Music Therapy as a mouth piece

Jennifer Zantopp

(translated by Ruud vd Pasch)

Research in music therapy with patients suffering from afasia

Deprived of interaction

Aphasia is an illness that is a result of cerebral damage, CVA or cerebral haemorrhage. It causes a partial or complete loss of speech- and language functions. There are several forms of aphasia. One of them is global aphasia, in a state of speaking, understanding language, reading and writing are no longer possible. With global aphasia an exchange of information (after this called interaction) is hardly possible. Because of the cerebral damage the ability to understand symbols, facial expression and written language are often affected as well. The patient loses the possibility to get in touch with others. He becomes isolated from his environment and from himself (Brumfitt, 1993; Lutz, 1996).
This situation often evokes strong emotional responses. The patient cannot express these because of his limitations, except by crying, passivity or anger. Contacts with relatives and friends are difficult. They are as powerless as the patient himself. The patient lives in insecurity about his own abilities. Things that used to be taken for granted (talking, reading, laughing), now do not seem to be so certain anymore. Furthermore it is not possible to get clarity about this, since it is impossible to ask questions or talk about this insecurity. The patient has to adapt his self image and discover a new identity. This can only be done after a process of grieving over the loss of the 'old' identity and the contact with people (Brumfitt, 1993; Pavlicevic, 1997).

Music as a way out

In general it is said that music, and music therapy in particular, is a means of expressing feelings in a non-verbal way. This article takes a closer look to see if this can be applied to patients with global aphasia. Interaction on a musical level should be a better way of communicating for a patient with global aphasia than the, however still possible, limited interaction on a verbal level.

Definition of the problem

- During the first phase of rehabilitation of broad aphasia, does music therapy offer a possibility, by means of music, to interact with the patient?
  Sub questions:
  - Can an outsider observe the interaction between patient and therapist?
  - If so, in which parameter of the music and/or the therapeutic contact does this become clear?
- Does this interaction (given the limited abilities of the aphasic) offer the patient sufficient ways of expressing his emotions and in this way aid the coping process of the patient?
  (The fact that music in general is a way to express emotions, and thus can support the process of coping with illness, is considered a fact. See Smeijsters, 1992; Bruscia, 1987 and 1998.)

Research set-up

The definition of the problem was approached by means of a qualitative research scheme. For the study, the music therapy sessions of two different patients were videotaped. Both patients had recently suffered broad aphasia and right side hemiparese due to a CVA in the left cerebral hemisphere. A music therapy session lasted for thirty minutes and took place once or twice a week for eleven and sixteen weeks respectively. Both patients were timid, withdrawn and dejected. Both were unable to utter a single word at the time when I first met them. The therapy existed of free improvisation and the singing of songs. My attitude was validating and supportive. From all video recordings a selection was made (a selection was made subjectively for technical reasons), so that four video fragments (two

of each patient) of 2-4 minutes each with a piece of free improvisation from the therapy session remained for this study.
These fragments were shown to a group of second-year music therapy students from Enschede. I used Bruscia's improvisation analysis (1987) as an evaluation method. The student group was trained to use this method to assess free improvisations on interaction. Each member was requested to fill out one evaluation form per video fragment, without discussing it. The forms were compared with each other by me.
Agreements, points the group had no single opinion about and points over which no judgments were passed, were determined. The video fragments were shown to the group again a week later. A discussion started within the group about the difficulties that arose while filling out the forms and the points of disagreement I had detected were explained.

Unexpressed rules

The observation group expressed that the musical team work mainly seems to be based on unexpressed rules. These rules are:

1. Both parties employ the same length of phrase. So both players have the same share of interaction.
2. 'When you play, I do not play'.
3. The same tempo and metre are chosen and maintained.

If we compare these observations with current literature, we notice that these musical phenomenons also play a part in other aspects of life. Matarazzo (1964/67 in Remmerswaal, 1998) indeed describes unexpressed rules regarding the length of a conversation share and the length of pause between conversation shares. According to group dynamics a longer conversation share in a dialogue means a higher position. The observation that there is a matter of equal share in music between therapist and patient, expresses that interaction in music can take place on an equal level, despite the limitations of the patient. According to Ruud (1998) a combined tempo/metre (Ruud calls this pulse) is a condition to get 'in the same groove' (page 157). Pavlicevic (1997) also describes that she adapts her tempo in therapy to that of her patients to get in touch with them. She expands this subject by the observation that we can keep the interaction going through our reactions to the actions of the partner (page 108). By continuing to accept and playing back the same phrase in the same tempo, therapist and patient keep the interaction going. The interaction is wanted and therefore does not get interrupted. The observed patients have accepted the playing situation with the therapist, can handle it and can act with the therapist on an equal level. (In this case, equal means that the therapist can adapt to the limitations of the patient in such a way that the relationship appears to be equal. However, because of his training and background a therapist can never be equal to a patient.) Verbally, aphasia patients often suffer from a much slowed down response pattern. Should we apply these interaction rules on a verbal level, our language would become grotesque and unnatural. Obviously, it is much easier for both the therapist and the aphasia patient to get in touch on an equal level musically. Accepting each other and being able to communicate in the same way is a condition for supervising processes of coping with illness. The unexpressed agreement to play alternately, may stem from the cognitive limitations of the patient. Performing acts simultaneously (listening and playing) and observing fore- and background are complicated actions that have been affected by the disease. Taking turns in playing is more clarifying. From a psychological point of view it could be a symbol for a still exploring contact between therapist and patient.

Using vitality affects

In addition it was observed by the research group that patient and therapist often use the same level of energy. Together they perform the same changes of volume and radiate the same vitality (which can for instance be seen by the pose).
Development psychologist Stern (1994) describes this phenomenon in his development theory as the communication prospect between mother and baby. Stern explains that all actions are characterized by 'vitality affects'. According to Stern, These affects are best described with dynamic, kinetic concepts. Stern indicates that a mother's actions are tuned to a child's energy level in such a way that they adapt to the vitality of the child. To calm a child, it is wise to connect to the child, first, and then slowly change to a lower energy level, according to Stern. In his opinion, the actions themselves (such as cradling, singing a song, reading aloud) make little difference. So possibly a mother can achieve the same result by singing a song as by cradling

or talking to the child, provided that she can make good use of the vitality affects. Music therapist Pavlicevic (1997) refers to Stern and says that vitality affects can be directly translated into musical terms such as crescendo (gradually getting stronger), diminuendo (gradually getting quieter), meno mosso (less vivid) and calando (getting slower and quieter). From the research observations it can be derived that aphasia patients still use these vitality affects, too. This way, equality in music can be reached. We can reason that, by employing these affects, the therapist is able (like the mother with her child) to influence the affects of the patient. This also means that the therapist influences the emotions of the patient and thus can support his/her coping with the illness. Bruscia describes the coming along with or gradually changing of the energy level of a musical improvisation with the improvisational technique 'pacing'. Moreover, the observation group established that the patient is capable of taking charge (the initiative), and the therapist is able to support this initiative well. De Bakker (1993) describes this technique as 'containment', Bruscia (1997) calls this improvising technique 'holding'. The group described the patient's initiative as 'emotion-outburst'. It follows from this that the patient is capable of expressing emotions through music, apparently. The therapist has the ability at his disposal to collect emotions adequately in music. This, again, is a condition for being able to counsel the process of coping with illness. However, in addition, coping with illness is a process of living through, expressing and researching several emotions.

It becomes clear from this research that the therapist can interact with the patient on an equal level through musical improvisation. The patient is capable of keeping the interaction going and of taking initiative in it. The therapist is capable of sensing the patient's expression of feelings and of influencing those. Nevertheless, there remains the question as to whether these musical and inter-human interactions can contribute to coping with the illness.

Mourn over illness

The process of coping with illness can be compared to that of mourning (Dechesne, 1990). A mourning process goes through several stages that have to be completed. Lingering in a stage is being described as pathological mourn. A depression can originate from this, for instance. The best-known description of a mourning process is by Kübler-Ross (1997). She describes the stages: denial - anger - negotiate - depression - acceptance. Rehabilitation psychologist Fink (1967, in Dechesne, 1990) adds the 'acute stage' to Kübler-Ross' model. He describes this as being the first stage, evoking feelings of fear and powerlessness in particular. In the early stage of rehabilitation we can assume that we will especially deal with the acute stage and the stage of denial. In both stages it is important to create a safe environment for the patient. Creating safety means taking care of the patient, listening to him and building up a good therapeutic relationship with him. (See also Benson, 1980, page 195; Brumfitt, 1993; Hora, 1959 in Remmerswaal, 1998, page 137). Then it becomes possible for the patient to overcome the crisis of 'lost identity', to cope with the illness. Because, as Hora (1959 in Remmerswaal, 1998, page 137) formulates so strikingly: "To understand oneself, one has to be understood by another."

In general, it is regarded as a psychologist's task to guide a mourning process. Psychotherapy requires language proficiency, problem solving thinking capability, verbal thinking capability and enterprise. For this reason, this task of counselling is often delegated to speech therapists or social workers (Benson, 1980; Lutz, 1996); professionals, however, who actually have neither the or nor the education to do this. Often, family cannot undertake this task either, because they have lost part of their confidence themselves and are experiencing their own mourning process. It is emphasized in current music therapy literature that music therapy can be used as psychotherapy (Smeijsters, 1992; Bruscia, 1998). It is agreed that changes can take place within music itself, without verbal explanation (Bruscia, 1998). Smeijsters (1992) warns us not to consider all music psychotherapy. According to him, music therapy only becomes therapy through the interaction in music and the interventions the therapist contributes. These interventions in music have been describes by Bruscia (1998). They do not need verbal explanation or evaluation. They are purely about improvisational techniques. Under the head 'techniques for empathy', Bruscia describes possibilities to realise the abovementioned conditions (security, listening, therapeutic contact) in music. With this, it becomes clear that music therapy is an appropriate means of supporting the first stages of coping with the illness.

Research is never perfect...

To guarantee objectivity, the research should have taken place on a larger scale and it should have been carried out by an independent researcher. The research method used (improvisation analysis after Bruscia) is initially not meant for this kind of research; the validity of this research method is yet to be tested. The described evaluation group and the assignment to the evaluation group, just as the discussion, are factors that may have influenced the research in the direction of my expectations.

'Do we need words?'

It becomes clear from the research that an aphasia patient with global aphasia is capable of interacting with the therapist in the first phase of rehabilitation. This interaction can be observed by outsiders as well. This becomes clear especially in the musical elements tempo, rhythm, pulse and dynamic difference and furthermore in unexpressed rules about the way of playing together. Compared to verbal interaction, musical interaction appears to be able to go easier and more equal. Musical interaction offers the patient enough space to express emotions and offers the therapist enough opportunity to receive and influence emotions.

Music therapy seems to be a significant contribution to the treatment supply for aphasia patients. It has become clear that the role of music therapy comes to lie in the field of the psyche, particularly since psychotherapy, with respect to aphasic patients, has become nearly impossible due to language restrictions.

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Summary

Are people suffering from global aphasia capable of musical interaction with their music therapist? We try to answer this question using qualitative research methods (analysis of musical improvisation). Second, we investigate whether and how music therapy can be used for psychotherapeutic purposes. A justification (indication) for music therapy as psychotherapeutic treatment follows from the primary and secondary symptoms of aphasia.

The author Jennifer Zantopp works as a music therapist for ArgosZorggroep. She graduated from Hogeschool Enschede in 2002. jennifer@zantopp.nl