A Comparison Between the Use of Songs and Improvisation in Music Therapy with Adults Living with Acquired and Chronic Illness.

Wendy L. Magee, PhD RMT
Institute of Neuropalliative Rehabilitation, London, and
Department of Palliative Care, Policy and Rehabilitation, Kings College London

Abstract

Music therapy can effect behavioural, emotional, and functional changes in adults with acquired chronic illness, even in the face of degenerative conditions. However questions remain about the methods which are most suited to meeting the complex physical and emotional needs of individuals living with chronic illness. Rehabilitative models tend to employ methods using pre-composed music with few recommendations for the application of improvisational methods, whilst palliative models apply both song-based and improvisational methods in contrasting ways with similar populations. Drawing from research findings (Magee & Davidson, 2004a), this paper makes recommendations for clinical practice with individuals living with chronic degenerative conditions. Illustrative data extracts from narratives of people living with chronic degenerative conditions reveal how pre-composed familiar music and improvisation have different roles in the therapeutic process. When working with adults with acquired chronic conditions, pre-composed songs of personal meaning carry associative and temporal properties which enhance their emotional meaning. Songs, therefore, are useful tools when working with individuals who have difficulty acknowledging and exploring intolerable feelings in the face of loss and pending death. In contrast to familiar pre-composed music, improvisation provides a physical activity in which individuals may negotiate their environment and test out their changes in physical functioning. Engaging in improvisation can shift an individual’s self-constructs towards a more positive identity as they experience a greater sense of control, resulting in feelings of ability, skill and success.

Key words: songs, improvisation, methods, acquired chronic illness, music

Background

There is a long history of music therapy in the treatment of acquired chronic illness, particularly with people with degenerative neurological
illness. However the treatment models employed and the recommendations for practice vary widely. Not only is the clinician working in this field confronted with a client’s complex clinical presentation, but an equally complex range of recommended approaches from which to try and draw best practice. In particular, there is a conflict between recommendations for methods which use familiar pre-composed music and those which use clinical improvisation. This paper seeks to make recommendations about this conflict drawing from the findings of a qualitative research study.

For example, rehabilitative models have been employed to address motor disabilities with people who have Parkinson’s Disease (PD) (Miller, Thaut, McIntosh, & Rice, 1996; Thaut, McIntosh, Prassas, & Rice, 1993; Thaut, McIntosh, Rice, Miller, Rathburn, & Brault, 1996) using rhythmic auditory stimulation, finding improvement in gait parameters and carryover effects. This procedure uses both familiar and unfamiliar pre-composed music. These research findings support descriptive observations provided by Cosgriff (1988) and Erdonmez (1993) who both advocated the use of well-known songs with strong rhythms in movement exercises with people with PD. Both the research and observational studies with the people with PD observed that internalising the music through singing familiar songs aided with entrainment of the rhythm. Similarly, rehabilitative models have been used in work to address communication disorders with individuals with Huntington’s Disease, stroke and other acquired chronic neurological conditions (Cohen, 1992; Cohen & Ford, 1995; Cohen & Masse, 1993; Erdonmez, 1976). All of these small research studies used procedures employing familiar pre-composed music such as singing instruction, lyric substitution to familiar songs, and forms of melodic intonation therapy, with mixed results.

Palliative models are also employed by music therapists working with people with chronic illness, using both improvisation and song-based methods. More typically, the aims of intervention address emotional and behavioural needs. Song-based activities are used as a catalyst for discussion and emotional expression (Dawes, 1985; Curtis, 1987; O’Callaghan, 1996) and to prompt active behavioural responses (O’Callaghan, 1999; O’Callaghan & Turnbull, 1987), however, improvisation is also described as a tool for addressing expressive and emotional needs (Davis & Magee, 2001; Hoskyns, 1982; Magee, 1995; Selman, 1988). In her work with Multiple Sclerosis (MS) patients, Steele

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1 “Rehabilitative models” here refer to the World Health Organisation definition which includes assisting people to attain independence and self-determination by providing and/or restoring functions, or compensating for the loss or absence of a function.

2 “Palliative models” here refer to the World Health Organisation definition which includes providing active total care of patients whose disease is not responsive to curative treatment.
(2005) found that the use of familiar pre-composed music promoted coping and adaptation to chronic illness through the music’s ability to enhance a patient’s sense of self and control.

Some of the papers describing work with individuals with chronic degenerative illness make claims as to how it is important to consider the musical structure to compensate for changed cognitive abilities, making recommendations for familiar pre-composed music (Curtis, 1987; Dawes, 1985; Magee, 1995; O’Callaghan & Turnbull, 1987). Such assumptions are generally made but remain largely theoretical, as no study yet has compared structured and unstructured music with cognitively impaired patients. Structured familiar music is recommended particularly to compensate for abilities lost due to dementia in Huntington’s Disease (Dawes, 1985; Magee, 1995) and to counteract problems of arousal, concentration, short term memory and problem-solving in people with severe brain damage from MS (O’Callaghan & Turnbull, 1987). However, completely contrasting recommendations are made with a similar population by Lengdohler and Kiessling (1989) who found in a study of 225 patients with MS that minimally structured improvisations in group therapy enabled exploration of feelings disability, uncertainty, anxiety, depression, and loss of self-esteem. The authors state that motor disturbances limited some people from participating in instrumental improvisation to some extent, but that anxieties about playing contributed far more in limiting participation.

Schmid and Aldridge (2004) report on the combined use of pre-composed songs and improvisation in music therapy with adults with MS. In a mixed methods study they examined the effects of music therapy on depression, anxiety, self-acceptance, quality of life, and cognitive and functional parameters of disability. Improvements in self-acceptance, depression, and anxiety were indicated by quantitative findings, supported by qualitative outcomes suggesting enhanced self-perception and well-being. The emphasis was on active involvement in the music-making rather than the type of music used although recommendations are made for examining the efficacy of specific music therapy interventions with this population.

Thus, the clinician working with people with complex chronic illnesses is presented with a bewildering array of treatment approaches and conflicting recommendations about which type of music to use in treatment. The descriptive and empirical studies all suggest that music therapy effects emotional well-being and identity, but the literature is either vague or contradictory in its recommendations for specific methods. As a clinician working in neuro-disability, this conflict prompted many questions for the author about optimal treatment planning. Methods using familiar pre-composed music appeared to address both functional and
psychosocial needs, although improvisation was also recommended to address emotional needs within a palliative framework.

Stemming from questions of practice, a research study was devised which used qualitative methodology in order to gather rich data from participants about their experience of music therapy. This paper presents recommendations for clinical practice based on the findings of an exploratory research study which compared the use of pre-composed familiar music with unfamiliar improvised music in music therapy with individuals living with chronic and complex chronic neurological illness (Magee & Davidson, 2004a). The purpose of this paper is to present the most important themes from the research findings for clinicians working with this complex group.

Method

Six adult participants living with chronic MS were recruited from multidisciplinary referrals and self-referrals at a residential and day care facility. One of the participants was Afro-Caribbean, and the remaining five were British Caucasian. The age range of the participants was 31–59 years. The time since diagnosis ranged from 3 to 25 years, with an average of 11.5 years. All the participants could communicate verbally, and their physical abilities ranged from moderate to complete dependence on others in personal activities of daily living. Participants displayed mild to moderate cognitive deficits affecting memory, reasoning, insight, and abstract thinking. Ethical approval for the study was gained by an external ethics review board and an internal medical and research advisory committee. Participants gave consent in writing.

Individuals were seen weekly for individual music therapy sessions for a period of approximately six months each with a mean number of 18 sessions. The session format included a musical welcome, exploration of instruments, joint musical improvisation, or singing songs which held personal meaning to the participant which they had selected, and a musical ending. Only live music was used in the sessions which were approximately 45 minutes long.

The music therapist was both the therapist and the primary researcher. Data were collected in a total of 56 focused interviews with individuals at the end of their music therapy sessions. The interviews focused on the individual’s experience of the music in the session and the meaning and effects of the music for that individual. Interviews were introduced at approximately week 10 and interview transcripts were analysed using modified grounded theory (Strauss & Corbin, 1990). Participants’ clinical material and the therapist’s responses were taken to an independent clinical supervisor who was not involved in the research. This
process addressed the dual role held by the therapist/researcher minimising
the risk of compromising the participants' therapy (Bruscia, 1995). For
further details about the participants, the music used in the sessions and
systems to ensure rigour, the reader is guided to Magee & Davidson
(2004a).

The results are presented here with a specific focus on the findings
related to unfamiliar improvised music and then to pre-composed familiar
music.

**Results: Improvisation with people living with chronic illness**

Improvisation is a highly interactive experience which requires
significant physical involvement through playing instruments. In this way,
improvising heightens awareness of living with a changed body and
changed functional abilities. In fact, individuals can monitor their disease
process through the experience of improvising. The combination of
physical and interactive properties of improvising can shift self-concepts
thereby contributing to a change in an individual’s sense of identity.

**Theme: The dynamic relationship in improvisation**

Participants used terms such as “following”, “leading”, “mirroring”,
“interacting”, “giving” and “receiving” when they described their
experiences of improvising. Whereas some of these are terms from music
therapy theory, such spontaneous descriptions offered by clients
uneducated in music therapy highlights the dynamic nature of improvising.
One participant adopted the word “corresponding” to denote the non-
verbal interactive aspect of improvising, suggesting that she felt “met” in
the music.

**Example 1**

Therapist: *I wonder what’s so special about, as you say, “corresponding with each other” in rhythm, I wonder what’s so good about that?*

Participant: *To get the music together! You know, get the sound almost the same way, like you’re playing up there and I’m playing here, we can make one sound together, you know, that we’re corresponding.*

**Example 2**

Therapist: *What about what is happening between us, the music between us?*

Participant: *I think we are corresponding well. Corresponding well. Yes. That’s right! ..... That’s why it was coming so good, because we*
weren’t saying anything, just playing and listening to each other, and follow one another and playing what you were playing. Makes it nice.

Whereas songs were shared both in therapy and with others in a wide range of social situations, improvising was shared solely within the music therapy relationship. It was, therefore, special to that relationship as the participants perceived no other possibilities for improvising. Hence, the experience of improvising existed outside other everyday interactions, intensifying the experience. In the following extract, the participant expressed that the shared experience of improvising brought an awareness of how she usually did things on her own, highlighting feelings around the relationship with the music therapist.

Example 3

Therapist: At the end of the improvisation, you said straight away ‘I’ve always been a loner’...  
Participant: Yes I have.
Therapist: And I wondered why you said that straight after the improvisation? What was it about the music that caused you to say that or think that?  
Participant: It was the music.
Therapist: What was it about the music... can you put that into words?  
Participant: I just thought about how I used to do things on my own. Because we played it together. And I’m used to being a loner.
Therapist: What was the feeling like of playing that together? Was that a...?  
Participant: Nice.

For others, however, heightened intimacy created through an activity which was peculiar to the therapy relationship caused it to be threatening and uncomfortable. This granted a sense of intimacy and potential intensity to improvisation which was not perceived to be part of the experience with songs. Greater intimacy was both a potential strength, but also prevented some participants from engaging in an authentic way in improvisation, as it had the possibility of being far too revealing. For example, one participant rarely allowed himself to become absorbed in improvising. Early on in therapy, at the end of one prolonged turn-taking activity in which he had become very engaged, he was “lost for words” and completely taken aback. After a pause and an awkward laugh, he made the following comments which suggested feelings of discomfort. His

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3 The participants involved in this study were severely disabled and hospitalised, which limited opportunities to access social or community resources where improvisation may have been offered.
difficulty with the intimate feelings raised through improvising were emphasised when he cancelled his session the following week, the only time he ever did so over a period of 11 months. The intensity of a non-verbal activity had exposed the participant in a way for which he was not prepared at this early stage of the therapy relationship.

Example 4

...(laughs awkwardly) ... Aren’t we funny? ... Funny watching me funny watching you ....

Theme: Improvisation and monitoring change and degeneration.

All improvisation within this study involved active participation. This meant it was an extremely physical act, prompting participants to reflect on their perceived physical ability and changes in functioning. At the heart of physical negotiation of the instruments was the concept of physical control and how this sounded out in the music. Improvising therefore can emphasise feelings of loss of control for people experiencing changes in physical functioning, as the following example reveals.

Example 5

Well because I can play ... play ... bash the drum or something, but I can’t really control my hands enough to get a proper rhythm.

Individuals monitored the extent of change which had occurred in their physical functioning by making temporal comparisons of “now” to “before” or “when I was young”. One participant used improvisation solely for physical monitoring throughout much of her therapy. This was noticeably bound up in her continual search for improvement in her physical functioning, as some sign that she was “getting better”. In every music therapy session she informed the therapist of her weekly progress in physiotherapy. Discussing this with her physiotherapist and occupational therapist, it emerged that the client’s monitoring of her physical status was a prominent process during other therapeutic interventions. Within other sessions she also made temporal comparisons of her abilities between weeks, and comparisons between her own functioning and that of others around her in the hospital. This focus became the dominating one in her experience of improvisation, overriding any emotional connection with the music or the therapist. In the following examples she progressively measured her performance against that of previous sessions.

Example 6

... the improvising gives me a good chance to use my right hand, which for so long was just there. You know, I couldn’t use it, (plays
Well, I mean I love the windchimes, (plays windchimes) .... and using my right arm on the Mongolian drum’s great as well, because (hits drum) you know I could never have done anything like that even when I first came to your music sessions. My arms ... you know it was a case of get it down and keeping it .. whereas now I feel quite happy with it. (Session 18)

Example 8

.... and I just think it’s brilliant (playing Mongolian drum all the time) being able to use my right arm in a more controlled way now. Before it would have been all over the place. Because when I first came to the hospital here, I couldn’t dream of touching my face (demonstrates touching face) ... not even with bitten fingernails, cause the ataxia was so much worse. (Session 20)

Individuals monitored their physical functioning through noting the control of arm movements and the types of movements they could make to play instruments, as well as how quickly fatigue affected their ability to play. Monitoring functional change increased an individual’s awareness and self-knowledge, helping them to regain some sense of emotional control. It was also noted that physical monitoring was particularly prominent for individuals who had something to gain by improving their physical functioning, such as a possible move back to the community.

Theme: improvisation and its effects on identity constructs

Participants shared their perceptions of changing physical functioning which took place as a consequence of illness. They also shared how they felt about such changes, including feelings of distress, loss, frustration, hopelessness, hope, success, and surprise. That is, they shared their changing and fluid responses to themselves in the world, shaped by their own performance and management of disability from moment to moment. Engaging in a physically demanding task such as playing instruments provided a forum for the testing and retesting of physical boundaries. As the preceding data extracts demonstrate, improvising could result in negative feelings about oneself and one’s ability (refer to Example 5) or positive outcomes (refer Examples 6-8). Self-constructs and the feelings elicited were bipolar in nature, dependent on the individual’s evaluation of their participation in a particular task. The bipolar nature of self-concepts is depicted in Figure 1. It should be noted that the pivotal point is control. That is, the greater the control an individual perceived themselves to have, the greater the chance of a positive self-construct.
Figure 1. The bipolar range of self-constructs forming identity in chronic illness and the relationship with control

The following example illustrates a participant describing her disabled sense of self following the changes to her functioning. All of this totalled to a loss of her social network, increased dependence, and social isolation.

Example 9

Well, I wish I could write my own letters ... I miss contact with all my friends. I don’t know where they are since I came here. I didn’t write to them because when I was blind in the right eye I thought the left eye would come better and I’d see better to write. But it got worse, and I can’t see at all to read or write. And I lost contact with a lot of friends...... I lost touch with all of them. With every one. This contrasts with how the same participant experienced herself following engagement in improvisation in music therapy. In this extract the participant expresses feelings of achievement, ownership, skill and ability, resulting in improved and positive self-constructs.

Example 10

I just seem to play, play, play, and .. playing something, it feels professional, as if it’s something you’re really doing that you learnt to do, you know .... Sort of, you know. It feels as if you’re doing something really professional. ...because it’s like it’s something you’re achieving .... you know, you’re achieving something of your own... really enjoy what you’re doing, you know, making your own
song, or your words, you can continue as much as you like... you feel like you’re doing something. You know .... achieving something.

Recommendations for practice stemming from the findings will be presented in the Discussion.

**Results: Using pre-composed songs of personal meaning in work with people living with chronic illness**

Songs from an individual’s life hold temporal and associative properties which enhance their emotional content and meaning. Through these properties, songs help individuals to implicitly acknowledge their emotional cores and express feelings which can not be stated in words. Songs therefore help individuals to drop the verbal defences used as mechanisms for coping, and instead move towards a more genuine expression of their feelings (Magee & Davidson, 2004a). In this way, songs facilitate biographical work, which includes the review, maintenance, repair and alteration of one’s life, as individuals live with changing health and an uncertain future.

**Theme: Songs and relationship over time**

Individuals in this study experienced songs over time and in relation to time (Magee & Davidson, 2004). Participants referred to songs in a temporal manner across the life span, in the past, present, and future. This is particularly relevant in chronic illness, where songs of personal significance often bear relationship to the past, encompassing people, memories, events, relationships and abilities which existed before the onset of the illness.

**Example 11**

*All of my life bends around music. One piece in my head can symbolise somewhere I’ve been to ... with songs I’m singing parts of my life ...reliving a part of my life...*

Songs help individuals to contextualise their illness into their biography. Providing a medium for temporal reference is especially significant when working with a person living with chronic illness. The temporal attribute empowered the songs to stimulate direct comparisons consciously and unconsciously between the present and the past, particularly in relation to people, relationships and current life situations as illustrated by the following extract.
Example 12

Playing songs that mean so much to me out of my past... it was nice to let loose the feelings I have about living here now through the music... how I’d like to get out of here and do things like walk again... It’s great when you can do that through music.

Isolation, resulting from illness, was a common theme that emerged from the qualitative data gathered in this study. Within music therapy, participants sometimes described their relationship with songs as one of the only constant relationships within their lives. It was the relationship held over time which distinguished songs from improvisation. One participant reflected that songs of personal meaning remained his companions in the light of growing isolation from his family.

Example 13

...as a matter of fact, life is a programme ... of experiences ... it’s also a programme of what songs go along with you at that particular time. At every stage of your life, there will be some songs that will accompany you. They will be with you. Forever. Forever. That’s what I’ve found anyway... well it’s all connected. It’s all interwoven. It’s all interwoven into your life. These songs are interwoven into my life. Into my experiences. They’re there. I’m glad they are.

The theme of one young man’s therapy centred around intimate relationships as he tried to come to terms with a particularly rapid illness trajectory leaving him profoundly disabled with repeated admissions to acute facilities to manage life-threatening episodes. In the following example he discusses the lasting relationship with his particular song in both the past and future.

Example 14

What’s in that song for me? ... I don’t know ... I like the music. I’ve got memories to it as well. And there’s probably some ... I like to see what comes in the future with it as well. That music will never die for me.

Being able to contemplate or imagine the future is highly significant for someone living with chronic degenerative illness, and for whom the future is unknown in every way. Providing a medium for temporal reference is particularly important when working with a person living with chronic illness. Engaging in multiple reviews of one’s life through imagery which recaptures the past, examines the present and projects into the future can assist someone who is managing their biography in the context of degenerative change. Perhaps most significantly, music stimulates feelings about future events, expressed as hope.
Theme: Songs to aid with coping

Participants living with chronic illness maintain a coping front which helps them to cope with intolerable situations by using strategies to mask feelings which are too difficult to acknowledge (Magee & Davidson, 2004a). Most of the individuals in this study presented with steadfast coping strategies which were challenging to negotiate in the therapy space. These strategies aided individuals in living day to day with incurable illness, increasing isolation and an unknown future. It is too simplistic to define such coping behaviours simply as denial. Instead, it is important for the therapist to respect and work with such behaviours as the client will allow. Additionally, becoming familiar with an individual’s coping strategies assists in developing a deeper understanding of the individual and can aid the therapy process overall.

For the participants in this study, the emotional quality of a song of personal meaning was more readily identifiable than that of an improvisation. Songs possessed emotional labels which were individual to the participant and often were chosen by participants to introduce a particular feeling into the session. At times, the emotion associated with the song was acknowledged overtly, such as in the following example. This participant discussed how she managed her difficult feelings by putting up a “bombastic, confident” front, but that songs of personal significance helped her to acknowledge and share her more sensitive side, which she kept hidden.

Example 15

Participant: *I put up a front. I’m so confident, which I am. But deep down, I’m sensitive. .... It’s good you see me when I’m with Elton John.*

Therapist: *Is that one of the things you feel these songs do - they show another side of you?*

Participant: *I think they do....*

Therapist: *And so, in choosing the songs....?*

Participant: *I was letting off some sentiments... I put on a bombastic confident front ...*

Therapist: *But ......?*

Participant: *Inside I’m sentimental.*

However, often participants chose to keep the personal emotional relevance of a song private, choosing not to share and make explicit intensely difficult feelings which they otherwise tried to suppress. Participants used songs to subconsciously express a mood which they were not willing to share overtly with the therapist. In the following example, the participant discussed the purpose behind her song choice, suggesting
that the song quite simply had “good memories”.

**Example 16**

Participant: *Well the songs that I pick are always bringing back good memories, I mean if you played something that brought back a bad memory, I would say “No, I don’t like this one!”*. But the ones that we’ve picked out from the book have been ones that I really like.

Therapist: *So it’s about bringing back good memories, so you’re selective about which memories...*

Participant: *Oh, yeah! I don’t want any of the bad ones back.*

In a later session, the same participant talked about the hope which was sustaining her. She requested a favourite song, “All Cried Out”, which she identified within the session as bringing back “happy” memories after reminiscing about her life. After we had sung her song, she shared the following thoughts. These highlighted how the underlying emotional meaning of her song choice reflected feelings of exhaustion and fear which were too difficult for her to acknowledge verbally. The song, however, could express these feelings for her.

**Example 17**

Therapist: *You say you’re very careful about the songs you choose, and you choose ones which only bring back happy memories -*

Participant: *Yeah ...*

Therapist: *Do you also choose ones which cause you to feel a bit sad or nostalgic?*

Participant: *No. Not really. I choose the good ones from the past.*

Therapist: *So we sang a song today, by Alison Moyet ...*

Participant: *‘All cried out’ ... And that’s how I feel ... (eyes fill with tears and reaches for her tissue) ...*

The findings will now be discussed with specific reference to the clinical application of each method when working with people with chronic illness.

**Discussion: Recommendations for practice**

To summarise, improvising provides a dynamic vehicle which is specific to the relationship with the music therapist. For people living with chronic illness, improvisation stimulates awareness of living with a changed body and changed functional abilities. Individuals monitor their disease process through the physical experience of improvising. The combination of the physical and interactive nature of improvising within the music therapy relationship can cause changes in self-constructs from negative to more positive constructs. However, two contra-indicators are...
suggested from this research. A client who focuses purely on the physical aspects of improvisation may be blocked from engaging with the emotional experience offered by the music. Secondly, as feelings of control are central to moving from negative to positive self-constructs, caution is recommended with those individuals with little physical control. In such cases, improvisational methods should ensure how best to enable the individual to control some facet of physically playing. The therapist needs to remain sensitive to the physical needs of the client, particularly fatigue, and ensure instruments are provided which offer a variety of physical movements in playing. For example, reaching out to the side a long way from midline in order to play a large drum or xylophone causes fatigue more quickly than playing instruments which can be placed in the client’s midline and close to his or her active hand.

Serious chronic illness “shakes earlier taken-for-granted assumptions about possessing a smoothly functioning body” (Charmaz, 1995, p. 657). The results from this research show that physical considerations are paramount in the individual’s experience of improvisation. It provides a forum for exploring physical performance. Through sustained exploration of their own individual physical change and loss, the physical experience becomes an intensely emotionally charged one relating directly to aspects of the illness identity. Through the process of physical monitoring, individuals measure even small changes in their performance, a phenomenon described in health sociology research as the dialectical self (Charmaz, 1991). This involves taking the body as an object, appraising it, and comparing it with the self in different temporal and situational frameworks. That is, individuals make comparisons of their performance between the past, present, and future, and also with others.

The “social” component in work with people with chronic illness must always remain a central issue, as prolonged immersion in illness takes its toll upon social relationships and self (Charmaz, 1991). Social isolation translates directly into emotional isolation and loneliness (Charmaz, 1991). Improvisation was experienced by the participants in this study as something which highlighted the client/therapist dynamic but also challenged feelings of intimacy. Therapists must remain sensitive to this potential and allow trust and safety to develop in the therapeutic process before improvisation can be used optimally.

Health sociologists Corbin and Strauss reflect that “when illness brings about a failed body ... the foundations of existence are shaken” (Corbin & Strauss, 1987, p. 252). The interactive dynamic nature of improvising allowed individuals to feel supported in their attempts to physically interact with the environment. This provided the “performance validation” which is necessary for reintegrating one’s identity into a “new concept of wholeness” (Corbin & Strauss, 1987). Through the act of
mutual music-making within improvisation, individuals were able to achieve shifts in self-constructs to a more positive sense of self.

Songs elicited spontaneous emotional responses about the past, present, and future, providing an immediacy in clients’ responses. Although songs stimulated intense feelings, analysis of participants’ statements indicated that songs did not provide the intensity of relationship with the therapist which improvisation prompted. However, songs did serve to assist in developing the therapeutic relationship, particularly when the client was heavily defended. A challenging issue for the music therapist with this population is how music may be used when working with individuals maintaining particularly resistant coping styles. A therapist must question the purpose of such coping strategies whilst recognising that these are in place for emotional survival. Songs are invaluable tools when working with clients who are heavily defended, by providing safety, comfort and reassurance. It should be noted that one participant monitored his physical performance through singing, and so songs may also provide a safe vehicle in which to explore physical changes through illness monitoring (Magee & Davidson, 2004b).

Furthermore, songs which held personal meaning facilitated a shift in coping strategies to help an individual begin to share more difficult feelings. This suggests they can provide a vehicle for the exploration of difficult themes or feelings on a musical level by the client, without the need for verbal exploration. In this study, premature attempts to make the mood of a song explicit by the therapist often resulted in the client dismissing the therapist’s verbal suggestion. As the therapeutic relationship develops, a client may start to explore these difficult feelings more overtly. For example, an individual may request a song with a sadder or more reflective emotional lyrical theme or musical content, whilst verbally stating throughout the session that they are happy. It is important to work with the emotional label given by the client, but just as important to remain sensitive to the underlying feelings which perhaps are too difficult or threatening for the client to acknowledge openly. The therapeutic potential for the use of songs is most likely if the therapist develops an understanding of the meanings attached by an individual to their particular songs. Once an individual moves from simply describing the song as sad or angry, they can begin to make links between the feeling of the song and themselves. When this happens, their awareness of and ability to acknowledge their feelings can really develop. This is most likely to happen when the song holds association with a past person or life event. Even if the client never reaches a point when they reflect verbally, songs can still be powerful tools to explore feelings non-verbally by offering a song of personal significance repeatedly within the session. In this way, the client can choose to experience the emotion musically whilst sharing
the emotion with the therapist through the music.

Control is a central mechanism for coping with the emotional responses to chronic illness, particularly in maintaining self-esteem. Loss of control in effect raises questions about whether ill people will live, or whether they want to (Charmaz, 1991). Social interactions are influential in reinforcing the individual’s perception of coping or managing (Brooks & Matson, 1987). In chronic illness coping is achieved through controlling one’s identity, and in doing so, one feels successful due to the front maintained to the outside world (Charmaz, 1987). Songs were seen to be central to the coping processes adopted within music therapy. Certainly songs were a way for the individual to acknowledge difficult feelings implicitly whilst maintaining a coping front. The use of songs as a mechanism to maintain defences has also been observed with the terminally ill (Bailey, 1984). Individuals with chronic illness can sing about unbearable feelings when they cannot speak of them. It is crucial for therapists working with this group to remain sensitive to how an individual may be using songs to express such difficult feelings in a subconscious way.

People living with chronic illness have been found to engage in multiple reviews of their lives through imagery which recaptures the past, examines the present and projects into the future. Corbin and Strauss (1987) identify three major dimensions to biography: conceptions of the self; biographical time incorporating past, present, and future; and the body, which exists as the medium through which identity is formed. The temporal and associative properties of songs enabled individuals to contextualise their illness into their biography through songs, developing a framework to make some sense of their lives.

**Conclusion**

For individuals living with chronic, progressive, degenerative, neurological illness, mutual active music making in music therapy can be a highly physical experience, in which they may monitor their own performance and way of being in the world. As therapists, we can validate our clients’ performance through mutual music making, thereby facilitating a new concept of wholeness, and aiding in identity reconstitution. For those clients who are unable to physically manipulate instruments, familiar songs which hold personal meaning can facilitate biographical work. Through their associative properties and the relationship held over time, songs operate on implicit and explicit emotional levels. Through the sensitive and therapeutic use of song our clients can explore emotional states which coping with their illness does not ordinarily allow.
Author’s note

Wendy L. Magee PhD BMus ARCM NMT, holds a post-doctoral fellowship at the Institute of Neuropalliative Rehabilitation, London and is Honorary Senior Research Fellow in the Department of Palliative Care, Policy and Rehabilitation, Kings College, London. She has worked as a music therapy clinician, manager and researcher with adults with acquired and complex neurological conditions since 1990. She has published widely on music therapy and neuropalliative rehabilitation.

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