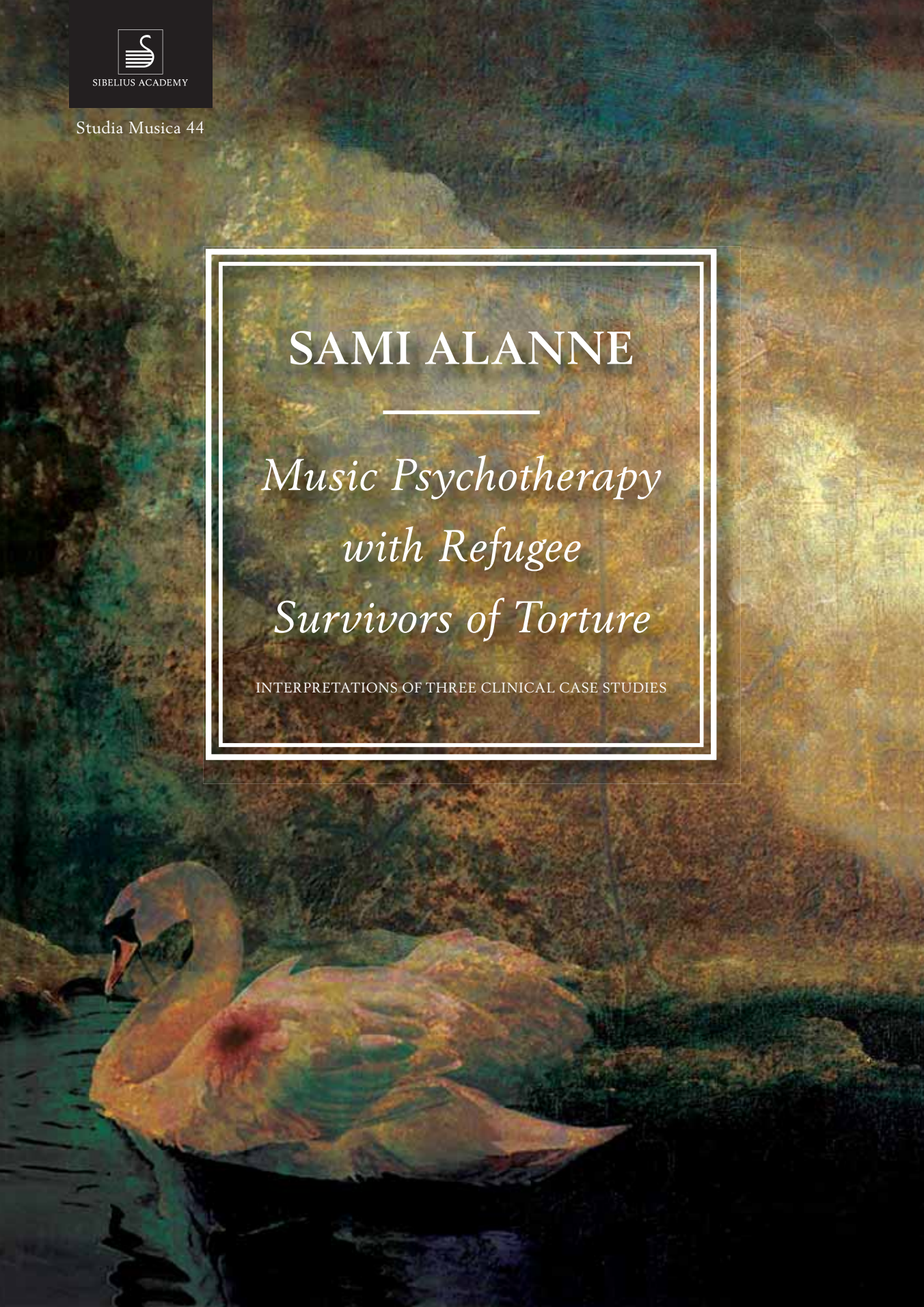

SIBELIUS ACADEMY

Studia Musica 44

# SAMI ALANNE

# *Music Psychotherapy with Refugee Survivors of Torture*

INTERPRETATIONS OF THREE CLINICAL CASE STUDIES

Sami Alanne

# *Music Psychotherapy with Refugee Survivors of Torture*

*Interpretations of Three Clinical Case Studies*

SIBELIUS ACADEMY

Helsinki 2010


*Music Education Department*
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## ABSTRACT

Sami Alanne. 2010. *Music Psychotherapy with Refugee Survivors of Torture. Interpretations of Three Clinical Case Studies*. Sibelius Academy, Studia Musica 44. Music Education Department. Doctoral dissertation, 245 pages.

The clinical data for this research were derived from three music psychotherapy cases of torture victims who in 2002 to 2004 lived as either asylum seekers or refugees in Finland. The patients were all traumatized men, originating from Central Africa, South Asia, and the Middle East, who received music therapy sessions as part of their rehabilitation. Music therapy was offered weekly or bi-monthly for the duration of one to two years. Music listening techniques, such as projective listening, guided imagery, and free association were applied in a psychoanalytic frame of reference. Data included 116 automatically audio recorded and transcribed therapy sessions, totalling over 100 hours of real time data that were both qualitatively and quantitatively analyzed by the researcher. While previous studies have examined refugees and other trauma sufferers, and some articles have even discussed music therapy among torture survivors, this is one of the first empirical research studies of music therapy specifically among patients who are survivors of torture.

The research thoroughly describes each of the three subjects in terms of their experiences relating to music, therapy, torture and encounters with Finland, as well as their progression through the therapy. The narrative of each case study makes frequent reference to transcribed data from the music therapy sessions to provide a naturalistic view of the patients and their experiences. Transcribed discourse and clinical notes from all 116 therapy sessions were analyzed in terms of 66 variables of the "situated person" pre-identified as significant according to both the pilot study and previous theory and research in this area. Within each session, the frequency and temporal location in which these variables appeared were systematically recorded and later factor analyzed for reformulating and reducing the dimensions of the data to achieve new meanings. From the analysis, 8 statistically significant factors emerged, suggesting explanations that, in terms of these particular variables, music therapy approaches were effective for promoting verbalization as well as regulation and expression of emotions.

The subjects also completed four tests on multiple occasions: (1) *Beck Depression Inventory (BDI)*, (2) *Symptom Check List-25 (SCL-25)*, (3) *How Do You Feel Today?* questionnaire, and (4) *Alanne Music Therapy Outcome Questionnaire.* All four tests were administered at the start of the therapy, at the end of the therapy, and six months following the conclusion of therapy sessions (for a total of three times), and two of the tests (*Alanne Music Therapy Outcome Questionnaire* and How Do You Feel Today?) were also administered one additional time 6 months into the therapy sessions. Three patients in music psychotherapy and their two compared persons of torture survivors who had the best other general psychiatric treatment filled the questionnaire similarly (N=5). Their general rehabilitation was followed for a two-year period with the questionnaires. According to the data analysis from clinical discourse and tests, all three subjects responded positively and demonstrated some improvement due to their music therapy treatment, although with varying degrees of satisfaction. The therapy increased the consciousness of patients regarding their traumatic experiences, however music was perceived as related to positive imagery and pleasurable experiences, and as an aid in calming and relaxation. These findings suggest that some music psychotherapy methods may be effective in treating patients who are survivors of torture and related traumatic experiences.



Keywords: music therapy, psychotherapy, psychoanalysis, factor analysis, refugees, torture survivors, traumas, asylum seekers, hermeneutic phenomenology, clinical improvisation, projective listening

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**CONTENTS**

# 1 INTRODUCTION

"Without music life would be like living in the cemetery" – a torture survivor

The data for this research were collected over a four-year period (2002–2005) in Helsinki, during which time I worked as a part time music therapist at the Rehabilitation Centre for Torture Survivors in Finland. Although it has been quite a while since the data was collected, the research project has continued analyzing the data qualitatively and quantitatively. Even though I only began writing the final report at the beginning of 2010, it is still the first dissertation, larger academic research or monograph concerning music therapy and torture survivors, or even music therapy and trauma sufferers and refugees, to emerge from this project.

I began working with torture survivors a year before starting the research, when the ideas and plans for the research project were developed. I was the first music therapist at the centre and may have also been the first in Finland to work with this patient group. Although there had been some experiences relating to music therapy with torture survivors, especially in Pakistan, the Netherlands, Denmark, Germany, and the United Kingdom at the time, there was not much in the way of literature, articles or research about the subject (Pervaisz, 1994; Orth. & Verburgt, 1998; Vinther, 1999; The BZFO reports 2000–2002*;* Dixon, 2002*;* Zharinova-Sanderson, 2004a). Theoretically, the area appeared interesting and suitable for music therapy. Because of the lack of specific research, it also seemed important to document and research music therapy with torture survivors. When I started working with torture survivors, there were no established instructions or clinical handbooks delineating how I should do my work and how it would be possible to help them. This is the reason why my basic research question was as simple as how could music therapy help torture survivors? What kind of benefits for their mental health would be gained from music psychotherapy? However, there were many sub-questions relating particularly to the meanings and experiences music would provide for torture survivors. What kind of imagery and memories would it bring up for them, for example?[1]

While planning the research, it was evident that my research question is actually a very wide question and that I would not be able to fully answer it with one empirical research and my limited resources – only myself working as both researcher and therapist. Regardless, I hope that my presentation on the research process, philosophy, clinical theories and experiences will provide a picture, even something of the essence, of music therapy with torture survivors. There are many possibilities for applying music in therapy with torture survivors and other traumatized patients, even though I have not been able to demonstrate them all in this project. Because of the wide range of various music therapy techniques and approaches – also illustrated in the review of the research literature documenting former experiences and studies of music therapy with torture survivors and traumatized individuals – I decided to focus on music listening techniques in general, and imagery work with music in particular, in my clinical research. The application of these clinical methods and their theorizing are

[1] Please note that all the research questions are thoroughly and explicitly presented and discussed in the Research Methods, chapter 6.1, where I also provide guidance for those readers who are especially interested in these topics at this point.

described thoroughly in chapter 4; in chapter 6 the clinical focus is further discussed, concerning the research methods used and data collection. I would argue that a review of the literature pertaining to former research and discussions relating to music, music therapy with trauma and torture survivors, fulfils the clinical data and findings of this research. Particularly, I assume that they may aid music therapists and researchers in developing their work in this area and attuning themselves more closely to the described phenomena.

In respect of the clinical data in this research, even though limited in terms of music therapy techniques and the number of participants concerned from the nomothetic perspective of knowledge, it seems that music and music therapy aided the patients on many levels. Scrutinizing their music psychotherapies and rehabilitations from an idiographic perspective, it seemed that music opened a passage way into their emotions and traumatic experiences during therapy. Music also appeared to hold their complex feelings as a conscious mastering of mind and provided words to describe emotions. It appeared during music therapy that development occurred in emotional regulation and reciprocity with music. I postulate that music therapy may have given patients a chance to relax for one moment in their day, with music bringing pleasure and positive imagery to their minds, as I will later illustrate with case studies and factors. These will also show how music psychotherapy enabled verbal encountering and the sharing of traumatic experiences. In addition to this, there was an increase in self-understanding and consciousness.

The clinical work and the research has been a journey for me, and not only my patients, in music therapy. In my own experience, therapy and the research process have similarities since they both keep the therapist researcher uncertain as to what is to be found along the way and how the journey ends. To my mind, this research project in itself has been a path across fields and woods with lots of different scenic views that I have had to walk by. With patient waiting, the phenomena and the landscape become disclosed and speak of how they really appear in themselves as first encountered (Gegend): "In waiting we leave open what we are waiting for" (Heidegger, 1959/2002, p. 44).[2] Contemplation and wondering without calculating, analyzing or interpreting the *things* (Ding) beforehand may also be needed. This is how Martin Heidegger (1959/2002) describes his concept of *releasement* (Gelassenheit); he illustrates it with a story about three persons holding a discussion among themselves while walking along a road across a field away from civilization and pre-considered constructions and representations. Through the open spaces (Gegnet) their surroundings are unveiled and seen as they truly are. In this research, Releasement has not only been a method but also an attitude held by the researcher during the whole research project, even while writing this book. In practise, I assume it has to mean that some of the research material and topics remain open for me and the reader as well. They cannot all be defined beforehand or determined afterwards either. What shows itself to us also hides from us simultaneously and thus requires an attitude of *openness to the mystery* as described by Heidegger. Releasement and an openness to the mystery belong together and provide new ground – soil – on which to stand while staying inside the technical world. (ibid., pp. 26–27.)

[2] pp. 54–57, 68 in the English edition of Heidegger, M. (1959/1969) *Discourse on Thinking. A Translation of Gelassenheit*. Transl. by Anderson, J.M. & Freund, E.H. New York: Harper & Row.

Music therapy has a long history, with its roots in ancient Greece. Hippocrates applied music in order to pacify patients, as did other doctors from ancient times like Xenocrates, Sarpender and Arion. Many philosophers referred to the therapeutic effects of music, including Aristotle who concluded that a flute has a more arousing effect than calming, so it should be applied in order to increase emotional excitement. He also considered it as a sexual instrument, which may have poor results on morality, according to him. Pythagoras applied music and physics/movement in support of the health of the emotional life and of coherence. In Greece, the principle that the excited mind could be calmed with peaceful music, and the opposite rule of the *iso principle* that music should be equal to the state of mind, was already known. This would mean that probably the best music in therapy for sad people would be melancholic, for instance. (Lehikoinen, 1973; Wigram, Nygaard Pedersen, & Bonde, 2002.)

The therapeutic effects of music have been known in many cultures throughout the world and used as part of ceremonies and healing rites. In Asia, music has been thought to promote contemplation and healing. The Islamic culture includes shamanistic rituals in healing which evoke spiritual forces or entities when the shaman goes into a trance. In Africa, music has been a connection to the spirits just as it has in Finnish Lapland, for example. Also in the rituals of North and South American Indians, music is included. For example, in Peru shamanistic traditions still occur. Music is also still part of the healing traditions, spirituality and health care throughout the African continent as, for example, in Sudan where songs are media to communicate with the Gods. In Africa, there is no equivalent concept for the word "music" as it is used in the western world, but the word music includes dance and movement as well. (Jones & Baker, 2004, pp. 92–93.) It appears even from these short examples that music therapy has its roots in many cultures that extend throughout the history and even pre-history of human kind. It also seems that the leap from ancient times to the modern era is not so long, considering therapy, music, culture and the human mind – not even in the light of this research. (Lehikoinen, 1973; During, 2008; Brummel-Smith, 2008; Olsen, 2008.)

The idea to apply music therapy to the treatment of torture survivors came to my mind because music in itself has the therapeutic potential to relieve the various emotions and traumatic experiences that the patients might have. The cathartic effect of music is very well known in music therapy, which Aristotle (1997, p. 164) had already noticed in his study of poetry (poiesis*)*. According to modern music therapy theory, music may express emotions, thoughts and unconscious conflicts even when they are not accessible with words. This has led to calling music a symbolic language in the field of music therapy. (Bruscia, 1998; De Backer & Van Camp, 1999; Wigram, Nygaard Pedersen, & Bonde, 2002.)

According to the object relations theory in psychoanalysis, music can do psychic work for an individual: Music may be a *good object* for a person and help him/her unconsciously. In this role it can be a *self-object* for an individual whereby s/he may reflect upon traumatic, personal emotions, conflicts and issues that relate to his/herself and work through them using the symbolic distance of music. Music can become to a person what Donald Woods Winnicott (1971/1997) called a transitional phenomenon, or an object. It provides an individual with the chance or potential to process difficult feelings unconsciously, and it also creates feelings of safety while one is suffering or being under threat. (McDonald,

1970/1990; Kohut, 1971/1987; Lehtonen, 1986; 1993; 1996; Dvorkin, 1996, Erkkilä, 1997a & b; Sinkkonen, 1997; Erkkilä & Rissanen, 2001; Syvänen, 2005; Nygaard Pedersen, 2006.)

However, there has also been dialogue and debate about the nature of music, what kind of meaning music represents and symbolizes in the field of music therapy. Is it a language or does it have a symbolic/dynamic form? In fact, Aristotle (1997, p. 159) considered that music and other art forms mimic reality, characters and emotions. I suggest that this provided a ground for modern music improvisation as is more thoroughly illustrated later. However, the debate has been especially strong between writers that seem to present a more psychoanalytic orientation and those who represent more eclectic, humanistic and music centred music therapy. This relates to the two fundamental traditions in music therapy as can be found, for example, in the United Kingdom. There are music therapists that apply music more as therapy, as opposed to the Nordoff-Robbins model and the psychodynamic/analytic schools of Alvin and Priestley that advocate more music in therapy and thus stress the verbal meanings relating to music. (Pavlicevic, 1996, 1997, 1999; Lehtonen, 1995, 1996, 2008; Stige, 1998; Aigen, 1999; Ansdell, 1999; Brown, 1999; Streeter, 1999.)

In modern developmental psychology, the question has been raised whether or not a musical experience is rooted in proto-conversations between a mother and baby; could this imply that music preceded symbolic spoken language as a sort of pre-language? Even the significance of psychodynamic theory and its traumatic experiences has been doubted and seen as more evolutionary, and biological development aspects have been suggested to re-formulate music therapy theory. (Kennair, 2000; Trevarthen & Malloch, 2000; Dissanayake, 2001.) However, in the past decade interest in traumas has increased in music therapy as well, especially after the 9/11 terrorist attacks and the New Orleans hurricane disaster. Tragically, these terrible events seem to have given renewed meaning to grief and loss and the importance of therapy. (Sutton, 2002; Loewy & Frisch Hara, 2002; Erkkilä, 2003; Carey, 2006; Wolf, 2007b; Bensimon, Amir et al., 2008; Weiß, 2008; Sutton & De Backer, 2009.)

Theoretical discussion about the role and meaning of music in music therapy practises has continued for a long time and will continue to do so. However, there also seems to be a need and pressure for evidence-based music therapy (EBM), which has forced the researchers of music therapy to change their methods from qualitative research and case studies to positivistic randomized control trials (RCT) (Wigram, 2001; Edwards, 2005; Silverman, 2010). Actually, positivistic music therapy research was ongoing during the 1950's and 1960`s, especially in North America. There were studies investigating how music affects the reactions of papillae and causes changes in galvanic skin response or other system responses, for example. These mutually furthered clinical work and research. Qualitative research approaches and case studies have been broadly applied in music therapy before, which in a way bridges two worlds of knowledge: clinical knowledge and scientific knowledge. However, it has been noticed that there is a lack of empirical outcome research in the field of psychiatric music therapy, for example, in spite of the progress in music therapists` clinical work towards temporary treatment models in psychiatry (Silverman, 2007, p. 411). (Bruscia, 1996; Erkkilä & Rissanen, 2001; Aigen, 2008; Maratos, Gold et al., 2008; Erkkilä, Gold et al., 2008, Silverman, 2010.)

In the decade spanning 2000–2009, much research relating to music and music therapy and the brain has been published. It is suggested that more information will forthcoming as to how the brain processes music and how music is experienced. This may help the music therapist to "tune" their instruments to the brain as researchers themselves suggest. New research has studied how genes relate to musicality, for example. Recent research has shown that music processing in the brain is related to many structures and areas in the brain. Thus it is not associated only with the right or the left hemispheres as was postulated in earlier music therapy theory. (e.g. Kujala, Karma et. al., 2001; Tervaniemi, 2001; Flohr & Hodges, 2002; Hodges, 2002; Levitin, 2007; Sacks, 2007; Särkämö, Tervaniemi et al., 2008; Ukkola, Onkamo et. al., 2009; Lerner, Papo et al., 2009; Peretz, Brattico et al., 2009).

Similarly, more specific research and knowledge has also emerged considering the brain and traumatic experiences, which suggest that early psychological traumas in childhood and infancy alter the homeostasis in the brain and thus affect the brain's development. Now it is known that the secure attachment of a child affects the social brain and its associative circuits positively. Similarly, failed unsecure attachment resulting from maltreatment and strong stress may lead to epigenetic changes and deficits in this area and may result in a poor capability for affect regulation and lead to mental disorders and physical illnesses later in life. This is referred to as the theory of *allostatic* changes in the brain, which is an operationalized concept of how the brain and the systems are trying to stabilize the equilibrium and normal functions in concurrent stress situations. It is proposed that music, as with singing in a choir, arts or other pleasurable co-activities, may have significance for the brain, increasing and balancing its well-being because it creates an "us-spirit" (Hyyppä, 2009, p. 354). This is further considered to have general effects on health and may prolong life expectations. There is recent research on genes and musicality which suggests that music may have an evolutionary importance in creating secure attachments (Ukkola, Onkamo et. al., 2009). This type of modern research relating to brain functions, genes and evolution, particularly concerning the mirror neurons and the previously mentioned epigenetic changes stemming from childhood abuse for example, may provide new information about human learning and behaviour in the near future. (Glaser, 2000; Kalland, 2001; Punamäki, 2001; Crenshaw, 2006; Hyyppä, 2009; 2010.)

However, I assume that the nature of musical experience as well as other human behaviour may have many layers of meaning and knowing, which may be explored through psychoanalysis, semiotics, philosophy, aesthetics, anthropology, ethnology among many other methods (see e.g. Tarasti, 1978/1994; Nattiez, 1990; Kurkela, 1997; Ruud, 1998; Välimäki, 1998; 2005; Davies, 2005; in print; Torvinen, 2007; LeVine, 2009). I also postulate that even though our biological processes, brains, genes and our perceptions, contribute to providing our world with meanings, these symbolic processes cannot be reduced to simply our biological being. In this sense, I have collected my research data and studied it from the many levels of being as proposed by Heidegger (1927/2000) in his hermeneutic phenomenology. It is Dasein analysis of music, music therapy and psychotherapy that studies how meanings arise as interpretations in terms of time and being from many dimensions (Alanne, 2002a ; 2005a; Bracken, 2002; Rauhala, 2005; 2009a; Torvinen, 2007; Lehtonen, K. 2008).

I consider the psychoanalytic approach as a part of hermeneutic science in this research, although I know there may be other opinions and aspects of psychoanalysis as well (Strenger, 1991; Lapplance, 1992; Enckell, 2002; 2004; 2009; Malmberg, 2009; Tuohimetsä, 2009; Wallerstein, 2009.) In a discussion relating to the clinical research of psychoanalysis and its development, Robert S. Wallerstein (2009) has recently proposed that both hermeneutic qualitative and naturalistic quantitative research paradigms and their mixed designs are applicable. Therefore it cannot be only a debate between humanistic traditions like psychoanalysis and cognitive- and neurosciences either, but rather a synthesis of many theories, research and philosophies as metatheories in order to provide us with the whole picture. It also seems that psychoanalysis is not even trying to answer all the questions of humankind (Reister, 1996, p. 248). However, psychoanalysis has broadened its spectrum towards neuroscience and learning also in the study of music and the arts (Alvarez, 1992/2002; Noy, 1993; Stern, Sander et al., 1998; Fonagy, Gergely et al., 2004; Rose, 2004; Stern, 2004; BCPSG, 2008; Enckell, 2009, Lehtonen, J., 2009; Takalo, 2009).

In fact, many of the latest findings in brain research seem to support earlier psychoanalytic theories such as Siegmund Freud`s (1923/1993) topographical model of the mind as consciousness, pre-consciousness and unconsciousness which may have equivalents in the hippocampal-based system in the brain. The amygdala- based system in the brain, relevant for emotional processing, appears to be congruent with *dynamic unconsciousness* according modern neuropsychoanalysis. Freud's (1920/1993) concepts of *primary and secondary processes* are often cited in music therapy and may well have correspondences in the prefrontal cortex between intellect and feelings, which also suggest an interplay between implicit and explicit memories and between imaging and knowing. They are also referred to as the experiencing and observing ego. (Rose, 2004, p. 121.)

According to Rose (2004) music affects the same brain systems in traumas. For him, musical knowing and experiencing is equal to language. In fact, he considers that our first memories are not verbal but rather more amodal feelings that are embodied in the self. He also postulates that it is those ambient experiences, and mutual affect attunement, that are internalized from the infant and caretaker dyad rather than verbal memories, which have correspondences in internalizations in psychotherapy. (pp. 126–127.)

The arts philosophy of Susanne Langer (1942/1957) presented the idea that music is *isomorphic* with the self and emotions. Heinz Kohut and Siegmund Levarie (1950) considered that music corresponds to a structural model of the mind, the ego, id and super ego of Freud (1923/1993). Rose (2004, p. 52) proposes a new name *concordance* for this theory of isomorphism in psychoanalysis in order to synthesize psychoanalytic developmental psychology and its relation to neuroscience and biology. I think this is a reasonable new formulation and type of theorizing, which in my opinion may be of a higher category, in the light of the latest brain research as mentioned. However, it is also wise to remember that it is still a theory and there may be some philosophical and practical problems relating to the integration of psychoanalysis and neuroscience in clinical use and research, as suggested by many authors recently (Enckell, 2009; Kotkavirta, 2009; Tuohimetsä, 2009). One particular problem concerning neuroscience and humanistic research, including psychoanalysis, is the fundamental differences in their scientific and methodological

traditions and knowledge interests. Neuroscience is interested in biological and physical explanations of human behaviour and consciousness as part of natural science and thus has nomothetic, generalizing, knowledge interests. Humanistic sciences and psychoanalytic psychotherapy emphasize the experiences of the individual, which means an idiographic knowledge interest. (Pally & Olds, 1998; Tähkä, 1997b; Enckell, 2009; Lehtonen, J., 2009; Rauhala, 2009b.)

In spite of that, I argue that Rose`s (2004) book and his studies are fundamental to the theory and practise of psychoanalytic music psychotherapy. They seem to continue, fulfil and provide new orientations concerning neuroscience and traumas, expanding upon earlier theorizing on symbolic processes and conceptions of music as dynamic forms in music therapy. However, I assume that music therapy has equal problems concerning the philosophical foundations of knowledge and applicable scientific methods when it comes to integrating knowledge and theory from multiple areas including neuroscience, music education, psychoanalysis, behavioural cognitive and humanistic psychology, evolutionary theory, anthropology, social sciences etc. (Rechardt, 1987; 1992; Lehtonen, K. 1995; 1997; 2008; Erkkilä, 1997b; Pavlicevic, 1997; Alanne, 2002a & b; 2005a; Sutton & De Backer, 2009.)

In this study, psychoanalysis has been the main clinical theory but, from the research respect, it has not been the only theory influencing me as a researcher or even as a therapist. I assume that in the end these questions of music and therapy circle back to ontological questions of what humans are and what kind of image does a researcher have of man. There are also epistemological questions as to what can be known from music and how it is possible. Therefore the phenomena investigated have also needed philosophical analyzing on many levels because they relate to the problem of mind and body, for instance. According to the philosopher Dermot Moran (2002, p. 5), phenomenology studies phenomena, which currently may be understood to include, as examples, all forms of appearing, showing, manifesting, making evident ("evidencing"), bearing witness, truth-claiming, checking and verifying. This may require, in all their forms, seeming, dissembling, occluding, obscuring, denying and falsifying. The material phenomenology of Michel Henry (1973;1999*)* is the phenomenology of life, how life speaks to oneself and thus how one finds the essence of its manifestation. Ruud Welten (2002) writes about the corporality of music in this context, how music is not an object; rather that I feel, hear and sing music with my flesh. My body is the object that is felt, heard and sung. Thus music reveals life in itself. This is analogous to the thinking of Maurice Merleau-Ponty (1945/1994); how we perceive and know the world subjectively through our bodies.

Eleanor V. Stubley (1992) has considered music as a mode of knowing through the senses, including listening to music, performing, composing and expression. She scrutinizes music and its research from the constructivist point of view as processes of intentional acts in the personal, social and historical dimensions. Musical knowing, according to her, can also be procedural knowledge, doing (praxis), as well as propositional knowledge. Wayne Bowman (2002) addresses Aristotelian *praxis* as part of musical knowing and musical doing; playing an instrument, for example, is practical knowledge that has its corporeal root in bodily knowledge. Thus praxis may be a part of hermeneutical understanding and research as are

the skills of a musician, a music therapist, a doctor and a teacher, as Hans-Georg Gadamer (2004) suggested earlier. However, thorough contemplation (phronesis) and the attunement of the researcher is also required in the praxis in order to guide the research in the right direction and to show the right way to do it (Bowman, 2002, p.70).

With research, this also means self-experiencing (pathos) and hence it comes near to Heidegger's above mentioned concept of *releasement*; the researcher stops to see and listen to what is around him/her, and thus notices the interaction between the world and him/herself (Moran, 2002; Keski-Luopa, 2009). In the famous movie by Francoise Truffaut, *Stolen Kisses* (1968), there is scene where the owner of shoe store, a businessman, visits a private eye agency. He explains that his marriage is happy and nothing is wrong with his life either. However, he is concerned because of the looks given to him by his wife and his employees that they must hate him. He has thoughts about attending psychoanalysis in order to better know himself, but decides that he does not have the time to lie on a couch, so he would rather hire a private eye to observe him and his employees to find out the truth about himself. Finally, his wife falls in love with the detective and betrays him. I think that this episode in the comedy has a serious meaning that seems to speak for current times particularly; how efficient economic and calculative thinking, "objectivism", has spread to many branches of life, thus affecting even our everyday solutions – and not just concerning therapy or research.

The focus of meaning in phenomenology is on the living experience and how phenomena appear and become manifest i.e. the structure of appearance, whether phenomena belong to cultural, physical, mathematical, aesthetic, religious or other areas. (Moran, 2002, pp. 4–5.) This makes the knowledge interest idiographic in this research; evidencing the phenomena relating to music psychotherapy with refugee survivors of torture from their individual points of view. However, not forgetting or denying that some research questions and hypotheses had nomothetic knowledge interests concerning particularly the possible benefits of music therapy on the symptoms of patients and their health conditions. I consider that this is actually one implicit research question, or at least the research purpose, of much therapy research, even though meanings or experiences, for example, are claimed to be the focus. This relates partly to the ethical reasons in health care that treatments, investigations and research should neither be pointless for the patients, nor harmful or over-burdening from the perspective of their treatment or rehabilitation. Partly it relates to the natural scientific traditions mentioned above; the demand for objectivity in particular, and the mind–body dilemma frequently referred to as the *Cartesian error*, which makes it easier, safer and more justifiable for the humanistic researcher to subjectively study meanings and the experiences of other people by interviewing them only, for example. However, when the meaning is a life in itself, thus making that life the research object which is to be heard with our flesh, there should be no excusing or denying that I as a researcher and therapist have continuously been in interaction with my patients and therefore have affected their world.

Heidegger (1927/2000) refers to the concept of *worldhood* in this context; how the researcher is not observing the phenomena from the outside, but belongs to the world with them, just as I, as a music therapist, have my history in the long tradition of musical healing (see also Gadamer, 1989/2002). I have knowledge and questions which arise from my

professional field as well as my personal situation and the preunderstanding that relates to my being-in-the-world (Dasein). In this research, it also means that all the later described "objective" research methods, such as psychological questionnaires and the factor analysis, are grounded in the subjective knowledge, experience and interpretation of the researcher and the participants; torture victims themselves. In fact, this research design makes me a participant as well, i.e. a *participant observer*. However, I postulate that together with this philosophy of science, hermeneutic phenomenology, and the use of objective research methods, some findings of this research are "objective" in the sense that they manage to describe, manifest and evidence the essences of the phenomena studied. They search for the truth and therefore may be transferable beyond this research, psychoanalytic context and, perhaps, music psychotherapy as well.

# *PART ONE*

# *THEORETICAL AND METHODOLOGICAL GROUNDS*

*Music for a while*
*Shall all your cares beguile:*
*Wond`ring how your pains were eas`d*
*And distaining to be pleas`d*
*Till Alecto free the dead*
*From their eternal bands,*
*Till the snakes drop from her head,*
*And the whip out from of her hands*[3] (John Dryden – Oedipus, A Tragedy, 1678/1692)

[3] From the song *Music for a While* of the Oedipus semi-opera composed by Henry Purcell 1692.

## 2 APPROACHES TO MUSIC THERAPY

Music Therapy as its own field of science emerged in the 1940`s/1950's when the first academic courses in the United States were established; however the first course, "Musical Guidance and Therapy" was already offered initially in 1938 at the University of the Pacific (O ´Connell, 1990). In the beginning, music therapy was frequently behavioural therapy, whose goals were, for instance, based on learning and cognitive processing. Behavioural music therapy (BMT), or educational music therapy, has remained one of the main models applied in music therapy. The first psychodynamic pioneers of music therapy included Juliette Alvin with her Free Improvisational Therapy and Mary Priestley (1975/1994) with her Analytical Music Therapy (AMT), from the United Kingdom. Other important pioneers of music therapy were Paul Nordoff and Clive Robbins with their Creative Music Therapy – The Nordoff-Robbins model – which may well be the most well known music therapy approach in the world that has its foundations in humanistic psychology. However, I assume that their approach, as well as that of many other pioneers of music therapy, has influenced music therapists in general. For example, their clinical improvisations and reflection techniques with music are even suited to a psychoanalytic approach, as later described more thoroughly. In Scandinavia, one prominent pioneer of humanistic music therapy is Even Ruud from Norway. Inge Nygaard Pederssen, from Denmark, is a pioneer of the psychodynamic approach and Analytically Orientated Music Therapy (AOM); she established the first master's degree training programme in music therapy in Scandinavia at the Aalborg University in 1982. (Ahonen-Eerikäinen, 1998; Eschen, 2002; Wigram, Nygaard Pedersen, & Bonde, 2002.)

Another currently influential music therapy approach, originally from the United States, is Helen Bonny`s Guided Imagery and Music (GIM) or, as it is currently named to differentiate it from other music listening techniques that apply imagery processing, the Bonny Method of Guided Imagery and Music (BMGIM). This model has its theoretical background in many different theories: Psychodynamic theories, Maslow`s humanistic psychology, transpersonal psychology and neurosciences. In my opinion, it may even be called its own therapy model or science because of its research and many clinical applications. (Wrangsjö, 1994; Grocke, 1999; Bruscia & Grocke, 2002; Wigram, Nygaard Pedersen, & Bonde, 2002; Körlin, 2005.)

BMGIM has also influenced many music therapists, this research and its clinical music listening methods notwithstanding. In this research the psychoanalytic theory developed by Freud (1900/1995) and his many followers, ranging from the previously mentioned object relation theories and self psychology to the phase specific theory of Veikko Tähkä (1997a) and the developmental psychology of Daniel Stern (2004), have been the clinical metatheories used. In this sense, it differs also from earlier models of psychodynamic music therapies in that its purpose is not to be a therapy model in itself but one contribution to and perspective on psychoanalytic music psychotherapy theorizing.

Another major music therapy field is biologically orientated music therapy, which may include various approaches in medicine and studies the physiological effects of music. For example, there are the vibroacoustic and vibrotactile therapies that have been developed by Olav Skille in Norway, Petri Lehikoinen in Finland and Tony Wigram in Denmark and

England. Treatments apply pulsed sinusoidal low frequency tones and music in order to treat pain disorders, muscular conditions, pulmonary disorders, general physical ailments and psychological disorders. Treatments employing Lehikoinen's physioacoustic chair may be used to relax patients with music during psychotherapy for instance. In this research I did not use such a chair or any other stimuli or device other than music to relax patients. I assume from my own clinical experiences that similar relaxing effects are possible using only a relaxed position and music, without massage being needed. However, physiotherapy and massage were used with the patients in this research as part of their general treatment and rehabilitation. (Wigram, Nygaard Pedersen, & Bonde, 2002, pp. 139–140.)

There are many definitions of music therapy, which may be influenced by the theoretical orientation and clinical work of the music therapist, but one general definition is the following:

*Music Therapy is the use of music and/or its musical elements (sound, rhythm, melody and harmony) by a qualified music therapist, with a client or group, in a process designed to facilitate and promote communication, relationships, learning, mobilization, expression, organization and other relevant therapeutic objectives in order to meet physical, emotional, mental, social and cognitive needs. Music Therapy aims to develop potentials and/or restore functions of the individual so that he or she can achieve better intrapersonal and/or interpersonal integration and, consequently, a better quality of life, through prevention, rehabilitation or treatment.* (World Federation of Music Therapy, 1996 cited from Wigram, Nygaard Pedersen, & Bonde, 2002, pp. 29–30.)

In my research and clinical work, I have been influenced by psychoanalytic theory and its guidelines for psychotherapy (Tähkä, 1982; 1997; Lemma, 2006). In Finland, as well as in the United Kingdom for example, there is a long tradition of psychodynamic music therapy: ranging from the 1950's in the United Kingdom and systematically from the 1980's in Finland at least. It has also been one of the main schools of thought in both countries until the present. (Erkkilä & Rissanen, 2001; Walsh Stewart & Stewart, 2002; Tervo, 2005.)

According to recent research by Silverman (2007), in the United States music therapists tend to work predominantly with groups in psychiatry, and have a more eclectic and behavioural approach to music therapy. However, a psychodynamic approach to music therapy is seen as a general, but not as a philosophical, approach which seems to be in contradiction with the music therapy approaches that therapists have stated they use. The results of another piece of research into music therapists in the United States suggest that a psychoanalytic orientation (2,3%) is rare as most music therapists considered that their theoretical orientation could be labelled behavioural (29,8%) or person-centered humanistic (29,2%). (Jackson, 2008, p. 200.)

However, I will admit that in actuality the music psychotherapy presented in this study contains elements of all the above mentioned music therapy models, and that I have applied research from these models to my theorizing, research and clinical work. I consider it natural because music itself as a phenomenon has many dimensions that are not only related to psychoanalysis or even to therapy, as will be shown later through philosophical analysis. Also, working with traumatized refugees and torture survivors has provided me with some specific objectives and guidelines.

## 2.1 Music Therapy with Traumatized Refugees, Asylum Seekers and Torture Survivors

I discovered, as my research began, that there was only a limited amount of research on music therapy with torture survivors. However, clinical experience from Pakistan, the Netherlands, Denmark and Germany had been reported. In the main, music therapy with torture survivors consisted of actively playing music in a group or active individual therapy. Frequently, patients were refugees from different cultures and so had a lot of social and economical worries because of their situation. Thus many therapies happened in the here and now moment. The objective of music therapy was to forge a connection to one`s emotions and imagination, thus re-establishing a basic trust in humanity. Rhythmic playing or drumming was thought to provide a safe basis from which to approach diverse feelings and traumatic experiences. The emphasis in music therapy could be on music and the non-verbal expression of oneself rather than verbal music psychotherapy. Music therapy and music were experienced as being helpful in discovering new identities and aiding acculturation and integration, as well as revitalizing communality. Music therapy methods could include singing, playing and even dancing. (Pervaisz, 1994; Orth & Verburgt, 1998; Vinther, 1999; The BZFO reports 2000–2002*;* Orth, Doorschodt et. al., 2004; Zharinova-Sanderson, 2004a & b; Alanne, 2005b.)

In his pilot project, Pervaisz (1994), from Pakistan, studied the therapeutic effects of music on Afghan and Pakistani torture survivors and refugees. Both group therapy and individual music therapy were applied. Patients held mini concerts that included vocal and instrumental artists. There were also raga improvisations, and instruments such as the Sitar, Tanpura, Tabla, Dhulak, Harmonium and Bansuri were used. During the 30–45 minute music therapy sessions, facial massages were given to aid muscle relaxation at the suggestion of the physiotherapist. Two research groups were studied: group X – a mixed gender group of 5 – received music in their treatment; group Y– a similarly sized control group – did not. In the results, group X showed better progress in recovering from their traumatic experiences. Their medication was also decreased. The Hopkins Symptom Check list was applied to screen for anxiety or depression in the patients from both groups. In the music therapy groups, anxiety and depression scores clearly dropped while in the control group they increased. The rehabilitation team reported how ragas soothed the participants and alleviated the suffering caused by torture, political repression and the situation of being a refugee. Through mini concerts, patients felt comfortable and confident and could present their culture with pride. The rehabilitation team behind the music therapy considered music therapy to be in line with other rehabilitation methods for torture survivors and recommended music as a good and valid "therapeutic tool" (p. 122).

In the essential book for the treatment of refugee torture survivors by John P. Wilson and Boris Drožđek (2004) *Broken Spirits. The Treatment of Traumatized Asylum Seekers, Refugees, War and Torture Victims,* there is a chapter entitled "Sounds of Trauma: An Introduction to Methodology in Music Therapy with Traumatized Refugees in Clinical and Outpatient Settings" written by Jaap Orth, Letty Doorschodt*,* Jack Verburgt and Boris Drožđek (2004). In their article they describe how music therapy has been used extensively in trauma treatment with war veterans, victims of sexual abuse or maltreatment and victims

of disasters. However, they noticed that there is a lack of clear methodological accounts of music therapy with traumatized refugees. I am in agreement with their findings as they reflect my own experience, especially concerning work with torture survivors. Besides accounts of clinical work, there also seems to be a need for clinical research as well. In fact, the authors do not describe or analyze work with torture survivors in particular, only the clinical methods they have applied with traumatized refugees in general.

Orth (2005) has been employing music therapy with severely traumatized refugees in a career spanning more than 20 years. Therefore his clinical experiences, along with those of his colleagues, have an important value in work with this patient group. They have used methods such as Guided Imagery and Music (GIM), which they have found to be problematic because of the difficulty in finding music which is culturally suited to the emotional states and needs of the patients. It is also sometimes hard for patients to concentrate on listening to music because they feel unsafe and stressed due to their situation as refugees. I have noticed the same issues arising myself with the use of guided imagery and music; however there are other listening techniques like projective listening and free association connected to music that could be useful. Difficult life situations affecting music therapy arise also in this research but, still, listening to music may be one of the easiest methods of applying music with this patient group because it does not require a music therapy clinic or expensive instruments. These are not necessarily affordable or even available everywhere.

Listening to music may provide a holding environment in a stressful situation similar to the vocal holding techniques proposed by Austin (1999; 2002) and Orth (2005). Singing and discussions are used to hold traumatic experiences and singing may enable the patient to reconnect to his/her feelings and provide an outlet for them. At the Pavarotti Music Centre of Mostar in Bosnia Herzegovina, singing, as well as playing instruments, has been used in working with children in post-war environments to stimulate the expression of thoughts, feelings, ideas and discussion through musical improvisations (Dammeyer Fønsbo, 1999; Lang & Mcinerney, 2002). Orth and his colleagues work at the Phoenix Centre in the Netherlands, which is a highly specialized inpatient facility for refugees and asylum seekers. Music therapy has been part of the treatment and has had many objectives, such as providing refugees with the means to express emotions relating to homesickness and loneliness. Their own cultural identity has been supported through music and group work. Musical structures have provided the refugees with safe limits within which to express themselves. Their social interaction has been proven with music; people can have positive experiences and enjoy them together. With music, the development of the positive aspects of psychic functions has been enhanced and initiatives have supported ego-strengthening activities. Even though Orth (2005) does not seem to refer to psychoanalytic theory specifically, this relates to the ego functions of music and how those functions that control experiences and regulate emotions may be supported by listening to music.

Orth (1998; 2004; 2005) describes five approaches to music therapy which have been used with refugees. They represent active music therapy mostly and include methods such as the selection of a song and the making of one's own tape/CD. This tape/CD may be used at home by the music patients when, for example, they cannot sleep or are feeling tense. Thus,

this may be relaxing music. Patients may also bring their own music to therapy, which provides an opportunity to engage in a discussion with patients about their backgrounds and their homes. This kind of listening to music has occurred in my research and I have referred to it as "cultural dialogue". In my opinion these methods may also include psycho-educative aspects relating to how to apply music as a self-treatment to aid relaxation, for instance. Orth has recorded music performed by patients and recommends it for use with individuals and groups. He also teaches them how to play instruments. This active music making may consist of one's own musical product, such as a song, which may be connected to the patient's story, for example. Orth also employs musical improvisation so that patients could directly express themselves. In fact, Orth applies multiple music therapy techniques with variations to achieve his music therapy goals. For those music therapists who work with refugees and traumas, these techniques are definitely worth reading about and learning. However, I argue that many of the methods applied are not psychoanalytically orientated, nor do they represent any other particular theory or frame of reference. They also seem to have an emphasis on educative and learning purposes, which in some cases may be contradictory to psychoanalytic music psychotherapy and its clinical objectives, for example free improvisation or free associating. From my own experiences of music therapy, CD making may be a demanding and time consuming project which, in my opinion, may distract from the psychotherapeutic or analytic process.

However, I assume that making a musical story or a role play as described by Orth (2004; 2005) may fit into the psychoanalytic process during music therapy. Orth has applied these techniques to patients suffering from Post Traumatic Stress Syndrome (PTSD). From my own experiences with torture survivors, borne out by this research, they may be too analytical and demanding for some patients, particularly those who have symptoms relating to psychoses and borderline conditions. There are patients in different life situations among refugees, so these techniques can be very useful but I think for some asylum seekers, especially those who do not have refugee status yet, they may be premature and their application should be thoroughly assessed. Active music making and improvisation as depicted by Orth and his colleagues could be useful with those patients that are in crises though. Then they could really express themselves in music beyond words and may experience control embodied in music improvisations and its dynamic forms. This could be a conscious, unconscious or preconscious applying of music in a *potential space* and in a holding environment, not necessarily related to cognitive learning processes at all.

Another important issue that concerns torture survivors is whether music therapy should be given in group or individual form. According to the literature and clinical experiences, groups involving active music making/improvisation are useful for refugees. However, I would assume from my own experiences, also illustrated by this research, that the most severely traumatized torture survivors could not necessarily participate in a group. It is possible that these patients would be too afraid to participate and would experience group situations as being too demanding or threatening for them because of their level of anxiety, stress and depression. I think this issue concerns all kinds of group therapy though. Anyway, music seems to hold potential for active participation in groups because it may lessen the feelings of "threat" and stress that groups naturally bring out in some patients. For example, it is possible to express oneself with sounds and instruments; there may be the chance to

experience humour and success through musical improvisations that would naturally bolster the group. It can be noticed from the work with refugees conducted by Orth and his colleagues (2004), as well as from the work of Oksana Zharinova-Sanderson (2004a & b), that active music therapy with improvisations may not require a common spoken language or the use of an interpreter when working with music as therapy rather than music in therapy. In the former case, music is the promoter of communication naturally. In my clinical work, as presented in this book, music is portrayed many times "in therapy" but also "as therapy" because music listening may promote both the intra and interpersonal processes. Therefore listening to music can perhaps increase a patient's ability to communicate even though there may be cultural differences relating to music, or there is no mutual language and an interpreter is needed.

Zharinova-Sanderson (2004a & b) has worked with refugee torture survivors at the Treatment Centre for Torture Victims in Berlin (BZFO). She also noticed that there was actually very little literature available when she started working with torture survivors. She has pondered questions similar to the ones arising from this research as to how torture victims could benefit from music therapy. She employed singing with her patients, which elicited memories, thoughts and ideas stemming from their homes. She describes her clinical work with groups and individuals as similar to that of a musical ethnographist who goes from village to village and finds new songs. Her patients were from Turkey, Bosnia, Chile and Angola. She needed an interpreter as she worked with the songs of the patients. Zharinova-Sandersson (2004a) has also noticed that social problems, threats of deportation, difficult living conditions and a lack of money affect the therapy that the patients receive. According to her, this made therapies happen in the "here and now" because the present moment was the only thing they could hold on to. I think this is in accordance with my notions of asylum seekers in the middle of crises as later described in the case studies. She suggests that traumatized and tortured patients may feel themselves as heard and accepted through music, even while the trauma still lives within them.

Zharinova-Sandersson (2004b) has also contributed to the book *Community Music Therapy* by Mercédès Pavlicevic and Gary Ansdell (2004). She describes how music may have given rise to a sense of unity and energy among the 70–80 male and female refugees from different countries and cultures chanting a simple melody together, clapping hands and stamping their feet under her guidance. She considers that music making and music therapy may re-establish in torture survivors a trust in humanity. Many traumatized patients suffer from a lack of basic trust and music may help to end their isolation by integrating them with others (Vinther, 1999). I think these aspects come up also in this research's case studies as to how asylum seekers may feel haunted or are still afraid of persecution even though they are no longer in their home countries. It is a controversial matter of debate whether community music therapy with its many forms – including possible public music performances, can be considered as music psychotherapy at all.

It is important to notice the impact of violent traumas and wars on communities, countries and cultures. They may imprint their traumatizing mark on many generations long after the events have unfolded; the children of holocaust survivors are a known example which may be encountered in psychotherapy. For instance, it seems that in Finland there has long been a

culture of silence and denial regarding the guilt and the shame felt over the violence and cruelties – including torture – inflicted during the ugliness of the Second World War. It can be assumed that this guilt and shame is transferred from generation to generation. It has also been speculated that this could be one of the reasons behind the Finnish school shootings of the 2000's. (Solkoff, 1993; Volkan & Greer, 2007; Näre, 2008). David Otieno Akombo (2009) writes about the positive effects of music and how musicians as healers worked among victims of violence suffering from PTSD after disputed elections in Kenya. I assume that this may be preventative work for future generations and that it might even be worth considering applying professional music therapy in the Western world after traumatizing catastrophes. Actually, music is already often a component of grieving during ceremonies and in churches, for example.

There is an emerging interest in applying music therapy to working with refugees. There may be traumatized refugee children and youth that need the support of music therapy as was applied in an Australian school. Music therapy methods in Australia, at a school in Brisbane for traumatized refugees, included *mirroring* improvisation with instruments and hip-hop and rap music. In research conducted into 31 new refugee youths attending a group music therapy at an English language reception centre in Brisbane, it was noticed that there were positive changes in generalized behaviour – as screened by the Behaviour Symptom Index. Cross-over research design was applied when group 1 (having music therapy twice a week for 20 weeks) was compared to group 2 (a baseline control group). Statistically significant results ($P<0.05$) using the Multiple Analysis of Covariance (MANCOVA) were achieved, with the group in music therapy showing a decrease in maladaptive behaviours, hyperactivity, aggression, anxiety, depression and attention problems. (Jones & Baker, 2004; Baker & Jones, 2005.)

It has been noticed that being a refugee may be traumatizing in itself, which I am in agreement with based on my experiences with this research project. Music therapy methods with refugee children have included improvisation, the singing of songs, music and movement and song writing using hip-hop and rap. The goal of music therapy has been to empower patients in order to foster a sense of belonging to a community. This has been conducted against a backdrop of rejection and racism which may be faced in the host society, for instance. I conclude that this is relevant for music therapy with torture survivors too and I think that later case studies illustrate the social complexities asylum seekers and refugees encounter. In Kenya, traumatized children have been storytelling with music, such as Kenyan folk songs, which are referred to as similar to a storytelling method used in Ethnomusic therapy. They have been depicting emotions with drums and voices and could also sing stories of survival and hope as proposed. (Akombo, 2001; Hunt, 2005.)

Traumas may even be transferred from generation to generation and thus affect the school work of the children of refugees, as an example. In fact, it can be assumed that almost all refugees may come from traumatizing environments and situations. Therefore, most of them have possibly experienced some violence, cruelty, persecution, dehumanization or have seen violence or have lived under the threat of it (Baker, R. 1993, pp. 87–88). Apathy and severe emotional symptoms have been reported among asylum seekers and refugee children, which I assume music therapy may prevent and treat (Montgomery, 1998; Akombo, 2001). There

has been music therapy with traumatized refugee children in Kenya and Australia and in other projects with traumatized post-war children as well, like in Croatia. However, there has not been much actual published research where research methods, questions and outcomes would be described (Barath, 1996; Akombo, 2001; Baker & Jones, 2005; Hunt, 2005; Sebastian, 2007, Storsve, Westbye & Ruud 2010[4]). The situation concerning music therapy with torture survivors is the same. There is even less specific literature or recorded clinical experiences mentioning music therapy with torture survivors and there is a lack of research, both explicit and theoretical, in this area in particular. Actually, it appears that the only published research reports/articles with described methods and data are studies by Pervaisz (1994) and Vinther (1999). They are rather small studies – more like pilot studies. However, these studies and the clinical experiences of torture survivors as well as work and research from other sources definitely show the potential of music therapy for this patient group.

### 2.2 Music Therapy, Music and Traumas

When I began my clinical work and research with torture survivors there was very little literature. So, while doing my research plan and thinking about how I could employ music therapy with torture survivors I had to rely on other references and clinical theories. Even though there seemed not to be much literature, clinical knowledge or theories about music therapy with torture survivors, there were music therapy articles about people suffering from other traumas. There may have been similarities with torture traumas in the PTSD symptoms resulting from violence, maltreatment and abuse. For instance, modern music therapy started in the USA from positive experiences relating to the treatment of war veterans with music in the 1940s.[5] Music therapy was used in many veteran hospitals in the 1950s to treat psychic problems like phobias and even psychoses. Physical problems like pain were also reduced with music therapy. (Gaston, 1956; Ahonen-Eerikäinen, 1998; Sullivan, 2007.)

Roberta Blake (1994) depicts how the music therapy method Guided Imagery and Music (GIM), that applies music listening and imagery processing, helped Vietnam veterans and sexually abused patients with post-traumatic stress disorder (PTSD). These war veterans may suffer from the traumatic experience of having been rejected by family and friends and they may not have received support from the government. They may suffer from moral confusion and can feel self degradation, anger and shame. It is difficult for them to confront memories and express their feelings towards the war. Therefore they may suffer from hyper-arousal states and be emotionally withdrawn from their families, abuse substances and have violent outbursts and even self destructive behaviour in their lives. Blake describes how veterans were able to express emotions and memories relating to their traumas after GIM. Veterans could also concentrate and relax better after music psychotherapy. Blake postulates that music therapy increased their self-understanding and made it possible for them to connect feelings to traumatic experiences. With PTSD patients, GIM therapy reduced hyper arousal and intrusive thoughts during the therapy sessions. Music psychotherapy provided them with holistic comfort and cohesion in areas of the mind and

[4] This important music project will be discussed in chapter 12.3 Music Psychotherapy and Torture Survivors: A Clinical Situation, Music, Culture.
[5] This will be discussed further in chapter 3.4 Music as Torture, Violence and Manipulation.

body, which increased their general sense of well being, empowerment and hope. The experiences and written evaluations of the 8 voluntary music therapy patients – who also received educational lectures, psychopharmalogical treatment, group therapy, individual, and family therapy – was combined with research studies over the 16 week treatment periods. Seven patients had three GIM and Directed Imagery and Music (DIM) sessions. The eighth patient had ten sessions of GIM for the multiple case studies. In DIM therapy, a therapist provided a theme for the patient that was directly related to a traumatic experience and each session`s goal was to retrieve specific traumatic memories and to connect them with emotions. I assume that this method, otherwise quite similar to GIM, may be too provocative and even too manipulative a technique for many torture survivors and other trauma patients as well. In fact, I have never applied this method in my own clinical work; I consider it to be related more with cognitive behavioural therapy and short therapy/consultation type work than a psychoanalytic approach to music and imagery. I would assume that this kind of working may require at the very least many forms of other treatments and support as part of an inpatient rehabilitation programme in order for it to be safe and ethical. Similarly, the writers themselves do not recommend DIM for outpatient or short therapy treatments. Blake also suggests a possible connection with unresolved childhood traumas and war traumas as a reason why some Vietnam veterans cannot integrate their war experiences.

Even though the results of this music therapy seem promising, it is good to remember that it is only concerned with eight patients and Blake did not have follow-up meetings/inquires to check whether the outcomes were durable. However, she had years of clinical experience with GIM and traumatized veterans. There were also a lot of other treatments, therapies and psycho-educative work that could have had an effect on the results of the music therapy. However, from the phenomenological point of view, I assume that it is also relevant to trust the descriptions and experiences of the patients undergoing music therapy. The fact that they were actually able to offer these descriptions suggests that they had the potential, ego-strength and structures already in place for this kind of direct working, which is not the case with all psychotherapy or trauma patients. This has led me to consider a phase specific approach with different patients in music therapy. Anyway, I consider the outcomes and experiences that Blake had using GIM with war veterans suffering from PTSD essential for music psychotherapy, and these experiences have helped me when I was planning my own music psychotherapy with torture survivors as well as when evaluating what kind of possible positive advantages it could provide them with. In GIM therapy, classical music and special music programmes like “Comforting” are usually listened to. This programme, as applied to one Vietnam War veteran, included music such as *Swan of Tuonela* by Sibelius, *Bachianas Brasileiras, No. 5* by Villa Lobos and *Oboe Concerto, Adagio* by Marcello. Blake also reports that they used new age music from Windham Hill and Paul Winter as examples in DIM to separate the trauma emotion. These worked better in their opinion than structured classical music.

Blake and Bishop (1994) have also worked with groups of traumatized patients. They have reported that GIM is effective in the treatment of PTSD symptoms, hyperarousal, intrusion and constriction. In their opinion, GIM has helped in both individual and group sessions when dealing with the core experiences of disempowerment and disconnection. Their

experiences in this article refer to the Vietnam veterans already described and the clinical work using GIM that Bishop had conducted with sexually abused women. They reported that applying GIM with traumatized patients led to an increase in their capability to concentrate. Patients felt themselves nurtured, relaxed and comfortable. They added that GIM therapy elicited images, memories and fantasies and provided an access to emotions and body sensations not only limited to the traumatic experiences. Blake and Bishop (1994, p. 126) describe an example of a 25-year-old woman "Gina" in GIM therapy and how she seemed to safely encounter her memories, images and emotions relating to the trauma of being sexually abused by her father as a child. Classical music by Britten, *Simple Symphony: Sentimental Saraband*, and Haydn, *Cello Concerto in C: Adagio*, were used in imagery processing. In the GIM group work with female survivors of abuse they reported similar experiences and results. GIM in groups differed from individual work, so that during listening to the music there was not a guiding therapist, however there was group interaction instead. They depicted that the general emphasis of GIM with hospitalized PTSD patients was on the identification of solutions, the building of healthier defences and the promotion of a greater sense of hope and new directions; in general the stabilization of the patients` conditions. The GIM treatments appeared quite short, perhaps only three sessions, and the authors themselves recommended it being as part of other inpatient psychiatric treatment. I agree with them that long sessions of pure GIM are demanding on the individual, and to confront very traumatic experiences in such a short space of time may even have negative consequences for the patients if their clinical conditions are not professionally followed and supported.

I also assume that there should be some longer working-through process in psychotherapy, so that the patients would really stabilize their conditions. Blake`s and Bishop`s (1994) important article and pioneering work has influenced my working with torture survivors and my goals for music psychotherapy and listening to music were quite similar. However, from the beginning the work with torture survivors appeared even more demanding because they seemed to have an even greater lack of trust in other people, which also affected listening to music and why they may have experienced music as a threat to their self-experience and weak ego-systems. I assume that it is relevant to notice from the research point of view that Blake & Bishop (1994) do not describe how they have collected or analyzed their data, in spite of providing few clinical extracts. Again, they do not describe any follow-up showing how patients have proceeded with their lives and were the important achievements reached during therapy durable. Both music therapists appear to be drawing their clinical experiences from inpatient settings where also other treatments were provided, so I postulate that their experiences and clinical methods are not totally transferable to outpatient music therapy, with which the authors themselves seem to agree.

There are other reported clinical experiences from the work of music therapists with sexually and physically abused women. Stephanie Volkman (1993) has described and theorized music therapy and music in the treatment of trauma-induced dissociative disorders with groups. In her music therapy, which appears to be based on clinical improvisations and active music therapy*,* she has applied improvisation techniques such as *holding*, *grounding* and *splitting* derived from Analytical Music Therapy (AMT). She depicts therapy sessions that happen in a here and now situation where music provides a safe space for the

traumatized patients. Volkman points out that she has worked primarily with short-term, acute-care patients, which, from my own experiences, makes her approach understandable. In her opinion, applying a grounding method at the beginning facilitates the expression of emotions and traumatic experiences. She assumes that healing from traumas requires "time travel" with music where a patient may return to the past but at the same moment be present in the current time. Thus music seems to be a bridge between the present, past and future according to her, while it is simultaneously a continuing process. I would add that music may be also similarly bridge different cultures as presented in this research and suggested earlier by Jones and Baker (2004). (Volkman, 1993 pp. 245, 250.)

Volkman (1993) describes how she has held or *contained* her patients and their expressions with music and with playing the traumatic experiences.[6] In the *splitting* technique used in AMT, group members improvise ambivalent or contradictory sides in another`s personality. I consider this to be a very confrontational technique and not actually suitable for very severally traumatized patients such as many torture survivors are. In my opinion, it also presents interpreting in such a way that it cannot be applied with all psychotherapy patients because they may not possess strong enough ego-structures i.e. thoughts concerning these contradictory aspects in their personalities, as an example. Therefore, I would suggest that more emphatic and holding techniques would be of primary importance for severely traumatized patients, as will be explained more thoroughly later in relation to the phase specific approach in therapy. Volkman concluded from short examples of working with traumatized young women that music succeeds in filling the gaps where words fail and thus holistically integrates all aspects of the experience. She suggests that music therapy improvisation integrates the body and mind through acts of expression. In my opinion, this is important with dissociative states such as she discusses and with the torture survivors too. Volkman assumes that, for a patient, music is a transitional object; bridging internal and external worlds as well as the flowing time of the past, present and future. I agree with this notion of hers but I would also like to suggest that describing music as an "object" is a paradox just as she seems to notice to some degree (p. 250).

Music is often also referred to as an "objectless art" and in a way it is; thus it would be better to discuss the *transitional space* music provides, which I postulate is more in line with what Winnicott (1971/1997, pp. 40–41, 100, 103) himself originally meant. We are not only dealing with "objects" in music therapeutic improvisations or active or receptive music therapy, but we are creating potential or transitional spaces, which also therefore mean providing patients with a content i.e. symbolic meaning. This also relates to the aforementioned "gap" between the mind and the body where music may be part of a symbolic process in its dynamic and cultural forms, as often cited (Rechardt, 1987; Ikonen & Rechardt, 1994/2010). In the case of refugees and asylum seekers, it may also be more relevant sometimes to discuss music and the contents that arise from music therapy improvisation as a cultural, and not just a dynamic, form to be in line with the original ideas and philosophy of Ernst Cassirer (1944). Volkman`s (1993) article is an important

[6] Music therapists and psychotherapists often seem to refer to Wilfred Bion's psychoanalytic concept as interchangeable with Winnicott`s concept of *holding*, as discussed further in chapter 4.1.1 Music as a Holding Environment.

contribution to the clinical theory of music therapy with traumatized patients. However, even though clinical methods are provided along with a general description of clinical experiences, it does not present a research project, method, data or an analysis of them. Therefore, I assume that there is a need for more clinical research as her experiences and theorizing convincingly shows the potential of music therapy with traumatized patients.

One of the pioneers of music therapy with sexually abused patients is Penny Rogers (1993). She has worked with children as well as adults suffering from sexual abuse and describes her attempt to study the efficacy of music therapy, and what it is like to be the first in the field (p. 205). Rogers writes about her clinical work and methods with children. They include clinical improvisations using instruments as symbols, such as the conga drum representing the father, the xylophone the mother and a hand chime the child him/herself. Her article contains short clinical examples from children working in her therapy expressing their emotions with music and instruments and making sound sculptures showing the inner world they cannot express. Music therapy may provide safety in the form of boundaries for children`s and adults` experiences, which have been broken by an abuser. Children may, according to her, distinguish good and bad feelings through music. Her article seems to also be a description of the research methods and design she is planning to use which consists of an analysis of audio–visual data, transcriptions, patient diaries and a therapist. However, actual research outcomes, data or analysis has not been provided in this article. I assume that her notions about the need for traumatized patients to develop boundaries for their self-experiencing is also essential with torture survivors and should be thoroughly investigated. She also discusses the researcher–therapist combination and its meaning for the research. In my own research I have applied similar methods and ideas to the ones she has suggested.

Later Rogers (1995) has theorized her work with sexually abused patients using a psychoanalytic frame of reference concerning the developmental theories of Margaret Mahler et al. (1975) and Stern (1985). In her article, Rogers discussed the issue of transference and countertransference; the emotions that abuse as a phenomenon engender in the therapy relationship and particularly the difficulties that arise when identifying with a victim. She also reflects upon the therapist`s countertransference/emotional responses, thoughts, and feelings that ensue from the patient. Rogers also notices the splitting mechanism; how the patients or their families may be divided into “good” and “bad” categories by the professionals, including the therapist, in their self-experience. She concludes, in this thorough theoretical article, that music therapy may be valuable in work with abused patients. This is because the abused patients do not have access to words to describe their traumatic experiences. However, she does not present case examples from music therapy and does not specifically connect psychoanalytic theory to music therapy practises.

It appears that many music therapists practising GIM have been interested in traumas. Stephanie Merrit and Cecilia Schulberg (1995) have experiences from working with second generation survivors of the Nazi Holocaust. The Jews and Germans they have worked with have unconsciously received the devastating horrors of the Holocaust through silent shame. With music and imagery processing, a child of Holocaust survivors and a child of a German soldier processed their grief, rage and guilt. Eugenia Picket (1995) has reported processing

traumatic childhood experiences and freeing a young man suffering from delayed PTSD in 12 sessions of GIM. He encountered traumatic experiences from many abuses, as well as his father abandoning him at age three, in music therapy.

Also, the cognitive behavioural approach to music therapy with traumas has been used by Cyd Slotoroff (1994). He applied special improvisational drumming techniques with his patients who had difficulties in anger management. Slotoroff developed his drumming method in an inpatient short-term psychiatric setting for patients who were physically, sexually or emotionally abused. In drumming improvisation the players could themselves lead the drumming by saying "no" or "stop" to another. This is assumed to increase anger management because abused patients may fear retaliation or rejection and therefore may feel unable to say "no". This is also related to physical and psychological boundaries and the integrity of abuse victims. Slotorow views his techniques as powerful and evocative, requiring a thorough assessment of the patient, especially in outpatient settings. The author points out that he has only used this method two times at most, with one patient at a time. Even though he postulates that the method may have potential for the treatment of traumas, there is not much experience and evidence. I agree, and add that from the psychoanalytic point of view such direct methods are not even necessary as patients may generally show similar feelings regarding whether or not they want to speak, play an instrument, listen to music or not to listen to music. I think it is important that a therapist does not decide for him/herself what patients want, for these reasons. Also, in free clinical improvisation patients may decide how hard they beat the drum or express themselves musically.

In addition to clinical reports, there has been at least one research report by Arpad Barath (1996) about applying music, as well as other creative therapies, with war-traumatized children. Conducted in Croatia from 1991–1995, creative workshops that included music were used to try to help 100 000 children. He reports that in general, 75 –100 % of the children who participated benefitted from the recovery programmes regardless of their age, gender or residential status. Musical supplements included audio tapes, music for guided imagery, music and Orff-instruments. Music workshops with children included active music playing and improvisation. Unfortunately, how music or music therapy was applied in practise with the children or how it was theorized is not specified. However, children were thoroughly screened with many inventories, and a statistically significant improvement in the children`s well-being in the Slovenian sample was achieved. From a Croatia sample, significant changes in mental health functioning were achieved through creative therapies. Evaluation tools consisted 23 empirical measurement instruments, including standardized screening scales for PTSD and questionnaires on the functioning of the children`s family.

In 2002 Julie P. Sutton edited and published a prominent book entitled *Music, Music Therapy and Trauma. International Perspectives* concerning research and music therapy with traumas. It covers articles from different areas, like the neurology of traumatic experience and how music may affect the brain in treating traumas – written clearly by Michael Swallow (2002) – which will be discussed further in later chapters. Marie Smythe (2002) writes about how the troubles in Northern Ireland have affected people. It appears from her article that among a total of 3000 people interviewed in Northern Ireland, there are many suffering from repeated nightmares, painful memories, lack of trust, distress and

emotional upset etc. stemming from the troubles. Smythe considers the troubles have impacted general expectations of well-being and safety among people. Whilst she does not write a lot about clinical music therapy in Northern Ireland, she postulates that music may facilitate the expression of emotions and help to break the silence of isolation in violently divided societies.

In the same book, Mathew Dixon (2002) writes about music and human rights in regard to his work as a music therapist at the Medical Foundation for the Care of Victims of Torture in London. He discusses political violence and presents one music therapy case example involving a refugee named Shareen. Dixon describes how Shareen expressed herself with a drum and how active improvisation was the medium for her therapy instead of verbalization and analyzing. Later Shareen moved from the chaotic, violent and angry playing of drums to piano improvisation with chords. Dixon interprets this as meaning a shift towards a more general "harmonical" development in her life situation. By the end of her music therapy "music is the best thing that was ever invented in all the world," according to Shareen (p. 127). Unfortunately Dixon does not tell us whether Shareen was tortured herself or what kind of work he has done with torture survivors. However, he postulates that music reaches and draws out humanity, as opposed to political violence which breaks it.

Ruth Walsh Stewart and David Stewart`s (2002) contribution is on psychodynamic music therapy with traumas relating to early abandonment and deprivation. Winnicott`s theories are referred to and the importance of a *holding environment* and *transitional play* are discussed, as in this research (pp. 137–138). A case study involving 8-year-old Barbara, who was institutionalized during her first two years in Romania, is analyzed thoroughly. In music therapy she could have experiences similar to early care giving and process her traumas relating to abandonment and loss through symbolic play.

Diane Austin (2002) considers traumas from the wounded therapist`s perspective. Her music psychotherapy consists of a vocal holding technique and free associative singing within a psychoanalytic frame of reference. In her work she tries to provide traumatic experiences with a voice. Two small case examples are included to illustrate her methods. In my opinion Austin raises an important issue for discussion when she considers the therapist as an "instrument" (p. 241). With this she is referring to the fact that dynamics such as transference, countertransference and other unconscious stimuli encountered by patients can arise in the therapist as well. A therapist may apply these dynamics to guide his/her work but may also need supervision, or access to his/her own psychotherapy, in order to process these issues. A therapist may even have his/her own traumatic experiences, which should not be complicating the treatment. It is also important to address the fact that a therapist is also a researcher of patients and their specific psychodynamics. In this research these counter-emotions from patients have been scrutinized as well and considered in interpretations of clinical observations. Thus, I myself have also been a research instrument in my work (see also Syvänen, 2005).

Austin has also contributed to the book edited by Lois Carey (2006) entitled *Expressive and Creative Arts Methods for Trauma Survivors*. This book is a collection of writings from several arts therapists covering drama therapy, play therapy, art therapy and music therapy.

Many clinical methods, especially for children, are discussed but also traumatized families and groups are included. In fact, many of the books and articles I have reviewed concerning music therapy and traumas are about work with children and young people. I think this is one of the lacks in current literature on music therapy and traumas. However, the reason for this may be as simple as that music therapists in general work more with children and music therapy may be seen from outside its own discipline as therapy suitable only for children, which is not of course totally true. Austin (1999; 2002; 2006) conducts her vocal psychotherapy with adults who were traumatized as children. Her definition of vocal psychotherapy is that it is the use of the voice, improvisation, songs and dialogue to promote intra psychic and interpersonal changes (2006, p. 135).

Austin (2006) considers, in her in depth analytic work with traumatized individuals, the healing of the splits between the mind, body and spirit. I think this is an important aspect with traumatized patients when considering their chronic pain for example.[7] Austin also discusses methods of *resourcing* in trauma work, which means ways of asking supportive questions at the beginning of a session to help the patient find his/her own inner solutions or empowerment. I think this is quite similar to solution focused brief therapy; the aim is to find solutions based in the patients themselves and to explore how they may be unaware or have forgotten how they have survived or coped as children. With resourcing, Austin helps the patients to be more present in their bodies before talking, singing and playing. This resourcing may also involve improvising songs of oneself to find and embody one`s own inner experience and strength. (pp. 138–139.) I postulate that this kind of working may be a part of a psychoanalytic interpretation of repressed material as well. In my opinion it also relates to the empowerment of music that is present when one is capable of singing and playing and feels that one is succeeding in something in one's own life. I have noticed that this is very important when working with the depressed and children with attention disorders. To have the chance to experience success through music therapy improvisation may change a child`s internal view of themselves; from having a negative self image a child can begin to utter positive statements about him/herself, as I was told when a mother phoned me and said that her 9-year-old boy had stated to her, "I am good" after a music therapy session. I argue that a similar change of experience and dynamics from one opposite to another, feeling oneself good or bad, may relate to an internalized traumatic experience, even from torture, and also to the recovery from it. (Alanne, 2007, p. 134.)

Heidi Ahonen-Eerikäinen (2004) has scrutinized and theorized imagery, dreams and music in a group analytic music psychotherapy process. She compares music and the imagery it brings to dreams. According to her, musically elicited images are sources for the reconstruction of traumas. In her theoretical article she concludes that music is a processor of hidden wishes and fears as well as repressed conflicts and object representations. Her theorizing seems to stem from Freud (1900/1995) and his dream theory of hidden wishes also being represented in musical imagery. Ahonen-Eerikäinen illustrates how a patient`s

[7] Psychotherapy with severely ill persons and "the mind" or the meaning of physical symptoms and illnesses have been discussed by Finnish psychoanalysts Martti Siirala (1983) and Pirkko Siltala (in print) (Alanne & Uimonen, 2000). In their opinion, psychic meanings behind somatic illness are not often seen or are split in their treatments as well.

talk may include manifest and latent contents in the processing of imagery relating to music in a group situation. It may also resemble free association to music in my opinion (p. 27). She has worked with traumatized adults but her article does not describe clinical cases relating especially to traumas and their music therapy. Rather it introduces theoretical possibilities of music in trauma work. I agree in many ways with her approach to dreams and music in therapeutic work and I assume the case studies in this research may be well scrutinized according to manifest and latent contents as well.

In fact, many of the books and music therapy articles are theoretical articles with case examples quite similar to the writings of Freud. Few of them are actually presentations of research processes, data, methods and results. Thus, there seems to be a lack of specific music therapy research about traumas concerning techniques and outcomes, although it appears that a lot of positive experiences from clinical work with traumatized patients have been reported. Even though there are new articles upcoming they seem to refer to the same authors, theories, clinical methods and even the same experiences, which means that the actual amount of specific literature and experiences is smaller than it first appears. Regina Weiß (2008) has done a summary of the literature relating to music therapy methods and clinical experiences with traumatized patients, but she also has a theoretical point of view concerning the current knowledge of trauma treatments and their relationships to music and music therapy. However, she adequately discusses the possibility of re-traumatizing a patient with music and the need for special knowledge and training in treating traumatized individuals. I agree with her but also warn of the possible harm that can come from misconceptions if music is considered as merely an "object" from the medical point of view. It could mean conceptualizing music as something bad or dangerous; similar to a specific medicine or a mere physical sound. I will discuss this more later in relation to the application of music and sounds in torture and violence regarding my own clinical experiences with torture survivors as well, which in my opinion may revoke such prejudices towards music and music therapy. However, I will later philosophically argue how music is not a simple object or a Thing (Ding) in a physical world but rather an opener of many possibilities in our experience of the world.

Dag Körlin (2005) has conducted clinical research in Sweden into creative arts therapies and BMGIM in psychiatric treatment. In his research he specifically studied treatment effects focusing on gender and trauma. Even though this was not a control group study, statistically significant changes from the treatments of 43 patients were achieved. Applying the Symptom Check List-90 (SCL-90) questionnaire, 6 out of 10 patients who received BMGIM moved from pathological (dysfunctional) to non-pathological (functional) status. Patients were also screened with the Dissociative Experiences Scale (DES-11), Relationship Style Questionnaire (RSQ), Trauma Quality Questionnaire (TQQ), Inventory of Interpersonal Problems (IIP) and the Sense of Coherence (SOC) scales. In this medical research, patients with separative trauma were seen to have the best results. Körlin also presents a neurobiological theory of traumatic imagery, which will also be referred to in this research. He also proposes how creative arts techniques such as art, music, dance, drama, poetry may evoke implicit, non-verbal memories and analogical symbols, which are sensory images with multiple and parallel meanings. I think that Körlin´s research is a very important contribution to the field of music therapy research in general. It has many meanings

concerning the outcomes of arts and music therapy as well as being a basic study of neurobiological processes in the brain relating to music and the arts. However, the results from the four weeks spectrum of treatments included many treatments combined, such as psychodynamic verbal group therapy, BMGIM, art therapy and occupational therapy. Therefore all the results cannot be generalized to all music therapies and this prominent research still leaves open questions as to which of the positive outcomes achieved were the results of music and BMGIM and what was the impact of the other applications on the psychiatric treatments. However, it is good to remember that active music therapy with improvisations also includes listening to music while one is playing an instrument. Körlin`s studies are valuable reading for understanding traumas and the use of creative arts therapies in their treatment and have influenced my view as well.

It appears from this literature review of music therapy with traumas that music therapy has potential for many traumatized patients, independent of their age and gender. However, more clinical research is needed, although there is already a lot of documented and theorized clinical work relating to applying music to traumas. For example, after the 9/11 disaster in New York, 33 music therapists provided more than 7000 music therapy interventions over a period of six months to children, adults, caregivers and families (Loewy & Frisch Hara, 2002, p. xiii). Unfortunately, it is not specified what these interventions actually were: were they single meetings and sessions with some individuals and groups or therapy processes and psychotherapy? It has been reported in 2009 that the New York City Commission on 9/11 has eliminated creative therapies from the approved list of providers because there is not enough evidence of their efficacy (Johnsson, 2009, p. 114).

Joanne V. Loewy and Andrea Frisch Hara (2002) edited the book *Caring for the Caregiver: The Use of Music Therapy in Grief and Trauma* where several of the contributing music therapists had been treating trauma victims. This book is mostly about children`s music therapy and provides examples of many clinical techniques and approaches towards music therapy with traumas. In many of the articles, songs seem to be the medium for dealing with traumas. Also, some trauma theory is included and an especial perspective is taken as to how music therapists may avoid traumatizing themselves in trauma work. The inspiration for the book came from the disaster of September 11, 2001 and the subsequent "The Caring for the Caregiver" training, where music therapists who assisted trauma victims were trained to learn about the traumas and work with their own experiences, reactions and fears relating to them. Also, others professions like police officers, social workers, medical professionals, psychologists, relief workers and survivors themselves participated in the training. (Loewy, 2002, p. 1.) For example, coping strategies for the therapists were suggested (Stewart, K., 2002, p. 13). I think this is important work because the trauma workers are themselves in danger of becoming traumatized and depressed after difficult situations, especially when confronted by great losses. This may relate even to those who have had former experience and education in trauma work, but particularly those professionals, including some music therapists, who have had very little psychiatric training and experience. Traumas and losses make even therapists more vulnerable if they have not had experience of psychotherapy themselves, or music therapy that has been orientated to depth psychology. Music therapists have to be able to integrate enough their own possible traumas and vulnerabilities to their self-experience and personality.

The book`s integrative approach to treating traumas is mostly evolved from humanistic psychology, and the only author who is especially influenced by a psychoanalytic orientation in her contribution is Benedikte Scheiby (2002) who writes about trauma, improvised music and how terror may transform into meaning. She emphasizes how a therapist`s own past traumas and countertransference may affect the music and the relationship with a patient and disturb it. This may also be the reason that a therapist takes on the role of rescuer where s/he is occupied with thoughts and emotions relating to a patient even outside of work, which may result in burnout. (p. 103.) Actually, in this article she does not discuss trauma and her clinical work in psychoanalytic terms much but more according to her own experiences resulting from clinical work with traumas. However, she has discussed Analytical Music Therapy and musical transference issues including countertransference relating to traumas more in an earlier book edited by Kenneth E. Bruscia (1998) *The Dynamics of music psychotherapy*. She describes, through the use of a case example, how through transference the imagery of a seducer, the seduced, a helpless angry victim and the neglected abused child may be projected onto the therapist in trauma work (Scheiby, 1998, pp. 239–240.)

In the same prominent book on music psychotherapy, Louise Montello (1998) describes relational issues in her psychoanalytic music therapy with traumatized patients. She uses songs and improvisational playing in her work where the traumatized individual may mirror their early parental relationships through music. Also concepts such as *dissociation* and *splitting* in a psychoanalytic context relating to traumas are discussed – including clinical examples with music. In addition to this, one case study is described where a 33-year-old man reenacts his sexual trauma in music therapy and through countertransference places his therapist in the role of perpetrator as well as victim. I think that these articles by Scheiby and Montello present well the depth psychology, the meaning of music and relationships in trauma therapy and how demanding it may also be for the therapist to hold on to such strong projections and countertransference. This relates also to work with torture survivors where the therapist may resemble a torturer in the patient`s mind and thus makes the patient peculiar and unable to fully trust the therapist.

Unfortunately, all the experiences and approaches for treating various traumas with music therapy cannot be scrutinized in detail but they have to be limited to the scope of this particular research. It also seems that more actual clinical research in music therapy with traumas is needed to provide evidence for its effectiveness. In Michael Silverman`s (2010) review of evidence-based research into psychiatric music therapy none of the mentioned research is related to traumas particularly. My focus in this research is especially on music therapy with torture survivors, refugees and asylum seekers with their traumatic experiences and not on the study of all the clinical and theoretical approaches relating to traumas. However, in the future, trauma-centered music therapy may even be developed as Weiß (2008) suggests, which probably would mean some kind of eclectic approach. This may also be concluded from the book *Musiktherapie und Trauma* edited by Hanns-Günter Wolf (2007b) and his article where different approaches to traumas have been discussed. They include

1) depth psychological model, which this research and psychoanalytic therapy represent
2) biologic model
3) learning theoretical model (cognitive behavioral)
4) system theoretical model
5) trauma model (Wolf, 2007a, pp. 16–17).

Whilst in my research psychoanalytic depth psychology has been the focus, it has been influenced by all the aforementioned models to some degree too. I argue that it is the nature of traumas that they may be approached on many levels. This could mean the mind, body, society and culture as has been noticed earlier in trauma research and clinical practice (Van der Kolk, McFarlane & Weisaeth (Ed.), 1996/2007).

It appears that there have been new articles by various writers quite recently, which will surely be interesting for those who need more information about the theories, methods and experiences from the perspective of music therapy and traumas (e.g. Loewy & Frisch Hara, 2002; Robarts, 2006[8]; Wolf, 2007b). However, they are not about torture survivors, refugees or asylum seekers with the exception of Patricia Braak (2007), who describes music therapy with war-traumatized people that may include them as well. Most of the new articles are not research as such, but clinical experiences, theoretical approaches and the illustrating of various music therapy methods with traumas. There has been qualitative research concerning songwriting in music therapy with mothers who were sexually abused as children. Five mothers were interviewed three years after completing their music therapy program, which they still felt was a positive experience and so had continued their song writing (Day, Baker & Darlington, 2009). Also, another theoretical article on Analytical Music Therapy from Gitta Strehlow (2009) has been published recently. It includes a case example from music therapy with an eight-year-old sexually abused girl. This article refers to Peter Fonagy's concept of *mentalization*, which I consider to be relevant also for other trauma patients, including torture survivors (Fonagy, Gergely et al., 2004).

Also Sutton and Jos De Backer (2009) have considered mentalization with traumas in their article about music, trauma and silence. However, they particularly comment that whilst they apply the word "mentalization" they do not refer to Fonagy`s concept. This appears contradictory to their writing, where they describe how patients may digest traumatic affects musically or mentally from silence within therapy, for example (p. 77). Is this not just what the concept of mentalization in psychoanalysis has meant? That in language, as well as in music I assume, there may be a psychic content to the affects, sensory feelings and mental states like needs, desires, purposes etc. of patients? It may also relate to the ambience of silence with multiple meanings that are internalized or mentalized in psychoanalytic therapy such as psychoanalytic music psychotherapy. I postulate that silence is one essential phenomenon relating to psychoanalytic therapy where words, music, imagery, in other words a whole world of experiences, arises from the patients themselves without the therapist putting words into their mouths. This means also letting patients improvise that music or play which naturally comes to mind – free association – without a therapist always

[8] This will be discussed in chapter 12.5 Overview of Clinical Evidence in the Research for presentational reasons.

making the decisions beforehand. I consider it confusing that Sutton and De Backer are using the same word "mentalization" in their conceptualization; maybe a better word or concept could have been the *integration* of traumatic experience in the self-experience as Pierre Janet has already applied in the context of traumas in 1911 (Van der Kolk, Weisaeth, Van der Hart, 1996/2007, p. 53).

The importance of this quite new psychoanalytic concept of mentalization in psychoanalysis has not previously been discussed much in the field of music therapy. I consider it to be a different concept than *integration* as applied in trauma therapy, from the cognitive as well as the psychoanalytic perspective. "Integration" seems to refer more to conscious reflecting and an insight into oneself, which may also be achieved with music and imagery processing in music psychotherapy (Van der Kolk, Van der Hart, Marmar, 1996/2007; Maragkos, 2007). However, considering the early development of infants and the "musicality" of vitality affects, the attuning of mentalization appears as a very essential concept and may provide a rationale for the recovery of some psychiatric patients who do not discuss much in therapy but improvise with instruments, for example. I assume that the case studies presented in this book will also illustrate both the concepts of mentalization and integration; how listening to music helps words or other psychic content such as imagery to emerge from the mind as well as helping to integrate personal experiences, like memories for example.

One of the few actual empirical studies of music therapy with traumas is the research conducted on post-traumatic soldiers and their music therapy through drumming (Bensimon, Amir, Wolf, 2008, p. 34). The research participants were nine men aged 20–23 years old, who were diagnosed as suffering from PTSD. The participants received both group and individual music therapy. After four weeks of group music therapy, three participants dropped out. The therapies were filmed, and open-ended in-depth interviews were conducted. Each interview was transcribed and analyzed. A therapist–researcher made self-reports of personal experiences, thoughts, associations and feelings, which were written in note form and then analyzed after each session. This research has similarities to methods used to establish *trustworthine*ss as the researchers have indicated that they have applied triangulation, peer debriefing, multiple observations and that they have analyzed data in the original sequence in order to obtain a reliable picture of the phenomena (p. 37). In addition to this, the researchers have conducted a lot of musical analysis of drumming, its patterns and dynamics – also illustrated in quantitative figures. This is connected to phrases uttered by the participants as taken from video recording of their experiences. The results reveal an increase in drumming, which in turn is seen to indicate a process of getting to know and trust each other (pp. 43–44).

This interpretation has a similarity to my research and its observation that a willingness to listen to more music could be a sign of positive progress and development in music therapy. The possible positive effects of drumming on regaining a sense of control are discussed in relation to former clinical experiences and theories. As a conclusion, the authors aver that group drumming increased a sense of openness, togetherness, belonging, sharing, closeness, connectedness and intimacy. They also report that drumming evoked associations connected to trauma, created a safe atmosphere and enabled the self-expression of rage in an acceptable way. However, actual durable changes to the health and PTSD of the participants were

neither demonstrated nor reported although the authors argue in their conclusions that music therapy reduced some PTSD symptoms. There were no follow-up meetings or questionnaires after 16 sessions of music therapy. I think that the amount of therapy was quite small considering the severe traumas participants suffered and, in spite of their relevant experiences and verbalizations which suggest the positive effects of music therapy, they are still only the subjective opinions of six to nine persons. I argue that the amount of data gatherable from such experiences are small, even though they were garnered from in-depth interviews and were also observed and illustrated during analyzed drumming therapy sessions. Therefore, in my opinion, the conclusions drawn cannot be generalized as such. As the authors themselves also concede, "cause and effect" research is needed in music therapy with traumas (p. 45). I agree with them that their research and its way of combining qualitative and quantitative research could be one starting point for developing such empirical outcome research.

Kenneth Aigen (2008) has done a recent analysis of qualitative music therapy reports from 1987–2006 in articles and book chapters. An example of the criteria for being qualified or identified as qualitative research included the following:

*"gathering of data along with some level of interpretation and/or analysis; a description of the method of gathering, analyzing, and/or interpreting data; a contextualization for empirical claims or interpretations in terms of the researcher, milieu, clients, or environment; a claim on the author`s part of the report being the product of qualitative research; the use of research procedures without labelling them as such; some check on the conclusion of a study that related to criteria such as trustworthiness, authenticity, integrity, etc.; quantitative measure that enhanced the status of the inquiry as research."* (pp. 251–252.)

None of the referred 124 qualitative research studies in music therapy were about music therapy with traumatic patients or torture survivors. Qualitative research in the German language was not part of the study, nor were studies in any other language apart from English where, like Finnish, there has been qualitative research in music therapy (see e.g. Lehtonen, 1986, Erkkilä, 1997b, Ahonen-Eerikäinen, 1998; Hairo-Lax, 2005; Syvänen, 2005). Aigen (ibid.) admits that, because of language issues, his analysis of qualitative research cannot be exhaustive. (pp., 251, 256.) The study by Bensimon, Amir, Wolf (2008) attains many of the above mentioned criteria but was published after the review of Aigen (ibid.). Similarly, I would argue that my research in this book meets the requirements of qualitative research. This research also attains the criteria of evidence-based medicine (EBM) on certain levels, which will be discussed more thoroughly in the context of the research methods.

## 3 TORTURE AS A PHENOMENON: CONSEQUENCES AND REHABILITATION

### 3.1 History, Prevalence and Definition

Torture has a long history, it is known to have happened in many past cultures – and it is still happening in numerous countries today. Torture has been documented in ancient Egypt, during the period of Ramses II. During the 21st century BC in China, at the beginning of Xia Dynasty, torture was included in official laws (Benfu, & Peicheng, 1994, p. 108). Torture was part of the judicial system and was practised publicly in European countries in the Middle Ages. The Spanish Inquisition used it extensively in the 15th century to force confessions from people who thought and believed differently. (Jacobsen & Smidt Nielsen, 1997, p.17.)

Torture still existed in 18th century France and could take on horrific forms, as Foucault (1975/2001) depicts. The body of the convicted was tortured and punished even after death. Foucault describes how Damiens was convicted on the 1st of March 1757; after confessing to the crime of attempted regicide he was condemned to publically make amends before the main door of the Church of Paris. He was ordered to be taken to the church in a carriage, wearing nothing more than a shirt and carrying a burning wax torch. From thence, he was taken in the same carriage to the Greve Square execution scaffold where he was tortured with red-hot pincers applied to his chest, arms, shins and calves. At the same time, Damiens had to hold in his hand the dagger which he had used in the murder attempt. This hand was burned simultaneously with sulphur fire. Molten lead, boiling oil, burning sap stone, hot wax and sulphur were poured onto those parts of his body where the flesh had been torn away by red-hot pincers. After this his body was drawn and quartered; four horses had to pull on it so that his body would be torn to pieces. The tearing took a long time as the horses were unaccustomed to drawing, so eventually, with the tortured man still living, six horses were used to tear the body apart. However, even the strength of six horses could not tear the calves asunder, so they had to cut through the tendons and crush the joints. His body parts were burnt to ashes, which were then thrown to the seven winds. (p. 7.)

In the 19th century torture had almost disappeared from European countries; philosophers had turned against it during the Enlightenment of the 18th century. However, it came back into fashion during the Second World War and has since spread to large parts of the world. The International Rehabilitation Council for Torture Victims (IRCT*)* states that it is still continuously and systematically used in a quarter of the world`s countries. In more than half of all countries it occurs regularly. This statistic has been gathered from the yearly reports of such organisations as Amnesty International, Human Rights Watch, United Nations and the U.S. Department of State. (Jacobsen & Smidt Nielsen, 1997; Modvig & Jaranson, 2004; Ruuskanen, 2007.) Torture can be physical, psychological or social punishment and humiliation. The convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) includes the UN definition of torture, which says:

*Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflected by or at*

*the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.* (Cited according to Genefke, 1999, p. 5.)

Methods of torture are in continuous development and apply modern technology, science and knowledge. Methods are developed so that traces of torture would be more difficult to find. In the following chapters I present some well-known ways of torturing to illustrate it as a phenomenon and explore how it affects the victim. However, my intention is not to write a handbook of torture, so I shall not go into detail – just enough so that the reader would better understand torture survivors, their traumas, rehabilitation and what kind of meaning and experience music may provide for them.

### 3.2 Torture Methods and Symptoms

Physical torture methods may include beating, which can be systematic or unsystematic. Wounds and injuries to the soles of the feet after systematic beatings are common; this method is known as "Falanga". Electric shocks are applied to parts of the body, usually to the genitals or the chest. This is called the "Tea Party with Toast" in the jargon of the torturers. Torturers use black humour, the purpose of which is to psychologically break the victim, "Tea Party" being one such phrase. Torture can also mean being suspended by the arms or legs. "Submarino" is used to describe forcing a head under water until the victim is about to suffocate. The burning of victims is still used; this may be done with cigarettes or red-hot iron rods. Sexual violence and humiliation is common too and the victims, both men and women, can be raped. Women are treated as sexual objects and men are harmed, so that their functioning as a man is disabled. Filthy food and bad water is given to worsen the detention – or no food at all. Victims are not allowed to sleep or wash themselves. (Vesti, Somnier, Kastrup, 1992; Jacobsen & Smidt Nielsen, 1997; Genefke, 1999; Modvig & Jaranson, 2004; Ruuskanen, 2007.)

Usually physical and psychological torture happens together as, for instance, in the case mentioned above, where black humour is used by torturers. During physical torture, torturers may verbally humiliate and degrade their victims with the most insulting words. During psychological torture, personal belongings such as glasses or important drugs may be removed. Children`s pets are killed and toys destroyed; adults, children and family members are beaten in front of the victim. Victims are given ill-fitting uniforms to replace their own clothes and their names are changed to numbers. Victims may be forced to wear a blindfold and their social contacts are denied. This kind of isolation is a typical method of torture, where the victim is separated from other people and their psychological support. There may also be mock executions and victims may be forced to torture others themselves. Victims may be forced to watch their loved ones and friends being tortured while they can do nothing to stop it. Torturers attack a persons` identity and may force them to say something bad about their families or political, religious views and values. (Vesti, Somnier, Kastrup, 1992; Jacobsen & Smidt Nielsen, 1997; Genefke, 1999; Modvig & Jaranson, 2004; Ruuskanen, 2007.)

Typical torture symptoms include emotional lability, sleep disturbances and disturbances in the ability to concentrate or to remember, which may be part of hyper arousal. This may result in “flashbacks” to traumatic experiences, or the victims may suffer from coercive thoughts and functions. Torture survivors may also avoid thoughts and emotions associated with torture and traumatic experiences. This avoidance may lead to a state of “dissociation” where traumatic experiences, memories, emotions etc. are restricted from the personality and consciousness. A person may appear as absent while one is talking to him/her, for example, or cannot be reached at all for a while. Victims may also avoid activities and situations which give rise to memories of torture. This is a very typical symptom of torture survivors and other trauma victims as well. (Vesti, Somnier, Kastrup, 1992; Mollica & Caspi-Javin, 1993,Jacobsen & Smidt Nielsen, 1997; Genefke, 1999; Ruuskanen, 2007.)

Other symptoms can be an inability to form relationships with other people and a lessening of interest in participating in meaningful action. This usually means more isolation. The future may be seen only in the short term. A person may act or feel as if the torture was happening again. Victims may feel that their personality has changed. They may feel guilty for having survived and hence become anxious. Also common are sexual problems and general tiredness. These symptoms and consequences are understandable reactions to such cruelty and violence. Many of the symptoms suffered by torture survivors fit the diagnosis of PTSD, which is a common diagnosis among victims. Trauma symptoms can be mild, moderate or severe and vary from neurotic symptoms to disturbances and a change in the whole personality structure. The degree of depression, anxiety and other symptoms also vary from mild to severe psychotic states. (Vesti, Somnier, Kastrup, 1992; Mollica & Caspi-Javin, 1993,Jacobsen & Smidt Nielsen, 1997; Genefke, 1999; Ruuskanen, 2007.)

### 3.3 Rehabilitation

In the rehabilitation of torture survivors, many treatment approaches are suggested and used. Among them are cognitive behavioural exposure therapy, which may include systematic desensitization, implosion and flooding for example, which has been used with PTSD. However, these methods have been criticized because they may disclose traumas pre-maturely and even increase and exacerbate symptoms. This may also result in serious and uncontrollable stress. (Kira, 2002, p. 59.)

Less intrusive are oral individual testimonies or history techniques, which can be recorded and also used as evidence of torture. The therapist may clarify, encourage and help to structure a complete story from the fragmented pieces. Thus it is possible for patients to identify, understand and integrate their traumas better. (Turner, McFarlane & Van der Kolk, 1996/2007 Kira, 2002.) Psychodynamic approaches especially may use concepts such as transference, countertransference, and secondary traumatisation and consider issues arising from cultural, colonial and ethnic identifications. In psychodynamic therapy resistance, regression and human relatedness are considered to be part of the therapeutic process. (Kira, 2002, pp. 59–60.) In this research, music therapy has been psychodynamic and it has included many of the above mentioned topics. Music and imagery were part of the process through which the patients structured their traumatic experiences and stories. This was one of the clinical goals of their music therapy as part of their general treatment and

rehabilitation.

Music therapy has been one alternative therapy used with torture survivors among other expressive therapies employing art, play, drama or dance. Also meditation, yoga, imagery, body work and massage techniques have been used with torture survivors. Body-orientated techniques may be possible with patients who somatise, dissociate and suffer from frozen states or severe pain. Sensorimotor therapy alone is considered insufficient though, and it is emphasized that therapy should cover cognitive, emotional and sensorimotor levels, so that the treatment would be effective. Eye movement desensitization and reprocessing (EMDR) techniques have been also suggested as suitable for torture survivors, as with PTSD patients (Turner, McFarlane & Van der Kolk, 1996/2007, pp. 548–549). (Kira, 2002, p. 60.)

The patients in my research also received physiotherapy and pharmacotherapy to some degree as part of their further rehabilitation. Music psychotherapy was, however, their primary therapy, although they also had appointments with doctors and social workers as well. It is common at the centres which rehabilitate torture survivors that many treatment approaches are combined. Spiritual or religious interventions have also been used to empower torture survivors and diminish their feelings of shame, guilt and rage effectively. However, it is stressed that these approaches must confirm the belief systems of the patient, and that the best potential outcome would be achieved in combination with some formal therapy. (Turner, McFarlane & Van der Kolk, 1996/2007; Kira, 2002.) Such interventions were not made in the therapies employed in this research even though music and imagery have the potential to bring spiritual experiences and symbolism to the fore – as the case studies will later illustrate.

Even though there seems to be many treatment approaches for torture survivors, there is little specific clinical research relating to their effectiveness. This concerns all the therapies suggested, even cognitive behavioural therapy with medication, which is thought to be the most promising treatment. However, this suggestion is based mostly on treatments with other PTSD patients and cannot necessarily be generalized to all torture survivors. There are two reasons for this in the literature: 1) None of the therapies suggested have been for studied for their effectiveness with a randomized controlled trial (RCT)[9] 2) there seems to be a cultural element to their effectiveness. For example, South American torture survivors are reported to have gained the most from psychotherapy that is focused on a detailed recollection of the trauma. Survivors from Indochina responded better to a broader combination of treatments that could include pharmacotherapy and assistance in practical life, besides supportive psychotherapy. I assume that there are individual differences too that could be related to personal development histories. (Kira, 2002; Modvig & Jaranson, 2004; Turner, McFarlane & Van der Kolk, 1996/2007.)

It appears that holistic approaches, including various treatments and examinations such as psychological questionnaires in the assessment of torture symptoms, are suggested

[9] In the data bases of the Cochrane Clinical Trials, Medline and Psychinfo were the only three studies on how treatments affect torture survivors in particular. One of them was a controlled study and only one of them was an RCT study. There is no published Finnish clinical treatment outcome study of torture survivors. (Livanou , Basogly et al., 2002; Carlsson, Mortensen, Kastrup, 2005; Punamäki, 2009.)

currently. Also, focusing on the treatment and assessment of torture victims in relation to their whole families and communities, using case management teams, has been recommended in the Wraparound model expounded by Kira (2002). (Ekblad & Jaranson, 2004, pp. 624–626.) In this research, music therapy has been psychoanalytically orientated individual therapy but all the patients have had some other previously mentioned treatment in combination with their primary therapy. Their rehabilitation was assessed by a whole team, including doctors, physiotherapists, psychologists, social workers and a music therapist working with them.

### 3.4 Music as Torture, Violence and Manipulation

*Southern trees bear a strange fruit.*
*Blood on the leaves and blood on the root.*
*Black body swinging in the southern breeze,*
*Strange fruit hanging from the poplar trees.* (Lewis Allan)

I consider it to be important to also discuss how music may have been used as one part of the torture, interrogation or even as a weapon against the torture survivors. In fact, it was one of the prejudices I encountered when I started working with them. Traumatized individuals may also react strongly with flashbacks and stress reactions to sudden noises and sounds as a part of their PTSD and brain injuries, which causes the body's flight or fight responses to over react when subjected to sudden noises (Swallow, 2002). However, there may also be psychological defences, strategies and even symptoms or changes in a patient`s personality as a result of torture and persecution that makes it difficult for them to trust other people and even to listen to music together with a therapist.

Using music as a weapon and as a part of military traditions has a long history, beginning with ancient wars such as the one in Italy in 218 BC when Hannibal`s army confronted the Gallic warriors who howled and sang. Hannibal won this battle but 16 years later, when he fought against the Romans, he was less successful. The Roman soldiers´ war-cry was in unison – in comparison with the Carthaginians discordant cries which contained many different mother tongues – making it more effective. One of the most famous depictions of applying music to war can be found in the Old Testament of the Bible, where Joshua used trumpets and a great battle cry to bring the walls of Jericho tumbling down. (Cloonan & Johnsson, 2002, pp. 28–29.)

Music as a weapon has been prevalent in the modern war tactics of the US army in the Iraq war. After the first Gulf War ended, Allied forces flew over Bagdad day and night assailing the populace with sound and music for months. The same strategy of acoustic bombarding, using AC/DC hard rock for example, was also used in Panama in 1989 when US forces attacked President Noriega. (Cloonan & Johnsson, 2002; Cusick, 2006.) From current knowledge, it also appears that using music and sounds has been systematic and continuous up until the 2000's. There was the sonic bombardment used in the Iraq war, and music and sounds were used in Guantanamo to interrogate prisoners. The development of "acoustic weapons" has been part of the US Department of Defence`s strategy since 1997 at least (Cusick, 2006, p. 1). As a result, US military forces have an "Acoustic Blaster" device, which was used during the Iraq War. The acoustic blaster produces repetitive impulse

waveforms of 165dB. It can be targeted at a distance of 50 feet (over 15 metres). Also, infrasound weapons have been developed that can be adjusted from disabling to lethal. This kind of sonic weaponry was used in the Iraq war, fired from helicopters. These weapons may also have an input for plugging in mp3 and CD players. The use of sound was part of the war strategy, but it seems that there were no particular or official orders or guidelines suggesting what kind of music to use. Thus it appears that the soldiers played AC/DC songs like *Hell`s Bells* and *Shoot to thrill* from their own "favourites" and used their own creativity while bombing Fallujah in November 2004. From the command level, sounds are considered as being in the same category as smoke bombs; it appears that the primary objective was to upset the enemy. This kind of weaponry has also been used in Israel, Gaza and the Lebanon, and it has been described as producing an effect like "being hit by a wall of air that is painful on the ears, sometimes causing nosebleeds and leaving you shaking inside" (Cusick, 2006, p. 2).

From the music therapist`s perspective, this does not sound like listening to music at all but more like being bombarded with something physical. However, music therapists are familiar with the effects of sounds because they have studied them for the purposes of treatment, as with low sinusoidal sounds. The Finnish physioacoustic method uses a sound frequency of 27 Hz–113 Hz, which is considered to be among the safe frequencies that may occur when playing the piano at home. However, sinusoidal sounds have only one wave in comparison with the note of a piano or guitar, which contains the coherent vibrations of many sinusoidal sounds. These acoustic sounds may be felt as a tactile experience as well, which is the idea behind the device that massages with sounds and may be combined with selected music. Infrasounds are too low for the hearing capacity of humans. These, as with ultra sounds, electrical impulses, x-rays, lasers, light and even radioactive vibrational energy, are used in health care. (Lehikoinen, 1994; 1997; 1998.)

It appears military technology has also utilized vibrations; they have even been used by torturers. For example, there has been systematic research conducted by the CIA (USA), MI6 (UK) and CSIS (Canada) looking to develop non-touch methods of interrogation and torture. It also seems that music has been involved purposefully; it has not been applied randomly. Intelligence agencies have funded such research from the 1950`s onwards at universities, including Yale and Cornell; non-touch methods studied have included the effects of sensory deprivation, manipulation and personal, sexual and cultural humiliation. This may include self-inflicted pain (e.g. stress positions), hooding, continuous noise (loud or not) and their opposite – soundproofing. A song by Barney the Purple Dinosaur – *I love you* – is mentioned in the US Army training manual for interrogators, even though it is actually a children`s song . *I love you,* along with Metallica`s *Enter Sandman,* was used to interrogate Iraqi detainees. These songs were played repeatedly at high volume inside shipping containers. At least three incidents have been described by an unidentified FBI agent where Guantanamo detainees were chained to the floor and subjected to extremes of heat and cold, or extremely loud rap music. Christina Aquilera`s music was used to wake up the prisoner Mohammed al Quahtani in the middle of the night; water was poured over his head to interrogate him from November 2002 to January 2003. Ethiopian prisoner Benyan Mohammed was forced to listen to Eminem`s *The Real Slim Shady* and Dr Dre for twenty days; after which they were swapped with ghost laughter and Halloween sounds. At

Baghdad International Airport, “high value detainees” were brought to the “Black Room”, a garage-sized place without windows, where rock `n` roll and rap were played at loud decibels (Cusick, 2006, p. 3). Detainees were usually chained in a humiliating “stress position” – hands tied between their legs and attached to an I-bolt – in a darkened place, which was made uncomfortably hot or cold (p. 3). It appears that this kind of “no-touch torture” with “deafening music” has been used on persons imprisoned from Afghanistan, Bosnia, Egypt, Ethiopia, Gambia; Indonesia, Iraq, Mauritania, Pakistan, Thailand and the United Arab Emirates (p. 3). There are also British and Canadian citizens included. (pp. 2–3, 7.)

I am in agreement with Cusick (2006; 2008) that this subversion of the meaning and purpose of music may be difficult for musicologists or music therapists respectively to approach. For them, as well as for musicians or composers, the logic behind such usage might be felt to be abnormal or asymmetric. Music has become a manipulative object, and the situation where it is played or performed may be something they have never expected. The meaning of *I love You* – a children`s song – has been subverted, becoming a violent parody and Barney, the nice dinosaur which may have been a child’s transitional object or bedtime toy, has become a medium of torture. These kinds of techniques come under the headlines “fear up” or “ego down” in the CIA field manuals for interrogators (Cusick, 2006, p. 3). Thus it appears that any music may be transformed from its original context to symbolically mean something else. However, from the soldiers` point of view, acoustic bombardment using music has a kind of symmetrical logic; after all, during a battle and in strategic planning, soldiers really do drop TNT or other explosives onto cities – they do not just play the AC/DC song *TNT*.

Music therapists have been careful in discussing or writing about using music for the purposes of violence and manipulation, although I assume that they have been aware to some degree about the possibility of applying music with dark intentions (Ansdell, 2004, p.70). There are ethical guidelines for music therapists in Finland, as well as globally, which at least particularly in Finland disallow the manipulating, offending, abusing and oppressing of clients.[10] Music therapists have to also respect cultural, ethnical, religious, gender and age issues relating to their clients` personality, identity and humanity. I assume, whilst it is not literally addressed, that this also covers the purposeful inducing of any physiological or psychological harm. Mostly, music therapists have thought rather of music as something positive, or have divided it into good or bad objects in the experience of an individual according to psychoanalytic theory. I assume this admits the possibility of using music as a form of oppression though. Music as a *bad object* could be seen from the perspective of an infant`s experience; the child projects part of him/herself or his/her experiences onto the unsatisfying object so that it is seen as something bad or even persecutory. (Lehtonen, 1986; 1997.) This is related to the *paranoid-schizoid position* proposed by Melanie Klein as one developmental phase affecting healthy infants and adults as well (Ogden, 1992, pp. 29–309).

I find of interest Eve Kosofsky Sedwick’s and Suzanne G. Cusick’s (2008) idea that our hermeneutic reading would include two styles:

[10] See www.musiikkiterapia.net, The Finnish Society for Music Therapy, Ethical Guidelines for a Music Therapist §2

1) Paranoid reading: What is wrong with this theory, research or book? Valued knowledge is efficient, cold analytic, exposing and demystificating.
2) Reparative reading: What new ideas does this text or theory have, what possibilities does it disclose etc? The reader seeks pleasure through experiences of joy in learning or finding something new, for example.

I would say that these reading styles apply to music as well; how we experience it and hear it. They may also be mixed up in our experiences and in our way of perceiving music and the world in general. I think that torture survivors may feel uncomfortable at first when listening to music for this reason. It is hard for them to trust a therapist and, with their personalities and identities, open up to music and the emotions that it evokes. However, after what they have experienced, I postulate that it is quite a natural reaction to analyze with doubt the outside world and its people and music: Can they be trusted? What does this means? What is wrong? Will this harm me? – and so forth. According to my experiences in music therapy with torture survivors, this paranoid attitude is familiar. One torture survivor especially asked me, with doubt on his face, "What you are trying to do to me with music?" That thought had been with him constantly while listening to the music, which made it difficult for him to concentrate and enjoy the music. This patient told me that in his torture there had been music involved but he considered those torturers who also employed music to be nicer than the ones that did not. In spite of this, he let me choose music for him which, in my opinion, showed developing trust. I postulate that people in general exhibit doubting attitudes – "something is wrong here". For some people, it is more difficult to find delight in new things at first sight or to trust in the future.[11]

However, a reparative reading of music would mean positive experiences and new discoveries; feelings, memories, imagery, feelings of success etc. that the individual may relate to him/herself. Cusick (2008) proposes that reparative musicology could restore a love of music and reconstruct musical experiences so that we would be able to love music again. From my point view as a music therapist, this would then also be one important goal in treating torture survivors and other traumatized patients with music (Alanne, 2005b). In fact, it could be a suitable goal for any music therapy to metapsychologically internalize "love objects" in music and not to feel a threatening resistance evoking the "bad object". I would also like to add that from my own clinical experiences in music therapy, with many psychiatric patients suffering acute psychoses, traumas and crises over past ten years and more, that I have not actually seen that patients would experience music as chaotic or particularly bad. Even though the patients` lives and symptoms may appear chaotic, music usually pacifies these patients and integrates their experiences, and thus may provide a coherent meaning for their otherwise chaotic experiences. This is what also happened in the cases discussed in this volume: even though music may be partly experienced as threatening, it still does not seem to promote chaotic thinking in patients but may strengthen their defences and promote their integration.[12]

[11] In Finland, it may be speculated that this is quite a common attitude. It is possibly the result of past wars and other tough times; poverty, persecution and a consequence of the whole nation being a battle ground during numerous wars.
[12] Factors 5–8 in chapter 10.1 Eight Factors appear to support and explain such observations in music therapy.

Part of the reluctance of music therapists to discuss music issues relating to violence may be connected to the common history shared by music therapy and the military forces. A recent historical study of American military bands during World War II by Jill M. Sullivan (2007) describes how, from the beginning, the US Army officially recruited women to perform and sing in military hospitals to injured soldiers. Sullivan interviewed the original band members. Sixty years after the war they still considered that their performances were the most important contribution of their service. In the War Department`s documents, it is mentioned that music "is one of the most effective vehicles for bringing a group together, for releasing the emotions and for creating a spirit of fellowship and esprit de corps... If he simply listens to music, his interests are broadened and his sense of well-being is generally increased" (p. 288). I think that the last line particularly is in accordance with the use of music in the treatment of torture survivors. In fact, music was used as a therapy already during the US Civil War, where regimental bands were assigned to perform to the injured. They were also playing while the doctor amputated limbs. It has even been suggested that modern music therapy emerged from these recruited women's bands from World War II (Sullivan, 2007, pp. 284, 303.)

Music therapist Joseph Moreno (1999) has studied music and therapy in relation to the Holocaust. He describes how music was employed as a form of deception in the concentration camps to falsely calm down prisoners so that they would not think of their death. Camp orchestras, composed of prisoners who played for their lives, were ordered to play music to other prisoners heading for the gas chambers. Music`s role was also to keep spirits up in the camps, so that the prisoners would work. Nazis also utilized music in the transportation of Jews to the camps. The aim was to provide an illusion of safety, that nothing was wrong. When the new arrivals came, Wagner`s *Lohengrin,* for instance, was played by a full symphony orchestra (p. 6). The use of music throughout the holocaust was systematic during the whole extermination process, hiding the cries of women and children. Working prisoners were forced to sing when they passed their family, friends and others who were going to their deaths in the gas chambers. However, it appears that music was also a form of therapy for prisoners during transportation, where they sang Yiddish songs to themselves to keep up morale and cope with the moment. Music and concerts provided some "freedom of will" and were "reaffirming something worthwhile" for the players and the audience of prisoners (p. 12). Some prisoners marching into the gas chambers sang songs like *Hatikva* in their last moments to affirm their group identity and faith. SS men themselves used music during meals to hide the unpleasant screams of prisoners being tortured.

Many of the Nazi officers in the concentration camps were music lovers, including Josef Mengele who has been described as whistling his favourite music while choosing who would live and would be sent to the gas chambers. Mengele is depicted as a cultural, or even a child loving, man who could be kind to children, bringing them sugar and discussing who amongst them enjoyed Mozart, Wagner, Verdi, Puccini and Johan Strauss *(*Lifton, 1987, p. 337). According to Moreno (1999, pp. 3–4), the meaning of music in such situations was not to taunt, but more akin to the simple enthusiasm and pleasure shown by any working man. One SS officer in the Birkenau camp always asked for Schumann's *Reverie* after an especially hard day at work selecting prisoners to be gassed. This could imply that music

was used as therapy, according to Moreno, but it may have operated as a kind of "reward" as well after a hard day's work (p. 7). SS men also listened to the music of prison orchestras for relaxation purposes, loved their music and felt pride in their playing. However, in the end they would feel no empathy for their lives and humanity. (Echardt, 1991/2001[13]; Moreno, 1999.)

I assume this kind of phenomena describes how the meaning of music may be controversial for a person. It may be used for many purposes, which do not seem to be in accordance with humanity. This would also relate to the recent use of music by the US soldiers during times of war and leads to unpleasant questions. Are the soldiers using music because it helps to raise their spirits during their work – killing? Does music increase the pleasure or mask the annoyance of killing and violence? Would it be possible that music makes violence strangely aesthetic, as in Stanley Kubrick`s famous movie *A Clockwork Orange* (1971), where young men listen to and enjoy Beethoven during their brutal acts of violence? There seems to be strange beauty – asymmetric aesthetics – which Kubrick unveils when he shows, in cinematic terms, the conflict inherent in the human situation. There is also the dance like movement in addition to the art music combined with the cruel violence, which could actually imply *flow experiences* and creativity in violence. The creativity behind applying music was entrusted to the "very young guys" during the Iraq War, as Ben Abel, the spokesman for the US Army`s 361st PsyOps company, which used sound and music as weapons, described in an interview (Cusick, 2006, p. 2). This could mean that they used their favourite music so that they would actually enjoy themselves, rather than using music as mere modern war-cries in action.

There is some evidence that music may correlate with violent behaviour (Penn & Kojo Clarke, 2008). A quite recent example, and perhaps one of the most horrible illustrations of music being used as a constituent of violence, is from Rwanda. It was reported that the musician Simon Bikindi`s music, and especially his song *Nanga Abahutu* (I Hate Hutus), was played on the radio continuously while people were literally being killed to the rhythms of his music during the genocide. (Ervamaa, 2002, p. B4.) It is also an example of musical manipulation and propaganda. During World War II, these kinds of propaganda songs were made also in Finland. Especially well-known is the *Silmien välliin* (Between the Eyes) polka, which was so brutal and de-humanizing towards Russians, that even Finnish people considered it as unacceptable. (Kirves, 2008, p. 41.) There are some studies that have shown that misogynous rap music like gangsta rap may promote sexually aggressive behaviour towards women, or its acceptance. During one research, participants were also exposed to the accompanying violent videos. Comparison groups had been listening to neutral rap and videos. There is also research using college students, where significant positive correlations were found between rap music and problematic alcohol use, illicit drug use and aggressive behaviours. Positive correlations were also achieved from techno and reggae music relating to alcohol and drug use. However, researchers commented on their findings that they may not actually reflect a causal effect between music and pathogenic, heath compromising behaviour. Instead they suggested that it is likely that musical choices are influenced by life

[13] This pioneering musicological study of music and Holocaust will be discussed in the chapter 12.3 Music Psychotherapy and Torture Survivors: A Clinical Situation, Music, Culture.

styles and personal predispositions for violent behaviour and substance abuse; then music could have a supporting role in such behaviour. (Penn & Kojo Clarke, 2008, p. 79.)

I argue that these kinds of findings and research on the effects of music and the media should be taken seriously by music therapists and music educators as well. We may not even know currently what kind of results violence portrayed on the TV, or through other music media, will have on future generations. Could violent entertainment also produce traumatic experiences? What kind of concept of man does it promote and how does it affect the behaviour of youths? As the research shows, it may have a part in the brutal behaviour of youth. However, I postulate that music therapy and modern music education may help to analyze media contents with the help of music videos and the internet (Haack, 1992, p. 463). Young people may also express what they are thinking and feeling to a therapist through media content on the internet; even sexual or violent contents. Then they have the possibility to discuss and analyze these issues with an adult therapist. I have had experience of this kind of music therapy with traumatized young people in recent years. It is good to notice that war-propaganda and media manipulation including music affects children and young people, especially those who have less capability to assess the information they are receiving (Kirves, 2008, p. 58).

It appears that music may well be employed in manipulation and violence, and it is not only related to the Nazis, or the US forces using music during military actions in the Iraq war. Also in the Balkans, in the 1990`s, music was used as a form of torture when Serbian soldiers forced Muslim prisoners to sing Serbian songs before killing them (Moreno, 1999, p. 5). Croat prisoners were made to stand and sing Chetnik songs until the morning light; those who sat down or became exhausted were taken away and they never came back. Croat prisoners were also forced to sing the Yugoslav national anthem while they were beaten, in other instances. In Zimbabwe it was reported that 300 hundred people frog-marched a young woman and her husband, both belonging to the Movement for Democratic Change in the Midlands, to a tree, tied them to it and beat them. In a beating that lasted for five hours, the crowd used machetes, batons and axe handles. During this the couple were forced to sing ZANU-PF party`s liberation songs and slogans. (Cloonan & Johnsson, 2002, pp. 34–35.)

Music is not only used as a weapon or as a form of manipulation in wars, but also in shopping centres, railway stations and parking lots, as with classical music, for example. This is called The Manilow Method in Sydney, where they had a six month trial programme in 2006 aimed at getting rid of teenagers` late night noise, roaring cars and loud pop music. Barry Manilow`s greatest hits were played through loudspeakers every night on weekends between 9 p.m. and midnight in car parks. They also used classical music, as well as any kind of music that did not "appeal to these people" according to Deputy Mayor Bill Saravinovski (Hirch, 2007, p.343). Similar methods have been used before in Santa Rosa, California in 1996, where the city council made an informal decision to play classical music using a radio to clear the Old Courthouse Square of youths. These musical interventions have been reported as being successful in their goals and this method of using classical music has spread to Canadian parks, Australian railway stations, London underground stops and other cities throughout the United States. As an example, in 2005 in British subways, robberies were down 33 percent, assaults on staff were lowered 25 percent and vandalism

decreased by 37 percent in trains and stations after playing classical music. Soothing music is not only used to drive people away but also to get them to come into shopping centres and supermarkets to buy things. This is referred to as Muzak, which was sold to hotels, restaurants and other business to make people stay longer and consume more. Currently, music of many kinds may be played in the background or foreground that could be considered to be Muzak, as well as other programmed or ambient music and original artists like Elvis, the Beatles, Madonna etc. (Hirch, 2007, pp. 343–344, 346.)

Hirch (2007) notices that classical music does not necessarily elevate youth or make them better, which concerns music education as well. It seems only to drive them away to do their activities elsewhere. In this context, she makes an interesting connection to how rodents are driven away from houses with high sounds that human cannot hear and which are not dangerous to pets. In fact, very loud 17 kHz buzzer sounds that older people cannot hear have also been utilized with teenage loiterers in stores in Wales. (pp. 348–349.)

In her article, Hirch also points out that peer pressure, familiarity and the coolness factor affect why teenagers do not like classical music. Their dislike relates their associations of classical music with the old, white, rich elite. Thus listening to classical music would mean the danger of peer rejection because it is not considered "cool" to listen to such music. From my experiences in music therapy with adolescents and children, I would say that there are many other musical styles, like most adult orientated rock, classic rock, pop and folk songs too, that may not be "cool" anymore. Only adults who have been listening to or performing this type of music when they were young themselves would find it so. Unfamiliar music, like classical music to some teens, does not fulfil the need for conformity and belonging together through shared musical taste. (p. 350.) From the psychological perspective, they are still in the middle of the natural developmental phase of creating their individuality and separating from their parents. Therefore, it might be more rebellious to listen to hip-hop and have its confirmatory dress code than to listen to the music that daddy likes – Iron Maiden or the Rolling Stones.

According to Hirch, music may be "both weapon and tool, depending on a context" (p. 353). In my conceptualization, I refer to the Situation of music in being and time in order to depict such a change in the meaning or the purpose of music.[14] This may be a change in musical taste – in personal history on an intrapersonal level – as well as alterations as to how a particular type of music is experienced in society or culture on an interpersonal level. For instance, one might conclude that it would be necessary to play music from their own culture and language to torture survivors, asylum seekers and refugees. I have encountered this view and preconclusion frequently during my research project and clinical work with torture survivors. The use of Western and classical music has been so far questioned as to even seem unethical. In fact, during my clinical work and research I have found that actually music does not have to be necessarily culture-specific with people from other cultures.[15] There are situations, and even some research regarding refugees, that have shown that their traditional

[14] This will be explained more in the chapter 5 Hermeneutic Phenomenology as the Philosophical Foundation for the Research.

[15] This issue will be discussed further in chapter 12.3 Music Psychotherapy and Torture Survivors: A Clinical Situation, Music, Culture

folk music has been used in the propaganda of the government they have escaped. For instance, Vietnamese refugees may have contradictory feelings towards some of their folk music because communists applied it in their propaganda, which provided the traditional music with new meanings and messages for the Vietnamese. It came to symbolize the new government which made them suffer and caused their losses. Traditional music was used to manipulate people. However, for some refugees, traditional music is still an important part of their cultural heritage, and not part of communism, and so represents Vietnamese people and their original culture, which the Hanoi government destroyed, in their opinion. (Reyes, 1999, pp. 147–149.)

In qualitative research applying grounded theory, triangulation and hermeneutics by Judith C. Heitzman (2005), she included in her interviews seven refugee women who were discussing how they felt music had helped them to cope with the stress of surviving violence (p. 84). In their unfortunately short answers, one participant – Mariah from Eastern Europe – responded that she would start crying when she heard an old traditional song. One of her favourites was *Carmina Burana*, not actually a traditional song, which she avoided for this reason. However, later she gave the researcher the feedback that she had subsequently been able to listen to it during a concert. Music was seen as part of the culture by Philamina, from Central America, who responded that she had seen women from her culture expressing their pain through music. According to her "women talk, and then as soon as they talk, they end in a song" (p. 124). They may sing and dance as well. Candida, from Central America, also told that in her family music was in everyday usage and that in their culture drums were used. In her experience, thumping took her problems away and the drums gave her a better feeling in her heart. Zee, from Africa, answered that "sometimes we sing those songs and then we cry and it helps us" (p. 125). Jonia, from Eastern Europe, played songs from her home country when she was homesick. Luna, Eastern Europe, was able to listen to music in the US just as she used to do before the war. She had music on the radio and videotapes from her homeland. She also regularly went to a restaurant that had music from her home country. Ruth from Africa, who had been tortured, answered that she had learnt a song from her older sister that she used to soothe her crying baby. All these women had experienced violence, e.g. sexual abuse and rape, in their lives. (pp. 123–125.)

These few experiences depict how music may bring back memories from the home country and provide a therapeutic experience for refugees. Unfortunately, in Heitzman`s research, raw data concerning the women`s experiences with music and its assumed role as a coping mechanism fell too short in my opinion. Therefore, its findings are not necessarily transferable to all refugee women because there is a lack of more thorough evidence from the interviews. The theoretical hypothesis still seems relevant though, but more research and qualitative material at least is needed to support such strong argument and psychological theory.

Mark LeVine (2009) has studied heavy metal in the Islamic culture. The listeners of heavy metal and punk rock are doctors, lawyers, economists or musicians who consider that music will help them and their society. Heavy rock and hip-hop aid in discharging the stress that wars and the pressure of their societies place on them. (p. 310.) For instance, in Morocco, police have tortured teenagers and tried to force one heavy rock fan to admit that he cooks

and eats cats. Reda Zine, one founder of the Moroccan heavy metal scene, says that "we play heavy metal because our lives are heavy metal" (p. 25). With this he meant that various aesthetical attributes of heavy rock, its angry tone, coldness and the contents of the lyrics are corresponding to the quality of life in current Muslim societies. It seems to reflect the feelings of even very highly educated citizens and their hopelessness towards the future as well. (p. 25.)

In Iran, rock music or heavy music is forbidden and therefore it is part of the underground culture. It is literally heard underground; garages, cellars, in the warehouses of department stores etc. (LeVine, 2009, p. 219). In Lebanon, the government forbade the selling of records by Metallica and Nirvana; however they are still available in many stores (p. 192). Many heavy metal fans are men, as it might be dangerous to be part of the heavy metal scene as a woman. In totalitarian Muslim societies, heavy rock fans are oppressed and even persecuted; thus one might argue that playing their music causes a threat of violence and endangers their lives. (pp. 21– 23.) Pakistani heavy rock star Salman Ahmad has received death threats because of playing secular heavy rock. In the Taliban culture, secular music or arts are *haram* – forbidden. In spite of the resistance of the Mullahs, and their threat that he will burn in hell because of his music, Ahman considers that "—music may build a bridge between people and religion; therefore it is the soundtrack of peace" (pp. 277–279).

According to LeVine (ibid.), heavy metal in the Muslim world is usually angry; however it may also be positive towards life. It may reflect the intention of young Muslims, Christians and Jews to create positive and open *project-identities* as conceptualised by sociologist Manuel Castells (cited in Levine, 2009). It seems music provides an alternative to those resistance identities so common in the Islamic areas of the Middle East and Northern Africa. It also raises the hope, and at least the possibility, of imagining "spring" and a "Suede revolution" in the minds of people, comparable to the past uprising of the people in Communist countries. (p. 330.) In fact, there was even a peaceful "singing revolution" in Estonia.

I agree with musicologist Philip Bohlman that music may be employed for many purposes; soldiers may pipe heavy metal and hard core rap during a battle or in interrogations to summarize their destructive goals with music. However, this angry music may also be the positive reactions of youth or people trying to resist and alter those societies and governments that oppress and torture. (Bohlman cited in LeVine, 2009, pp. 12–13.) Musicologist Simon Frith (2004) has asked why does music make people cross? I consider that in this context it is not actually the music in itself that makes people angry but the Situation and purpose; the where and how it is used. I postulate that music may only reflect the anger that is already in people. In this situation, music does not discharge these emotions but may instead intensify them. Then, the questions relating to music are more those of ethics or morals than therapy; is it good or bad that music expresses such emotions at all? It may be more constructive to be violent or cross using music or arts than to actually hurt other people physically. Music and other art forms may raise hope and thoughts of a better future in people's minds – thus they may transcendentalize our experience of painful and devastating situations. This is what Negro spirituals did for slaves, this is what religious Jewish songs or even secular classic music in concentration camps achieved; it provided

people with the “wings of an angel” so that they could momentarily, at least, transcend their situation. Philosopher Richard Shusterman (2008; 2009) has recently discussed the idea how any music may give rise to religious and transcendental experiences and how music could even be a substitute for religion. In Muslim countries, this might actually be so for some citizens who are agnostic, atheistic and listen to heavy metal (LeVine, 2009, p. 23). I assume that classic Western music applied in receptive music therapy with the intention of providing emotions and imagery may promote such transcendental or peak experiences in patients, whether religious or secular, as will be seen from one research case.

Music, together with lyrics, may also symbolically depict violence, oppression and racism, as in Billie Holiday`s classic song *Strange Fruit*, cited earlier, where the lynching of a black person is depicted. It was originally written by New York schoolteacher Abel Meeropol under the pseudonym Lewis Allan in 1937 as a poem entitled *Bitter Fruit*. (Penn & Kojo Clarke, 2008, pp. 87, 92.) This is one clear example of how musicians, poets and other artists may have to use pseudonyms and hide their message in symbolism because of their ethnic origin, political opinion and the censorship they may be under. For instance, *Finlandia* by Jean Sibelius was already composed in 1899, long before the independence of Finland in 1917, but it still causes very patriotic emotions in Finnish people. However, for some Europeans it may be a reminder of the later Nazi period and German propaganda films from World War II, where it was used. I assume that this depicts the Situation for music as well and how the same musical piece may symbolize the raising of national feelings under oppression or being under military attack. It may also be manipulated for use as a musical weapon by a hostile country. Similarly, the music of anti-Semitic Richard Wagner, the favourite composer of Adolf Hitler, has not been accepted by Holocaust survivors because it is still strongly associated ,and even conditioned, with Nazi parades, rallies, newscasts and some people still experience it as offensive (Moreno, 1999; Cloonan & Johnson, 2002).

In this context it should be mentioned that Sibelius was not anti-Semitic or a part of the Nazi movement, but it did not stop his music from being employed in violence. However, philosopher Martin Heidegger was an advocate of National Socialism and a member of the Nazi Party. I assume it should be mentioned at this point because his philosophy is used in this book, which some readers may find a bit disturbing in this context. Another phenomenologist, Edmund Husserl, was excluded from university activities because of anti-Semitic laws at the same time (Moran, 2002, pp. 4, 18.) It is a well-known historical fact that Sigmund Freud`s books were burnt in Nazi German and Freud himself, as a Jew, had to escape to London. Four of Freud sisters died in concentration camps because of their Jewish origins (Gay, 1988/1996, p. 786).It seems that oppression and politics do not only affect music and artists but also philosophers and scientists. In the opinion of totalitarian societies and in the politics of dictators, they may be considered dangerous or decadent because of their ethnic origins and their thoughts. During the Nazi period in Germany, blues and jazz – the music of blacks – as well as Jewish music and composers like Mendelssohn, Mahler, Schoenberg and Offenbach were forbidden, and the avant-garde approach in particular was thought be an expression of degeneration in the arts. (Moreno, 1999, p. 5.)

In this respect, it is not simply what kind of music would be suitable for torture survivors or refugees. Music that has been advocated by oppressing governments may hurt and offend them, which may be the same music they have loved, which was a part of their identity before. The world is not black and white from a musical point of view either, but many musical cultures seems to be entwined in different countries, and Western music and its influences can be heard even in the traditional music of the Vietnamese, for example (Reyes, 1999).In fact, it could even be relevant to listen to the Sex Pistols or Metallica with refugees from Muslim cultures that have been oppressed because of their musical identity in music therapy. From my own experiences with torture survivors, many of them had adopted western styles – of clothing as well as music, – in their identities. In Abdul`s music psychotherapy, the second case described later, we once actually listened to the Finnish punk glam band Hanoi Rocks and the song *In My Darkest Moment* as he grieved for his dead father. It was my choice, with Abdul`s permission though, to discuss death, sorrow and longing. At the same time that it was a musical interpretation and discussion, the music was also helping to provide understanding for Abdul and his loss. With their agreement, I also used Western classical music with all the patients. The classical music used included music from Sibelius – *The Swan from Tuonela*, *Valse Triste*, Holst – *the Planets*, Gershwin – *American in Paris*, Smetana – *Moldau*, Mahler – *Adagietto from Symphony 5*, Debussy – *Reverie* etc. I also applied some ambient, new age style music for relaxation and imagery purposes, as will be illustrated in the case studies.

The composers, artists and music were not selected for any ethnic or cultural reasons; they were not chosen in any coercing or manipulative manner. The patients themselves brought their own music, including ethnic music as well as Western pop music. If I was choosing the music, I usually improvised as to what music we would listen to, taking into account the patients` emotional state and current situation. I actually assumed that Western classical music would be quite neutral for the patients because they probably had not heard it much before. The situation is similar with many Western music therapy patients; with the exception of pieces like *Finlandia*, which may have too obvious associations. Frequently patients themselves selected the music, which is a safe way of listening to music with trauma patients and which lessens the possibility of making cultural errors by playing something offensive to the patients. However, it is good to remember when one is not manipulating a patient with music in therapy that one can never be absolutely sure what kind of memories, emotions and imagery a particular piece of music will bring. Patients themselves will not always know it either; whilst they may unconsciously or consciously avoid some kind of music or even unconsciously wish to listen to some song that describes their situation. It is important to remember not to coerce the individual into listening to anything s/he does not want to hear. That would be similar to using music in a violent and manipulative way, and it could resemble, to some degree, the experience of being tortured in the mind of a patient. However, I emphasize here that in this research and in music psychotherapy otherwise, the therapist and the patient have made a mutual treatment contract; a verbal or literal agreement on the music therapy, its methods and goals. Therefore, in this respect, it is not comparable to a real torture situation, violence or even manipulation, because the patient is in the treatment from his/her own will, is not forced to do anything and is free to interrupt his/her therapy anytime.

I consider it to be a bit confusing, whilst also relevant to some degree, that some authors consider noise, such as loud music coming from neighbours, could be construed as torture or violence (e.g. Cloonan & Johnsson, 2002). Even though noises and music unwillingly overheard from the neighbours may be disturbing, and could personally be experienced as "torture", I assume that it is rarely a conscious violent act towards other people. I doubt that the neighbours are trying to break down someone's personality for instance, which is how torture is usually defined. However, in some cases I agree that it could be a conscious disturbance and acoustic vandalism. It is a matter of situation again, partly relating to one's personal taste in music and which voices we like or find annoying (see Frith, 2004). For example, a baby`s cry in a train or on a bus could be quickly felt to be very disturbing for natural reasons. In the same way, even the quiet howling of a dog in a neighbour's apartment could be felt as "torture" because of the content of the sound. However, I consider it more of a metaphorical use of the word "torture" to describe music that one does not like, whether it's heavy metal, rap, classical or piano music, than actual torture or violence. From the medical, juridical, and even philosophical, viewpoint it would broaden the concept of torture too much and could result in it being possible to accuse anyone of torture at anytime. If personal taste, opinion or the subjective experience of being tortured would be the only thing that mattered, then we would be "hunting witches" again, I am afraid. I understand the meaning of *sound territories* as proposed by Cloonan & Johnsson, (2002) and Frith (2004) that individuals have their acoustic spaces in their homes, for example, and that sudden noises, like music, may interrupt the silence or the integrity of this personal space. This is what torturers or soldiers are trying to do, break the integrities of individuals with deafening sounds and music. However, it is the purposeful and conscious use of sounds to manipulate, which again makes it a totally different situation, after all, from the sudden noises made by neighbours. Actually, music applied in interrogations may be so loud that it is felt as physically painful and may, perhaps, not be experienced as music at all anymore. Guantanamo detainee Ruhal Ahmed depicts his experience as follows:

"... after a while you don`t hear the lyrics, all you hear is heavy, heavy banging, that`s all you hear. Um, you can`t concentrate on drums, or what the person`s saying, all you hear is just loud shouting, loud banging, like metal clashing against metal. That`s all it sounds like. It doesn`t sound like music at all." (Cited in Cusick, 2008, pp. 2–3.)

This does not look like the pleasurable "easy listening" of Western classic music, used for relaxation and imagery processing purposes or clinical improvisation in music therapy, either. Music psychotherapy is the conscious use of music in order to bring coherence to self-experience and integrity back with music`s potentialities to hold and promote various emotions, imagery, thoughts in their expression and to achieve insights. The purpose is to understand and thus help patients, which is a totally opposite action from manipulation, violence and torture – with or without music. However, to really succeed in this it assumingly requires a professional understanding of music on many levels; its psychology as well as its situational aspects relating to the personal history of the patients, their culture and societies. Unfortunately, it is also evident that there is the "dark side of the moon", which music therapists have to be ethically aware of whenever they apply music with their patients or are participating in any action such as research relating to music.

# 4 PSYCHOANALYTIC THEORIES AND THEIR CLINICAL APPLICATION IN MUSIC THERAPY

As a music therapist, I had a theoretical background to my work that affected my way of thinking and the solutions that I arrived at as a therapist and also as a researcher. For example, there are marks in my notebook where I have made clinical interpretations of some particular situations in therapy. However, later on while I was doing my research, and when transcribing my own sessions for example, I tried to forget my clinical position as a natural attitude in phenomenological bracketing, while still acknowledging that it would not be completely possible to do so and not always wise. I am aware that even some common medical, psychological, psychiatric and music therapy theories are influenced by psychodynamic theory, although one may not be psychodynamically orientated consciously as a clinician, researcher or even as a lay person. This of course makes the mentioned bracketing even more complicated, however in this I have been helped by the aforementioned concept of *releasement* and the self-experiencing attitude of the researcher, which will later be explained more thoroughly.

In this chapter, I shall present how I have integrated diverse psychoanalytic theories and concepts with music therapy theory and how I have applied them in my work with torture survivors on a general level. Firstly, I will be explaining the phase specific theory of Finnish psychoanalyst Veikko Tähkä and how it may be approached in music therapy. Secondly, I will synthesize it with the conceptions of another psychoanalyst, Daniel Stern, whose theories are more commonly part of the background of music therapy and which are also influenced by experimental developmental psychology and cognitive theory. Finally, I will provide a summary as to how I have applied this synthesis as a clinical theory in my own work with torture survivors. As one result of this research project, I shall present my own proposal for a clinical approach to severely traumatized individuals, especially concerning torture survivors and other PTSD patients respectively, in music psychotherapy. In the last chapter on clinical theory, I will present precisely how I have applied projective music listening, free association to music and guided imagery and music in the case studies of this research. Particular attention and discussion will also be paid to their relationship, influence and differences to the earlier described Bonny Method of Guided Imagery and Music (BMGIM).

## 4.1 Phase Specific Approach

In my clinical work as a music therapist, I have applied the phase specific theory of psychoanalyst Veikko Tähkä (1997a). He has developed his own approach for the treatment of psychoses, borderline disorders and neuroses which he postulates to have a different psychological origin in the patient`s psychic development. In his opinion, the patient's development has been arrested at different phases in these problems. Tähkä suggests that due to this the goal of therapy for psychotic patients is their *differentiation* and the protection of it. For borderline conditions, the goal is *individualisation*, whilst for neuroses, the objective is *emancipation*. Achieving these goals requires methods such as gratification for psychotic patients, identifications for the borderline conditions and insights for neurotic patients. In this sense, Tähkä`s approach may be seen as part of the

integrative development of psychoanalytic theories and treatment methods stemming from the 1990's involving diverse patient groups, where uncovering the unconscious and insights into it were not seen as essential goals with every patient (Wallerstein, 2004, pp. 6–7). However, Tähkä's theory is purely a psychoanalytic dynamic theory and so does not include aspects drawn from cognitive psychology and neuropsychology, which are more typical of some integrative approaches. Neuropsychoanalysis has developed as a new branch of psychoanalysis in the past decade, which has found congruence with dynamic theory and brain physiology. (See e.g. Alvarez, 1992/2002; Fonagy & Target, 1997; Stern, Sander et al., 1998; Rose, 2004; Stern, 2004; BCPSG, 2008; Lehtonen, J., 2009.) In spite of recent developments in psychoanalysis and neurosciences, these approaches have not replaced psychodynamic stage theories of child development, such as Tähkä's theory among others, developing from Freud (1905/1971) and Margaret Mahler et al. (1975), as examples. Rather, they are considered as additional layers and perspectives on the dynamic theories, which typically use concepts like unconscious, transference and defences.

Tähkä (1997a) believes that psychotic patients need holding and supportive care from the therapist, so that the therapist can reach a meaningful good object. Tähkä has taken this concept from Winnicott (1971/1997) and applies it in the same sense. For the borderline conditions, the therapist is a *functional self-object*, giving a patient selective identifications; the supportive role is emphasised here too. Tähkä also presents his own technique, *emphatic describing*, which means a thorough depicting of the patient`s situation, emotions, reaction, experiences etc. Tähkä assumes that the patient introjects more developed psychic structures from the therapist and in the end is able to learn more mature and developed ways of experiencing and being in a relationship. Traditional interpretations are left for the neuroses and Tähkä stresses that other patients do not have use for them necessarily.[16] This is because other patients do not own the structural capability in their experiential world to internalise them. Neurotic patients can identify with the attributes of the therapist, while borderline patients need more structural identifications where the whole personality, how s/he is and how s/he functions, is internalised.

[16] With this Tähkä is especially referring to genetic interpretations in psychotherapy. This will be discussed more in chapter 12.1 Genetic and Transference Interpretation, Neuroscience in Music Psychotherapy.

Table 1. The techniques, functions and goals of the therapist in phase specific therapy with various disorders (Tähkä, 1997a).

| DISORDER | TECHNIQUE/ FUNCTION | OBJECTIVE |
|---|---|---|
| Psychosis | Holding holding environment, nurturing, a therapist as an all good object, gratifier of needs and supporter – compare Winnicott (1971/1997) | Differentiation, returning of dialogue – returning of a subject–object experience |
| Borderline condition (Personality disorders) | Holding nurturing, empathic describing, a therapist as an auxiliary self i.e. self-object – compare Kohut (1971/1987) | Individualisation – a stabile self experience and an object constancy |
| Neurosis | Interpretation, providing insights, collecting of memories, repairing and adding of individual functions in the structures of self, searching of individual norms and ideals, shaping of historical view from one`s own life | Emancipation - own ideals and norms, liberation from the past |

Two other important concepts that Tähkä explores are *the transference child* and *the developing child*. They are the metaphorical aspects of a patient from the therapist's perspective that the therapist works with, but they are not directly equivalent in the patient: The transference child represents the development which is arrested in a patient and only repeats itself. According to Tähkä, a patient also has the potential to continue his or her development; this Tähkä calls the developing child. In therapy, a therapist has to ally with the developing child of a patient. There is no reason to gratify the transference child because it cannot change. The transference child represents failed parental figures and development models in a patient. It does not want to change and it will resist all opportunities to change in therapy. So, the satisfying of the transference child leads only to regression and a continuum of problems and defences. The developing child has the potential and the will to change and a therapist has to gratify these aspects in a patient. There will be progression in therapy and new development representations can emerge in a relationship between the therapist and patient. In the next three chapters, I will explain how music and music therapy may be applied according to the phase specific theory: Firstly, music as an element of holding when treating psychotic and borderline patients. Then secondly, how music may depict and give rise to diverse emotions and vitality affects in the treatment of borderline patients. Lastly, I will explore how music may provide insights, which are important for the neurotic patients in the phase specific therapy. However, all these aspects can be useful and important factors in any music therapy, independent from the pathology and the developmental phase the patient represents.

### 4.1.1 Music as a Holding Environment

Some well known issues in music therapy state that with music it is possible to bind and relieve diverse emotions like angst, sorrow, hate, joy, fury etc. (Lehtonen, 1986, 1993, 2008; Erkkilä, 1997b). Music can bring a feeling of safety when it unconsciously gratifies various

needs that need to be nurtured: compare the isomorphisms in the tenses between a mother and child (Kohut & Levarie, 1950/1978; Stern, 1985/2004). The rhythms, structures, harmonies, rules and enjoyable repetitions of music support the functions in the self that keep up the experience of control, like Kohut`s (1957/1978) *ego music*. Music has been also considered as a *transitional object* and *potential space,* strengthening and widening the experience of differentiation as was earlier described and discussed more thoroughly. (Winnicott, 1971/1997; Lehtonen, 1986; 1996; Dvorkin, 1996; Wigram, Nygaard Pedersen, Bonde, 2002.)

Music therapists have consciously applied music and improvisations to hold patients' emotions: Therapists attune to patients' emotions through music and interactions, mirroring them as Summer (1998) does when she chooses music for a Guided Imagery and Music (GIM) session. Jensen (1999) depicts how he supports and holds with music a man with schizophrenia and tries to provide him with structures. Austin (1996a&b; 2002) describes the holding of patients with her singing and playing; the feelings of being used and angry that one patient displays. In the Analytical Music Therapy of Priestley (1975/1994), there is a specific musical technique called *the holding technique*, the objective of which is to help the patient to experience his/her emotions to their full potential while the therapist supports the emotions with musical grounding. One of the improvisation techniques defined by Bruscia (1987) is *holding*, however, he does not refer to Winnicott here. Pavlicevic (1997) has applied the mirroring between a mother and child in her own improvisation model that has its basis in the *affect attunement* theory of Stern (1985/2004).

According to many theories, music has a lot of similarities with the interaction between a mother and baby, considering the emotional, linguistic or even cognitive development and the symbolism that is created through music therapy. (Stern, 1985/2004; Alvarez, 1992/1999; Trevarthen & Malloch, 2000; Alanne, 2002b; Rose, 2004; Lehtonen, 2008). Music therapists advocating various approaches, psychotherapeutic or neurological, have applied this knowledge of music holding emotions, which the phase specific theory emphasises in the treatment of psychoses. However, in a music therapy context, it may be a more essential aspect in every therapy because of the non-verbal nature of musical communication. Sometimes, also in psychotherapy, there is a need for the therapist to take a more supporting role whilst the therapy may be analytically orientated otherwise.

### 4.1.2 Music Providing and Portraying Empathy

In music therapists` theories and techniques are similarities to what, in the phase specific theory, is called empathic describing: Many theorists, also other than psychodynamic authors, seem to analyse that there is a some kind of correspondence, *isomorphia*, between the structures of the self and music even though the arguments vary (Bruscia, 1987; Rechardt, 1987; Aldridge, 1989; Andsdell, 1991; Lehtonen, 1997; Ruud, 1998). Recently Rose (2004), as mentioned earlier, has proposed the concept of *concordance* to describe the relationship between the brain and the symbolic processes in the mind, concerning also music. In music, one`s own identity is improvised like it is improvised and told in one`s life (Ruud, 1998, pp. 28–29). Music in itself may function as a self-object/auxiliary self where diverse emotions and attributes of a self may be transferred and handled in the symbolic

distance (Kohut, 1971/1978; Lehtonen, 1986; 1997). The basic idea of clinical improvisation is the "from inner to outer and from outer to inner" principal where music is the communication between the inner and outer worlds of an individual (Ahonen, 1993, pp. 182-183). Music may also communicate inside the individual, while listening to music for example, as in this research. It is possible to understand another without words by choosing music to listen to which corresponds to the patient`s emotions, i.e. the mentioned *iso principle* of music (Wigram, Nygaard Pedersen, & Bonde, 2002, p. 60). Music may create social or cultural togetherness and sharing through national anthems, folk songs, hymns and, similarly, wedding and funereal songs, etc.

Nordoff-Robbins` Creative Music Therapy includes an improvisation technique called *reflection* where the child`s emotions and doings are matched with music and songs. A therapist improvises a "portrait" of the patient, including his/her personality and the mood of the moment. Also the movements, gestures and sounds of a patient may be imitated and reflected by the therapist`s with a song or through playing. (Bruscia, 1987, p. 46.) Actually this music therapy technique appears to be the old musical equivalent to Tähkä`s verbal empathic describing in psychoanalysis. Bruscia (1987) has defined the techniques that apply for providing empathy with music as *imitation*, *synchronising*, *incorporating*, *pacing*, *reflection* and *exaggerating*. In music therapy, it is common to *mirror* patients` emotions, thoughts, music etc. which is one of the cornerstones of musical communication and sharing (Pavlicevic, 1997; Ahonen-Eerikäinen, 1998).

### 4.1.3 Music as a Source of Insight and Interpretation

Insight is a verbal or non-verbal experience where new information and understanding relating to one`s self and relationships with other people and things etc. is born. It is important therapeutically that emotion, information, memories and imagery are connected in the insight experience. Music can help in raising discussion, evoking memories and collecting them. Music may be essentially connected to meaningful and important phases of life, as Lehtonen (1997; 2002a &b; 2007) has addressed in his research on psychiatric inpatients` and music therapists` meaningful music. In therapy, it is possible to listen to music from different periods of life; childhood, teenage, young adulthood, middle age or music that reflects one’s current life situation. Music creates images that include unconscious and symbolic material, which can be compared to dreams and the effects of some drugs. In music it is also possible to have peak experiences with important insights.

In Priestley`s (1975/1994) Analytical Music Therapy (AMT), there is a technique called *splitting* where the therapist and the patient play different parts of the patient`s personality. The objective is for the patient to gain insight into his/her different parts and attributes and to integrate them. In the same way, feelings and projections onto other people may be explored. The GIM therapy applies imagery journeys where insights and peak experiences are the goals of the therapy. Insights can emerge in a patient while listening to music or discussing an experience with a therapist afterwards. Patients have experienced strong emotions, grief, fear, deep love, respect etc. and have said that these peak experiences have even changed their lives. (Grocke, 1999, pp. 204–205.) Also, other imagery techniques are applied in music therapy such as *free association* using music and the Jungian technique *activation of*

*images*. There are other techniques used to gain insight which are defined by Bruscia (1987). These are *doubling;* where a therapist plays various patient`s emotions that are hard to express, *contrasting;* where a patient plays the opposite emotion to one earlier expressed, and *incorporating;* where a therapist plays the opposite emotion to that of a patient, thus trying to balance, connect and integrate various feelings. These come close to the verbal psychotherapy techniques of confrontation, clarification and interpretation that may also be applied in music psychotherapy. Kari Syvänen (2005) has studied the countertransference emotions of a music therapist and proposes that a therapist may respond musically and verbally to a patient`s emotional reactions. According to him, when these responses are conscious and cultivated they enable interpretations. I assume that they may musically function then as transference here and now interpretations.[17] (pp. 52–53.)

### 4.2 Attunement and Mirroring: Adaptation to the Patient`s Development Phase

In verbal psychotherapy and psychoanalysis, it has been noticed how important it is to attune to a patient and his/her gestures and presence, so that the interaction is similar to the interaction between a mother and her baby: the tones of voice, the rhythm of speech etc., *amodal sensing.* Attuning to another's sense modality could help the patient to obtain cohesion and to gain insights without words. A psychotherapist may also apply words, speech and his/her voice in different rhythms, silences, tones and contents of voice similarly emphatically relating to them like a musician playing an instrument. (Rayner, 1992; Ogden, 1999/2005; Rose, 2004.) Stern, Sander et al. (1998) propose that part of the changes in psychoanalysis relate to this kind of attunement to the patient`s emotions, moving in the "now" moments and the encountering of emotions. This means encountering the patient emotionally by attuning, like a mother encounters her baby, which is similar to a situation that occurs when two people discuss and relate to each other emotionally. So, this is not a traditional clinical interpretation but rather a way of encountering the patient with an implicit knowledge of being in a relationship with a human. This happens in *the procedural memory*.

As presented earlier, there are musical attributes in the relationship between a mother and baby (Stern, 1985/2004; Alvarez, 1992/1999; Trevarthen & Malloch, 2000; Rose, 2004). In the light of attunement and verbal or non-verbal interpretation in a relationship, music therapists always somehow interpret the patient`s musical improvisation when making decisions as to how to reply or mirror the playing of a patient. Some of these decisions are unconscious, like *the procedural memory* which works when driving a car. (Pavlicevic, 1997, pp. 163–164.) Conscious musical interventions, where a music therapist applies therapeutic knowledge in his/her playing to give rise to an insight in a patient, may be likened to a clinical interpretation in psychoanalysis. This can be compared to *the declarative memory*: Could this music relate to that when…? Was this music nice or scary because…etc.? Music therapists change their playing according to the reactions, moods and therapeutic needs of the patient. Here they may apply some of the diverse improvisation techniques discussed earlier and try to consciously provide patients with insights into their relationships with others, their own personality, emotions or to their past.

[17] Theoretical discussion of transference interpretations and their difference to genetic interpretations from the clinical point of view is in chapter 12.1 Genetic and Transference Interpretation, Neuroscience in Music Psychotherapy.

### 4.3 Therapeutic Change in Clinical Improvisation

In this sense of interpretation, the change or "the corrective experience" in a patient does not only happen in the verbal area with *the discursive knowledge*. This is the traditional view. It also happens when positive experiences and models of being in a relationship accumulate and change in phases with non-verbal and *the implicit knowledge*, the procedural memory, where the traumatic experience is lived through. (Stern, Sander et al., 1998, Stern, 2004; Enckell, 2009.) In music therapy, this happens when a therapist mirrors their patients with music. However, it needs understanding and empathy towards the patients and their emotions, reactions, personality attributes etc. Understanding and caring for the patient is at the core of psychoanalytic therapy and without it, it is difficult to relate to patients and provide them with insights, identification, holding or any other positive gains.

Music therapy improvisation may be conceptualized as a *dynamic form,* as proposed by Pavlicevic (1997), where the emotions, meanings, tensions, sounds, musical motives etc., and the music of the patient and therapist are encountered. This is a mutual form/area/space, which is clearly not the result or expression of the patient only – nor the therapist – but theirs together. Music and improvisation sort of begin to live their own lives. In these forms and structures where the therapist is a sounding board, empathic relating dictates the way the therapist acts, experiences things and responds to different relationship situations with the patient. This happens in a similar way to therapeutic discussion and being with a patient. Meanings and experiences being exchanged between the therapist and patient can be verbal or non-verbal. Attuning and mirroring the patient enables new identifications, introjects and a change in the structures of the self. Similarly, the phase specific encountering of a patient is possible because in the psychotherapeutic process the patient usually evokes emotional responses i.e. countertransference in a therapist that relates to the developmental stage of the patient. (Syvänen, 2005, p. 55.)

Rose (2004) questions the old conception of verbal interpretations and insights in order to achieve the goals of psychoanalytic treatment. According to him, many psychotherapists currently consider that actually much of the therapeutic change comes from the “emotional ambience of the therapeutic relationship”. He also discusses the need for lingual interpretations related to the nonverbal area of the brain and thus links to the effectiveness of interpretation in current neuroscience. According to him, the nonverbal system is activated by pictures, sounds, tastes, smells and feelings. He raises as an example experimental studies on imagery and how important they are for mental representations. Imagery and emotions are both associated with the nonverbal brain system but are important for thoughts, as well concerning mental representations. Therefore language, which is activated in the verbal system of the brain as the spoken word, inner speech or verbal thoughts, cannot be considered as the only component of thoughts anymore. (pp. 6–7.)

Rose (2004) has proposed that the attunements of a caretaker act as a hidden regulator of chemical agents that affect the maturing of centres in the temporal and orbital frontal cortices in the brain. The gazes and smiles of the caretaker and mutual mirroring become imprinted in the right orbital cortex. They increase endogenous opiates in the growing brain and make social interaction pleasurable. Thus, he postulates music may provide a *holding*

*environment* of an infant–caretaker dyad that effects, or attunes to, the structures of the brain, e.g. amygdala, and thus enables grieving, which is important for recovering from traumatic experiences and loss. He even suggests that music does not only evoke these feelings in the brain and experience, but that these early internalization and models of affect regulations are embodied in music. (pp. 126–127.)

From the music psychotherapy point of view, this is essential knowledge because music raises imagery, thoughts and emotions, as can be seen from the cases in this research as well. Thus psychotherapy, as well as music in itself as an element of therapy, may produce enduring changes to the structures of the self and even affect the brain with internalized ambience. This relates also to the earlier discussed attunement of a therapist and seems to place verbal and mentioned musical interpretations and interventions on the same level as therapeutic tools, according to recent neuroscience.[18] (Rose, 2004, pp. 6–7.)

### 4.4 Traumas, Phase Specific Theory, Neuroscience

From the grounds of my psychoanalytic frame of reference, and my experiences of music therapy with PTSD patients and torture survivors, developed a conception as to what should be the objectives of their music psychotherapy. It relates clearly to the hypotheses and the goals of this research: The objective of music therapy with these patients is that they would learn to control their disturbing thoughts and cope with the troubled emotions relating to them. This also means a development in the capability to concentrate that listening to music and playing naturally demands in different ways. In this context, from the psychoanalytic respect both music and the therapist may be considered as functioning as auxiliary selves for the patient, as described earlier.

On the other hand, from the cognitive respect a therapist may be for the patient a sort of "coach" who supports and guides the management of difficult experiences, encountering and working through them. In trauma therapy this is known as *stabilization*, which can mean grounding the patient with questions such as How do you feel now? What do you see? (Van der Kolk, Van der Hart & Marmar, 1996/2007, pp. 320–321.) My experiences with PTSD and patients who have been tortured have taught me that the therapist`s objective is to try and pull patients out of their dissociative states and away from their disturbing thoughts with music and with questions, as mentioned before. I also postulate that the therapist must help patients to control their emotions so that they would not be able to carry away the patient totally. This would mean also the *emphatic describing* of the situation of the patient, bodily feelings as well as music, which may lead to *identification*, exploration and the modification of traumatic experiences and the memories relating to them (Van der Kolk, McFarlane & Van der Hart, 1996/2007, p. 426). In this research, applied *projective listening* techniques such as *guided imagery* and *free association to music* are examples of how to provide stabilization and grounding in music psychotherapy for patients suffering from traumas. I postulate that when patients verbalize their current thoughts and emotions relating to the music, for example, it may *deconditionalize* traumatic memories and responses, e.g. music

[18] There are some apparent problems in connecting neuroscience and psychotherapy though, which will be discussed in chapter 12.1 Genetic and Transference Interpretation, Neuroscience in Music Psychotherapy.

or sounds as a threat. It may also *restructure* personal thoughts – peculiar and paranoid thoughts for instance – and schemes concerning traumas and interpersonal relationships and validate the patients` perceptions and emotions. This may result in an accumulation of positive and *restitutive* emotional experiences with music and the therapist. I emphasize that this means a more active and verbal role for the music psychotherapist with torture survivors and other severely traumatized (PTSD) patients. To a varying degree, it means also the rejecting of analytic abstinence and silence in the general phase-orientated treatment of traumas. A therapist has to also help the patient reestablish secure social connections and interpersonal efficacy as emotional attachments can be inhibited by traumatic experiences. (Van der Kolk, McFarlane & Van der Hart, 1996/2007; Alanne, 2005b; Maragkos, 2007; Wolf, 2007a.)

I assume that one of the objectives of music psychotherapy would be then to raise positive imagery and experiences in patients, which they may seldom experience otherwise. I argue that music is then a mentioned "good object" that helps in confronting troubled emotions and provides integrative experiences for the self. Music therapy happens in "here and now" moments; especially while listening to music or playing it. In this research project, music therapy applied only receptive music listening techniques but, referring to my other clinical work with this patient group and the other earlier referred to music therapists working with PTSD, torture survivors and trauma patients, I assume the objective would be the same. Also, the psychotherapeutic discussion between the patient and therapist may occur in the "here and now" similarly (Tähkä, 1997a; Stern, 2004). In musical action and discussion, a therapist attunes to a patient and tries to understand their emotions, thoughts, stories, symptoms etc. With such a therapeutic attitude, it may be possible that traumatic patients can learn new generalized models of being in relationships and so replace the disturbed models influenced by torture, as has been proposed by The Boston Change Process Study Group (Stern, Sander et al., 1998). I postulate that there is a similar process of change with internalized early childhood developmental models of reciprocal relationships and their introjects where development has been arrested. The intention in therapy is to increase positive experiences and representations of being in relationships so that new structures would occur. I assume that in trauma therapy it would mean also reestablishing a *secure attachment* with a patient to provide an experience of *basic trust* again. This could help the patients to better cope with their traumatic experiences and imagery. Thus therapy may also develop control strategies for dealing with traumatic experiences by encouraging musical or other artistic activities. (Van der Kolk, McFarlane & Van der Hart, 1996/2007; Bilić, 2003.)

With respect to cognitive psychology, these functions are in the area of *procedural memory* where anxiety and other emotions arise frequently without words. It is specific to torture survivors that it is difficult for them to find words and meanings for the experiences that are related to their traumas. Then one cannot initially assume discussion of the traumatic experiences, but the therapy must first happen in the areas of procedural memory and functioning. Experiences may be approached more with words later when the patient is ready and there has developed such meanings that can be verbalized and processed psychotherapeutically in the area of *discursive memory*. This may mean even identifying and verbalizing the somatic states first (Van der Kolk, McFarlane & Van der Hart, 1996/20,

p. 427). However, this may lead to the *transformation of destructiveness* to the musical meaning or expression (Bilić, 2003, p. 5). (Alanne, 2005b, pp. 687-688.)

Beside this, the traditional psychodynamic thinking that a patient works through the traumatic experience with a therapist and music is also assumable. Then music therapy`s objective is to provide *corrective experiences* and integrate traumatic experiences. This could mean also analyzing archaic defenses like massive projection and idealization *(*Bilić, 2003, p. 15). It is possible to see as one dimension or a "layer" of this the aforementioned cognitive approach of Stern, Sander et al. (1998) to psychoanalysis. In such a case, the corrective experience occurs, at least in verbal therapy, frequently with discussion and thus in the area of discursive memory. Then it is possible to apply verbal interpretations because the patients are able to process and take advantage of them with their psychic functions. They are more able to verbalize memories, emotions, imagery, and thoughts relating to the music, for example. However, in my own experience with torture survivors, which was also one premise of this research, they are not always able to process traumatic experiences verbally and so may need other kinds of therapy or treatment as well. They may rather seem to avoid the verbal processing of these experiences for different reasons such as the anxiety or the shame these experiences may evoke. For this reason, they may need more supportive treatment first, then the therapist`s role and the role of music is also to hold the structures of the Self. When treating trauma patients I have noticed that it has been especially important to create the *holding environment with music* that I have described earlier, which relates to the early infant–parent relationship (Sutton, 2002). It also seems, as earlier discussed, that this kind of psychotherapeutic relationship may have a rehabilitative affect on the traumatized amygdala in the brain and its other functions, as suggested by recent research (Swallow, 2002; Rose, 2004). (Alanne, 2005b, pp. 688–689.)

In severely traumatized individuals, the *amygdala,* the area in the brain which relates to the regulating of emotions, may be injured. Then the brain cannot regulate its normal functions but, for instance, panic and the fear–flight reaction may be conditionalized and triggered without cause. This also increases mental anxiety and releases stress-hormones into the system. On the other hand, the brain of a severely traumatized individual cannot necessarily produce enough pleasure providing transmitters, like endorphins. It has been noticed that music may have relaxing and calming effects on the vital functions of the body and may also increase the level of endorphins in the brain. (Swallow, 2002, Ruuskanen, 2007.)

I postulate that for patients that have experienced torture, or other severe traumatic experiences, the creating of a holding environment and *containment* are primary for their therapies, so that they could approach traumatic experiences, feelings and memories safely *(*Bilić, 2003, p.16). A patient may feel these emotions to be so threatening that s/he does not want to encounter them at all and may even strongly resist these issues in therapy, which may show up in the form of numbness or not coming to appointments. Some patients have told me that when the memories of torture or other disturbing thoughts, with their relating emotions, come to mind they can ruin the whole day. In music therapy, it is possible to approach these threatening feelings carefully by listening to peaceful music, for instance, when the person may calm down and relax and so let him/herself have an opportunity to encounter his/her emotions. Then music sort of "holds" the patient and his/her hard feelings

and may gently open defenses. Music may be played then softly as background music to create a peaceful and relaxed situation so that it would be easier for patients to talk about their own feelings and so that they could feel comfortable in general. While listening to music with psychotic patients, for instance, I may ask short questions such as do they feel comfortable etc. to orient them to the present moment and to create a safe holding environment with music. With traumatic patients, this could be conceptualized as *stabilization* or *grounding* as well. In fact, there is a grounding music therapy improvisation technique, the purpose of which is to "promote feelings of safety and stability" (Bruscia, 1987, p. 541). This can be rhythmically grounding the patient to the physical reality, similar to integrating and holding with music. I have used this myself with many patients to provide easier "soil" from which to continue their own playing, so that the sounds do not stop completely but there continues a kind of "heartbeat" quietly emanating from the instrument.

Music may provide torture survivors with *constancy* as well as *reality* which are considered to be important abilities from the viewpoint of their therapist *(*Bilić, 2003, p.16). Musical rhythms and structures have regularities that may clarify and pacify self-experience with their sounds, for example. Similar musical effects have already been applied for a long time in elevators, airplanes and shopping malls to make people feel comfortable, as earlier described. However, in psychoanalytic music psychotherapy the intention is not to manipulate people into shopping a lot of course; the patient is informed as to what is the purpose of music therapy, why music will be listened to and their permission to listen to music will be asked. The emotional expression of music may correspond to the patient's own emotions – like sadness – and s/he can experience the controlling of them in similar *dynamic forms* of music, which therefore gratifies the ego. Music that is too rough or too loud may be experienced as a chaotic and violent intrusion that may remind the patient of the trauma and the violent incidents relating to it, the breaking of his/her intimacy and integrity. Then music does not hold the structures of the self but functions as the opposite – a psychological persecuting and anxiety provoking *bad object,* as earlier discussed (Lehtonen, 1986; 1997) Thus, the informed consent of torture survivors for music therapy and its research is important because patients may have been forced to listen to music while being tortured. Music could have been part of the torture; used violently, as propaganda, as cheating or for other manipulative or humiliating purposes, as described before. (Alanne, 2005b, pp. 688–689.)

Many torture survivors, and other individuals with severe traumas, have weak self-boundaries and structures, which I assume have to be considered in their therapies *(*Bilić, 2003, p.13). They may lack emotions because they have lost their capability to experience ordinary feelings like joy, sadness, anger, despair etc. or their expression may be weak and they may have lost the words to describe them. Controlling one`s own emotions or coping them may also be difficult. I postulate that it is possible to then emphatically describe with words or music these feelings, emotions and effects in helping the patient to reformulate and reach their own self-experiences. With particular *emphatic describing,* proposed by Tähkä (1997a), a therapist may depict the patient`s situation in the way the therapist sees and experiences it in the present moment, and with those feelings and imagery it gives rise to. The objective of this intervention is to provide a patient with the chance to identify with the therapist and introject how emotions are felt and what kind of experiences

may arise involving music. Especially, a patient has the possibility to see and, in a way, feel his/her own experience from the point of view of another; with "another`s eyes". How does it feel in this particular situation? What is it like to be in this relationship? What kind of person am I and how do other people see me? Music and the playing of instruments may also depict emotions and it is possible to apply them in order to provide another with psychotherapeutic understanding. A torture survivor, or a person otherwise severely traumatized, has lost control of his/her experiences and because of strong defenses his/her emotional experience may be dissociated, fragmented and partly flattened. In this respect, their therapy may be reminiscent of the aforementioned psychotherapy relating to borderline/personality disorders patients. Actually, some torture survivors have diagnoses of changed personality as a consequence of torture. (Alanne, 2005b, pp. 689–690.)

Music may be applied to help torture survivors and other traumatized individuals, so that for the psychotically depressed, and for those who have lost their feeling of self control, a therapist has to create a holding environment with music and establish him/herself alongside music as a meaningful good object for the patient. Vedran Bilić (2003) suggests that this would be the objective with all torture survivors in psychotherapy because bad internal objects have become prevalent for these patients. They frequently use archaic defenses, like projection, and their behavior may be paranoid. Actually, Bilić considers that torture as a phenomenon in itself is psychotic and analyses that patients regress to a *schizoid-paranoid position* when their bad objects become re-actualized. Primary annihilation and Oedipus castration fears may be activated too, as results. (pp. 13–15.) Therefore, I would say that when torture survivors are capable of sorrowing and mourning their loss with help the help of music, for example, it may be seen as a development in his/her rehabilitation. I assume that it would mean that a patient has reached a *depressive position*. However, there are "perennial mourners" among refugees, those who have lost their home countries, husbands, culture etc., which is different to "normal" mourning where sad memories of lost ones are in the realm of futureless past memories and the mourning work can be completed. Many immigrants seem to stay as perennial mourners in varying degrees from "usual" to "extreme", where one dynamic reason may be their persecuting guilt. (Tähkä, 1997a; Volkan, 2004.)

For those patients who suffer from altered personality, flattened emotional life or emotional labiality, a therapist has to depict with music the patient`s situations and their world of experiences, i.e. a therapist establishes him/herself as a functional object/auxiliary-self for the patient. As patients are more able to reach their experiences, provide them with meaning and to verbalize them, more therapeutic discussions, insights and interpretations are possible. Then a patient is already capable of mainly functioning in the area of discursive memory and it is possible to *integrate* the traumatic experience therapeutically to one`s own personal history with language and music, so that the trauma is no longer a separate anxiety provoking a "black hole" in the patient`s personality. The patient is capable of releasing him/herself from the burden of the past and, through the means of rehabilitation, s/he is able to develop more flexible coping strategies and defenses. Throughout their therapy, trauma patients may be seen reflecting and also fluctuating between the *transference child*, who lives in the past, dissociates and is regressive, and the *developing child,* who is able to

sorrow but may orient to the future, who proceeds in life and is able restructure and integrate traumatic experiences.

In the psychotherapeutic process, music may give the patient the chance to communicate with his/her inner self and emotions, and also with other people. Music may also open meanings and experiences in an individual`s personal history and various psychosocial layers. Disturbances in these constitutions and constructions of meanings and experiences may be musically approached from different stages, applying the phase-specific psychoanalytic, or other similar psychological, theory. Thus, with music it could be possible to help patients in achieving new meanings, experiences and repairing old ones. Music as an art form of the present time provides the music listener or musician with all the necessary dimensions of time and being in the present moment – the past, the present and the future – that shape the being in the experiencing mind. So, music as one medium of knowing may also orient to the future and thus provide hope, joy, praise and other possible feelings that were not perhaps concurrent in the present situation as yet. Music may *transcendentalize* the being, providing a slave or a prisoner with internal imagery of freedom and hope, providing relief from the external tortured or pained body.

### 4.5 Music Listening and Imagery as Clinical Applications in this Research

In this research project, the central music psychotherapy method has been listening to music and imagery, which means processing one`s own imagery with music. I have applied, in particular, the Guided Imagery and Music approach, (GIM), because there have been previously reported good experiences when used in the treatment of PTSD (Blake, 1994; Blake & Bishop, 1994). In this method, a patient is provided with ready themes that may even relate directly to the traumatic experience, or they can be purely imaginative like "path". Actually, these kinds of direct approaches to traumas and imagery are known as *flooding* and *implosion* in cognitive behavioral therapy. In this study, the traumatic experience in itself was not the theme with any of the patients but the purpose of therapy was to approach them with positive imagery and emotions and not to confront them musically or otherwise directly. With some patients, the objective and the level of therapeutic processing may have been this because they were so severally traumatized. In the original The Bonny Method of Guided Imagery and Music therapy, (BMGIM), developed by Helen Bonny, sessions may last from 90–120 minutes, with patients lying down, perhaps with their eyes closed. The music used is clearly defined and programmed classical music, selected to give rise to diverse emotions and imagery. Therapy may lead a patient to a very relaxed state, providing positive experiences, but it can also be a little regressing and may provoke strong emotions. (Wrangsjö, 1994; Bruscia, 2002; Moe, 2002; Körlin, 2005.)

In the treatment of traumatized individuals, more applied versions of BMGIM or GIM have been used, which was also the case in this study. However, there are such major differences in my theoretical, clinical and philosophical premises that I do not consider my music psychotherapy approach as GIM in this research. I admit I have applied its clinical theory, research and experiences to some degree, though. For traumatized patients, therapy sessions are shorter in applied GIM, approximately 45–60 minutes; the patient is in a sitting position and frequently has their eyes open. The therapist`s intention is to help the patients in

controlling their emotions during listening to music. In my own clinical application of listening to music and imagery, I also used other music than just classical music and allowed the patients themselves to choose and bring their own music to sessions. In both BMGIM and its applicative version GIM, a therapist asks the patient clarifying questions such as "where are you now", "what do you see" and "what do you think now"? The purpose is to work on the here and now moment while listening to music and to verbalize experiences, which is thought to pull the patients away from their compulsive thoughts and dissociative states. After listening to music, the patient and the therapist reflect upon the experienced imagery, feelings and music through a discussion, which may include interpretations as well.

The music of BMGIM may be described as having medium dynamics and it is also worth while to note that with some traumatized patients – especially torture survivors – a therapist should be careful, at least in the beginning with a particular patient, regarding the dynamics of the music used. There are some reasons for this: In a way fantasizing with music is a bit of a similar mental process to dissociating and the patients may have difficulties processing their imagery, they may even experience it as frightening and so become afraid of losing control of their minds because of this similarity. However, I assume from my own experiences of traumatized individuals and refugees from other cultures as well as from the research, that music can also be an integral part of their lives and played loudly in refugee centers. In their home countries, music and dancing may be a natural part of their daily lives as described by one of my African patients in this study. (Reyes, 1999; Heitzman, 2005; LeVine, 2009.) Thus, the oppositional stance of traumatized patients in music therapy may have more to do with their own psychic processes and traumas, not music itself as a "threatening" phenomenon in general. With patients who have proceeded in their therapy and rehabilitation and who are mainly functioning from a neurotic stage or a depressive position, then the producing of imagery and its processing is easier. Psychotherapeutic discussion and dialogue are more possible and they may have similar attributes to *free association* in psychoanalysis.

I postulate that the connecting of music and imagery processing and the insights they may provide can have equivalences to free association in psychoanalysis. However, I assume that it is free associating in the narrower sense because there is the musical element and the more active role of the therapist than in classical psychoanalysis. If a music therapist is more abstinent, then I argue that music and music therapy improvisation may be free associating similarly to child psychotherapy and psychoanalysis where children`s play is considered to be free associative (Brummer, 2005, p. 128). Music, with the imagery and fantasies that it gives rise to, can also be compared to dreams and the work done with them in psychoanalytic psychotherapy. With regards to psychoanalysis, working with musical imagery or music psychotherapy differs because transference is also projected onto music and not just the therapist. (Wrangsjö, 1994; Ahonen-Eerikäinen, 2004 Syvänen, 2005.) In my clinical work my intention was to select music to match somehow the patient`s emotional state whenever possible. I assume that this can be considered to be a sort of pragmatic "musical interpretation" in a psychoanalytic context, as earlier proposed, which has predominantly been my theoretical background.

The theoretical background of the original BMGIM is based on a humanistic and transpersonal psychology, where the spiritual aspect of humankind may be emphasized. For instance, Abraham Maslow`s *peak experiences* are one essential part of the BMGIM and GIM theory, where they are assumed to be experienced with the help of music and imagery. In GIM therapy, there may also be other kinds of theoretical combinations like Jungian, Freudian, humanistic and neurocognitive theory and therefore I assume its nature is more psychodynamic, in the broad sense.[19] BMGIM music therapists go through their own specific music psychotherapy training which has its own psychological–philosophical approach and method for applying music in therapy and healing. (Clark, 2002; Bruscia, 2002.)

However, many music therapist`s apply music and imagery broadly from the grounds of their own training. Imagery processing with music may be considered as one essential creative method used by music therapists, which as an improvisation belongs to the "tools" of many music therapists with varying theoretical orientations (Bruscia, 1987). So it was in this research project and its clinical work as well, even though knowledge and experiences gained from BMGIM and/or actually from GIM was used. It was not the only method though and it was applied more freely, according to the clinical needs of the therapist and his patients. In this research, music psychotherapy was orientated by psychoanalytic theories and practices (Tähkä, 1970/1982; 1997a; Lemma, 2006). Additionally, there were clinical points of view relating to music and psychotherapy with traumatized individuals and torture survivors particularly. To summarize, I must conclude that as a therapist and a researcher in this study, I had a different clinical and philosophical frame of reference from BMGIM therapy and the clinical approaches directly evolving from it. In the next chapters I shall explain my philosophical orientations for this research.

[19] The concepts *psychodynamic* and *psychoanalytic* are sometimes used interchangeably in the literature, whilst the latter is the most specific term relating to the psychoanalytic theories and the therapeutic approaches originating from Freud. The first seems also to be an "umbrella" concept for approaches and eclectic theories which emphasize the meaning of the unconsciousness for therapy in varying degrees.

## 5 HERMENEUTIC PHENOMENOLOGY AS THE PHILOSOPHICAL FOUNDATION FOR THE RESEARCH

The philosophy of science used in this research has been developed from the phenomenological philosophies of Martin Heidegger (1927/2000) and Edmund Husserl (1995; 2005), in particular. While Husserl is often credited as the founder of phenomenology, the roots of modern phenomenology go back further to Franz Von Brentano, (1995/2002), who introduced the concept of *intentionality* (p. 52). However, it was Husserl who provided many of the phenomenological concepts of intentionality – *epoché (bracketing), mind*, *horizon*, *noema*, *noesis* – as we currently know them. In this research, they have basically still retained similar meanings and purposes, however these concepts are also seen through the ideas of his followers, especially Heidegger and his existential phenomenology, Maurice Merleau-Ponty (1945/1994), and Hans-Georg Gadamer (1989/2002; 2004). Heidegger (1927/2000) presented that being is always in relation to time, which therefore provides the ultimate borders for knowing and experience in an individual situation. Merleau-Ponty further developed the bodily aspect of being; how we perceive the world through our senses and are always in a relationship with the world through our bodies. Our physical being and mortality shapes our present, past and future in a situation. Gadamer (1989/2002) thought that all understanding is based within the historically affected consciousness, and is therefore always affected by the history of an individual, which constitutes the hermeneutic situation (Moran, 2002, p. 312).

It is important to notice that Heidegger himself thought that his phenomenology was hermeneutic. For him, the phenomenology of Dasein was a hermeneutic interpretation, answering questions as to how the world discloses itself; how Dasein (Being There) is in the world. Thus, he discerned philosophical phenomenology by analysing "what" is in the world and what are its material contents. Heidegger thought of phenomenology as a method of disclosing how Things are in themselves, scrutinizing the being itself from an ontological point of view. His fundamental analysis made it possible to approach the phenomena as the possibilities of being; not necessarily representing what they really are. (Heidegger, 1927/2000, §7 pp. 50, 61–62.)

In his later philosophy, Heidegger (1959/2002) described *releasement* (Gelassenheit) as a particular attitude or method of understanding the world, and how our surroundings are revealed through patient waiting (Gegnet). Similarly, Michel Henry (1973; 1999) has emphasized the self-experiencing of phenomena in the manifestation of essences. In his late philosophy, Husserl (1970/2002) wrote about the pregiven *life-world* (Lebenswelt) of sensations; the way in which our bodies inhabit a world in which others also exist.

Finnish psychologist and philosopher, Lauri Rauhala (1974; 1983; 2005; 2009a) has studied psychology and psychotherapy from the existential phenomenological philosophy point of view; especially considering the works of Husserl and Heidegger. His founding work in this area, and the results of his "holistic image of man", has provided me with the ground on which to develop a philosophy of science from whence music psychotherapy in practise can

be explored.[20]

### 5.1 Holistic Approach to Understanding the Human Situation

The basic idea behind the holistic image of man is that the individual`s world of experience is influenced by three dimensions 1) the Mind 2) the Body and 3) the Situation (Rauhala, 1983, p. 25). All experiences and meanings are considered to arise from the interaction of these three dimensions. Their total separation is only possible in philosophical analysis. The Mind aspect describes those issues of consciousness which have meaning and which symbolize something. Frequently, this kind of experience can be verbalized as, for instance, when one experiences some kind of image arising from music. In phenomenological vocabulary, this is referred to as a noematic experience (*noema*). Experiences may also be more like feelings, as when we experience some issue as funny or uncomfortable but we cannot fully describe what amuses or annoys us. Then, the experience has not been constituted as the actual meaning of what is funny or annoying in a particular situation. This is referred to as *noesis* in phenomenology. (Husserl, 1983/2002.)

Phenomenological philosophy proposes that the Mind – meaning – arises from *acts of knowing*, when something teleologically directs us to something in our consciousness. This is known as "intentionality" in phenomenological conceptualization, which means the individual purpose is to provide subjective meanings to sounds and pictures, for instance. The cornerstones of phenomenological thought are the active subject and the process of knowing, where the perception of the object constitutes and defines itself in terms of a subjective experience. (Husserl, 1900/2005, pp. 199–200.) Thus, completely objective experience is not possible, but is always shaped by the individual`s experience of the world and *preunderstanding*. Preunderstanding is referring to all the former experiences of the individual; conceptions, meanings – including those relating to music, for example. *Horizon* stands for the general terms and frames of the real world itself, which always form the boundaries of preunderstanding and the individual experience. These may be laws, history, climate, cultural rules, music theory, the rules of the hospital etc., which are independent objects in themselves – separated from the individual and the researcher. Therefore, the influence of the Horizon on the subjective experience is inescapable. (Rauhala, 1974, pp. 47–48, 54–56, 62.)

With the help of phenomenological *bracketing* (epoché), a researcher may free him/herself from preunderstanding and other earlier conceptions, which, in music psychotherapy, could be various diagnoses or the therapist researcher`s conceptions about other cultures and the music relating to them (Husserl, 1983/2002;1995). This happens frequently as a form of mental processing and with the questioning of one`s own possible former knowledge and prejudices: What do I really know about this person? In this research project, I argue that the phenomenological bracketing has been partly externalized, leading to something that is not purely the inner process of the researcher or immanent reduction, but something that is

[20] Rauhala (2009a) has not written much about music or music therapy although he refers to the physioacoustic method of Lehikoinen (1994; 1997; 1998) and how music as a treatment directly affects the brain physically, like pain, providing the ground for life-world experiences. He argues that the musical experience is possible without the life-world and the interpreting mind of the individual. (pp. 274–275.)

partly accessible to the researcher, as well as others, to scrutinize afterwards. I claim that the categories and the items in the Variable Template for Factor Analysis (appendix 1) I outlined in a pilot study may be regarded as bracketing, which screened my preunderstanding as to what I would consider as a sign of progression in the therapy.

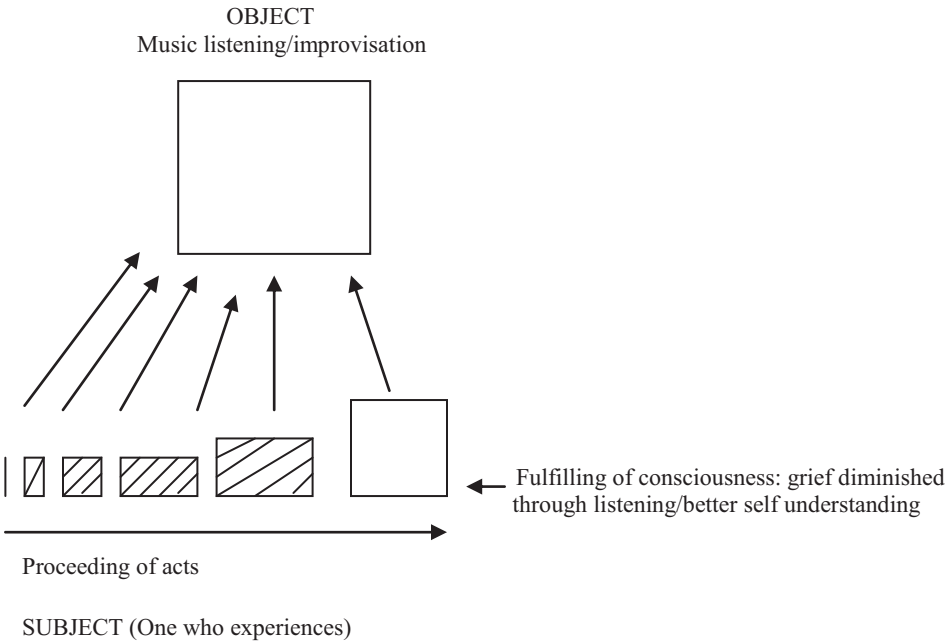



Figure 1. The nature of knowing as acts in music therapy (modified from Rauhala, 1974, p. 56–57; figure cited from Alanne, 2002a, p. 54).

From the perspective of the holistic image of man, the Body refers to the organic area of an individual: the brain, the organs that adjust the functions of the system, the genes etc. It is then possible to study how music affects brain functions and systems. Has music a stimulating or relaxing effect on a biological cellular level? How do our genes correspond to our musical experience or knowing? Evidently, I assume that the organic being of an individual provides the boundaries for experiences, perceiving and also meanings, whilst I postulate that meanings in themselves belong to the dimension of the Mind (Rauhala, 2009a, pp. 274–275). Therefore, such phenomena that relate to an individual experience, and how the meanings are achieved, belong to the area of the Mind and thus should be studied using the terms and methods adequate to it, garnered from human and behavioral sciences. It is possible to study bodily experiences using natural scientific methods and positivistic terms through measurements and the use of a test–hypothesis research design. However, from the phenomenological and the individual points of view, that would mean reducing the human being to one dimension of its being and so it would also mean over simplifying the complex human situation that may be scrutinized on many levels. Music is also, no doubt, a physical phenomenon and affects the human body and brain in addition to the Mind.[21] Therefore, the

[21] See the chapter 3.4 Music as Torture, Violence and Manipulation for evidence of how music and sounds affect the Body.

Body dimension of being may also be considered and focused upon in research and therapy. For instance, in treating traumas with music, the relaxation and pleasure music brings has its own important meaning in music therapy, helping to revitalize the patient`s experiences and meanings.

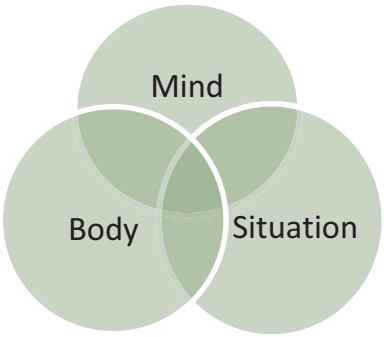



Figure 2. Holistic Image of Man (Rauhala, 1983)

In music therapy, Ruud (1998) has had analogous opinions as to how music and identity should be conceived as parts of various aspects of being, such as the organism, the person and the social – which are interactive. This facilitates the conception that identities may fluctuate, and therefore be played with, during music therapy improvisations. I argue that this relates to the Situation of music therapy improvisation and its previously mentioned dynamic/symbolic forms, where the meanings and experiences derived from the music arise from the interaction between the therapist and the patient, for example. There are also other theoreticians in music therapy with similar holistic conceptions of music and being, like Bruscia (1987) who applies existential analysis to the psychic, physical and social aspects of being in his Improvisation Assessment Profiles (IAP).

From the research point of view, this research`s methods do not reveal the possible effects of music on the brain and the system, even though evidence for its potential efficacy from the perspective of brain research has been described in other studies (Swallow, 2002; Rose, 2004). In order for it to have been possible to conclude something concrete concerning the brain, I would have needed to apply one of the following brain imaging research methods: Positron Emission Topography (PET); electroencephalography (EEG) – to screen for miss–matched negativity brain responses; magnetoencephalography (MEG) or functioning magnetic resonance imaging (fMRI). These are examples of methods which are currently used to research the brain and its potential involving music (Tervaniemi, 2001; Flohr & Hodges, 2002; Särkämö, Tervaniemi et al., 2008; Lerner, Papo et al., 2009; Peretz, Brattico et al., 2009).

Therefore, I have to admit that even though the possible positive effect of music on the body has been one of the premises of my clinical work and the research, it has not actually been studied. The body dimension idea propounded by Dasein (Being There) has been in the therapist researcher`s mind as one possibility affecting the patients` situation. Information about the perceptions and experiences gathered through the dimension of the Body has only been obtained through how the patients themselves have described their situation and how

the therapist has interpreted the patients´ experiences: For instance, a patient may have taken up a relaxed position, calmed down, or said that s/he felt good. My intention as a therapist has not been to treat patients` brains with music or their other physical symptoms either. However, I have considered that it may be possible to indirectly affect this aspect of being, the organisms of the patients, which I assume Rauhala (1974) has earlier described as "organic understanding" in psychotherapy; how injury to the brain affects the organic situation of an individual (pp. 149–150).

I assume that in the research on torture survivors and their treatment, it is important to consider the patients´ physical injuries and the pain relating to them as part of an organic situation that music may relieve momentarily through psychotherapy. These physical traumatic experiences, and organic illnesses and injuries, are also good to keep in mind during psychotherapy because they form the bodily self-experience of a person and how they feel about themselves situated in their bodies and flesh respectively. Their causes, what happened and why, are intended to verbally and cognitively process their trauma because it is possible that torture survivors may have to live with these injuries throughout their lives. Sometimes the pain is a way of expressing psychic anxiety. Then it is important to listen to the patients and what the pain tells about their lives. In speech, words like "heart" and "blood", relating to the body, may be metaphors of loss and grief. Traumatic injuries, like scars, are also historical organic Horizons in their experiences, which will remind them of the torture. (Arcel, 2002; Ruuskanen, 2007.)

In practice, I noticed that these physical traumas are at least part of the background of a torture survivor`s music therapy. Patients cannot talk on any other themes than continuous pain and insomnia, for instance, which will be illustrated in the case studies. It may even be impossible for the patients at times to create imagery or meanings other than perhaps, for example, that one has a severe headache all the time and eventually cannot think of anything else but the physical discomfort, or describe themselves in any other way but through their pain. I assume then that one is on the edge of the Body and Mind world of experiences – where traumatic experiences manifest themselves as physical effects and experiences, or annoying feelings which have no clear image or meaning. However, I postulate that these experiences relating to the physical aspect of being are not completely "senseless", even though they may not have clear symbolic or verbal representations. I think of them as fragments of the Mind, *sensations*, that are not integrated yet, which, in the phenomenological act of knowing, are referred to as *noesis*. From the psychological aspect, these experiences may be scrutinized using cognitive concepts like knowing and memory, as well as through the use of psychoanalytic terms like unconsciousness, defenses and the resulting symbolic processes. As shown earlier, these symbolic processes – what is known or experienced through arts like music – may also have a bodily concordance in the structures and systems of the brain (Rose, 2004).

Merleau-Ponty (1945/1994) argues that individuals constitute their world of experience through their bodily being. According to him, individuals are always in a relationship with the world via their bodies and senses, which is the way in which their individual situations become disclosed. To give a simple example, he uses the illustration of how through looking into another person`s eyes, we become attuned to the world in a different way than we would

if we were gazing into the eyes of a dog; the gaze of an unfamiliar person may be seen as disturbing, but it would be unlikely that we would find a dog`s gaze so. On the other hand, the utterance of a stranger, some word or gesture, could make us feel relaxed and we could, perhaps, open ourselves up to a discussion with him/her because we feel that we are familiar with the Situation and the human voice through our bodily preunderstanding of human relationships. (p. 361.)

I assume this same phenomenon also relates to communication between adults and babies, where there is a lot of non-verbal communication like gestures, uttering and movement. Taking care of babies, communicating with them, talking and playing, is usually a natural human behavior that only in especial circumstances needs to be taught or guided. Similarly, we are able to perceive easily without words if someone is angry, glad or sad; it is possible to tell from the look on a person's face, so that we may feel stressed, excited or relaxed in the company of another. For instance, through our sense of sight or hearing, we immediately connect with another person and understand, with the help of our own bodily existence or memory, that we have met someone who is suffering; we notice that s/he is feeling pain because we too have felt pain in our lives through our bodies. We feel pain with our flesh because it is the living body which manifests suffering, as described by Henry (1999, p. 358). Therefore, I postulate that it is possible for us to notice if another person feels pain or is happy through our visual sense, whilst we do not experience the pain ourselves. In fact, recent brain research has found evidence that the same areas of the brain are activated in the examiner as in the patient. (Ruuskanen, 2007, p. 491).

I assume that the same also applies to relaxing; we are inclined to notice if someone is relaxed merely from their gestures, position and looks – their physical appearance. We gain from our existence in our own bodies – our heart beats, the frequency of our breathing – the knowledge of how it feels to be relaxed and comfortable, and hence, how that feeling appears. Another person seldom has to confirm it; rather, we might even think the opposite from verbal reassurances. I assume that we attune ourselves with our body and senses to the being of another without even consciously regulating our minds. Therefore, meeting an angry person may make us feel nervous and easily stressed. This relates to the aforementioned flight or fight reaction in the brain, and how our senses may provoke the amygdala to produce the adrenocorticotrophic (ACTH) hormone in the autonomic nervous system (Rose, 2004, pp. 121–122).

I think this is also related to affect attunement, cross-modal perception and the vitality affects that Stern (1985/2004) has studied with infants and their mothers. He describes in his observation how mothers emotionally attune themselves to their babies cross-modally by voice, nodding, smiling and bodily expression. For example, one mother related to the excitement and joy exhibited by her nine month old girl upon grabbing a toy, saying "aaaah", looking at her mother and simultaneously shimmying with her upper body like a go-go dancer. (pp. 140–141.) I suppose that music may also be concerned with representing the "uttering" and sounds that arise between two unfamiliar people – the therapist and the patient – opening up possibilities for natural contact and discussion.

Mirror cells, (or mirror neurons), are one of the recent findings of brain research, stemming from an accidental discovery made during research with primates: It was noticed by Giacomo Rizzolatti, Leonardo Fogassi and Vittorio Gallese that some of the neurons in a monkey`s brain would respond when it saw the researcher reaching for a banana. Afterwards the same phenomenon was also found in the human brain, which may explain why infants learn from an early age through mimicking different faces, for example. There may be a relationship between mirror cells and musical imagery as it has been noticed that the visual perception of playing an instrument awakens physiological hearing responses in the brain. From music therapy conducted with patients suffering from Parkinson's disease, it has been observed that music, such as singing with its rhythmic element, activates the motor cells of these patients and thus enables them to walk. Actually, they have been observed as being able walk even when they have just imagined the music. With Aphasia patients, music and movement, gestures, prosody and physical contact in tandem with a therapist activates mirror cells, which eventually may enable these patients to talk more and to incorporate the actions of others, rather than just imitating them. Levitin (2007) assumes that mirror cells may explain why music moves us emotionally and physically. He also speculates, in accordance with some neuroscientists, that this physiological information about mirror cells may be of importance concerning music and leaning an instrument, although there is no solid evidence as yet. (Swallow, 2002; Levitin, 2007; Sacks, 2007; Hyyppä, 2009.)

It has been also suggested that humans recognize the intentions of other people through the use of mirror cells, which I consider to be in accordance with the phenomenological conceptions of perceiving that Merleau-Ponty (1945/1994) has described.[22] In fact, as described in the original discovery of mirror cells, these brain responses do not seem to be species specific but may also relate to relationships between a man and his dog, as well as other animals. In the light of mirror cell research, human brains seem to react continuously to our perceptions of another person`s emotions, purposes, movements and gestures. Therefore, it seems also that our bodies actually know before we are aware – from perceptions, sensations and meanings (noema) – what we are going to think and feel. From the cognitive respect, our knowing appears to be occurring on the border between implicit and explicit knowledge. Considering psychotherapy, mirror cells and this type of bodily knowledge are interesting in relation to dealing with the counter emotions and transference that therapists study in themselves. It seems to support the relevance of such intersubjective experiences as sources of information, from the clinical perspective as well as from the respect of research. I assume that in music therapy, the therapists' counter emotions may even be incorporated or embodied in music when therapists play an instrument and reflect with their patients. Greg Corness (2008), has suggested a similar relationship with our bodily knowing of listening to music and has discussed its relationship to mirror cells and the philosophies of Heidegger and Merleau-Ponty. Ruud Welten (2002) has also discussed the corporeality of music, citing Henry (1990/2008), as to how music is born from the pathos of life. According to Welten, music is not an entirely intellectual pursuit, nor is it purely a part of the material or spiritual world, because it is our body that is always the subject and object of an experience. We are in a relationship with music through our bodies; through

[22] The most recent brain research has directly recorded mirror neurons in humans and the results show that these neurons reflect the perceptual and motor aspects of actions, including hand grasping and facial emotional expressions (Mukamel, Ekstrom et al., 2010).

feeling, hearing, playing and moving. This adds one more important source of knowledge as to how music psychotherapists can analyze transference and counter emotions embodied in music; how we are moved by the music of our patients. (Syvänen, 2005; Dillard, 2006; Nygaard Pedersen, 2006; Enckell, 2009; Lehtonen, J., 2009.)

Table 2. Music considered from the holistic point of view. (Alanne, 2002a, p. 62.)

| THE MIND | THE BODY | THE SITUATION |
|---|---|---|
| Experiencing music psychically: emotions, meaning, imagery, language etc.<br>Symbols, unconsciousness, consciousness, transference, defences.<br>Memory, learning, thinking | Sound as a physical phenomenon: sound and music as vibrations.<br>The effect of music for the system, perceiving and producing of music physiologically etc.<br>Instruments, recordings etc.<br>Genes | History and aesthetics of music, diverse cultures, values, beliefs of music.<br>Music theory: norms, scales, styles etc.<br>Individual experiences relating to music in the various phases of life<br>Music education and hobbies |

As presented here in the holistic image of man, the Mind and the Body are not considered as separate levels of being; rather, they have an effect on one another. On the other hand, neither are they considered as different dimensions of the same being. Therefore it differs from the *Cartesian error* in the dualistic image of man, where the Mind and the Body are divided from each other; they are either considered to be completely separate phenomena or two different manifestations of bodily being. The latter point of view is presented, for instance, when it is proposed that the Mind and the brain are the same thing, and that it is the brain which contains and produces all meaningful experience. Usually this hypothesis also includes the idea that these meanings could perhaps be traceable in the brain if only we knew the "code"; how they are "recorded" or "restored" in there. We would maybe then be able to discover where the Mind exits or the *homunculus* is located in the brain. Thus, the word "brain" could be replaced with the word "machine" in such arguments because they literally come close to other mechanistic conceptions of consciousness where the machine has also got a soul or a spirit. Instead, I postulate that the Mind and the Body are in interaction with each other in psychic disorder, or musical experience, for instance. I assume that brain research previously presented on thoughts, imagery, emotions and music suggests this. Using such a frame of reference, it is considered that psychic disorders could possibly have an effect through both the Mind and the Body. Senses (noema) and meaningful experiences are thought to arise from the interactive processes of the Mind, the Body and the Situation; one needs to be aware, however, that bodily being should be considered as a primary condition of being in order for individual experiences and meanings to emerge. Another premise in this research is that the being of an individual is considered to be affected by the culture in which s/he lives and how her/his personal existences have been constituted in her/his social environment.

An individual is considered to be here an historic person, which consciousness and the world of experience has constructed from personal experiences like education, studying, career choices etc. as described similarly by Merleau-Ponty (1945/1994, pp. 416–417). Self-experience is continuously reconstituted and is formed from many timely layers of

being. Thus the concept of "Mind" contains all this self-experience, along with all the historical–cultural structures that are related to one`s thought and being in general. These layers and structures may be conscious or unconscious. To conclude, we are in the world and not outside of the world looking in. (pp. 346–347.)

Such thoughts are based on Heidegger`s (1927/2000) existential phenomenology where he scrutinizes the being of an individual in relation to time. Time provides the being with its ultimate borders and terms within which the being itself is always constrained. From the respect of an individual`s experienced world, this implies that how we perceive the object and what meanings arise in the subject from the object is not only dependent on the individual, but also that meaning arises from interaction with the being. The being is in a situational relationship with time. Thus, the meaning of the object is not derived from the object as it is perceived and the being itself does not dispose to an observer as it is, even with critical scrutinizing or Cartesian systematic doubting. On the other hand, the meaning of an object does not disclose itself completely from the individual`s preconceptions, either with free observing, introspection or the bracketing (epoché) of earlier experiences. Earlier phenomenological thought considered that, with bracketing, it would be possible to find a transcendental truth or the essential meaning of a phenomenon (essence). Heidegger`s fundamental analysis, as he himself described it, goes a step further as he continues to scrutinize phenomena according to their ontologies and considering how being discloses itself in existence. The being constructs itself from *things* (Ding), which have their own ways of being.

For example, music includes various factors, principles, rhythmic patterns, melodic figures and harmonic orders. So that these musical Things would be music, they require the Mind of the subject to receive and create music. Therefore, music in a way is "reborn" in the listener`s mind, and how this musical experience discloses itself to us is dependent upon our earlier experiences; our preunderstanding of music and what kind of music we are familiar with. What we prefer to listen to aesthetically is also dependent on the period and culture in which we live, and may vary according to them as well, as was seen in the research on refugees discussed earlier (e.g. Reyes, 1999). What is considered as good music may also vary. Music is also utilized in the torture process to make the torturer`s job easier and to camouflage its noises, as was more thoroughly described earlier. It has also been described, with reported examples from many authors, how music continues to have a part in violence, manipulation, propaganda and torture, even in the present day. Torture survivors, including my former patients, have reported that in prisons music was played continuously, so that the prisoners were unable to sleep or communicate with each other. The music applied may have been patriotic march music played with the intention of manipulating or brain washing and breaking down the prisoner and his/her identity. After such circumstances, listening to music and enjoying it later in life may be difficult because former musical experiences and associations are so strongly connected to traumatic experiences.

Therefore it may be difficult to achieve pleasure from music, and listening to it does not feel safe anymore because it brings forth annoying feelings, imagery and memories related to the torture suffered. Then, the individual`s former musical experience and conception of music have changed in relation to time and their experiences in their *situation*. Music does not

disclose itself only as a mere pleasure bringing Thing, but becomes anxiety and discomfort provoking, whilst the music itself has technically, and as a *given* (Vorhandensein), remained the same. However, in the individual`s world of experiences and as it is perceived, its meaning or *import* – as proposed by Langer (1953) referring to the emotional content or ambience of music – could be different. In the case of music, the context where music is heard or performed, affects how it is experienced. A composer may have meant or hoped that his/her music would bring positive thoughts and aesthetic beauty to the world, but when it has been played to manipulate and cheat prisoners arriving at concentrations camps the meaning and function of it has altered (Echard, 1991/2001; Moreno, 1999).

Heidegger (1935/1936/1998) refers to arts like music and their capability to open new worlds, experiences, and point of views, as being what discerns works of art from mere artifacts or Things. For example, a shoe is not a work of art because it does not evoke an artistic experience in itself, but is instead closer to a mere Thing, just as stones or sand are material Things. Also, not all musical Things, such as the sounds of music and instruments, individual notes, confounding noises like feedback, the tuning of a guitar, the clanks and bangs of drums, are automatically considered as music or art. Music history is full of attitudes toward new or modern music and commonly known examples of this manifestation of a situation in music cultures; each culture has its own ideas as to what kind of music, scales or instruments are good for the people. Examples can be found from ancient Greece and Plato (1933 pp. 122–130) to today's rock `n` roll, and its offspring heavy metal, which is claimed to ruin the youth or to be a sin (LeVine, 2009).

I postulate that this makes music as a phenomenon a very complex experience, which is affected not only by the culture and history we live in but also by our personal history and former experiences. Biologically our senses, genes, capabilities to produce and understand music and be creative may affect it as well; these could include things we may not even know, or cannot be absolute sure of yet, as shown in the latest biological research on musicality and genes (Ukkola, Onkamo et al., 2009). This raises interesting questions, especially considering music psychotherapy and how bonding/attachment behavior and creativity may be influenced by music, because there also seems to be a neurobiological relationship to our genes (ibid.). However, even in light of the latest biological research on the brain and genes in music, it seems to me quite impossible that the human situation, with its many layers of individual experiencing and time modalities and the possibility of its being affected by history, culture and society (Horizon), could be reduced to a biological cell or the level of a gene – even though biology may reveal to us more about the nature of our very being itself and its many possibilities for Dasein (Being There), too.

Some readers may wish to consider the spiritual aspect of our image of man. I have been aware of it and do not deny its importance for humans, as can be noticed from the discussion in previous chapters relating to culture, music, therapy and spiritual healing. The meaning of religion as an existential dimension for severely traumatized patients arises also in later case studies. However, spiritualism in itself, as relating to music therapy, its clinical methods and theorizing, has not been the scope of this research. In my conceptualization, spiritual phenomena, including different forms of religion, as well as atheism, are considered as manifestations of the human situation. In the next chapter, I shall explain and argue more

thoroughly what hermeneutic phenomenology has meant for my research in practice.

### 5.2 A Holistic Image of Man from the Clinical and Research Points of View

An image of man is frequently personal and is partly based on various theories, philosophies, religious or spiritual views, values and individual backgrounds and experiences. It differs from the concept of man, which is the scientific picture, or explanation, of humans; what is known about humans according to different sciences. Thus, an image of man is a general conception and knowledge of what we know from the physical development, health, biology, psychology etc. of man. An image of man affects how clinical work and research is done. It influences primarily how we see, and what we assume, mental disorders to be in their nature for instance. Are they biological illnesses or are they relating to the dynamics and relationships between family members, for example? From the research respect, the philosophy of science – metatheory – in clarifying what the image of man may represent helps us to choose the right and adequate methodology for the research. It may aid us in answering questions, just as the measuring methods of natural sciences are needed when studying the brain, or depicting qualitative methods are required when the therapy interaction is investigated. Sometimes research objects may require the application of both quantitative and qualitative methods as well as their different combinations. In many research projects today, they have been entwined in those situations where they may support each other and guide the research forwards (Brannen, 2007). I postulate then that it is the philosophy of science which is important to consider, and how the researcher therapist sees the research object and is able to combine the knowledge or data provided in its frames.

In my music psychotherapy practice with torture survivors, I had to consider the Mind, the Body and the Situational aspects of the Holistic Image of Man. I felt this to be a natural and an adequate point because they all manifested clearly in the treatment. Torture may be physical, psychological or targeted as social, cultural or ethnic humiliations and manipulations. It may even leave lifelong physical injuries, like scars and pains. They affect also the individual`s psyche and may manifest as insomnia, depression and concurrent repulsive thoughts of traumatic torture experienced on a psychic stage. Also, social and cultural circumstances are emphasized because frequently torture survivors are refugees and asylum seekers. They may have been bound to leave their countries, families, social networks and their own cultures. Their life situation has altered suddenly and completely, and this may in itself affect the individual as traumatizing. Asylum seekers have to try and adapt to their new environment and culture. In practice, all these issues are reflected in the rehabilitation and music psychotherapy of torture survivors. This makes the role of the therapist and the therapeutic situation different than with other patients. It is also common to employ an interpreter in psychotherapy and in other treatments as well, they have been used with traumatized children in music therapy at the Pavarotti Music Centre in Bosnia (Jacobsen & Smidt-Nielsen, 1997; Lang & McInerney, 2002). In the rehabilitation of torture survivors, the object of psychotherapy is the Mind whilst physiotherapy is targeted at somatic pains and a social worker may used to help find an apartment and affect the patient's social circumstances, as simple examples. However, all these phenomena may be reflected in music psychotherapy, so to limit their access to outside therapy would also mean setting boundaries for patients` experiences and their processing, particularly where the worries and

anxiety arise.

**The Mind – Psychic**

From the perspective of clinical music psychotherapy, music may create new meanings and experiences for the patients and therefore may perhaps prevent their compulsive thoughts. Music may raise positive imagery and so cheer up the patients, providing empowerment and hope, as was noticed during earlier experiences of music therapies with traumas. It may also help in grieving. Music may create reciprocality and communication between the patient and the therapist and thus increase verbal processing and the sharing of problems. It may be possible to find words, metaphors and images for anxiety creating experiences, fears and continual feelings of depression. Music may function as an auxiliary tool or praxis for the therapist in helping the patient to cope and control unbearable feelings and intrusive thoughts, flashbacks and memories of traumatic experiences. I also assume that listening to music may exercise the capability to concentrate, as well as other cognitive functionings. I suppose that these psychic rationales of music therapy, with variations, are quite common among music therapy professionals. Why would one bother to do music therapy if one did not believe in his/her methods?

**Situation – Social**

From the research, and even from the clinical respect, therapy does not always proceed as in a text book, which may be easily seen from the later cases presented in this study. Therefore, it is the human situation, which Rauhala (1974; 2009a) has described as the *regulative situational circuit* in his conceptualization, that makes, with its many layers of personal Horizons and its constitutions of acts in their knowing, an individual experience unique. To not see what we want to see, i.e. to avoid circular reasoning, the therapist researchers also need to adopt the doubting and questioning attitude of hermeneutics to bracket their immanent preconclusions about music and therapy. After this, alongside "testing" their assumptions using other methods and theories, therapist researchers are on firmer ground with their comprehension of a situation, which may also match well their former preconclusions (hypotheses). In music therapy, Lehtonen (1993; 1996) has referred to Heidegger`s phenomenological destruction as being the researcher`s general attitude. However, phenomenological reduction and hermeneutic doubting already had their roots in the systematic doubting of Descartes (Husserl, 1995). In respect to questioning reality and the truth, their starting point can be found much earlier in the Platonic dialogues of Socrates, which represented dialectic (Cassirer, 1944, pp. 4–5).

From the social aspect, music represents the possibility of interaction between people and the chance to reflect upon traumatic memories and experiences. It forms a mutual factor between the therapist and the patient, which enables communication, emotional expression and the sharing of thoughts without language. In musical interaction, mutual listening to music also presents the possibility of getting to know the other person, or a different culture, and so to help patients to adapt to a new life situation. I assume that music may hold the therapeutic situation and the feelings involved in it, and bring feelings, thoughts, imagery etc. forward and thus help push more negative or compulsive thoughts aside. If former

experiences can change in the therapeutic situation using music, then it is possible for corrective experiences to occur in one`s mind.

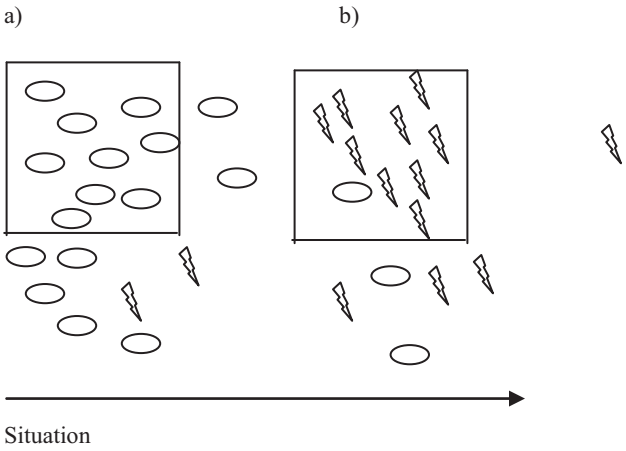



Figure 3. An abstract presentation of a torture survivor's changed experience as to how s/he relates to music: a) an earlier conception of music as embodied with pleasure b) a later conception of music that hurts as *things (*Alanne, 2002a, p. 52).

Even the general attitude towards music may alter in music therapy so that music does not appear as threatening anymore and the traumatic experiences it may give rise to in the Mind disappear. In my experiences, a patient that has not been able to listen to music anymore, or sounds/voices in general, because it has been present in his torture may bring forth fear reactions, but after music therapy his capability to enjoy music may have returned. One function of music therapy, or even a goal, could be to try and return the pleasure music naturally provides because I postulate that losing this capability is a part of the individual`s trauma. With torture survivors, the "losing" of music may be considered to represent also losing their humanity and personality , especially if an individual has enjoyed music before or it has been his/her hobby.

**The Body – Organic**

From the bodily point of view, music as a physical phenomenon also effects the system and its functions. There has been knowledge of the physiological effect of music for over a century, showing how it may slow the heart rate and other vital system cycles. The latest information on arrhythmia and electrophysiology has sharpened this knowledge of how listening to various rhythmic phrases and crescendos are synchronized with autonomic responses in the system and thus may convey their arousal (Bernardi, Porta et al., 2009). Therefore, it is adequate to assume that if an individual in his/her world of experiences relaxes and calms down, it may happen also on a physiological level. I postulate that relaxing is a psycho-physical phenomenon and it may also have meditative, releasing of thoughts, aspects. I also assume that the aforementioned music`s capability to increase the amount of endorphins and decrease stress hormones, helps with relaxation and pacifying in that respect. Therefore, it may be possible to shape and alter the conditionalized responses of

the amygdala and its stress reactions. In torture survivors` therapy, the physical and the psychic join together in an experience because learning to relax and become calm involves both the Mind and the Body. For torture survivors, anxiety and fear appear as powerful physical symptoms, which are similar to panic symptoms, related to an arousal in breathing and heartbeat. Similarly, the experiencing of pleasure is a psycho-physical phenomenon like pain when it is assumable that music may aid in relieving the pain to some degree.

Bearing in mind current knowledge in neuroscience about the flexible brain and mirror cells, music seems to connect neural circuits between the hemispheres of the brain and its structures. For example, there are the aforementioned clinical observations from aphasia patients and those suffering from Parkinson's disease detailing how music may help them to use words and move. Rose (2004, pp.78–80) has proposed that music seems to work as a "temporal prosthesis" for sundown syndrome and other dementia patients, returning their capacity to function, walk, talk and memorize things, as well as be present . When music such as Bach, Handel, soft rock or country rock has been played to them, and the TV has been turned off, sundown syndrome patients have been observed to calm down rapidly; perceptual disturbances like illusions and hallucinations, as well as emotional disturbances like fear, anxiety, paranoia, confusion and agitation, are lessened. Rose postulates that music, as an art form of time, provides these people with a sense of time flow in their brain functioning, concretely wiring separate neural circuits together and synchronizing them. (pp. 87–88.) It is an interesting idea how the past, the presence and the future as modalities of time may have a physical equivalence in our brain functioning and music. Heidegger`s (1927/2000) philosophy of being and time, and Merleau-Ponty`s (1945/1994) view on their relationship with our bodily being and perceiving, seem to be very relevant in this context. Contemporary neuroscience, with its recent findings, actually seems to concretely support the idea of music being a physical Thing as well as discloser of the world of possibilities in our timely being. (Swallow, 2002; Levitin, 2007; Sacks, 2007.)

**Research Approaches**

As I have mentioned before, methods have not been employed in this research project that would screen or measure the functions of the system or the brain. It is possible to observe emotional changes in the brain and one can study relaxation through measuring blood pressure, for instance. In addition, one could investigate, through the use of questionnaires, how relaxing, pacifying, pain killing or stress reducing music therapy is. However, these were not my actual research questions, so there was no intention to quantitatively measure them. Instead, I have trusted the therapist`s and the patient`s own subjective observations, experiences and evaluations of their feelings of relaxation and sense of tranquility. In this aspect, the therapist`s countertransferences from the patients that were used in the psychodynamic music therapy research previously were helpful. (Syvänen, 2005; Nygaard Pederssen, 2006.)

One objective measurement has been made through the use of psychological questionnaires, which have enabled the evaluation of subjective interpretations afterwards, which may support or reject the therapist researcher`s conclusions and hypotheses. Similarly, factor analysis has been applied to aid in explaining the therapist researcher`s and the patient`s

experiences and qualitative describing of music therapy. This has been made to lessen subjective errors and wrong interpretations respectively. With both the psychological questionnaires and the factor analysis of the qualitative data, I have tried to achieve more objectivity in my research, since I have been both the therapist and the researcher. This does not mean that with quantification I would have reduced and made into artifacts (objectified) the typical qualitative data and descriptions of lived experiences like human dialogue, interaction, experiences, meanings and thoughts. Rather, my purpose has been to study through *triangulation,* i.e. applying various methods as to how qualitative phenomena and descriptions in themselves, which are based on the subjective interpretations of the patient and the therapist, manifest on a quantitative level (Lincoln & Guba, 1985, pp. 305–307). Simultaneously, an individual is still tried to be understood as a whole according to the holistic image of man, thus returning the achieved data to the hermeneutic spiral and understanding.

I shall clarify the issue with a simple hypothetical research on houses. We could count how many red, blue, green and houses in other colors exist in one particular area. From the research point of view, it would not be enough to conclude that there are red and blue houses in that area. More information would result if one would count how many houses there are of similar color and what would be their numerical relationship. One might conclude from this, and from the relationship between different styles of buildings, something important and essential about how people have lived during that particular time, decade or century. One might also learn something about their culture, architecture, aesthetics, what colors have been used and how people in general have lived. With this simple and concrete example, I am trying to suggest that a phenomenon including human experience and meaning may consist of both quantitative and qualitative aspects. I assume that sometimes it is adequate, and even required, to study both sides of a phenomenon, so that a trustworthy enough conception of the researched phenomenon would be achieved, revealing how it manifests itself and how common it is. If I can observe in myself, or in another, an experience and provide it with meaning, then I should be able to index the point at which it occurred, when it might also be possible to quantify.

This research`s basic question is how music therapy could help torture survivors; i.e. how it affects them positively. In fact, the structure of the question is in itself quantitative or positivistic: how does the change manifest in them? In clinical music therapy and in psychiatric treatment generally, the progression of treatments is continuously evaluated. Frequently, conclusions are made from the appearance of specific things happening in the patient`s life, such as fears decreasing, feeling more cheerful, and relating to other people, among many other things. Treatments are evaluated professionally, focusing attention on positive or negative changes in patients. In clinical practice too, when the outcome of some therapy, treatment or rehabilitation is evaluated, it is not usually one experience or observation that is trusted, but a longer follow-up is required showing how frequently positive or negative behavior or reactions occur. Then it is clearer that some change towards the positive or negative has happened and how durable that change may be. Frequently, the opinion, observation or experience of one worker, like the therapist or the patient him/herself, is not enough but equal feedback from other workers and the team is needed, for example, from a doctor, a teacher or parents etc. Therefore, I postulate that in clinical

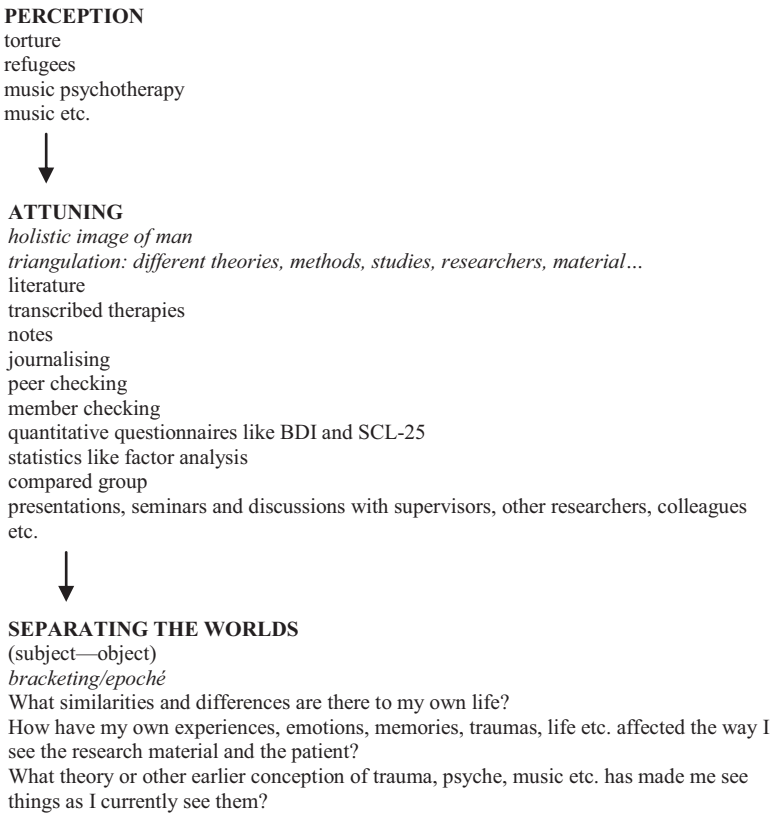
practice the quantifying of qualitative situations and meanings occur too, even though they may be partly unconscious or unintentional. One might call it triangulation in clinical work when experiences, observations or opinions from a patient are shared with a rehabilitation team.

In this research project, my objective was to collect data from many sources simultaneously and thus validate my observations. With this, I have tried to correspond to the challenges and requirements of modern humanistic research regarding my research`s validity and reliability. However, I do not use the term "reliability" because my research is not a hypothesis–test design in the natural science sense, and in my hermeneutic context there is no need to actually repeat my research process. My goal has been to achieve relevant data, which has not been distorted by subjective misinterpretations. At the same time, the purpose of the factor analysis has been to ensure that the achieved results would be sensible and consistent, comparable to the concept of "validity". In other words, the intention of this research is to describe issues as truthfully as possible so that somebody else with similar approaches and methods might achieve analogue experiences from music therapy with torture survivors. I shall evaluate the *trustworthiness* of this research instead of its validity and reliability according to the terms of the *naturalistic paradigm* at the end of this book (Lincoln & Guba, 1985). A natural paradigm provides one alternative research methodology for the positivistic paradigm in social and psychological sciences.

Taking the holistic image of man as my philosophy of science has enabled me to divide various phenomena into preliminary categories, which has made it possible to apply quantitative and qualitative methods in the same research project. It has guided me and provided me with a preunderstanding of what kind of phenomena they are and how they should be approached in therapy and research. My intention has been to achieve a wider and more truthful view of torture survivors` music psychotherapy, so that individual experiences of patients do not vanish. My objective has been to disclose wider relationships through individual experiences and idiographic knowledge interests, and I assume it is possible to scrutinize the whole studied phenomena from the Situational perspective. What do different issues, qualitatively and quantitatively observed experiences, add to the total view of studied phenomena while considering it from the individual patient`s point of view and from the higher metatheoretical stage? My principle has been to reach and make visible the subjective view of therapy patients, even though there have been quantitative and evidence based objectives and a pressure to demonstrate how the progression of music therapy/treatment manifests itself. The subjective point of view is usually lost or consciously faded into the background of the general numeral data in pure quantitative and statistical research. Instead, in this research the quantitative data and calculations are returned to the hermeneutic circle to provide more understanding without forgetting self-experiencing and the naturalistic situation. The research process is focused and returned from the general knowledge, nomothetic knowledge interest, to individual therapies that can be qualitatively described.

## 5.3 The Hermeneutical Core in Practicalising the Epoché and Clinical Research Methods

The nature of my research is hermeneutical in the sense that it tries to understand the human being and the phenomena investigated as thoroughly as possible. This kind of study avoids over explaining phenomena and situations, but instead depicts and interprets them from the subjective point of view. From the hermeneutical point of view, the objective truth is not even possible but the theories and the conclusions of researcher result from the interpretative work s/he does during the research. This interpretation is always with the researcher when s/he chooses theories, methods, and hypotheses at the beginning, and again at the end when s/he reports on the conclusions, results and meanings of the research. At the core of the existential phenomenological research is the hermeneutical circle, which is several continuous circles or a spiral, rather than a "vicious circle". In the next figure I depict the epoché, or the hermeneutical circle, beneath my research and how it has affected my choice of research methods, theories and viewpoints in regard to my patients and research. The hermeneutic circle may also include measurements and tests, as in this research. However, I have to address here that it is the complex totality of the whole and the holistic interpretation of the research data and methods which have affected one another at every phase of this research. There is a long chain of subjective interpretations gathered from diverse data starting from the very beginning with me being my research participants' therapist. (Varto, 1992; Aigen, 1995.)



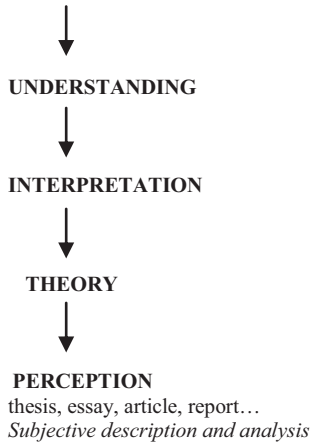



Figure 4. The hermeneutical circle at the core of the research and the practical application of epoché in its methods. (Continues)

This application of hermeneutic phenomenology in clinical research methods has some similarities to the operationalising of hypotheses in a quantitative or positivistic study. However, I would rather name it as *practicalising*, so that these two concepts would not be confused with one another. In the end, they come from different frames of reference and whilst they may look similar they are in fact opposite methods. Operationalising aims to form research questions and procedures from theories and hypotheses that are possible to study using test methods. Even though the researcher`s preconclusions are considered while making a hypothesis, the operationalising and the test are thought, as far as possible, to provide an objective result. Things and phenomena are considered as being seen and studied as they are and as they appear; interpretations are avoided or are kept to a minimum.

However, from the hermeneutic phenomenological point of view, this is not possible as the human mind is always shaping our perceptions and our ideas about the world. Our experiences of the world are our own subjective impressions of the outside, the other or the real world, as we experience them. According to Heidegger`s phenomenology, the discussion on research enframes the research – making it an object. It becomes preunderstanding. This happens with *Logos*, which here means discussing, or verbalizing the being. In every discussion of being (Logos), the being has already spoken to itself, which makes it a *Categor*y. A category is being as it already is, and it shows itself to everyone in its being. However, Dasein is being in an existence, in experiences with a world, and so it cannot be known beforehand nor can it be categorised. This makes the operationalizing of positivistic science radically different from rigorous hermeneutics in that it goes beyond categories – "to things in themselves", as Heidegger puts it. (Heidegger, 1927/2000, §7, p.50; §9 pp, 69–70.)

When phenomenological researchers begin their clinical study they have to bracket their preconclusions regarding the phenomena. In the first phase, this process produces the research question(s). In a clinical study these questions, dilemmas and preconceptions of the researcher must have some kind of practical form, allowing the researcher to progress in the

study. This giving of names and actual purposes to preconclusions, theories and clinical methods, I call *practicalising*. It is also similar to *thematising*, which again makes it similar to the aforementioned categories and *categorising* in qualitative research (Varto, 1992, pp. 50–51). However, I assume that this is a natural and essential part of any scientific research or philosophical analysis because language is a method of approaching our being-in-the-world. Language is one scientific method, just as music is a method employed by a music therapist or musician. They are Things or *Pragmata*, methods of praxis in a caring (Sorge) relationship with the world. (Heidegger, 2000, §15, p. 96.)

At a clinical level, practicalising should aid in the understanding of phenomena and human experiences, making it easier for researchers to bracket their former conceptions of the phenomena. In a way, it makes the part of epoché concrete and visible; however it does not make it in any way perfect or absolutely objective. This is not even the purpose of it, but to help the researcher to see the studied phenomena from many points of view, *triangulation*, and to understand them better (compare Lincoln & Guba, 1985). For Heidegger (1927/2000), phenomenology meant "letting it show from itself what manifests how it shows from itself" (§7 p. 58). Thus, this practicalising, or triangulation, in no way lessens the importance of the researcher's self-reflection or bracketing. Self-reflection has to be ongoing throughout the practicalising and the research procedure. Researchers have to keep on processing their thoughts, emotions and experiences, because it is through these perceptions and praxis that being-in-the-world is unveiled. Gadamer (2004) describes hermeneutic understanding as happening when something has been accepted as another; then it may speak to us from itself. Hermeneutic understanding goes in circles through language. (pp. 38–39.)

Michel Henry (1999) writes about how life reveals itself in "the way in which it speaks" (p. 353). He refers to the *speech of life,* meaning the capacity of language to manifest the being itself; how we read, speak and particularly how we say what we feel. Henry talks about the importance of self-experience and pathos in understanding because being is already in our language: When we hear somebody`s cry of suffering, according to Henry, we know from our former bodily experiences – corporality – what it actually means to be suffering, without the need for intentional language. The cry of suffering is inherent as one of life's modalities and thus differs from the verbal expression of "I am in pain", which only signifies it. (p. 358.) According to Henry, music is similarly an immediate expression of pathos. Also painting, with its colours, forms and way of pure impression, draws its phenomenological material and dynamism from life. In his thinking, Henry refers to the *life-world* (Lebenswelt) of Husserl; how the world secretly speaks the language of life to us in its sounds, colours, odours and flavours thus providing us with impressional self-revelation through our sensations and perceptions. (pp. 362–363.) However, Henry summarizes that material phenomenology "neither uncovers nor reveals life" because "we are always already in life" (p. 364). Life is given to us by ourselves with pathos in its speech, and therefore we are always late in "the task of making life advent to itself" even in philosophy (p. 364).

Therefore the great difference between phenomenological practicalising and positivistic operationalising is that while the target of operationalising may be to make the preconclusions stabile and so testable, practicalising is aimed at creating a living research

process with pathos. Practicalising may change the preconclusions of the researcher and aims to separate the former conceptions and experiences of the researcher from the world or things as themselves; in this study, the patients` own experiences, for example. So, practicalising, together with the active mind of researcher, is an ongoing process in comparison to a research procedure. It is a spiral like process that does not end in the completion of the research procedure or the collection of the raw material – it goes on while the researcher is still planning the research proposal and while s/he is writing the research report. Practicalising does not have a clear beginning or an end, even while conducting the clinical/empirical study or while writing the report. This is because it involves the living mind and self-experiences. Life itself, with all its sensations, vividness, experiences, speeches and bodily immanence, is the material from which the researcher really gains understanding of the phenomenon, according to Henry (1990/2008).

However, this living mind does not mean that researchers should continuously keep changing their clinical research methods, which may not even be possible because of ethical guidelines, for instance, that may demand a stabile research proposal and procedure. I was requested to make a stabile research procedure and schedule for my research project. However, to fully follow it was impossible for the same ethical reasons it was made, because of the treatment and safety of the patients. In this sense, I do not necessarily see that the stability of the research procedure would be a flaw in the research project but rather something unavoidable that is part of the nature, or even the essence, of the phenomena investigated. For example, part of the general guidelines and rules of health research is that patients are not forced to participate in any other examinations than those needed for their health conditions. It is also up to their own free will as to whether or not they participate in the research. In fact, to truly make this decision from their own free will they also need to be informed as to what the purpose of the research is and what methods are included. So, when I am studying the rehabilitation of torture victims, I conduct my research under the conditions and terms of the rehabilitation and my patients. I cannot just do anything I want because I have agreed with my patients and the institute what kind of research will be involved. It is the world, with its net meanings and experiences that I cannot be fully separated from. This may be called the *situation*, for example, the treatment culture, in existential phenomenology or the *horizon*, the realistic knowledge we have from torture survivors and traumas.

However, I can confront and criticise particular terms of treatment or research and perhaps adopt something new. Actually, to go beyond “realistic knowledge” or “formal knowledge”, I have to bracket myself from this natural attitude in order to really go to the things in themselves and how the phenomena appear from within life itself. This may require a bracketing of the many scientific and other concepts that may be former representations of unconsciousness, learning schemes, therapy models and brain or gene physiology. In this study, it has meant collecting holistic and individual points of view, for instance, which has meant taking a questioning attitude towards general truths and testing my immanent assumptions or interpretations by partly “externalizing” them in my research (see figure 4). I suppose it also may be seen as indicating a sort of “reality testing” and a search for objective truth, though I have been aware that this may be idealistic or not be totally possible. It could be seen as contradictory as well.

However, I claim that life in itself is contradictory. Where individuals can be studied according to their immanent experiences of music and therapy, what kind of imaginary worlds can they provide and what can they manifest in their personalities? At the same time, individuals are part of their society and culture, they have a relationship with the external world which connects them to life and the contents it provides for their experiences. An individual life may be approached from the perspective of culture and society, with all their former conceptions and models of man, which may actually affirm general conceptualizations about the individual or lead him/her to be seen as mere numeric data and statistics, for example. However, in this research the case studies are illustrated with extracts from transcriptions of the patients` music therapies in order to provide material from their actual life and experiences. This same research data, from automatically recorded music therapy sessions, has provided me with a lot of living material for coding for later factor analysis. Therefore, I argue that the later presented factors are also descriptions and manifestations of life, even though they are no longer the experiences and life of one individual particularly. An individual and idiographic point of view is emphasized in the case studies.

**The Phenomenological Method**

Whilst I have bracketed my knowledge and experiences using external methods like questionnaires, bracketing has to still mainly happen in the researcher`s mind through its inner processes of evaluating, analyzing and scrutinizing his/her emotions and experiences. Bracketing usually requires two forms, the immanent and eidetic reductions, as Husserl (1995, pp. 59–60) has presented in his principle of epistemological reduction:

1) In *immanent reduction* the earlier knowledge, theories, text books, scientific research results, particularly statistic and other generalizing information of the phenomenon are bracketed from the Mind of a researcher, which form his/her preunderstanding.
2) In *eidetic bracketing*, which means turning the focus of the Mind to what is perceived with our senses and to similarly forget the earlier conceptions, interpretations and pre-conclusions.

Thus, I argue that eidetic bracketing may mean the reduction of the first naive understanding of an object (music or painting, for example) to going beyond what is heard or seen with senses, to scrutinize the immanent experience of the music or painting. What do my earlier experiences of life tell me about the meaning of this musical work, for example? How does this music speak to me? Similarly, Husserl (ibid.) considered in his original formulation of phenomenological reduction that without this epistemological bracketing we do not comprehend that our perceiving and our sensations are not the cogito, which is evident. This is what makes pure phenomena different from psychological phenomena, which is what neuroscience currently studies, for example. He warns against making the rudimentary error of concluding that they would be the same phenomena, but explains that the contents of the experiencing subject must be separated from the world, time and ego, as with his/her sensations, situation and acts. (pp. 61–63.) Similarly, Henry (1990/2008, p. 55) has considered the phenomenological method and transcendental reduction presented in the

1907 lectures by Husserl (1995). For Henry, eidetic and immanent bracketing seem to be the simultaneous mental processes of lived experience, where the gaze proceeds as bodily apperception with auto-affection (pathos), the cogito and language. Henry criticizes that Husserl`s transcendental reduction still preserves the Cartesian gap between perception and cogito, which Henry, with his material phenomenology, tries to fill. He emphasizes that the perception, the gaze, is already transcendental (abstract) in itself.

Unfortunately, it seems that in the English language there is no equivalent for his concept of life as expressed by the French words "la vie" and "la vécu" with their etymological connection. They are translated as "mental processes", "auto-affection" or "lived experiences" in the context of his phenomenology of life. In German, there is a connection between "Leben" and "Erlebnisse", which also in the context of Husserl is translated as "mental processes", whilst emotionally it means more. In the Finnish language, there is a similar etymological connection between "elämä" (life) and "elämyksellisyys" (moving experience), where the latter is important for understanding what Henry means by the pathos of life and how it may speak to us. (Davidson, 2008, pp. xiv–xvi.)

The essence of practicalising for phenomenology would be that it must be understood as a continuing of mental processes, with pathos. This is why I suppose that there cannot be something similar to the operationalising of positivistic research in phenomenology. Every phenomenon has its own essence, how it is in itself as *things*. According to Heidegger, we are within the world and it can be discovered in various ways and at many stages (Bracken, 2002, p. 96). These stages may include different methods and aspects of a phenomenon like the Mind, the Body and the Situation of an individual, as earlier explained (Rauhala, 1983). This is why the researcher cannot know beforehand what kind of raw material or experiences s/he will encounter. Just as every human being is somehow different, the researcher may need diverse methods and theories for every phenomenon and subject. Doubting and continuous questioning prevents the researcher from objectifying the phenomena and evaluating them beforehand, which was the original meaning of *epokhé* for the ancient sceptics (Himanka, 1995, p. 22).

**Releasement**

As I mentioned in the Introduction, the underlying tone of my research process has been the concept of *releasement* (Gelassenheit) by Heidegger (1959/2002). Heidegger depicted it as the opposite of the ruling technical and calculative thinking of our modern age. Releasement requires one to patiently wait to see how Things disclose themselves in the world as they really are, without defining, analyzing, speculating or interpreting beforehand the nature of Things. Heidegger does not oppose technology in itself, instead he writes that with waiting patiently, the mysteries of technology may also be revealed to us. (Bracken, 2002, pp. 191–192.) In my research project, this meant that I had to try hard not to interpret and analyse my research data too early. At times this was difficult because I was both the therapist and researcher, so I had to make clinical interpretations, for example. However, from the research point of view I had to avoid premature interpretations of phenomena and the knowledge I was confronting. I tried to "forget" a scientific attitude, psychological theories, and even phenomenology from time to time, so that things in themselves would

open up to me. Considering Henry in this context, the research required me to attune myself to the research material of life, so that I would notice how life in itself manifests and speaks to me through pathos. This makes sense when it is understood that life is not an object but an eternal movement of experiences from suffering to joy (Henry, 1988/2005, p.121–122). I assume that this process of the living mind, Releasement, feelings and the experience of really getting to know something, breaks the "vicious circle" of hermeneutics in the researcher's mind. It goes beyond the former concepts, diagnoses and theories that affect the researcher`s work. It even goes beyond words and language.

I think music is a good example of this – how we "know" music whilst we may not have the technical vocabulary or formal knowledge for it. We can enjoy and appreciate music without former knowledge of it if we patiently listen to it and let it touch us. Partly, this is because our biological nature hears and understands sounds as bodily modality. In fact, according to Henry (1999), Cartesian reasoning prohibits us from feeling emotions and relating to the world, for example. It is the living body, with its gestures in dance, music and sports through which we spontaneously relate to the world as manifestations of life. (p. 361.) We can sense various tempos, pitches, tones and their alterations without formal musical education. We can usually analyze incidental noises and separate them from melodies and music. Recent brain research has found evidence that even infants are already capable of memorizing and recognizing music and differences in its structures, beat, harmony and melody. However, we also grow up in the culture in which we live. From the very earliest age, we began to learn the musical traditions of our culture. The music we prefer to listen to is as much dependent on our culture as what we have learnt to listen to as music. For example, it is known that people tend to keep the same favourite music throughout their lives – that which they have listened to as 10–11 years old and as teenagers (Levitin, 2007, p. 231).

This may also make appreciating music from other countries and cultures difficult, whilst not impossible. Soo-Jin Kwoun (2009) has researched the cross-cultural decoding of emotions in music between young Koreans, young Americans, older Koreans and older Americans, which indicated that there are universal auditory cues. Expressive music seems to embody and communicate emotional meaning across cultures. I think this point of view also arises in the case studies of this research. It is an important aspect to assess when beginning music therapy with someone from another culture or ethnicity because there may be some culture-specific differences relating to musical experience and depression, as another recent research indicates (Werner, Swope & Heide, 2009). Among a group of college participants including African Americans, Asian Americans, whites and other ethnic groups, it seems that there were statistically significant differences relating to musical experience and depression, even though the differences were quite small. In a research that employed the Music Experience Questionnaire (MEG) and factor analysis, negative correlations were found between subjective/physical reactions and depression among Asian Americans, for example. It seems that music is embodied as well as encultured in our being-in–the world (Dasein). (Bracken, 2002, pp. 94–95.)

I also assume that music and art need patient waiting, so that a painting could reveal its embodied meaning, for example. However, as described earlier, meaning is also already embodied in the musical experience itself and how it immediately makes us move and tap

our feet with pathos, for example. Waiting patiently relates to the symbolic and metaphorical meanings, which are noematic experiences. In the same manner as the patiently waiting listener may understand the essence of a piece of music, the artist or the composer had to wait in the process of making art. In this way, the artist and the researcher are in a similar position with their work. Earlier I discussed music as a dynamic form, which in my opinion comes very near Heidegger`s notions of art in this sense. Music and clinical improvisation in music therapy seem to be embodied with meaning and emotions. Thus, the philosophy and phenomenology of music as a *symbolic* or *dynamic form,* developed by Ernst Cassirer (1944) and later Susanne Langer (1953), seems to be well comparable with the hermeneutics proposed here. Artwork is a symbol and this makes it different from an artefact (Heidegger, 1935/1936/1998, pp. 15–16). Music and art do not imitate reality but discover it. They search for the truth, but in a different manner to language or science. Music and art intensify nature while language and scientific deductive thought abbreviate it and make it abstract. (Cassirer, 1944/1992, p. 143.) They further the experience from the nature of the experience, which I think Heidegger means with his concept of Releasement, and Henry (1999) with his self-experiencing of life and how language may transcendentalize the being itself. For Henry (1988/2005), all paintings, including other art forms, are abstract, which is a different and quite contrary conceptualization of arts in comparison to the philosophy of symbolic forms by Cassirer. However, it becomes understandable bearing in mind Henry`s conception of life and how music and other arts are fulfilments of the essence of life, as they express life with pathos (p. 123). Henry continues that the essence of art is different from our ordinary existence where the force of pathos remains unspent and, according to him, as such may change to “anxiety”, “monstrous behaviour of denial” and “self-destruction”, which is “killing our world” (p. 123).

From the clinical point of view of music therapy, it may be essential to be attuned to music, including all the affects and emotions that may relate to sadness, joy, hate etc. with their vitalities, as earlier described. These emotions may be imported as qualities of emotions like bursts or explosions in clinical improvisation. (Langer, 1942/1957, pp. 223–224.). I assume this applies to dialogue, silence and interaction in psychotherapy with its different verbal tones and atmosphere, too. These may also require patiently waiting and self-experiencing, attuning or auto-affection (pathos), to understand their essences. This may reveal the actual meaning of experience in being, and the hidden metaphoric and symbolic aspects of being that manifest in life. It is unconscious of lived experience, which may manifest itself as fantasies, desires, creative thinking and work. In his book *Genealogy of Psychoanalysis,* Henry (1985/1998) criticizes Freud and his concept of unconsciousness as an “idea warehouse” (p. 319). However, Henry does not deny the unconscious as a phenomenon but rather sees it as an ontological representation in psychoanalysis that has a long history in philosophy before Freud. His actual criticism towards Freud seems to be critique of how psychoanalysis uses the unconscious as a formal psychological representation and as a concept of being itself and forgets how life expresses itself through auto-affects (pathos) – seeing, hearing, feeling. Consciousness or unconsciousness is not merely a question of thoughts in the verbal sense. (O`Sullivan, 2006, p. 155–156.)

However, I consider that Henry`s criticism of psychoanalysis may be partly out-dated, since current psychoanalysis is also interested in metaphors, intersubjective experiences and

neuroscience, among many other things. I argue that Freud`s idea of listening to free association and dream*s* is essential concerning the speech of life because the purpose of it is precisely to speak aloud uncensored what comes to mind before analysing, explaining and representing ideas and feelings in more formulated ways. This means also listening to oneself and what one really has to say; how I feel. Actually, a similar critique could be targeted at many current psychological and medical theories, conceptualizations and representations as a part of Western thought, as it in fact was. It is possible to use these theories as sort of furthering "lenses" in the research, therapy and life in general, which may result as a failure to see the material of life in its own contexts and how it discloses itself before analysing them with cogito and technical knowledge. Henry considered Freud`s psychoanalysis as the end of a long history of Western thought and not as the new beginning (O`Sullivan, 2006, p.155). In the light of the latest technical and economical development, which has seemed to become an over-ruling way of thinking in modern society and its regard for efficiency, even in health care, it could be argued that he may have been right, but in another way than he suggested.

Our practical work, as music therapists, psychotherapists, doctors etc., may include practical knowing that is based on our specially trained skills, just as carpenters or musicians have bodily knowledge based on their technical skills, which they as experts easily know: For instance, how the special connection or rhythm is achieved from many previous similar experiences of music making. An expert may complete his/her tasks very intuitively without much conscious pondering, while some novice, like a student, could need much more time to consider how to manage them. Thus, this technical competence may represent implicit knowing, as described earlier. It seems also that there is a similar expert or "human knowledge" applied to emotions; we usually know what the categorical emotions "sad", "anger", "joy", "happy" mean and how they can feel too, which Charles Darwin (1872/1965) already argued. The above-mentioned cross-cultural research of universal emotional cues regarding our experience of music seems to indicate this when it studied Korean folk songs using the adjective scales of happiness, sadness and anger (Kwoun, 2009). We do not have to consider these categorical feelings a lot before we know them, and even quite small children can sense them whilst they do not have all the words to describe them.

Our being and acting in the world may also be knowing and understanding. For example, as adults we do not always jump in the air when we hear good news like children do, because that is how children relate to the world (Henry, 1999, p. 361). We have learnt to act more patiently. However, when we score a goal in football, or our favourite team wins, it is socially acceptable for adults to jump up and down and shout out the victory. According to Henry, there is an expression of pathos in all the diverse modes of existence of our ordinary life and not just related to the arts and higher forms of culture in cooking, work, eroticism and in relationships with others, living or dead. (p. 363.) This practical or bodily knowing, may be part of hermeneutics as the word "hermeneutic" originally meant "interpreting" (Heidegger, 1927/2000, §7C, p. 61): Music therapists interpret with their musical skills, knowledge and self-experience the patient and his/her musical choices, improvisation and expression i.e. how the being and life reveals itself in music or language. This may happen consciously or unconsciously, or be something in-between, like physiological sensing and

the bodily knowing of what is immanent in the music, the language and the presence of patient. I also assume that the researcher similarly interprets explicitly or implicitly while observing, as described earlier in how a therapist does so in clinical work. Thus, interpreting may be conscious, preconscious or unconscious, where a researcher or a therapist may also listen to their dynamic counter emotions and self-experience and how they speak for them. This has been one premise in this research. Hermeneutics may be understood as a scientific method of understanding, but there is an underlying implication that we have a natural human capability for knowing (Gadamer, 2004, pp.129–130).

One of the reasons why I am not calling my phenomenological practicalising operationalising is that the concept of "operationalising" comes from a different frame of reference and would provide the reader, or the researcher, with the wrong kind of preconception that I would be doing something similar to, and as objective as, a quantitative study. It would be objectifying my phenomena and experiences and would provide the illusion of doing something that I am not doing, or do not even want to do. I did not want to do a quantitative research using a positivistic paradigm and methods; I wanted to do something different, where the subjective voice and experience of the patients could be heard more clearly. By using a phenomenological frame of reference, the experience is emphasised and it means that I, the researcher, have to observe my own experiences, how I feel, and to understand the phenomena myself. This *self-experiencin*g or *releasement* is essential while doing research because, with the aid of it, it is possible to avoid objectifying the phenomena or to see them through concepts and representations that are not part of the essence of the phenomena – the life itself. Rather, they may be something different; conceptions that we are bound to through the power of politics, religion, laws, curriculum and science. They may have come from statistics and generalised knowledge that governments and other institutions employ as tools or justifications for their use of power. On the other hand, they may be part of the world that the researcher or any individual is within and reveal an aspect of how life discloses itself through many forms of regulation, control, management, exploitation and coercion. This may concern qualitative research, as well as any other research, how it interprets, conceptualizes, represents, categorizes with definitions and "puts the world in neat boxes". Science actually manipulates the phenomena and life itself with knowing.

There are three modes inside the hermeneutic circle:

1) releasement, waiting patiently
2) suspension from " already knowing"
3) self-experiencing i.e. turning the focus inside the researcher with self scrutiny (Klemola, 2004, pp. 69–70).

They have also been part of the epoché as continuously and simultaneously ongoing processes in this research. I might even call them my general attitude towards the research project, where I allow myself to be in a position not to know, or not to know yet, and suspend myself from preconceptions (see also Gadamer, 2004, pp. 38–39). This may sometimes be conscious, sometimes quite unconscious, but at the same time include intuitive knowing or a feeling of getting to know something and going in the right direction. I do not necessarily see

that these modes have to be in any specific order while considering the epoché, and in this study they have not been. In my research, they present the described “living mind”, which continuously processes between the subject, the object and their separate worlds (see figure 4). The presented Releasement in general may be a part of therapists’ introspection and hermeneutic reading of their countertransference, as it was in this research. This will be further explained in the next chapters concerning the research methods, clinical notes and the journalising of a researcher particularly.

## 6 RESEARCH METHODS

In my research plan, the primary research question was how could music therapy help torture survivors? As described earlier, relating to the lack of former research and literature on the topic, one purpose of this research was to help torture survivors and find therapeutic approaches using music, including applicable clinical theories, and to examine what theoretical frame of reference would apply to music therapy with trauma survivors.[23] The purpose of this research is in accordance with ethical guidelines in medicine that stipulate that research, its methods and examinations, should benefit the patients and should not produce any unnecessary harm, anxiety or symptoms affecting their general well-being. Therefore, such research methods that are not of benefit to the patients' treatment or recovery, or are otherwise unnecessary for their treatment or research, are forbidden. For this reason, my research proposal, including its clinical part and music therapy methods, was presented to the ethical committee before starting the research project in practice. Ethical issues relating to the research and its methods will be discussed later more thoroughly. I assumed that with this research project it could be possible to develop a treatment approach for torture survivors as a part of their rehabilitation in Finland. This, together with the other mentioned goals aimed at improving the conditions and treatment of torture survivors, is in accordance with international ethics and objectives for research into torture survivors in the field (Mollica, 1993, pp. 25–26).

While planning and starting the research I formed an assumption, based on earlier experiences and knowledge relating to the aforementioned literature from the therapies of torture survivors, that music therapy could benefit the patients in the following ways: (1) Music therapy would lessen anxiety, depression and obsessive–compulsive behavior such as repetitive thoughts in my patients. (2) Music psychotherapy would help patients to concentrate and relax more easily. These were my research sub-questions at the beginning of the research. They are also quantitative hypotheses because such methods as questionnaires and factor analysis were applied, as later described. These hypotheses were considered in this research to be related to the above mentioned ethical issues and the current demands of evidence-based medicine and practice, with regard to music therapy too (Wigram, 2001; Wigram, Nygaard Pederssen & Bonde, 2002; Edwards, 2005, Silverman, 2010). With factor analysis, I expected to find further descriptions and conceptualizations for the observations and situations found in music psychotherapy which would explain the possible recovery of patients.

After examining the raw data from the pilot study, transcriptions, clinical experiences from music therapy and the questionnaire results, the research questions were elaborated upon. Also, the final number of participants became clear only after the pilot study, which affected the decision as to which would be the primary research methods. This relates to the aforementioned attunement of the researcher to the contents of the raw data, which will be discussed in more detail later. The basic clinical hypotheses were formed from an earlier preunderstanding of the research field and my clinical experiences from music therapy with

[23] As one result of this research, the whole of chapter 4, Psychoanalytic Theories and their Clinical Application in Music Therapy, forms the clinical frame of reference for music psychotherapy, which can be applied to torture survivors and other traumatized patients.

torture survivors. However, taking into account the available literature and information sources at the time regarding music therapy with severely traumatized individuals, I also assumed that as torture survivors have individual problems there could be some other positive outcomes from music psychotherapy as well: Some patients may have the problem that they isolate their traumatic experiences from their feelings or being and cannot discuss them while other patients may suffer from obsessively thinking about the torture experiences, leading, perhaps, to dissociative states. Therefore, the objective of music psychotherapy would be different for these individuals –with patients suffering from isolation and constriction, it may be to help them to speak and work through their traumatic experiences, and with dissociative patients, it may be to help them to concentrate and control their minds better. (Volkman, 1993 Blake, 1994; Blake & Bishop, 1994; Slotoroff, 1994; Orth & Verburgt, 1998; The BZFO reports 2000–2002.)

### 6.1 Research Questions

The following research questions were developed as a result of the pilot study, which served to guide the direction of this inquiry:

1. To what extent, and in what ways, will the mental health condition of the research subjects change during music psychotherapy treatment, according to evidence from (a) psychological test scores, and (b) explanations derived from factor analysis of transcribed therapy sessions; how could music psychotherapy help torture survivors?
2. To what extent do the research subjects (and researcher) perceive that any mental health improvements were caused by the music psychotherapy treatment?

From the musicology and music psychology viewpoints, I had research questions concerning:

3. What meanings do various forms of music represent for torture survivors, and what are their observable reactions to music in a clinical setting?
4. What kinds of imagery and memories are related to listening to music among torture survivors?

The Rehabilitation Centre for Torture Survivors in Finland had patients from 21 countries during the study and it was interesting to see how various cultural backgrounds could affect responses to music, arts and imagery, and what kind of meanings would emerge during the music therapy process. I assumed that these experiences could impart important knowledge for the subsequent music therapy of torture survivors. This relates to the question of what kinds of music therapy techniques, active, receptive, imagery etc., would be proven to be applicable to torture survivors. In the light of my own experiences, and the aforesaid literature, I chose to use listening to music and imagery processing as the main techniques. This relates to the aforementioned fact that there was very little specific literature relating to music therapy with torture survivors and there had been some good experiences and evidence from this kind of music psychotherapy with post-traumatic stress disorder patients (PTSD) particularly (Blake, 1994; Blake & Bishop, 1994). Taking into account the limited

space and equipment at the centre, I thought this approach would be reasonable and practical. This decision was also to focus the research on specific music therapy techniques and the research questions relating to them, which will later be explained further. However, I have described other music therapy approaches, techniques and research in earlier chapters as well.[24] This is to provide answers and background to the research questions 3–4 concerning particularly the meaning and experience of music for refugee torture survivors and what kind of therapy approaches and music would be suitable for them.[25] It also relates to the purpose of developing a treatment approach in music therapy for traumatized individuals, particularly concerning torture survivors and other severely traumatized PTSD patients.

All the research questions were influenced by the philosophical inquiry presented in the earlier chapters, which aims to provide a critical appraisal of music therapy. With philosophical approaches, I have also tried to answer questions relating to the meaning and experience of music for traumatized and tortured individuals. Decisions as to what kinds of research methods would be best and possible for this study and its contents have been made bearing in mind the previous philosophical inquiry. Therefore, one of the considerations relating to this research was how the quite long music psychotherapy process and its outcomes could be studied so that I would not reduce the important individual meanings and experiences of the patients to mere numerical data. For example: How could I show that there was a positive change or outcome without quantifying the phenomena? What phenomena and experiences would imply therapeutic change in patients? What kinds of scientific methods, qualitative or quantitative, would be needed to answer these questions adequately?

These questions were especially related to the fact that I was both the music therapist and the researcher for the patients. It means that experiences and information were received from the participant observation. In regard to the earlier discussed hermeneutic paradigm, this is not necessarily a problem though because the subject and the object can be only separated in a philosophical analysis of the observer and the one being observed (Gadamer, 1989/2002, p. 329). Using outside peer observers and coders was considered while planning the research proposal but in practise it would have been very difficult, time consuming, expensive and maybe even impossible to arrange because actually there were no other music therapists working with this patient group in Finland. Also, it was estimated that the number of sessions and the hours of audio recordings would become so large that it would have been very problematic to use external coders in this research. It would have meant that there would have been different kinds of problems relating to the hermeneutic paradigm, because of its emphasis on subjective experiences and interpretations.

Therefore, I decided to use myself as a participant observer and apply my own experiences, attunement and countertransference as methods of interpreting the experiences and idiographic information arising during the therapies. In psychoanalysis, the analysts are

[24] See especially literature review chapters 2.1 Music Therapy with Traumatized Refugees, Asylum Seekers and Torture Survivors and 2.2 Music Therapy, Music and Traumas.
[25] Chapter 3.4 Music as Torture, Violence and Manipulation is especially focused on the meaning of music in this context.

researchers, using their emotions and unconscious respectively as information sources in order to understand patients (Freud, 1964; Tähkä, 1997a; Lemma, 2006). In previous research on counter emotions in music therapy, Kari Syvänen (2005) analyzed his countertransference with a check-list of three patients. Music therapies were followed over the course of 13 months and counter emotions were analyzed during the first five months of the therapies and for one month at the end of the following periods. The counter emotions of the music therapist were compared to the counter emotions of other therapists treating the same patients. Also, some selected audio recordings, short 30-second segments of the therapies, were shown to an external audience who analyzed their own countertransference. Finally, the counter emotions of various observers were compared and found to be similar.

I consider this to be an important development in the study of music psychotherapy because the therapist's counter emotions are essential in psychodynamic therapy, as has been described earlier. In this research, I go a step further by using my own counter emotions and subjective experiences in observing, interpreting, analyzing and *event recordin*g (tallying*)* the whole of the clinical research data. Instead of using external coders or a checklist I have marked my subjective observations on audio recordings, transcriptions, clinical and other notes relating to all three patients' complete music therapies, which were later factor analyzed. This is part of the methodological development of this research relating to the aforementioned philosophical question of how to study psychotherapy from the subjective point of view but still remain objective. It led to developing the concept of the *situated person* for statistical purposes, relating to hermeneutical phenomenology and clinical observations. This will be more thoroughly explained in chapters 6.6.3 and 6.6.4 in the context of the factor analysis. Even though there were pre-defined categories including research variables (appendix 1) that I have recorded, i.e. marked from the sessions, they have not been operational definitions in the usual sense but more an interpretative and hermeneutic reading of the research data. I consider this to be in accordance with the clinical work of psychotherapists and music therapists; how the critically used analysis of one's own countertransference may be an important source of information about the experiences of patients, music and the interaction between a therapist and a patient. This has been also recognized as a relevant topic of study in recent music therapy research (Syvänen, 2005; Dillard, 2006; Nygaard Pederssen, 2006; Jackson, 2010).[26] (Wheeler, 1995, pp. 223–224.)

I postulate that by using objective research methods, one can provide objective outcomes from the subjective experiences of the researcher and other participants. In fact, I argue that any scientific methods and preconclusions that advocate objectivity through the use of external observations, test designs and statistics, ignoring the subjective experiences of the participants, forget that they also reflect the subjective interpretations of the researchers and their scientific opinions. I consider this to be an example of the earlier mentioned *Cartesian error,* with ramifications that still affect scientific research with its dualisms and concepts such as the subject–object and quantitative versus qualitative research. It shows how the philosophical mind–body problem still occurs in scientific research. In this research, and

[26] The responses of 29 music therapists to anger in patients were studied in the research of Jackson (2010). They were found to redirect, validate, contain or work-through the anger with their patients. This hermeneutic phenomenological study included a semi-structured anger questionnaire and calculations in addition to the phenomenological descriptions of participants' responses.

while choosing its methods, I have needed the philosophy of science as earlier described to obtain essential information relating to music therapies, how patients felt about their therapies, and what kind of therapy processes and meanings arose from the patients. Thus, the patients have not been reduced to mere numeric or statistical data, even though quantitative methods were applied.

**Self-experience**

To provide answers to the research questions, I have philosophically dialogued issues like music, traumas, culture, torture, therapy and the theories relating to them without forgetting the *self-experience* and the *releasement* of the researcher, as explained earlier.[27] I postulate this prevents one from objectifying the phenomena or distancing oneself from them; i.e. forgetting the human being who has been the target of violence and torture and who is suffering from the consequences of those acts. I assume it enables us to understand and emphatically relate (ethos) to the torture survivors through self-affirmation. In some respects, it has also influenced the language I have used whilst writing, as will be seen later in the case studies, presenting the reader as well as myself with the possibility to understand and affirm. Military personnel may employ language and concepts like "target", "operation", "intervention" and "threat removed" on television when they are actually talking about violence and killing as they do not want to speak of these things explicitly because it would give rise to empathy and emotions that may lead to a possible resistance to war in the audience. Thus, with language it is possible to distance phenomena from self-experience in order to use things as "neutral objects", which can be "externalized", "processed", "produced", "calculated" , "analysed" or "to have an advantage" when it may after all consider people`s lives, the work they are doing for their living or their suffering from torture, like in this research. Similarly, I argue that the language of ready concepts, representations from generalized statistical information in research, distance the experience from life in itself which Henry thought of as "barbarism" (Henry, 1987/2004, p.138). Therefore, it relates as well to my role as a researcher in the sense that I preserve my self-affirmation by understanding that I belong to the world of meaning and that I cannot try to observe it from the outside if I really want to see the phenomena as they manifest themselves (Ricoeur, 1981/2002, p. 590). (Alanne, 2005a; O`Sullivan, 2008.)

**Research Focus**

I decided to consider only listening to music and imagery techniques as the clinical focus of this research. In practice, they were actually the only ones possible because there was no music therapy clinic with musical instruments available at the rehabilitation centre. Also, from the research point of view, it made sense to focus on listening to music with my research patients because music therapy techniques vary so much and there are so many of them (see e.g. Bruscia, 1987; Erkkilä, 1997b). I assumed that the researched music therapies with various therapy techniques could become too different from one another, so it would be difficult to argue that there were any shared underlying processes or to compare their outcomes. However, I thought to compare only therapies and their outcomes, numeric data

[27] See chapter 5.3 The Hermeneutical Core in Practicalising the Epoché and Clinical Research Methods.

etc., not actual people and their subjective experiences and situations.[28] As described, the subjectivity and the lived-experiences of patients were meant to be heard, and their individual therapy processes depicted and emphasized. I thought that the case studies of each music psychotherapy process would be used to achieve a better and deeper understanding of how patients appeared to experience music and their therapy. The case studies also enable us to have a look inside the rehabilitation, the asylum seeking processes and the situation of the patients in general. I assume that it would have been difficult to study and describe these essential aspects more fully with some other method, such as questionnaires.

**Choosing Methods**

The research methods were chosen in collaboration with the Centre for Torture Survivors in Finland, and their clinical experience was consulted to ensure that the methods were safe and ethically applicable. All the research methods, and my research proposal, were approved by the Helsinki Deaconess Institute`s ethical committee before the research began. The methods included both qualitative and quantitative approaches. These studies, or small-scale research, were chosen in part so that I could show some "objective" outcomes, which are preferred in the health care system nowadays. Also, the demands of my own field, music therapy, were considered because there seemed to be a lack of outcome studies (Silverman, 2007; 2010) even though there have been a lot of case studies of different patient groups and a long history of their application in research (see e.g. Bruscia, 1991/1996). The third thing was that I wanted to discover essential meanings and processes from music therapy with torture survivors. I wanted to keep a hermeneutic core to my research and have tried not to objectify or reduce the phenomena even though I also applied quantitative methods.

In my research methods, I considered the concepts of Amedeo Giorgi (1985/1996a & b; 2008) as explicated in his phenomenological research of psychology. He stresses that the researcher cannot choose all his/her methods beforehand as s/he does not know what the contents of the phenomenon investigated will be. I agree with this, but in practise I was not allowed to change my research methods because I was the therapist and the researcher at the same time. My research also studied the outcomes of music therapy, so if I had changed the methods completely it would have been very difficult for me to convincingly show afterwards any evidence of possible positive changes or outcomes. It could have been considered or suspected that I had manipulated the research material and saw in it only what I wanted to see. This is also an ethical issue relating to research methods.

I agree with Giorgi (1985/1996a & b) that it is wise for researchers to choose their methods taking into consideration the raw material that the research produces and what kind of methods will be applicable. In my research, it was possible to do so by collecting former knowledge and experiences from the studied phenomenon beforehand, which in my opinion could be regarded as *bracketing* too. I conducted music therapy work with torture survivors before beginning the research project in order to gain experience and I also consulted another more experienced therapist. I assume what Giorgi means is that he applies the

[28] Even the subjective experiences of participants were compared in the mentioned hermeneutic phenomenological study of Jackson (2010).

phenomenological *epoché* in empirical research, which ensures that important aspects of the phenomenon will be studied, that the *essences* will not be missed while collecting the research data. In my research it is exactly the same, however I cannot start to do therapy with someone I do not know at all. I cannot research a matter or therapy I know nothing about. In fact, if I would do research without knowing anything about the research object it could be possible that I would miss those essences because perhaps I would be looking at other, less important, issues. However, if we consider philosophical methods or psychological theories as research methods, then it may be applicable to vary them to some degree and not to choose them all in advance. Then it is possible that one sees only those things that fit into his/her clinical theory in music therapy, for example, which I have tried to avoid by choosing many research methods and deciding on most of them beforehand. I also conducted a short pilot study to see if research into music therapy with torture survivors would be possible using these methods. I have interpreted that this would be in accordance with Heidegger`s criticism as expounded in his fundamental analysis of how sciences decide upon their methods, theories, norms and opinions in advance. So, they only achieve knowledge that applies to their methods and see the phenomena in a predesignated light, not as they really are. (Heidegger, 1927/ 2000, §10 pp. 70–71.)

I postulate that, at least with some post-modern approaches that apply many methods and theories without analysing the structural history of knowledge, there is a danger losing a deeper understanding and rigorous human study to some degree. Thus, it appears that Heidegger's (ibid.) criticism could also be targeted at scientific approaches that change their methods, research questions and theories frequently. Actually, would it then also mean that a researcher knows the correct methods or finds suitable research questions beforehand so that the wanted answer would be achieved? Even though I have myself elaborated, developed and re-defined my research questions, mentioned at the beginning of this chapter, I have not actually changed or replaced the original ones. I would even argue that it would be deceptive to do so, as it would manipulate the research results and be against the ethical guidelines. How could I argue logically that there had been any positive changes in my patients, for example? My argumentation would be circular and I could be accused of changing my research questions to fit the research results or the data to my advantage. To conclude, it appears that this kind of approach, be it a single method or many approaches and theories, actually fragments the human situation and knowledge in research. This may work from the pragmatist point of view, as can indeed be shown from the results of many research projects based on test designs. However, their preconclusions may be circular and thus actual new evidence, affects, results or meanings may not be achieved. It may also lead in the opposite direction to real understanding and what is essential concerning the investigated phenomenon. With self-experience and pathos, researchers are able to orient ethically to their object in order to assess its meaning and possible disadvantages for an individual, as well as society and the whole of humankind. The blind exploitation of nature, with research targeted only at increasing economic benefits without caring about waste, could be one example of such disadvantages.

## 6.2 Pilot study

At the beginning of this research project was a short pilot study that included two individual therapies. These short music therapy treatments consisted of 6–8 music psychotherapy sessions. I assessed the suitability of the patients for music psychotherapy before the sessions by meeting them. The objective of the pilot study was to have some experience of the music and therapy techniques, and to explore if patients could possibly gain an advantage from music psychotherapy. Also, the objective was to find the correct, and suitable, research methods for torture survivors. In the pilot study, I could test my research questions, described in an earlier chapter, and examine what kind of methods I could apply in order to answer those questions. At the end of the pilot study, psychological questionnaires along with the Music Therapy Outcome Questionnaire were filled in.

From the results and experiences of the pilot study, I transcribed and collected variables that depicted the positive or negative changes in a patient, or differences in behaviour, during the music therapy session. However, I did not start to collect the variables from nothing. I made a short list of categorised phenomena (appendix 1) from my own experiences of music therapy with torture survivors that would mean therapeutic change in a patient. In the evidence-based practise (EBP) of music therapy, it is expected that "observable and measurable change" in patients will be achieved (Wigram, Nygaard Pedersen & Bonde, 2002, p. 262). I also listed some issues that would mean the opposite, such as the symptoms that the patients suffered from. I interviewed a more experienced therapist and psychiatrist, so that I could take advantage of his experiences and advice as to how positive and negative development may occur in the psychotherapy of torture survivors. I also discussed this issue with my scientific supervisor and listened to his advice on how to name the variables, so that I could observe the changes in them. In this way, I planned my research so that it would not be "a shot-in-the-dark", which is not the meaning of research and therapy according to EBP in music therapy (ibid., pp. 257–258). I consciously chose and focused my research on what kind of phenomena I would be looking for. Initially, there were even more categories, variables and research targets, so I had to decide which categories of phenomena and their variables of experiences would be my focus. In my opinion, this process of naming the phenomena, first as groups of categories, which would appear as relevant for my research purposes *(essences)*, and then as smaller units of actual variables or items, was part of *epoch*é and going to the things in themselves as proposed by Heidegger (1927/2000, §7, p. 50).[29] As described, these essences began to show themselves while making the research plan and the pilot study (see appendix 1). So, the variables named were already confronted phenomena in my research and were assessed as worthy of study by many other experts in the field.

In this way, the pre-identified categories, including actual phenomena and meanings thought to be essential for evaluating possible change i.e. outcome of music therapy process, became variables for the later factor analysis. At the same time, they were depicting categories of phenomena of torture survivors and their music therapy. They described *situated persons,* as

[29] See chapter 5.3 and the discussion of hermeneutic phenomenology and the identifying of research objects and categories particularly.

later explained more thoroughly, and not real or living beings anymore, but rather abstract meaning units garnered from individual entities experiencing various situations and acts during music therapy sessions. These acts of the situated person were in a relation to the time and the phase of the therapy, which were transcendentalized in multiple case analyses. However, I still argue that they are empirical observations because they extend from real persons i.e. the patients and their experiences variating in music psychotherapy, and therefore do not represent idealism in the forms of metapsychology or metaphysics.

After the short music therapies, the two patients filled out the research questionnaires and expressed their willingness to continue with music therapy, so they also became participants in the main research. Their music therapies continued without a break and the research data from the pilot study was added to the main research data. After the pilot study, I received some good feedback from patients stating that they felt music therapy had helped them. This was helpful concerning a more thorough assessment of the patients` needs and the objectives and expectations for their music therapies as recommended for the EBP (Wigram, Nygaard Pedersen & Bonde, 2002, p. 262). After I had fully transcribed all the sessions from the pilot study, I noticed that there were some new essential variables/items that I should look for in the subsequent material. I also noticed that the variables I had made before, or the phenomena they represented, could be found from the cases. They seemed to make sense. I also ran some test factor analyses from the small transcribed pilot material to see if logical factor loadings would arise from my observations and interpretations of the raw data, including my transcriptions and clinical notes. As a result, it seemed like the research data could be factor analyzed as designed. Two participants, Ben and Abdul, who started their music therapies in the pilot study, were also willing to continue their music therapies and be participants throughout the whole research.

### 6.3 Multiple Controlled Case Studies of Long Music Psychotherapies

The main phase of the clinical part of the research included three individual music psychotherapies. Two of these were the music therapies of Ben (Case One) and Abdul (Case Two), who had already started their therapies in the mentioned pilot study. Osama (Case Three) started his music therapy after the pilot study. Actually, there were four participants in the beginning; however one of them just disappeared after his first session. He was not heard of or reached after that. Sometimes this happens in the treatment of refugees and torture survivors. Initially, it was thought to include both sexes in the research but, in the end, only men were referred. Individual music therapies were meant to last for one year but actually all of them took longer because of the patients' situations: They needed more therapy and so did not provide a chance to complete the therapies in the scheduled time. For two of the patients, Ben and Abdul, music therapy sessions were once a week and for the third patient, Osama, approximately every second week. Every patient had the possibility to affect the frequency of their therapy sessions; for example, Osama did not want to come in for therapy more often even though I suggested it and would have been better for him. I emphasize that at this point there was no coercive test-design regarding the frequency of sessions. I decided the frequency of the therapies according to the situations of the patients; although a similar frequency of therapy for all would have been preferable from the research validity point of view. However, I held in mind the ethical rationale for the treatment of the

patients, allowing us to meet even more frequently if warranted by the clinical conditions of the patients. Patients were allowed to interrupt the research at anytime yet still continue their therapies.

In Part Two of this study, three case studies on refugee torture survivors illustrating the therapeutic process and the patients' experiences are described. Raw transcribed extractions from automatically audio recorded music therapy sessions are provided in every case. These narrative reports are in accordance with the recommendations of EBP in music therapy as to how to describe events in the therapy process (Wigram, Nygaard Pedersen & Bonde, 2002, p. 263). There were several separate tests; a pre-test, a middle-test conducted after six months of therapy, a post-therapy test and a follow-up test. Together, the multiple cases form a controlled case study group of three persons with two compared persons (N=5). Therefore this research obtains the criteria of evidence-based medicine (EBM) at level three that "includes all studies that have used comparative method but are not ´properly designed` randomized control trials" and level four, which is "evidence obtained from case study or single subject designs, either post-test or pre-test and post-test" (Edwards, 2005, pp. 294, 298–299).

### 6.4 Data Collection

Every music psychotherapy session was automatically recorded and later transcribed. Patients were given the opportunity to draw or write during the therapy sessions while listening to music, however, in the end such material was not obtained. They seldom needed a pencil to clarify or express their thoughts, which may relate to the fact that there was an interpreter present during their therapies. Video recordings were also considered as one possibility while planning the research protocol but it was soon neglected for ethical reasons. In fact, the ethical committee looking into my research proposal and its methods commented that the video recording and photographing of patients is forbidden in this type of research to protect the patients` integrities. Every patient that participated in the research signed a *consent form* where relevant information was provided about the research, music therapy and its methods (appendix 3). Consent forms were translated into the patients` own languages.

As a therapist and a researcher, I continuously evaluated the effects and outcomes of music psychotherapy from various sources, which is referred to as *triangulation* in qualitative research (Lincoln & Guba, 1985, pp. 305–307). This was based on the observations of both the therapist researcher and the team, including psychiatrists, psychologists, social workers, a neurologist and a physiotherapist. I also had access to patient files and documents and was able to read about their observations, treatments, consultancies and examinations, besides the oral sharing of information. I made clinical notes from all the appointments with my patients and the team meetings as well as other oral discussions.

In order to evaluate the outcomes of music psychotherapy, there was also a similar enough compared group of two other patients who did not receive music psychotherapy in their rehabilitation but other treatments or therapies instead, for example verbal psychotherapy. It was endeavoured that these two patients would be a close match to Ben (Case One) and

Abdul (Case Two) with regard to gender, age, culture and symptoms. For Osama (Case Three) I could not find an individual compared person during the schedule of research project. From the beginning, I considered it quite difficult, or maybe even impossible, to match individuals in order to create a comparison group, especially concerning a study of this kind of with its comparison of individuals and their personalities (Wigram, Nygaard Pedersen and Bonde, 2002, p. 259). Therefore, in my view relating to my own clinical experiences with torture survivors and other psychiatric patients, there was never the assumption that the situations of the case studies and their compared persons could really be thought of as identical. However, I argue that together these five torture survivors as research participants provide some information about the research topic, and the rehabilitation of torture survivors in general, when they are compared with one another.

All five participants, three patients in music psychotherapy with the pseudonyms Ben (Case One), Abdul (Case Two) and Osama (Case Three), and the two persons compared with Ben and Abdul who did not receive music therapy but had the best general treatment, filled out psychological questionnaires during their rehabilitations. All the questionnaires and their applications shall be described in the next chapter. The use of all the research questionnaires and forms, including the mentioned consent form and the Permission to Record Music Therapy Sessions form (appendix 4), were approved and commentated on by the ethical committee before the research began.

### 6.4.1 Administration of the Four Psychological Questionnaire Forms

Psychological inquiry forms were filled out at the beginning and the end of the therapy process, as well as six months after the music psychotherapies had ended. The inquiry form used was the Symptom Check List-25 (SCL-25), which is a questionnaire that screens for anxiety and depression in individuals. This shorter version of the standard questionnaire SCL-90, with only 25 questions, was used as it was considered to be better for severely traumatized persons and torture survivors. I assumed that SCL-25 would be easier and more comfortable to fill out than the SCL-90 for example, such as used by Körlin (2005) in his studies on creative arts therapies and BMGIM in psychiatric treatment. In addition, there were more questionnaires to fill out simultaneously, like the Beck Depression Inventory (BDI) and the Swedish anxiety, depression and obsessive–compulsion questionnaire, How Do You Feel Today*?* (Hur mår du i dag?) which has been especially designed for the rehabilitation and assessment of torture survivors. It was translated into Finnish for the purposes of this research project. How Do You Feel Today*?* was completed during the middle section of each patient's music psychotherapy and after six months of therapy. The Alanne Music Therapy Outcome Questionnaire (appendix 2), designed by the researcher, was also filled out after six months of music therapy, at the end of each patient's music therapy and six months after all the music therapies had been completed.

Participants had the right to refuse to fill out the questionnaires but in the end they were all willing to complete them. They did not have to answer all the questions, for example, if they found them to be too exhausting or anxiety provoking. In this research project, it was not assumed that these questionnaires would result in statistically significant results because there were only three participants receiving music therapy and two other torture survivors as

a similar enough compared group. These two patients had the best possible treatment at the centre, but no music therapy. They filled out all the same questionnaires respectively, including the Treatment Outcome Questionnaire, which was literally the same questionnaire as the Alanne Music Therapy Outcome Questionnaire, only the words referring to "music" or "music therapy" were altered to "treatment". Any information in itself relating to the scores of any of these questionnaires was not used as variables for the factor analyses.

The designing of the quantitative aspect of this research began from the viewpoint that the research would probably only come up with a few case studies. In the end, three quite long case studies were included. Three persons are not an adequate enough group for factor analysis if one wishes to achieve a statistically significant sample. In fact, concerning this research, it cannot be called a "sample" at all because in a naturalistic and quantitative research test design a sample refers to a randomly chosen group of people. Also, the randomized group should be so large in its extent that the possibility that it would be chosen in some systematic way, or be too homogenous, would be as small as possible. Thus, in this research I had to consider other conclusions for the factor analysis and the quantitative study. Actually, not all medical research fits the terms of a randomized sample because the participants may be chosen systematically. For example, when studying the advantages of treatments and medicines, participants can be chosen according to their particular age, problems and diagnoses. In this study as well, people who could possibly gain an advantage from music psychotherapy were located among the torture survivors; those who had difficulties in verbally expressing their feelings, for example, which made them thoroughly chosen. They had other treatments too, which would be a biasing factor in Randomized Control Trials (RCT). To form a bigger group for the research was deemed to be impossible in practice because there were not enough patients available. Afterwards it is also easy to say that one researcher and therapist could not do much more using this kind of research design so that the rigorous terms of human studies would apply.

### 6.4.2 Clinical Notes from Recorded Music Psychotherapy Sessions

As a therapist and a researcher, I automatically took notes during every music therapy session with each patient. In them, I wrote my visual observations; how the patient looked, did he appear calm, anxious, sad or happy? I also made notes about gestures and the physical appearance of the patients; did they look relaxed and comfortable or stressed and tired? Were they restless while sitting, for example? In my clinical notes I also marked down notions that arose in therapy with regard to my own feelings, i.e. countertransference issues relating to the patients, and I considered what they could possibly tell me about the patient`s situation. I tried also to keep in mind and separate out thoughts, experiences and feelings which were related to my own personal history. In my notes, I tried to separate my observations of phenomena from the patients` worlds and my own reflections. I journalised my own personal reflections and emotions so that I could later analyze which feelings came from me and which came from the patient.[30] This also relates to the psychoanalytic self-analysis of the therapist in applying transference between the therapist and a patient. In

[30] See figure 4 earlier in chapter 5.3 The Hermeneutical Core in Practicalising the Epoché and Clinical Research Methods, and the point of "separating the words" in the hermeneutic circle.

my clinical notes, I marked my interpretations and other verbal or musical interventions with their purposes for the patients.

In these personal notes I could mark my observations as to how patients reacted during listening to the music; for example, did they take a more relaxed sitting position or did they close they eyes or keep them open? After every music therapy session I wrote down notes relating to how patients seemed to experience a particular piece of music and how they seemed to feel while we were discussing it. I think this was important for the later analysis and transcription of the recorded material because there was no possibility to video record sessions. I also took notes during interdisciplinary team meetings, including clinical supervision sessions, about patients and recorded how their situations were considered in these meetings. These clinical notes could also contain clinical theories, assumptions, concerns and questions relating to the patients that would help me as a therapist to attune to the patients' situations and later, as a researcher, separate our worlds (compare Giorgi, 2008, p. 7).

In addition to this, I kept a personal diary from the time when I was planning the research procedure and had just started my clinical music therapy with torture survivors. It includes scientific questions and ideas related to the planning of the research as well as my personal journalising of emotions and thoughts concerning different phases of the research. The purpose of all these notes was to clarify the therapist–researcher combination and simultaneously apply myself as a "research tool" (praxis) using my counter emotions (see e.g. Syvänen, 2005; Nygaard Pedersen, 2006; Malmberg, 2009). From these different notes on music therapy with torture survivors and meetings with interdisciplinary experts developed the categories of the variables for factor analysis in the first place (appendix 1). Later, while I listened to and transcribed the therapy sessions, I used my notes to systematically attune myself to the situations of the patients again. I reflected upon the phenomena, observations and experiences mentioned in my notes and used that information in attunement as well. This could mean marking a phenomenon appearing only in my notes, like the look of the patient, onto the factor analysis matrix if necessary. In this phase of the research, notes from official treatment documents were also consulted to confirm my interpretations of the patients' situations and their experiences. I consider this to be triangulation and part of a hermeneutic reading and continuous attunement to the studied phenomena (see figure 4). I shall clarify further, and specifically explain the relationships between the data collection, observations, notes, transcriptions, hermeneutic reading and interpretation of the research categories with factor analysis over the next chapters.

### 6.5 Factor Analysis

Factor analysis has been applied in this research to reduce the attributes of variable dimensions and to uncover and explain latent structures in the observed phenomena of three music psychotherapies. All the therapy sessions that were included, 116 sessions in total, were factor analyzed according to 66 pre-identified variables considered as relevant to the study of music psychotherapy processes with refugee torture survivors. These 66 variables, presented in the Variable Template for Factor Analysis (appendix 1), are explained and discussed more thoroughly in chapter 9 in the context of the findings from the factor

analysis, as well as other statistical procedures. The following methodological chapters provide a philosophical introduction and rationale for combining factor analysis and qualitative research.

The purpose of factor analysis in this research was to try and find other explanations and conceptualizations, or qualitative interpretations, for the observed phenomena in the case studies. Factor analysis is applied in this research in a different context than usual – relating to the intersubjective observations of a therapist researcher and not to the above mentioned research questionnaires. It is a micro analysis of situated persons which, as explained later, are only three individuals undergoing music psychotherapy (N=3). Therefore, the application of factor analysis and its findings in this research cannot be reported as they would usually be in quantitative research reports. They require more a linear and synchronic approach to writing and reasoning, similar to philosophy, to be correctly understood in the context of this research. Fundamental philosophical analysis is also needed to evaluate the research process, its findings and meanings, which seem to be in the border areas of quantitative and qualitative research.

Factor analysis is widely applied, especially in social sciences and psychology. It has been a useful tool for studying complex phenomena like intelligence and personality. Factor analysis refers to a wide range of statistical methods that try to find a smaller group of factors from a larger group of variables. In an empirical research, there are frequently quite large amounts of observed variables and it is necessary to work out how these various observed variables and phenomena are related to one another; how they can be depicted, understood and explained using factors. In this research, the diverse observations of a researcher into torture survivors` music psychotherapy have been the data for factor analysis. In addition to this my purpose has been to validate the observations and interpretations of the therapist researcher, which have their ground in subjective experiences. (Leskinen, 1987; Miettunen, 2004; Vehkalahti, 2008.)

Factor analysis can be easily thought of as positivistic method which tries to find explanations for studied phenomena, a typical goal in natural sciences. This corresponds well to the natural scientific paradigm where human behavior, for instance, is postulated to be governed by some sort of "law of nature" or structure. However, even though it may be possible to shape latent biological–genetic models or structures of behavior with factor analysis, it is important to understand and remember that factor analysis in itself does not explain anything. For instance, it cannot explain how different quantities are related to one another; it can only explain that connections between these relationships can be calculated. With the help of these calculations, which have been made by computer software for decades, groups of numbers are achieved that, because of their mathematical relationships, form a factor which has to be interpreted primarily according to a theory. Factor analysis does not prove, for example, that a real psychological process exists behind a certain factor. However, it is possible to find evidence that supports this kind of hypothesis or theory, which the researcher may then use as an explanation of some process relating to intelligence or musicality, for example. (Karma & Komulainen, 1984/2002; Leskinen, 1987; Miettunen, 2004; Cooligan, 2005.)

Factor analysis is a fully statistical process whereby a researcher is subjectively involved with many aspects which influence the analysis. While doing factor analysis, a researcher may choose according to his/her subjective interpretations and preferences how the factors will be calculated and rotated. Factor analysis is frequently applied to validate research inquiries and methods in social sciences, behavioral sciences, psychology and psychiatry when the purpose is to ensure the objectivity of the achieved knowledge, and that the research methods really study what is intended. (Karma & Komulainen, 1984/2002; Leskinen, 1987; Miettunen, 2004.; Cooligan, 2005; Vehkalahti, 2008.)

### 6.6 Use of Statistical Methods with Qualitative Material

I ended up wondering how enough quantitative data could be achieved from only three persons so that it would also be possible to scrutinize my research from a statistical point of view. One possibility was found in single case statistical studies, where diverse material could be collected from one person with *event recording* (tallying). There can be so much data and variation of experiences and observations, even from one person, that it is possible to do statistical calculations. (Lathom-Radocy & Radocy, 1995; Wheeler, 1995.) The idea of a situated person came from this ground. At the same time, I considered what kinds of issues and phenomena I should observe from music therapies so that they would answer my questions as to how music therapy positively affects torture survivors.

What kind of observations should arise and experiences develop so that I could say, and somebody else could also understand, that music therapy had helped? I assume that this kind of positive development must somehow be able to be seen concretely, so that I could say that some change for the better has happened in the form of a positive experience of music, for example. At the same time, my own depiction should be open to others, so that it would be possible for somebody else who understands these issues to end up with similar conclusions; that positive events or experiences have occurred in therapy. I began to think of therapy situations where the patients` reactions appeared to me to be positive or negative when considering their treatment/rehabilitation in the light of my own experiences. I also consulted a more experienced clinician and researcher. The concepts were not operationalized in a strict and mechanical sense either, so even though I would try to write down and quantify the phenomena, the observing of patients in therapy and research was a very interpretative process.[31]

#### 6.6.1 Real World as Experienced and the Dasein

This research has the premise that the subject and the object may not be fully separated from the real world of experiences. Then, completely objective knowledge in the broad sense, and in a relationship between the object and observer, is not possible. This especially concerns human relationships, at least in this study, rather than arguments about the physical world concerning its nature, structure, dynamics etc. In my opinion, a *participant observer* is a mild version of the former, because in that too observations may be mechanically transcribed and calculated. In my own research, I have been a participant observer but there

[31] Compare to the *checklist* method (Wheeler, 1995, p. 224).

have not been any strict operationalized concepts for my observations. My own work has proceeded in the opposite direction, so to speak, and my objective has been different: I have searched for how particular phenomena manifest i.e. how the data in itself provides their appearance. How do they appear in practice with music psychotherapy patients? What kind of meaning does music, music therapy and those traumas common to torture survivors arise in an individual's world of experience? I have not tried to hide how I have experienced myself as a therapist and a researcher.

Using Heidegger`s concept, my approach may be considered as *Dasein*, which means viewing the world as it is experienced where the subject and object are situationalized and affect each other. It means seeing how the reaction, happening and experience disclose themselves in a situation and how they are dependent on both the observer and the object. They constitute themselves in *acts of knowing*. If a phenomenon would be operationalized beforehand in a qualitative research, or in a rigorous human study, then it would have to be considered as something similar to a mere artifact or a Thing from the physical world that stands only for itself (*Vorhandenheit*). In this kind of case we would have to consider what we had completely designated beforehand and it would break the unique "meaning net" of humans and their culture. Other interpretations, which could be essential or important for the phenomenon, would not perhaps have been noticed or been possible because we had totally decided and designated beforehand what would be counted as part of the phenomenon. However, I assume that mere calculation in itself would not make the human situation into an artifact if its purpose would not be consciously to do so by representing individuals as mere numbers on a checklist that may be distanced, manipulated and used in many ways.

Heidegger (1927/2000) himself thought that those Things which may be approached mathematically are truly what they are; it is the being that always is what it is, and stays that way too (§21, p. 129). It appears that he did not assume that there would be any mathematical ontological structure in the world though but argumented that with mathematics it is possible to approach one of those aspects of being that forms the being of being (ontic). Mathematics is a way of knowing, and what appears as something that can be counted truly is. Something that can be ruled and counted can be trusted, as Heidegger implies. (§21, p. 129.) Then, mathematical reasoning is a combination of substantiality and how the idea of knowing is apprehended. Unlike Descartes, he does not seem to make a clear difference between the material world of being and perceptions. For Heidegger, the world does not rest upon the idea of a true being whose origins are concealed and so have to be proven. In his Cartesian criticism, Heidegger rejects the dualistic image of man; how sense experiences and how we perceive the world, sensation, *noein/noema*, for example, are pointless ontologically: For Descartes, it did not matter whether music is hard, melodic, clear and soft for example, or wine sweet, bitter and tasty. Sense experiences, the qualitative aspect of them, and sensations were meaningless to Descartes; they did not represent the being for him and so they could not provide knowledge of being. For Heidegger, the being discloses itself from the being itself, which Heidegger refers to and analyzes with his conceptualization of Dasein (Being There). (Heidegger, 1927/2000, §21 pp. 128–130.)

To conclude, from this research point of view, the mathematical calculation of observations is a way of knowing too. However, in this study calculated phenomena and the perceiving of

them are considered to be experiences, mine or somebody else`s, and not Things that stand for themselves (*Vorhandenheit*) that can be treated as physical objects or artifacts. The premise has been from the beginning that they are meanings; interpretations of the perceived world and how it is situated. They do have a correspondence to reality and the data though, the therapies in themselves, which have been preserved as physical recordings and transcriptions from real empirical situations, where interpretations can be checked, confirmed or repeated. They still represent the physical being and the actual physical voices of the patients. However, none of this physical material has been calculated, analyzed or otherwise explored in a positivistic manner on purely materialistic or physical grounds. Emphasis has been on the meaning of these recordings and transcriptions as language, text, speech, quality of experiences, emotions and auto-affects and how they disclose the phenomena in themselves for the researcher. In this interpretative process, the researcher has been an interactive subject with his experiences and emphatic reactions, which have also been his knowledge sources. In the clinical theory of psychoanalysis and music therapy, this is referred to as *countertransference* that guides the therapist in his or her interpretations (Syvänen, 2005; Dillard, 2006; Lemma, 2006; Nygaard Pedersen, 2006; Malmberg, 2009). The preservation of lived situations through audio recordings and transcriptions enables the continuity of the hermeneutic process by further listening, reading and interpreting in order to deepen understanding.

### 6.6.2 Quantified Phenomena and the Hermeneutic Circle

In this research, quantified phenomena were the depictions of different situations in music therapy as they were revealed to me as a therapist in my own world of experiences. They are not objective observations but interpretations, which are intended to be understood. It is typical for these interpretations that they have developed during the therapies and research processes. One might compare the Situation to a friend that one is getting to know and understand better as time goes by. Then, one does not have to speak out loud all that is evident but friends can understand one another based on earlier experiences and a prior knowledge of each other. There are similarities to both therapy and research in this kind of dialogue and process where the knowledge about another accumulates due to hermeneutic interpretations and understanding. It may be possible to read somebody else`s text and depiction of a friend and understand what it is about and perhaps find new aspects, historical Horizons, of him/her. One may notice that one did not know everything about this friend yet. (Gadamer, 1989/2002, pp. 334–335.) With this “friend” allegory, I depict my own role as a researcher whereby my own notes, doctor`s anamneses and patient files may also have been part of the hermeneutic circle in addition to the therapy sessions. I have also used knowledge collected from them in the factor analysis when it seemed necessary and there was something essential documented in the patient files. However, the emphasis in the data collection for factor analysis was on the therapy sessions, which were:

1) recorded
2) listened to
3) transcribed
4) coded (interpretation)
5) added to the raw data matrix.

I did not do this mechanistically; instead I listened to the recordings attuning myself to them with empathy: What was happening in the sessions? How did they speak to me? What kinds of phenomena were there? This was not just about observing issues, or surface discussions about what was said straight out loud, rather the intention was to achieve a deeper understanding and interpretation. What experience was the patient describing? What does he try to express even though he cannot say it directly? Sometimes the silence may be very significant and meaningful (see Sutton and De Backer, 2009). Thus, the listening to, transcribing and coding of the therapy sessions was a very interpretative process. Still these interpretations, which I have transcribed and coded, have their ground in the world of reality (Horizon). Added to this, I have also counted how many times these kinds of situations, happenings, experiences and phenomena were present during one therapy session (see appendix 1). I assume that the quantitative prevalence of some phenomena may be an essential part of the phenomena themselves, as well as the qualitative information gained from them. How frequently some happening or behavior arises during the therapy process may well depict in some patients their pathological symptoms, reciprocity and transference. It is typical of clinical work that various symptoms, emotional reactions, inclinations and their ritualizations are observed; how they repeat themselves in one individual. So, I conclude that quantitative and qualitative information may be different dimensions of the same phenomenon after all.

### 6.6.3 Situated Persons as the Manifestations of Ontological Structure

When using this kind of design, it is not possible to discuss "test persons"; actually it's not possible to talk about flesh and blood "persons" at all. They are manifestations of how the "real individual" or "personality" opens up to another person in our real world of experiences. These manifestations are neither these particular individuals nor their experiences anymore, even though really the primary intention was to observe them. What are they then? They are depictions or metaphors; they are situations and experiences in the act of knowing. They are *situated persons* where the experiences of a patient in music therapy, and observations of him by a therapist researcher, are constituted to meanings. In other words, they manifest how the studied person has opened up to me in my world of meanings, in my own situation. They describe how the Dasein, the possibility of being, has aroused between two people and how it has manifested itself in the experience worlds of the therapist, researcher and patient. All of these "roles" have affected how our mutual situation, music therapy, has formed itself and how we perceive it. With the concept of the situated person, I refer to this kind of intersubjective situation where it is not always possible to clearly separate the experiences of the observer and the object – one that is observed – but they are often affected by each other.

I have collected the phenomena from recordings of items which are possible to interpret as the experiences of the patients (see appendix 1). This prevents them from being merely aspects of my experience world and, therefore, purely subjective interpretations. These experiences are rooted in the real world of experience and its Horizons, just like any other experience which we can subjectively affirm as *self-evidence*; for instance, we can recognize as experiences the being itself that exists, the "I am", or our sensations "I hear a melody" , " I see a patient laughing" (Husserl, 1995, pp. 46–47). Husserl (1970/2002), a mathematician

originally, considered in his late work on the *life-world* (lebenswelt) how even natural–scientific, positive–scientific and mathematical insights have their grounding in such "prescientific ontic meaning" and *pregiven* meanings (p. 167). Therefore, whilst the situated persons are presented in a metatheoretical and metapsychological light, in this study they do not have their origins in my own theoretical speculations and inductions because they have their intuitive ground in intersubjective experiences and perceiving, which are verifiable – the things in themselves (p. 167). Then, they are not mere transcendental ideas because the Dasein, or rather one of its possibilities becomes seen and the phenomena become open through my subjective perceivings and world of experiences. According to Heidegger (1927/2000, §13, p. 88), "knowing is the manner of being-in-the-world" i.e. how it manifests itself.

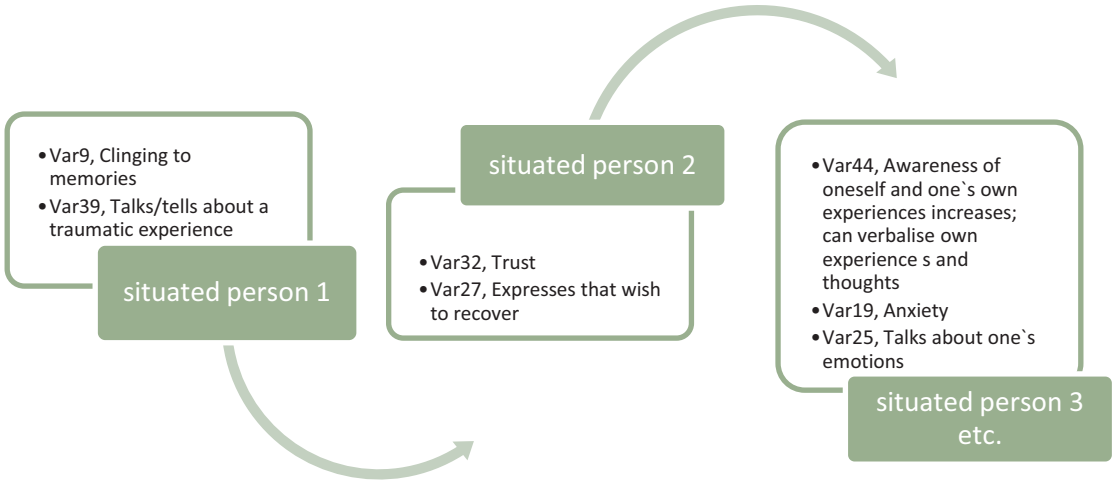



Figure 5. Metatheoretical example of situated persons in the therapy process and their variation during therapy (see appendix 1).

In figure 5 is presented how, theoretically, situated persons may occur as one possibility in the fulfilling of consciousness as acts of knowing. However, this is just a philosophical abstraction as to how experiences may fluctuate in the therapist researcher`s observations as well as in the patients` experiences. Thus, situated persons are metaphysical or transcendental aspects of experiencing in this manner as they depict the possibilities of being, the Dasein, but they still cannot depict it exhaustively. I mean that they are metaphors of real phenomena but are not symbols or persons in themselves, just as the speech of patient about his father or a discussion about music, art and a dream in therapy, for example are not the father, the music or the dream in itself but their abstract manifestations in speech.

Situated person are like *thing*s in the world of meaning behind our everyday meaningful experiences and mental processes, including scientific concepts and theories. In a way, situated persons have been bracketed with quantitative study when they are also no longer one individual`s experience world because the data has been collected from several persons. When I consider these situated persons together with factor analysis, then they do not

correspond to the three separate individuals in this study anymore but more generally to the structure underneath them and how and where they manifest themselves. I assume that factor analysis studies then the universal ontological structure of torture survivors' music psychotherapy and provides nomothetic understanding and explanations for what seems to be behind the meanings essential to it. It is not philosophy but rather empirical science because the studied data has been collected from the real world of experiences i.e. the life-world. Factor analysis provides knowledge of the validity of the researcher therapist`s various interpretations, such as are they grounded in reality and are the interpretations from the phenomena clear and logical. I argue that with factor analysis and its study of ontological structure, it is possible to find also new qualitative interpretations, and ways of being, as to how the phenomena represent themselves. In fact, as already earlier described in Heidegger`s hermeneutic phenomenology, The Dasein manifests itself in how phenomena are disclosed to oneself and how their way of being arises (Heidegger, 1927/2000, §4 p. 32; §7, p. 50).

The point that situated persons were only collected from the experience worlds of three individuals limits the generalization of the achieved knowledge. However, I assume that with factor analysis it is possible to focus the study on a universal ontological structure and what explanations could it provide from the three individuals that would also be applicable to a larger group of people. In this respect, quantitative research in a case study setting and qualitative research are not in contradiction considering the *transferability* of knowledge and the nomothetic interest of understanding in scientific research.

### 6.6.4 Situated Persons in the Raw Data Matrix

In this research, three individuals` music therapy sessions, 116 sessions altogether, provided 348 situated persons. Each session with every therapy patient was divided into three separate parts:

1) the first part of therapy, approximately 20–30 minutes
2) the latter part of therapy, approximately 20–30 minutes
3) the therapy sessions as a whole, approximately 40–60 minutes in total.

How many times one phenomenon, for example "humor" or "fear" , became aroused during the first part, the latter part or the whole therapy session was calculated to the raw data matrix. Then the matrix could have values related to the phenomenon "fear", for example, from three different situated persons, as follows:

a) situated person 1 (whole session) 2 times
b) situated person 2 (first part) 1 time
c) situated person 3 (latter part) 1 time.

Situated person 1 (whole session) was usually the sum of the first part and the latter part of the therapy session: how many situations there were altogether, even though in some especial cases there could have occurred an incident or phenomenon which, although marked down, was not possible to place clearly in either the first or the latter part. However,

in practice and with careful scrutiny, for instance by listening to or reading the transcript for a second time, it was possible to find a place or an interpretation for where the phenomena came into being during the session. There was actually only one exception to this in the end, which will be explained later in the context of the findings from the factor analysis. A more exact explanation of the factor analysis procedures and a glossary of concepts relating to them will be introduced in chapter 10 for presentational reasons. Whereas this chapter explains the concept of the situated person from the philosophical perspective, in chapter 10 it is explained more from the empirical, statistical and practical perspectives. I argue that all these perspectives are needed to truly understand what the situated person means in this research. In this sense, the methodological chapters from 6.5 to 6.6.4 and the factor analysis findings in chapter 10 should support each other in providing the reader with a more profound understanding of the situated person concept as applied with factor analysis.

One might conclude that if situated person 1 is the sum of the first part and the latter part of the therapy sessions, is it even possible to count it as a separate "person" due to the fact that the same perceived variables are calculated. I argue that it is possible because this research did not have as a premise that the therapy session is the sum of both the first and the last parts. I postulate that the therapy sessions can be described and understood as phenomena in both the smaller parts and the whole. On the one hand, by scrutinizing the smaller parts it is possible to achieve important knowledge as to how the therapy is proceeding but, on the other hand, frequently the whole therapy session forms a meaningful totality that cannot be separated into parts in practice, where some of its parts, the first or the latter part, would be more important for therapeutic experiences. I have the feeling from my own clinical experiences that it is the totality that is especially important. For instance, one cannot ignore the preluding conversation at the beginning of the therapy session that may feel useless because of insights achieved by the end of the session. Without one there would not be the other. However, I do not neglect the fact that, with quantitative calculation for example, it could be possible to achieve a result that finds that patients have more meaningful experiences in the latter part of their therapy sessions. This is also true in the light of my former clinical experiences.

A therapy session may be compared to the path mentioned at beginning of this book; one starts walking in the knowledge that it is not always possible to know beforehand where one is going, even though one might have a map, i.e. a theory, because the map is not nature itself. However, when a traveler takes a path s/he usually ends up somewhere. Especially, from the psychoanalytic respect, an issue that frequently appears to be a meaningless association on the surface may indicate a road that leads to very meaningful and important considerations of one`s own mind and one's world of experiences. From the surface level of the conscious mind may lead a path to the unconscious world of experience, the deep or latent level. According to Freud, this may happen with dreams and language when using free association (Freud, 1900/1995 & 1964). Music may be considered as a similar medium in music psychotherapy, one that gives rise to imagery and emotions and so opens up roads to the unconscious. Thus, music may be an essential element of therapy and a Thing in itself that opens up views to different levels or layers of experiences as a way of knowing. Music may take the therapeutic process further with its capability to recharge emotions (catharsis) and it can hold the individual and the whole therapy process through difficult times.

# *PART TWO*

# *FINDINGS I: DESCRIPTION OF CASES*

In the real dark night of the soul
It`s always 3 a.m.
It`s always darkest before the dawn
It never dawned on me
At my weakest I`m pretending to be strong
Sometimes the demons are too hard to control[32] (Hanoi Rocks)

[32] The first phrases of the song *In my Darkest Moment* written by Michael Monroe and Andy McCoy performed by Hanoi Rocks 2002.

**Preface**

I left the presented case studies quite as they were when I first wrote them while listening, transcribing and analyzing the therapy sessions for the factor analysis. The purpose and the focus of the case studies was to further describe the therapy process and how it manifests itself rather than to analyze the process in detail psychologically or medically. This has been an on-going decision while writing the final report as part of the hermeneutic phenomenological bracketing and Releasement. Thus, I would rather let the case studies speak for themselves as much as possible and conduct the analyzing, theorizing, discussing of the phenomena and drawing of the final conclusions from my research project in other chapters. This solution relates also to the protecting of the patients integrities and to keeping the scientific discussion and analysis more on the level of phenomena, whilst not forgetting that the meanings and experiences arise from the personal and subjective levels of the torture survivors and the therapist. I assume it also benefits other more theoretical and philosophical chapters, because it relates to the self-experiencing of the researcher therapist and how the studied phenomena have spoken to me and where they are related. I feel that this solution enables a freer discussion of torture experiences and the expression of more general phenomena relating to the context of research and its nomothetic knowledge interests, rather than "coercing" all the theories and reflections of the researcher in regard to the case studies and the personalities of the research participants. In the final chapter of this work, I will discuss my clinical assumptions and theories and interpret them in the light of the whole research data.

Music therapy sessions lasted from 45 minutes to 60 minutes with each patient. Usually, at the beginning of the sessions there was a short general discussion before we began listening to music. In all cases there was an interpreter in attendance during the therapy sessions, which is a common practise in the psychotherapy of refugee torture survivors. This affected the intimacies and transferences of the therapy sessions to some degree because there was always the third person present, even though it was usually the same person. With Abdul (Case Two) we did not have an interpreter at the end of his therapy because we were able to communicate in English and it appeared that it was a bit easier for him to talk then. Patients listened to music in a sitting position and discussed with me face to face. At the beginning of listening to music, I gave the patients some instructions in order to help them to try and relax and concentrate on listening to the music. I told them that they could close their eyes if they wanted to. I also asked them to tell me freely what came to their minds when listening to the music; associations, imagery, memories, and any thoughts. Patients were allowed to choose music if they wanted to and to refuse to listen to music if they did not feel like it for some reason. In that case we just talked.

In listening to music, as with the music chosen and the imagery approaches, there was no strict pattern followed within every session. The music that was listened to was frequently chosen during the session to match the emotions or the situations of the patient. It was also suggested that patients could bring their own music to therapy which could be music that they were currently listening to or that reflected their emotions. Sometimes I gave patients some short themes like "a meadow" to help with their imagery work because I felt that it was difficult for some patients to start processing imagery without support. In current music

therapy literature this kind of approach to music and imagery is referred to as *directed music imaging* (Grocke and Wigram, 2007, pp. 131–132). No coercive methods were used, such as directly introducing the patient's trauma as a theme, or using very emotionally provocative music on purpose. During listening to music, I asked the patients short guiding questions as to where they were in their imagery so that they would not be alone with their experiences. In this I applied shortened GIM techniques for trauma patients, which are also specified as *guided music imaging* (GMI) in recent literature on receptive methods in music therapy (Blake, 1994; Blake and Bishop, 1994; Grocke & Wigram, 2007).[33]

The central music therapy techniques were guided imagery, projective listening, and free association to music. Sometimes the purpose of the music was to bring forth positive imagery and emotions in patients. As a therapist, I tried to create a safe situation and holding environment for patients to explore their experiences with music. With discussions during and after listening to music, my objective was to pull the patients away from their dissociative states and stabilize their experiences with verbalizations. At end of the each therapy session, there was enough time scheduled so that we would be able to work through and integrate the issues and experiences that arose during listening to music. With different patients, my psychotherapeutic approaches and techniques varied according to the psychic disorders and the situation of the patients individually. Such receptive music therapy techniques defined recently as "directed music listening" GMI and *unguided music imaging* (UMI) include projective listening and free association and are overlapping if they are scrutinised in the psychoanalytic context theoretically (Wigram & Grocke, 2007, pp. 129, 136–139). In the clinical work of a music therapist, there are various ways to mix and apply the different receptive music therapy techniques recently defined by Grocke and Wigram (ibid.), as in this research. Different patients may also need different phase-specific approaches and clinical applications to music listening.[34]

In the following three case studies of Ben from Central Africa (Case One), Abdul from South Asia (Case Two) and Osama from the Middle East (Case Three), I describe their music psychotherapies as I experienced them. I have written them after listening to all the audio recordings of their therapy sessions during the transcription work. I have also examined my different notes and the patient files compiled during their therapies.[35] The outcomes of the research questionnaires have also affected my interpretations of their situations. The names of the men are pseudonyms and some personal information and descriptions of each patient and their traumatic experiences are restricted to protect their integrities and to avoid re-traumatizing them. In the transcripted raw material of the lived experiences illustrated in each case study I use the following abbreviations: T= therapist, P = patient, I=interpreter and I/P= an interpreter explaining with his/her own words what the patient is saying. The music relating to a particular session's discussion is marked after each extract where the transcripted conversations relate to the case studies. I chose to do it this

[33] See chapter 3.5, Music Listening and Imagery as Clinical Applications in this Research, for a more thorough description and theoretical discussion of this method.
[34] See chapter 3.4 Traumas, Phase Specific Theory, Neuroscience for a discussion on different therapeutic approaches and their meaning for trauma patients in music psychotherapy.
[35] See the previous chapter 6.4.2 Clinical Notes from Recorded Music Psychotherapy Sessions for a more thorough description of this process.

way because I did not want to "objectify" and emphasize the music or its significance as used in this research for the reader, whilst I admit the importance of music for the described therapeutic processes.[36]

[36] This relates to my philosophical view of music in therapy and the aforementioned releasement, which will be discussed in chapter 12.2 Music as a Thing and the Discloser of Experiences and Meanings in Therapy.

## 7 CASE ONE: BEN FROM CENTRAL AFRICA

Ben was in his thirties when he came to music therapy. When I first met him he appeared to me to be a relaxed and peaceful man. I felt that it was easy to be in contact with him emotionally and to talk with him, and it seemed as if from the very first evaluation meeting that there began to develop transference between us. Ben was quite a tall man, about the same size as me and he had a fit, sporty body, like some athletes. His muscles and body shape reminded me of runners in their elasticity rather than those sports men who have a lot of mass and muscle. Ben spoke French and laughed a lot, when he got excited out tumbled even more words and laughter and his voice grew louder as he related to what he was saying. It felt like he enjoyed laughing and telling stories, and we were his audience; me as the therapist, and a female interpreter who had been working with him previously so they already knew each other. However, usually while listening to music his face was serious and he was silent, always with his eyes open. Frequently, it seemed to me as if there was something inside him under the surface that made his face and eyes turn emotionless or pale, like something would shadow him for a while. He usually laughed again afterwards and said everything was all right when the music was finished.

The first music we listened to in the evaluation session was Chopin`s *piano concerto no. 1 op. 11, part 2*. Ben told me that he liked the music and that it made him feel comfortable. He explained to me that he usually liked African music and not hard rock because he was not used to listening to that sort of music. During the first meeting he also told me that he used music at home for the purpose of relaxation and to help him sleep because music might take away his thoughts from other things. Music usually brought memories to the surface for him.

Ben had escaped from Africa where he had lived with his family. He had been tortured very badly using the cruellest methods, including a mock execution and sexual violence. Ben did not remember anything about his journey to Finland and it was assumed that during it he was drugged. Whatever happened, he was very confused when he first arrived in Finland. During the first two years he was in Finland, when he was in rehabilitation, he was still extremely disorientated and in a similar state to psychosis. He was also very depressed and anxious. He had shown progression with the help of verbal psychotherapy and had better control of his mind.

The objective of music psychotherapy was to strengthen this experience of mastering his mind and emotions with the aid of music. It was also an aim to help him find positive experiences. When referred to music therapy, Ben still suffered from depression and anxiety and he also had symptoms that were connected to his traumatic experiences, such as dissociation and restricted emotions. Ben and his wife both had asylum in Finland but their children were still in Africa. During music therapy, they started the process of applying for family unification. Naturally this caused Ben stress and affected his therapy and rehabilitation. Music psychotherapy was his primary therapy for about one and half years but he still continued visiting his psychiatrist/psychotherapist occasionally during music therapy.

Ben himself had a military background, which was why he was probably tortured but it was also the reason why he survived, because of the relationships he had formed in connection to it. I would not have guessed at his military background when I started music therapy with him because to me he seemed so relaxed, friendly and social. With his spontaneous plentiful laugh, French speech and European casual clothing, he appeared to me more like one of the "home boys" saying "hey man" at some Paris or Helsinki underground station than a pedant or the tough warrior that one might expect a military person to be. However, his physical appearance had changed radically after prison and the torture he suffered: The big and muscled man had become slim and thin bodied. The heavy weight loss, 50 kilos according to him, had also affected his face and made him look different than before.

### 7.1 First Music Therapy Sessions

Ben became interested and attached to music therapy very quickly and realised that therapy with music was his "thing". The first seven sessions were about getting to know each other, the music and the music therapy as a treatment method, and building trust. After these initial sessions, he agreed that he was ready to begin longer weekly sessions with me for a year. During the pilot therapy of six sessions, Ben noticed that he used music in many ways to control his mood and even began to work with music in a similar way to the way we did in music therapy. These first sessions encouraged him to work psychotherapeutically with music and he thought it was a good treatment for him combined with verbal psychotherapy. In the sixth session, he was already more open about his feelings towards music and could tell me a little bit about his traumatic experiences and how he coped with them.

*What kind of experiences arose in you when you listened to it? (T) First, most important for me is that music, which is a love song but it doesn't touch me as a love song. Whilst I understand that it is the idea of the song I turn the meaning of it to my own purposes and in a way to my own life. I go through all that in it when I`m in prison, I had lost my family, when I was completely alone and isolated from everything. During that song it is there that I get everything this back, my family, little by little. It is more this my own life. Touches me in this way. (P) I guess you did not have a possibility in prison to listen this; did it bring in your mind the times when you missed your family and thought them? (T) Not really, I mix with that everything when I was in prison and there was the missing of them, that I didn`t have them. Also that now I am free and getting everything back, all kinds of things. No music in prison (laughs). (P) There are many songs; every song has its own story for me. (P) In a way that song while listening to it had many levels. On the other hand it was about love, quite happy issue, but there were also sad tones too somehow, I think it felt sad, at least for me, so it can relate to many things in that way I assume. (T) There were really many levels like was said that those words were simply jus a love song but there are definitely levels. I made from them my own case, I turn that love concretely to my own life and on the other hand it really mixes, connects, without love there is no life. Everything is included in my own thing to that life. (P) It is ordinary that people transfer their own life to songs. Songs may relate to one`s own life situation and what is going on. It is normal. (T) Music helps people many times, so that there can be someone sad, really sad, who listens to one little song or something and s/he can find a solution to his/her problems from there. (P) yes, true. (T)* (Ben, session 6, music: Lionel Richie, *Lovers at First Sight*.)

In this example from Ben`s music therapy, it is evident that music has a special meaning for him: Songs depict his own life story and he reflects upon his own emotions through music. People tend to transfer diverse meanings to music, which provides music with personal

symbolism. For Ben, the meaning was about love and hope and how he will achieve his life back – how he will survive. Music worked for him as a *transitional* and a *self-object* from the psychoanalytic point of view, as discussed earlier in the theoretical part of this work. Thus, music was helping him to go through his painful memories and at the same time was providing him with feelings of safety, strength and a wish for something better in his life through a musical *holding environment*. From the phenomenological perspective, Ben experienced music positively and it seemed to relate to such feelings and imagery as happiness, hope and love, which made the experience of listening to music transcendental for him. Music also provided him with feelings of empowerment and the strength to carry on, in my opinion. I argue that this was important for Ben, as well as for torture survivors in general who have many times lost hope completely and cannot find anything positive in their lives. They may not even be able to feel positively anymore. So, in this sense Ben`s experience was something that I assumed from the onset of the research would be one of the outcomes or objectives that music therapy would provide for a torture survivor. This was also in accordance with former research on music therapy with PTSD patients and other traumatized persons as discussed in the literature review. From this extract, it is also easy to see how Ben seemed to understood the music`s therapeutic meanings and possibilities, which helped him to dialogue with me and his inner self. Actually, he had self-experienced the therapeutic use of music for relaxing and emptying his mind before he came to music therapy and therefore already had cogito of it in his bodily experience. It was logical and recommendable to continue music psychotherapy, especially as he himself seemed to be motivated towards it and assured of its effectiveness. However, there was still a lot do with rebuilding and stabilizing the basic trust, which is not easy for torture survivors and may take years.

In the end, his music therapy was prolonged to one and a half years, and we also met six months afterwards, because of the research. It characterises Ben well how he could not "as a soldier" close his eyes while listening to music and during the guided imagery. He always kept his eyes open and this did not change as his music therapy progressed, even though he began have more trust in me otherwise. This was shown soon after the first seven sessions. Already during the ninth meeting, he confided in me and told me some things about what had happened in Africa and gave me information about issues relating to the government, to which he had had access through his previous job. However, he also made it clear that he could not tell me everything because of professional confidentiality.

*– – Of course I have professional confidentiality, which means that I could only tell my wife a little part, just this kind of international issues. And those inner country… Most of them are inside of me and I have never told them to my wife or anyone. It is my job, so I cannot go and tell them. – –* (Ben, session 9)

It is because of such confidential and secret information that people are often tortured and this is why they may feel conflicted as to what to tell others. Revealing confidential information during torture is felt to be shameful and deceitful whilst, in fact, almost every one breaks at some point. This confidential information may make the telling of some experiences difficult in therapy and even talking generally can be difficult because of conflicting emotions and personality changes. A patient may ponder the consequences of

telling things to me, and others, even though there is no evidence of danger anymore. It is typical that victims of torture fear authorities, and even the sight of police, doctors, soldiers, or someone in uniform, may reactivate fear, which is associated with the torture experiences and the time of being arrested or imprisoned. Ben also avoided the authorities and was afraid of being in contact with the police.

*How did you feel when you see policemen or when you went there, what kind of thoughts you had, what kind of feeling did you have of it? (T) Very bad, very bad. Sometimes, some days but not always it is enough to see an uniform somewhere further like on the street, then I might feel very bad but not always. (P) I asked then, is it continuous and he said that not always (I/P) Especially when I have just waken badly, then some days just the seeing of uniform makes me… It comes from there inside, for example my heart starts to run terribly. I feel sick in real, last year in May, June and July was such time continuously. (P) Are you then sweating or shivering? (T) Bones? (I) Yes, that kind of way, I need to clarify. (T) I can say that I feel myself really sick then and suddenly feel myself completely powerless. It takes all my strength. (P) Are you feeling then somehow paralysed? Do you mean that you cannot move somehow? (T) Like discouraged? (I) Yes discouraged somehow, really stiff and terrified. Would it depict it some way? (T) Yes, one might call it paralysing, it feels like you come paralysed inside and then it slowly comes out. It feels very discouraged, terrible and it is very difficult to get rid of. (P) – –* (Ben, session 15)

Ben`s rehabilitation was quite advanced during the beginning phase of music therapy and he could analyse and control his experiences and memories even though traumatic experiences still bothered him. During this period, the police mistakenly investigated and body checked him because they thought he was a wanted foreign crime suspect. This brought back the vivid fear of how people were scared of arrest in his home country, which taught them to be wary of sudden arrests. Traumatised people may have this concern and state of emergency on their minds and brains continuously. It activates the "flight or fight" reaction in their brains as a chemical process and physical function, causing their mind and body to become over stimulated. The brain of the traumatised person may be physically injured in this respect, as discussed earlier, so that they may overact to those situations which remind them of the original traumatic experience. For instance, when a torture survivor sees a police uniform, the brain associates it with torture and the traumatic experience and starts a stress reaction, even though there is no evidence of danger anymore. It seemed as if Ben also had such fear reactions, which he felt as bodily experiences. (Swallow, 2002, pp. 48–51.)

*– – It came to my mind, was it something like your own arresting situation? Was it similar, it could come to mind that are they coming to get me again and bringing tortured? Somewhere away and don`t know where they are taking. (T) It is that it comes as a surprise, fast. He told that he had come out already but the surprise was behind the corner, suddenly they were around him. They were coming from cars and it is the same situation in the home country when they are coming to arrest. It always comes without a warning. You cannot expect that suddenly it comes so hard like an attack. There they come so that there are many of them in a minute and they have weapons. He told that they have machine guns where is that round thing there on the top when they come without a warning. That is why everything like that, which happens suddenly, always fears me a quite a lot, I don`t like it at all, it makes me feel really bad. Such tremendous fear. There, when they come to arrest it doesn`t matter if there are children playing; they just like walk over. In it the whole thing is torn apart, it is very violent happening. That`s why it always scares. One has to always keep in mind this thing when kids are playing and be aware and keep eye on them. (I/T) That`s why I asked because it sounded so sudden*

*that it can be equal to moments when somebody is taken away to be arrested and tortured. Probably all the horrors come to mind fast and they must leave their marks too. (T) Those things come automatically like you pushed a button, they are in the mind`s eyes in such situations, you don`t have to go and look for them; it is there right away. – –* (Ben, session 15)

In this part of the music therapy, we could discuss with Ben so that he could tell me clearly about his own experiences and what kind of traces traumas can leave on a person. I could clarify this through his personal story and experiences. We also discussed how such a traumatic experience evolves in the mind if one forces him/herself to keep these issues, however difficult and painful, out of the consciousness. In Ben`s case, the progression of his rehabilitation was already observable at the beginning phase of his music therapy when he could already analyse his experiences and what was going on in his mind quite thoroughly. One example of this was the imagery exercise "river in a jungle", where he evidently had a peak experience, as referred to in BMGIM therapy discussed earlier relating to the clinical methods and theories of research (e.g. Grocke, 1999, pp. 204–205). Ben`s experience interestingly shows the cultural differences and spiritualism in his situation relating to therapy and healing when Ben compared me to a "medicine man", for example. This was noticeable in some other parts of the therapy and was also related to other differences in Western and African cultures which led me to renew my preconceptions of Africa.

Frequently our discussions in music therapy were a sort of "cultural dialogue" in a way, where my conception of ourselves was shaped; what we are and where we came from. I noticed, for example, that my image of Africa was built on something dated from African history a hundred years ago and was romantically coloured by films and books. A clear example of this can be seen from the Tarzan films, familiar to many Finns from their childhood, and similar stories which tell about the colonial era in Africa. However, many of the problems of African countries, including civil wars and coups, stem from this period. So the pondering of these topics was relevant from the existential point of view in Ben`s therapy because they were part of his cultural Horizon in his society. Frequently, modern conflicts and ethnic prejudices have long histories reaching back to former wars, oppression and the racism of past centuries. In the case of immigrants and refugees, this cultural aspect of therapy and rehabilitation is emphasised because the patients evidently strike against the cultural differences, contradictions and problems that arise when they come to this country. These problems, which affect the everyday life of patients and how they adapt to society in general, also affect their therapies and rehabilitation respectively. In Ben`s situation, this kind of stress and concern was due to the fact that their children were still in Africa and he did not know how he would be able to get them to Finland. The next extract from Ben`s therapy shows how these cultural differences arise in therapy. It is also an example of how Ben was better able to analyse his experience and trust me. I assume that this enabled the "peak experience" described earlier.

*Had you something during that end of the journey; did you get away from that river? (T) Yes, I got to the harbour, you are some kind of medicine man, you have some kind of magic. How is it possible that I see Africa and I am here. I am right here, sitting here, how can I see that far? (P) They are that kind of images, memories that you have from Africa. Music can arise them and was it sort of music that particularly can bring them to your mind. (T) So, you didn`t make any spells? (I) No, I haven`t done any spells. (T) How is it possible that I am not thinking about it or looking for those memories anyhow*

*and I am there anyway. How is that possible? (P) Well, I don`t know can I explain it for good but if we discuss about it, then we maybe together we can find an explanation. Did those memories feel good? How did you experience it when the Africa arises in your mind and you were like there but still here? (T) It felt like I was in Africa, (P) I asked was it like you were at home (I )It felt like I was in Africa and perfectly, it was total, it is not just like some place but total – I was there in Africa. It has nothing to do with this Europe, it is that in whole. (P) He is there like in emergency that explain me how this is possible (I) My physics is here, I am here and then I am completely there, suddenly with a help of some music. What really happens there because I was there in real? What is it that makes the memory turn upside down or something? (P) I think that you relate to that exercise that I gave to you and then also to that music, so that it sort of took you with it. You were there in it so intensively. Sometimes the imagery can be so powerful in a way that it feels you are there while you know that you are not in fact. (T) The feeling can be so strong, it can be pleasure also, and it can return from the very deep memory traces with those experiences. Those memories can be even odours sometimes or voices, you can smell or hear something. So powerful experiences. (T) – –*

*How can it be when it is said that I have forgotten it, I have forgotten all of it and then it comes just like that like a real picture, alive? (T) Maybe you have not forgotten it, people have many issues like that, they don`t ponder them continuously and they think they have lost them but there they are anyway somewhere deep in mind. Then they come to mind and one remembers them in some situation. One may see something, now I gave you this kind of rehearsal to go such imagery and thoughts and then that music must suits them too, so that it brought you an alive experience. (T) – – I don`t understand, here is something peculiar, for example when I was there in Joensuu for a long time. If I want to go to Joensuu I can remember it but if I want to go there for real, I go there by train and I go there and I look this is the way this was, this is the way it was here. However, now the going there was completely similar and equally powerful whilst I sit in a chair here. So, how was it possible that I was there in Africa? In a same way like I have to go to Joensuu I have to physically go there, I cannot go that way, what happened? (P) Anyway you knew all the time that you were sitting with us here even though you experienced that you are there in Africa. (T) I can say I was 80 percent there and 20 percent here but I knew, yes I knew. It was a bit similar like sleeping and in a dream, you go to somewhere but you still know that you are sleeping in your bed. (P) We talked there in the middle. (T) Yes, you had courage to go along with your experience so strongly, it was safe for you to let music take your imagery ahead and that arose such a strong experience in you. It can be a little difficult to explain but once we talked about such mystic experiences that are sometimes called as peak experiences in music therapy. In this kind of exercises they may sometimes come when you experience very live, powerful experience that can be very difficult to explain to another person. It may feel very good but one cannot really explain it, it may be different to others. It sounded me that there could be a little bit something like that. (T) Can it be said that it happened in another level? (I) Yes, in the different level of consciousness, just like in a dream. Like you described yourself, your mind went to different, was not quite awake and on a normal conscious level. (T) – –* (Ben, session 16, music: *Ambient Planet* CD, pieces 1) *Goa-Kosafrica* 2) *Nirbandh-Eastern Voices* 3) *Magic Planet-Space Groove*.)

I argue that this musical experience of Ben's depicts the potential of music to open up worlds of possibilities. It seems like music would resonate with the past, the present and the future in Ben`s experience, mingling the imagery and immanent experiences of Ben, as in a dream. He describes his experience like he would have been in an altered state of consciousness; present with me listening to music but at the same time having very vivid experiences of being physically in Africa. Ben himself had no explanation for this experience, and I cannot have one either because I could not see what was in his mind as he listened peacefully to

music; he was serious, and it felt from my own experience of counter emotions as if he was a little absent from the present moment. Thus, it could have meant that he was very eagerly concentrating on the music and the imagery theme, a sort of bracketing of the present moment, which transcendentalized his experience so that it actually felt like being in Africa. Ben seemed to be excited about this experience, as was the interpreter, like there would have been some kind of concrete and external musical Thing in the ordinary consultancy room that had taken one of us to the other side of the world. From the perspective of recent brain research, it would have been interesting to know what happened in his brain processes during such a state of vivid imagery and altered consciousness. However, relating to the subjective and therapeutic experience, I doubt that it would have been anything compared to the actual immanent experience, like holding the magic of a crystal ball, which we unfortunately could not share.

### 7.2 Cultural Dialogue

During the imagery journey "village in jungle", Ben and I ended up in a cultural dialogue where Ben told me about current Africa. I clashed with my own preconceptions. All Africans do not live in villages anymore and do not feel themselves at home in an agricultural jungle environment. Ben even experienced such an environment as threatening. The next excerpt illustrates the imagery music gave rise to and the conversation that followed it.

*Where are you going? (T) It is difficult to say but let`s say I`m on that path (P) Is it somehow familiar path for you? (T) I don`t know it (P) What is happening now? (T) Nothing yet, I´m still on that path going to that village, I`m not yet there in the village. (P) Do you already see that village from the path? (T) No, I just see those trees and plants (P) How do you feel being there on the path? (T) I`m alone (P) Is it nice to be there alone? (T) No (P) where are you now going? (T) I`m there in the forest (P) Are you moving ahead that village? (T) Absolutely because I hear the screaming of monkeys (P) What time of the day is it there? (T) Afternoon, about that time when the moon begin to show, 5 or 6 pm. Sun is beginning to descent, I can see that from the moon. I can see very far even though there are dozens of those trees, you can still see very far. (P) Is it somewhere high, on some mountain? (T) It is a bit like a mountain (P) Where are you now? (T) Now I´m climbing down that mountain, there are no visibility anymore, I cannot see so far and it looks like there would be that village. (P) In the bottom of mountain? (T) Yeah (P) Do you want to get there in the village? (T) I am going there, I´m almost; my purpose is to go there. It looks like there is no one in the village, people have gone somewhere. (P) Is that village familiar to you? (T) No, but it is African village anyway. (P) How do you feel to look at that village when there is no one? (T) It feels bit strange (P) – –* (Ben, session 18, music: Philip Thornton, *Fire Queen*, 1) *Laughing Wolf Madrigal* 2) *Volcanic Dust*; Smetana: *Moldau*; Mahler: *Adagietto symphony nro 5*.)

After the imagery exercise, together we processed Ben`s thoughts, the emotions associated with the village and what kind of imagery he had had. I learned that what may probably feel exotic and imaginable for a European music therapy patient may not necessarily be the same for an African. In fact, an African person may be confronted with ordinary things and memories, which maybe not feel at all nice and pleasurable.

*What did you think, feel about that journey? (T) It was up to question (P) You could not make it to the village? You couldn`t see it all or you couldn`t get that far? (T) Yes, so it went. (P) You reached to see it anyway? (T) Yes, I was there above it, it was not very far, I could see it well. (P) Yes, did it feel difficult somehow to go that village or approach it? (T) No, it wasn't difficult or hard that way but let`s say that where I come from people don`t want and like to go to the village. We have that kind of image that in villages there are all kinds of witches, dead people and all sort of weird. (P) I see (T) You cannot compare them to villages here in Finland, it is not same thing at all. Here they show me villages and say here is one house and another one is there somewhere far away you can hardly see. In my country it is very tight. (P) Very close together. Was the reason that there could be witches or something others in the village that made it so slow for you to go there? You didn't want go there after all? (T) It is so different because we have born in the capital city and been there for all our lives. It is very difficult for us to go to the village. There are others who have relatives there but very little. It is so closed community and foreign; they do totally foreign things. It is like from the other era. The village is in a way always empty because they leave in the morning, they go working in a field, hunting, things like that, which we don't understand at all and are totally foreign for us. In the village you can see people after six or seven p.m. when it is dark already. Besides, the fact is or I believe or assume that today those villages are empty because all the people have ran away. – – (P)* (Ben, session 18)

On the other hand, the music and imagery journeys that took Ben`s thoughts and memories back to Africa helped in integrating these hurtful, maybe repressed memories, enabling verbal processing. Dissociating patients cannot perhaps reach the meanings (senses) of, and connections to, the emotions and feelings that bring anxiety without the aid of music and the therapist. In the same way, good memories and experiences can be covered with anxiety and repressed memories. Memories of the home country where the person has grown and developed may be important for an asylum seeker and refugee in a foreign culture and in exile. Personalities are structured in these experiences and in these familiar environments or situations. The torturer has tried to undermine and destroy these experiences and the inner integrity of the home country where one has grown. I assume that a strange foreign culture, and not understanding the treatment of asylum seekers, can increase this disintegration, which may result in negligence, apathy, depression and even psychotic symptoms.

### 7.3 Bringing the family together

One thing that was increasing Ben`s anxiety and was probably slowing his recovery was that his children were still in Africa and he had not been able to meet them for years. His sons had grown to become young men during the time their parents had been in Finland. A family reunification project was started during Ben's music therapy, and the emotions relating to it also came into the therapy situation. Getting the children to Finland was a long and demanding process and problems relating to it were handled in music therapy.

*What kind of thoughts, feelings have you had this morning? (T) I don`t have any special thoughts or feelings today (P) You didn`t have any disturbing thoughts? (T) All I have is one thought in mind, I`m waiting an answer because we had that interview and those blood tests were made for bringing the family together. For boys it is there on next Thursday 2 p.m. They took blood tests from them in Africa and on Friday they have that interview. Those are the thoughts. (P) Yes, they are exhaustive; they are checking are they own children. (T) Yes, they say that is the reason. (P) Yes, so I heard in one seminar too that they are so close here in Finland with these issues and who they let come to the country. What*

*did you think yourself and how did you feel when you suddenly were taken blood tests then when you were waiting for your own children? (T) Nothing, nothing. (P) It did not annoy or made you angry? (T) When this is organized by Finns and a Finnish organization I don`t have anything against it that they take them. Of course, if it was in Africa, it would be a totally different thing. In Africa no one takes a drop of blood from me. You cannot trust there in hygienic either, if somebody takes a blood test you are absolutely sick in couple of days. In here it is a different thing. (P) – –* (Ben, session 19)

The process of family unification raised general questions that concerned their adaptation to Finland. Whilst Ben and his wife had been in Finland for some years, their adaptation was not finished and bringing their children to Finland brought new problems and gave rise to old ones again. In addition, they had to face once again the difficulties of Finnish bureaucracy and achieving asylum status, its many phases, and most of all, its slowness.

*Have the times been exciting lately? (T) Not at all, I`m always like this, all things that come I take them just like that. If I start to think and ponder then comes no good. Better be like this. (P) Has it always been your style or has it come nowadays? (T) It has just come here (laughs) (P) I see, how has it come here in Finland? (T) It has come under the pressure of self protection because everything there has been, has happened in a way that when they have promised a decision of some issue in a week it has come after four months finally. You wait every week, every day and they promise you. If you get nervous and wait, really are tied to it, it does not come anything. This Finnish system, it should be proved a little. (P) Yes, it must be bothering and tough if one waits for something every day and has to time after time… (T) and promise (I) be disappointed. I guess no one can take it. One has to somehow adapt to it then and not ponder it too much because they cannot be trusted at all. (T) Yes (I) It`s Finland (P) It was a wrong word that "prove", one has to adapt really. Like you have to adapt to climate you have to adapt to this system too. How can you prove that climate but it was that in the beginning when you come here in winter and you freeze. If you freeze here that this is terrible, I`m going to die here, then it doesn`t work. Little by little you understand that you have to dress up yourself completely other ways, you have to use, protect yourself from the cold and then it begins to go, you can live there. But if you don`t open your eyes and take in that adaptation, then nothing comes of it. (P) Yes, that`s the way it probably is. Being in a foreign country is difficult in that way, if one doesn`t want to adapt or take in something from the other culture. I guess the climate and other things differ here from Africa. I assume it would be hard to live here like in Africa. (T) Adaptation is a big project from inside as well as outside. (P) Yes, it is surely so that many people who move to other country have to experience similar things like laws and habits are different in one country. I guess it is a bit so that foreign people are treated as a little lower class and differently in other countries than in the home country. (T) Yes, that too (I) – –* (Ben, session 20)

In Ben`s music therapy, we occasionally processed those problems that he and his family encountered and Ben had the possibility to discharge his feelings with me. As a main rule, I tried to keep a neutral attitude in such issues, whilst it was not always possible. In some instances it would have been unnatural to act otherwise with my patients. As a therapist of tortured people, I had to live through and empathise with the many everyday problems they had to encounter in a foreign society, among them racism and the slowness of official bureaucracy. Some issues were clearly connected to Finnish politics concerning foreigners and the treatment of asylum seekers, where people may even have to wait for years for the final asylum decision. They had to live their everyday lives in an uncertain situation; will they be allowed to stay or do they have to leave. A negative decision would mean that they would be forced to leave the country. If the asylum seeker had already complained about

his/her first negative decision, the second negative decision for refugee status from the Supreme Administrative Court in Finland would mean the police coming in perhaps just a few days to expel the asylum seeker from the country.

These issues, and the worry and stress concerning the asylum seeking process in Finland, were clearly reflected onto the therapies and the conditions of my patients. Asylum status, and the waiting for it, was one of the main themes in music therapy too. In these issues, the maintaining of a neutral position would even have been offensive to my patients and would have turned me into one more bureaucrat among the many others they were speaking to. So I was not an official but a therapist and I occasionally consciously commented on some issues very directly and I was on my patients` side when they were under pressure from bureaucracy. In the first place, I always believed my patients; I did not have any reason to doubt them without knowing better. However, I did consider all the time the possibility of some kind of misunderstanding and that the things people told me about their experiences were subjective and may have included unintentional false memories and interpretations. My job as a therapist, according to the core idea of psychoanalytic therapy, was to try to understand the patients and their world of experiences. With this understanding, I tried to provide patients with new, alternative or better interpretations of their experiences. As a therapist, I also intended to clarify the disoriented and dissociating experiences of patients and to support the integration of their thoughts. In Ben`s case, it could even have been considered analytic psychotherapy because it clearly involved dialogue and its goals were insights into oneself and one`s thinking patterns. Ben could process these topics in his mind and he seemed to have enough capacity for introspection. Not all of my patients had that, nor have all torture survivors who suffer from severe traumas in general this capability, as described earlier in relation to the clinical theory. This is the reason why therapy was usually supportive of my patients and had to begin from the very fundamentals of reciprocity and being or sharing with another person.

### 7.4 Traces of Torture in Therapy

In the lives of many patients, music was a thing, sometimes perhaps the only thing, which brought them pleasure and made them feel better and this enabled them to concentrate while listening to music. So it was with Ben, and he enjoyed listening to music a lot and also applied it at home for controlling his emotions and in order to relax – just as he had learnt in music therapy, as he explicitly said. However, there were also times when he did not want to listen to music in therapy because he felt bad in some way. We had agreed already at the beginning of the therapy that if voices and music were too intrusive and did not feel good then we could just talk. So we did occasionally, though the reason was not always music but sometimes Ben had so much to discuss that we just did not have enough time for music. I think this is a natural phenomenon in music psychotherapy processes when the increased symptoms of patients also produce the pressure to talk more. On the other hand, the increased need to speak and discuss may also mean progress in the patients` rehabilitation as they can more easily analyse and share their thoughts verbally. Therefore, this may also manifest as developing trust, reciprocality and verbal capability, depending on the interpretation. In the case of torture survivors, increased speech usually meant progression and was one of the goals of the therapy. The next extract from Ben`s therapy illustrates in my

opinion traces of torture and the usual symptoms relating to it but, on the other hand, it also shows some kind of developing capability in him to cope with such emotions.

*Should we then do such an imagery journey? (T) He said that I don`t know. I asked what that does mean, don`t you want? He said, let`s say that the mind is not really peaceful. (I/P) Aha, yes (T) It is not in order. (P) Yes, how do you notice that your mind is not in order? (T) I have that kind of feeling like I had fever and such a feeling that I had problems. I am not feeling calm at all in the head. (P) And did you sleep well at night? (T) No (P) Nightmares? (T) – – I slept at 4 am and woke up 7 am, 3 hours. (P) Yes, then that mind can be weird and one can have a weird feeling if one doesn`t sleep much. (T) And feels tired (P) Yes, is it connected to a some kind of thought that is disturbing you at the moment, connected to a thought that the mind is not in the order now, you cannot sleep? (T) It was just that when I went to sleep in the evening the sleep did not come (sounds tired in general too). I had such a feeling like I had some problems. I don`t know what the problem is, I couldn`t get it but it was that kind of feeling. I cannot explain, I don`t know, where it, what. (P) Yes, in some way it can be a bit unconscious bad feeling, anxiety. Can you connect it where it could come? (T) I cannot catch that; I cannot understand what happens in my mind. (P) Yes, you probably cannot, maybe it goes away after all. Is it related to such situations you had last time or maybe similar feeling? (T) No, it is not the same, it is quite different. Last time I had a some kind of thought or had thoughts that took me with them. Now I don`t have any thoughts, I don`t think at all. (P) Okay, is it then some kind of restless feeling or how could you describe it? (T) Sort of restless, "restless" is a good word. You know, sort of feeling like when you have a problem. You are not there like… (P) yes (T) You are not feeling well, not mind or physically either. Then you feel also sick like you are getting ill or are ill. (P) Yes, maybe we can drop that imagery journey this time. (T) I cannot concentrate (P) Yes (T) Mind would leave anyway. (P) – –* (Ben, session 20)

Evidently Ben experienced and feared that his mind would dissociate and that music would raise images, memories and emotions which he would not be able to handle. This relates to music`s ability to pass through defences. However a sudden, coercive and intentional breakthrough of defences would cause the patient anxiety and would not be therapy in my opinion as it does not forward integrative processes or the well being of the patient, but is rather diffusing. This relates to the earlier described psychoanalytic theories of the ego mastering of the mind and music respectively and illustrates how music may represent a bad and persecuting object and thus be seen as a threat in a patient`s self-experience. It is also an example of avoidance and resistance in therapy, which may be necessary in some situations for trauma victims. In the case of traumatized people and torture survivors, it is good to be especially careful with music and sounds because their defences do not function normally and diverse sensory stimuli may influence them more easily and cause anxiety. The therapist`s task is to develop and support the coping strategies and defences of the patient and not to undermine them. A patient like Ben owns the right to choose when he wants to listen to music and participate in an imagery exercise, which may offer him the chance to develop but also demands a lot from him. This capacity to choose, to stick up for one`s rights and in a way keep one`s integrity, can be interpreted as development because it represents a recognition of specific feelings and threats in the mind and a way of controlling them. In Ben`s therapy this was one of the main focuses.

Some everyday situations may bring to mind old feelings and experiences for torture survivors, sometimes they may concretely relate to torture and being in prison. For example, the date/anniversary of when one was arrested may give rise to extreme anger, which is

followed by hurt and bitter memories. This happened to Ben in one therapy session when sleeplessness, tiredness, anxiety, difficulty in depicting emotions and an incapability to concentrate were the results of a trip abroad. Ben had accidentally met an old friend during the holiday who had thought that Ben was dead. This must have upset him on some level and brought forth many disturbing thoughts.

*What did you think yourself when you heard this that you have been thought to be dead in your home country? How did it feel? (T) It feels very strange and not good. The first thing is weird, very weird. Not a good feeling, no good. (P) It must have felt like maybe being dead or the fear for when everything ends, what other people think and so on. (T) Yes, I have some fear of dying. For instance, if I would call home and told them I have met you no one would believe. (P) Yes, it may probably make you sad or even angry. (T) And the person he knew. (I) You hit the right spot, it is very sad and tremendously raging. This person in Sweden lived then in Nigeria and had heard from her mother by the telephone that I had been killed that time. Then when she returned to her home country she had asked everyone about it. Either it was clear dying or then people said that we don`t know, he was taken to prison and he had not been heard or seen ever since, nobody knows nothing. In that time it was evident then. (P) When one has disappeared vaguely, then s/he is many times dead, never found and so probably dead. (T) Yes, so it is. (I) Yes, it is very common, it happens to so many. (P) Yes and in many countries. (T) Yes. (C)* (Ben, session 22)

At the end of the therapy session, we made it to the issue which had bothered him. One positive aspect was that he could share with me explicitly this extraordinary experience and tell me about the emotions relating to it, like his fear of dying. Making the expression of emotions easier was one of the objectives of Ben`s music therapy. In this particular session music was not applied, however music therapy and psychotherapy in general have to be considered as long term processes where one session may only be verbal reflecting and the ventilating of issues that have arisen during therapy. Music is one therapeutic element, an additional tool for the therapist if you like, in helping to verbally express such emotions. Actually, at some point in music therapy, music may itself become unnecessary in regard to its former function of opening up dammed emotions and stiff useless defences. When progress happens in therapy, a patient can already express such issues and emotions without the facilitating effect of music and outer stimulation. This happened also with Ben.

### 7.5 At the Origins of Trauma

After half a year of therapy, Ben`s trust in me clearly increased and it seemed like he was able to therapeutically make better use our sessions. This was shown also in imagery journeys with music. During therapy session 29, he went to back to the time he was held in prison and was mock executed. This imagery exercise was made with free associating to music without a theme provided by the therapist. Ben agreed to this himself. The music that I used included

1) *Gymnopedia* by Satie
2) *2nd Symphony, Parts 1 and 2* by Sibelius
3) *Reverie* by Debussy.

At the beginning, Ben`s imagery led him to his home country and he thought of people there in the countryside and in the city. His images went to his home town and he felt good, there was no threat and he was alone. Ben saw fishermen which he started to approach, and then he sat down on a bench by the riverside after sightseeing. The music ended and we began to analyse his music listening experience and the imagery evoked. He told me that his head had begun to ache while listening and he felt heavy. This heavy feeling and a feeling of pain emerged at the very end of the musical piece. He was just coming down from the scenery when the view started to look peculiar and the day of his execution came to mind. He did not want to tell me much about it but told me that it was a mock execution. The place looked similar to where they were taken; near the riverside, young trees, a bank. I said to Ben that I had noticed he was looking tense when the music was ending. Ben told that he did not want these pictures to come to mind but they just came. He explained that in everyday life they arrived too, but that he did anything to keep them away. Usually, he absented himself in his thoughts during the bad memories and imagery. However, now he said that he was present even though these thoughts were in his mind at the same time. He added that sometimes, when these thoughts arrived, they destroyed the whole day, “eat it”. During our appointment, when he told me about these annoying incidents, he appeared mainly calm and relaxed.

It was during this session that Ben went deeply into the roots of his traumatic experiences for the first time with his imagery. He also talked to me for the first time more explicitly about his mock execution. What is special in this incident is that Ben went into the traumatic experience himself after positive imagery and worked through it with the help of music. This situation also depicts how familiar scenes, surroundings and noises may give rise to traumatic memories for the torture survivor. However, Ben was able to cope in this situation and was not totally caught up by these emotions. From the psychoanalytic point of view, I can say that it is assumable that music was a *good object* for him and helped in controlling and structuring his experience. Music provided an emotionally peaceful feeling and supported the self while freeing rigid defences. This enabled the experiencing of repressed memories and emotions safely. It is worth noticing the clear resistance Ben experienced towards discussing these kinds of memories and experiences and how he tried to keep them off his mind. In this way, in a psychological sense, the traumatic experience is closed out of the mind by repressing, isolating or completely dissociating it from self-experience. It is also evident in this short example how psychological experiences, which are kept out of the mind with various defences, may arise in the form of somatic symptoms such as pain or uncomfortable feelings. They may partly be the results of extreme attempts to keep these memories and experiences at bay. However, many of the torture survivors who have traumatic symptoms also have various vague pains, where the meaning connections between the Mind, consciousness, and the Body have been lost because of the massive use of defences and dissociation. It is also possible that connections have not emerged because of the nature of such traumatic experiences in the first place. A certain similarity can been seen between patients suffering from traumatic experiences and so called borderline patients, regarding the way in which they experience their own emotions and control them. It is worth noticing though that the reasons and the origins of this are different, this concerns also other similarities like the lack of self-structures and undeveloped defences.

It had been just a little over six months since the beginning of music therapy with Ben when he opened up and told me about his traumatic experiences. It was then May. The next time we met, it was already June. He told me how May and June were difficult times for him because it was then that something bad always happened. It was during these months that he was arrested, jailed, convicted and sentenced to the death penalty. Ben had been feeling bad lately, thoughts had been circulating and he had not been able to sleep. He had not come to one therapy appointment during this time and did not want to listen to music because he was feeling so bad. Ben told me how he had been beaten and tortured in prison and how he had begged them to kill him so that he would not have to wait to see if he would be executed the next day or the next month. He was completely finished and the begging increased the beating. This torturing and beating continued the whole time he spent in prison, which was about one and a half years. The guards just continued beating him with the butt of a riffle and did not listen to anything he said; instead they made his suffering worse. His time in prison was one of living in uncertainty and we noticed how there were similarities with his present uncertain situation and how he waited for the decision on his family's reunification; would his children be allowed to come in Finland. The issue had already taken over three months, and the decision should have come. This was the first time that Ben had talked me so explicitly about his traumatic experience, which I think showed developing trust between us.

For individuals who suffer from traumatic symptoms and who have been tortured, it is typical that traumatic memories and experiences come back without their own volition on the anniversary of the traumatic circumstances. It is probable that the strong emotions involved, that usually arise even long after the traumatic situation, keep the related symptoms active. Ben, when he was remembering his time in prison, told me that he experienced a very great hatred towards his torturers and that if these persons would walk his way today, "they probably would not live for a second". This sounded like a very strong and rough expression because usually Ben was very peaceful and relaxed in his behaviour and verbalisations. However, these traumatic experiences still evoked such powerful emotions in him. He told me that his humiliation was increased by the fact that he had become so small physically – faded – in comparison to the big muscular man he had once been. On the other hand, whilst Ben was clearly under a huge amount of pressure with the destiny of his own children and the traumatic experiences obtruding on his mind simultaneously, he still felt that he was currently being born again. He let me know clearly that he was not giving in even though he was feeling sick, had insomnia and was suffering from all the general uncertainty. It was important for his rehabilitation that he went through his traumatic experience with me and was able to express those strong emotions like hatred and anger that he still experienced towards his torturers.

During therapy session 36, he told me how he had thought about his own coming to manhood while listening to music. At this point he had disturbing thoughts, even though he told me that otherwise his thoughts progressed "logically" to the end and he could think clearly. His disturbing thoughts were related to memories of prison. Before that his life had gone brilliantly, everything was fine, but then this happened, which destroyed everything. Ben told me that he experienced a great deal of hatred at that moment. He described the situation as if he had been dropped from number eleven to zero. One cannot climb higher immediately but is confused at first, then one has to wake up and recover, and only after a

long time may one wish to reach the top again. However, he was able to go ahead with his thoughts during listening to music and found thoughts about “peace” and felt that the “the fight continues”. After music, he said that he has to open the stocked gate, so that he can orient to the future. Ben said that occasionally he has to “put in brackets” the whole thing.

### 7.6 Completing the Music Therapy

We had come quite a long way with Ben in applying music and it seemed as if he was going through his emotions and thoughts relating to his time in prison and the torture he had endured. However, when the autumn came, we had to begin to think about ending his music therapy and how he would continue his rehabilitation and therapy with his doctor. At this point, a more thorough processing of prison and his torture experiences was getting more difficult because of the social situation involving Ben and his family: The family was evicted from their flat unexpectedly and Ben had to spend some days living outside because he had only enough money to pay for his wife to spend the night at a hostel. The family’s money matters were somehow mixed up with their own social worker and it seemed as if there were some misunderstandings relating to their eviction; they had thought that their rent and unpaid back rent had been taken care of and that everything was fine. These feelings also came up in therapy and during the worst time Ben could not reach the therapy appointment at all. It appeared like Ben always got into trouble with his social worker somehow, and in therapy he spent a lot of time talking emotionally about these situations. When Ben explained his situation so passionately, I experienced through my counter emotions that he was also dissociating. Later Ben himself admitted this when I told him about my feelings. So, there were still dissociative states even though Ben could clearly better control his mind and had made progression with his rehabilitation.

Ben`s stress was also increased by the fact that only one of his children in his home country got permission to come to Finland when they applied for family reunification. Naturally, this raised conflicting emotions in him. The other one of their children had come to the interviews and the blood tests at the wrong time, so this application was initially denied due to Finnish law. The problems in his present life, and the stress they brought, were mainly the themes during the last sessions of Ben`s music therapy. However, Ben did not give up on bringing his family together but began to apply again for permission for the second child to come to Finland.

During the very last sessions, we were waiting for the other child to arrive in Finland. There should not have been a hindrance anymore but nothing happened. Ben took his own CD to therapy, *The London Pop Orchestra Plays Bee Gees*, which he used at home to relax and to bring pleasure. Ben described his experience of listening to his CD; it made him feel that he was very “alive”, that he was a decent person and the negative thoughts stopped and his consciousness was free. It could fly completely free. Ben described that little by little feelings of pleasure were arising and he occasionally could feel that he was almost Finnish. Sometimes the feelings were so good that it felt like he was at home. In a way, he explained, he shut off the outside world, everything which was outside of himself, so that it did not exist anymore. Ben did not like the new apartment and did not feel at home there. There, what is inside, I am at home, he continued. It can feel so good. Towards the end of his music therapy,

Ben could describe his thoughts concerning music and his emotions more thoroughly. It also seemed like he was having peak experiences while listening to music where he trancendentalized or "bracketed himself", as he actually literally verbalized his experience. In a way, this was similar to a phenomenological "bracketing" of his gloomy state of mind and living conditions.

Ben continued his description of how he experienced music during the same therapy session, number 47, and said "without music life would be like living in the cemetery". Music discharged anxiety and brought his home country here and made Finland feel like home, he explained. He said this even though he had had many troubles in his ordinary life in Finland because of his foreign background. Ben added that when the mind goes to bad things, then music changes it more clearly, so that he can live. Ben also clarified his earlier description of his musical experience, stating that previously any music which he listened to annoyed him quite a lot and made him angry. Even this kind of music, which he now described as "gently" annoyed him then even though he even tried to turn the volume down. Ben told me that for the past six to seven months music had felt good and he had learnt to apply it. For the past six months, music has felt good and it frees me from all those thoughts, occasionally I felt asleep, he depicted.

Ben continued with his free association, sounding almost like a poet or a philosopher when he said how music changes everything – the miserable things – and how it is good to be like there would not have been such things, which he said just when we had been discussing his money problems. He said that music was like "a wall", which came between things; then they are there but it is good to be here. He could forget everything when he put on a CD, even the torture experiences, for example, as I mentioned. Ben continued that if he would have to dive continuously into this everyday reality, he could not manage. He would be like "a robot" that should be turned on again. If one dives into every matter at full speed, then the motors have to be pulled on constantly. He postulated that music is such a thing that can pull aside the miserable things. If one dives into everyday situations at full speed, then there has to be "a gate", which one can pull in front of oneself. Ben told me that he had to do things in this way with his aforementioned social worker, whom he refused to meet with anymore in the end. Ben felt that things always went wrong with the social worker who promised that everything would be fine but then they turned out to be the opposite. I described to him what I had noticed in him now and what I had discussed with the centre`s doctor as to how Ben still falls deeply into these emotions and dissociates while he talks about his problems with his social worker. Ben said that I had understood the situation very well. This is why I considered it necessary for Ben to continue therapy with his doctor after his music therapy had been discontinued, which I also recommended to him during the same discussion.

During the last two sessions, we filled in the research questionnaires as agreed, at the same time many things in Ben`s life were changing and we had to discuss them as well. Good news was the sudden twist that Ben had found a job. In the beginning, the job was only meant to last three months. This naturally made him feel really happy. However, there was also a lot of stress involved because he was awaiting his child`s arrival to Finland and there still was no precise information as to when it would happen. Ben`s doctor considered that Ben still needed therapy because dissociative states were still occurring. In addition to this,

while filling in the questionnaires it came up that Ben still had surprising fears which caused him to turn around suddenly when, for example, he would find himself going somewhere and did not know why. That is why he was sometimes terribly late. He still experienced restlessness and the feeling of being locked in. The ending of his music therapy annoyed Ben and he would have wanted it to continue. I argue that Ben gained an advantage from music psychotherapy in many ways. We had gone through his traumatic experiences and he had had a chance to discharge various feelings relating to the difficulties of his everyday life and his tough life situation. Ben had found a way to confront and process his emotions through music. It helped him to relax and calm down. I postulate that with music and music therapy, Ben`s capacity to concentrate and control his own emotions and thoughts had developed even though there still was some dissociation and anxiety. During the last session of Ben`s music therapy, Ben wanted to listen to *Fly Away* by Lenny Kravitz, which he expressed fit his feelings. Ben listened to the song in a good mood and with his feelings, even though there was also the more serious underlying aspect of completing his music therapy, which he would have wanted to continue.

## 8 CASE TWO: ABDUL FROM SOUTH ASIA

Abdul was a man of about 30 years of age from South Asia who had escaped to Finland without his family. Abdul had been a political activist and a shopkeeper in his home country where he had got into trouble with those in power because of his activities. He had been arrested and beaten badly all over his body. This made him suffer from traumatic memories and pains, he also suffered from depression. In addition to psychic disturbances, he suffered from insomnia and chronic pains. Pains from violence are common among torture victims. The situation was worsened because Abdul`s wife and children were left in his home country when he had had to escape quickly. Abdul`s father helped him to escape. However, his father died soon after Abdul had escaped. This had nothing to do with Abdul or his escape but still Abdul blamed himself for his father's death. Evidently, his father had died of natural causes.

When I first met Abdul he appeared to me to be anxious and a bit restless, which seemed to make him sweat. In my counter emotions towards him, I felt that he was also distant, as if his mind would have been elsewhere. Abdul was quite a thin, middle-sized man who looked very miserable and droopy in the hallways, which caught the attention of the other staff. It caused us to worry about how he was and whether or not he managed to sleep or eat at all. His condition seemed quite bad as he could not always sleep because of his disturbing thoughts and nightmares, which made his friendly brown eyes look very tired. He seemed to be stuck in a cycle of complaints of physical pains, insomnia, tiredness and hopelessness. It felt very difficult and heavy to talk with him, since he frequently just said "yes" or "no" and could not describe much more than his present feelings and state of mind in a very tired and hushed voice. His thoughts were usually on the past and were related to his father`s dead and the family he had left behind. He felt that his life was hopeless and could not think ahead much in his life. In the first assessment meeting, he told me that he liked Hindi music where there is singing. He told me that he did not like songs in English because he did not understand the language. During the music therapy assessment he also told me that music brought up good and bad memories in him, sometimes it made him feel good though. However, he described that his moods and feelings altered so frequently during the day that it was difficult to tell. Anyway, he was willing to try music therapy, even though he could not listen to music much at the time. In my counter emotions, Abdul appeared to me to be very desperate and difficult to reach and communicate with, even with music. He also seemed to be pleading, humble and ready to take all the help he could get. I had heard that verbal psychotherapy was almost impossible with him because of his curtness. However, he had come to appointments and seemed to especially like physiotherapy and massage, which continued during his music therapy.

His father`s death affected Abdul very much and he mourned him deeply, which made him appear very depressed and anxious. His depression even had psychotic characteristics because he talked with his dead father, who tried to control and manipulate his life. Abdul`s life had narrowed and he had difficulties in taking care of himself, such as eating and washing. He only slept for a few hours each night and was isolated from his environment. To make a hard situation even worse, he was in the middle of the asylum seeking process. This made him even more anxious. The objectives of music therapy concerning Abdul were that music might provide him with some kind of pleasure and hope. Also, the aim of music

therapy was to help him be in better contact with his emotions. It was assumed that some kind of therapy involving activity would be good for him because he could not really talk about his issues, most of his speech being confined to internal conversations with his dead father, to whom he would talk and complain about his physical afflictions, such as pain. Abdul also had meetings with a psychiatrist/psychotherapist and had regular physiotherapy and music therapy. Later, music therapy became his primary therapy and meetings with the psychiatrist were reduced to the occasional.

### 8.1 First Meetings

At the beginning, music therapy was especially difficult with Abdul because he could not discuss much about the stressful matters that were on his mind, like feelings and memories. Sleeping was hard for him and he could seldom feel any pleasure. This is typical for severally traumatized people and torture survivors. For Abdul, the recent death of his father and separation from his family made the situation worse. Therapy meetings, approximately 45 minutes or less at the beginning depending on what he was capable of, concentrated on being in the present and how we could carry on from that in the early phase of therapy. Real dialogue was rarely possible and Abdul frequently answered me with just one word and his voice was quiet and tired. In the meetings, he was clearly sweating, anxious and suffering on many occasions. Sometimes he even felt that listening to peaceful music caused too much anxiety, so that he did not want to listen to music and was only able to listen to it with me. He could only verbalize his experiences a little. The lyrics to music became important when working with Abdul because he could tell me what the song was about and so it made conversation possible and we were able to discuss a little how he experienced music.

*What the song was about? (T) About own life and the story of it (P) Did the singer tell about himself in it? (T) I don`t know. (P) What was that story about? (T) It is difficult to explain; it is easy to feel but hard to explain. (P) Somehow it sounded like a quite happy song. It came to my mind that was it a love song? (T) No (P) Was it anyway about happy things somehow because there was that easy and peaceful mood? (T) Yes (P) Do you think that it had a peaceful mood; do you remember? (T) I don`t know. (P) (break) How did you experienced it when we were listening to it? (T) I already told that it just don`t feel good, I can`t concentrate like earlier and enjoy like before (tired) (P) You told me that you like to listen those song lyrics. (T) Yes, earlier I have liked but currently it doesn`t feel good because in my mind there are thousands of thoughts, thousands of problems, so I cannot enjoy. (P)* (Abdul, session 2, music: Mannade.)

Even after a short song, we could begin to start a conversation about Abdul`s experiences and what he thought in general. Otherwise he might have answered just “yes” or “no” to my questions, no matter how I would have formulated them. He felt that Western arts music was strange because he could not “understand” it; it was the same situation with Western pop music because he could not understand what they sang about in those songs either. However, he felt the same way about music that was in his own language; so it seemed that the lyrics and songs were important to him. It appeared as if language would have helped him to control his mind better because he told me that he could not “understand” instrumental music from his own country either. From the psychoanalytic perspective, this appears to be a form of defence against music and the possible feelings it could bring to the surface. Without the means of language, it seemed like Abdul restricted or denied music as something

threatening in his self-experience, which could imply super ego control particularly. It is also possible that this phenomenon may have had to do with fragmented self-experiences and the dissociation of feelings and language relating to his traumas: Abdul needed the support of language to reach his emotions, in his experience.

*What kinds of problems there were going around your head now when we were listening here? (T) It is difficult to explain because there is suspension all the time. I didn`t know that people can live in such troubles. (P) Yes, this what has happened to you now, sorrow and then the torture experiences too. (T) Yes and it feels the most difficult that my father is dead and all has gone to it. All the time I blame myself that maybe it was my fault that he is dead. (P) Did your father live here too? (T) No, in my home country. (C) Did you think that your father is dead because of you?(T) Because I have been his only one and maybe because of me he has thought and worried a lot and maybe it is the reason he got ill and died. It was because of me he got ill and died. (P) How did your father died then? (T) He got ill and all the time there was thinking and considering, finally he died. (P) Do you remember when was the last time you talked with the father or got a message from him? (T) I don`t remember it precisely, maybe in August or September last year. Maybe few days before I escaped to Finland. (P) Did you say farewell to each other then? (T) Yes (P) It is quite difficult, sad situation too… (T) Yes (P) One cannot really know when you see the next time. (T) Then when I get to him because my father continuously asks me to come to him. But I have a wife and children too, if I would go to him who would take care of my family. (P) Was that family here in Finland near you or did they stay there? How they are there now? How do they manage to live now? (T) They currently live with my wife`s parents. (P) They don`t have anything to fear there? (T) Yes they have and that`s why they have escaped there; it is a bit far from our house. They seldom go outside and children cannot go to school either. (P) How old are your children? (T) Ten and seven years old. The third one is still very little. (P) You really miss them, don`t you? (T) Yes (C)* (Abdul, session 2, music: Mannade.)

After a short piece of music we could usually get to talk about Abdul`s emotions and thoughts relating to his father`s death, for example, which he otherwise could not directly discuss when asked. I tried as a therapist to clarify Abdul`s thoughts and experiences and also to *emphatically describe* his situation, so that he could, for instance, notice what kinds of feelings and thoughts his experiences or music gave rise to in another person (Tähkä, 1997a). My objective was also to verbally revive Abdul`s own experiences and emotions and in this manner to support, develop and strengthen his then still fragile self and its coping strategies. In session 2, I also used *The Swan from Tuonela* by Sibelius as music to emphatically describe Abdul´s situation, with his permission. This did not lead to much discussion; Abdul said he did not "understand" the music and the emotions related to it, even though his thoughts were centred on his father`s death and his family occasionally while listening to music. However, when given my interpretation that not finding one's emotions easily anymore could be one of the resultant traumas from torture, he answered: "yes, that emotion has been destroyed", "the most of them in torture and when the father died the rest". He admitted simply by saying "yes" to my clarification that "those emotions may be so big and heavy that one is tired to experience all". I postulate that music provided a *holding environmen*t, as described earlier, as the background to our short and fragmented discussion, which was my purpose. It enabled the working through, expression and verbalization of some of his traumatic experiences, which Abdul seemed to dissociate from his self-experience.

## 8.2 Threats and Fears Left by Torture

Abdul`s life was very hard in many ways because he suffered from continuous insomnia and physical pains. Partly, his insomnia was caused by the fears of being tortured and persecuted that still made him see anxious nightmares. In addition to this, he was grieving over his father`s death and his compulsory separation from his children and family. Traces of torture were also found in the way he was isolated in his home and how he feared informers, even in Finland. So it was difficult for him to trust people, which is one essential trauma among torture survivors. At the rehabilitation centre, we were almost his only contacts with the outside world.

*Do you have plans for the weekend? (T) I`ll be at home, I seldom go out. (P) I have no place to go. (P) Are here other people from your home country? (T) Yes, but I would not like to go, it scares me. (P) Do they have different background than you? (T) I feel scared myself that there would be an informer or then someone would try to do me something bad, hurt me. (P) Yes, it is probably so that feelings and thoughts that one is not given peace or that somebody follows, does something are not easy to get rid of. (T) Yes (P) Here in Finland it is known that you are here, so probably no one could do you anything here or what do you think? (T) What if somebody did; once hurt is difficult to cure. (P) Yes, do you mean those torture experiences and being arrested? (T) Yes, they are still searching for me in the area. (P) There in the home country? (T) Yes, my opponents are very powerful, superior force. (P) Do they represent another political view? (T) Yes (P) Is it possible then that here in Finland are advocates of another political view? (T) Could be, I don`t know and I have not asked anyone. (P) It probably arises uncertainty that can one trust that person whilst s/he is there from the home country, on whose side s/he is, does s/he accept me because I`m like this, advocated that politics in one`s own country. Because of that you are here then. (T) Does it come easily to a conversation always why you have come here in Finland, do people know about it? (T) Yes, they ask but I don`t tell anyone why I have come here. (P) Yes, you don`t probably have to tell it so thoroughly, what feels good to yourself like in other things too. I assume that kind of delicate matter may divide people. (T) Yes (P) Political issues can be a little bit sensitive issues to discuss, it could be here in Finland too that unfamiliar people don`t always talk about it so deeply, they could be arguing soon. Then they don`t come to talk much. (T) Yes (P)* (Abdul, session 7)

Abdul`s trust in me had evidently increased because he talked to me more openly about his experiences and the fears that were partly behind his insomnia. In the therapy session following the last extract, he told me about his repetitive dream and the fear of death associated with it. The evolving of this kind of trust towards a therapist or another person can be one objective for torture survivors` psychotherapy, also a prerequisite for any therapeutic processing and relationship.

*Does that walking help a little bit to get a sleep too? (T) Yes, that`s why I walked. Now even going to sleep scares. The fear comes when I go to sleep. (P) Are those fears relating to something? (T) I usually see nightmares that some come to beat up me, I run away from there. (P) Is it a regular dream that repeats? (T) Yes, quite frequently. (P) What happens when that dream comes, do you wake up? (T) Yes, I`m frightened, I wake up again, sweat comes, I feel tired and the heartbeats increase. (P) Are they like common dreams among torture survivors where somebody is chased and beaten up? (T) In some moments I feel like dying. (P) Do you mean the dream is so horrible that you wish you would die or fear that you are dying? (T) Yes (P) Such fear comes? (T) Fear that if I would die. (P) Yes sure (T) or if I would be killed (P) Probably it is a terrible experience that somebody chases you, beats you up and if one knows what has done to you and people in general. I assume it is a real fear about your own*

*life. (T) Do you recognise some persons or situations that are happening in that dream? (T) Those persons are not familiar; I have not seen them before. (P) When you were beaten for example, did you see them or did they put a hood in your head for instance? (T) So you mean police? (P) Yes (T) No, my eyes were not covered. (P)Yes, it is a common torture method that they cover the eyes of the tortured, so that s/he cannot testify afterwards who is doing what. (T) They are policemen and against them there would not be any cases in court. (P) It could be also difficult in Finland to bring it court. (T) In here it is possible though and there would be no consequences, however it might be difficult to prove something but those things will be investigated if one complaints about a treatment of police. (T) In our country making report from police is almost impossible, if somebody did so, then it would be difficult to stay in country after that. (P) Yes, it varies in different countries. (T) Yes (C)* (Abdul, session 8)

One major addition to Abdul`s worries at that time involved waiting for the decision on his asylum application, and finally receiving it. According to my own experiences, waiting for the asylum decision was intolerable for many victims of torture and brought them more anxiety. For its own part, waiting and the uncertainty as to whether or not he could stay in Finland made Abdul`s rehabilitation and therapy more difficult.

### 8.3 Negative Asylum Decision

In the initial phase of Abdul`s therapy, a bad situation was probably worsened by the uncertainty over whether or not he would receive asylum in Finland. When the decision finally came after six months of waiting, the information it contained made him more anxious and hence made sleeping more difficult. The result of this was that he was obviously more tired in general. During this period, he was seen to fall asleep for a while in the waiting room. To receive the asylum decision, he had to travel to another town`s police station where his reception centre was. There was no danger that he would be taken out of the country immediately because it was possible to appeal against a negative decision at the Helsinki Administrative Court. The processing of his appeal took approximately a year at that time, about the same amount of time as the processing of this first asylum application. However, the receiving of the so called “first decision” was still tough for Abdul.

*How has it gone? You heard the decision last week? (T) Naturally bad, I feel sick in all the ways I mean. (P) He said that he feels like he is paralysing. (I/P) You mean like depressing that you cannot think? (T) Paralysing in mind. (I) Yes, I just heard that the decision was negative. (T) Yes (P) How did they explain that then? (T) They did not explain anything to him, they just said there is no problem at all and he could return to his home country already. (I/P) He knows does he have a problem or not, how could they know that. (I/P) Did they say there that you could return to your home country? (T) Yes (P) What do you think about that yourself? (T) He will try again, it depended on everything possible. (I/P) Yes, so we spoke last time that you can complain about it and it takes a long time. (T) About a half year (I) Yes (P) – –* (Abdul, session 11)

In Abdul`s case, being handed a negative decision affected him dramatically: He became anxious, got more depressed and could not see anything positive in the future. It appeared as if Abdul had lost all his hope in life, and the knowledge that lodging an appeal against the negative decision may also result in a positive decision did not seem to alleviate him in any way. There had been some essential information and statements missing from Abdul`s

asylum application which was the reason why it had been rejected. However, it was astounding considering his bad health.

*He said that he loathes life at the moment and did not have strength to carry on this life. (I/P) Yes, here sure is a big crises, it surely doesn't feel nice and creates more of that uncertainty. (T) Yes, it is better to die than to be alive in this situation. (P) Yes, it is tough and humiliating absolutely when you come to be refused in a way after all you have experienced. They are putting you back there from where you have been forced to escape. He said that if he had had a family it would have been other ways. (I/P) What do you mean with family? (T) He apparently has a family in the home country too. (I) Yes, I know that. (T) Means that if he did not have a family, I assume he means that (I) You can clarify from him (T) I ask him (I) Now he mentions there that if he would not have a family he would have gone by his father. He says that the father is well, he is in peace at least, and he has a family in a way whilst everybody refused him but he cannot refuse his family. (I/P) The father is apparently dead. (I) Yes (T) That`s what I thought that you want to die but you think about your family after all and you are not considering to do something to yourself. (T) He says that even though he had not a family, what is, is that he is thinking about his family quite a lot but if he has no other choice then he would go to his father gladly. (I/P) Yes it is a heavy situation there, so that the death would feel relieving. The last time we talked about that there is no use in throwing away all the hope. It is possible to complain here and it takes time. Now we have that information that there was not your testimony and statement about your torture involved. It will surely affect the decision then. (T) Everything is mixed in the head, so that I cannot think things peacefully like you do. Then when I ponder those things I get a terrible headache, which is totally intolerable. (P) One and half years I have been sleeping that way, usually sitting when it is supposed to be sleeping. (P) Do you mean sitting during the night or day? (T) He talks about night at least. (I) He says that he is sometimes in bed, sometimes walks, sometimes sits in the night, takes coffee and ponders how one and half years has gone now. (I/P) That`s the way it has gone, I know because you have told me. (T) Yes, he says that he has got medication too but it has not helped according to him in anyways. (I/P)*

*It probably arises strong emotions that decision issue, makes you ponder things. I assume you feel hatred towards many instances, why am I treated this way and I am not understood and so on. However, one probably cannot be fully in anger or in those stirring emotions all the time. It must result as a headache then. (T) He said that he really feels too tired addition to this. (I/P) He said that whilst he knows that it is not good for him he tries to avoid that thought or anger or everything. He cannot help it that those things arise unavoidably. (I/P) So it surely does, they consider such big issues, that I assume no one can be so full of anger continuously. Still it comes to mind though. (T) He says that he doesn`t know, the current situation is really bad, no good to sleep; things come to mind all the time. (I/P) He says that there have been days he has even forgotten to eat. (I/P) Yes, when things go bad, then those thoughts really go around, after that one does not remember to do things that one normally does. One does eat much and doesn`t feel really hungry, however probably such things in deed. It would be good to try and concentrate and to remember eat, go out and try not to be much thinking about those issues too thoroughly. Those issues cannot be really affected; it is best to try and live as normally as possible. (T) What will he do? He is already in bad condition, nothing feels good now. (I/P) So it goes but you must not give in, you have to go forward like earlier, that decision really doesn`t mean anything yet actually. Treatments continue, and the life here in Finland to a better shape. (T) He says that yes, true, he has tried and knows from that, trusts it and tries, himself just has his head mixed the way that he doesn`t know what to do. (I/P) – –* (Abdul, session 11)

In Abdul`s case, it was clear that he was already in a very bad condition before the negative decision and that all the extra stress had made him feel worse. His defences were so weak and his psychic tolerance so burdened that he could not cope with the situation

rationalistically. Thoughts about leaving to go back to his home country made him feel really confused and out of his mind holistically, so that he felt bad in every way, even physically, and he could not control his bad feelings or get any relief from them. His mind could not handle so many difficult and traumatic experiences, and the continuous uncertainty that seemed never ending. He felt as if only death could bring relief to his mind. From here on, Abdul`s situation began to worsen in phases even though we tried to support him in many ways at the rehabilitation centre. One major objective for therapy and rehabilitation in this phase was to try and keep Abdul alive and slowly raise a little hope in him.

### 8.4 Music Portraying One`s Own Life and Emotions

Independent of Abdul`s difficult situation and the negative asylum decision, our music therapy continued intensively. After the decision, there was an opening and increasing of trust towards me in Abdul. He could already talk about music more and begin to recognise in it his emotions and similarities to his own life situation. Actually, we were really at the starting point of psychotherapeutic processing.

*To me this piece sounded a little bit of different, I don`t know about those words. (T) Yes, this is sadder. (P) This was sadder? (T) Yes (P) Was it because of the words then? (T) Yes (P) To me it sounded somehow happier, lighter. What were those lyrics about then? (T) Yes (P) About what? (T) The singer or writer has told about his own life and there was a river as an example, how the river goes on the other side. It breaks the area but on the other side it makes it flat. (P) Did it mean that there had been hard times in life; did the river mean that? (T) Yes, he has compared himself to the river whilst the river does not stay at the same place it goes on its way and either breaks the other side or another side levels off. The author or singer was still in difficulties, so the neither of sides were all right in him. (P) That situation was still in the middle there, didn`t know what to do and the things were not really well or very bad yet. (T) Yes (P) What this arose in you? It came to my mind now when you told what he sang that there was quite a lot sort of connections to your own situation at the moment. Like being there somewhere, the river goes a bit like many ways, sometimes it goes bad, sometimes has gone well and really don`t know what happens. (T) Yes, my whole life is like this song, I don`t have any direction where I would be, only this moment. (P) Yes, that`s the way the river runs too, so that it just like goes forward. It does not have an exact direction, it goes here and there. You don`t have information too now; your asylum application is still in the process and you don`t know, do you have to leave Finland in future or what happens. (T) Yes (C) —* (Abdul, session 15, music: Mukharjee, a song translated as *River, I Want to Tell You about My Own Life*.)

After a long time, Abdul began to notice emotions first in music and then also at the same time in himself. It also became easier for him to produce imagery that related to the lyrics of the songs. So, with the aid of music, there began to develop more dialogue between us; but also between music and himself. We could also listen a little bit more to music. The lyrics of songs brought Abdul to his own experiences, emotions and memories. In this way we could get to know each other better and there emerged a sharing between us. Music made me know Abdul as a therapist and a person, I also got to know his home country and its culture. Many therapy discussions became sort of a “cultural dialogue” and music seemed to open up the discussion on various things in life. They could be shared on a general level, as well as on the personal levels of memories and experiences.

*How did that sound? (T) good (P) What was this about? (T) Sad one, about failed love. (P) To me it didn`t sound so much sad again because I didn`t understand those lyrics. Was it really sad? (T)Yes (P) Was that loved one dead or otherwise just left him? (T) Has just left or has not gone together. A woman who has left the man (P) It was that way then, sometimes it goes so that women leave. (T) Yes (P) What kind of thoughts it arose in you to listen that kind of story, song? (T) Not any particular (P) Did it bring in your mind any experiences from your own life? (T) Yes, some thoughts about the similar story I had when a girl left. (P) Was it in a way that story, that crush with whom you were considering marriage? (T) Yes I had wishes but it didn`t work out. (P) Does it relate to that when your rivalry men threw acid on you? (T) Yes (P) How that story ended then? (T) Family moved to another town, so there was no connection. (P) Yes, it ended there when they pour acid on you? (T) Yes, after that acid happening family moved from there and I haven`t been in connection ever since. (P) Were those acid pourers somehow related to the family, I don`t understand that connection? (T) No, it was some rivalry. (I/P) Is it such a common manner that men who propose may do that to their rivalries? (T) Yes, earlier it was a common manner and especially using acid but nowadays it has lessened. (P) Its purpose is to terrify other or more like hurt? (T) Yes (P) You mean terrify? (T) terrify (I/P) Yes, it sounds like a quite rough manner. In Finland and many countries too there may be quarrels if there are many men rivalling about a same woman, some fights may result occasionally. (T) Yes (P)*
(Abdul, session 18, music: Mukharjee)

Even though Abdul could talk more and identify a little with his emotions, still his condition was not improving. His general tiredness was constantly visible, session after session, and it worried me and the other staff. Abdul also began to look more untidy so that it was clear he could not take care of himself, for example, washing and shaving. Occasionally my emotional responses, *countertransference* in psychoanalytic terms, disappeared during the therapy sessions and it felt as if he had somehow gone away, become distant, whilst in other respects we were still in contact. This made me worry that he could try to do something to himself or maybe had already decided something in his mind. I reported my worries to the other staff and found that they had come to similar conclusions. Abdul`s visits to the centre were intensified so that he visited the centre every day, at least for a while. Hospital treatment was also considered and was suggested to him but he did not want it. So, the whole situation was very concerning even though therapy sessions continued and there was progress in the therapeutic relationship and therapy.

*How are you now since we last met? (T) Not very well; restlessness has continued. Head feels hot sometimes. (P) Yes, you had that hotness in head last week too. (T) Yes, nothing feels anything and I`m too tired to do anything. (P) I was myself worried after the last session, I felt a bit that you were sort of away. (T) I don`t know, it feels like I`m changing a lot and I have such thoughts coming that what point is to be alive. (P) So you talked last time too and that situation worried me then because you were a little bit, we talked but you were somehow like given in. (T) We talked with a physiotherapist too, you had said that during the weekend it was especially difficult time. (T) Yes, this continuous restlessness disturbs me and the mind goes around all the time, excites. (P) You have not shaved for a long time now it seems that you have. (T) Yes (P) Are you growing a similar beard than the interpreter has or? (T) No, otherwise it tickles. (P) Has the shaving a little bit forgotten; you have been too tired to shave? (T) It does not come to mind, only when it tickles terribly I shave. (P) When one is in own thoughts, sad and depressed then one doesn`t notice own look what clothes to wear and when change them and when to wash up. (T) Yes (P)*

*It is now a little better feeling here this week? (T) Not very much but compared to last week a little. Last week I thought many times what if I would kill myself but again when my own family and children*

*come to mind it has ended. (P) Yes, children and family miss you and you will surely see each other sometimes when it is time. (T) Yes, on the other hand my father asks me to come to him continuously, sometimes he gets angry too, why I don`t come to him. Now it is a hard situation, what would I decide, really difficult situation. (P) What do you think would the father insist you that way if he lived now? Would he have said when living that you must die, he wants that way? It is a different thing because then he did not see me. Then he sent me to abroad, so that I would survive to live. When he sent me to abroad he died himself. (P) Does it sound like he wanted otherwise that you would specially live and send then, organised, so that you would survive and not die? (T ) Yes (P) Fathers usually want good for their children and you would probably not, when you think about your own children, you would want them to live no matter what happened to you. (T) Yes (P) I assume many fathers think that even if their own life would end they would safe their children from some accident for example. (T) Yes, but maybe because my father is alone now he asks me to join him. (P) Where is your father there alone? (T) Up (P) Are there up other people, such people that have died earlier? (T)They are not close relatives there to him. In a same way like in Finland a lot of people but I`m alone. (P) Yes, so you are lonely. (T)Yes, I don`t have any close relatives here. (P) That`s it, that it surely is, many refugees don`t have. (T) Yes (P)* (Abdul, session 19)

My concerns and suggestions were confirmed at the next therapy session by Abdul himself. The situation was quite bad and we were on the edge of it continuously but, on the other hand, Abdul seemed to try in therapy: He could openly speak about his experiences, including death wishes, which was a good thing from the treatment point of view and made it possible for us to talk things out. Abdul had brought along new cassettes to therapy and we listened to them one song after another, so that we did not have to choose any one in particular. The songs were in Abdul`s native language and I did not have any idea at all what they were about or what were the titles of the songs. However, from this starting point we could begin to talk and Abdul told me what each song was about. I postulate that songs from Abdul`s home country were very important for creating therapeutic contact with him.

*What was this about? (T) This was sad, told about one`s own life. (P) What has happened in it? (T) He wants to leave everything and go away. (P) Was there some reason for that? (T) Maybe he has sorrow, it is difficult for him to go and leave everything when he looks back. (P) Who was he watching? (T) Past life (P) Where he was going? (T) He totally wants to go away from the world. (P) What were you thinking when you heard him singing that? (T) He is similar to me because I want to go away too. When I look back then I cannot be. (P) Yes, it came to my mind also when you told me that it is just like your situation what we were talking there in the beginning. This song seemed to fit those same thoughts. (T) Yes (P) What is the name of this song? (T) – – (looking for the song`s name) Forth song (I) Forth song; what is the name of it in Finnish? (T) "I fall like a wizard river myself "(I) Go or regret?*[37] *(T) Disappear, river goes somewhere and it disappears. (I) I disappear like a road or a river. It had a quite poetic name. (T) Yes (P) – –* (Abdul, session 19, music: Mukharjee: a song translated as *I Fall like a Wizard River Myself*.)

It is very interesting to note, and enigmatic too, how Abdul had chosen to bring to these therapy sessions just the sort of songs that suited his life situation well, even though we had not chosen them accordingly. Abdul never told me on what basis he had chosen these very cassettes, however there were precisely about leaving, which had been expressed when Abdul had mentioned his death wish. This may have been simply coincidental but the situation could be analyzed with the help of such concepts as Freud's dynamic unconscious

[37] This relates to the Finnish translation and errors in it which are impossible to translate exactly.

and preconscious. Maybe Abdul unconsciously chose the sort of cassettes that related to his thoughts and emotions. However, already at the beginning of therapy, I had asked and guided Abdul to bring to therapy music that would match his feelings. It is also possible that by bringing in these particular cassettes, he, with his actions, was expressing to me what kinds of thoughts and feelings were in his mind and that they represented a metaphor of his life and unconscious. Had this manoeuvre a communicative purpose for Abdul – at least unconsciously, a wish to be heard and understood?[38] At least listening to those songs and speaking about them helped him to share his thoughts and feelings with me. It may have had a clarifying, supporting and holding meaning for Abdul in part. They also added to my knowledge and understanding of him and his current situation from the existential phenomenological point of view. Thus, music seemed not only to be determined by past experiences but it also intentionally and teleologically oriented Abdul in his situation to the future as a metaphor. However, we simultaneously listened to and discussed the music and the feelings it evoked in the present moment.[39]

### 8.5 Interruption of Music Therapy

Even though there seemed to be an improvement in Abdul`s situation after the negative asylum decision, still his condition was changing and there was no stable recovery. Abdul`s nightmares, sleeplessness and headaches continued. He still had discussions with his dead father and the tone of them became even more demanding from his father's side. Independent of his difficult situation, he could just about cope with the help of music therapy, his primary therapy, physiotherapy and other intensive support provided by the rehabilitation centre. Also his medication was increased. However, his condition fluctuated from better to worse over the period of a week or two, which is typical for depression. In spite of this, I had the impression that Abdul still tried hard and had not given up.

*Have you had pains this week? (T) What pains? (P) Just like headaches for examples. (T) Always. (P) You look a little bit tired today; did your night go bad? (T) I have been wake almost all night and I have a tough headache and neck ache. (P) Yes, so I noticed that you are sort of look tired and had not slept much. (T) Sometimes I can sleep but occasionally I have a sleepless night, I`m awake. (P) How has this affected, how have you felt yourself when the days have gone longer and there is light in the morning? (T) I don`t know. (P) I have noticed myself when I have incidentally woke up earlier that it is difficult to sleep again because it is so light and it has felt like a day. (T) Couple of days my father has disturbed me terribly, continuously asks me to come to him. (P) That`s why you have been feeling bad because the father comes and asks you to come? (T) Yes, he disturbs quite a lot. Sometimes he is very angry. (P) About what? (T) Because he asks me to come to him. (P) And he is angry because you don`t come to him? (T) Yes, he says that he is all alone there. (P) What kind of place it is where your father is? (T) Rather beautiful (P) Does he tell you about that place then? (T) Yes (P) What is there then? Landscapes or…? (T) Yes, he has a fancy apartment surrounded by gardens and he has made me an own room there and he cannot be alone there. (P) Is it a fancier place than your father had in your home country? (T) Yes (P) Then that house has a room for you too. (T) Yes, it is quite beautiful. (P) Off course it begins to feel like a better place, there`s a better apartment, you don`t have to be*

[38] According to Freud (1900/1995) and his dream theory it would mean an unconscious wish.
[39] This view of music psychotherapy is in accordance with the current knowledge interests of modern psychoanalysis to investigate unconscious relating to the metaphors and the future (Borbely, 1998; Enckell, 2002; 2004; 2006).

*alone, feels tempting. (T) Yes (P) When you are there yourself too. (T) Yes (P)*

*We people have many times a manner to think that when we die we will get to a better place; these kinds of beliefs are related. (T) Yes (P) We have not talked about religion; do you have an exact religion or what do you think about religion? (T) I don`t live really religiously or according to a religion. (P) No, not everyone in that way; I guess it is about the same with different religions, others may believe every word and live by the norms of sacred teaching. Others belong to church but the religion does not regulate their lives so much. (T) Yes (P) What religion do you belong or do you belong to any? (T) Islam. (P) Islam ok. (T) It is a big religion, maybe the biggest in the world. (T) I don`t know. (P) I think it is either Christianity or Islam but it comes to my mind that there may be more Muslims though compared to a population. (T) I don`t know. (P) – – How does Islam see the time after death? (T) If one lives well, behaves very religiously he will get to a paradise and if one does not and does evil he will go to hell. (P) In fact it is the same idea than in there Christianity. (T) Yes (P) According to the teaches of religion one gets to a life after death in heaven, paradise. (T) Yes (P) In Christianity many people believe that in a way you are not alone in heaven but you will see those people in heaven who you have lost before. (T) Could that father be alone there then? (T) There may be other people but not the one he knows and he misses the close people. (P) For everyone the closest people are the ones you miss. (T) Yes (P) I guess you don`t have yourself many close people around here? (T) Yes (P) Do you have here such people you know that you consider closer? (T) I don`t talk much to other people but there are some with who I discuss occasionally. (P) Yes, the life surely feels hard when you are alone in here and you have no one to talk and in a way to trust. (T) Yes (P)* (Abdul, session 23)

There emerged a little bit more dialogue between Abdul and I, and an interesting observation was how different Abdul was when we met two times without an interpreter and spoke English together. It was surprising that Abdul was able to express himself in English even more naturally than with his native language. He appeared increasingly open and took more responsibility for the ongoing discussion, where he had to use more words and show initiative. In spite of these positive observations and developments in therapy, it was evident that Abdul`s situation and depression was worse at the time. This can be noticed from the above therapy discussion for instance, where we talked about and processed death, religion and I am trying to clarify Abdul`s partly psychotic thoughts. In addition to this, we are within very deep foundational questions of human existence in times of sorrow and distress. The final setback and hindrance to his out-patient treatment occurred when he was forced to leave his rented apartment and move back to his own reception centre.

Soon after this, and almost exactly six months after the beginning of his music therapy, Abdul suddenly went into hospital under his own initiative. The hospital treatment was in another town and music therapy was interrupted for the time being until Abdul was able to come visiting me again at the centre. However, our treatment relationship, and even the therapy, was not totally interrupted because we made an arrangement with the psychiatric hospital that I would call Abdul by phone weekly. I considered this to be important even though it is not a common solution in psychotherapy in such situations.[40] As I have referred to earlier, Abdul did not have people close to him or contacts in Finland and

[40] However, there is recent clinical research of cognitive behavioural telephone psychotherapy for depression in the US where it was reported that it had significant clinical benefit (Simon, Ludman et al., 2009).

actually the centre staff and I were almost his only contacts. In addition to the basic language problems, it was also difficult for him to build trust and speak with the hospital staff, so my phone calls and the continuation of therapy and treatment at the centre was in their best hopes and interests too.

Probably it was a good decision for Abdul to go hospital because he was psychotically depressed and overwhelmed by grief. Perhaps he also wanted to protect himself this way. It is easy to see that circumstances were not the best, or even quite suitable, for therapy at the time, even though music therapy and other treatments from the centre had helped Abdul to stay by himself for a surprisingly long period of time without hospital treatment. However, his whole situation, depression, grief, psychotic symptoms added to social distress, like the lack of contacts, loss of his apartment and, most of all, the negative asylum decision, was so difficult that hospital treatment was probably inevitable. It is assumable that music therapy alone, or any other kind of therapy, would have not been enough for him anymore.

### 8.6 Hospital Treatment and the Telephone Therapy

Abdul went to the hospital by himself very shortly after he had moved back to the reception centre. There his condition weakened so that his illusions and fears worsened: he saw nightmares where figures came to kill him with a knife, and he only slept one to three hours each night. Discussions with his dead father became more threatening and his father pressed him to come to him. He did not eat much of his own volition and had to be fed. At the hospital they discovered that Abdul had already had psychotic symptoms and had heard voices in his home country. At first it seemed that with hospital treatment Abdul`s condition would get better and become more balanced but as the treatment was prolonged throughout the summer it got worse. He had tried to call his wife but could not reach her because the number had changed. His medication did not seem to help the situation. It was probably because of Abdul`s moving that his social and psychic safe structures collapsed in the new environment and he went completely psychotic.

Unfortunately, in addition to this Abdul went into hospital just before my summer holiday. The purpose was that I would phone Abdul weekly at the same time as our therapy would usually have taken place; this was also the hope of the hospital. However, during my summer holiday there was a pause and when I came back Abdul`s situation had weakened, so they decided to begin ECT (electric convulsion treatment). Abdul was continuously willing to continue music therapy, as soon as it would have been possible. However, his hospitalisation continued because his state was so unstable and fluctuated so much; after a more peaceful period the situation worsened again. When he was away from the rehabilitation centre his things got stolen and he became even more depressed and pondered suicide because of his bad luck. He felt that the ECT had not been of much advantage to him, which was also his doctor`s opinion. His mood was still low, he saw nightmares, and still talked with his dead father.

In the autumn, meetings at the centre were considered again but they were postponed because Abdul stopped eating and was in poor condition physically. He did not eat for

days, and at one point went over a week without eating, so that in the end they had to drip feed him. However, on the phone he could mostly talk quite clearly about his issues in English. I tried to support him with his eating and we discussed his illusions and fears, which I tried to clarify. I assume that our discussions were evidently important to him because on the ward he avoided people and did not talk much, even to the nurses. There were also language problems. When he talked with me on the phone, he became more open about his feelings and was able to express his thoughts better, so that there started to emerge a little dialogue. He told me that he was afraid of his suicidal thoughts, that he might not be able to control himself and would jump under a car, for example. That was the reason he did not want to go out and walk by himself much. Just when there were plans to finish the hospital treatment and things appeared to be slowly getting better, he started to ponder joining his dead father again and he stopped eating as well.

Abdul was on the ward with a nose and stomach hose because he refused to eat. His dead father demanded that he should come to him. In Abdul`s case, his asylum application was hurried through because of health reasons. He wanted to die, but he waited for the asylum decision and if it would be positive then he would want to go and work and get money. He also began to say that he would not do anything to himself if he could achieve asylum. He waited for the decision at the hospital and then started to eat again and walk outside with the nurses, becoming a little more cheerful. Finally, after over six months, Abdul received asylum in Finland but no permission to bring his family to Finland. This changed his situation rapidly as he began to eat better and make contact with other patients. Going back to the reception centre was on the cards again, as was the continuation of therapy at the centre. He felt that asylum had saved his life. He started to plan to study the Finnish language. At least some therapy sessions with me were also considered because we had had a long therapy relationship that was suddenly interrupted. In addition to this, I had been in contact with Abdul regularly, about once a week, while he was at the hospital and so I was a part of his rehabilitation also during that time. Hence it was important to complete our meetings and the therapy relationship properly. Finally, after about a month, Abdul could come to see me at the centre, along with a nurse, for the first time in over six months, and so music therapy continued.

### 8.7 Music Therapy Continues – The Last Spring

As we met for the first time in over six months, there was a nurse with Abdul from the hospital. Abdul`s habitué had changed quite a lot, he had gained more weight, muscle and his hair had grown longer, which he cut quite soon afterwards however. Also, the therapist had changed and his hair had grown too during that time, which we laughed about. Abdul`s situation had improved considerably as he now went shopping by himself, for instance. He was also in contact differently and talked more. Music therapy continued without problems, so that after we had all briefly discussed Abdul`s current situation and the practical arrangements of his therapy, we did a musical imagery exercise. It was easy to notice immediately that he could concentrate better and listen to more music. Now we could also share and listen to Western arts music with no words.

During the spring, Abdul`s general cheering up began to show clearly, he started his Finnish language studies and searched for an apartment for himself. It was agreed to continue music therapy until the springtime so that there would be a proper period of closure. He could now listen to music differently than he did before, we could use longer pieces while concentrating on listening. During the music listening session he was calmer and noticeably more relaxed. Still, he did not experience much imagery while listening to music, or if he did he kept it to himself. However, he looked calm while listening. Usually, he felt that music brought him pleasure. With the aid of music, we were able to talk about the emotions connected to his long period in hospital, how he wanted to die there and how he even somehow tried to commit suicide but was stopped before there were any injuries. During the final spring, Abdul contacted his family by telephone for the first time since he had come to Finland, i.e. for over two years. Now he could analyse his thoughts and emotions relating to these issues, and our therapy sessions really became dialoguing. He was clearly present and in contact. However, Abdul still had some disturbing thoughts and bad feelings, which he was now better able to control in his mind. At night, he still slept poorly and had nightmares.

Abdul did not feel at home at the reception centre, where he was alone mostly. When he achieved asylum he wanted to move back to Helsinki and so was in the process of looking for an apartment during the period of our last music therapy sessions. There were difficulties in this process because he was a foreigner with no regular job, so they would not rent an apartment to him in the first place. Finally, assisted by the social worker at the centre whom I had consulted, he managed to find an apartment. In conclusion, Abdul`s life situation and his psychic condition had improved a lot during his complete period of music therapy. He slept better when he moved into his new apartment and also became more active and cheerful. However, he could not get rid of his sleeping problems completely and so he bought himself a CD player and records and began to listen to music so that he could relax and sleep better while finishing his music therapy. At the beginning of his therapy, as mentioned earlier, he probably did not listen to music at home even though I had recommended that he could do so. Then it was assumable that he experienced many outer voices and therefore extra stimuli, like a television, would have been too heavy. He had not complained for a long time that music made him feel bad; instead music had become a relaxing and pleasure bringing experience for him. He also nursed himself with music. I would say that in this aspect music therapy had succeeded in his case because the therapy enabled him to reaccess a natural capacity for the enjoyment of music.

During the last actual music therapy session, session number 42, we listened to Indian film music, which Abdul had bought in himself. I had asked him to bring along some music that would fit his emotions in therapy. While listening to it, I thought that he looked a bit sad, which I also felt in my counter emotions. However, he seemed concentrated and calm while listening to music; he could look me in the eye and be in contact with me. The music was sort of Indian pop music from different movies, including a comedy he had seen, they sounded light, rhythmical and joyful. We both noticed that time went by quickly on this occasion when listening to music and discussing the songs related to the movies. This may imply and depict the altered mood and atmosphere of the therapy and the change in Abdul, which the happy sort of music and dialoguing seemed to also reflect. The last song he

chose in his music therapy had the title *Tear in my Heart*, which he initially translated as "Love of my Heart", which could be psychoanalytically interpreted as resulting from unconscious conflicting emotions relating to the end of the therapy relationship, as expressed by a slip of the tongue. According to him, the song was about heartaches relating to the loved one, like the previous song *Heartbeat*, to which we listened. At the beginning of the therapy session, he had told me that he had no specific thoughts relating to the end of the therapy but remembered that at the beginning of the therapies he had had a hard time and that now things were better. I postulate that music therapy held him through difficult periods of sadness and crises, including his long and painful asylum application. In my opinion, for its part, music therapy helped him to integrate his experiences, orient the future and to continue his rehabilitation and life on stronger ground.

## 9 CASE THREE: OSAMA FROM MIDDLE EAST

Osama was a young man in his twenties from a troubled area in the Middle East where he had been abused and oppressed. He was a Kurd in origin, which was the reason why he had been persecuted and tortured. Finally he had had to escape from his home country and come to Finland. When he came to Finland he suffered from passivity, flattening of emotional reactions and concentration, and memory problems. His diagnoses were Post Traumatic Stress Disorder (PTSD), common among torture survivors, and unspecified depression. In his case, music psychotherapy was supportive, and initially he visited me every second week. More intensive therapy sessions would have been better for him but he was not willing to meet more often at the beginning. However, during this period he met a psychiatrist on those weeks that we did not have an appointment, right up until the psychiatrist finished her job at the centre. The objectives of his music therapy were to recognise his emotions and go through them with music and to find positive experiences.

Osama appeared to me to be a nice young man who smiled a lot. He had short dark black hair and he wore clothes similar to the contemporary fashion of Western young people in Finland. He was frequently physically restless, like it would have been difficult for him to sit still. Osama seemed to be careful with his words and expressions, which made him laugh nervously and flush easily. In a way he reminded me a lot of young Finnish people his age. It was difficult at first for Osama to commit to therapy and to treatment at the centre, which is also typical of young people in general. He could not really understand why he needed treatment. On the other hand, distress, anxiety and the need for help was major in his opinion but it was difficult for him to concretely come to treatment appointments, for instance. So, there were a lot of missed sessions at the beginning, which may have later had an effect on the worsening of his condition and situation. However, there were many things happening and going wrong simultaneously, which probably could not have been predicted by anyone.

Music therapy with him was projective listening to music and doing small imagery exercises that applied methods from Guided Imagery and Music (GIM) with traumas. With these techniques, the purpose was to try and help Osama activate his images, memories and emotions, and process them together with the help of a therapist and music. Osama did like listening to music and had listened to sad music and noticed that it made him feel better. During the first assessment session, he could obtain positive feelings and verbalize them too. So, at the beginning it felt that using music therapy was a natural thing to do, especially as he was unable to discuss any of his experiences or the torture he had suffered either. I consciously left approaching his torture experiences in the background because I felt that, as he was so delicate and fragile, it would have been intrusive. He seemed to already become anxious easily about issues asked of him during the common health questionnaire (SCL-25), which screened for anxiety and depression.

### 9.1 The Early Phase of Music Therapy

With the help of music, we were able to work with Osama already from the beginning as he could associate imagery and emotions with the given theme. The first music we listened to together with him in his therapy was Gustav Mahler`s *Adagietto* from the *Fifth Symphony*.

We did a short imagery exercise “island” where he appeared to be able to concentrate. Osama told me that he liked the music, which brought to mind positive images of trees and beautiful flowers, for example. The first music therapy sessions were affected by his psychiatrist leaving her job at the centre, which made me his primary therapist. We also discussed the research questionnaires, which he said he did not want to fill out anymore in the future. He had felt that the questions were difficult and explained that it was the first time in his life he had been asked such questions. He told me that they made him feel “bad” while filling them in, but that he felt “normal” afterwards and that the questions had not harassed his thoughts later. We agreed that he did not have to fill out the research questionnaires again if he was not willing to do so and did not feel like it. However, later he was willing to fill out the questionnaires.

The period at the beginning of Osama’s therapy was complicated because of his psychiatrist leaving the rehabilitation centre. It is possible that it made him feel a general lack of trust towards rehabilitation, making it difficult to commit to treatment on its behalf. On the other hand, his condition was characterised by a general feeling of ailment and anxiety, which evidently made his logical functioning in everyday life more difficult. He suffered from fears, and the frailty of his personality easily projected these fears onto his environment. There was also a war going on in his home country, where his mother and many of his relatives were. When we conducted an imagery exercise “jungle” in music therapy these fears about everyday life became aroused; one of the results being a physical conflict at the reception centre. In fact, Osama was not able to imagine the jungle after the initial period of relaxation, so I had to change the theme a little bit to “exotic forest” to help him to begin his imagery work. Maybe he had never seen a jungle? In the first place, he had difficulties achieving images because he thought of music as strange. This may have been another phenomenon he had never experienced before which could have also reflected the differences in our cultures.

*Where are you in your thoughts? (T) I imagine that I`m lonely, at the while I`m not alone, at the while there is war and I`m sort of running away. Such thoughts arising at the moment. (P) Do you have someone behind you in those images, who are you running away? (T) Something is behind me that I`m not afraid of or care about them. (P) that`s right (laughs like being nervous) (P) Keep listening on (T) – – Somebody is running in my back (P) You don`t see behind you, is it dark or? (T) I`m afraid to turn my head (P) (laughs) Where are you running away? (T) I`m in a sort of place like jungle, in there jungle there are such savages and I`m running into middle of them. (P) Are those savages somehow threatening? (T) They look like a little bit scary but not much. (P) Do they have spears or? (T) I assume that they have fire in their hands (P) You mean torches? (T) Yes exactly (P) (music changes) – What happens now? (T) Are there still savages? (T) Now there is no more savages and not the same group anymore (P) Oh, it changed (T) or the same tribe (C) yes (P) What they are doing there, what happens? (T) This tribe is dancing (P) Some ritual going on? (T) yes (P) Are you watching it from somewhere on the side, are you watching it? (T) Wait a minute (P) I`m among them in the middle (P) How do you feel to be there in the middle? (T) I feel myself completely strange person, I mean I`m different compared to them but I`m not still afraid of them. (P) They don`t look threatening? (T) No (P) – – (music changes) Kurdistan language (P) – –*

*Where are you now in your thoughts? (T) Do you still see that other tribe? (T) I still see it, I see a part of them but I hate them now. (P) aha, why do you hate them? (T) I don`t like them (P) Are they going to do you something evil? (T) They treat me badly (laughing like being nervous) (P) What they are*

*doing to you? (T) I cannot change it, I don`t like them, I hate them. (P) Yes (T) They are disgusting in front of my eyes, very disgusting. (P) I can them now normally (P) In reality, I have seen them earlier. (P) Aha, where have you seen them? (T) In Tampere where I have gone mad because of them. (P) I see (T) Have you had with them some kind of incidents? (T) Yes, once I had a fight with them. (P) I really hate them (P) Was it sort of a real fight? (T) In reality I fought with them and there were some of them (P) How did it end up? (T) I slapped one of them (P) Did it stop there then? (T) He said that "I will go and complain about you", but he asked for a fight, made a face on me. (P) Was it there at the reception centre? (T) Actually, I don`t like them, they are like different people, I don`t know is it because I hate them because this music reminds me of them. (P) Yes, music may sometimes arise those feelings and thoughts. (T) Maybe it is because of the music that this group comes to my mind. (P) – –* (Osama, session 3, music: *Ambient Planet* cd, pieces 1) *Goa* 2) *Nirbandh-Eastern Voices* 3) *Sic`e Ceya Ce/Mother Earth Round Dance-Ellis Island* 4) *Hai Kai Yai-Tresor Perdis* (included the Kurdish language) 5) *Xenophon-Alex Xenofontos* 6) *Pink Forest-Laurent Lombard and Cyberland*.)

This extract could be a depiction of Osama's defensive and projective attributes, which were aroused when he began to perceive threats in his environment. Because of this, he was clearly open to outside conflict situations, which increased over the next months. In imagery aroused by music, there could be seen his fear and the feeling of being persecuted in his experiences, represented in the form of savages. Osama`s imagery may be interpreted similarly to dreams, and they can also be seen as reflecting metaphorically his inner world, unconsciousness and its hidden conflicts. The savages probably symbolize unconsciousness and its archaic energies, like instinctual needs and intentions which the conscious mind feels are strange, chaotic and threatening. This results in the self becoming stressed, which leads to a dynamic need to project feelings outside the self. In this case, suitable targets found for this projection were people from other nationalities. It was evident though that everyday life situations were mixed up with Osama`s imagery, which revealed the boiling and fragmentation going on inside his mind; this was discharged as action, resulting in violent behaviour towards the end. However, "torches" could also symbolize bringing consciousness to the memories of threatening fights and the fears related to them. Thus music seemed to access this past situation and enable its verbalization and integration into current self-experience in the present moment.

### 9.2 Osama`s Mind Begins to Collapse

Osama`s therapy was very infrequent at the beginning because he could not even hold to twice monthly meetings. For example, he forgot to come or explained that he had not enough money to come. So, we ended up meeting about once a month, then, in the middle, there were also my summer holidays. Before my holiday happened a new incident, when Osama told about me his experimentation with hashish, which made him feel very anxious and terrified. Then, he had also experienced compulsory movements. However, there was no evidence then or later that he had a true drug abuse problem; rather it appeared to be the simple experimentation of a young man. Anyway, Osama felt even guiltier than was really necessitated by his little experimentation. When I came back from holiday, we continued our meetings but it was still difficult for Abdul to hold to the agreed appointments. This happened even though he had moved away from Tampere, and the reception centre, to move closer to the rehabilitation centre. This move was influenced by the aforementioned

conflict and the fear that he was under threat in Tampere. However, his anxiety and fears continued in spite of moving, the worsening in his condition and whole social–psychic situation began to also show in our meetings.

People were really concerned about his situation because he was mostly by himself, suffered from fears and felt under threat. In addition to this, there were changes in his behaviour: At home he was uptight, he became isolated and there began to emerge inappropriate laughter, his compulsory movements also increased. His habitué became more untidy in general. He could state that he was feeling bad but could not analyse or express it more thoroughly with words as to what were the causes and what was it about. This was, of course, part of the reason why he was in therapy in the first place. Now, even though we were close to the edge, we could not talk about it in therapy in his case because our sessions were so infrequent. We could not always do imagery exercises either because he was so anxious, so we just talked and listened to some peaceful music. He felt this to be calming. Music and imagery exercises brought interesting unconscious and symbolic material to the surface but my intention was not to analyse these in detail with Osama because it was not applicable either to the objectives of his music therapy or to therapy that was so infrequent. For Osama, it was enough that music provided good experiences in the form of a holding environment and a way to talk out those things that were on his mind. It was not necessary to try and interpret the contents of his imagery but mainly just to support and clarify his world of experience so that he could discharge his feelings and somehow process and integrate issues in his mind.

*How you are since we last met? (T) Quite bad. (P) In what way bad? (T) I mean psychic continuously (P) Can you tell me a little more thoroughly? (T) The pain is like before (P) Is it headache or? (T) Yes, the most of pain has been in the head. (P) How have you slept now? (T) I don`t sleep enough. (P) Last time you told me that you had been pondering something the night before, has it still been the same way? (T) Yes (P) Is it still the same matter? (T) Yes (P) You don`t want to tell me about it more? Do you want to talk about it now, you don`t have to, it is all your decision. (P) You have known something about it? (P) What is on your mind? The last time you didn`t tell me at all, you didn`t want to tell. (T) Yes, it is the concern in itself that is bothering and stressing me. Then there are these disappointments when I have been with other people, get to know someone and completely trusted and have been betrayed. They have disturbed a lot in life. (P) Yes, that`s the way it goes sometimes, I guess we all come up with some unpleasant disappointments. (T) Yes (P) It can take hours of course during the night when one cannot fall as sleep and ponders those things. (T) Yes, the thing is the insomnia and then these dreams and nightmares disturb really a lot. (P) – –*

*Do these nightmares relate to torture experiences? (T) I have nightmares about upsetting things during the day. (P) So it is many times that the day thoughts come to dreams. (T) Yes (P) Last time you talked that you have been a quite alone there by your relatives (T) Yes (P) Have you still been inside a lot? (T) Yes, unfortunately I cannot much enjoy being outside home. (P) Do you have some fears in mind when you go out or? (T) Burdensome, boring feeling really. Yes, sometimes I sit in some café when I move; when the bad feeling comes I have to rest. (P) Have you get to know people in your surroundings? (T) I have no friends; it is hard to trust, really hard to trust. There is a danger that I will disappoint again if I get to know someone. (P) Do you have now some relationship or a person who has left you or? (T) Yes, unfortunately so has really happened, as a matter of fact stabbing and talking bad behind the back. (P) Are they there from Tampere or? (T) Yes (P) You have heard that something have been talked about you? (T) Shortly said they are not good, really bad people. (P) They*

*are not really your friends then? (T) Kurdish men, I have got to know them and I am afraid, so has happened, only bad experiences. (P) So, it probably is, it is always unfortunate if something bad is talked behind one`s back but then when one is far away from home country. (T) Sort of experience (I) Then the men from one`s own home country talk (T) Yes, it is really insane. How is this possible that this kind of thing can happen when one is here? (P)*

*Have they somehow put you out of their own circles or has there happened something; can you tell me about it more? Do you want to stay separate from them? (T) In that way I defend myself that I withdraw to solitude. It is that only way. (P) But there isn`t any physical threat that someone would threat you with violence, isn't there? (T) If I have not got to know it in time, it would have happened as even worse. (P) You don´t have to fear moving outside or going downtown, don`t you? (T) Yes, I`m afraid. (P) Like they could come to harass you? (T) Yes, it is the truth really that I am afraid. (P) All right, now I`m beginning to understand what this is about why you want to be inside and don`t want to go out. (T) Yes, that`s true and difficult too. (P) Are you going to tell me more about this and continue why they are after you? (T) It is difficult to really understand sometimes what this is about and why it is so unfortunately. The chances are that they are evil and wrong or I am myself wrong but I trust myself though that I have not ever inflected any bad to anyone. It is surely on their side. (P) Yes, I don`t believe at all that you would have inflected any bad, it sounds like those things are connected to the own fear and you are much alone, ponder there at home. (T) It is good to talk about these things more thoroughly when you are ready yourself and willing to. Now we had a little beginning of where the shoe pinches as so to said. (T) – –* (Osama, session 8)

Osama began to suffer more from fears and felt under some kind of threat, which I felt to be a little suspicious. Afterwards, it is easy of course to notice that these were the initial symptoms of an increasing paranoia, which started to also affect his imagery related to music, where the threat was perceived too. In addition to this, Osama began to laugh peculiarly afterwards. This may also relate to early psychotic symptoms – along with inadequate emotional responses and even hallucinations – but it may also be interpreted from a positive point of view as an indication that he felt some kind of relief from anxiety and experienced music and interaction as pleasurable. From the psychodynamic point of view, the lower the amount of stress that the mind is subjected to and the smaller the amount of threatening contents, the less dynamic need there is for violence and defensive externalizing, splitting and projecting. I argue that listening to music and imagery processing enabled Osama to express his thoughts and emotions and therefore aided him in forming a connection and dialogue with what was in his mind and what was happening to him.

*Where are you? (T) Are you just resting? (T) (Osama does not answer) Where are you now, what happens, did you get in that meadow? (T) I`m in a forest all right. (P) What happens there? (T) Searching (P) What kind of feeling do you have? (T) All right, I enjoy here. (P) Are you looking for something? (T) I cannot say; I`m looking for something though. (P) What it looks like there? (T) It is peaceful there. (P) Is there something threatening?* (T) *Yes there is.* (P) *What it looks like? (T) I don`t know, I cannot say (laughs) (P) You don`t have to go that way if you don`t want to. (T) What do you see there now? (T) I see something scary and I`m frightened (P) Is there a some threatening being or a person? (T) A person I say. (P) Is it a familiar person to you? (T) Yes, the figure doesn`t actually show clearly. (P) Is that figure still behind you? (T) Yes (P) What do you do, do you run away or? (T) I move normally. (P) What kind of feeling do you have now? (T) I feel lonely (P) – –* (Osama, session 9, theme "meadow", music: 1) Edward Grieg: *Morning Mood* 2) Friedrich Händel: *Morning rises* 3) Carl Nielsen: *Fog Vanishes* from the play *Modern* 4) Oskar Lindberg: *Old Chorale*

*from Dalarna* 5) Camille Saint-Saens: *The Swan* from the *Carneval of Animals* 6) Eric Satie: *Gymnopedie nro 3*.)

Osama was clearly more reserved, so in this phase he did not talk much about his imagery. He appeared to be physically restless; he twisted himself in his chair and held his chest with his hand. He looked as if he was in pain and complained that he felt bad and told me he was tired of it all. Osama explained that this bad feeling arose when he came to the centre. Maybe he felt music and the therapy situation was threatening in part, which might be natural considering his other fears. It has been argued that music bypasses the defences and so brings to the surface subconscious material in music therapy. If a person is under a lot of tension, is delicate and is afraid, one might not want to provide experiences that are too powerful because it could bring more anxiety and all those fears directly to the fore. However, this is not the objective of music in music therapy, at least in psychoanalytic music psychotherapy, to apply such "flooding" or other intrusive, coercive methods and but rather to go forward on the patient's terms. In Osama`s case, the objective was to support his coping mechanisms and to keep up the coherence of his self-experience. However, with Osama the fragmentation of his self-cohesiveness began to show in his inner world, as well in his outer habitué, and in his capability to adapt socially. Whilst he appeared to be very anxious and restless at the beginning of the music therapy session, I frequently observed that by the end of the session, after listening to music, projective listening, imagery processing and discussing with him, he became more relaxed, and he even laughed and looked me in the eyes. It appeared as if his emotions had discharged. I chose peaceful music, as mentioned in the earlier extract as an example from his therapy, in this period of his therapy to hold his emotions particularly.

*Did you get away from there? (T) Yes (P) Did there come something new in the end? (T) Nothing really new, these figures yes. (P) You couldn`t get rid of them? (T) No, I couldn`t get rid of them (laughs). (P) Are they still sort of threatening? (T) Yes (P) There were more of them then? (T) Yes (P) Does it come to your mind what they could be, so frightening figures? (T) Nothing can be done to it that I`m so afraid of them. (P) It did not come clear to you what they were, some people, those who you are afraid of or? (T) Bad, bad they were surely, at least it looked like so, bad people. (P) You did not feel like running away or? (T) No (P) No, they were not coming on you in a way? (T) Yes (P) How many were them, did you count? (T) Quite many (P) Sometimes there comes such imagery and emotions which you don`t know. It is common to not to know what they are about, they can be such unconscious material exactly, which you don`t know at once what it is. (T) A little bit like dreams they may relate to something what has happened and one is afraid of something anyway. (T) Yes (P) Or then what has happened sometimes earlier. (T) Yes (P) However, you said that you had some good feeling in the beginning but did you feel worse there in the middle while we were listening? (T) Yes (P)*

*I noticed that you had a little restless feeling today. (T) Since I left home I`ve had a bad feeling. (P) Yes (T) We saw when you came here today that you were calmer than the last time we saw. Now you were here in good time. Did that feeling come on you second time? (T) Yes (P) Sort of peaceful music it was. (T) Yes (P) Did you have this day the fears in your mind about those you experience are threatening you? (T) Yes (P) Was it then such feeling of threat about issues that arose from music to your mind? (T) Yes that is it I`m afraid. (P) So it may come those annoying imagery and fears in this kind of therapy processing that one otherwise has. (T) It comes easier then when one confronts those feelings whilst it hurts. (T) Exactly such dreadful things and horrors what has done, so one tries to keep them out of the mind. They might then arise as pains and bad feelings. (T) Yes (P) Precisely may*

*come that kind of restless feeling, it may belong to those traumatic and torture symptoms like the physical feeling of bad that don`t know where (T) yes (P) But this way when we get to always experience those emotions and talk out and handle them, I assume that bad feeling lessens. (T) Yes (P) You did survive it now, didn`t you, whilst it felt bad and I could see from you that you were not feeling well. (T)* (Osama, session 9)

During the next sessions, Osama`s condition worsened as he became more anxious and nervous. He did not want to tell me everything that was on his mind and he pondered over what he could tell me. He also lost his home and came to one meeting after a night spent outside, looking tired and worn out because of this. So, it was time to try to get him into the reception centre or some kind of other residence. In the end, the only place he could go to as an asylum seeker was his own reception centre because he could not afford to rent an apartment. Then he went to the Tampere reception centre but the situation went in the wrong direction quickly and soon a doctor called me from Tampere to tell me that Osama had jumped from a balcony and it was assumed that he had attempted to commit suicide while in a confused state of mind. He was now in the hospital and it could not be said how long the hospital treatment would last. However, during that time I managed to talk with Osama weekly by telephone and supported his treatment at the hospital. It was planned that music therapy would continue when Osama would be in such condition that he was able to come back to therapy.

Luckily his injuries from the suicide attempt were minor and only his hand was in sling; actually it remained obscure as to whether his hand had been injured in the fall or later when he was detained by the police. When the police found him, he had been very confused and he had had a bag of what was suspected to be drugs on him. However, it was later found that it was just wood. In addition to this, he had talked about a knife, which was not found on him in the end. At the hospital, he still suffered from fears and was very anxious. He was kept in hospital against his will. During our telephone discussion, he asked me to help him in a suffering voice and wanted very much to come and see me and continue his therapy. I promised that this would happen after he had gotten into better condition at the hospital first. However, the recovery of his situation took time at the hospital and he did not talk there much about his things or feelings, he just wanted to get away from the hospital and back to the reception centre. After about two months` break in therapy, he was allowed to leave the hospital and was able to come and see me, even though he had clearly not fully recovered. However, he was evidently calmer and less anxious when we finally met. On the following occasion, he was even able to fill out two research questionnaires without getting too anxious. It was clear though that Osama`s situation was still very demanding and his emotional responses had become even more flattened, which brought to mind hospital patients suffering from psychoses.

### 9.3 Asylum and the End of Music Therapy

As we continued Osama`s music therapy after his long hospitalization and the Christmas holiday, his condition was better although his situation was still serious. Osama`s character was more peaceful, however he spoke very little and it was difficult for him to talk and describe his feelings and even to achieve imagery from the music. On the other hand, he

could usually clearly relax while listening to music. He also felt that music brought him pleasure and his habitués was calm. There were not so many threatening images anymore, or at least he did not tell me about them. He had memorized some feelings and images from his torture but could not remember them properly and could only describe them in a very few words. Even though Osama`s condition had improved, he still suffered from very bad anxiety, which could be clearly seen in him, so that he might phone me during the week before his therapy time and try to hurry along our appointment, for instance. He also pondered going back to hospital; later that spring he went back a few times for short periods of his own free will. It looked as if Osama was not feeling very well anywhere and so he did not enjoy being in the hospital ward for long because he did not feel that his condition had essentially changed there either. According to his own words, he took his medication but felt that it did not help. Osama had mixed emotions also because he did not feel comfortable at the reception centre in Tampere and wanted to move to Helsinki. At the end of the music therapy period, he even considered moving back to his home country.

Osama`s feelings fluctuated constantly and he complained of feeling bad and repeatedly described how "tired" he was. Clearly he was feeling bad. After the hospital treatment he was more willing to contemplate treatment in general and he considered music therapy to be very important for him and wanted it to occur more often. I recommended music therapy twice a week for him, which he frequently requested too, but finally it was not possible due to financial and medical reasons. Osama`s health situation was so difficult and unstable that it was considered that his main treatment network should be in Tampere where he lived. It was planned that his treatment would continue in Tampere and that his sessions at the rehabilitation centre would be wound down. It made the planning easier when he surprisingly received asylum quickly because of his worsening health. So, when the information arrived that he was allowed to stay in Finland, it also made possible the planning of his continuing treatment. Osama`s situation was very complex and the mere support of the rehabilitation centre and the once a week therapy was not enough for him. In addition to this, it was suspected that there might be an underlying progressive illness, like schizophrenia, behind his condition. There was also the need for thorough psychological and neuropsychological examinations because it was observed that there was a general decrease in Osama's cognitive and emotional functions. It was considered doing the examinations during music therapy at the centre, but in the end this never happened. Osama`s treatment at the centre was ended quite soon after as it was thought that the centre was unable to help him more at this point. I myself evaluated that infrequent music psychotherapy sessions, even once a week, were not enough at the time.

Osama still visited me for some time after and we processed the ending of his music therapy. He would have really wanted the music therapy to continue intensively. Osama was not especially delighted about his asylum; instead he thought of returning to his mother and other relatives in his home country even though the situation there was unsafe and still bad. After the ending of his music therapy, nothing was heard from Osama and I was unable to get hold of him six months after the music therapy so that we could have met and filled out the research questionnaires. However, he suddenly phoned me briefly from his home country at the beginning of November 2007, over three years after completing his music therapy. He sounded happy and told me in poor English that he was

working in a shop. He told me he was satisfied with his life, thinking of me every day and asked if I still remembered him. He stated he had friends in Tampere and that he would like me to help him to return to Finland where he could continue his music therapy. I could not help him with that, which I explained to him.

It is possible that Osama returned to his home country to stay because he felt so bad in Finland and maybe thought that he could not achieve enough treatment and support here. During our last sessions, he often brought up a lot how much he missed his mother and home. In therapy, I could clarify his experience so that his strong anxiety was related to this yearning and to images of his mother. Approximately one year of infrequent music therapy, about every second week, probably supported Osama somewhat in the difficult twists and turns of his life and helped him to carry on. Music pacified him, enabled him to relax for a while and brought him pleasure. I also assume that discussions with the therapist clarified his emotions and his whole situation. It is clear, though, that he would have needed more intensive therapy and social support but it was not yet possible in his case because of his being in the middle the asylum seeking process. On the other hand, as I mentioned at the beginning, nobody could anticipate how his situation would develop and how his problems would culminate when his rehabilitation and therapy was started at the centre. In the end, as a result, he probably may have survived through his worst crises and made his way into regular treatment. On second thoughts, maybe he discovered that it would be best for him to be in his home country, close to his relatives, even though the situation there was still in disorder. However, he thought that he had benefited from music therapy and it appeared that for years after he still retained a positive image of it and would have wanted it to continue. Unfortunately it was not possible.

# *PART THREE*

# *FINDINGS II: ANALYSIS AND CONCLUSIONS*

## 10 FACTOR ANALYSIS OF QUALITATIVE MATERIAL FROM THE CLINICAL CASES

Factor analysis from the whole research data relating to the three patients produced statistically significant meaningful descriptions and explanations regarding the music therapies and their outcomes. Statistical analysis showed that the patients were able to process their traumatic experiences, memories and feelings in their therapies. Music and musical therapy work seemed to have a major role in relaxing, pacifying and engendering pleasurable experiences. Music therapy and music appeared to also aid in verbalization and sharing of traumatic experiences. These issues seem to be in accordance with both the therapist`s and patients` views on their rehabilitation, life situation and recovery in varying degrees, depending on the individual patient. In chapter 11, the research questionnaire results are analyzed as to how patients in music therapy (N=3) and their compared persons (N=2) considered their health, music therapy and treatment, using the form of questionnaires.

In my report on the factors and their interpretations, I only use the pronoun “he” when referring to an anonymous person or an individual. The reason for this is that all my patients in this research were men. However, I postulate that the factors in themselves, or as I have interpreted them at least, are not dependent on gender and that the knowledge from them may be transferred also to women. There could be gender related and dependent issues as well but I could not study these because there were no female participants in this research. They were not part of the research questions either. There could also be factors relating to the ethnic backgrounds of torture survivors and their music psychotherapy, which did not arise in this study of only three male participants.

I also emphasize that the interpretations of factors, their argumentation and designation are not supposed to be generalizations in a positivist scientific sense, whilst they may appear so at first, but rather a transformation of knowledge in a qualitative/naturalistic inquiry. The *transferability* of the research is one of the issues that a researcher should be concerned with in order to evaluate the trustworthiness of qualitative research. This is very different to the external validity concept of positivistic research and does not require generalizations, nor does it assume that any strict generalizations are even possible. Rather, a “thick describing” is proposed as a research technique in order to present the audience with points of interest, and to evaluate if the conclusions, hypotheses and interpretations unveiled are relevant and possible. In this particular research, the included case studies are parts of the proposed thick describing and therefore should be considered alongside other earlier described material – theoretical, philosophical etc. – to be in relationship with the factors and their background. Thus, the previous theoretical and philosophical chapters provide the reader with the chance to evaluate the trustworthiness of the results, and their interpretation, in the factor analysis. In the last chapter, I shall discuss and provide the reader with a summary and a more thorough overview of trustworthiness concerning this research and the factor analysis. (Lincoln & Guba, 1985, pp. 316, 328, 359–362.)

In order to better understand the findings from the factor analysis, I shall introduce briefly the main concepts and procedures with explanations as to how variables for factor analysis

were achieved, how they were coded and what specific meanings they have in the context of this study. Real "test-subjects" as such were not used in this research, but factor analyses were made from *situated persons*, which were the phenomena, behavior and experiences achieved from the three individual participants (N=3) who received music psychotherapy.[41] Each music therapy session was divided into three parts during the therapy; these were the first part of the session, the last part of the session and the therapy session as a whole.[42] In this way, from 116 music therapy sessions involving three participants were achieved 116 abstract situated persons in therapy (n=116) for the first parts of all therapy sessions. Similarly, there were 116 situated persons for the latter parts of all the therapy sessions (n=116). Considering all 116 music therapy sessions as a whole, there were 232 situated persons in therapy (n=232). As there were only three participants in music therapy and a limited possibility for observation, the rationale for this division of each music therapy session into three parts was to achieve enough statistical data and variation of phenomena for factor analysis. It was assumed that in the multiple case study design there would be the possibility to achieve statistically significant results, together with further descriptions and conceptualizations from the research data with these procedures.

**Factor analysis.** Factor analysis was done in this research to reduce the data dimensions of the 66 variables pre-identified as relevant to observe from the three clinical cases of music psychotherapy (appendix 1). Factors were calculated with SPSS software version 18.0, using the extraction method of Maxim Likelihood and the rotation method of Varimax with Kaiser Normalization.

**The size of the data.** Research data analyzed included 116 sessions of music therapy involving three different patients (N=3). The pre-identified 66 variables (appendix 1) were not in the form of a questionnaire, but rather a checklist for each session used by the researcher to observe and calculate each variable's occurrence. They were not mechanically calculated or necessarily considered to be observed in every session but rather I expected that there would be changes, i.e. variation in their occurrence, during the therapy processes. In one therapy sessions of 40–60 minutes, there were approximately 10–20 coded variables. Thus, an approximation of the estimated observation needed for 5 factors for each part of the therapy is achieved when factors are multiplied with variables within each session and summed up with all the variables: e.g. 5 x 20 variables/the whole session + 20 variables = 120 parameters. When there were observations from 232 situated persons for each session as a whole, there were enough parameters to calculate five factors, or even more. For the first and latter parts of the music therapy sessions, the estimated amount for factors is half of the parameters needed for the whole session i.e. 60 observations of situated persons. Respectively, there were 116 situated persons for the first and the last parts of therapy, which is enough to form 5 trustworthy dimensions for the factors. (Vehkalahti, 2008, pp. 95–96.)

**Procedures.** To begin the factor analysis of the situated person in a music therapy context, I listened to recordings of the therapy sessions and transcribed the entirety of the first six months of therapy, as well as what I perceived as essential parts from the remaining sessions.

[41] See chapter 6.6.3 Situated Persons as the Manifestations of Ontological Structure.
[42] See chapter 6.6.4 Situated Persons in the Raw Data Matrix.

I simultaneously listened to 116 sessions of automatically audio recorded music therapy, over 100 hours of real time data, and examined my clinical notes from the therapy sessions.[43] During listening to music therapy sessions aimed at attuning myself, I marked observed phenomena of situated persons from the Variable Template for Factor Analysis (appendix 1) relating to both the complete recordings and former clinical notes. This listening to recordings and the transcribing and coding of variables was done from 2003–2007, starting with a pilot study and ending approximately three years later when the music psychotherapies had ended.[44] The listening to and transcribing of each session was very time consuming because there was so much qualitative raw material, which I had to interpret and code personally. It was not possible to use external coders because of my subjective clinical interpretations and countertransference, which were applied as information sources similarly to clinical psychotherapy. Most of the research work, including listening, transcribing and the coding of each session, had to be done after other daily activities and the clinical work of a private music therapist.

**Variables for the Factor analysis.** Based on a background of: (1) a review of the related literature, (2) previous clinical experience as a music psychotherapist, (3) consultation with experts in the field, and (4) a pilot study, an analytical instrument was produced entitled the Variable Template for Factor Analysis (appendix 1). In the Pilot Study chapter 6.2, developing of research variables as smaller units of meaning – research objects, from categories pre-identified as essential phenomena for research purposes in music psychotherapies of torture survivors, are further explained. In the template, categories are headlines for groups of variables, which are issues for evaluating the conditions of patients and the progress of their therapies; for example, what could be clinically interpreted as a positive reaction to music therapy.

**Coding of variables in the raw data matrix**. Each coding of a variable was marked in the matrix for factor analysis in relation to the time and phase during which it took place, depending on whether the observed phenomena occurred in the first or the last part of therapy. In addition to this, each therapy session was considered as a whole, where the sum of the coding from the first and the last parts of therapy was marked. In one especial situation concerning variable 60, "uses music at home to find own feelings", the phenomena was coded to occur during the whole session of Case One, session 7, even though it was not possible to identify or code it from the recording either in the first or the last part of the therapy session. It was coded to manifest in the whole session because I received important information for the research from another source after the session. It was actually the only observation and mark of that variable in the whole data matrix, so I considered its inclusion important.

In other observations, it was possible to discern at what point in the therapy the phenomenon occurred using multiple information sources such as recordings, clinical and research notes and patient documents. Each coding of a variable was also marked in the transcribed text where it took place. In those circumstances where it was not possible to find the observation

[43] With automatically audio recorded sessions, I mean that every music therapy session was recorded in its entirety; there was no selection or any focus on audio recording specific parts or phases of the therapy.
[44] See chapter 6.2 Pilot Study.

of the therapist or the researcher directly in the transcribed text, it was simply put into the matrix. For example, if a patient appeared to me to be tired in his speech and in my clinical notes, but had not explicitly said "I am tired", it was coded as var1 "tiredness". A similar situation could be found especially with var5, "resistance". Psychotherapy or music therapy patients do not always say aloud "I am against my treatment", but it can actually manifest in many ways, as silence for example, which are very personal and dependent on an interpretation of the context. Variable 40 "laughs, humour" could be one possible example of an interpretative coding of variables. Humour coming from the torture survivors was pre-identified as a positive sign of recovery in therapy from depression or traumatic experiences, for example. However, if there was not a contextual reason for laughing, it could be also a sign of psychotic behavior and could therefore be coded as var10 "psychotic symptoms". None of the variables in the Variable Template for Factor Analysis (appendix 1) list was operationalized or defined beforehand to have an exact or objective meaning. Instead, the subjective clinical interpretations of the therapist were emphasized during the whole coding process of the raw data, including audio recordings and clinical notes, which might also include the use of countertransference as a source of information. Also, it was admitted that the therapy in itself, with discussions and the praxis of the therapist, was already a clinical interpretation of situation in music therapy.[45]

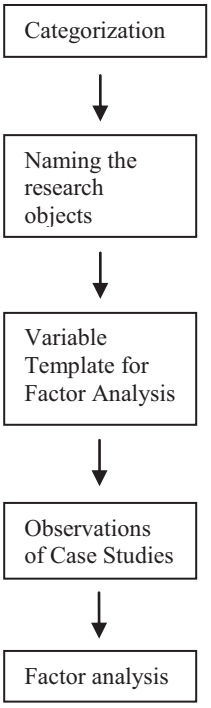



Figure 6. Research procedure.

[45] See chapter 6.6.4 Situated Persons in the Raw Data Matrix for more information.

**Situated Person**. By the situated person, I am referring to a systematically quantified representation of the essential components of the researcher's interpretation of the observed phenomena and experiences gained from individual therapy sessions.[46] It is an abstract contextualization of perception, experience, phenomenon and behaviour relating to a therapy session, which does not denote the research participants described in the case studies personally as themselves. The concept of the situated person refers to the first part, the last part and the therapy session as a whole within every music therapy session.

**Variable Template for Factor Analysis (appendix 1)**. This is an analytical instrument for pre-identified variables arising from the issues and phenomena that were considered as important to evaluate during the music psychotherapy process. It includes 66 variables grouped into 6 pre-identified categories explaining what the variables under them were expected to index. In developing this instrument, there were even more possible categories for variables, but they were dropped for diverse reasons such as their variation would have been too difficult to observe or measure directly. The remaining variables were assessed as being measurable, so that the increasing or decreasing number of their occurrences would index changes in the music therapy processes. These categories included

1) "Issues that make the treatment of the patient more difficult" which are variables that relate to those aspects of patients that could affect their progress in therapy negatively.
2) "Patient`s symptoms arising in therapy" where are collected aspects, particularly concerning torture survivors, relating to the psychic disturbances of patients suffering from trauma, like PTSD.
3)"Positive reactions of patient in therapy", which are phenomena interpreted as signs of positive experiences occurring in the therapy process that would increase the possibility of recovery from trauma and other psychic disturbances, relating particularly to torture survivors.
4) "The way patient feels about music", is a group of variables relating especially to the patients` experiences of music. It was collected from my own experiences of music therapy with torture survivors and the pilot study, where I noticed that some torture survivors do not always feel comfortable listening to music. Examples from experiences displaying these variables are described in the case studies.
5) In the category "Symptoms music gives rise to in a patient", there are only two variables, which arose especially in music therapy with Abdul (Case Two) and had to be considered as one possibility with other patients in music therapy as well. The variable 57 "depression" in this category may even suggest that music would induce depression or give rise to psychic material and symptoms which are related to a depressive state of mind as phenomena.
6) "Others" is a category of those variables which were added to the Variable Template for Factor Analysis after the pilot study. They are variables that were found in the clinical raw material that were considered important to search for in the rest of the material. Naturally, those sessions that had not been coded with the new variables were re-analyzed.

[46] See chapters 6.2 Pilot study & 6.6.3 Situated Persons as the Manifestations of Ontological Structure for further details.

These variables from the Variable Template for Factor Analysis (appendix 1) were presented after the pilot study to researchers, music therapists, psychologists and music educators at international conferences. It was part of my epoché and triangulation to have feedback on the research, which I would use to help to attune myself to the research data.[47] The 6 category groups of 66 variables are the result of my outlining the research object in order to reveal what kind of phenomena, their occurrence and variation, would imply positive outcomes in music therapy with torture survivors. Therefore they also represent my original *preunderstanding* of the research object.

I would like to emphasize that all the variables were free from pre-defined contents of behavior because they were not operationalized in the usual strict sense. Therefore, in this context the use of the variables was as interpretative as real clinical work in psychotherapy, by this I mean the collecting and analyzing of idiographic and intersubjective knowledge that is dependent upon context and the Situation of patient. Sometimes, the same situation in therapy, or a phrase that the patient uttered, was coded simultaneously with many other variables because it was self-evident that many of the variables may naturally be related to one another, as can be seen from the variables in category 2 " Patient`s symptoms arising in therapy". For instance, psychotic symptoms (var10), or symptoms relating to depression (var20), may manifest in many ways, even at the same time, which meant that were coded together in this study, depending on the context in which they appeared. The content free meaning of variables was an advantage in this study because it enabled multiple coding of the same situation in therapy if needed. The procedure used with category 3 "Positive reactions of patient in therapy" was similar, where one can see possible cross-over variables, which, in practise, were necessary to code together with variable 41 "Talks about emotions, memories, thoughts, imagery etc. connected to music" , for example. Variable 41 occurred very often because it is quite free from pre-defined contents and therefore also open to many kinds of interpretations and hence may overlap with many other variables. The coding of variables was not mechanistic in any phase of the analysis, even though it was done as logically and carefully as possible using professional knowledge from music psychotherapy.

Due to the content free aspect of each variable, neither is it possible to define them afterwards. The reader may consider variables to be "self-evident", able to have many kinds of meaning ascribed to them, depending on the Situation and behaviour of the patient. However, the 6 categories, as headings for 66 variables, explain some of the assumed meanings and apply such variables and theory necessary in order to search for them within the therapies. Sometimes variables may have not been seen explicitly in the transcriptions but have needed interpreting by the therapist researcher. Variable 22 "Death wishes", var9 "Clinging to memories", var43 "Processes one`s traumatic experiences with music", var61 "Absent/dissociates", var62 "Inability to concentrate" and var63 "Listening to music with emotions involved" to take just a few examples from the variables which required subjective interpretation in order to be understood relating to their context. There are more of these in all categories. However, with pre-defined and strictly operationalized variables, it would not have been possible to code many of the situations in therapy because the same phenomena in therapy may manifest themselves in multiple ways. Many of the types of behaviour

[47] See chapter 5.3 The Hermeneutical Core in Practicalising the Epoché and Clinical Research Methods, figure 4.

occurring during therapy needed an understanding of the unconscious aspect of the situation, which may only manifest itself symbolically or as a metaphor for the patient's meaning.

Another example is var5 "resistance", which is a psychoanalytic concept which, in music therapy, could mean that even though a patient has started therapy and is willing to come to therapy, there are contradictory feelings and s/he may not want to listen to music or discuss anything (Greenson, 1991, pp. 59–63). There could be other rationales for this behaviour but in the end, whatever the reason, the patient does not want to do the thing that s/he is supposed to do in therapy. Then, it could imply resistance as a phenomenon even without a psychodynamic explanation. In general, the variables were chosen so that there would not be any explicit scientific or theoretical concepts but that the variables would relate more to the "things in themselves" and the expected experiences and behaviour of patients phenomenologically. Variable 5 "resistance" is contradictory in this sense but was considered also to be an essential phenomenon in therapy, and not only in theory.

Table 3. Extraction from raw data matrix of Case One (Ben) and some coded information from his first three music therapy sessions as an example.

| Subject | Session | Part | var1 | var2 | var3 | var4 | var5 | var6 | var7 | var8 | var9 | var10 | var11 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1,00 | 1,00 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 |
| 1,00 | 1,00 | 1,00 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 |
| 1,00 | 1,00 | 2,00 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 |
| 1,00 | 2,00 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 |
| 1,00 | 2,00 | 1,00 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 |
| 1,00 | 2,00 | 2,00 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 |
| 1,00 | 3,00 | ,0 | ,0 | ,0 | ,0 | ,0 | 1,00 | ,0 | ,0 | 1,00 | ,0 | ,0 | 1,00 |
| 1,00 | 3,00 | 1,00 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 | 1,00 | ,0 | ,0 | 1,00 |
| 1,00 | 3,00 | 2,00 | ,0 | ,0 | ,0 | ,0 | 1,00 | ,0 | ,0 | ,0 | ,0 | ,0 | ,0 |

In table 3, it is illustrated how each observed variable (situated person) was marked into the raw data matrix with running positive numbers and calculated using factor analysis. Only variables from 1 to 11 are shown for presentational reasons but the variables continue to the right, including all 66 variables that were studied (see appendix 1). "Part" in the matrix indicates the part of each therapy session where ",0" indicates the whole session, "1,00" the first part of session and "2,00" the latter part of the session. These provide three "situated persons" in each of the 116 music therapy sessions with three subjects, resulting in 348 situated persons altogether.[48]

Even though there are many over-lapping phenomena in the coded variables, which sometimes may even be contradictory, they do not necessarily make them false interpretations. They manifest the assumed correlations and the factor structure of the phenomena, and the theory of their occurrences and variations in therapy (appendix 1). With confirmatory factory analysis, it was possible to exhibit the correlations between the factors and find new meanings and explanations. I argue that it is a part of life, and the essence of psychoanalytic therapy or music psychotherapy, that there are multiple meaning and interpretations, even contradictory wishes and impulses. In fact, some variables are near opposites of one another, like var40 "Laughs, humour" is to var20 "depression" or var14

[48] See chapters 6.6.3 Situated Persons as the Manifestations of Ontological Structure and 6.6.4 Situated Persons in the Raw Data Matrix for further details and explanations on counting and marking the variables.

"fear"; depressed people can have a sense of humour too and one may laugh nervously out of fear. Therefore, I claim that it could be very difficult to define variables to precisely match human behaviour, and particularly experiences relating to free association and imagery from music listening, because of their multiple meaning contents of personal memories, emotions and unconscious behaviour. They could be as unpredictable as any improvised or artistic behaviour in life. However, in the light of this factor analysis, it seems that subjective interpretations and countertransference of clinical work may be applied to achieve logical and reliable results, even with statistical procedures. In addition to this, the results from the factor analysis confirm that the subjective interpretations and theories of the therapist researcher also have validity.

### 10.1 Eight Factors

From the factor analytic studies of three patients (N=3) in music psychotherapy, eight factors appeared as the best solution for the factor structure (see appendix 5). They were retrieved from the data collected of each therapy session (N=116) and the three patients being analyzed according to the parts of each session divided as a whole, the first part and the latter part. These temporal parts of each session were considered as *situated persons* in therapy, as earlier described. Factors have been achieved as the result from observed phenomena during the two parts of the therapies; the first part being approximately 20–30 minutes in length, as was the latter.

When one therapy session was divided in two parts, it increased the statistically calculated number of sessions, doubling them to n=232 situated persons. I would especially like to emphasize to the reader that then n=232 does not index the real "test" persons anymore but rather the phenomena relating to the three patients` various situations in therapy (see figure 5). Thus, the results achieved with the factor analysis in this research, whilst significant, are not generalizable to a wider population beyond these three persons, i.e. to all victims of torture in the world, or all individuals partaking in music therapy. This kind of statistical generalization cannot be made with such a small group of people. The statistical calculations are related to the phenomena that happened inside three music psychotherapies, their correlations to each other and the factor loadings. I argue that with factor analysis, it was possible to confirm that theories of phenomena, their relationships and variance were not coincidental and that they had inner coherence (validity) and objective logic (reliability). It was also possible to find new meanings, interpretations and explanations for the phenomena and their occurrences in the therapies. In appendix 5 can be found all the calculated factor loadings and the communalities for each variable as presented in the Variable Template for Factor Analysis (appendix 1). In that which follows, I will interpret and analyze each of the eight resultant factors in detail.

**Factor 1 Music as a bringer of pleasure and positive imagery** (N=3, whole sessions, *situated pers*ons n=232)

| Variable | Factor loading |
|---|---|
| 35 Can recreate a positive image | 0,778 |
| 52 Music gives rise to positive imagery | 0,652 |
| 36 Can experience pleasure/feeling good | 0,606 |
| 66 Discharging of tensions/feelings | 0,370 |
| 48 Feels good (music) | 0,340 |
| 65 Peak experience while listening to music | 0,302 |
| 45 Notices that therapies or treatments help him/her | 0,275 |
| 25 Talks about one`s emotions | 0,268 |
| 38 Can orient to the future | 0,254 |
| 44 Awareness of oneself and one`s own experiences increases; can verbalise own experiences and thoughts | 0,251 |
| 41 Talks about emotions, memories, thoughts, imagery etc. connected to music | 0,205 |

**Eigenvalue: 2,561**

Factor 1 appears to imply how music feels good and experiencing pleasure is also possible for the patients. The patient can think positive thoughts and see a brighter side to life too. Correspondently, music brings forth positive emotions, thoughts, memories and imagery. It is possible for emotions to be released during verbal interaction and listening to music in therapy. The patient is more emancipated from his inhibitions and fears, so that he can relax, become calm, feel pleasure, orient to the future and let the music guide his thoughts and emotions.

**Factor 2 Music as relaxation and conscious mastering of mind** (N=3, first part of sessions, *situated persons* n=116)

| Variable | Factor loading |
|---|---|
| 65 Peak experience while listening to music | 0,924 |
| 66 Discharging of tensions/feelings | 0,788 |
| 42 Employs music at home to relax and empty mind | 0,766 |
| 37 Experiences sense of calming down | 0,577 |
| 49 Pleasure (relating to music) | 0,523 |
| 58 Music calms | 0,494 |
| 63 Listening to music with emotions involved | 0,490 |
| 50 Likes what one hears | 0,408 |
| 44 Awareness of oneself and one`s own experiences increases; can verbalise own experiences and thoughts | 0,367 |
| 41 Talks about emotions, memories, thoughts, imagery etc. connected to music | 0,363 |
| 28 Can listen to more music | 0,333 |
| 64 Discusses emotions involved | 0,311 |
| 52 Music gives rise to positive imagery | 0,285 |
| 51 Music relaxes/listens to music for one`s relaxation | 0,261 |
| 30 Is interested in something other than oneself | 0,231 |
| 25 Talks about one`s emotions | 0,221 |

**Eigenvalue: 3,377**

This factor seems to be related to listening to music during the first parts of the therapies. Generally, the music listening period started at the beginning of the therapy sessions. The patient is able to listen to music and enjoy it. He is listening to music with his emotions

involved, which pacifies and relaxes him. The patient has noticed that music has a pacifying and relaxing effect on him and helps to keep him from disturbing thoughts. The patient is more aware of how music is affecting him and is able to talk about thoughts, memories and imagery relating to the music. The individual applies music consciously as a self-treatment and has considered music therapy to be an adequate form of therapy for use at home too. His inner capacity to experience and feel more freely has developed and he can control various experiences, like disturbing thoughts. The patient can experience and allow himself pleasure. Music may discharge annoying emotions and help to verbalize issues and experiences in the mind.

**Factor 3 Insight and verbal reflection** (N=3, first part of sessions, *situated persons* n=116)

| Variable | Factor loading |
|---|---|
| 33 From monologue to dialogue | 0,722 |
| 29 Can talk more | 0,674 |
| 44 Awareness of oneself and one`s own experiences increases; can verbalise own experiences and thoughts | 0,560 |
| 26 Notices change in oneself | 0,504 |
| 31 Presence | 0,487 |
| 28 Can listen to more music | 0,353 |
| 30 Is interested in something other than oneself | 0,301 |
| 16 Talks about symptoms | 0,294 |

**Eigenvalue: 2,801**

This factor appears to be related with the progression of the patient in therapy. The individual is able to verbalize and share his experiences with the therapist. He is more present and can generally talk and listen to music more. Consciousness relating to the self and the traumatic experiences has increased and the person may notice that change has occurred in himself. The individual can express himself more verbally. The patient may achieve insights through therapy. There has developed transference towards the therapist and the therapist has become a meaningful object for the patient.

In addition to factors related to the progression of patients in therapy i.e. the positive effects of therapies, there were factors connected with the patient's symptoms, problems and feeling worse etc. I assume factor 4 emerged from the first part of the therapies because frequently patients spoke about their current situation and condition at the beginning of the therapy session. For example, with patients Abdul (Case Two) and Osama (Case Three) particularly, their symptoms were stressed in discussions. The next factor, from the first part of the therapies, appears to be related to their situations but may also be connected more broadly to experiences left over from the torture, and symptoms that manifested through their experiences particularly.

**Factor 4 Sequelae of torture** (N=3, first part of sessions, *situated persons* n=116)

| Variable | Factor loading |
|---|---|
| 20 Depression | 0,687 |
| 10 Psychotic symptoms | 0,652 |
| 22 Death wishes | 0,572 |
| 19 Anxiety | 0,518 |
| 61 Absent/dissociates | 0,495 |
| 21 Self destructiveness | 0,466 |
| 3 Difficulty in describing emotions | 0,314 |

**Eigenvalue: 2,433**

This factor seems to be related to the various psychic sequelae of torture, like depression, anxiety and dissociation. Continued over a long period of time and very severely, they may appear as psychotic thoughts and behavior in an individual. Death wishes may result from psychotic thoughts, continuous anxiety and severe depression. They may even proceed to self-destructive behavior, as was seen in the case studies. Patients suffer from the sequelae of torture long after the torture has ended. In addition to this, they may have been driven to a dead end in their lives and perhaps have become separated from their families and friends. They have deliberately needed to run from their home countries and have left their occupations behind. All this has affected their general psychic condition, which may even lead to a total collapse. Death may be felt as the only way out in their minds; the only escape from their problems. The individual may live only in this moment and it is difficult or even impossible for him to see any hope or future.

**Factor 5 Hope and integration** (N=3, latter part of sessions, *situated persons* n=116)

| Variable | Factor loading |
|---|---|
| 38 Can orient to future | 0,535 |
| 44 Awareness of oneself and one`s own experiences increases; can verbalise own experiences and thoughts | 0,510 |
| 35 Can recreate a positive image | 0,481 |
| 63 Listening to music with emotions involved | 0,399 |
| 40 Laughs, humour | 0,385 |
| 25 Talks about one`s emotions | 0,359 |
| 64 Discusses emotions involved | 0,342 |
| 30 Is interested in something other than oneself | 0,324 |
| 50 Likes what one hears | 0,266 |
| 54 Thinks that music helps people to solve their problems | 0,260 |
| 36 Can experience pleasure/feeling good | 0,250 |
| 66 Discharging of tensions/feelings | 0,247 |
| 32 Trust | 0,240 |
| 49 Pleasure (music) | 0,236 |
| 65 Peak experience while listening to music | 0,230 |
| 26 Notices change in oneself | 0,213 |
| 33 From monologue to dialogue | 0,211 |

**Eigenvalue: 2,183**

According to factor 5 the patient is able to think positively and create positive imagery. He is no longer totally stuck in a cycle of compulsory thinking about traumatic experiences but can also orient to the future and to others. Music may help in this process of discharging emotions. The patient may achieve new insights from listening to music and through discussions, and his thoughts and experiences are more conscious. Even something like

"peak experience" may be possible while listening to music, where the patient reaches something that has a completely new meaning and experiences strong pleasure. He is also more able to trust and analyze his experiences verbally and the integration of traumatic experiences to the personality is possible.

**Factor 6 Working through of traumatic experiences** (N=3, latter part of sessions, *situated persons* n=116)

| Variable | Factor loading |
|---|---|
| 9 Clinging to memories | 0,961 |
| 39 Talks/tells about a traumatic experience | 0,799 |
| 32 Trust | 0,542 |
| 38 Can orient to future | 0,518 |
| 43 Processes one`s traumatic experiences with music | 0,397 |
| 44 Awareness of oneself and one`s own experiences increases; can verbalise own experiences and thoughts | 0,363 |
| 27 Expresses the wish to recover | 0,280 |
| 31 Presence | 0,226 |

**Eigenvalue: 2,677**

Factor 6 suggests that the individual is able to process verbally, and with music, traumatic experiences in therapy. The patient has developed an increasing trust towards the therapist and is able to disclose himself verbally and talk about his traumatic experiences and the memories relating to them which are still bothering him as compulsory thoughts. However, there has emerged a will to recover and a new orientation towards the future, which is not seen as totally hopeless anymore. The patient is able to take advantage of the therapy and work through his traumatic experiences. As a therapist and a researcher, I considered in my preunderstanding that talking about traumatic experience in therapy is positive thing, which may promote rehabilitation and therapy.[49] I postulate that the encountering of traumas in psychotherapy is important and has to be one of its objectives as without it there cannot usually be durable change in the patient.

**Factor 7 Recognition and depiction of emotions with music** (N=3, latter part of sessions, *situated persons* n=116)

| Variable | Factor loading |
|---|---|
| 3 Difficulty in describing emotions | 0,769 |
| 45 Notices that therapies or treatments help him/her | 0,619 |
| 2 Curtness | 0,594 |
| 36 Can experience pleasure/feeling good | 0,552 |
| 58 Music calms | 0,475 |
| 27 Expresses the wish to recover | 0,451 |
| 50 Likes what one hears | 0,384 |
| 51 Music relaxes/listens to music for one`s relaxation | 0,368 |
| 48 Feels good (music) | 0,298 |
| 55 Notices that music corresponds with one`s own emotional state | 0,235 |
| 41 Talks about emotions, memories, thoughts, imagery etc. connected to music | 0,217 |
| 37 Experiences sense of calming down | 0,201 |

**Eigenvalue: 3,218**

[49] See appendix 1 and the variables in the category "Positive reactions of patient in therapy".

This factor depicts the traumatic sequelae of torture victims where the patient has lost connections to his emotions. It is difficult for the patient to analyze verbally his emotions, and his self-expression is flattened otherwise too, which manifests as curtness. The cognitive thinking processes of an individual have become more difficult and the patient may be too exhausted to speak because of his general tiredness, which may be the result of sleep disturbances relating to the traumatic experiences as well as depression. However, the patient may experience music as a pacifying thing and recognize emotions with its help. Self-focused experiencing, which may manifest as clinging to memories and complaining of different symptoms, begins to decrease and the patient notices that the therapy and his treatments generally may help him. Music seems to promote verbalizations of experiences and emotions.

**Factor 8 Avoidance/resistance** (N=3, latter part of sessions, *situated persons* n=116)

| **Variable** | **Factor loading** |
|---|---|
| 20 Depression | 0,703 |
| 13 Pessimism | 0,629 |
| 19 Anxiety | 0,536 |
| 61 Absent/dissociates | 0,488 |
| 5 Resistance | 0,376 |
| 15 Fear/concern for family | 0,367 |
| 8 Lack of trust | 0,357 |
| 39 Talks/tells about a traumatic experience | 0, 343 |
| 25 Talks about one`s emotions | 0,325 |
| 52 Music gives rise to positive imagery | 0, 293 |
| 62 Inability to concentrate | 0,272 |
| 21 Self destructiveness | 0,258 |
| 49 Pleasure (music) | 0,245 |
| 44 Awareness of oneself and one`s own experiences increases; can verbalise own experiences and thoughts | 0,209 |
| 45 Notices that therapies or treatments help him/her | 0,206 |
| 11 Avoidant behaviour | 0,204 |

**Eigenvalue: 2, 966**

This factor seems to be related to the symptoms left by torture which manifest as an avoidance and a resistance towards therapy. The patient experiences a strong lack of trust towards the therapist and people in general. He is feeling pessimistic about himself and life, and experiences anxiety and/or depression. Thoughts and emotions run away with him and it is difficult for him to be in the present moment. He may feel that therapy is a threat to his psychic balance, which he desperately tries to maintain without success. Traumatic experiences create an inner threat that the patient does not want to re-experience, which psychodynamically may manifest as various symptom formations. However, it seems that music affects him positively and helps to raise other kinds of thoughts and feelings than just pessimistic ones. Music may bypass the patient`s resistance and defenses and positive feelings in the patient may emerge. Even though the patient may have contradictory feelings about his treatment, music no longer necessarily feels like a threatening bad object.

## 10.2 Conclusions from the Factor Analytic Studies

It is interesting to consider that significant results from factor analysis were achieved from the phenomena that were particularly related to progression in therapy and music`s role in it. Opposite factors could have been possible as well, as may be concluded from the earlier case studies and the assumed factor structure of the Variable Template for Factor Analysis (appendix 1). The factor analysis of observed phenomena in music psychotherapy confirms the therapist researcher's theory as to how various phenomena would correlate and what the variation and occurrences of them would mean. For instance, factor 4 *Sequelae of torture* equates well with the category of "Patient`s Symptoms arising in therapy" where almost all the variables except var3 "difficulty to describe emotions" are included. Similarly, factor 3 *Insight and verbal reflection*, factor 5 *Hope and integration* and factor 6 *Working through of traumatic experiences,* have many correspondences with the category "Positive reactions of patient in therapy" in the Variable Template for Factor Analysis. Almost every variable in each of these factors found in this category was pre-identified as important to look for in the clinical cases. With confirmatory factory analysis, it was possible to find new meanings and conceptualizations for these experiences and observations in the music psychotherapy of refugee torture survivors. Factors 3, 5 and 6 seem to be related to verbalizations of experiences in therapy and their relevance for the recovery of severally traumatized patients. They also suggest what kind of experiences may be important signs of recovery, like variables 30 "Is interested in something other than oneself", 31 "presence", 33 "From monologue to dialogue", 44 "Awareness of oneself and one`s own experiences increases; can verbalize own experiences and thoughts" as examples from factor 3. This factor can be interpreted in the light of the aforementioned phase specific approach in psychoanalytic theory, stating that a patient is more capable of using insights and the verbal or musical interpretations of the therapist.

Factor 5 appears to be related in particular to a recovery from traumatic experiences, and it can be interpreted according to the aforementioned theories of trauma therapy. The patient is already able to look to the future, as the strong positive loading of variable 38 "Can orient to future" suggests. There is also an increasing awareness and capability to verbalize and integrate experiences and thoughts, as is seen from occurrences of variable 44, "Awareness of oneself and one`s own experiences increases; can verbalize own experiences and thoughts". However, this factor is also related to music, as can be seen from the occurrence of variables 63 "Listening to music with emotions involved" and 65 "Peak experience while listening to music". This means that music may have an effect in promoting such integrative processes with trauma patients.

Factor 7 *Recognition and depiction of emotions with music* is also related to music as well as other positive reactions of the patient in therapy; variables 41 "Talks about emotions, memories, thoughts, imagery etc. connected to music", 48 "feels good" (music), 50 "Likes what one hears", 51 "Music relaxes/listens to music for one`s relaxation" 58 "Music calms", are to be found in this category "The way patient feels about music". Observed effects of music seem to correspond to the variables 45 "Notices that therapies or treatments help him/her", 36 "Can experience pleasure/feeling good", and 27 "Expresses the wish to recover", which add strong loadings to the factor. This finding suggests that the way a

patient feels about music is related to the positive reactions of patients in therapy, and music in therapy would explain some of the positive reactions and progress of patients.

Factor 1 *Music as bringer of pleasure and positive imagery* and factor 2 *Music as relaxation and conscious mastering of mind* are relating to the musical experiences of patients in therapy. Listening to music seems to strongly load both factors with positive experiences relating to music. In factor 1, variables 35 "Can recreate a positive image" and 52 "Music gives rise to positive imagery", have almost equally strong loadings. Also, variable 36 " Can experience pleasure/feeling good", in the category of "Positive reactions of patient in therapy" strongly loads these factors, as well as variables 48 "Feels good" (music) and 65 "Peak experience while listening to music" together. Thus, factor 1 confirms the theory and assumptions of the therapist researcher as to how music could provide trauma patients, like refugee torture survivors, with positive experiences and imagery. On the other hand, it rejects the theory in the category "Symptoms music gives rise to in a patient" as an overruling effect of music for torture survivors, even though there were such direct observations from the variables 56 "Headache" and 57 "Depression" relating to music in patients. Sometimes the patients were not able to, or did not want to, listen to music as was described in the case studies. As discussed in the theoretical and philosophical chapters, it may relate to an altered experience of music and sounds as a consequence of torture. However, according to the observations and factor analysis, music did not seem to have any such general negative effect on the patients but quite the opposite, as was assumed at the beginning of this research.

Factor 2 explains how patients were observed to relax with music in their therapies. Music also enabled the discharging of emotions and a conscious mastering of the mind, as the very strong loadings of variables 65 "Peak experience while listening to music" (having almost the value of one), 66 "Discharging of tensions/feelings", 42 "Employs music at home to relax and empty mind", 37 "Experiences sense of calming down" and 49 "pleasure" (relating to music), are suggesting. In factor 2, variables 44 "Awareness of oneself and one`s own experiences increases; can verbalize own experiences and thoughts", and 41 "Talks about emotions, memories, thoughts, imagery etc. connected to music", together explain a lot of the observed change in patients` reactions relating to music.

Factor 8 *Avoidance/resistance* does not conform directly to any of the categories pre-identified in the Variable Template for Factor Analysis (appendix 1). However, it relates to the variables of observed phenomena in the categories "Issues that make the treatment of the patient more difficult" and "Patient`s symptoms arising in therapy". Symptom variables 20 "Depression", 19 "Anxiety", and 61 "Absent/dissociates", have strong factor loadings. Also, variables 5 "Resistance", 8 "Lack of trust", 39 "Talks/tells about a traumatic experience, are loaded. Contradictionarily, in this factor are loaded together variables relating to the opposite phenomena because many variables that were also considered as positive reactions in patients were loaded. Variable 39, as well as variables 25 "talks about one`s emotions", and 52 "Music gives rise to positive imagery", can also be interpreted positively in therapy, making factor 8 have two sides and opposite poles at the same time. I argue that this is a projection of the clinical picture in psychotherapy, where there can be two sides to a patient, affecting therapy and its transference. These two poles, one that is

opposing the change and one that wants to recover, fluctuate in therapy continuously.[50] In the context of traumas, they may be a part of avoidance engendered by the threat of re-experiencing such experiences in therapy, a fear which even the positive imagery aroused by music may bring to the forefront.

In analyzing the separate parts of the sessions, the first parts of therapy seemed to bring up some traces and consequences of torture in patients (see factor 4). I think this is natural because, in practice, there were more discussions and elaborations on the patients` situations in the first parts of the therapies. Therefore, symptoms were emphasized because the patients talked easily about them in the first place. This was usually related to their current conditions, feelings, tiredness, headaches; insomnia etc. as can be noticed from the case descriptions. When we moved on to the music listening part in the therapy sessions, then also positive experiences occurred. It seemed that positive experiences arose in patients especially while listening to music (factor 1). The discussion during listening to music and imagery processing appeared to ease the patients by regulating and controlling their experiences (factors 2 & 3). As therapies proceeded, patients seemed to be able to process their thoughts and experiences more consciously and encounter their traumas verbally with the help of music (factors 5, 6, & 7).

It can be concluded that the differences between the first and the last parts were caused by preceding the therapy process with discussion and listening to music in the middle of the therapy session. In the latter parts of the therapies, occurred the discharging of emotions and the working through of traumatic experiences (factors 6 & 7). The first parts included the discussing of symptoms and the encountering of emotions and thoughts relating to traumas, with verbal and musical processing (factor 2). In the latter part, these feelings and experiences were more deeply elaborated and patients seemed to be better able to analyze their experiences (factors 5, 6, & 7). It was possible for them to describe and designate the emotions confronted. Patients looked as if they could process their experiences and thoughts more freely (factor 5). Therefore, it can be said that in the last parts of the therapy sessions there was also a more interpretative approach to therapy.

In spite of the progression made and self insights, it seems also that the difficulties and dynamic resistances in working through traumatic experiences became separated in the factor analysis (factor 8). The patients' problems, their difficult life situations and experiences, arose in the latter parts of their therapies where the reflecting upon listening to music was part of the therapy structure. Naturally, also the traumatic experience and its sequelae for the life of an individual came into discussion and under psychotherapeutic scrutiny (factor 6). In a psychoanalytic psychotherapy context, this encountering of their problems in therapy is usually considered as positive interaction on the behalf of the patients. Thus, its occurrence cannot be mechanically perceived and calculated as a negative manifestation of their symptoms. However, I postulate that it is dependent on the Situation, and the therapist researcher`s interpretations in therapy, whether or not a patient talking about his symptoms should be considered as positive or negative. In some cases, as presented in the case of Abdul in this research, a patient talking only about symptoms may

[50] Compare Tähkä's aforementioned "transference child" and "developing child" (1997a).

be interpreted as negative interaction and a manifestation of the patient`s obsessive symptoms.

Dynamic resistance and avoidance towards encountering traumatic experiences and their discussion is a common phenomenon in psychotherapy and implies difficulties in approaching verbally, mentally, emotionally or even musically etc. the problematic issues relating to one`s personality, emotional and social life. Patients may consider something in their lives or experiences as too shameful to speak of or to confront, for example. Even though music psychotherapy appeared to encounter resistance in patients, still it seemed to increase the control of hard experiences simultaneously (factor 2). In the latter parts of the therapies, where factor 8 was found, patients` avoiding behavior, which may have included resistance too, appears to lessen according to findings from the factor analysis (factors 5, 6, 7). This can be explained with listening to music and particularly the relaxing and pacifying effects of it in the therapeutic process.

## 11 RESEARCH QUESTIONNAIRE RESULTS

All three persons who participated in music psychotherapy filled out questionnaires that studied their symptoms and health conditions during their therapy and rehabilitation. These questionnaires were filled out at the beginning, middle and end of their therapies, as well as six months later. There was also a compared group of two persons who were not in music psychotherapy but otherwise had the best possible treatment; they filled out the questionnaires similarly.[51] The treatment Outcome Questionnaire was almost the same questionnaire as the Music Therapy Outcome Questionnaire (appendix 2); the only differences were that words like "music" or "music therapy" were altered to "treatment" or "therapy". I myself designed both questionnaires for the purposes of this research project. I consider that these questionnaires and their results provide some kind of views as to how the research participants have experienced themselves, their health condition, rehabilitation and music therapy. General treatment, rehabilitation and the therapies of the 5 participants (N=5), three in music psychotherapy and the two compared persons having general treatments, were followed and compared with questionnaires over a period of approximately two years.[52]

The questionnaires could also be considered as some type of interview, posing those kinds of questions that may possibly have naturally arisen during a clinical or thematic interview. However, I learnt through the music psychotherapies that thematic, or spoken, interviews would have been very difficult or even impossible because of the nature of the patients´ problems, which included curtness and other difficulties in verbally expressing themselves.[53] In this respect, I assume that the questionnaires were more adequate for these patients and could provide additional information about them. I also think that the therapies, with the discussions involved, in their part represented some kind of interview. I emphasize that in this research these questionnaires have been scrutinized in a clinical sense and from the respect of individual treatment follow-ups. Their results as such are not intended to be generalized beyond these three music therapy patients and their individual compared persons (N=5).

Table 4. Questionnaire scores for Ben from Central Africa (C= Compulsatory symptoms; A= anxiety, D= depression)

| Questionnaire | pre-test (pilot) | post-test (pilot) | six months | post-therapy | six months after |
|---|---|---|---|---|---|
| How Do You Feel Today? | C 5,5<br>A 12<br>D 4 | C 3,5<br>A 9<br>D 4,5 | C 3,0<br>A 7,5<br>D 4,5 | C 5,5<br>A 11<br>D 7,5 | C 5<br>A 5,5<br>D 5,5 |
| Beck Depression Inventory (BDI) | 17/63 | 19/63 | - | 12/63 | 15/63 |
| Symptom Check List (SCL-25) | 45/100<br>A 23 D 22 | 39/100<br>A 22 D 15 | - | 47/100<br>A27 D 20 | 45/100<br>A21 D 24 |
| Music Therapy Outcome Questionnaire | - | 16/60<br>mean: 1,07 (a little) | 38/60<br>mean: 2,53 (a lot) | 45/60<br>mean: 3,0( a lot) | 37/60<br>mean: 2,47(moderately) |

[51] See chapter 6.4.1 for a more thorough description of the administration of the four questionnaires.
[52] See chapter 6.3 Multiple Controlled Case Studies of Long Music Psychotherapies for more information.
[53] See the cases studies of Abdul and Osama in chapters 8 and 9.

Table 5. Questionnaire scores of compared person 1 from Central Africa (The best possible other treatment) (C= Compulsatory symptoms; A= anxiety, D= depression)

| Questionnaire | pre-test (pilot) | post-test (pilot) | six months | post-therapy | six months after |
|---|---|---|---|---|---|
| How Do You Feel Today? | C 3,5<br>A 5,5<br>D 3,5 | C 2,5<br>A 4,0<br>D 4,0 | C 3,5<br>A 6,0<br>D 7,0 | C 2,0<br>A 2,0<br>D 2,5 | C 1,5<br>A 2,0<br>D 2,0 |
| Beck Depression Inventory (BDI) | 17/63 | 9/63 | - | 5/63 | 1/63 |
| Symptom Check List (SCL-25) | 41/100<br>A 18 D 23 | 44/100<br>A 25 D 19 | - | 32/100<br>A 16 D 16 | 34/100<br>A 16 D 18 |
| Treatment Outcome Questionnaire* | 43/60**<br>mean: 2, 87 (a lot) | 49/60<br>mean:3,27 (a lot) | 45/60<br>mean: 3,00 (a lot) | 46/60<br>mean:3,07 (a lot) | 48/60<br>mean:3,20 (a lot) |

*= Identical questions with Music Therapy Outcome Questionnaire
**= Did not answer one question

With Ben (table 4) and his individual, similar enough, compared person (table 5) – a 31-year-old man of about his age – it appears that they had no big differences in their questionnaire results. They both seemed to be recovering but still had some problems or concerns about their health conditions. Their conditions appeared to be already better at the beginning of this research and they both had about two years of treatment before the follow-up period, so I assume that very dramatic changes were unlikely in such a relatively short space of time. However, Ben and the other patient both experienced that they had gained advantages from their treatment. In the case of Ben, this positive experience seemed to especially increase during music therapy, the effects of which were still experienced six months afterwards. It is assumable that he could have made further use of music psychotherapy if it could have continued because, in the psychoanalytic psychotherapy context, his therapy was quite short and there was still work to be done in some respects. In his Anxiety scores from his post therapy and six months after music therapy tests, there were small differences between the questionnaires How Do You Feel Today? and SCL-25. They may look a bit contradictory but How Do You Feel Today only screened the experiences of the last three days whereas SCL-25 screened the past week, which may explain the difference.

Actually, it is possible that Ben`s raised anxiety scores during the last three days while filling out the How Do You Feel Today? questionnaire could be the result of his music therapy contact ending (table 4). He seemed to appreciate music therapy, which can be interpreted from his Music Therapy Outcome scores too. I also heard feedback afterwards that he would have still liked to continue his music therapy. However, his general scores on all the questionnaires remained at almost the same level six months after music therapy, even though he had verbal therapy and other treatments. It was left open why, but his music therapy was relatively short compared to his problems and traumas. He also had some social problems, for example he and his family were homeless at one time and he could not get his other son into Finland. So there was crisis after crisis in his current life situation during music therapy even though after his music therapy he was able to start work training. It is no wonder at all that his feelings of anxiety, and other symptoms, continued while he was waiting for the decision as to whether or not his other son would be allowed to come to Finland, for example, in spite of all the therapy and treatment he received. It can be concluded that Ben had gained an advantage from both music psychotherapy and verbal

psychotherapy as there was no big differences between the scores at the end of music therapy and six months later when he had had verbal psychotherapy.

Table 6. Questionnaire scores of Abdul from South Asia (C= Compulsatory symptoms; A= anxiety, D= depression)

| Questionnaire | pre-test (pilot) | post-test (pilot) | six months | post-therapy | six months after |
|---|---|---|---|---|---|
| How Do You Feel Today? | C 20<br>A 26,5<br>D 18 | C 17,5<br>A 26,5<br>D 20,5 | C 18,0<br>A 27,0<br>D 20,5 | C 7,5<br>A 9,0<br>D 10,5 | C 13<br>A 12,5<br>D 10,0 |
| Beck Depression Inventory (BDI) | 52/63 | 56/63 | - | 17/63 | 37/63 |
| Symptom Check List (SCL-25) | 98/100<br>A 47 D 51 | 95/100<br>A 44 D 51 | - | 49/100<br>A 24 D 25 | 63/100<br>A 30 D 33 |
| Music Therapy Outcome Questionnaire | - | 11/60<br>mean:0,73 (a little) | 24/60<br>mean:1,6<br>(moderately | 35/60<br>mean:2,33<br>(moderately) | 28/100<br>mean:1,87<br>(moderately) |

Table 7. Questionnaire scores of compared person 2 from Eastern Europe (The best possible other treatment) (C= Compulsatory symptoms; A= anxiety, D= depression)

| Questionnaire | pre-test (main research) | six months | post-therapy | six months after |
|---|---|---|---|---|
| How Do You Feel Today? | C 11,5<br>A 20,5<br>D 13,0 | C 6<br>A 10,0<br>D 11,0 | C 9,0<br>A 12,0<br>D 9,0 | C 0<br>A 2,0<br>D 1,0 |
| Beck Depression Inventory (BDI) | 43/63 | - | 39/63 | 9/63 |
| Symptom Check List (SCL-25) | 50/100<br>A 25 D 25 | - | 65/100<br>A 28 D 37 | 32/100<br>A 16 D 16 |
| Treatment Outcome Questionnaire* | 26/60<br>mean: 1, 73<br>(moderately) | 24/60<br>mean: 1,60<br>(moderately) | 30/60<br>mean: 2,00<br>(moderately) | 41/60<br>mean:2,73(a lot) |

*= Identical questions with Music Therapy Outcome Questionnaire

I assume that in Abdul`s case (table 6) the dramatic changes in his condition during his music psychotherapy were dependent upon his general situation. He also had a lot of symptoms at the beginning of therapy and was feeling very bad even though he had already been receiving other treatment and rehabilitation before music therapy for approximately a year. However, with music psychotherapy contact, and because of the hospital treatment, his situation and condition improved a lot. I postulate that this change may be seen clearly in his questionnaire results, and also that he experienced feeling better and considered that he had gained advantages from music therapy. It was reported by his doctor that he had continued listening to Indian music continuously at home six months after his music therapy had ended; his condition was stable and good. It was evaluated by the doctor that he was progressing well in his rehabilitation.

I postulate that the positive asylum decision was very important for his condition after all, which awoke his will and motivation to recover. There was an increase in his positive feelings towards music therapy and how it had helped him, and he still felt the same way six months after his music therapy had ended. Abdul`s music therapy, with its quite long

interruption, was not a typical case of music therapy and his life situation was not the best possible for it, or any other therapy. I postulate that it would have been of advantage to him to have had music psychotherapy for a longer period of time and he actually still needed treatment. In fact, he continued psychotherapy, and other treatments, with his doctor after music therapy. Even though he frequently participated in other therapies and treatments after his music therapy had ended, his entire symptom questionnaire scores increased, which suggests that music psychotherapy had supported him tremendously. Over all, in the light of the questionnaires, Abdul`s anxiety, obsessive compulsion symptoms and depression clearly diminished, which is concurrent with the clinical observations of him as described in the earlier case study. Six months after his music therapy it was evaluated by a psychiatrist that he did not have psychotic symptoms and that his functioning was good in general (GAS 65), even though he still felt lonely, mourned, had nightmares and could not always sleep.[54]

Abdul`s compared person (table 7), a 34-year-old man from Eastern Europe – about same age as Abdul – appeared to have gained a lot of advantage from his treatments and there occurred continuing progress throughout the whole of the follow-up period. He started a regular job, for instance. However, he still had some problems in his life, which were also reported by the staff of the rehabilitation centre. Previously, this patient was also in quite bad condition and had already had a long history of treatment, so I argue that his overall health status and general situation was already much better at the beginning of the follow-up. This can be seen when the scores of compared person 2 (table 7) and BDI and SCL-25 scores from the beginning of the research are compared with Abdul`s first scores (table 6) using the same questionnaires. Abdul`s SCL-25 scores were similar to compared person 2 at the end of his music psychotherapy, about one and half years after his follow-up period began. Compared person 2 was clearly at a different phase of rehabilitation. Thus, there were no such dramatic situations and changes during the follow-up. He had asylum for instance and had already stayed longer in Finland too, which had given him more time to adapt to a new culture. To draw conclusions in respect to his treatments and situation is difficult as they were hardly comparable with Abdul´s very difficult situation during music psychotherapy after all. However, these results of compared person 2 (table 7) as well as compared person 1 (table 5) suggest that long and persistent rehabilitation with therapy may help torture survivors and stabilize their conditions. Similar general progress in rehabilitation can be seen from the questionnaire scores and follow-up period of Abdul. The only difference being that music and music therapy was used in his treatment in a situation where only verbal psychotherapy was evaluated as being too difficult by his attending doctor as well.

[54] Goal Attainment Scaling (GAS) scores of Abdul evaluated by the psychiatrist.

Table 8. Questionnaire scores of Osama from Middle East (C= Compulsatory symptoms; A= anxiety, D= depression)

| Questionnaire | pre-test (main research) | six months | post-therapy | six months after |
|---|---|---|---|---|
| How Do You Feel Today? | C 14,5<br>A 9<br>D 15,5 | C 12,0<br>A 6,0<br>D 9,5 | C 16,5<br>A 18,0<br>D 15,5 | - |
| Beck Depression Inventory (BDI) | 20/63 | - | 19/63 * | - |
| Symptom Check List (SCL-25) | 58/100<br>A 30 D 28 | - | 44/100*<br>A 25 D 19 | - |
| Music Therapy Outcome Questionnaire | - | 12/60<br>mean:0,8 (a little) | 17/60*<br>mean:1,13 (a little) | - |

* Answered “cannot tell” to many questions

Osama`s (table 8) music therapy period was the shortest and the most infrequent of all three patients in music therapy as it had many complicated aspects, as was described in the case study. I assume that this shows itself in the questionnaire results. He could not answer all the questions and it was especially hard for him to even consider them. He easily became anxious, in my opinion. From these results in themselves, it is very difficult to interpret or conclude how he felt about music therapy and his situation in general. I think he had very contradictory feelings towards being in Finland which made his treatment difficult. I argue that we were just at the beginning of his therapy when he eventually left Finland, so I could not reach him six months afterwards. However, he phoned me from abroad a couple of times over a three-year period after his music therapy had ended and wanted to see me again and continue our work, which was not possible. He sounded happy, he told that he was working in a shop and seemed to be grateful to me even though our meetings did not last very long at the time. Music therapy, and contact with me, appeared to remain a positive experience in his mind long after the event, and long since we last met. I argue that this positive attitude towards music therapy and the therapist tells us that music psychotherapy was an important experience for Osama, even though it is not clearly shown in the questionnaire results. In a different situation, these durable internalizations of therapy and its ambience, what it meant for him as a sign of developing positive transference, could have provided a good grounding for the continuation of rehabilitation and therapy.

## 12 SUMMARY AND DISCUSSIONS FROM THE THEORETICAL, CLINICAL AND RESEARCH POINTS OF VIEW

On the basis of this research, it appears that all three patients in music psychotherapy experienced some improvement to varying degrees, depending on their general life situation and the phase of their rehabilitation. Their treatments may be scrutinized in the respect of phase specific psychoanalysis, for instance, so that music and therapeutic processing aided them according to the level of their problems and functioning. All therapies included the supporting approach of a therapist with music. However, music also enabled patients to work through their problems and provided insights through the collecting of their own life history and experiences alongside a therapist using an integrative approach. The therapist`s objective was also to create a psychotherapeutic dialogue and engender a basic trust with traumatized individuals through the use of music. I noticed that it was important to raise emotions in patients with music and to empathically describe those emotions to patients according to phase specific theory.

Music appeared to illustrate metaphorically a persecuting object in torture survivors` self-experience relating to their traumas, which seemed also to affect their relationship with music. Even though music and sounds are evidently used as weapons, or even as part of the torture, music also seemed to have many therapeutic factors promoting recovery from traumatic experiences. This is the main result of this research. The positive role of music in therapy arises in the case studies as well as the outcomes of the factor analysis, demonstrating clearly how music may bring positive imagery, emotions and help in verbalizing and integrating traumatic experiences. According to the questionnaire results from a two-year follow-up period of three refugee torture survivors in music psychotherapy and their two compared persons who received other general treatment (N=5), music therapy was in line with other treatments.[55]

I will not repeat all of the conclusions and findings of this research, which I have already discussed in their own contexts and chapters. The following chapters will only summarize some of the topics that I have found of interest to further discuss in relation to the findings and methods of this research. In chapter 12.1, Genetic and Transference Interpretation, Neuroscience in Music Psychotherapy, I shall discuss some of the theoretical issues that arose from the theoretical and clinical parts of this study. I will scrutinize the clinical role of music in psychotherapy from a psychoanalytic context and explore the implications it may have considering recent discussions in the field relating to the latest developments in neuroscience and music research. This is relevant because many music therapists, including myself, who currently use music psychotherapy with children and adolescents in particular, encounter traumatic experiences based in early childhood development, neuropsychological dysfunctions and learning problems in their work, all of which can even sometimes be found in the same patient. In chapter 12.2, Music as a Thing and the Discloser of Experiences and Meanings in Therapy, I shall continue the discussion on from the previous chapter in the light of philosophical analysis and the findings of this research, which it will summarize. Chapter 12.3, Music Psychotherapy and Torture Survivors: A Clinical Situation, Music,

[55] See chapter 11 Research Questionnaire Results for individual analysis and conclusions of treatments.

Culture, explores the topic further and summarizes some of the issues relating to the clinical setting of music psychotherapy with refugee torture survivors, including clinical experiences and the results of this research as well as earlier clinical work and research with this patient group and related fields. In chapter 12.4, Evaluating the Trustworthiness of Research, I discuss the research methods and processes according to a naturalistic inquiry. In the final chapter 12.5, Overview of Clinical Evidence in the Research, I shall evaluate the results of this research according to the criteria of Evidence-base Medicine (EBM). I will also discuss some other current research in the field relating to the topics and findings of my research from the theoretical, philosophical and methodological points of view to orient future research and discourse.

## 12.1 Genetic and Transference Interpretation, Neuroscience in Music Psychotherapy[56]

Currently, many psychotherapists seem to include similar techniques and verbal approaches to the emphatic describing used in this research as an interpretation, as well as almost all the verbalizations of a therapist, without the classical separation of confrontation, clarification and interpretation in a interpretive process (Tähkä, 1997a, p. 461). In spite of differences in the clinical vocabulary of interpretation, there is consensus among scholars that patients with different levels of problems need specific interpretations that are dependent on their developmental stage, level of problems and individual situations. For example, there are differences between *genetic/reconstructive interpretations* and *transference/here and now interpretations.* The first is directed at the past and those feelings and thoughts relating to the patient`s developmental stages. The second refers to patients` patterns of behavior and how they appear in their transference to a therapist. Here and now interpretations are recommended for patients who experience inner fragmentation, have weak ego-boundaries or self-integration and who may have difficulties regulating their emotional states. Thus, it may be more useful to help patients to identify their feelings first before interpreting their meanings from the past. This assumption can also be found in this research`s clinical work where patients were severely traumatized and therefore suffered from weak self-integration and from difficulties in controlling their minds and feelings. I postulate that music may be considered as a part of empathic describing, or a here and now interpretation, as was proposed earlier in the clinical theory chapter. Music and imagery also enable reconstructive interpretations when memories are aroused in a patient from their unconsciousness and their past. (Lemma, 2006, pp. 185–192.)

In the light of this research theory and practice, it seems that music and music therapy as intentional musical treatments (praxis) may have possibilities to support and hold the patients` emotions. Also, the role of a therapist as a sort of fellow traveler with the patient was essential; I do not necessarily consider this as being a "guide" because I cannot personally know beforehand the other and his/her world of meanings and experiences. Rather I consider that my approach to music and imagery has similarities to *free association* in psychoanalysis. I learned that the particular essence of psychotherapy with torture survivors and the traumatized was to help the patient to be in the present moment and to give

[56] See chapter 4 Psychoanalytic Theories and their Clinical Application in Music Therapy for the ground of this discussion.

rise to thoughts and experiences relating to it.[57] This differs in some points from traditional analytic abstinence, including the relative passivism and silence of a therapist, for example. However, I stress that it is important to remember that there are many views and clinical practices in psychoanalysis currently, which may differ quite a lot from each other theoretically and clinically depending even on the individual therapist. Some analysts and psychotherapists may be verbally more active than others, independent of the patient`s problems. For instance, Levy (1985) recommends various interpretations and verbal activity for the therapist, starting from the very beginning of treatment to assure the progression of the therapy. According to him, a therapist should notice the personal needs of patients for interpretations and, for example, the resistances of patients should be interpreted immediately. From the phase specific respect, it is important how interpretations are made, and the kinds of interpretations the patients become aware of may be of advantage in different parts of their therapy. This may also require that the music therapist makes the assessment as to whether musical or verbal approaches are more suitable concerning a particular patient and his/her situation.

In music psychotherapy, I assume therefore that it is also music`s capability to support, hold, depict emotions and provide insights with a therapist that is essential. Music is a dynamic/symbolic form of art that happens in the present when a patient is listening to or playing music. I postulate that this enables verbal and musical interpretations of transference in here and now situations. Because music is happening in a particular time, it necessarily has to include in its situation all the other elements of time as well; the past, the present and the future. Therefore, genetic/reconstructive interpretations with patients are possible too because it also seems that music provides associations, memories, fantasies, imagery and pleasure that are dependent on the development stages and personal history of the individual and how it may be related to their traumatic experiences and torture.[58] How patients regulate their feelings may be represented and interpreted with music, for instance. Music appears to bring up emotions and memories that have their origins in our childhood development, adolescence and other later life situations. They may even precede our language in development and thus there may be no direct verbal access to these archaic feelings or patterns of behavior but they can only be displayed or otherwise expressed with music, movements, gestures etc. (Trevarthen & Mallock, 2000.) This may also be related to the physiology of the brain; how music and language are processed in different brain structures (Rose, 2004). Another possibility is that the original meaning connection has been lost or distorted because of the traumatic experiences and subsequent defenses built, and that music may revoke these feelings once again so that it may become a transitional object of a mother and her love, for example. Music may also pass through defenses and give rise to various feelings in individuals, which can then be verbalized, formulated, analyzed and scrutinized more thoroughly.[59] Thus a patient becomes more conscious of his/her emotional regulation, patterns of behavior and the thoughts relating to them.

[57] See factor 2 Music as relaxation and conscious mastering of mind in this research, for example.
[58] See factor 1 Music as a bringer of pleasure and positive imagery in this research.
[59] See factor 6 Working through of traumatic experience.

I also postulate from my own experiences with torture survivors and severely depressive or psychotic patients, taking into account former research on holocaust survivors and other trauma victims, that music may bring hope and comfort to their lives (Echard, 1990/2001; Moreno, 1999). Thus, it orientates the mind to the future and enables conservation of their integrities relating to their memories of their families, friends and their life before traumatization.[60] It will be interesting to see will psychoanalytic genetic interpretations, verbal or musical, also take into consideration brain structures and functions in the future or will they be governed by knowledge of biological genes, which seem to show a correlation between music and attachment behavior as recent research suggests (Ukkola, Onkamo et. al., 2009). Relating to traumas, childhood stress and the sequelae of torture in the brain, such a development seems possible and even suggestible according to recent brain research (Glaser, 2000; Kalland, 2001; Punamäki, 2001; Swallow, 2002; Körlin, 2005; Crenshaw, 2006; Hyyppä, 2009; 2010).

In this research, I have integrated some views from cognitive psychology and the neuroscience of memory functions with psychoanalytic music theory and practice. The sequelae of torture and traumas can be studied also considering the traces they leave behind in the areas of procedural and discursive memories. Music may aid in the arising and recognition of memories, images and feelings in the procedural memory, which can be then interpreted and analyzed in the discursive memory with words.[61] However, I also assume that musical pieces or clinical improvisation, i.e. the music in itself as a musical expression of feelings and imagery, may be likened to a verbal interpretation of a therapist when it is applied as a tool of empathic understanding. I postulate that it provides possibilities for moments of meeting and here and now interpretations verbally or musically. A therapist and a patient are involved in a process of "moving along", as proposed and described by Stern (2004, pp. 150–151). I think this was happening in the music psychotherapy processes as well with the torture survivors when we listened to music or discussed. The objective was to proceed from the implicit memories in the procedural memory to the explicit memories in the discursive memory, which is similar to psychoanalytic processing from the unconscious to the conscious.[62] In this respect, music and psychoanalytic therapy work are intermingled in a therapist`s and a patient`s interaction with music, which they mutually share. Music may first provide insights in the areas of implicit, and more functional, procedural memories that can then be more verbalized, described and analyzed in the areas of explicit and discursive memories.[63] (Stern, 2004, pp. 184, 187–188.)

Even though modern physiological research relating to the brain, genes, emotions, language, music and therapy is promising and there seems to be concordances with psychoanalytic concepts and musical behavior, I argue that its results are still preliminary considering clinical psychotherapy work. This relates partly to different philosophies of sciences. Psychotherapy, and particularly psychoanalysis, has an ideographic knowledge interest and therefore emphasizes individual experiences. Usually brain and gene research are interested in generalizations of human behavior, which have a nomothetic knowledge interest.

[60] See factor 5 Hope and integration of this research.
[61] Like factor 7, Recognition and depiction of emotions with music, in this research suggests.
[62] See factor 3 Insight and verbal reflection.
[63] See Factors 3 Insight and verbal reflection and 6 Working through of traumatic experience.

Therefore, I consider their results as such cannot be equal to an individual's experiences in music psychotherapy. However, the developing understanding of mirror neurons and how they affect human relationships, including learning, music or the therapist attuning to and mirroring a patient, may emphasize the interaction between the mind and the brain in the future. They may have psychic equivalents in the lived experiences of countertransference, emphatic reactions and the auto-affects of the therapist, which future psychotherapy research may find of interest. (BCPSG, 2007; 2008; Enckell, 2009; Lehtonen, J. 2009; Wallerstein, 2009.)

Neuropsychoanalysis is not actually a new idea because already Freud (1923/1993) as a neurologist considered the equivalents of the ego, id and super ego in the neural systems. For Freud, ego was primarily a bodily ego and he thought of the body as the source of external and internal perceptions in the form of pain, for instance. (p. 136.) However, comparing such upper conceptions as consciousness, unconsciousness and pre-consciousness to brain structures or to how external stimuli may affect the functioning of DNA by activating or slowing it to Thanatos and Eros – which modern neuropsychoanalysis also interestingly suggests – appears quite crude in light of how rich human experiences and meanings are in language. As an example, consider the varying tones of language, the many meanings of a spoken personal story, emotions, prosody, poetry, even musicality, vivid memories, the dreamlike imagery of speech and the imaginary world of experiences, and how they can be encountered individually in therapy. They may have many different forms of expression, affected by music, play, the discussion of lived experience, where they can be analyzed and scrutinized using the life history and personal situation of an individual. Therefore, subjective experiences in psychotherapy should not be neglected because of the auto-accomplishment of speech, music, arts, the expression in itself with auto-affects (pathos) of free improvisation and the association that appears to be essential for music psychotherapy. Therefore, whilst biological and neuroscientific knowledge may be useful for psychotherapy in the organic understanding of an individual, they cannot govern the relationship between a therapist and a patient because the therapist cannot directly provide the patient with neuroscientific contents or concepts in speech or with music, which would help the patients with issues that are related to their unique subjective experience of their being in the world. However, it seems relevant to consider neurobiology in the implicit memory and the knowing of a therapist in the "moving along" and the "here and now". For music therapy with dementia patients, as described earlier, knowledge of the mirroring neural system is essential for the conscious application of clinical work because the rhythms in music activate motor neurons, for example. (Rauhala, 1974; Swallow, 2002; Rose, 2004; Sacks, 2007; BCPSG, 2007; 2008; Rasinkangas, 2007; Enckell, 2009; Lehtonen, J., 2009; Takalo, 2009.)

## 12.2 Music as a Thing and the Discloser of Experiences and Meanings in Therapy[64]

From the phenomenological respect, traumas and their therapy may be considered as a process of acts in knowing, where the dissociative states of patients losing their concentration or when they are dissociating may be interpreted as disturbances in the patient`s *situation* (Rauhala, 1974). For example, traumatic experiences and memories arising in the Mind may interfere with a patient`s emotions and meanings while listening to music. Then, one might conclude that acts of knowing are broken and interrupted uncomfortably. I postulate that there is a disturbance in an individual`s world of experiences and in his way of constructing meanings then, which are consequences of the traumatic experiences in his real world Horizon and individual history. I argue that it is possible to reconstruct and repair the individual world of experiences and its psychosocial layers, where experiences and meanings are constituted and constructed, with psychotherapy to some degree (ibid.). These issues are related to the many cultural premises and possibilities of an individual existence, the Situation, which for their part have affected the development of one's personal world of meanings.

In music psychotherapy, music may be a Thing (Ding) or one possibility for opening the net of individual meanings and experiences when it gives rise to personal memories, feelings, imagery and experiences. It may be a praxis or a tool in addition to language that can approach one`s unconsciousness in psychotherapeutic work. Music as a Thing and as a possibility of Being There (Dasein) provides possibilities for individual experiences and knowing to reconstitute and reconstruct themselves in the material of life itself. When music is considered in relation to time and being, it may bring experiences and meanings for an individual that arise from the past, present and future. Music may provide one's present existence with hope, joy and empowerment, which may orient a person`s way to the future in his/her life as well bring memories of loved ones, sadness for passed ones or nostalgia for old times, as examples.[65] I postulate that psychoanalytic music psychotherapy especially considers individual´s experiences and their world of meanings according to their developmental history and structures, their multiple meanings i.e. symbolic interpretations and their uniqueness in an individual`s world of experiences.

It also relates to the life-world of individuals, how music is heard, felt, played or moved in our bodies (Welten, 2002). This seems to provide music with primary immanence and sensations of lived experience (pathos), which makes every art experience abstract (Henry, 1988/2009). It also means that our bodily being has meaning in itself, how we play music, how we feel it in our flesh. There is an abstract musical meaning in the rhythmic body and the pulse of playing an electric guitar, for example, which a therapist may mirror with his face, and by his/her own reactive drumming with the patient in music therapy improvisation. The meaning of being in music has a similar meaning to when a mother is holding and attuning to her baby, because the presence of a small baby activates auto-affects of caring, loving, joy etc. in the mother. The meaning of the baby is in the bodily existence of the baby

[64] Summary and discourse of issues presented in chapter 5 Hermeneutic Phenomenology as the Philosophical Foundation for the Research particularly.

[65] See factors 1 Music as a bringer of pleasure and positive imagery and 5 Hope and integration of this research.

in itself: the baby is not an object but a living Thing which, with its gaze, automatically engenders emotional responses and holding in another person. I argue that similar mental processes, auto-affects, projections and emotions in the form of self-affirmation, occur with music in therapy when we improvise our identities as we improvise our lives (Ruud, 1998).

However, these processes may differ depending on the Situation and the praxis of life: When an individual is driving a car s/he may behave a lot differently than when meeting and discussing with another person in a cafe. In a car one may swear, yell, name call, drive too fast, pass every other car dangerously like in a race, as one drives the car with pathos, improvising his/her life. This may have to do with the fact that cars are machines and objects, which can have various imagery projected onto them and be treated as objects as well. However, I postulate that people may manifest themselves similarly playing an instrument or listening to music; how they are moved by the music, how they raise their fist in the air, jump, shake their heads rhythmically and strongly relate emotionally to their favorite music. In classical music concert halls and opera houses, people dress and sit with dignity to listen to art music, expressing with their existences the meaning of that particular culture. However, at the end they may express themselves more freely by clapping their hands and yelling "bravo" or "encore". In a pub, players might get a beer as thanks; in a concert hall they give roses.

### 12.3 Music Psychotherapy and Torture Survivors: A Clinical Situation, Music, Culture

It appears to be the general view of my three music therapy patients in this research that they considered their therapies to have had a positive effect on them. However, I have to admit that especially with Abdul (Case Two) and Osama (Case Three) therapy was not just working with music or music therapy but actually demanded all the methods, knowledge, "tools" a therapist can use with patients in deep crises and very difficult situations. Thus, their cases taught me that working with tortured and very severally traumatized individuals is a challenging job and that various methods like music may be applicable in order to contact and have a positive effect on them. For example, in many of my music therapies with torture survivors there had to be an interpreter involved in the sessions, which is common with this patient group but not in general with music therapy or psychotherapy (Dammeyer Fønsbo, 1999; Lang & Mcinerney, 2002; Zharinova-Sanderson, 2004b).

In spite of that, the results of this study seem to be in accordance with former experiences of music therapy with this patient group (Pervaisz, 1994; Vinther, 1999; The BZFO reports 2000–2002; Zharinova-Sanderson, 2004a & b). However, in this research I have also delved into the life situations of my patients with case studies so that the whole picture of their difficult situation could be seen. I considered it to be important to provide an essence of music therapy work with torture survivors, how their life situations appear and why they need therapy, rehabilitation and help in general. In this sense, because of the interpretive nature of the research, there can be no simple outcomes for music therapy, although the results of the research questionnaires did show some clear evidence of a decrease of symptoms and positive outcomes from the music therapy, especially with Case Two, Abdul (table 6). However, applying only research questionnaires would not have been enough to

provide the right picture of patients` complicated situations and what they actually experienced in music therapy and in their lives.

In this research, music therapy has not been just working with music, which could be possible too with active music making, for instance, as has been shown in former experiences with torture survivors and refugees (Orth & Verburgt, 1998; Zharinova-Sanderson, 2004a & b; Orth, 2005). Unfortunately, in this research project there was no active music therapy, like playing instruments and being in groups. Such activities were not included in the therapy considered in this research because of practical reasons, such as there was no music therapy clinic with instruments. Another reason was related to the research, which needed to be focused in order to manageably address the guiding questions of the study. However, later I had additional experiences from the tortured women`s music therapy group where we played instruments and did musical improvisations. Then an interpreter was not needed because the music, the playing and the interaction enabled us to communicate with each other. There were a lot of emotions involved, including plenty of humor. Therefore, I postulate that active music psychotherapy and groups could have potential for torture survivors as well. I assume that playing instruments and producing sounds by oneself enables the expressing of one`s emotion, their release and the controlling of them, which recent research from music therapy groups of PTSD patients also suggests (Bensimon, Amir & Wolf, 2008).

It does not have to require much guiding and definitely no forcing or manipulation to have patients express their emotions with music because, as earlier discussed, music is immanent in our bodily being. Therefore, free clinical improvisations, similar to free association in psychoanalysis, for music psychotherapy with torture survivors and other traumatized patients could be useful. I learnt, with music listening methods, that not all traumatized/tortured/refugee patients were always able to concentrate on listening to music or on long guided music exercises, as has been reported earlier from clinical experiences with refugees (Orth & Verburgt, 1998; Orth, Doorschodt, Verburgt & Drożdżek, 2004; Orth, 2005). They may even think of strange music as a psychic threat because of their difficult life situations and crises. However, listening to music with free association, or with a very simple and short theme given as an instruction to begin with, was possible with most of the tortured patients in my clinical experiences. In the recent book *Receptive Methods in Music Therapy* by Grocke and Wigram (2007) there are lots of music listening methods, techniques and suggested music gathered for various patient groups, when music therapy may also be palliative, preventative and health promoting. These perspectives for therapy, especially concerning those suffering from severe traumas like the torture survivors in this study, are also relevant goals for music psychotherapy. Music psychotherapy of traumas may not always need to have only curative goals in treatment depending on the situation of the patient when the patient is in the middle of crises, for instance. However, there are still no specific inductions, experiences, suggestions or discussions for music and music therapy of trauma work concidering cultural aspects, therefore, this research adds to the knowledge of music therapy.

One of the ethical concerns while starting my clinical work with torture survivors was what kind of music they would they like to listen to and how would they experience music from

other cultures.[66] I was told by other therapists and torture survivors that music had been used as a part of their torture sometimes and that it had been also played continuously in prison. There were also concerns raised that it would be too stressful to play Western music for patients from different parts of the world and ethnicities. Also considered was the question of whether music as a physical sound would activate stress reactions like arousal, or panic similar to acoustic experiences from loud traffic, television, radio, sudden noises, as is typical with patients suffering from PTSD. These were the reasons why any music was used cautiously with all music therapy patients in such a way that there was no coercing or flooding with music and imagery. As noticed from the case studies, sometimes the patients were not able to listen to music because of their stressful situations. In this respect, it was assumable that when patients are able to listen to more music, or any kind of music, it could be a sign of recovery from traumatic experiences.[67] It could also be a sign of a developing trust towards the therapist as well to let him choose the music.

One conclusion from this research relating to the case studies and literature review of music as torture, violence and manipulation, is that music in the music psychotherapy of torture survivors would not need to be culture specific. The patients were also able to listen to and enjoy Western arts music as well as pop music. However, there was also the need to listen to music from their own culture in their own language, which may support their cultural identities.[68] Then music may help as an integrative approach in therapy. Robert Neustadt (2004) has suggested a similar process when writing of music as torture and repressed memories, which may have had integrating, protesting and recovering meanings for torture survivors in Chile and Argentina. In this sense, "autobiographical song writing" could be one potential music psychotherapy technique for torture survivors, similar to "testimony" used in verbal psychotherapy (Vesti, Somnier & Kastrup, 1992, pp, 48–49).

There are some issues relating to culture-specific music in therapy that music therapists and other personnel applying music with refugees and torture survivors should be aware of and even cautious about. Referring to my own experiences with torture survivors, as well as to the literature review of this research, it seems that it is precisely culture-specific music that is used in torture, violence, manipulation, propaganda and the humiliation of refugees, trauma victims and torture survivors.[69] It can be patriotic military music, national anthems and even folk music relating to the ethnic culture, as was seen in the study by Reyes (1999) about Vietnamese refugees and their experiences and memories towards their traditional ethnic music. Using traditional music as a form of humiliation has already a long history from the Nazi concentration camps were where one inmate was forced to sing the spiritual song *O Haupt voll Blut und Wunden* (O Sacred Head Now Wounded) while being tormented (Echardt, 1991/2001, p. 279). In the systematic use of music tormenture, there were camp orchestras accompanying the beatings of prisoners to the rhythm of a Wiener waltz, for example. On one known occasion from the Buchenwald camp, an opera singer was even

[66] See chapter 6.1 Research Questions.
[67] See appendix 1 and the variable 28 "Can listen to more music" in the category Positive reactions of patient in therapy.
[68] See the Case Two of Abdul in chapter 8.
[69] See previous chapter 3.4 Music as Torture, Violence and Manipulation for more thorough discussion and information of literature.

singing arias during such mass-beating or "punitive-sport" (p. 279). The soundscape of concentration camps appears to have been full of music to disguise killing or torture and to deceive the prisoners. Prisoners waved their hands cheerfully to the playing of an orchestra on their way to the gas chamber in Auschwitz (p. 280). It is interesting that at the same time there was underground music activity by prisoners, even secret bands and choirs rehearsing their own music, including jazz. The music of Mozart, Beethoven and Haydn was rehearsed at midnight in the pathology barracks of the Buchenwald camp, while surrounded by preserved human heads, bullet-pierced hearts, and tautly stretched tattooed human skins. Also, sarcastic songs were made up about the Nazis. (pp. 285–287.)

It is evident that a similar use of music for military purposes in war, and as part of interrogation, torture and imprisonment, has been continued until the present day, as many authors have reported. It also seems that using music for such humiliating and violent purposes touches many countries and cultures around the world. It is also a part of modern warfare strategies and the techniques of "non-touch" interrogations as used by the US Military Forces. (Moreno, 1999; Reyes, 1999; Cloonan & Johnsson, 2002; Frith, 2004; Neustadt, 2004; Alanne, 2005b; Cusick, 2006; 2008; Hirch, 2007; LeVine, 2009.)

As described earlier in the literature review, Western pop music has also recently been used during interrogations and as a weapon, similar to torture (Cloonan & Johnsson, 2002; Cusick, 2006; 2008; Hirch, 2007). In the future, this may also affect the work of music therapists and even music educators because there are refugees from many countries and cultures, among them children and adolescents. These experiences relating to war, traumas and music may pass through generations, so that it is difficult to predict what kind of memories and experiences will be related to the music from a war period in the future. However, as presented earlier, western pop, rock and heavy music may also imply freedom and express the emotions of young people as well as adults in totalitarian countries. On the contrary, traditional folk songs, spirituals and national songs may have been used by the oppressing governments in prison and in nationalistic propaganda. This kind of music may be directly related to traumatic experiences, torture, persecution and becoming an asylum seeker and refugee. In fact, then the music therapist should really know about the situations of the refugee and his/her country and culture to be really culture-specific as to what kind of music could be used and in what way. (Reyes, 1999; LeVine, 2009.)

David G. Hebert (2010) discusses and questions the boundaries of ethnicity in musical understanding and practicing. To what extent do musical meanings transcend ethnicity and culture? I think it is a relevant question considering also music therapy with torture survivors and refugees as well as multicultural music education. Hebert considers as naïve the conclusion that ethnicity would imply an innocent social category for a group of people, with which they often are associated, even by themselves. Refugees and torture survivors have usually been persecuted and tormented in their own countries because of their ethnicity, political opinions or religion. In the same country may be multiple ethnicities with their own sub-cultures, including musical sub-cultures. There may be differences relating to ethnicities, cultures, gender and age regarding responses to music, for example. Lately, music therapy research has addressed how different ethnicities experience music and it appears to suggest that there would be universal cues for communicating the emotional

meanings of music across cultures (Kwoun, 2009). When I started my research, I had a similar an assumption about the potential of music in therapy, including Western arts music. I assumed music would enable communication and sharing between people because of its universal musical communalities. There are, of course, various musical cultures with their own styles, which I also considered torture survivors from other cultures would perhaps prefer to listen to. This relates to cultural specific cues from cultural conventions of music that also seem to be a part of the cross-cultural decoding of emotions in music. According to the aforementioned study, there seemed to be some differences between young Koreans, young Americans, older Koreans and older Americans. (ibid.)

There has been also a recent study about ethnicity, music and depression, exploring differences between African Americans, Asian Americans, Whites and other ethnic groups in the US (Werner, Swope & Heide, 2009). No major differences were found relating to a commitment to music, innovative musical aptitude, social uplift, affective reactions, positive psychotropic effects, reactive musical behavior and depression. This may be partly due to the fact that all the research participants lived in the same country and were therefore also part of the same mainstream United States culture. However, I consider that these kinds of studies become more important for music therapy when cultures are pluralistic, as also suggested by Kwoun (2009). Considering asylum seekers, refugees and torture survivors, I would assume that it would be relevant to also study further the meaning of their situation as referred to in this study; how it would affect their emotional responses, experiences and memories relating to music. In the light of this study, the situation of being a torture survivor, a refugee or an asylum seeker would seem to be an even more important aspect to study regarding music therapy than cultural factors.

Considering the culture and its meaning for music simply from the psychoanalytic perspective of therapy, it does not actually matter beforehand where you are from, what music you listen to or what you have experienced. It is only the individual that matters. It would be important to allow the patients to try and speak as freely as possible about music and about themselves, or to bring their individual music to therapy. A therapist in music psychotherapy does not teach music or decide without discussing with a patient what music should be listened to or played. The need for culture-specific music may reflect only the enthusiasm of the music therapist for ethnic music rather than any other need to introduce or teach the patient music which is more of interest to the therapist him/herself than the patient. The only possible way for patients to truly express themselves without social or cultural constraints verbally or musically is to let them decide what music is listened to or what music therapy method is used.

I argue that in promoting human communication any music would do when it is mutually discussed and shared. Sometimes cultural-specific music relating to ethnicity is needed when a patient wants to listen to or play such music and it is a part of his/her identity. However, as shown in the case studies of this research, a sort of “cultural dialogue” with music – exploring what experiences diverse music brings – may help in creating an interaction between the therapist and patient. With unfamiliar music like Western arts music, it may be easier for a patient to project imagery from the unconscious. However, it may also be difficult in some situations when not “knowing” the music would appear to produce a

dynamic threat in the self-experience of the patient.[70] Therefore, in this research it was interpreted as progression if a patient was able to listen more to any kind of music. In conclusion, applying Western arts music with trauma victims may be useful because it does not necessarily have the direct cultural cues which could be associated immediately with traumatic experiences as could happen if ethnic music was used in propaganda, humiliation, violence or in prison.

Recently, there has even developed community music therapy, which seems to be also related to music education promoting health with musical practices and activities like learning and playing music. One such project influenced by the community music therapy has been the Norwegian community music project among youth in a Palestinian refugee camp, ongoing since 2002. To begin with, negative Muslim attitudes towards music education were found because music was considered sinful – haram – associated with alcohol, sexuality and taking the focus away from God. The six children interviewed, three boys and three girls aged 12–20, thought that learning to play an instrument had provided them with hope, created pride, promoted motivation for school and given them a sense of belonging. Even though I admit that this is an important music project, conceived also as a music educational project by the authors with many teachers and participants, the interviews of only 6 students as examples of participants with their personal opinions which are not further analyzed or described in a years` long project, are not convincing as such. They do not allow for much generalizing of the positive experiences and effects of music. The article is more like a project description illustrating the musical methods they have used with students which makes it interesting for the practical information. However, the authors argue that sometimes it is more useful to affect the community with a music project than finding individual explanations in therapy because the difficulties are collective and may result from oppression and unbalanced power relationships. They are interested as to what extent such a music project, or community music therapy, may strengthen a sense of self and cultural identity. This could be a useful point of view as long as individual experiences and personal traumas are not neglected. Participants should not be coerced into adopting a new culture, or even their main home culture either, if they do not appreciate it because it may be a culture and have community values that oppress and persecute. Authors describe how students performed *Norwegian Sunset* at a concert for Palestinian Land Day, which appears to be a sort of "cultural dialogue" as presented in this study. (Storsve, Westbye & Ruud, 2010.)

There is a long tradition of patients being involved in concerts in music therapy. However, I argue that the authors` arguments about "avoiding a treatment trap" of individual explanations and thus "blaming the victim" relates only to their own community music project and its frame of reference, which seems to be on the border of music education and therapy as the authors themselves argue and open up for discussion (ibid. pp. 1, 15). It is also a general problem of community music therapy because its goals are culture, society and community oriented and therefore cannot actually always say or explain much about the individual. The only "treatment trap" I see in these kinds of music projects – which are not actually psychotherapy and sometimes may not even be music therapy at all– is that if they would really be interested in the individual problems of their students they would have to

[70] Compare Case Two and the situation of Abdul in chapter 8.

provide them with therapy. I do not consider either that any psychotherapy really consciously "blames the victim", even though there may be external reasons like oppression when they come to therapy, because it would be unethical. It sounds more like sociological theory and a reconstruction of therapeutic situation. Usually therapists support victims like torture survivors and I assume that not all trauma victims among refugees even have the possibility to have the treatment and the therapy they would need (McFarlane, 2004). However, I understand "the blames the victim" argument in the context of the philosophy in this book to be similar to the diagnosing or interpreting of something as an "illness" or "disorder" that has not resulted from the individuals themselves, but is more related to the general situation of their lives or country; their political opinions, social status of being poor, a foreigner, an asylum seeker or a refugee. Still I would rather label it as "misunderstanding" a situation from a social respect, rather than "blaming" because in reality it would be very odd if a therapist would actually blame asylum seekers or refugees for their situations because that status has been forced upon them, as Storsve, Westbye & Ruud (2010) seem to imply correctly.

Considering torture survivors, it is precisely they that have been betrayed and politically persecuted by their governments, which they could not have helped or avoided. It is part of their tragic destiny and loss that they have lost their home countries, families and identities respectively, which is the reason why they need individual help as well as many other kinds of refugee support on a community level in their new country (Aroche & Coello, 2004). This is one of the goals of the Wraparound Approach proposed by Kira (2002) in the rehabilitation of torture survivors. With torture survivors, Zharinova-Sanderson (2004b) has been part of the community music therapy movement focusing on active music therapy methods to promote socio-cultural change and integration. Music therapists have also contributed to peace activism with musical projects and there has been an organization, Music Therapists for Peace (MTP) founded by Edith Hillman Boxill, since 1988 (Ng, 2005).

In this research, music therapy has been practiced in the frame of music psychotherapy. Therefore, I have focused this research`s theoretical part on psychoanalysis and its clinical solutions and developments for working with various patients. I have also integrated music therapy theories and methods with psychoanalytic theories and practices.[71] In this respect, I have to admit that it has not been possible to study all the dynamics of music and music psychotherapy relating to psychoanalytic theory in detail. There is a quite recent study of musicology applying psychoanalysis in musical signification by Susanna Välimäki (2005), which includes a comprehensive up to date literature review relating to psychoanalysis and music. However, many of the articles about music in psychoanalysis do not consider music psychotherapy particularly but offer a classical reading of psychoanalytic theories relating to music. Another profound theoretical study and literature review of psychoanalysis and music has been written by Pinchas Noy (1966–1967), which is still relevant reading as a pioneering work, but is already quite old and does not cover the latest developments and approaches to psychoanalysis and music or their application to music therapy.

[71] See chapter 4 Psychoanalytic Theories and their Clinical Application in Music Therapy for the developed theory and clinical methods.

Therefore, it seems that there are still unfinished tasks in this area relating to how different elements in psychoanalytic music psychotherapy, transference, resistance, developmental phases, defenses and the unconscious, affect music and manifest themselves in music psychotherapy processes, although there is some theorizing and research already conducted (e.g. Lehtonen, 1986; 1993; Bruscia, 1987; 1991/1996;1998; Erkkilä, 1997b; Lecourt, 1998; Streeter, 1999; De Backer, 2004; Syvänen, 2005; Nygard Pedersen, 2006). With this, I mean psychoanalytic music psychotherapy in its own right, which is not only informed or governed by psychoanalytic theory but produces its own theory, clinical research and praxis according to its own clinical practices, problems, phenomena and the experiences essential to it. This may even include or require a new clinical language, concepts and philosophy to illustrate the essences of music psychotherapy and the relationships of musical elements, tones, rhythms, melodies, chords, harmony and disharmony to mental processes and self-experiences. For instance, Sutton and De Backer (2009) have recently studied the psychodynamic meaning of silences and their variations in music relating to traumas. In this research, the musical meaning relating to the torture, trauma and situation of being an asylum seeker and refugee in the context of therapy was studied particularly.

There have been of course the pioneering works of Mary Priestley (1975/1994) and Juliette Alvin who developed their music therapy models, influenced by psychoanalytic theory. However, today's music psychotherapy is eclectic and has been inspired by many theories, approaches and techniques other than psychoanalysis (Bruscia, 1987). Even Priestley`s Analytical Music Therapy (AMT), which applies the symbolic use of music as improvisation and is also influenced by Jungian theorizing, is currently called Analytically Orientated Music Therapy (AOM) in Denmark and Germany. The reason for this is that AOM is no longer based on psychoanalytic theory and analytic psychology but has also its theoretical ground in communication theories and developmental psychological theories, for example. It has been seen as a logical development to integrate AMT so that it meets the standards and requirements of current eclectic music therapist training. (Wigram, Nygaard Pederssen & Bonde, 2002, p. 123.) Similar is the situation with Kenneth Bruscia`s (1998) pioneering book *The Dynamics of Music Psychotherapy*, which collects various music therapy approaches, including AMT , GIM, Creative Music Therapy, together with psychoanalytic approaches in music therapy. Even though the book has a psychodynamic or psychoanalytic orientation, where some premises of music psychotherapy are defined, it still does not present a cohesive psychoanalytic music psychotherapy approach similar to verbal psychoanalytic training. However, many of the important concepts and premises applied in this research, which also define modern psychoanalysis, such as transference, countertransference, defenses, corrective emotional experiences and their meaning for making past experiences conscious, are defined and discussed already in this important book.[72] (Bruscia, 1998, pp. 13–14.)

Still, the essences of the psychoanalytic approach could be lost in the eclectism of current music therapy approaches. This may have to do with the history of music therapy, which has developed from the "models" of various pioneers. These have become a sort of general

[72] The importance of it is emphasized for the reason that until this day it has been the only book entitled "music psychotherapy", which covers contributions from several prominent authors in music therapy.

theory of music therapy, with many of the techniques and approaches having been inspired by many different philosophical and psychological theories. (Bruscia, 1987; Wigram, Nygaard Pederssen & Bonde, 2002.) In Finland, the general development of music therapy has been similar, so that music therapists have worked in many clinical fields, including psychiatry, neuropsychology, special education and psychotherapy, which have also affected the training of music therapists (Ahonen-Eerikäinen, 1998). A recent development in music therapy training in Finland has been the integrating of verbal psychotherapy training and music psychotherapy in the first four-year psychoanalytic music psychotherapy course (2007–2010) at the University of Oulu. It provides the graduating music psychotherapist with official psychoanalytic psychotherapy training at the advanced special level (VET) in Finland. There has not been a similar training for music psychotherapists in the history of music therapy globally.

### 12.4 Evaluating the Trustworthiness of Research

As I have briefly commented upon earlier, I have not employed terms like validity and reliability much in this research because I think they would have obscured the difference between my research and natural scientific paradigms. I am aware these have been applied in qualitative study also and I have myself referred to them shortly. However, I shall next evaluate my research, its methods and results using the trustworthiness criteria proposed by Lincoln and Guba (1985) for a naturalistic inquiry paradigm, which I argue to be more adequate and in accordance with my research solutions.

A naturalistic inquiry has four major aspects from which to evaluate trustworthiness; *credibility*, *transferability*, *dependability* and *confirmability*. The techniques for establishing credibility include prolonged engagement, persistent observation, triangulation, peer debriefing, negative case analysis, referential adequacy and member checks during the research process and at the end of the research. In this research project, I assume that all of these, with the exception of negative case analysis, have been applied. I have consulted other experts or researchers and asked the patients for their opinions and experiences regarding their conditions and therapies in the form of questionnaires, for example. I argue that the audio recording of all the therapy sessions and the transcribing of them enabled referential adequacy for later interpretations, data analysis and critiques. I also wrote field notes from the therapy sessions, the team meetings and the treatment documents, so that I could later evaluate my own interpretations in the light of them. I assume that negative case analysis and generalizations were not needed in this research and were beyond the focus of it too. It would have required more participants to statistically calculate some hypotheses afterwards. (Lincoln & Guba, 1985, pp. 283, 309–310, 328.)

A technique for establishing transferability is the thick description of the material and the case studies, for example. I assume that the case studies of this research represent this, and have been written to include raw material. They include mostly pure description of lived experiences and phenomena rather than theoretical or psychological interpretations and speculations. However, I admit there are clinical interpretations of situations but I think this is quite natural in the context of therapy and difficult to totally avoid. In the end, they reveal and depict my views and experiences as a researcher and a therapist, which I have left quite

as they were when I first wrote the cases. I have not tried to make them look better or manipulate them in any way by changing them much afterwards. In this sense, they present a hermeneutic reading and depict my dialoguing with the research data as well, which makes my interpretations justified in this respect. However, It does not necessarily mean that they are the right interpretations. I postulate that this is also a part of the *releasement* (Gelassenheit) of this research. I have also described my methods, theories and research data extensively, so that it would be possible for a reader or another researcher to make judgments as to what experiences and knowledge may be transferrable to other research, for example. (Lincoln & Guba, 1985, pp. 214–215, 316, 328, 359–360, 365–366.)

The techniques for dependability and confirmability in naturalistic inquiry include auditing, which also includes audit trailing. Dependability in naturalistic inquiry is the equivalent to reliability in conventional research. In this research project, there have been a number of phases where some external audit has been involved: The research plan has been accepted by scientific and ethical committees, for example. There have been supervisors who have familiarized themselves with transcriptions, the research plan, the manuscript and the ideas of the researcher. I assume that the openness and the intention of transparency revealed by the presentation of my research process in seminars for example is part of the external audit and peer checking too. It has helped to maintain objectivity and neutrality, even though I argue that for a hermeneutically orientated researcher, objectivity cannot be the main goal because of its own premises of interpretation and being in an interaction with its research objects. At least, the objectivity required will be different. However, actually almost all documents with dates, raw data, field notes, journalizing and especially audio recordings of every therapy session have been saved for an external audit as well as for me as the researcher so that I could use them for further analysis or return to check information. Right from the beginning, even the first sketches and planning schedules for the research project have been archived. The last technique for establishing trustworthiness that covers all the aforementioned criterion areas are reflexive journals, which I have kept throughout the whole research project. (Lincoln & Guba, 1985, pp. 283, 316–320, 327–328.)

I have also been a participant observer in this research, giving rise to subjectivity in my research, which I have not tried to hide or deny. In the light of naturalistic or constructivist inquiry, this is not a problem but the inquirer and the object are considered to be in interaction and influence one another (Aigen, 1995, p. 291). According to naturalistic inquiry the world is full of dichotomies like form–substance, medium–message, mind–body, theoretical–empirical, psyche–soma etc. However, when they are analyzed many dualisms disappear, which is also the case with the investigator–object dichotomy of positivistic research and the quantitative–qualitative dichotomy of phenomena. I assume it is concurrent with Heidegger`s philosophy of Dasein and hermeneutic phenomenology represented in this study that the subject and object cannot be fully separated in the research or the world of experiences. It requires ontological and epistemological philosophical analysis and the asking of questions as to what can be known from the research object; how is it possible and why? Hermeneutic phenomenology and the Holistic Image of Man as the philosophies of science underpinning this research are used to try to ensure the trustworthiness of this project. (Lincoln & Guba, 1985, pp. 92–93.)

## 12.5 Overview of Clinical Evidence in the Research

In this book I have added some points of view relating especially to the interpretative work of a music psychotherapist that may include musical elements beside verbal approaches. I have also continued the discussion of philosophy in music therapy, its image of man and how music may be understood and applied in therapy as praxis equal to language. It may also shed a light and provide some ideas from methodological viewpoints on to how music therapy in general, and especially music psychotherapy, could be clinically studied. Researching music therapy and psychotherapy is difficult according to the terms of natural science and evidence based medicine, although not impossible (Wigram, 2001; Wigram, Nygard Pedersen & Bond, 2002; Edwards, 2005). Wallerstein (2009) has discussed the difficulties relating to it in the context of psychoanalysis, which are quite similar to music therapy, what kind of research and methods would be suitable to prove the efficacy of psychoanalysis and make it science. It is difficult, time consuming and resource heavy to study the effects of long music/psychotherapies lasting from three to five years, for instance. It is demanding especially if the individual therapy processes should be described and analyzed. This is one of the practical reasons why in this research there was such limited time for music therapy. In fact, usually music psychotherapy may take several years, even three years or more, which is the longest time The Social Insurance Institution of Finland (Kela) pays for psychotherapy currently, for instance.

However, many patients could actually gain an advantage from more therapy. I assume that the case was so with the torture survivors I worked with in this project. I postulate torture survivors as severely traumatized patients need longer therapies than usual. This research cannot answer questions as to how effective would longer therapies be for traumatized patients but my own clinical opinion is that all the music therapies presented in this study were too short. I consider this research and the whole of my clinical work with this small patient group (N=3) as a sort of "experiment" and a "pilot" study both clinically and research methodologically. Even though there were positive experiences from applying music and music therapy with torture survivors, its full potential still remains unclear. More research has to be done with more patients from different cultures including both genders. Especially, longer music psychotherapies should be studied with patients that are in more stabilized conditions in their lives and not in crisis, which would be more in accordance with the psychotherapy situation in general.

In this research project, I have tried to find some solutions as to how statistically significant results could be achieved in multiple case studies with factor analysis. I have been aware that three individuals in music psychotherapy are not enough statistically for such a claim considering the whole population. However, it seems that even in one therapy with a single subject it is possible to observe a lot of relevant phenomena and find many factors relating to the traumas, therapy and music, and this information may be also transferable to a larger group of patients (see appendix 1). Sometimes N=1 studies have relevance in science because according to William Dukes when evidence is negative, N of 1 is as useful as an N of 1,000 in "rejecting an asserted or assumed universal relationship" (Dukes, 1965 cited in Wallerstein, 2009, p. 114).

Similar would be the statistical situation when uniqueness is involved in research as when "a sample of one exhausts the population". Dukes continues with an example of when a researcher "reports in depth one case which exemplifies many'' (ibid., p. 114). In my research, there were three in-depth case studies of refugee torture survivors in music psychotherapy whose therapies and situations may exemplify the treatment and rehabilitations of torture survivors in general. With one patient in music psychotherapy, there was also a major change in the health condition of that patient according to the research questionnaire follow-up period as well as the clinical picture of his case study.[73]

N=1 may be also relevant when some kind of problem is studied like a rare disease or psychological abnormality, which I suppose could be the occurrence of some relevant phenomenon or situation in therapy too (ibid., p. 114). In this particular research concerning one patient, it is important to note the occurrence of a single piece of information that the patient had started using music at home in a way similar to music therapy.[74] The last point when N=1 is relevant as addressed by Dukes is "a limited opportunity to observe… a report of which be useful as a part of cumulative record" (ibid., p. 114). In this research, not only time but the number of participants to observe and the audio recordings of music therapies were limited, which was one reason for developing the concept of the *situated person* for factor analysis, in order to have cumulative information and a variation of different phenomena and experiences in therapy.[75]

All these arguments are relevant for showing that even though the three cases in this research cannot prove in general the positive effect of music and music psychotherapy on torture survivors and other traumatized patients, they show evidence that these kinds of experiences may also occur. They may over-rule or support some earlier conceptions and observations of music and its meaning for therapy, especially with refugee torture survivors. My argument about the possible positive or negative effects of music psychotherapy is not based on mere factor analysis numbers or research questionnaires but is also rooted in the qualitative case studies, relevant literature and theory. In this sense, my research has been a naturalistic inquiry like that proposed by Lincoln and Guba (1985, p. 7) as an alternative to the positivistic natural scientific paradigm. Whilst I surely cannot argue with this research that music therapy necessarily lessens depression, anxiety and the obsessive compulsive symptoms of all torture survivors, I can report that all the patients in this study felt they had attained some advantages from it to varying degrees according to the research questionnaires. In the case of Abdul, symptom scores for depression and anxiety decreased moderately during the course of his therapy (see table 6). It still seems that music and music therapy may help these patients as assumed, which is evident when the case studies and the results of the factor analysis are scrutinized together. Many factors relate to music and explain the positive meaning of music therapy in trauma work with refugee torture survivors and how it made a difference.

Because this clinical research applied such questionnaires as BDI, SCL-25, How Do You Feel Today? and Alanne Music Therapy Outcome Questionnaire (appendix 2) as pre-tests

[73] See table 6 and chapter 8 Case Two: Abdul from South Asia.
[74] See chapter 7 Case One: Ben from Central Africa.
[75] See chapter 10 Factor Analysis of Qualitative Material from Clinical Cases.

and post-tests, including also middle checks and follow-up checks six months after individual music therapies were completed, it reached level 4 of Evidence Base Medicine (EBM) as used by the Australian National Health and Medical Research Council, which adopted recommendations made by the US Preventive Services Task Force (Edwards, 2005, pp. 294–295). Level 4 means "evidence obtained from case study or single subject designs, either post-test or pre-test and post-test" (p. 294).

In this research, compared persons for two patients in music psychotherapy were also employed, cases one (Ben) and two (Abdul), which would in my opinion also fill the criteria for level 3 of EBM in addition to level 4. Level 3 "includes all studies that have used comparative method but are not ´properly designed` randomized control trials" (ibid., p. 294). The Case Three of Osama would obtain only level 4 because for this controlled case study there was no compared person. However, it was possible to compare his case with the results of the other patients in music therapy and their compared persons.

Level 2 of EBM is "evidence obtained from at least one properly designed randomized control trial" and level 1 is "evidence obtained from a systematic review or meta-analysis of all randomized control trials" (ibid., p. 294). In conclusion, it would appear that this research after all showed some evidence of music therapy positively affecting trauma patients and torture survivors according the research questionnaires and EBM criteria for the levels of evidence. Respectively, also the compared persons, one and two for Ben and Abdul, obtained levels 3 and 4 using the criteria of EBM for the positive outcomes of their general psychiatric treatment at the Rehabilitation Centre for Torture Survivors in Finland. The most recent Oxford Centre for Evidence Based Medicine (CEBM) levels of evidence indicate that those therapy studies which present "outcomes" , like this research including all its participants (N=5), would even obtain level 2C using their criteria.[76] Also, qualitative research is mentioned among their study designs. The psychiatric music therapy literature base is still small and most of the current research is at the lowest levels of evidence, even though there is already some level 1 and 2 research depending on the evidence criteria applied (Silverman, 2010, pp. 4–5).

In the light of EMB and its evidence requirements for the efficacy of therapies similarly to any medical treatment, it could be useful for music therapy researchers and clinicians respectively to apply questionnaires as with this research. Whilst they are quantitative measurements, which may be against the philosophical and clinical attitudes of the researcher, they are after all quite simple to apply in a single-case design and can be connected to a hermeneutic reading and idiographic understanding, as presented in this study, without objectifying the individual. As can be seen from some of the questionnaire scores in this study, there may not always be differences in scores but in the longer time span of year or two of therapy they may show some direction for the treatment and its effectiveness. The therapist may notice and observe this personally too but research and clinical questionnaires can add something to this understanding and show some objective feedback from the patient point of view. This could provide more power for the arguments of qualitative research, like proposed by Aigen (2008).

[76] See the criteria updated in March 2009 at www.CEBM.net.

These kinds of objective results may help music therapy to remain part of modern psychiatry and as an aspect of other medical treatments when the efficacies of treatments are considered, including financial issues (Silverman, 2007; 2010). As mentioned earlier, the New York City Commission on 9/11 removed creative arts therapies from the providers` list because there was insufficient evidence for their efficacy, according to them (Johnsson, 2009). This may also relate to the fact that there may not be enough training to treat traumas psychologically among music therapists; there may be no cohesive theories or clinical methods and therapies may be too eclectic theoretically and methodology so that on what basis music therapy was actually done and what their results actually were may be difficult to evaluate. In the US, psychoanalytic music therapy, as well as GIM in private practice, appears to be quite rare. It seems psychoanalysis was not applied explicitly in methods or theories with 9/11 victims much, but in actuality more eclectic approaches such as humanistic and behavioral–cognitive methods were used (Loewy & Frisch Hara, 2002). Similarly, many US music therapists who reported using behavioral or psychodynamic approaches thought that their primary philosophy of clinical work was eclectic. (Silverman, 2007.)

Considering many theories of music therapy relating to brain research, music education, social science, psychoanalysis, cognitive–behavioral approaches and their apparent mixes, it would seem wise to present the music therapy approach, clinical methods and their clinical theory in a way that it is ontologically cohesive, whilst various theories and results from research could be used in an idiosyncratic way. With this I mean that I consider that it is not enough to keep playing or listening to music with children as usual and garner a clinical theory from several authors representing different fields, approaches and research. There is an apparent danger that it would be a mere collection of scholarly opinions, arguments and theories of music being health promoting that could have no connection with each other, nor real experiences of individuals in music, when they are presented without describing from whence this argument or opinion actually came. Did it come from empirical research, neurobiology, or was it evidence from actual clinical research, philosophy etc. and how did it affect the music therapist`s work indigenously? On what theoretical basis or clinical hypothesis did the positive music therapy experience occur? What would explain the change in a patient?

I take as an example the clinical article by Jacqueline Robarts (2006) about music therapy with sexually abused children. It describes intersubjective theories, symbolization, musicality and affect regulation, including psychodynamic theory, poesis, autobiography and the importance of living experiences in music in an interesting and well-written way, which have similarities to this research. However, I found it difficult to follow the proposed positive outcomes of actually only one girl`s music therapy, that lasted seven years from the age of 7 to 14 once a week, back to the presented clinical and scientific theory. It is an example from a “small descriptive” study of 6 therapies (p. 256). However, no scientific, qualitative or quantitative methods are introduced in the article, no measurements have been included or goals expounded for music therapy. Robarts has not described the other therapies employed, how many sessions or what happened in the other 5 therapies of traumatized children between 4 and 12 years old. Only diagnostic problems are presented for

one evidently severely traumatized girl. Music therapies have been audio and video recorded but no method of analyzing them quantitatively or qualitatively is demonstrated. Robarts describes her observations of one therapy in short extracts, which seem to have little verbal contents, mostly clinical improvisation and behavior with music is illustrated, which in my opinion is not convincing as an example of an "autobiography" of traumatic experience. I argue that just documenting and presenting music therapy clinically is not actual research. In this context, the theory of intersubjectivity of an infant does not have much explanatory power for psychotherapy alone because all human activity and early infant development is primary biological and intersubjective.

Also in Creative Music Therapy, as well as psychoanalytic music therapy, music is a way of communication similar to speech, regarding which I have similar opinion to Robarts`. However, the therapeutic method in itself, innate musical communication with intersubjectivity, cannot simultaneously be an explanation of therapeutic change as Robarts seem to argue circularly. In addition to this, no clinical descriptions of psychoanalytical concepts like countertransference or dynamic unconscious are applied even though she argues that they are central to her "psychodynamically informed music therapy" and are implicitly in the case material (pp. 252–253). It is difficult to explain without falling into *adultomorphism*, the projection of adult contents and imagery onto objects, the observations of the children from intersubjective theories of observed infants and, vice versa, the adult behavior according to early intersubjective biological theories and infant experiment research. This is the reason why psychoanalysis has long applied metapsychology to avoid this fallacy in reasoning and considers concepts like the "transference child" and the "developing child" as metaphors for a therapist in clinical work (Tähkä, 1997a, Vuorinen, 2004). I would say the same would be wise for the "music child" proposed in music therapy theories (Bruscia, 1987; Wigram, Nygaard Pederssen & Bonde, 2002).

For the reason of argumentation and explaining the changes in this research, I argue that it has been important to thoroughly describe my clinical orientation, theory and the objectives of therapy, in the form of phase specific theory as an example, as is suggested for evidence-based practice in music therapy (Wigram, 2001; Wigram, Nygaard Pedersen, Bonde, 2002). However, such concepts as the "transference child" and the "developing child" have not been the focus and the way of analyzing the case studies even though they have been applied in my clinical notes and in the living mind of the researcher (imagery). In the case studies, the emphasis has been on a description of the lived experiences of music therapy. I share Robarts` (2006) and Alvarez`s (1992/2002) clinical opinions about their importance for therapy. Philosophical analysis has helped in discerning research and theory from different fields, what kind of information they provide and what methods they have applied in generating such knowledge. I disagree with Robarts as to how she applies the philosophical concept of *poiesis* in her own context as a definition of change, referring to its etymological origin from the Greek word "poien", which means to make or to construct (p. 255). In my opinion there is once again circular theory and argumentation where the poiesis, construction of meaning, is now at the same time the method and the result – the observed change in music for instance. I prefer using poiesis in its original verbal meaning, to make poetry, music etc. as the mimicking of emotions, like Aristotle (1997). Heidi Westerlund (2002, pp. 182–183) seems to apply poiesis in a similar manner discerning the "praxis" as

action in the sense of doing music for itself and the poiesis as the making of musical product with "know-how" in the philosophy of music education. In the context of music therapy, poiesis would be in accordance with *reflection* as a musical improvisation technique and the technique of emphatic describing verbally or musically as presented in this research (Bruscia, 1987, pp. 540–541).

According to the positive findings from the quite short music therapies in this research, it would be logical to assume that longer music psychotherapies could have similar positive effects. There is recent research evidence from a randomized trial of the effects of four forms of psychotherapy on depressive and anxiety disorders (Knekt & Lindfors, 2004). In The Helsinki Psychotherapy Study (HPS) were studied and compared the effects of short-term psychodynamic psychotherapy, solution focused therapy, and long –term psychodynamic therapy with 367 patients, 40 of them in psychoanalysis. There were many measurements including BDI and SCL-90 and multiple other tests within a 5 years follow-up period. Both short-term psychodynamic psychotherapy (5–6 months) and solution focused therapy had equally positive effects after one year's follow-up, but were not uniformly suitable or sufficient to induce recovery in all patients. None of the therapies were audio or video recorded. In the follow-up 5 years later, it was noticed that the long-term psychodynamic therapy was the most efficient and had more durable outcomes but short-term therapies benefitted the patients more quickly in their ability to work (Knekt, Lindfors et al., 2008). Referring to the findings of HPS, I assume that theoretically and clinically more developed music psychotherapy could even increase positive outcomes for patients. There seems to be developing especial theory and praxis for trauma therapy, including also psychoanalytic theory in music therapy, to the benefit of clinical work and research with various patient groups (Wolf, 2007b; Weiß, 2008). However, more actual clinical studies of music therapy outcomes in psychiatry are still needed with traumatized patients as well as with other patients groups suffering from depression, psychoses and anxiety, to mention but a few (Edwards, 2005; Silverman, 2007; 2010). In Finland, the first RCT study of short-term psychodynamic music therapy (3 months) in the treatment of depression has just been completed and the final report is awaiting publication (Erkkilä, Gold et al., 2008).

I hope this research, for its small clinical part (N=3), would help to develop music psychotherapy research that would demonstrate further its potential, which the critical literature review of earlier experiences, studies and theories relating to music, therapy and traumas seem to imply. The most recent developments in brain and gene research and their findings appear interesting considering clinical practice and the theory of music therapy. I assume that it could be interesting to study similar micro and macro -analyses of situated persons in therapy with more patients. With factor analyses, counting factor scores for each patient in therapy to see the variance during the therapy processes, it could be possible to demonstrate the change in therapy. However, further factor analyses were not done in this research, whilst they were thought of, because of the small number of participants (N=3) which means they would have appeared over-scaled and unnecessary for the purposes of this study. I already applied case studies and the research questionnaires to describe the changes, therapy processes and outcomes of therapies, which was sufficient to enable a deep analysis of such a small group of participants. Also my focus and knowledge interest in this research was more theoretical, philosophical and clinical than statistical or aimed at exploring and

demonstrating the methods, experiences and research already existing in music therapy relating to torture survivors, traumas and refugees.

However, further factor analyses of the situated persons seemed possible but I decided to leave future studies to demonstrate their usefulness for clinical therapy research methodology. I assume that with more research participants, therapists and researchers as part of a larger scale therapy research project, it could be possible to achieve statistically significant results, which could be generalized to a whole population with a similar statistic approach using situated persons. There may be other possible designs for similar factor analyses of situated persons using various phases and times of therapy as measuring points. They could be conducted over very short periods of time, just a few seconds on a micro-level, like in the present moment study by Stern (2004) with the video recording of the gestures, faces, and movement of patients, and the works of the Boston Change Process Study Group (BCPSG) (Stern, Sander et al. 1998; BCPSG, 2007; 2008; 2010), discussed and applied in this research. In addition to such micro-analytic approaches and audio recording of discursion and music in therapy, there could be also macro-level longitudinal studies from weeks to years for calculating and analyzing various correlations and variations between therapeutic phenomena, approaches, experiences, music, techniques and disorders which could imply and explain changes in demonstrating the effectiveness of therapy. I emphasize that within these calculations and studies of change processes, the lived experiences of patients and their situations in therapy should be described along with the meaning of music, not forgetting intersubjectivity.

*Words move, music moves*
*Only in time; but that which is only living*
*Can only die. Words, after speech, reach*
*Into the silence. Only by the form, the pattern,*
*Can words or music reach*
*The stillness, as a Chinese jar still*
*Moves perpetually in stillness.*
*Not the stillness of the violin, while the note lasts,*
*Not that only, but the co-existence,*
*Or say that the end precedes the beginning,*
*And the end and the beginning were always there.*
*Before the beginning and after the end.*
*And all is always now*.[77] (T.S. Eliot, Burnt Norton, 1936/1944)

[77] From the *Four Quartets* by T.S. Eliot (1944/2007), p. 20. Helsinki:WSOY.

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**APPENDIX 1 Variable Template for Factor Analysis**

**Issues that make the treatment of the patient more difficult**

1) Tiredness 2) Curtness 3) Difficulty in describing emotions 4) Feeling guilty 5) Resistance 6) Shyness 7) Shame 8) Lack of trust 9) Clinging to memories

**Patient's symptoms arising in therapy**

10) Psychotic symptoms 11) Avoidant behaviour 12) Sleeplessness 13) Pessimism 14) Fear 15) Fear/concern for family 16) Talks about symptoms 17) Blaming oneself 18) rise of alertness 19) Anxiety 20) Depression 21) Self destructiveness 22) Death wishes 23) Inappetence 24) physical injuries/sequelae of torture/detention like pain etc.

**Positive reactions of patient in therapy**

25) Talks about one`s emotions 26) Notices change in oneself 27) Expresses the wish to recover 28) Can listen to more music 29) Can talk more 30) Is interested in something other than oneself 31) Presence 32) Trust 33) From monologue to dialogue 34) Can grieve 35) Can recreate a positive image 36) Can experience pleasure/feeling good 37) Experiences sense of calming down 38) Can orient to the future 39) Talks/tells about a traumatic experience 40) Laughs, humour 41) Talks about emotions, memories, thoughts, imagery etc. connected to music 42) Employs music at home to relax and empty mind 43) Processes one`s traumatic experiences with music 44) Awareness of oneself and one`s own experiences increases; can verbalise own experiences and thoughts 45) Notices that therapies or treatments help him/her

**The way patient feels about music**

46) Displeasure, annoyance 47) Feels bad 48) Feels good 49) Pleasure 50) Likes what one hears 51) Music relaxes/listens to music for one`s relaxation 52) Music gives rise to positive imagery 53) Music tells a story about one`s own life 54) Thinks that music helps people to solve their problems 55) Notices that music corresponds with one`s own emotional state

**Symptoms music gives rise to in a patient**

56) Headache 57) Depression

**Others**

58) Music calms 59) Can concentrate 60) Uses music at home to find own feelings 61) Absent/dissociates 62) Inability to concentrate 63) Listening to music with emotions involved 64) discusses emotions involved 65) Peak experience while listening to music 66) discharging of tensions/feelings

**APPENDIX 2 Alanne Music Therapy Outcome Questionnaire**

**MUSIC THERAPY OUTCOME QUESTIONNAIRE** © Sami Alanne 2001

NAME:_____

DATE OF BIRTH:_____

DATE:_____

*Here are some statements, the purpose of which are to determine how music therapy has affected you and how you have experienced it to be. Choose from the alternatives given, circling the answer that most closely corresponds to your current opinion or experience.*

1. Music therapy has helped me to relax

0 none/I cannot say 1 a little 2 moderately/quite a lot 3 a lot 4 very much

2. Music therapy has decreased my anxiety

0 none/I cannot say 1 a little 2 moderately/quite a lot 3 a lot 4 very much

3. Music therapy has decreased my depression

0 none/I cannot say 1 a little 2 moderately/quite a lot 3 a lot 4 very much

4. Music therapy has helped me to sleep

0 none/I cannot say 1 a little 2 moderately/quite a lot 3 much/a lot 4 very much

5. Music therapy has taken my thoughts away from the things that disturb me

0 none/I cannot say 1 a little 2 moderately/quite a lot 3 much/a lot 4 very much

6. Music therapy has helped me to be with other people (e.g. friends, family, colleges etc.)

0 none/I cannot say 1 a little 2 moderately/quite a lot 3 much/a lot 4 very much

7. Music therapy has made it easier for me to notice and accept my emotions

0 none/I cannot say 1 a little 2 moderately/quite a lot 3 much/a lot 4 very much

8. Music therapy has decreased my feelings of distress

0 none/I cannot say 1 a little 2 moderately/quite a lot 3 much/a lot 4 very much

9. Music therapy has decreased my feelings of grief

0 none/I cannot say 1 a little 2 moderately/quite a lot 3 much/a lot 4 very much

10. Music therapy has given me empowerment

0 none/I cannot say 1 a little 2 moderately/quite a lot 3 much/a lot 4 very much

11. Music therapy has taken my thoughts away from torture experiences or those experiences that I came to treatment for

0 none/I cannot say 1 a little 2 moderately/quite a lot 3 much/a lot 4 very much

12. I feel that I have changed with music therapy

0 none/I cannot say 1 a little 2 moderately/quite a lot 3 much/a lot 4 very much

13. Music therapy has decreased the emptiness I have experienced

0 none/I cannot say 1 a little 2 moderately/quite a lot 3 much/a lot 4 very much

14. Music therapy has helped me as a part of my treatment

0 none/I cannot say 1 a little 2 moderately/quite a lot 3 much/a lot 4 very much

15. I feel that music therapy has been a meaningful experience in my life

0 none/I cannot say 1 a little 2 moderately/quite a lot 3 much/a lot 4 very much

Total points:_____/60

**APPENDIX 3 Consent Form**

**KIDUTUSTA KOKENEIDEN IHMISTEN MUSIIKKIPSYKOTERAPIA**

Sinut kutsutaan osallistumaan tutkimukseen, jonka tarkoituksena on selvittää musiikkipsykoterapian vaikutuksia ja merkitystä kidutusta kokeneelle ihmiselle. Tutkimuksen keskeinen olettamus on, että musiikkipsykoterapia vähentää kidutuksesta selvinneiden masennusta, ahdistusta ja pakko-oireita sekä auttaa heitä rentoutumaan ja keskittymään paremmin. On mahdollista myös, että tämän tutkimuksen yhtenä tuloksena syntyy musiikkiterapian kuntoutusmalli suomalaiseen kidutettujen kuntoutukseen osana muuta kokonaiskuntoutusta.

Tutkimuksesta julkaistava tieto tulee olemaan vain sellaisessa muodossa, ettei siitä millään tavoin voi tunnistaa tutkimukseen osallistujaa. Tutkijalla/terapeutilla on samanlainen vaitiolovelvollisuus kuin muilla Kidutettujen Kuntoutuskeskuksen työntekijöillä. Musiikkipsykoterapia ja siitä tehtävä tutkimus tapahtuu tiiviissä yhteistyössä Kidutettujen Kuntoutuskeskuksen henkilökunnan kanssa. Muu hoitava työryhmä, esimerkiksi lääkärit, psykologit, voivat antaa tietoja musiikkiterapiaa ja tutkimusta varten, mikäli suostun osallistua tutkimukseen. Näitä tietoja voidaan käyttää osana tutkimusprojektia, kuitenkin vain siten, että henkilöni ei paljastu.

Käytetyt tutkimusmenetelmät, kuten kyselyt ja psykologiset tutkimukset, tullaan valitsemaan siten, että ne eivät ole tutkittavalle millään tapaa vaarallisia tai liikaa kärsimystä tuottavia. Käytetyt musiikkiterapian menetelmät valitaan yhteistyössä potilaan kanssa eivätkä ne tule sisältämään minkäänlaista pakottamista tai sellaisia menetelmiä, jotka olisivat liian raskaita hänelle. Tutkimukseen osallistuja voi missä vaiheessa vain keskeyttää osallistumisensa tutkimukseen ilman seuraamuksia: esimerkiksi musiikkipsykoterapia voi jatkua tästäkin huolimatta, mikäli potilas niin haluaa.

Jos sinulla herää minkälaisia kysymyksiä vain tutkimukseen liittyen, niin voit koska tahansa ottaa yhteyttä tutkijaan tai Kidutettujen Kuntoutuskeskukseen lisätietojen saamiseksi. Tutkijan yhteystiedot: *Musiikkiterapeutti, FM Sami Alanne*

Allekirjoituksesi alhaalla merkitsee, että olet lukenut ja ymmärtänyt tämän tiedon sekä haluat osallistua tutkimukseen.

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Päivämäärä, tutkimukseen osallistujan allekirjoitus ja nimenselvennys

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Päivämäärä, tutkijan allekirjoitus

**APPENDIX 4 Permission to Record Music Therapy Sessions Form**

**LUPA MUSIIKKITERAPIATAPAAMISTEN ÄÄNITTÄMISEEN/VIDEOINTIIN/VALOKUVAUKSEEN**

Minä annan _____ luvan äänittää/videoida/valokuvata (yliviivaa tarpeeton) minua. Tätä informaatiota tullaan käyttämään ainoastaan seuraaviin tarkoituksiin:

___ *Kliininen*
Tätä äänitettä/videota/valokuvaa tullaan käyttämään osana hoitoani. Sitä ei tulla esittämään kenellekään muulle kuin itselleni ja hoitavalle työryhmälle.

___*Koulutus*
Tätä äänitettä/videota/valokuvaa voidaan käyttää ammatillisiin koulutustarkoituksiin. Nimeäni ei tulla mainitsemaan missään yhteydessä.

___*Tutkimus*
Tätä äänitettä/videota/valokuvaa voidaan käyttää osana tutkimusprojektia _____. Olen jo antanut kirjallisen luvan tähän tutkimukseen osallistumisesta. Missään yhteydessä ei nimeäni mainita.

___*Muu*
Määritys:

*Mitä, jos muutan mieltäni?*
Ymmärrän, että voin perua antamani luvan milloin tahansa. Pyynnöstäni äänitteitä/videoita/valokuvia ei enää käytetä.

*Muuta*
Ymmärrän, että minulle ei makseta siitä, että minua äänitetään/videoidaan/valokuvataan.

*Lisätiedot*
Mikäli haluan lisätietoja äänitteistä/videoista/valokuvista tai jos minulla milloin tahansa on kysymyksiä tai huolia niistä voin ottaa yhteyttä terapeuttiin/tutkijaan:

Musiikkiterapeutti, FM Sami Alanne

Tämän kaavakkeen pitää terapeutti/tutkija. Minä saan siitä kopion.

Nimi:
Päivämäärä:
Osoite:

Allekirjoitus_____

**APPENDIX 5 Factor Loadings.** Factor 1 Music as a bringer of pleasure and positive imagery (black), factor 2 Music as relaxation and conscious mastering of mind (red), factor 3 Insight and verbal reflection (red), factor 4 Sequelae of torture (red), factor 5 Hope and integration (green), factor 6 Working through of traumatic experiences (green), factor 7 Recognition and depiction of emotions with music (green), factor 8 Avoidance/resistance (green), communalities of variables (blue). Factors were calculated with SPSS software version 18.0 using the extraction method of Maxim Likelihood and the Varimax rotation with Kaiser Normalization. (Continues)

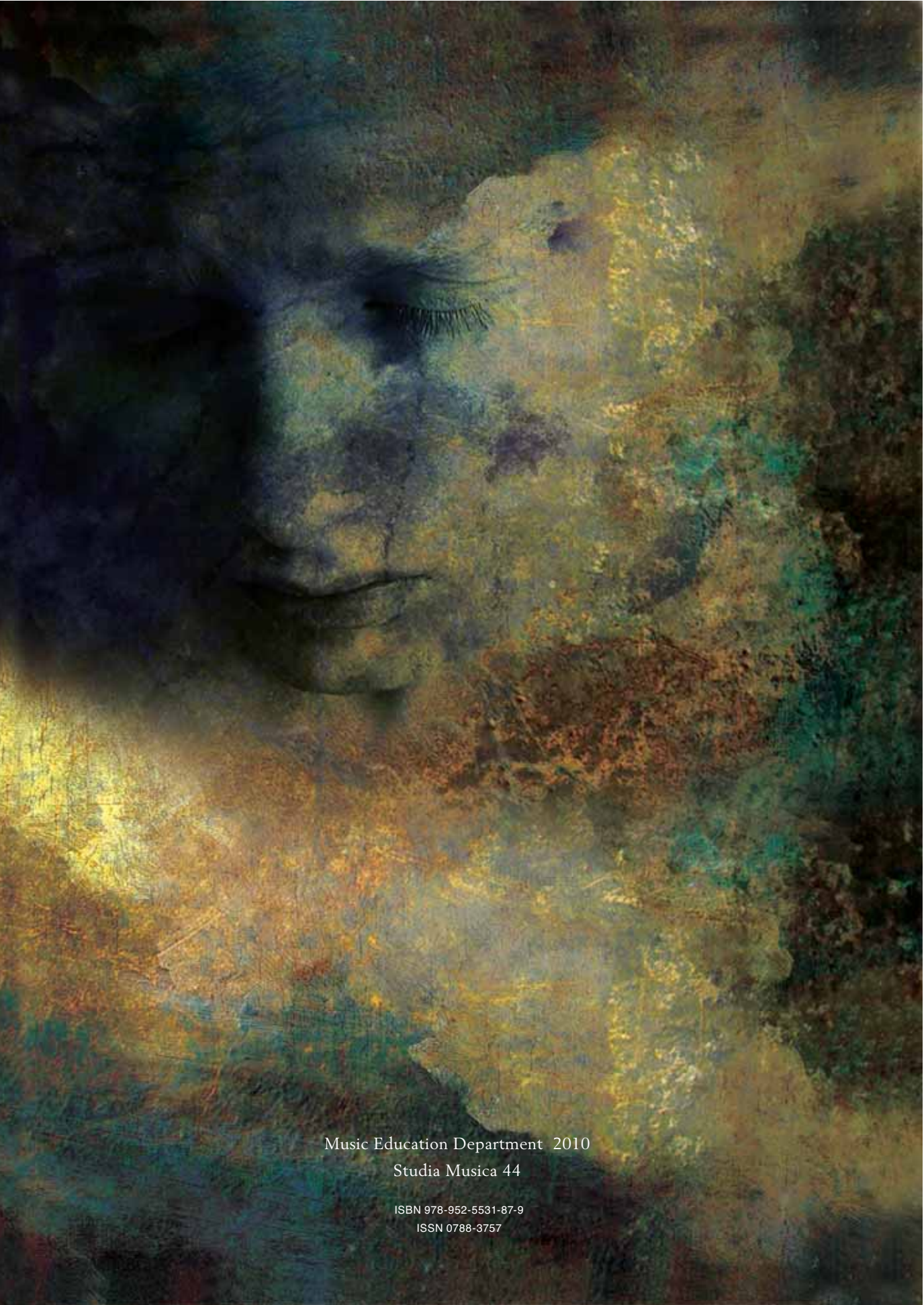
| whole | whole | first part | first part | first part | first part | latter part | latter part | latter part | latter part | latter part | communalities | communalities | communalities | communalities |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| variable | factor 1 | variable | factor 2 | factor 3 | factor 4 | variable | factor 5 | factor 6 | factor 7 | factor 8 | variable | whole | first part | latter part |
| 42 | -,053 | 65 | ,924 | ,102 | ,068 | 22 | ,026 | -,024 | ,005 | ,150 | 1 | ,164 | ,231 | ,180 |
| 65 | ,302 | 66 | ,788 | ,059 | ,040 | 10 | ,041 | -,025 | -,039 | ,079 | 2 | ,552 | ,051 | ,505 |
| 48 | ,340 | 42 | ,766 | ,012 | ,020 | 18 | -,075 | -,032 | ,002 | ,159 | 3 | ,743 | ,176 | ,668 |
| 37 | ,031 | 37 | ,577 | ,045 | -,019 | 12 | -,127 | ,167 | -,080 | -,033 | 5 | ,422 | ,267 | ,293 |
| 51 | -,088 | 49 | ,523 | ,040 | -,107 | 1 | -,197 | -,074 | -,069 | -,048 | 8 | ,105 | ,016 | ,142 |
| 58 | ,069 | 63 | ,490 | -,171 | -,209 | 55 | ,060 | -,043 | ,235 | ,056 | 9 | ,875 | ,999 | ,925 |
| 41 | ,205 | 50 | ,408 | -,112 | ,120 | 29 | ,123 | ,120 | -,123 | -,009 | 10 | ,593 | ,454 | ,586 |
| 66 | ,370 | 64 | ,311 | ,007 | -,084 | 20 | ,098 | -,041 | ,084 | ,703 | 11 | ,454 | ,324 | ,127 |
| 50 | ,073 | 35 | ,138 | ,008 | -,088 | 13 | ,088 | -,038 | -,095 | ,629 | 12 | ,216 | ,306 | ,204 |
| 49 | ,054 | 36 | ,109 | ,170 | -,088 | 19 | ,065 | ,029 | ,134 | ,536 | 13 | ,297 | ,174 | ,570 |
| 9 | ,013 | 48 | ,192 | -,016 | -,102 | 61 | -,055 | ,094 | ,180 | ,488 | 14 | ,230 | ,346 | ,010 |
| 39 | -,073 | 52 | ,285 | -,003 | -,102 | 5 | -,300 | ,103 | ,195 | ,376 | 15 | ,224 | ,271 | ,164 |
| 32 | ,081 | 41 | ,363 | -,149 | -,234 | 15 | -,058 | -,063 | -,116 | ,367 | 16 | ,174 | ,159 | ,008 |
| 25 | ,268 | 2 | -,034 | -,097 | ,069 | 8 | -,045 | -,025 | -,076 | ,357 | 17 | ,049 | - | ,007 |
| 44 | ,251 | 33 | -,111 | ,722 | -,127 | 52 | ,129 | -,037 | ,035 | ,293 | 18 | ,269 | ,304 | ,581 |
| 18 | ,003 | 29 | ,119 | ,674 | -,043 | 62 | -,028 | -,095 | ,189 | ,272 | 19 | ,334 | ,386 | ,315 |
| 43 | ,036 | 44 | ,367 | ,560 | -,023 | 21 | ,194 | -,030 | ,051 | ,258 | 20 | ,549 | ,487 | ,584 |
| 33 | ,035 | 26 | ,162 | ,504 | -,135 | 49 | ,236 | -,057 | ,061 | ,245 | 21 | ,280 | ,237 | ,151 |
| 29 | ,166 | 31 | -,120 | ,487 | -,188 | 28 | ,036 | -,046 | ,068 | -,189 | 22 | ,887 | ,349 | ,999 |
| 31 | -,129 | 28 | ,333 | ,353 | -,118 | 42 | ,047 | -,022 | -,018 | -,106 | 23 | ,031 | ,043 | ,006 |
| 28 | -,237 | 16 | -,049 | ,294 | ,174 | 34 | -,004 | -,031 | ,037 | -,098 | 24 | ,183 | ,263 | ,071 |

**APPENDIX 5 Factor Loadings.** Factor 1 Music as a bringer of pleasure and positive imagery (black), factor 2 Music as relaxation and conscious mastering of mind (red), factor 3 Insight and verbal reflection (red), factor 4 Sequelae of torture (red), factor 5 Hope and integration (green), factor 6 Working through of traumatic experiences (green), factor 7 Recognition and depiction of emotions with music (green), factor 8 Avoidance/resistance (green), communalities of variables (blue). Factors were calculated with SPSS software version 18.0 using the extraction method of Maxim Likelihood and the Varimax rotation with Kaiser Normalization. (Continues)

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **59** | ,021 | **23** | ,002 | -,118 | ,109 | **16** | -,007 | -,024 | -,046 | -,073 | **25** | ,426 | ,270 | ,276 |
| **26** | ,010 | **55** | ,012 | -,107 | -,067 | **14** | -,028 | -,041 | -,032 | ,068 | **26** | ,251 | ,308 | ,108 |
| **30** | ,179 | **8** | ,013 | -,081 | -,065 | **47** | -,064 | -,047 | -,060 | ,065 | **27** | ,480 | - | ,287 |
| **16** | ,116 | **20** | -,092 | ,002 | ***,687*** | **3** | -,262 | -,058 | ***,769*** | ,022 | **28** | ,388 | ,276 | ,044 |
| **22** | ,023 | **10** | -,075 | ,045 | ***,652*** | **45** | ,170 | -,040 | ***,619*** | ***,206*** | **29** | ,446 | ,746 | ,073 |
| **10** | -,104 | **22** | -,053 | -,036 | ***,572*** | **2** | -,335 | -,036 | ***,594*** | ,178 | **30** | ,225 | ,280 | ,152 |
| **21** | -,072 | **19** | -,038 | ,083 | ***,518*** | **36** | ***,250*** | -,056 | ***,552*** | ,166 | **31** | ,391 | ,381 | ,076 |
| **19** | ,014 | **61** | ,176 | ,225 | ***,495*** | **58** | ,017 | -,070 | ***,475*** | -,155 | **32** | ,564 | ,479 | ,397 |
| **1** | -,107 | **21** | -,031 | -,094 | ***,466*** | **27** | ,033 | ***,280*** | ***,451*** | ,053 | **33** | ,806 | ,620 | ,063 |
| **12** | ,017 | **3** | -,089 | -,125 | ***,314*** | **50** | ***,266*** | -,070 | ***,384*** | -,028 | **34** | ,084 | ,017 | ,012 |
| **3** | -,165 | **59** | -,102 | ,114 | -,292 | **51** | -,116 | -,043 | ***,368*** | -,204 | **35** | ,705 | ,916 | ,274 |
| **2** | -,160 | **38** | -,046 | ,115 | -,161 | **48** | ,099 | -,052 | ***,298*** | -,124 | **36** | ,495 | ,632 | ,399 |
| **27** | ,048 | **47** | -,010 | -,055 | ,099 | **41** | ,121 | ,014 | ***,217*** | ,002 | **37** | ,397 | ,608 | ,061 |
| **20** | ,030 | **34** | -,020 | ,029 | ,084 | **37** | -,124 | -,023 | ***,201*** | -,068 | **38** | ,411 | ,060 | ,566 |
| **45** | ***,275*** | **9** | -,033 | -,137 | -,025 | **23** | ,008 | -,016 | -,063 | -,036 | **39** | ,851 | ,560 | ,825 |
| **13** | ,056 | **32** | -,045 | ,176 | ,066 | **56** | -,020 | -,016 | -,063 | -,046 | **40** | ,254 | ,268 | ,153 |
| **60** | -,067 | **39** | ,062 | -,056 | -,080 | **9** | -,039 | ***,961*** | -,019 | ,021 | **41** | ,376 | ,424 | ,067 |
| **35** | ***,778*** | **18** | -,035 | ,151 | -,056 | **39** | -,251 | ***,799*** | ,015 | ***,343*** | **42** | ,492 | ,723 | ,014 |
| **52** | ***,652*** | **25** | ***,221*** | ,168 | -,115 | **32** | ***,240*** | ***,542*** | ,077 | ,171 | **43** | ,194 | ,999 | ,167 |
| **36** | ***,606*** | **13** | -,039 | -,030 | ,123 | **43** | -,068 | ***,397*** | -,029 | ,043 | **44** | ,595 | ,734 | ,437 |
| **34** | -,203 | **30** | ***,231*** | ***,301*** | -,106 | **31** | ,094 | ***,226*** | -,071 | -,079 | **45** | ,333 | ,085 | ,465 |
| **64** | -,177 | **56** | ,045 | -,092 | -,065 | **24** | -,079 | ,175 | -,083 | -,116 | **47** | ,081 | ,015 | ,016 |
| **54** | -,037 | **62** | ,015 | ,068 | -,075 | **38** | ***,535*** | ***,518*** | ,076 | -,017 | **48** | ,485 | ,404 | ,120 |
| **63** | ,095 | **43** | -,066 | ,125 | -,051 | **44** | ***,510*** | ***,363*** | ,012 | ***,209*** | **49** | ,149 | ,299 | ,132 |
| **40** | ,138 | **53** | ,026 | -,068 | ,037 | **35** | ***,481*** | ,000 | ,170 | ,097 | **50** | ,305 | ,461 | ,224 |
| **38** | ***,254*** | **14** | ,018 | ,257 | ,066 | **63** | ***,399*** | -,018 | ,144 | -,133 | **51** | ,466 | ,522 | ,193 |
| **15** | -,148 | **15** | ,085 | -,069 | ,038 | **40** | ***,385*** | -,034 | -,056 | ,013 | **52** | ,568 | ,429 | ,160 |

**APPENDIX 5 Factor Loadings.** Factor 1 Music as a bringer of pleasure and positive imagery (black), factor 2 Music as relaxation and conscious mastering of mind (red), factor 3 Insight and verbal reflection (red), factor 4 Sequelae of torture (red), factor 5 Hope and integration (green), factor 6 Working through of traumatic experiences (green), factor 7 Recognition and depiction of emotions with music (green), factor 8 Avoidance/resistance (green), communalities of variables (blue). Factors were calculated with SPSS software version 18.0 using the extraction method of Maxim Likelihood and the Varimax rotation with Kaiser Normalization. (Continues)

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **55** | ,052 | **11** | ,041 | -,185 | ,154 | **25** | ***,359*** | ,192 | ,018 | ***,325*** | **53** | ,218 | ,504 | ,009 |
| **53** | -,045 | **40** | -,018 | ,046 | -,184 | **64** | ***,342*** | -,048 | -,046 | ,029 | **54** | ,295 | - | ,071 |
| **62** | -,048 | **5** | -,032 | -,028 | ,024 | **30** | ***,324*** | ,133 | -,054 | -,156 | **55** | ,253 | ,022 | ,137 |
| **61** | ,027 | **12** | -,087 | ,094 | ,074 | **54** | ***,260*** | ,004 | ,029 | -,044 | **56** | ,999 | ,939 | ,007 |
| **47** | -,091 | **24** | -,018 | -,026 | -,022 | **66** | ***,247*** | ,136 | ,104 | ,070 | **57** | ,381 | ,008 | - |
| **17** | -,122 | **1** | -,038 | -,017 | ,144 | **65** | ***,230*** | -,014 | ,066 | ,029 | **58** | ,498 | ,999 | ,257 |
| **56** | ,009 | **45** | -,022 | -,001 | -,039 | **11** | -,223 | ,124 | ,050 | ***,204*** | **59** | ,258 | ,193 | ,060 |
| **57** | ,049 | **57** | -,004 | -,048 | -,015 | **26** | ***,213*** | ,149 | ,010 | ,194 | **60** | 029 | - | - |
| **24** | -,044 | **58** | ***,494*** | ,180 | -,041 | **33** | ***,211*** | -,055 | -,043 | -,059 | **61** | ,635 | ,470 | ,283 |
| **5** | -,075 | **51** | ***,261*** | ,183 | -,081 | **59** | ,180 | ,098 | ,022 | -,124 | **62** | ,640 | ,673 | ,127 |
| **11** | -,014 | **-** | | | - | **53** | ,074 | -,007 | -,035 | -,020 | **63** | ,512 | ,399 | ,200 |
| **14** | ,013 | **-** | | | - | **17** | -,048 | -,044 | ,019 | ,043 | **64** | ,482 | ,236 | ,123 |
| **8** | ,093 | | | | | | | | | | **65** | ,454 | ,934 | ,060 |
| **23** | -,057 | | | | | | | | | | **66** | ,374 | ,838 | ,097 |
| | | | | | | | | | | | | | | |



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