Music and Psychosis.

The transition from sensorial play to musical form by psychotic patients in a music therapy process.

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Introduction

This study examines the transition of sensorial play towards a musical form as a central aspect in the music therapy treatment of psychotic patients. From my twenty years' experience of clinical work with psychotic patients I came to the conclusion that there was a tendency towards an endless, monotonous and repetitive play in the musical improvisations of these patients, where certain rhythms or melodic sequences are repeated continuously, or the play is fragmented, dispersed or incoherent. Previous research and case study reports confirm that this way of making music is characteristic for the psychotic patient. Psychotic patients do not experience their play as something that comes from themselves, and they do not mentally take part in the sounds that they produce. They are not inspired by their music. This is the case because of their pathology, the consequence of which is that they do not possess any psychic space in which symbolising is possible and where the musical object could be appropriated. In music therapy this translates into an inability to create a musical form.

This study reveals that with psychotic patients, music therapy can contribute to the creation of a psychic space, which gives the initial impetus to a certain symbolising process. Essentially there is a transformation, during the therapeutic process, of sensorial play towards an experience that can be integrated, a musical form.

Hardly any music therapy research can be found which describes and examines this essential therapeutic process in the work with psychotic patients, even though it is recognised that this symbolising process is fundamental in the treatment of psychotic patients (Bion1962; Dührsen 1999; Killick and Greenwood (1995); Metzner (1999);Van Bouwel 2003; Van Camp 2001).

This study was undertaken using a single case design in order to describe and examine this therapeutic process. The phenomena sensorial play, moments of synchronicity and musical form are defined. For the results of this study to be relevant and useful to clinical practice, therapeutic interventions and the attitude of the therapist were also explored and analysed.

Research method

Design

A case study design was applied in order to answer the research questions, and two subjects were recruited who met the inclusion criteria. It was decided to limit the subjects in order to undertake a very comprehensive and multidimensional analysis of data to explore in detail the process of therapy.

A feature of this study is that it was always treated from a clinical perspective, and the design was developed in response to the subjects (patients), rather than the subjects having to conform to a pre-determined design. This was necessary in order to stay true to the unique characteristics of the clinical situation and, as a consequence, to come to an adequate formulation of the theory.

If one were to apply the research strategy in this clinical research in a rigid way, one would not be able to give any respect towards the research subject. Therefore it was important to refine the research methodology as much as possible in order to come to a more adequate description of the subject and how the therapy was effective for them.

Participants

The two subjects recruited for this study were patients who diagnosed with psychosis and were treated in the psychiatric hospital where the therapist/ researcher works. The female patient referred herself for individual music therapy. The male patient was referred for individual music therapy through the multidisciplinary team of the ward. A primary inclusion criterion for the subjects in this study was that they displayed a specific way of playing involving repetitive or fragmented characteristics in their music that correlated with an inability to mentalise, meaning they were unable to achieve any level of symbolisation. Each patient received one 45-minute individual music therapy session each week.

Treatment sessions and data collection

The music therapy treatment of the two patients took place in their familiar therapeutic environment. The therapist was a full member of the ward staff where these two patients were hospitalised. The treatment itself was kept as authentic as possible, without any conscious interventions that could influence or contaminate the research.

A description of the anamnesis and behaviour of the patient in group music therapy (only for the first case) was written. All the music therapy sessions were audio- as video recorded, up to the point when the improvised music of the patient included a musical form (i.e. case one: four sessions; case two: eight sessions). After each session, the music therapist recorded his first impression of the session, the patient, his own experiences, and the musical improvisations.

Analysis of the data

A phenomenological description of all the video-recorded sessions was written down by the therapist/researcher. He also analysed his own personal record that he made after every session. A retrospective analysis was undertaken with a psychoanalist that involved the observation and interpretation of therapeutic and musical events. All therapeutic aspects, such as transference, countertransference, projective identification, and impressions of the therapist were considered. All the comments relating to these areas were recorded and were subsequently transcribed by the researcher. A temporal structural conceptualisation of the sessions was made to provide a clear visual overview of the whole sessions and delineate the actions of both the patient and the therapist. From each patient, a clinical case study report was written using all the reflexive material (i.e. impressions, phenomenological description of the sessions, personal record, transcription of the music and retrospective analysis) the researcher had. These case study reports were necessary to provide a linear description of what actually transpired in each session and in the treatment process, and in order to place the analyses of the selected video fragments into the context of a therapeutic process.

The selection of the video fragments was undertaken based on pre-established criteria for sensorial playing and musical form, and was validated through research intervision and by an independent music therapist. The analysis of the selected video fragments was undertaken through a careful and systematic process, and documented as follows: a description of the selected video-excerpt, a notated score of each excerpt and a description of the musical elements; selected comments from the patient relating to his experience of playing; selected

impressions and reflections from the therapist about the patient's way of playing; selected reflections from clinical intervision.

Results and discussion

From a systematic analysis of the selected video fragments of the session, one could clearly observe an evolution in the musical play of the patients, and in their psychological and inter-relational behaviour. The musical analysis of these video fragments made clear many hidden musical structures. Through these extended analyses, three clear phenomena (that can also be defined as musical/therapeutic phases) could be distinguished in the music therapy process, each with their own specific characteristics with regard to form, musical aspects, psychological aspects, aspects of body posture and aspects of inter-personal / intra-personal experiences from the music therapist's point of view.

On the basis of the analysis, these three phenomena (i.e. the three phases in the therapy) were described as: sensorial play, moments of synchronicity and musical form and were defined as follows:

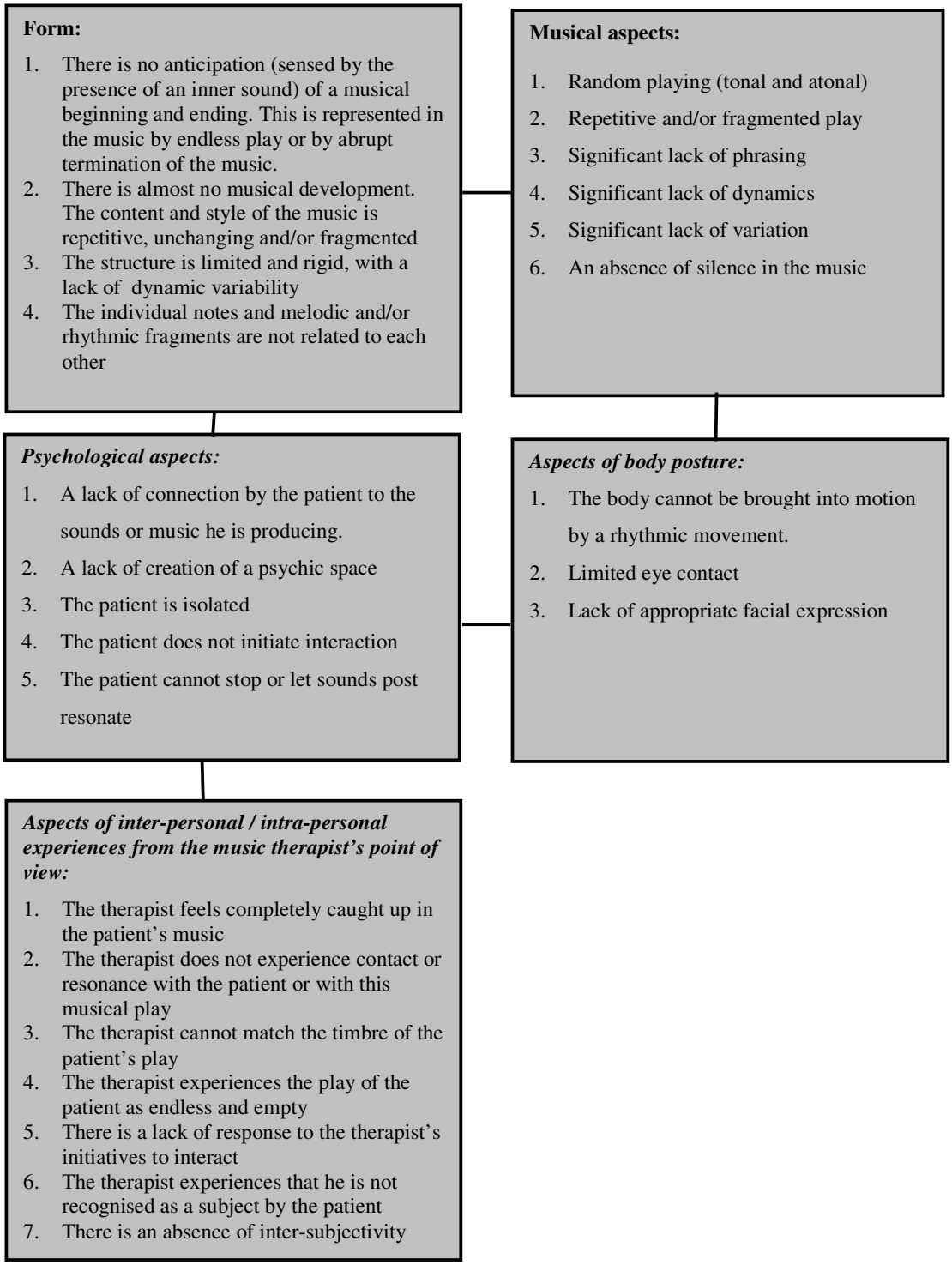
Definition of sensorial play in a music therapy context

Sensorial play is a term describing the characteristic playing of a patient where, while producing sounds, the patient is not able to connect with or experience these sounds as coming from himself. The patient's music is characterised by repetitiveness and/or fragmentation. The improvisation cannot really be begin or end, and there is no clear melodic, rhythmic or harmonic development, no variation and no recapitulation. The patient is perceptually and emotionally detached from his own musical production.

Further explanation:
Therefore, improvising is not a real 'experience' for the patient. He is not inspired or affected by the music and he remains disconnected from the sounds and the playing. There is an absence of shared playing and inter-subjectivity with the therapist in the sense that the patient does not engage in the joint music. The sounds remain outside the patient and do not have any connection to him. In terms of the psychopathology of psychotic patients, one can say they

cannot create a psychic space that allows symbolisation, thus making it impossible for them to appropriate the musical material. The music therapist experiences the patient as isolated, becomes completely caught up in the patient's music (i.e. the musical behaviour), is not free to introduce his own musical images, and because of this no interaction is possible, and it is impossible to engage in a shared timbre in the 'co-play'.

Criteria of Sensorial Play (CoSP)



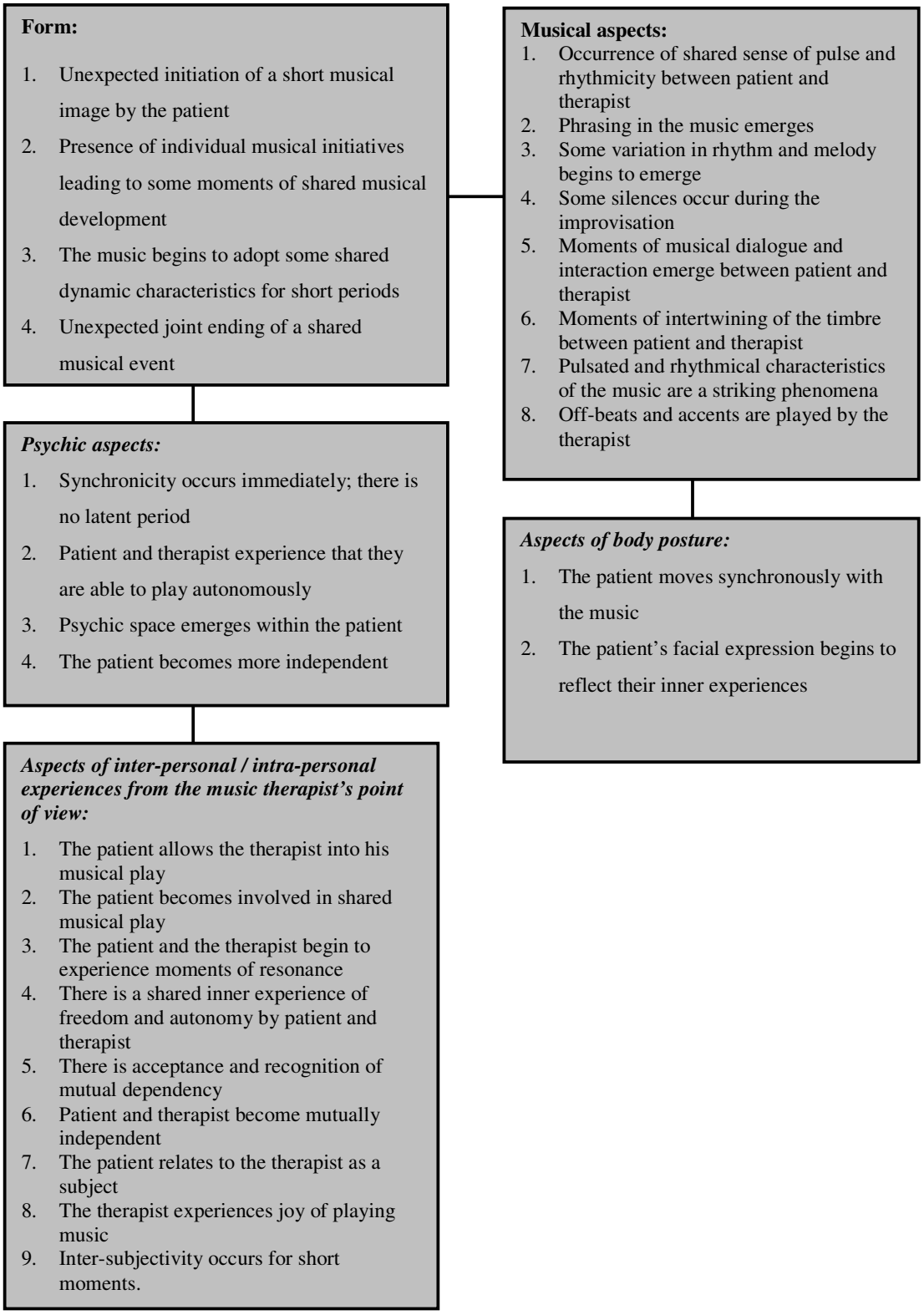
Definition of moments of synchronicity in a music therapy context

Moments of synchronicity is a term describing points in time in which there is a shared inner experience of the patient and the therapist, in which they feel free and autonomous in their play during a musical improvisation. This shared experience appears unexpectedly and unintentionally, and is characterised phenomenological by attunement between the musical parameters of the patient and the therapist.

Further explanations:
Both patient and therapist have the feeling that they are able to come into a genuine shared play for the first time with an intertwining of two musical lines into one entity, or one whole - for example, where both share the same pulse with shared accents in the meter. Underpinning this is the paradoxical experience of each individual's freedom and autonomy. The mutual dependency in the creation of a shared musical object leads to a liberating feeling of being able to make music in a completely independent way. The patient and therapist are free in relation to one another and can play, think, exist and develop their own musical thoughts. This paradox involves emerging autonomy in the patient and therapist, while at the same time, there is acceptance and recognition of mutual dependency. During this, brief moments occur where the timbre of both players intertwines.

These moments of synchronicity can be brief, unexpected and infrequent, acting as possible precursors for the development of the musical form. Moments of synchronicity usually appear at a specific or sensed 'right-moment' in a shared experience.

Criteria of Moments of Synchronicity (CoMoS)

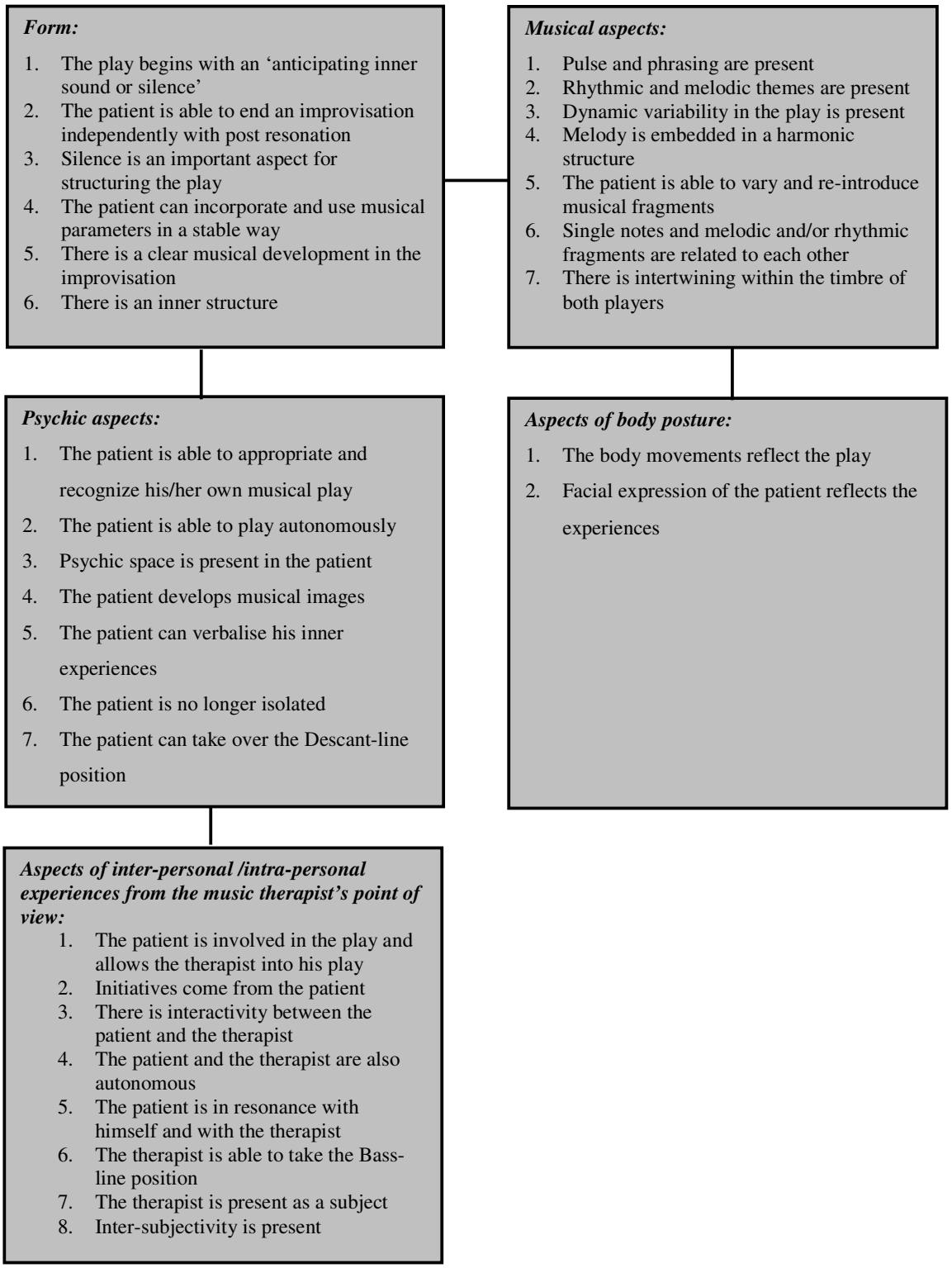


Definition of musical form in a music therapy context

Musical form is a term describing a musical structure that is created within a symbolising process. Musical form develops from the foundations laid during moments of synchronicity. Clear rhythmic and melodic themes may appear that can be further explored or varied. Musical figures can be characterized by phrasing and pauses. Features of the musical improvisation typically have a clear beginning and ending, and the patient and therapist prepare mentally for these. This is always an inter-subjective phenomenon between patient(s) and therapist, who experience being equal to each other and feel free and autonomous to play, think, exist and develop their own images and thoughts. There is an intertwining of the timbres of both players.

Further explanation:
During this process the sounds that are generated in a musical improvisation are guided by something unknown to the subject. The music resonates with an inner awareness of something that is no longer experienced as external or unrelated.

Criteria of Musical Form (CoMF)



Process

From this study it emerged that moments of synchronicity were an essential step in the transition of a patient's sensorial play towards a musical form. These moments can be brief, unexpected and infrequent. In these moments the therapist is experienced as a subject by the patient. The timbres of both players intertwine and both players are able to come into resonance with one another. What is notable and remarkable in this process is that different modalities of silence originate, that make a musical development possible. The phenomena of *compact* and *open silence*, *timbre* and *inter-subjectivity* have a common characteristic that is not always audible or visible, but can be experienced by the patient or the therapist.

From the research one can see that in the first instance the patient cannot hold these moments, as found from the unsustained moments of synchronicity. This is only possible when musical form originates and stabilises. A common musical and psychic space then originates, and can be termed a transitional space (Winnicott 1971), in which intersubjectivity can be fully present, and in which images can be created and where the patient is able to take a step towards a symbolic order, and is no longer imprisoned in what is the *Real*. The patient is now able to create a mental space in which something can be thought and in which something of meaning can take the place of chaos and repetitiveness. This is a space in which ideas can be mentalized and in which the psychotic patient is not subject to the 'unimaginable storms' (Jackson 1994). The patient and therapist are independent and autonomous from each other. Musical themes can be developed, recapitulated, varied and appropriated.

Music therapy interventions

This study also entailed a description and interpretation of the music therapy interventions and the attitude of the therapist. Because of this, it became clear that interventions such as taking *the Bass-line position and Descant-line position, anticipating inner sound, post-resonation, the empathic listening stance, therapeutic provocation, mentalisation after the session, improvising in the absence of the patient* make possible, facilitate and support a therapeutic process (De Backer 2005). It is essential that these music therapy interventions are not techniques that are applied intentionally (through pre-planning or directed activity), but rather, belong to the attitude of the therapist in relationship with the patient. The interventions are used 'at the right moment' through an unconscious response to the transference.

Limitations of the study

A limitation of this study is that only two subjects participated to this research. In this sense, it is hard to talk about an external generalizability. However, these two subjects, who display two different kinds of clinical profiles of psychosis, can be seen as exemplary. Because of the in-depth and extended analysis of these two cases, the theoretical insight, gained through the findings of this study, can be considered as good-enough in order to also relate them to other therapeutic contexts or situations.

Implications in clinical practice

For the clinical music therapist working in psychiatry, this study offers a theoretical framework through which one can achieve insight into the course of a therapeutic process with psychotic patients. Not only are these theoretical insights valuable in the treatment of psychotic patients, but also for other pathologies, where the symbolising function is affected, such as patients with developmental disability, autism and borderline problems. This, however, will be a subject for future research. The insight into influential music therapy interventions, that were specific for the development of a therapeutic process with these two patients, will also be important for clinical practice. This study demonstrated the specific relevance of music therapy as a contribution to the treatment of psychotic patients. This clinically applied research offers the clinicians a theoretical frame of thought that can be applicable in the clinical practice with psychotic patients.

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