I understood. I began to pick up some important clues during the following two sessions. In the next one, I discovered two things that seemed to quiet her down a little. I improvised some melodies on my tenor recorder. These were soft and slow, with a modal quality, somewhat in the style of Native American flute music. During these improvisations she was quiet, but would start screaming again once they were over. I started singing to her the lullaby "Hushabye, Don't You Cry," then began improvising on that tune, which evolved into an improvisation specifically for Miriam, "It Will Be All Right" (see Appendix). Miriam would once again become quiet while I sang it, although when I stopped she would start screaming again. But

unlike other songs I sang, she did not interrupt this one.

This session was just a little more successful than the previous one, but the difference was significant. I did not ask as many questions. More importantly, the music did not demand anything of her. This time the musical improvisations did not originate from her symptom ("Miss Inez"), and so did not call attention to her way of expressing herself or implicitly ask her to change it. If Miss Inez had been a real person, improvising on that name might have made sense: I would have been joining Miriam in her search, or in her grief. The next session gave me a clue as to what Miss Inez really was. It contained the following dialogue:

> M: Miss Inez, Miss Inez, Miss Inez [starts to cry], I'm sick!
>
> C: You're sick.
>
> M: [cries] Yeah.
>
> C: Oh I think I understand, Miriam, I think you're very unhappy because you're not well, and you don't know why.
>
> M: Right.
>
> C: That's right, I see. Okay, I understand. Well I want you to know that while I'm here, okay, I'm your friend, as long as we're here together, and it doesn't matter to me if you're sick or if you're well, I'm here today anyway.
>
> M: I know, but I Inez Inez is Inez.

C: I think what you're just telling me is, you understood what I said, but you still are unhappy about being sick.

M: That's the story.

C: That's the story, right.

M: Inez Inez.

C: Yeah, well I can understand, I can understand it's very difficult for you to not be able to speak the way you want to.

M: Miss Inez Inez Inez. [Sobbing:] And I can't get anything in Inez. [More sobbing, incomprehensible].

C: Yeah, so you can't get it out the way you want to, and there is nothing that will help you. Is that what you're saying?

M: Right.

Miriam had been telling me all along that she is upset with herself because she knows she cannot speak the way other people do. My first mistake had been to assume that Miss Inez was a real person, and to try to help Miriam either find her or come to terms with having lost her. My second mistake had been to assume that "Miss Inez" was a symptom of her agitation, something she did to express her distress. I had been trying to influence her, even through music, to give up this symptom, to show that her distress was diminishing. Of course, her distress only increased. Miriam had no control over Miss Inez.

Miss Inez was not a person, or even a symbol. "Miss Inez" was simply a symptom of aphasia. When

Miriam said "I want Miss Inez," she was not calling for Miss Inez. "Miss Inez" is just what came out instead of what she really wanted to say, which she could not articulate.

I don't think such symptoms, as bizarre as they seem, are uncommon in aphasia. My father had been the proprietor of an Albert's Hosiery franchise for many years. When he was almost eighty a stroke left him aphasic. For a while, he could not retrieve the words he wanted to express, and used business terms instead. He would call my mother "Credit," or my sister "Beigetone." Every other word he uttered was "pantyhose": "Get the pantyhose" when what he really might want was his dinner or even a newspaper, which he could no longer read. My mother, sister, and I were caught uncomfortably between the humor and the tragedy of the situation.

For some reason that nobody, not even her husband, could explain, Miriam must say "Inez" in order to produce any utterance at all. It was therefore a mistake on my part to view it as a behavior that needed to be decreased or extinguished. But it still took me a while to use this insight, because I had not yet completely worked through my own countertransference. The turning point came one day when she spotted me in the doorway and cried, "I can't stand that man!" It

was hard for me to deny that I was doing something wrong. I had to find some way of changing the direction of therapy, or I would lose the entire process.

Reflecting on previous sessions, I realized that I had been throwing a lot of words at Miriam, asking her a lot of questions. I had been asking her to do precisely what she could not do, which was verbalize. Now I kept my verbalizations to a minimum. I sang popular songs for her, supporting myself on guitar, which I had just begun to play. Her chart told me that she used to enjoy dancing with her husband at the local senior center. I chose songs I thought she would be likely to know, like "Ain't She Sweet," "Let Me Call You Sweetheart," "You Are My Sunshine," "Daisy, Daisy." She would begin to be attentive if I just let her listen. When I asked for her preferences, she became upset. I stopped asking. I now spent the subsequent sessions playing and singing for her, allowing her to listen without interruption, seeing if I could get through an entire session without speaking a word. Typically, Miriam would lean forward in her chair, looking interested while I played. Once or twice she even sang along. She even began to thank me after the sessions, and she stopped getting upset when I came to the floor to greet her.

It was now clear that Miriam experienced any verbal approach, even the most gentle and reassuring, as a profound stress. Even asking her the most simple question was a demand for her to speak, a burden she could not carry. It placed her repeatedly in a position of frustration and failure. My insistence that I demanded nothing of her only sent her a double message: I was still asking her questions and hoping for answers.

Miriam tried to tell me this before. What she said made perfect sense: she said no when I asked her if she knew any Inez, or liked the name, or enjoyed saying it. Of course she did not enjoy it; she was compelled to do it. She told me I wasn't listening to her. She yelled at me, and at first I attributed that to dementia, instead of trying to understand its meaning.

The truth was that I had been so caught up in my own world that I failed to see Miriam's. Miriam was one of my first patients, and I wanted to be a good intern, to do a good job. I believed I was there to do "therapy," and not just to play music. I feared I would be seen as lacking if I failed to make "interventions," if all I did was play for the patient. I allowed these internal pressures to influence me, and so I cut off the flow of my own intuition and did not

realize how unreceptive, even rejecting, I had been despite my best intentions. Projecting my own insecurity onto Miriam's music therapy sessions made it a countertransferential issue, and once again I saw how crucial it can be to examine and become aware of one's countertransference.

And then something happened that finally made Miriam's situation clear to me, the last and decisive piece of the puzzle. One day when I went to get Miriam for the session, I found her husband with her. I invited him to join us. Miriam was already upset. Every time she cried or said "Miss Inez," her husband would bark at her: "Stop crying!" or "We've heard enough!" Of course, this did nothing to quiet Miriam. What it did was reveal an important dynamic. Miriam was clearly very dependent on her husband, who was frustrated with her, under a great deal of stress himself, and did not know how to reach her. Without realizing it, he constantly rejected her. While I found that soft, slow music tended to soothe Miriam, he kept asking me to play something fast, up-tempo and vigorous. When I did as he asked, Miriam became agitated, as I knew she would. I tried to make him aware of this pattern, but he was unreceptive. His musical choices seemed to express his denial, his

frustration, and his wish to force Miriam out of her dementia.

Being so dependent on someone who is so rejecting has instilled in Miriam a deep sense of futility and frustration with herself. I could now see where she got the sense that any approach is a demand she cannot fulfill, a burden she cannot bear. She so much wanted to please her husband, who let her know in many unintentional and subtle ways that she was failing. I became the object of a powerful transference: for me to approach her in any way, even to ask her a simple question, triggered her fear that once again she would be asked to perform beyond her capacity, set up to fail.

I tried putting myself in Miriam's place, asking myself what I would need if I were faced with constant disapproval. I began to give Miriam a lot of positive reinforcement. I praised her for listening, for paying attention, for enjoying the music. I told her repeatedly that she had done very well. I gave her a message opposite to her husband's. The results were almost immediate. Miriam began to listen attentively, no longer cried while I sang, and even started saying "Yes" when I asked her if she enjoyed the session. This was indeed something new!

For Miriam, music was most therapeutic when it asked the least of her, when I simply allowed her to listen. Like my depressed patients, Miriam needed to be fed. She also needed to be truly accepted. This meant I had to become aware of Miriam's world, and of the violence I had unintentionally been creating within it.

Miriam helped me see even more clearly that love is not just a positive feeling; it requires awareness. My feelings toward her were always positive; I had been practicing "unconditional positive regard," but it was not enough. Miriam showed me how one can feel positively toward someone while still unwittingly rejecting her. I may have enjoyed working with Miriam, may have relished the challenge, may have felt extremely sympathetic, but Miriam could only begin to feel love once I truly became aware of her.

Once I became able to see Miriam's perceptual world as different from my own, I could use music to cross that barrier. Words alone certainly would not have helped. My awareness of her, expressed in the musical presence of the session, gave her a sense of recognition and love, so that she no longer dreaded the sessions but expressed much regret once they were over and my internship came to an end.

CHAPTER 5

EXAMPLES FROM GROUP WORK

What do you do when you think you're a therapist, but your "audience" thinks you're an entertainer? This was the ambiguity of the music therapy group, as I experienced it. I struggled a lot trying to find my way in music therapy group work. I had already had much experience in hospices and nursing homes using music with individuals. But music in a group? How does that happen without becoming a performance? How does it become therapy?

Originally I was very skeptical about what could be done in a music therapy group. I had been used to working with patients who would have made poor candidates for group work: terminally ill patients, patients in comas, patients with severe dementia. Compared to the individual work I already knew, I did not think group work could treat patients with severe disabilities in nearly as much depth. It took a year of experimenting, floundering, discovering, for me to discover how wrong I was.

First Group: Patients in Rehab

My first group met on a rehab floor. This meant the duration of hospitalization varied greatly. Every patient on the floor was involved in a rehab program, usually physical therapy, and expected to go home once the program was completed. Patients who did not recover in rehab and who had to be hospitalized indefinitely were eventually transferred to other floors. In fact, while some patients did indeed stay in the hospital many months, by the end of my internship the membership of the group was completely different from when it began almost a year earlier.

This posed a special challenge. Since the group kept turning over, with members leaving and new members taking their place, how does one create a cohesive group environment? I never had the same attendance two sessions in a row. At times the attendance roster numbered up to thirty people, but rarely did more than a third show up at any one session. This was only partly due to the large turnover. Even members who were there for many weeks could not always attend, either because another therapist wanted them, or because they were too sick on a given day.

Members of this group were generally in their fifties or sixties, with an occasional exception. Many were victims of stroke. Some were accident victims.

Sometimes there would be a patient with a chronic illness like multiple sclerosis, but this was the exception. I had more such patients in another group, on a chronic floor.

This group really made me wonder: what is the "therapy" in a music therapy group? I was used to doing group therapy with clients who are verbal, who initiate ideas and issues. It seemed like these people wanted me just to sing for them, to entertain them. It was hard to get them to suggest anything. And above all, I didn't want to be just an entertainer. I thought music therapists were supposed to be clinicians.

On my very first day Harry, an elderly, pleasant, and talkative man, set the tone for this group. He wanted a "song-fest" to "cheer the people up." He specifically wanted some happy, upbeat songs, to counteract the "down" mood of starting a new week in the hospital. He suggested many songs, songs like "When Irish Eyes Are Smiling," "Easter parade." "April Showers," "Always." It was wonderful to sing these songs with the group. But didn't they want to talk about how they felt, to verbalize their depression and help each other cope with it? Not usually.

Harry's attitude was typical. He did experience his share of sadness and depression, of homesickness

and longing to leave the hospital. But he did not like to talk about it. He wanted the music therapy group to take him to another place, a time and place other than the present, in which he could be happy. It was soon Harry's last day in the group. He was going home. We sang one of his favorites, "Always." Harry started to cry as we sang it, as he thought of how his wife had helped him over many years. It was a touching moment, one that might have led to much remembering and sharing. But Harry was embarrassed, and despite my reassurances he wanted immediately to change the subject to lighter, more superficial things. We said a warm good-bye, and Harry left with encouraging words for the group.

Singing familiar songs was always what this group liked to do best. I would try to experiment with other things, which occasionally worked. To the tune of "Down by the Riverside" I would sing "I'm gonna lay down my burden," and let the members take turns saying in the song what were their greatest burdens. One day Eleanor, another member, complained that the nurse didn't come when she needed her. I improvised a song, "What Can You Do When the Nurses Won't Come?" It was a simple tune, over alternating I and ♭VII chords, which provided a dark, "Mixolydian" flavor to fit the

subject. Each member got to answer the question. Alby said "Nothing!" Louise said she does as much as she can for herself. In general, however, this group showed great resistance to doing anything improvisatory. Once when I suggested that they move their arms to the music, they complained that they had already done a lot of movement in physical therapy, were tired, and wanted just to sing. Nothing seemed to give them as much pleasure as singing old songs that were dear to them.

I continued to wonder: Was I doing real music therapy, or was this just a sing-along? It seemed to me as if they only wanted to be entertained; they did not like talking about issues. So I tried to put some "therapy" into the songs. If I sensed an issue that was difficult for the members to articulate, I would look for music that could express it in a nonthreatening way. One day some members were expressing frustration about being in the hospital for so long. I could tell many of them were feeling homesick. I looked for an appropriate song, and came up with "The Sloop John B," with its refrain "I feel so break-up, I want to go home." This touched off a rebellion. Even the humor in the song did not mitigate the reaction: some members thought it was too depressing and wanted to sing about something more

uplifting. One member criticized practically everything I did, telling me I shouldn't make such a big deal about music therapy, because "music itself is therapy."

Those words haunted me. I felt I needed to change what I was doing, perhaps taking more cues from the members themselves. Because I am legally blind, I carry with me a notebook with words to songs in extremely large print. The print is large enough for most members to read easily at a distance. I noticed a number of them taking an interest in this book, reading the words, wanting to know what songs it contained. I went back to my computer and printed copies of the songbook that each member could use during the session. I included the songs they requested most, songs like "When You're Smiling" and "What a Wonderful World." Since the members didn't like to play instruments anyway, I felt having them hold a songbook in their hands took nothing away from them.

This seemingly incidental change transformed the character of the group. With the words right in front of them, members' participation in the music increased dramatically. The sound of singing could be heard in the corridors, attracting more patients to the group. The membership of the group literally doubled.

My whole idea of music therapy in a group setting began to change. I saw that we did not necessarily have to process issues as in a psychotherapy group in order for the results to be therapeutic. At the same time, this was not simply entertainment. These people were letting me know precisely what they needed. If at the end of an hour of singing, the mood of the group changed and the members felt uplifted, what more would I have wished to accomplish? My main concern was to make sure the experience was interactive, that I was not doing all the work entertaining them while they sat passively. The challenge became how to give them what they needed while still encouraging them to be a fully functioning group rather than just an audience.

I wanted to explore how love could be present in such a group. I first needed to learn to love them, by becoming aware of what they needed instead of imposing my own program or preferences. If they did not want to talk about their grief, their sense of loss, their depression, I would not be helping by trying to force them. Once I became more aware of them, I could help them become more aware of each other. The group could still help them come out of their own private worlds, to recognize and try to understand one another. In this way also love could be present in the group.

Love was perhaps most present in the group in the music itself. The music gave them pleasure; it gave them joy; it gave them a sense of togetherness, of being united in spite of a difficult situation. Often one member would suggest a song that nobody else knew. I would try to learn that song, then teach it to the group. Then other members might then request the same song, because they knew it would give joy to the member who first suggested it.

I tried to use music in very simple ways to make the members more aware of each other. I composed two "Hello" songs (see Appendix). The first song leaves a little space for each member to respond; the second has more the flavor of communal singing. Both songs use the members' names, which helped me and the group learn the names of new members. I also used another song I wrote, "By the Magic Willow Tree" (see Appendix), which has an interactive structure: The whole group sings the first three lines, then each member has a turn to sing the last line and "hand it off" to another member of the group. I hoped these songs would help them break the ice and overcome any sense of being strangers.

My goals for the group shifted. Instead of trying to get the members to speak about their feelings and express them directly, my goals became: to promote group cohesiveness, and to help the members strengthen

themselves from within, to become more able to resist what I call "institutional depression." The group seemed to be meeting those goals. Members became more aware of each other, often asking about any member who might be absent on a given day. The overall mood of the group greatly improved, and the group remained about twice as large as it had been before.

Something else happened in the group, a rather ironic development. As members felt more comfortable within a friendly and loving musical environment, they spontaneously opened up in ways they never did before. If someone had a crisis that needed immediate attention, they seemed more comfortable expressing themselves and talking about it. I had wanted them to do this before, but my direct approach only inhibited them. Now the music provided a "holding" or "facilitating" environment, giving members the security to express themselves spontaneously.

Kelvin was a very depressed man who covered his pain with a raw sense of humor. "I was two hours late for my wedding," he once told us, "because I was out shooting pool. But my wife didn't mind, because she knows me." Once Kelvin requested the song "Amazing Grace." Something in his manner prompted me to check in with him. For the first time he opened up, sharing with the group his anguish about his teenage sons, who

were acting out in his absence, missing school, staying out all night, and talking back to their mother. He expressed great sorrow about not being there to discipline them. He also spoke of how he used to act out himself when he was young, and how his father talked sense into him and made him realize the importance of getting an education. He said he loved his kids and talked to them every day. I asked the group how they might support Kelvin musically. We sang a song for him, "Let It Be," and for a moment one could see how touched Kelvin was, just before he reverted to his old joking self.

It is important to find musical ways of supporting members through difficult transitions. One of these is saying good-bye, which we often had to do when a member would be discharged or a particularly loved staff member would be transferred. At such times I would have the group sing Woody Guthrie's "So Long, It's Been Good to Know Ya," with a concluding stanza I wrote in which we inserted the departing member's name:

> So here is to _____ who's been such a good friend,
> Her stay at the hospital's come to an end,
> With some of the best people we'll ever see,
> So may God go with you wherever you be.

Once again, the music demanded nothing of the members, but supported them in a way that made them able to express themselves if they needed to. On one

such occasion Kelvin revealed his own feelings about saying good-bye to people. He said he tries not to get close to people, because the separations that follow are too painful. He told us how close he was to his father, who died very suddenly. He said he didn't want his own sons to get too close to him--he tells them to get close to their mother instead. I asked him if he wanted to sing something for the group to express the way he felt. He seemed grateful that someone recognized his need. He sang an old spiritual, "When you confess to the Lord, Call Him Up, Call Him Up," something he used to sing in church. It was a plaintive tune in modal minor, revolving around the tonic minor third, then followed by three ascending notes on the repeated "Call him up" as if the melody itself would rise to heaven. Kelvin had a haunting, beautiful way of singing it, full of feeling, with the expressive "blue" notes characteristic of much black spiritual music. I was able to find his key, E flat minor, and supported him at the keyboard. Kelvin did not return to his defensive good humor so quickly this time.

The stories of two other members may perhaps illustrate how the people in the group supported each other, and the role love played in their therapy.

Alby was a Jewish man, in his early forties, with multiple sclerosis. He could not walk at all and had little use of his arms. He would sit in a wheelchair with a very tall back to support his head. He must have suffered some cognitive deficit due to his illness. He would speak impulsively and inappropriately, seeming to address the air rather than anyone in particular. In the middle of a song, or a meditation, or when another member was speaking, he would suddenly say "I hope I go home fast," or "I hope my kids come to visit me," or "I want to be healthy." His comments were always self-referential, with no coherent context.

I felt very deeply for Alby, who was a soft-spoken man with a sweet disposition that invited sympathy. But I found him very difficult to work with in a group, largely because I was worried he might become disruptive to the others. My initial objective was to ground Alby's self-expression in the context of the group as a whole. I wanted to connect him to the other members. I asked him to speak about himself and his life, so that the others could hear him. Alby told us he was born in Turkey, and had lived 16 years in Israel. He speaks Turkish, Hebrew, French, and English. He told of his father and brother, how he barely knew his brother, who is only three years

younger and lives in Israel, and how he was eagerly looking forward to his brother's upcoming visit.

Giving Alby room to express himself at some length helped the other members get to know him. I also wanted to integrate him musically into the group. Alby did not relate easily to the popular songs and spirituals that the other members liked. I played a Hebrew song for him, "Hatikvah" ("The Hope"), and had the other members participate by playing along with their instruments. Alby recognized the song and brightened when he heard it. I commented on the religious themes in the song, then sang "Amazing Grace," another song with religious themes that was a favorite of the other members. I noted how similar the two songs are, and particularly how hope is so important in each.

Now that Alby was becoming more visible to the others, he needed to learn how to interact with them. When once again Alby started to speak to the air, I asked him to direct his words to Eleanor, a member of the group suffering serious complications from diabetes and who was also severely depressed. Alby turned his head towards her and said in his halting English, "I hope you feel better."

For a while after that I gave similar direction to Alby whenever he would spontaneously vocalize. I

wanted him to practice being more aware of the other members. Alby picked up this new habit fairly quickly, and after a while his verbalizations became much less self-referential, and much more solicitous of the others. Instead of just talking about himself he would now often say, "I hope everybody will feel more healthy and get better." Alby even showed he was becoming more aware of me. For several sessions after I mentioned to the group that I am legally blind, Alby would ask me, "How are your eyes?" I was touched. Alby had learned how to express his loving nature by becoming more aware of other people.

Gradually his disease progressed, and he could no longer sit up in a wheelchair. This meant he could no longer come to group; he was confined to his bed. I hoped the group could find a way to return the love that Alby had begun to express. At my supervisor's suggestion I had the group improvise a song for Alby, which I taped and later played for him at his bedside. The tune was a Hanukkah song that he knew and loved. Interestingly, the words the members improvised indicated that they valued Alby as someone cheerful, always smiling, nice to be around, and a kind spirit. As I played the tape for Alby I saw tears form in his eyes. But he kept smiling and said that he doesn't cry. I told him it was good to see him smile.

Lucille was admitted to the hospital only two months before my internship ended. She was about 60, recovering from a stroke, very frail, and very angry. "There is not enough love in this hospital!" she would announce, with audible bitterness. In one sense she was right: the hospital could often be a cold, impersonal place. But Lucille also seemed oblivious to the good will the group tried to offer to counteract this impersonal atmosphere. Sometimes she would criticize the other members, telling them we all need to love each other more. And she especially criticized me. She let me know that she did not trust me, and did not care for the way I ran the group. The spiritual songs we sang were not enough for her: she lectured me a few times for not ending the group with a prayer, even after I explained that this is not a religious group and that we have members from many different backgrounds.

Lucille personified a basic human dilemma. There were reasons for her lack of trust; still, her lack of trust was her worst enemy. One day she had an accident. I was not present when it occurred, and heard about it later from the others. I had wheeled Lucille into the dining room, where our group was going to meet, and then I left to bring in another member. Lucille apparently did not like the spot where I had

placed her, but instead of waiting and asking for help, she tried to move her own chair. Even though she could hardly walk, she stood up and tried to wheel her chair from behind. She slipped and banged her head hard on the floor. I heard the others suddenly cry out for a nurse, and I ran back into the dining room, where I saw Lucille sprawled on the floor. The nurses took her out and revived her. I tried to speak to her, but she was incoherent. She was removed to another hospital for observation and treatment.

Two weeks later Lucille was back, as ornery and feisty as ever. I let her know I was concerned, and glad she was doing better after her accident. In her own way, Lucille contributed to the spirit of the group. She had a beautiful soprano voice that the other members liked to hear. And this time, after we sang "This Land Is Your Land," Lucille made us sing it again, demanding "more oomph." I picked up the tempo and dynamics, and it worked well.

Lucille never lost her angry edge, but the other members seemed not to react to it or take it personally. One member, Alqueen, also a strong presence, told Lucille directly: "You know, there's a lot of love in this group." This time Lucille could hear it. She insisted on saying that there is also God, to which everyone agreed. I was glad that in

spite of her anger, Lucille got a positive response from the group.

My goal for Lucille was to enable her to trust others more, when trust is appropriate. One sign this goal was being met was Lucille's change in attitude towards me. She began to speak to me no longer with anger, but with much warmth. On the last day of my internship Lucille was too sick to come to group, and had to stay in bed. After the group I went to her room to say good-bye, and I gave her a copy of the songbook we had been using, with a personal note inscribed. She looked up at me and said, "You really do love me."

The last day was a day of mixed emotions. Many in the group were crying. I told them I felt we had established a little community here within the hospital, and that I hoped they would continue that sense of community after I left. The members expressed much love towards me also. It is an important part of the termination process to enable them to do this. Some of them gave me a card with a personal note expressing their appreciation, saying they would have felt incomplete had they not done so. People who are disabled, living in a situation where so often they feel powerless, derive a healing sense of their own power through knowing that they too are capable of expressing love and giving back to others.

Second Group: Patients in Long-Term Care

This group was very different from the first. Since it began in the second semester of my internship, it lasted only four months. The members' disabilities were more severe, and their needs were very different from those in the first group. One thing this taught me is not to generalize too much about what a music therapy group is or what it needs. Nevertheless, love played as important a role in this group as it did in the other one.

Since this was a long-term floor, the turnover in membership was not as great. Those who attended most regularly were:

Bernard: age 68, cerebral palsy and mental retardation. Bernard has virtually no mobility. He is strapped into a very high wheelchair that barely gives him adequate support. He can communicate only through facial expressions and very simple verbalizations.

Lori: age 55, multiple sclerosis. Lori is the highest-functioning member of the group, and often looks out for the others. She is a former schoolteacher who used to teach music and still has a limited ability to play the piano. She is very articulate and her spirits are usually good, although she easily becomes physically exhausted. While she can use her arms, she needs a wheelchair for mobility.

Rosemary: age 50, multiple sclerosis, depression. Rosemary is far more severely impaired by her m.s. than is Lori. She has limited use of her arms, and her speech is slurred and halting. She also has some cognitive deficits, particularly in short-term memory.

Odell: age 80, acute cardiovascular disease, right hemiparesis. Odell is totally dependent on others for mobility; he is either in bed or in his wheelchair. He is also totally blind, and has some cognitive deficit. Odell would often complain of constant pain, and has a strong tendency toward depression.

Eva: age 102, organic mental syndrome. Eva is a small, frail woman, usually optimistic, with a good sense of humor. She also has no independent mobility, but is able to use her arms.

This was a very challenging group. Except for Lori, the members volunteered or suggested very little. Lori became a helpful catalyst for the group. I often had her lead the others in a familiar song at the piano. This accomplished two things: it gave Lori a sense of fulfillment in being active and practicing her skills, and it promoted within the group a sense of the members helping each other.

It was easy to rely upon Lori to energize the group, but the obvious danger was the possibility of focusing attention on her at the expense of the others.

How could I become aware of each of their worlds, which seemed so limited? How could I help them become aware of each other?

I began by asking them for their musical preferences. Lori loved all kinds of music. Rosemary had a special love for the Beatles. Eva loved religious music and spirituals. Bernard liked to listen to the radio. Worlds so different, I wondered how they could meet. I could at least try to recognize each one.

When it came to Odell, his preferences were quite definite. "'Drums Along the Mohawk!' 'Flight of the Bumblebee!' 'Indian Love Call!' 'Jungle Drums!' and 'Teekwa!'" (Later we were able to figure out that this last one was "Tequila.") I thanked Odell for letting me know what he liked. "'Drums Along the Mohawk!'" he intoned again, and went through the entire sequence. He would do this repeatedly throughout the session, and for many sessions thereafter. I often had to interrupt him, to help him learn to listen when it was another member's turn to speak.

I wanted to meet Odell in his world, to let him know that I recognized it. I was never able to identify "Drums Along the Mohawk" and "Jungle Drums," but I located the music for "Indian Love Call," a duet from the show Rose Marie that I remember once hearing

in a movie. It was a love duet between a man and a woman, so I had Lori sing the part of the woman, while I took the man's part. It didn't work. First, it lacked an engaging rhythm to make it attractive as a piece for group participation. Second, Odell didn't recognize it. But he did love it when I brought in tapes of "Flight of the Bumblebee" (Rimsky-Korsakov) and "Tequila" (The Champs). I had Odell conduct the tape while the rest of the group played along on instruments, giving them a chance to share Odell's world.

Finding Odell's music and making it a group experience helped relate the others to his world. A more difficult task was relating Odell to theirs. Odell had a tendency to perseverate, and his blindness was an additional factor tending to isolate him in a world of his own. I began each group by physically orienting him to his surroundings, letting him know how many other people were present and where they were sitting. I also let him know whenever anyone directed a question toward him, or said something that I wanted him to hear. He often needed someone to direct his attention, since he would become so caught up in his own perseverations.

I think it was the power of the music itself more than anything else that drew Odell out of himself.

Recognizing something familiar seemed to make him happy. And as the weeks progressed, a sense of humor emerged that at first was completely hidden underneath his depression. When I first tried to surprise him with the tape of "Tequila," I found to my dismay that I had unintentionally recorded over it. I had just promised Odell a big surprise, and so I explained the situation to him very apologetically. To my amazement he seemed to think it was funny. I had never seen him laugh the way he did. I thought to myself, I should always be this lucky when I make a mistake.

While the draw of Odell's internal world was strong, it did not imprison him. He began to show an extraordinary ability to laugh at himself, and to transcend his limitations. One day we heard it for the umpteenth time: "Drums Along the Mohawk! Indian Love Call! Jungle Drums!" This time the group made a joke out of it. Everyone was laughing, but none so hard as Odell himself. I thought he would fall out of his wheelchair. He became even more expansive, adding to his repertoire: "St. Louis Blues! Kitten on the Keys!" I found "St. Louis Blues," and turned it into a jazz improvisation for the group. And "Kitten on the Keys" became some quick glissandos on the piano. Odell was having such a good time asking for it that he didn't care how authentically I played it. Something really

seemed to change in his personality. He responded to the atmosphere of the group in a way that took him out of his depression. I was also gratified to see him occasionally address other members or ask them simple questions.

In a similar fashion I tried to recognize the world of each of the other members. Eva loved spirituals, and some spirituals that involved the whole group very nicely were "He's Got the Whole World in His Hands" and "Amazing Grace." The first song is especially good for group work because it has a good strong rhythm that members can play along with, and it is easy for members to make up their own verses to it. Even a more personal song like "Jesus Loves Me," which Eva sometimes requested, became a group activity as I invited the other members to play in support of Eva if they did not want to sing it. Unlike my other group, which loved to sing but shunned instruments, this group loved to play. This was understandable, since most of these members were far more limited in their ability to express themselves vocally.

I found a clear entrance to Rosemary's world through the Beatles. The first time I played "With a Little Help from My Friends," her reaction surprised me. She looked up at me, moved her arms in the stiff, flailing motions of which she was capable, and said in

her halting, soft voice, "That's_____great!" But her eyes spoke with greater eloquence; they seemed almost to fill with tears.

Rosemary would respond this way whenever we sang the Beatles. It was like this the next session, when we sang "O-Bla-Dee, O-Bla-Da," and the next one, when we sang "Octopus's Garden." This song was appealing to the group as a fantasy of what it would be like to have complete freedom, and to live out one's dreams. Rosemary was pleasantly shocked to learn that it was written by Ringo Starr, not known for his composing ability. I wondered why that meant so much to her; it seemed she was impressed with good things coming from unexpected places. I observed that these songs must bring up some very pleasant memories for her. She nodded vigorously and promised to talk about them someday.

The group had a special meaning for Rosemary, who was chronically depressed. I believe that the group, and myself as well, represented for Rosemary a loving presence within the coldness of the hospital. Once Rosemary was late for group because she had a special appointment in physical therapy. Since no one notified me (as usual), I did not know where she was, and set out to find her. I got to physical therapy just as they were finishing with Rosemary. They promised to

send for a volunteer to bring her to the group, a process that might have taken an extra half hour. I thought it was important for me to bring her up myself, even if that meant delaying the group an extra few minutes. I can still feel the fear and relief I noticed on her face when she saw me, and see her arms reaching up to me. She seemed like an abandoned child who just suddenly found someone to take her home.

My greatest challenge in the group was Bernard. His physical and cognitive impairments were far more severe than those of the others. Bernard could not be specific about his musical preferences, but aside from wanting to listen to the radio (which I always turned on for him after the group), I sensed he also liked the Beatles songs we sang for Rosemary, or the jazz we played with Odell. Bernard could not move his body, but he could smile, and I used this response to communicate with him. I would mention his smile in songs the group would improvise together, and then he would smile even harder.

Bernard received some assistance from the other members. Lori was a good lip-reader, and used her ability to help me communicate with him. One day, as usual, I ended the group with a quiet musical meditation. Most members appreciated the chance to relax. However, Bernard's mood got noticeably worse.

He stopped smiling, and looked agitated. I wondered if the music brought up difficult feelings for him. Rosemary, sitting next to him, reached her hand out to him and told him she wanted to help. Bernard once again began to smile. Not to interrupt the poignancy of the moment, we ended the group without saying a word, skipping the customary good-bye song.

After that day I tried whenever possible to seat Rosemary next to Bernard. For a while Rosemary was too sick to come to group. As I did with Alby in the other group, I had the group make up a song for her, which I taped. We used the tune "With a Little Help from My Friends," since Rosemary loved the Beatles so much and also since the theme was most appropriate. Bernard was unable to offer words of his own, but at the mention of Rosemary's name he gave a big smile.

I was happy to see the members becoming more aware of each other in loving ways. It took Rosemary a couple of weeks to recover, and when she returned to the group we sang the Beatles song "Hello/Good-bye," to welcome her and to comment musically on her comings and goings. She was delighted by this. However, Rosemary's usual mood was to be so self-effacing that at times she would even attack herself. One day, after singing "With a Little Help from My Friends," one member commented that while in a way we are all

strangers, when we all sing together she feels like we are friends and that supports her. Rosemary was profoundly moved. She expressed strong feelings about how much this song, and the group as a whole, have meant to her. Then she immediately berated herself, saying she felt "like a jerk" for having those feelings. Lori rushed in to support her. It became important for Rosemary to see that telling us what the group meant to her made Lori very happy.

From time to time I liked to use an improvised song, "I'm Gonna Lay Down My Burden," to the tune of "Down by the Riverside," because singing it often brought up the unexpected. I asked all the members in turn to sing a verse about what burdens they would like to lay down. One said "weariness"; another said "pain." When I got to Rosemary, the music stopped. She began talking about her husband, how she missed him and wished he could visit more often, how she wished she could be cured because her disease has kept them apart. Then her tears took over. When she could speak again, she said she felt stupid for having these feelings. I wanted her not only to express her feelings but to accept them, and I knew that support from the other members would count much more than support from me alone. I asked if anyone wished to say something to Rosemary. Bernard indicated a desire, but

could get no words out; nevertheless, Rosemary was touched. Others started talking about their own losses, so that Rosemary would not feel alone. Then on a hunch I asked Jennie, a member who attended very rarely because of extreme immobilizing back pain, if she had anything to say. Jennie said she is very fond of Rosemary and that she loves her. I told Jennie to say this directly to Rosemary, and she did. For at least a moment, Rosemary seemed to forget her self-hatred.

In these little ways, members were becoming more aware of each other. Something else that seemed to help was an ongoing group "theme song" that I had them compose. We used the tune of "This Land Is Your Land," which Lori could play at the piano while I supported on guitar. This tune has a small melodic range, a simple, symmetrical phrase structure, and a clear, engaging rhythm. It is very easy to sing, and perfect for a communal song. We built each verse line by line, each line contributed by a different member. Even Odell's impulsive interjections ("Thanks for the buggy ride!" "Let the good times roll!") fit in perfectly. For the last two stanzas I asked each member in turn to contribute a line describing a different member, hoping once again to promote their awareness of each other. This was the result:

This group is your group
This group is my group
It is a lovely group
Let the good times roll.
Let's play the beat (clap, clap, clap, clap),
Let's play the beat (clap, clap, clap, clap).
This group was made for you and me.

It may be raining
But we have sunshine
It's deep inside us,
Right in our hearts.
We're having fun,
We're having fun!
This group was made for you and me.

It's an all right group,
A very tight group,
And even visitors
Are glad they came.
Thanks for the buggy ride!
Thanks for the buggy ride!
This group was made for you and me.

Florence loves to sing along,
Lori is a fine teacher,
And we do love her
Very much.
And Bernard smiles,
That's very nice.
This group was made for you and me.

And Mollie's singing,
And Mack is laughing,
Lucia and Eva
Like religious songs.
We're having fun,
We're having fun.
This group was made for you and me.

This song became an ongoing project spanning many weeks. It represented what I hoped to help the members provide for themselves: a sense of community.

On the last day there was sadness, but also much joy. It was the members' opportunity to give something back to me. I received many good wishes from all of

them, each in his or her individual way. Some were more articulate than others, but all were equally heartfelt. Lori recited a poem she had written for me.

> Charles, I'm sad to see you go
> I know I'm going to miss you so,
> I wish you luck wherever you're going to go.
> I enjoyed all the songs you presented to us,
> Both fast and slow.
> And for all the music you provided for me
> I thank you so.
> You're a special person, you cared for one and all,
> And I loved your personality and your style,
> You showed happiness in seeing us smile.

The last line touched me the most, because it showed Lori's awareness of my own feelings, and hence her capacity for love.

Another member told me, "May the good Lord go with you and keep you." For others, their feelings were more evident on their faces than in their words. It was important for me to let them know I was aware of this, and how moved I felt. As with my other group, I learned how empowering it can be for people who feel helpless to know they can return love to someone who has been kind to them.

And so I have come full circle, from initial skepticism about the depth of therapy possible in a music therapy group, to realizing how these groups can become a unique medium for teaching and expressing love. I learned about love by becoming aware of the specific worlds and needs of the individuals in each

group, especially when these differed from what I originally thought the group should want or need. The members also learned something about love, by becoming more aware of each other and responding more to each other in ways that expressed this awareness. And the music itself added an element of love and warmth to a difficult and stressful environment.

CHAPTER 6

A LOOK AHEAD: MUSIC THERAPY AS PASTORAL CARE

Previously I compared a music therapy group in an institutional setting to a small community. A music therapist can play a special role within such a community. As in any pastoral setting music can bring comfort and support, helping people find their inner strengths, bringing them the presence of love in the various crises they may face. I came to feel that this was very much my role in the hospital this past year.

> To me, music therapy is really spiritual caregiving, but instead of a clerical collar I carry a flute or a guitar. I want to touch the person's soul, to let him or her know that love is still possible. As a music therapist, I know there are many kinds of music: a voice's gentle sound, a hand's light touch, the soft cadence of loving words. This music is available to all of us. (Gourgey, 1977, pp. 38-39)

Since the work I do is so much like chaplaincy, I have often been asked, have I ever thought of becoming a rabbi? My answer is yes, I have thought of it, but if I became a rabbi I would only be able to work with Jewish patients. To me, the essence, as well as the challenge, of love is bridging worlds that are different. I want to do the work of a minister without

the limitation of being able to minister only to certain populations.

Ministering to people means being present at critical moments in their lives, and not only at the officially scheduled hour. I now see this as one of the greatest potentials in work with music therapy groups. Through the structure of the group one becomes acquainted with many patients, and can follow the course of their progress over time. I have shared the joys of patients as they progressed in rehabilitation and became ready for discharge. I remember when Carmela, in our rehab group, first became able to walk again: she made a point of telling us even before telling her family. I could also remain present with patients who deteriorated, and who had to leave the group. The group enabled me to know them, but it also gave me the opportunity to move beyond its own structure in helping to care for them.

Since my first group was on a rehab floor, it was hoped that all patients there would eventually recover and leave the hospital. However, not everyone gets better. Sometimes patients decline, and cease to be candidates for rehabilitation. These patients can no longer remain on a rehab floor. Either they are transferred to another institution or, as often

happens, to the older, chronic wing of the hospital. In such cases I am still able to follow them.

I remember the day Kelvin was transferred. The other members of the group told me about it, and they were worried and concerned. Kelvin had not been making progress, and it looked like he was eventually headed for a nursing home. But first he was taken to the hospital's old wing, where the patients are sicker, the floors are more crowded, and even the lights are dimmer. Instead of a semi-private room, he was now in a ward. Because patients on these floors are generally lower-functioning, both cognitively and physically, there is little intellectual or interpersonal stimulation for those patients who do come with greater capacities. As a result these patients are at greater risk for institutional depression, and I have seen a number of them deteriorate markedly both in mood and mental capacity once they were transferred.

This started happening to Kelvin. His latent depression increased and became his dominant mood. He withdrew into himself, becoming quiet and sullen.

It so happened that I was already seeing individually another patient on the same floor to which Kelvin was transferred. Hattie was in her eighties, a tall, thin woman, totally blind and unable to walk. I would always find her sitting in the dining room,

listening to the radio whether or not she wished to. She would have her head cocked to one side in a thoughtful, or perhaps dreamlike expression. When I came to greet her, I always felt like I was awakening her from a deep sleep.

Hattie lived in terror. Her blindness made it difficult for her to trust: she was not well oriented to her physical environment, never quite knew where she was, and asked for constant assurances that I was taking her to the right place. Still, words never reassured her. She would not believe me when I told her we were in her room, but relaxed a little when I moved her hand so she could feel her bed nearby.

Hattie was a deeply religious woman, and loved spirituals and hymns. "Jesus Loves Me, This I Know" was the song that comforted her most deeply. This song was foreign to my own background, but I was glad to learn it and share it with her. This and others, "Blessed Assurance," "Take My Hand, Precious Lord," "Amazing Grace," made Hattie feel at home and safe in her own world. When she heard them she would smile and say, with her soft Carolina accent, "That's beautiful."

I became a part of Hattie's world. I seemed now to belong to her old church in the Carolina countryside, near the farm where her father worked as a sharecropper, near her home where her mother would sing

those same songs to her from behind her sewing. I also became a link to her deep faith, because no one else was sharing it with her in that way. This created a difficulty: Hattie always had a hard time saying good-bye. "Are you gonna leave me now?" she would almost cry, at the end of nearly each session. "Don't forget about me." And then her underlying depression would threaten to engulf her once again.

Hattie needed the stimulation of being with others like her, but the patients on her floor were so impaired that they could be no source of companionship. When Kelvin arrived, I brought the two of them together, and formed a "mini-group." At first Hattie was reluctant, fearful of any kind of change. But soon she saw that they had much in common.

Each one asked for a favorite Gospel song. I told Hattie that Kelvin is a wonderful singer, and invited him to sing. Kelvin sang a number of spirituals, among them "When You Confess to the Lord, Call Him Up," which I remembered from the other group. He accompanied himself by tapping a salt shaker on his bed table, in flowing syncopated rhythms. Hattie was enthralled: she waved her hands to the music, and smiled.

Kelvin then did some Bible readings, including Psalm 95, which begins "O come, let us sing to the Lord." I suggested reading John 14. This is the

chapter where Jesus addresses his disciples, telling them that after he departs they will have the Holy Spirit to comfort them. I wanted to send Hattie a message telling her that her faith is within her, and that saying good-bye to people would not take that away from her.

Then Hattie and Kelvin sang more Gospel songs together, some of which I did not know. I was happy to be left on the sidelines, yielding the leadership of the group to them. Hattie wanted Kelvin to pray for her, and he offered a beautiful prayer to God for "servant Hattie, who is blind in her body but who in her spirit sees better than a sighted person." Hattie's dark eyes filled with tears.

They lifted each other's spirits more than I ever could. I tried to bring them together each time I visited the floor. Hattie, so fearful of strangers, would now ask about "Mr. Kelvin" whenever I came to see her. I would tell Kelvin that Hattie had been asking for him, and let him know that it would mean a lot to her if he could find her in the hallway or in the dining room and say a kind word.

I wonder how the hospital's atmosphere would change if there were a lot of music therapists doing this kind of work, tracking patients as they worsened or were transferred, letting them know they would not

be abandoned. Such contact with patients could serve a function similar to a clergy visit, but with the added power of music.

Eleanor was another severely depressed patient from my rehab group who became worse and had to be transferred. Just before she left I remember how black her mood became. She had already lost one leg, due to poor circulation caused by her diabetes, and said if she were to lose the other her life would be worth nothing. She did not yet know that her kidneys were beginning to fail and she would soon become a candidate for dialysis. When she became too sick to come to group, I would go to her room right afterwards and do a couple of songs for her. This always made her smile.

Then one day when I went to her room she was not there, and her name was missing from the door. Carmela, her roommate, told me she had been transferred to the old building, at the other side of the hospital. I looked for Eleanor, and found her on the same floor as Miriam, the woman with severe dementia I had been seeing individually (see chapter 4). There was no longer any hope of rehabilitating Eleanor. She was now in a dementia ward, and had no one to talk to. Her depression became extreme, and in my view, critical.

I resolved to keep in touch with Eleanor and find room for her in my filled-up schedule. I began

including her in my sessions with Miriam, forming another "mini-group." They were good for each other. Eleanor identified and sympathized with Miriam's isolation and was very kind to her (as not many others were), and this show of affection helped both of them. Eleanor also showed me something: with a fond smile she would hold her hand out to Miriam, who would quietly take it into her own. Miriam could not speak an intelligible sentence, yet a rapport had clearly developed between them.

In time Eleanor's mental condition badly deteriorated. No doubt her illness was the major factor, but I am convinced that staff neglect and the change in her environment greatly accelerated the process. She developed paranoid ideation and ideas of reference, believing that staff members were speaking about her with hostile intent when they might just be casually conversing in the halls. She became belligerent, yelling and cursing at staff members and accusing them of lying and other forms of abuse. This lost her even more sympathy and aggravated her isolation. The only time I ever saw her mood improve was during music. She said she loved it when I sang to her, and she would always smile.

I was walking through the hall towards the old building one day when I heard screaming. It was

Eleanor, sitting in the lobby, waiting to be picked up for dialysis. The pickup was late. She was shouting abusively at the security guard, calling him a liar and a son of a bitch. I stopped and tried to calm her down. The security guard lost his patience and confronted Eleanor: "Now you've blown it. You've lost your privileges and you'll have to wait for dialysis upstairs in your room." He started to wheel her into the elevator when I told him I knew where she lived and offered to take her up myself. He was grateful to hand her over to me.

I took Eleanor to her room and we talked for a while. I could almost feel the tension in her body pulsing through the air. She told me again how much she hates herself. Her body was failing her, and she did not know how to react. I sang a song I taught her earlier that day, "Lean on Me." She sang the chorus with me, remembering most of the words. The melody seemed to carry the message of those words so simply and sweetly, and the subdominant chord in the second phrase always gives me a sense of warmth, which I hoped I was communicating to her. I asked her how the song made her feel. She said she loved it, that it made her feel good. She settled down, and for the first time in a long while I saw her smile again. The last thing I told her was to remember how that song made her feel,

and to keep that feeling in her heart, when she is alone and things seem hopeless. She promised to try.

Eleanor died the next day. She developed an infection, apparently resulting from the invasiveness and stress of the dialysis, that she could not overcome. I felt comforted that our work together ended in a warm, intimate moment. To the very end of her life, love was still available to her. She showed love to Miriam when others around Miriam rejected and ridiculed her. And even at the last minute Eleanor allowed music to show her that she could still have a little love for herself.

Pastoral care has many dimensions. Part of the work is looking after the one who gets lost, as Kelvin and Eleanor became lost from their group and nearly disappeared in the recesses of the hospital. Another important part of the work is looking after people at the most critical moments of their lives, even to the end of life itself. In such moments a music therapist can also play a role not unlike that of a rabbi, priest, or minister.

Bella was a 90-year-old woman who was so unresponsive she seemed to be in a coma. She was not actually comatose. Her admitting diagnosis was congestive heart failure; she was also blind, hard of hearing, diabetic, and severely demented. Medical

staff described her to me as very agitated, even hostile. When she was verbal she would cry out things like "Leave me alone!" or "Not now!" or she would cry out for her mother. Staff found her difficult to reach, not just because of her dementia, but also her defensive anger.

This was not the woman I found when I went to visit Bella. I was fortunate to be with her alone on my first contact. Bella was dying, and for a while I was back in hospice, an environment totally different from the tense and hectic scene of the hospital. We were alone in the small ward. I played a Jewish folk song for her on my tenor recorder, the one with the low, mellow sounds. Bella lifted her head from the pillow, opened her eyes wide, and looked straight at me. Then she took my right hand in both of hers, moved it toward her mouth, and kissed it. She did this twice. Then she moved my hand closer and placed it over her breast, underneath her gown. At first I resisted her motion, but her strength was deliberate and surprising for someone so ill.

My first reaction was anxiety. How would I explain the scene to a nurse or a family member who might suddenly walk in? But I was in hospice now, and these things happen in hospice. My anxiety was soon

replaced by a profound peace. Bella was letting me know what she needed.

After the visit I called a good friend of mine, one of the nurses at the hospice where I had worked, and described the scene to her. She asked me which breast it was, and I told her the left one. She said Bella was trying to tell me that the music had touched her heart.

When I next saw Bella, she was leaning over the side of her bed, coughing. She seemed agitated. I played some folk-like improvisations on my tenor recorder, something soft and low and quiet, then held her hand for several minutes. She covered my hand with her other one.

Bella was a different person when her daughters were present. They were not merely upset; they were cynical. I called the eldest to let her know that her mother had been referred to me for music therapy. She told me her mother was very sick, probably "on her way out," and that music didn't make any sense. She told me how frightened and weak her mother was. I explained that the purpose of music in such situations is not to entertain, but to help the patient relax, become calmer, and take away some of that fear. She listened attentively, but I felt her struggling with her grief.

I gently let her know this, and she seemed appreciative.

The last time I saw Bella her youngest daughter was with her. She would address her mother in a loud voice, trying desperately to get through. Now I saw what the staff people meant by describing Bella as ill-tempered and quarrelsome. Her daughter was trying to get her to drink, repeatedly making her take water from a cup with a straw. Each time Bella would cough and spit it up. Bella moaned and writhed on the bed. I went to her bedside and began to sing to her. Nothing changed, however, until her daughter went out, leaving me alone with Bella for a few moments.

I stood by her bed and let her hold my hand. Bella's breathing slowed down and stabilized. She stopped moaning and became still. She grasped my right hand with both of hers and held on with firm pressure. She kept holding on. I spoke to her reassuringly, told her she would be all right, that she could relax now.

Her daughter returned, and noticed the change. I asked her to take over. I withdrew my hand from Bella's grasp and put her daughter's hand there instead. I told the daughter this is all she needs to do, that her mother just needs to know that a caring person is present. I left her mother in her hands.

An hour later, Bella died. The floor nurse told me she went peacefully. I was grateful to hear this.

So often in hospice I have seen the effect that a family's anxiety and grief can have on someone who is dying. I can often minister best to the patient by treating the family members, helping them relax and let go of their anxious clinging as best they can. If the family is receptive, one can feel a noticeable change in the room, and see it in the patient. In such situations music may be the most universal form of prayer.

I have been using words one might associate with a pastoral setting, words like "minister," "spiritual," and "prayer." Music therapists do not commonly use such language. Is it possible to define a specific area within the field that one might call "pastoral music therapy"? Bruscia (1989) has already offered a definition, or at least a description:

> The pastoral area includes all applications of music and music therapy in religious settings which are aimed at spiritual development and the resolution of related problems. (p. 86)

Bruscia portrays "pastoral" music therapy as using music for specifically religious or inspirational purposes, endeavoring "to help the client gain spiritual insights and to develop a relationship with God that will facilitate emotional adjustment and

growth" (p. 124). While this may fall within the purview of what I would call "pastoral" music therapy, as a definition it is far too limited. Bruscia's description seems mostly to apply to religious settings. The specific examples I have described in this chapter point to a way of looking at music therapy as pastoral care that in my view is far more comprehensive.

The word "pastor" means not religious leader but shepherd. As a verb, to "pasture" means to feed, to nurture. Pastoral care means caring for people at all phases of their lives, at times when they are most needy. A "pastor" is not a specialist brought in from the outside to treat people only at certain appointed hours. A pastor is part of a community, and is felt to be so by members of that community. I have already given examples of the need to go beyond the regularly scheduled time and place of the group to follow members who went into crisis and had to be transferred. It was important to me not to lose track of these members, even though they were no longer officially part of my music therapy group. I have done this kind of work before. When I worked for an organization serving homebound elderly people, I would be on call to visit clients who had special illnesses or problems and who would not respond to visitors who could only

communicate verbally. Similarly, when I worked in hospice I was on call to visit patients who were entering a crisis, or were becoming close to death. My goal was to make music available as a comforting presence to people at times when they needed it most.

As I see it, pastoral music therapy may or may not be associated with formal religious settings. What makes it unique is the use of music to maintain a presence with people at critical as well as ordinary moments in their lives, and also bringing music to where people actually live, to their homes or hospital rooms. From a spiritual perspective, the presence of music represents a higher presence that we call God, which music can help make more accessible to people, even though God need not be explicitly mentioned. This is as far as I wish to go in addressing the spiritual role of music directly in this thesis; it has been implicit all along, but to go any further would require another lengthy presentation. Perhaps the following tentative definition will briefly summarize this discussion:

> Pastoral music therapy is the use of music to enter and to affirm the client's perceptual world, to maintain a presence with the client over time, to care for the client's emotional and spiritual needs in all phases of the client's life, through health, sickness, and even to the moment of death. By expressing awareness of the client's individuality, pastoral music therapy tries to make available to the client the experience of

> love and the healing effects of love, using the power of music to help the client become more motivated and capable of loving self and others.

Pastoral music therapists can work in a wide variety of settings. Large institutions are good places for this work, first because the need for a loving presence is especially strong in such places, and also because many patients are concentrated in a relatively limited space, making it easy for the therapist to keep track of them and maintain contact with them. But I can also see this approach applied to other settings. Why not have a music therapist as part of a religious congregation, available to visit the sick or comfort the dying and their families? Or as part of a nonreligious community, which may have no ministers or houses of worship while still needing ways of caring for its members' needs? When I worked with noninstitutionalized elderly people I visited them in their homes, bringing my instruments and music stand with me. It took a little longer and I did not get around to as many, but the idea is the same as working in a large institution: bring the music to where people live.

If pastoral music therapy is to be considered a specific approach to music therapy, it is important to ask what special qualities or competencies might be required of the pastoral music therapist, beyond those

required of music therapists in general. We might particularly emphasize the following:

A strong clinical background is highly desirable. As was emphasized since the very first chapter, issues of intrapsychic and interpersonal dynamics, transference, and countertransference are no less important for music therapy than for psychotherapy. They are especially important for pastoral music therapy, because the pastoral music therapist seeks to be present at the most vulnerable moments of a client's life and is concerned with becoming part of the client's world. The relationship can become close and intense. Very strong transferences can develop. I have given the example of Hattie, who did not trust easily but trusted me completely once I became able to join her world. Hattie had much trouble letting go of my presence; the ends of sessions were hard for her. I met this transference by trying to use her own faith to give her an inner strength to help her become independent of me, and by very carefully supervising the transition to another music therapist once the time for me to leave began to approach. I chose someone who I knew would relate to Hattie's spirituality, and educated him about her world, at the same time introducing him to Hattie and helping her trust him as she had trusted me.

Countertransference issues are also no less important than in any other form of therapy. One takes a risk when one enters the world of another; if one is not certain of one's own boundaries, there is a chance of getting lost. It is important to have a firm sense of where one ends and the other begins, even while one may need to play a role in someone else's world. It is likewise important not to confuse love, or entering the client's world, with merging with the client or feeling exactly what the client feels. Overidentification is a constant danger. If one identifies too strongly, becomes too enmeshed in the client's pathology, one may lose one's grounding in objective reality, and the client will lose a lifeline to the outside world.

This is especially true when working with dementia patients. Unless one is able to see the patient's world and actually assume a role in it, these patients may not be able to relate at all. One becomes like a "double agent," with two identities, one inside the patient's world and one outside. It is important to be able to experience both of these fully at the same time. Very often dementia patients are treated with contempt, fear, or indifference because those around them do not know how to relate to and enter their world, and so cannot form a connection with them. It is hard work.

Another important quality in a pastoral music therapist is familiarity with different religious and cultural backgrounds. Love, as awareness and presence, means bridging worlds that are different. Although my own background is strongly Jewish, my familiarity with the New Testament enabled me to speak Hattie's language, and to form a relationship. I think it is also important to observe that I was not just pretending or simply playing a role. I had a genuine feeling and sympathy for Hattie's faith, the result of having studied Christian theology and religious practice for many years. I was able to relate to her faith on more than just an intellectual level.

Familiarity with different cultures is especially important when it comes to music. Speaking the musical language of others, especially when it is not originally one's own. is the special challenge to the pastoral music therapist. I grew up mostly with folk and classical music. Rosemary loved the Beatles. If I was to enter her world and join her, I had to learn to love them too. And I had never even liked the Beatles when they were most productive and popular. Approaching this music required a stretch--entering another's world always does--and I studied Beatles songs, learned them, and came genuinely to love them. As with Hattie, I was not pretending, or it would not

have worked. If I did not genuinely love those songs, I could not have shared Rosemary's love for them, and thus could not have provided a loving presence for her. Rosemary stretched me--she made me confront some of my musical preconceptions, and she shattered them. And in the process, she expanded my own capacity to love.

Along with being "multilingual" musically, being multilingual verbally is a great help in pastoral music therapy. I was able to include some patients in my groups who spoke only Spanish, and who would not have been in those groups if I had not been able to speak their language. I remember also one patient who was almost completely aphasic, who could speak only in fragmented phrases in his own language. He was usually depressed and ill-humored, but I remember how his face would light up when I found I could still tap well enough into my high-school French to communicate with him, and when I sang with him some old French songs that he used to sing in his childhood.

One simple but highly desirable quality in a pastoral music therapist is maintaining a cheerful and friendly demeanor whenever possible. Because it can be so simple, I think we can easily overlook its importance. This was brought to my attention one afternoon when I was working individually with Miriam. After I sang my good-bye song, a woman entered the ward

wheeling in her frail and elderly aunt. The woman saw my guitar, and said she was sorry she had just missed the music. So I did one song, "Amazing Grace," just for them. The aunt was not responsive; she seemed totally incapacitated. But her niece was very touched. She couldn't thank me enough. A sudden impulse prompted me to ask: "What would we do without faith?" At this she opened up. She said faith is what keeps her going, and spoke to me about herself and her aunt and what they had meant to each other. What I remember most is what she said at the end: she thanked me for bringing so much joy into the hospital. I did not think I had done anything special. Her comment helped me appreciate what a difference it can make for people in such a place to encounter someone who is warm and friendly, and who does not treat them with "professional" distance.

Finally, an important quality for a pastoral music therapist is to have personally experienced the type of love that he or she wishes to communicate to others. One needs to know what it means to be loved in the sense of being seen and understood by an awareness beyond oneself, whether one experiences this awareness as another person or as God. One also needs to know what it means to see and understand others in this way,

to respect another's world as completely different from one's own, approaching it as sacred ground.

All these issues are important for supervision. Countertransferences will inevitably arise, and a therapist may well fear that a negative reaction toward the client will impede the communication of love. As in any supervision process, these countertransferences need to be recognized and worked through. Fear or resentment toward the client can become obstacles to love, but they are not reasons for a therapist to become harshly self-judgmental. Rather, they are part of the therapist's learning process. A therapist struggling with these issues can be comforted by two things: First, love does not require "unconditional positive regard," an uninterrupted positive response toward the client, but awareness and respect for the client's inner world. And as a therapist who experiences a negative reaction struggles with it and uses it to gain more self-awareness, a deeper awareness of the client will follow, which can then open possibilities of love.

I would like to conclude with two examples, both from hospice, illustrating how music therapy can become a ministry not only to the patient but to the family as well. Isabel was a 61-year-old woman dying of cervical cancer. At first the nurses told me she would probably

not be receptive to a visitor, but when I spoke to her in her native language, Spanish, she warmed to me and let me in. She asked specifically for religious songs, which seemed to comfort her--she wanted nothing else, not even love songs.

I visited her again two weeks later. By this time she was in a semi-coma. Although her consciousness was fading, she was hyperactive. She seemed almost to jump when I touched her, and if I played too fast it agitated her. I slowed myself down, and felt a connection starting to form between us. Her family was with us in the room: her son, grandson, and a close friend. I sang some songs, new to me but familiar to them: "Pescador de Hombres" ("Fisher of Men," a song about Jesus' calling his disciples) and "Noche de Paz" ("Silent Night"). They sang with me, while the friend held Isabel's hand. Coincidentally, at the word "sonriendo" ("smiling"), which occurred in the first song, the grandson, about five years old, came up to me and gave me a big smile. For a moment I felt part of the family. And I also felt Isabel's agitation dissipate, as her family comforted her.

Another woman, whose first name I never learned, was also in a semi-coma, suffering the effects of gastric cancer. This type of cancer produces extreme cachexia, a wasting away of the body, which can no

longer properly utilize available nutrition. I sensed in her presence an overwhelming sadness, and I felt drained. The nurses told me that her relationship with her daughter, who had many emotional problems, was very troubled, and suspected this had something to do with the patient's response.

The daughter arrived, and I asked her if she wished to be alone with her mother. She said no, she might need the music for herself as well. And so I stayed and sang at the bedside. Virginia, the daughter, told me her mother liked church songs, hymns and spirituals. I asked Virginia to hold her mother's hand, then sang "Amazing Grace," "Jesus Loves Me," "There is a Balm in Gilead," "Swing Low, Sweet Chariot." Virginia took her mother's hand in both of hers, and caressed it. Then she went to the head of the bed, began stroking her mother's forehead, and telling her soothingly, "Your work is done now. You don't have to cook and clean anymore. You don't have to iron anymore. You did really well. You'll be all right now." The tears on Virginia's face also brought tears to my own. The nurses were surprised at this connection; they told me Virginia's relationship with her mother had been distant. Hospice work has shown me how music can become a healing bridge not only between the worlds of therapist and patient, but also between

the worlds of family members and friends, even when relationships have been estranged.

Pastoral music therapy therefore means not only ministering to patients themselves, but to their families, who often may need more attention than the patient. It means bringing people together. Crossing bridges into worlds that are different, emotionally, culturally, or linguistically, requires a great deal of energy, far more energy that one needs when remaining within familiar territory. The Bible recognizes this, and therefore both the Hebrew Bible and the New Testament make a big point about loving those who are different. Pastoral music therapy will therefore bring these additional issues to the supervisory process: What prejudices or preconceptions may be elicited by a particular therapeutic encounter? Because the therapist gives so much of himself or herself to the process, how is the therapist's energy level affected?

There are many ways of doing pastoral music therapy. The examples I have provided reflect only my own way. With so many ethnic and cultural groups represented in a large city, no one person can learn how to minister effectively to all of them. There is a need for people of many backgrounds and capabilities to be trained in appreciating the "pastoral" perspective of music therapy. I am sure that therapists working

with populations very different from my own can find many different ways of applying this comprehensive approach to what is now sometimes called "caring for the soul."

This is how I would like to continue working as a music therapist: working in a home or an institution or a community where I can get to know the residents, share their joys as well as their losses, be with them when they are sick, and even help them prepare for their final moments. Such work requires many levels of training: musical training, clinical training, and familiarity with the cultural and spiritual backgrounds of many different kinds of clients. Music therapy deserves respect as a full clinical discipline, and I am afraid it does not always get this respect in the real world. I would like to see a time when music therapy will be considered a discipline in its own right, and not automatically subsumed under the heading of recreation. Music offers recreation, but it also offers much more. The healing that results from the therapeutic use of music takes place on many levels.

I have learned a lot this internship year about music, about therapy, and about the struggle to understand what it means to love. I may always see this as an ideal I will never fully acquire, but I feel enriched by the process of working with it and learning

more about it. Music adds a dimension to therapy that takes therapy to the boundaries of life itself, the places that fill us with awe and anxiety, and even deep peace. Working this way, as a "clinical pastoral music therapist," gives me a chance to make more real, to bring a little closer, the words that have always filled me with wonder: "There is no fear in love, for perfect love casts out fear."

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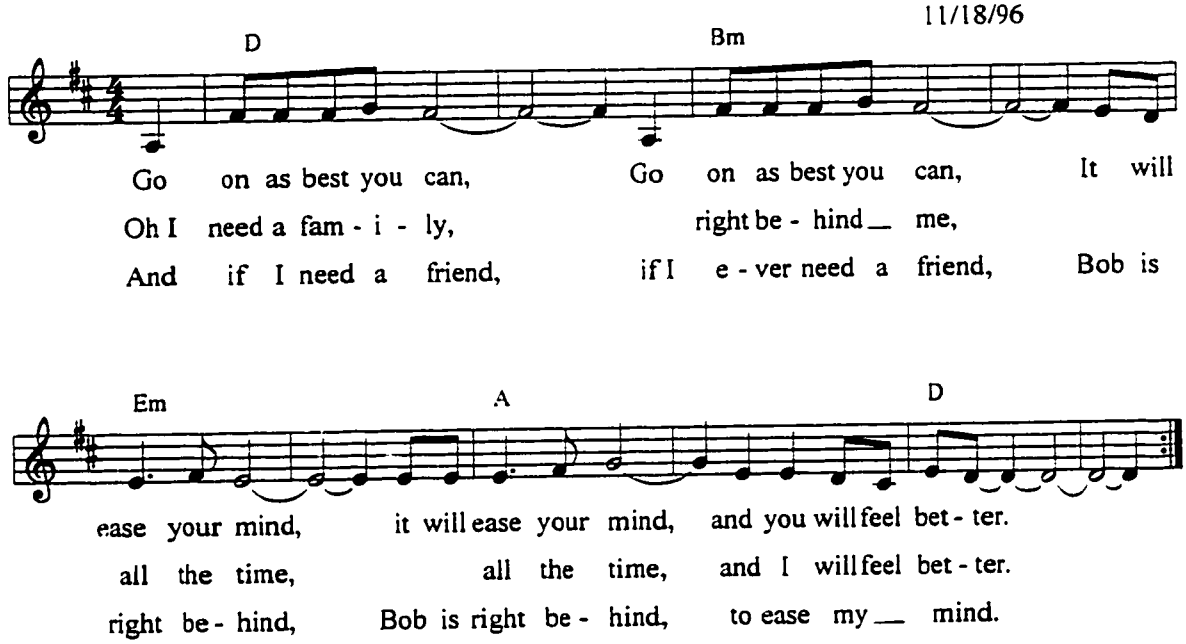
APPENDIX

Musical Examples

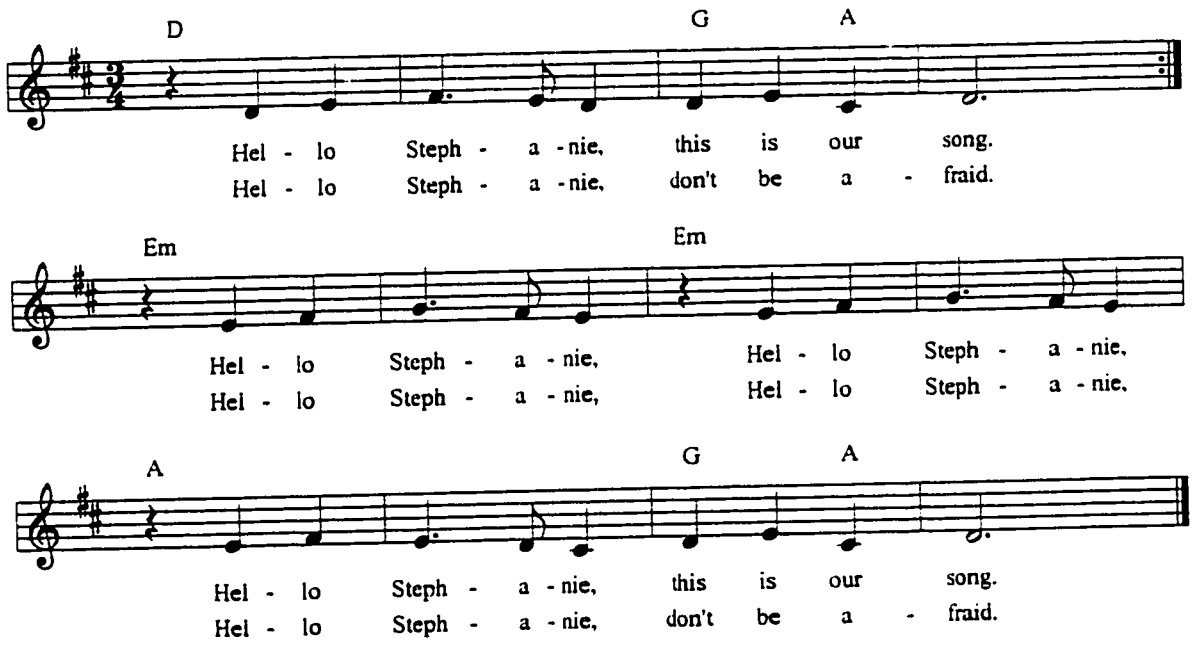
To Ease Your Mind

by Annette
11/18/96



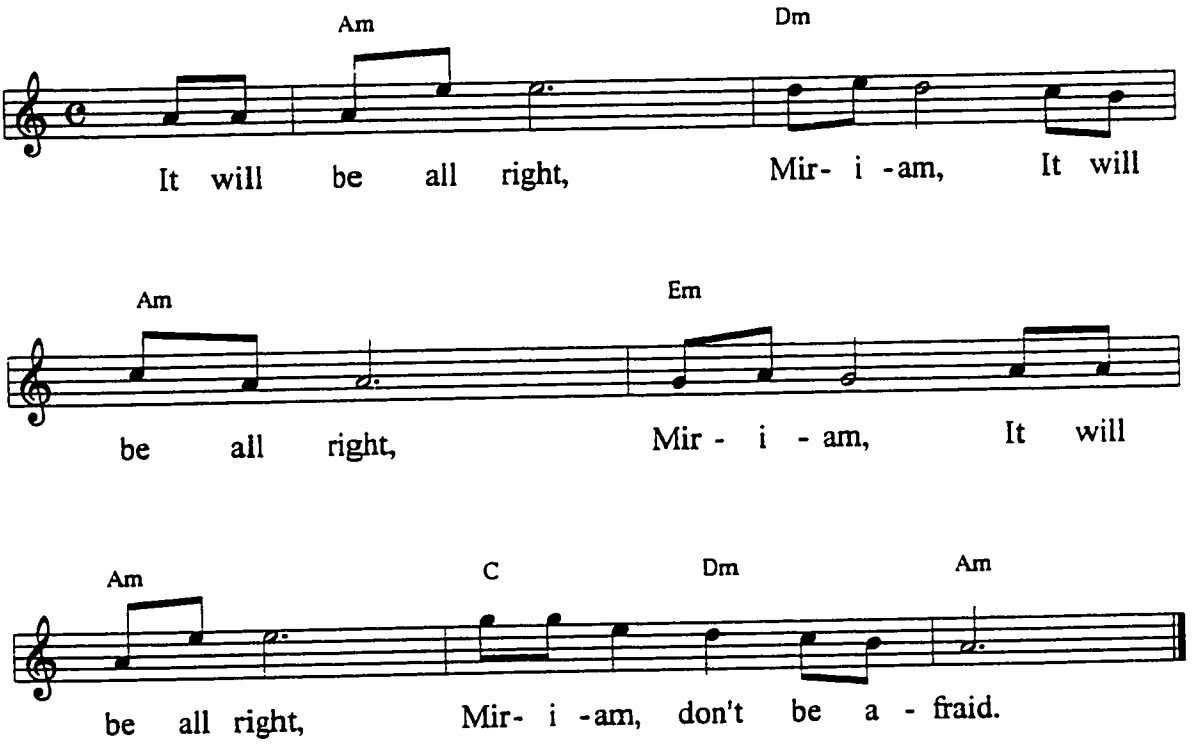
Stephanie's Song

"Contact Song" introduced 10/30/96



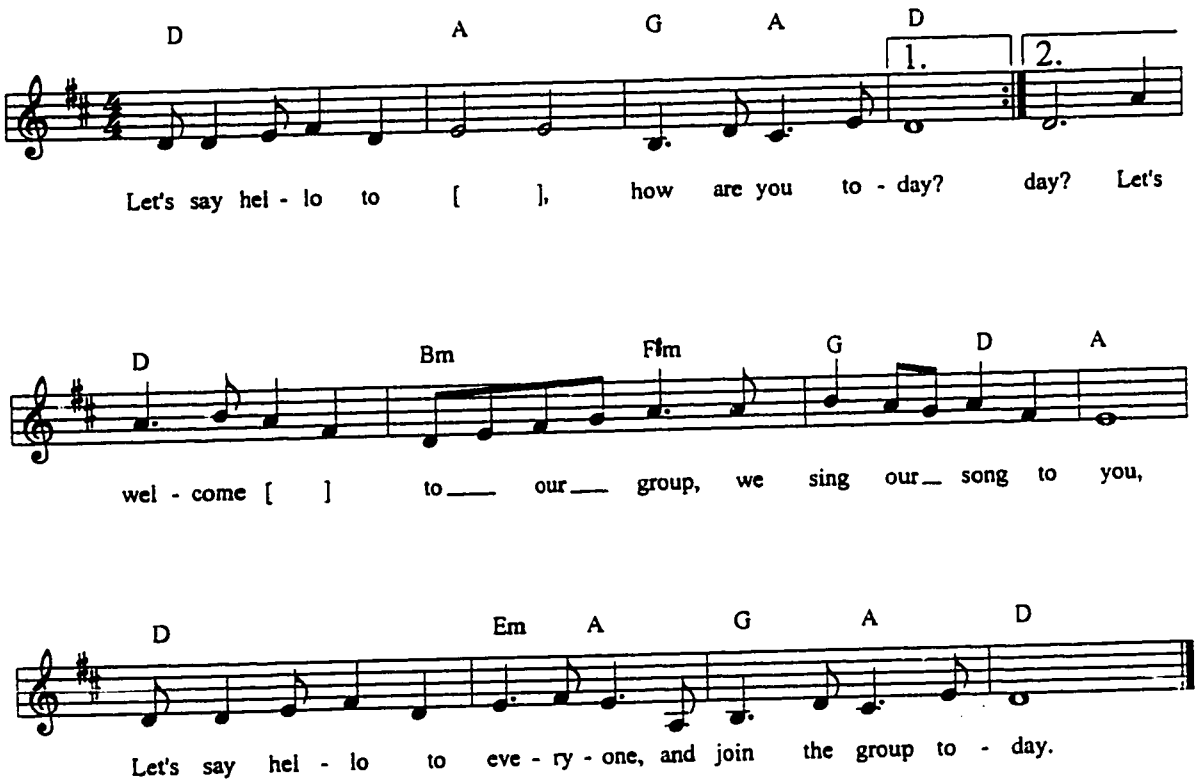
It Will Be All Right

for Miriam
12/11/96



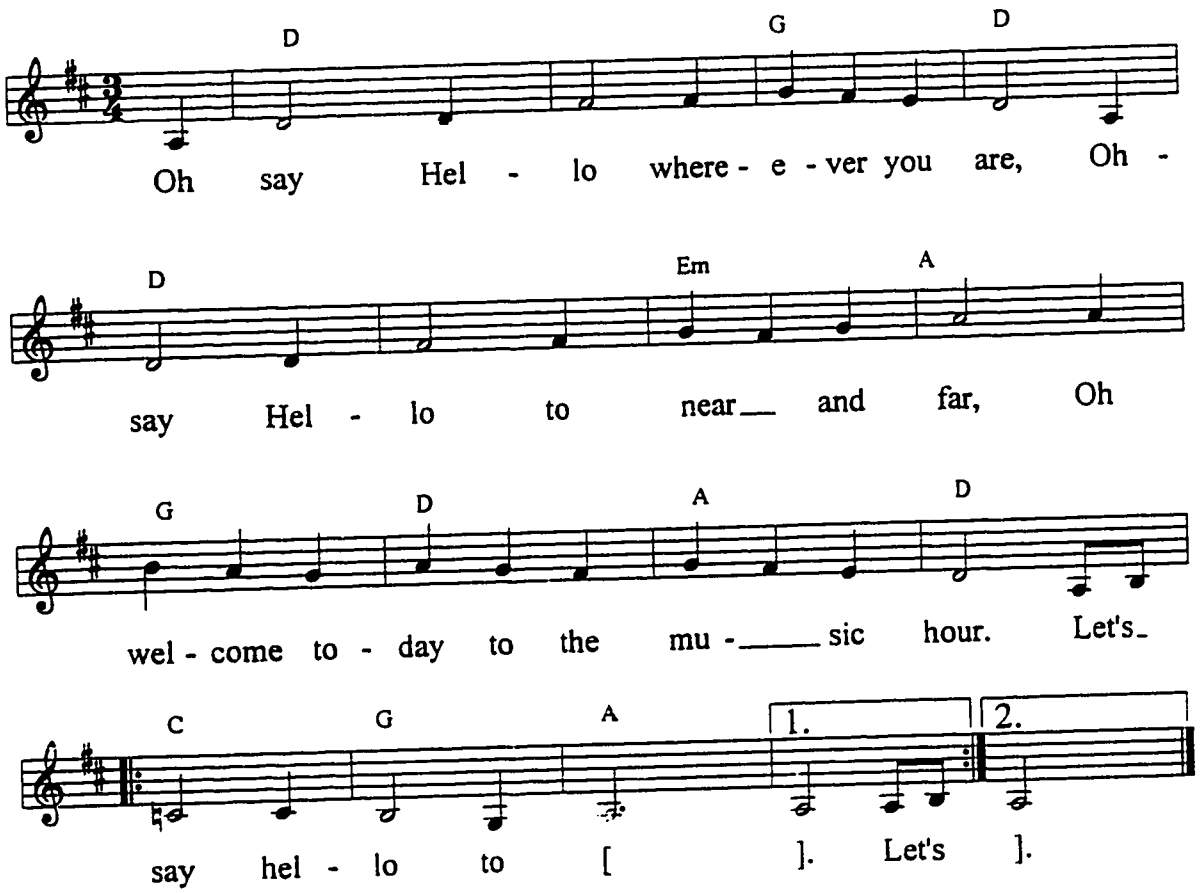
Hello Song #1

Charles Gourgey



Hello Song #2

Charles Gourgey



The Magic Willow Tree

C. Gourgey

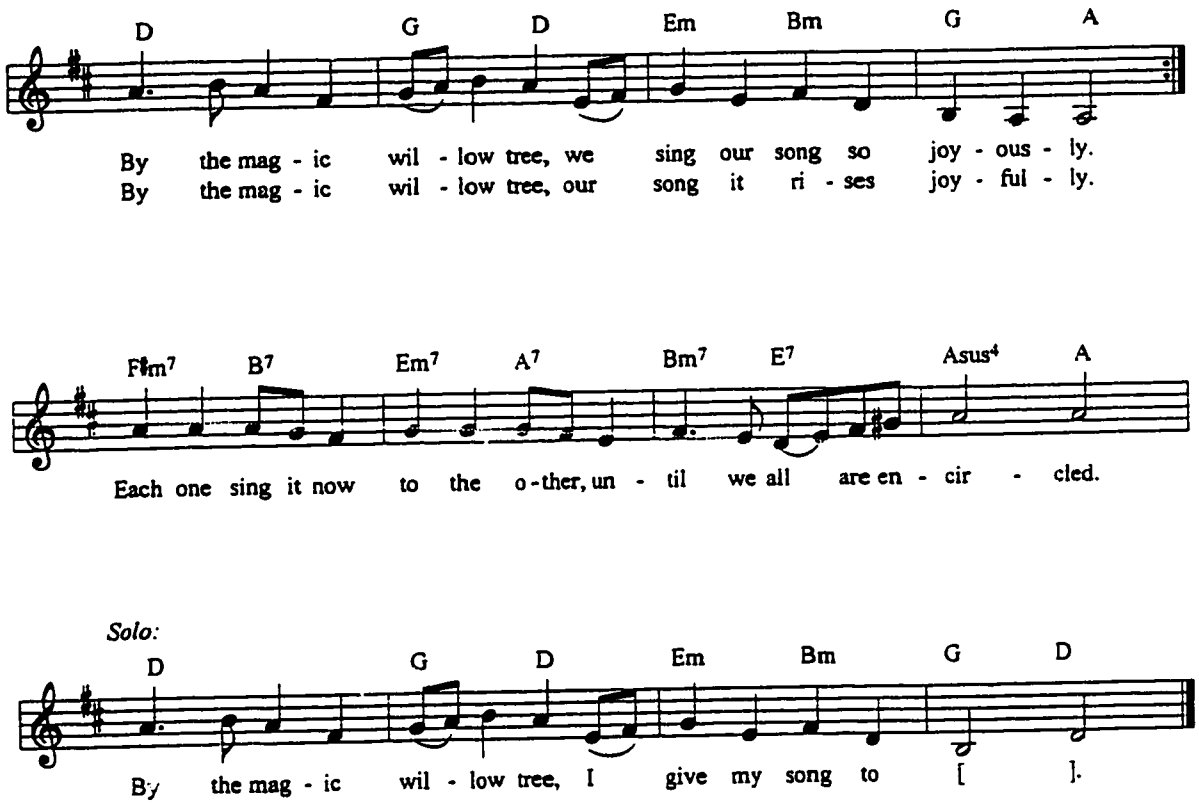
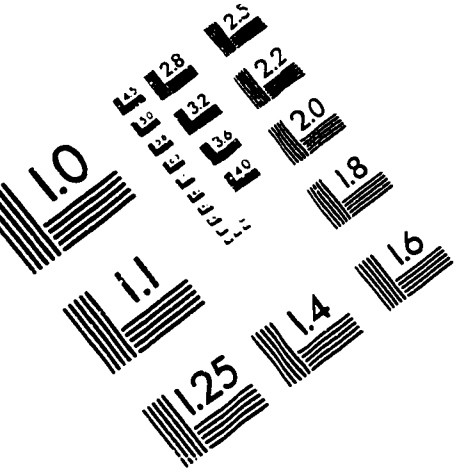
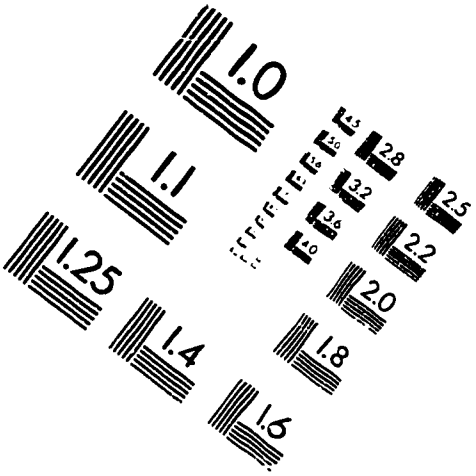
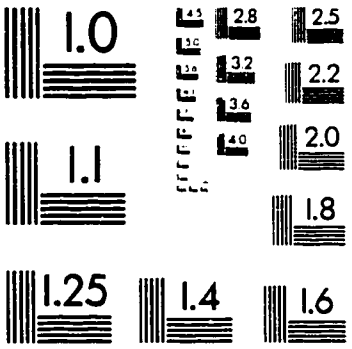
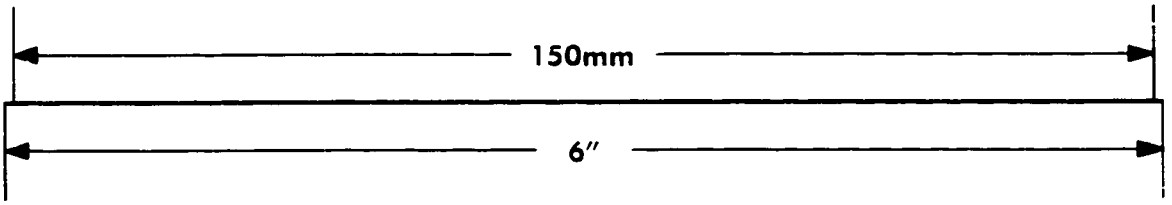


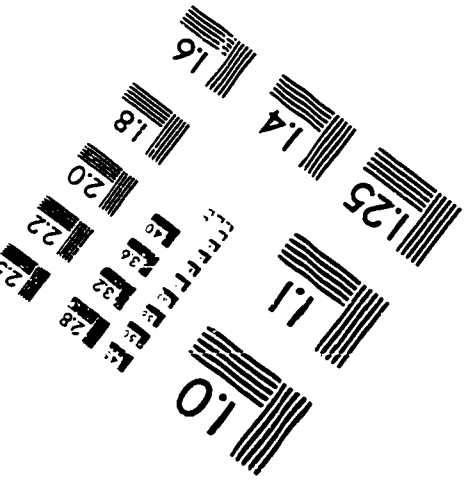
IMAGE EVALUATION
TEST TARGET (QA-3)

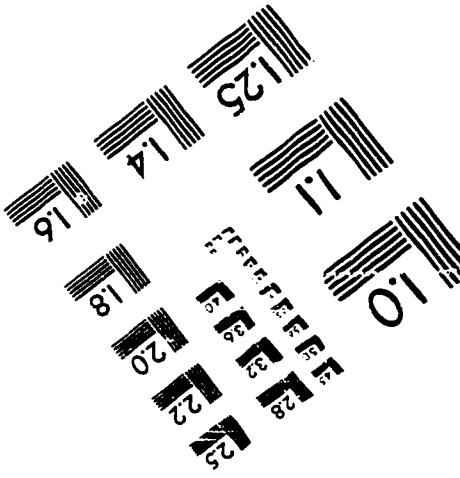












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