Everybody Is a Star: Recording, Performing, and Community Music Therapy

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ABSTRACT: This article explores public creative expression as an intervention of Community Music Therapy (Stige, 2002, Pavlicevic & Ansdel, 2005, Turry, 2005) for adult clients with long-term disabilities accessing supportive services such as post-acute rehabilitation, day treatment, and residential programs. Involving clients in situations that seem to blur the lines between music therapy and mainstream music activities such as recording songs, doing concert performances, releasing CDs, and producing music videos, extends the role, aim, and possible working environments for music therapists. Such endeavors offer potent opportunities for positive psychosocial outcomes but may also introduce complex dynamics that could compromise their integrity as a legitimate form of therapy. In-depth discussion and case studies examine the issues involved in assisting clients in moving outside of traditional therapy settings and into the wider social contexts typically involved in music.

For most of human history, music was an essential aspect of communication and sense of connection within a tribe or village and was deeply integrated into the rituals, ceremonies, and celebrations that related to the deepest needs of the community (Netti, 1956). The current belief that music is primarily entertainment to be enjoyed separately from life’s more serious obligations dominates contemporary culture with musical “products” such as CDs, DVDs, and concert performances produced by professionals within the highly lucrative entertainment industry. (Lieberman & Estgate, 2002, Negrus, 1996). This perception of music as basically a form of recreation permeates our society right through to our health and rehabilitation institutions. According to Anthony Salerno, founder of numerous residential rehabilitation centers:

The fact is, the vast majority of people who work in our profession, not to mention the clients, families, advocates, regulators, policy makers, legislators, elected and appointed officials, and the community at large - too often think of music therapy as only a recreational activity and they regard recreational activity as a method of residents keeping occupied. The fact that this belief is endemic is disturbing, but factual (personal communication, October 24, 2007).

Many music therapists work within recreation departments of institutions and are often expected to facilitate large groups, making it challenging to establish an authentic alliance with many, if not most, clients. It is possible the music therapist may consciously or unconsciously align more with needs of the institution than the needs of the client by seeing a lot of clients, increasing the visibility of music in the facility, attempting to generate an appearance of “fun,” and generally making things “look good” from an outward perception.

One problem in determining what is, and is not, music therapy is that music lends itself to these types of activities. Concerts, festivals, parties, living room sing-alongs and similar enjoyable social gatherings are familiar aspects of most people’s musical lives. In my experience, even under the worst conditions from a traditional therapy perspective, music is still a generally positive and uplifting experience for most clients in rehabilitation programs and institutional settings. Music makes people feel good. We play music. As such, it may appear inconsistent with the principles of serious work.

Pinker (1997) dubbed music “auditory cheesecake” because he could discern no evolutionary benefit to mankind’s universal and enduring practice of it. That our prehistoric ancestors made music is clear as evidenced by the discovery of bone flutes more than 50,000 years old (Tramo, 2001) and the fact that the limbic system, an ancient part of the brain in evolutionary terms, has been demonstrated to be strongly responsive to music has led some researchers to conclude that music predates spoken language (Menon & Levitin, 2005). Brown (2001) proposed that early pre-language humans utilized a music-language that conveyed information as well as emotional meaning using discrete pitch levels and expressive phrasing. Eventually, what Brown has termed “Musilanguage,” would split into two specialties, music and spoken language.

Although some studies on the evolutionary benefit of music have looked at it from a sexual/courtship perspective (Miller, 2000), Benzon (2001) hypothesized that the brain and music evolved together and that music continues to play the role it did in human kind’s beginning, what he called the forge in which the new forms of social being emerge. As human civilization developed, music has reflected its period as much as it has illuminated the future and stretched social boundaries. To offer a few relatively modern examples, in the Middle Ages, the Church restricted the use of certain harmonies that are now common. In the 19th century, the Waltz was considered immoral. In the 20th century, the music of Stravinsky, avant-garde experimentation, Jazz, Rock, and Rap idioms were all met with resistance and outrage. All these forms advanced the prevailing musical vocabulary and social culture in their day and are now accepted.

Music allows for the expression—melodically, harmonically, rhythmically and lyrically—of both positive yearnings such as peace, unity and beauty as well as problematic feelings such as violence, conflict, and despair. Such artistic impressions do not directly act out these desires but, nonetheless, bring them into public awareness. Cross (1999) referred to this function of music as enabling risk-free action and facilitating risky interaction. It is a given that music therapy endeavors to effect progress in the client, but does music applied as therapy also contain a socio-political impetus that can, or should, encourage cultural movement? Small (1998) claimed that all music is ultimately a political act and Zharinova-Sanderson (2005) referred to the music therapist as a “campaigner for music as a force for change in the community” (p. 245). Therein lies the
rationale for music therapy to sometimes reach out from behind closed doors.

Many individuals with lifelong disabilities such as mental illness, autism, intellectual disability, dementia, severe physical impairments, brain injury, and neurological disorders tend to spend most of their time in sheltered environments such as therapeutic programs, residences, and institutions. Since music therapists work to a large degree in these settings (AMTA, 2010), it may serve to briefly consider an ethical question. Where is the need for healing greater: in the individual with a disability or in the social conditions within which the disabled person resides? The medical model of disability is based on the assumption that the individual is impaired by some observable and diagnosable abnormal function of body or brain, while the social model reverses this to explore how socially constructed barriers (such as discriminatory attitudes, social norms, design of buildings, modes of communication and transport) create perceived impairments (Barnes & Mercer, 1996).

If the idea and appearance of disability does not conjure completely negative connotations for the general public, where the person is viewed as incomplete, tragic, or a financial burden (Corker & Shakespeare, 2002), it still remains at least out of the ordinary for many. It is an uneasy problem that only appears when the “disabled” person appears. The World Health Organization has expressed that the true measure of a society can be seen in its willingness to cooperate with its dependent (Welter and Schonle, 1997). Or is the idea of dependence largely a matter of social oppression as Abberly (1987) has argued? Clearly, we must acknowledge that some individuals have severe physical or cognitive problems and are in need of cooperation. But does that mean that those partaking in months, years, or a lifetime of supportive services such as day treatment, residential programs, and institutional care need remain their own subculture, essentially outside of the mainstream of public awareness and activity for the majority of their lives?

Community Music Therapy

One way in which the field of music therapy has responded to these questions is with the Community Music Therapy model (Stige, 2002, Pavlicevic & Ansdell, 2005, Turry, 2005). Music’s “ripple effect,” illustrated by its tendency to spread outward, naturally attract people and move them into increasingly wider social contexts (Pavlicevic & Ansdell, 2005), makes it a perfectly suited modality to encourage clients’ participation and connection within community. A Community Music Therapy approach, according to Ansdell (2002), reflects the essential communal reality of music-making. The aim is to assist clients in accessing a variety of situations and accompanying them as they move between traditional therapy approaches and the larger music-making community. It involves extending the role, aim, and possible work sites for music therapists.

Performance related situations as rehabilitation must never be a requirement or an expectation; however, employed judiciously, they can function as an epiphany of sorts. Ansdell (2005) noted that people can perform beyond themselves, breaking out of habits and discovering, not who they are or were, but who they previously were not. Aldridge (2006) referred to identity as achievable only through active feedback and dialogue with others. We are performed beings, Aldridge says; that is, we reveal and realize ourselves in the world—mentally, physically and socially—as performances. Various aspects of performing and recording, showing up to sessions, rehearsing, group effort and decision-making, dealing with nervousness, disagreements, boredom, or setbacks, can be approached as real-life opportunities that naturally challenge and strengthen vital community skills, such as:

1. Managing relationship and effective collaboration
2. Self-organization
3. Handling difficult feelings such as frustration, competitiveness, insecurity
4. Expressing oneself assertively and clearly
5. Maintaining concentration and motivation
6. Problem-solving

Nurturing a client’s journey into the communal world of visibility and stress involved in public endeavors raises some essential considerations for the therapist. Who wants to perform (or record or make a film) more, the client or the therapist? Who is the star of the show? Austin and Dvorkin (1998) have advised that a therapist must remain constantly aware of his or her own narcissistic need for recognition and validation that has not been worked through. If not, the therapist’s projections and ambitions can complicate the client-therapist relationship and may even be, in some cases, exploitive. What if performance is not in the best interest of the client? Austin (2003) described a situation in which her client pleaded with her to perform and later thanked her for refusing the request. The feeling of being safely contained from her impulsivity was a more important clinical concern for this client. However, utilized discerningly and with awareness, performance situations feed back into the therapy process. Turry (2005) regarded the experience of being valued and attended to by the therapist after a performance to be more powerful than the public response in helping clients to feel an internal sense of validation.

The Dynamics of Performance as Therapy

The sounds awaken primal emotions
Unannounced they take our lives
They appear from the past
They are lessons we have all learned throughout our lives
The words inspire, teach and are taught to our children
So that they can live lives inspired by their parents
The sounds coagulate into a mixture of rhapsody and learning life lessons
The words - they move us
The words - they move us
Move us to a higher pedestal
All we must do is create and sing
Sing to the beat of a drum or the strings of a guitar
For our children are always listening – Ben (client)

I have compiled numerous personal interviews and written reflections by clients discussing their experiences following the completion of various public expression projects such as recordings, video shoots, and live performances. All participants had histories of long-term disabilities related to
brain injury, stroke, spinal cord injury, dementia, complex medical conditions, psychiatric, and neurological disorders. Their statements relating to their artistic achievements revealed self-assessment of a high degree of functionality and fulfillment in certain desirable personal qualities and experiences. In analyzing the material, I have categorized the areas of greatest impact as:

1. Self-Efficacy—feeling that one is autonomous, competent and making a meaningful contribution
2. Engagement—being active, focused and immersed in one’s interests
3. Self-Expression—feeling that one’s unique personality and ideas are being communicated and received
4. Affiliation—establishing positive relations and sense of cooperation with others
5. Enjoyment—deriving pleasure and fulfillment from one’s experiences

These categories, which I would term “Elements of Well-Being” (Soshensky, 2010), correlated with theories aimed at defining positive psychological functioning such as Maslow’s Hierarchy of Needs model (1968), Positive Psychology (Seligman & Csikszentmihalyi, 2000) as well as currently popular articles and books about the “Science of Happiness.” (Wallis, 2005; Klein, 2006). The general areas of functioning that music therapists typically assess such as affective, communication, social, cognitive, physiological and musical overlap and are not in any way contradicted by these categories. However, the “Elements of Well-Being” are not clinical. They refer to universal qualities of experience all people need to develop. In general, most fields of therapy have been more oriented towards assessing pathology rather than the factors that influence well-being, a point expressed by Maslow (1987):

The science of psychology has been far more successful on the negative than on the positive side. It has revealed to us much about man’s shortcomings, his illness, his sins, but little about his potentialities, his virtues, his achievable aspirations, or his full psychological height. It is as if psychology has voluntarily restricted itself to only half its rightful jurisdiction - the darker, meaner half (p. 354).

If we focus on an individual as a self-defining entity whose sense of well-being derives entirely from the degree to which one perceives the above elements to be met, the term “disability” becomes irrelevant: an externally applied construct where their projects. In this process of identification with one’s own creative power, the rehabilitative intent is to begin to shift the self-image towards increasingly greater degrees of self-acceptance. In this context, I would differentiate self-acceptance from the more frequently used term, self-esteem. Self-esteem often relates to one’s perception of success or failure in a given area within a given time and, as such, it can fluctuate. Self-acceptance implies a more stable sense of one’s worth regardless of shifting external circumstances or opinions of others. Life span theories have emphasized self-acceptance as the single most important characteristic of personal development and well-being (Ryff, 1989). This observation was similarly expressed by Parker (1957), who concluded that when we begin to appreciate that we are part of the creative power of the universe, we begin to know that nothing is impossible.

Relaxed in the wait, yet tension in the knowing that when your turn comes, for one moment in time, it has to be exactly right—Peter (client)

As clients increasingly feel productive, validated, competent and aware of progress, disability can begin to be redefined as only one aspect of a multidimensional sense of self rather than having one’s self and life completely defined by the disability. The dominant message is that being an individual with a disability does not preclude having active, creative, and interesting experiences in life. Within the freedom of artistic expression, one may come to understand, perhaps momentarily or perhaps more enduringly, that one thing remains forever within one’s grasp and that is what Victor Frankl (1984) called the last of the human freedoms, to choose one’s attitude in any given set of circumstances.

I loved the concert. I loved it! The songs - the poems - I loved telling my stories. Everyone was so attentive. I really got into it.—Linda (client)

“So You Want to Be a Rock & Roll Star”: A Case Example

Darryl was a 52 year old resident in a long-term post-acute rehabilitation setting. His history included severe neglect and abuse as a child and his current diagnoses included schizophrenia, acquired brain injury stemming from chronic alcohol abuse since early adolescence, and frontal-lobe traumatic brain injury (TBI) stemming from a car accident. He was a talented rock guitarist and singer who was very easily frustrated with attention deficits, short-term memory problems, and was prone to rapid escalation into rage, paranoid ideation, accusatory statements, and threatening behavior.

I tried to involve Darryl in several upcoming ensemble performances scheduled to take place in local community venues. He agreed, somewhat reluctantly, and rehearsed with other client-musicians only to explode over some seemingly minor issue and quitting the event each time a day or two prior to the concert. I was aware of my own feelings of countertransference (Bruscia, 1999) including guilt and regret for having encouraged him to take part in situations that “set him up” for failure. I knew that Darryl was volatile and impulsive and had a hard time compromising his music and playing time for the sake of the needs of others, particularly when he saw them as lesser talents. I also had feelings of anger towards him for letting us down at the last moment again and again.

Such moments define the “process versus product” issue of performance within a Community Music Therapy construct. What is the primary focus, the “show” or Darryl? True, when Darryl walked out on the group, we still went on with the
Darryl often referred to his imminent success as a rock musician when he was discharged to the community. Whether or not this was realistic was not my concern. If I was going to help Darryl make any progress in managing his rage, capriciousness, and isolation, conditions had to be designed such that he could achieve a constructive outcome. A string of situations that simply exacerbated his pathology would be of no use. In terms of the “Elements of Well-Being” (Soshensky, 2010), Darryl’s key areas of need for progress related to Self-Efficacy with regards to improved emotional self-management skills and to Affiliation with regards to his need for improved collaboration skills.

I was able to arrange a performance at a local community fair where Darryl could play a “solo” show with me and other staff/client musicians comprising his backing group supporting his music, his way, without him having to compromise or negotiate with others. This idea appealed to Darryl. He rehearsed diligently, in good spirits, developing a strong set of classic rock covers. Privately, I hoped that the same scenario of a last minute “storm out” would not transpire. Happily, it did not and as show time approached, we all had to manage some stress as the transportation to the event fell through and we had to scramble to arrange an alternative. Darryl took this in stride as he seemed to find it part and parcel with being a musician needing to get to the gig. Further, the venue for the first performance was not the most inspiring situation, but we carried on in the best “the show must go on” tradition and enjoyed ourselves. Darryl played well and received some nice ovations from the crowd.

For me, his meeting the situation and managing these frustrations was success enough. I offered what I considered to be an appropriate degree of positive feedback (laying it on too thick could be interpreted as being condescending). Once the respect and support for Darryl as a musician and a person was established, he was able to thrive in his element. He was out in the community playing his music and he felt good about it. His kindness, humor and supportiveness of others, became apparent but previously overshadowed by his anger, such as his kindness, humor and supportiveness of others, became more dominant. Darryl became a prominent and appreciated, rather than dreaded and avoided, member of his community.

This transformation was poignantly underscored by Darryl’s sudden and unexpected death from acute medical complications. He was warmly memorialized by a large group of staff and clients. This was not a mere formality. Darryl’s contributions to the community and personal growth inspired a genuinely moving and sincere tribute to his life and music. That a man so troubled and limited in one way could still make progress and have a meaningful impact on those who knew him imbued the service, with some sadness to be sure, but also

Seems I took the long way to go
You don’t know if it overflows

There’s been so many times
I felt so alone
I didn’t know
If I was alone

There’s been so many times
I’ve been left out on my own
I didn’t know if I was here
If I was there
But I knew I was alone

I was alone
I felt just like a rolling stone
All alone

Seems so many things
Have come and gone
Come and gone
I didn’t know if I was here or there
Didn’t know if I was anywhere

Darryl sang the following:

Bay,” the song was essentially an expression of his core feeling of loneliness. Darryl sang the following:

In addition to the hundreds of classic rock songs Darryl could play based on his decades of continuous listening, he also possessed the ability to improvise complete and cohesive songs on the spot. These songs were often stunningly poetic and vulnerable. However, it was very difficult to develop this new material because his short-term memory was so impaired. Virtually upon completion he could not recall these songs. He seemed incapable of focusing on lyric sheets while singing, and he certainly read no music. Even if I managed to record new material because his short-term memory was so impaired.

Darryl became relaxed and friendly, even magnanimous. However, in those situations where his music transcended his psychopathology, it was his mood at that moment that determined if he decided to participate or not. Such a “no pressure” attitude was often not compatible with a scheduled and upcoming public performance.

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with a sense of accomplishment, hope, and love. What greater legacy can anyone leave?

**Community Reverberations**

The positive side to music being identified with the entertainment industry is that in writing songs, performing, and recording, the client is doing something that’s culturally idealized. In this way, the perception of being disabled can be almost instantly transformed. If a friend, family member, caregiver, or peer hears a client singing or playing on a CD, video, or concert stage doing something they may think only “stars” do or something they might think they couldn’t do, that person may also think of the performer differently. It expands the context and nature of the client’s personal relationships. Beyond personal relationships, CD’s, videos, and concerts are meant to share one’s talent and message with the general public. If an artistic statement moves the listener, the fact that the performer may have a disability can become subordinate to the experience of the music. In writing about the original songs on a client-produced CD, an article in the local print media stated:

The message of life is greater than the message of damage, telling us this is another way of experiencing life. We all make this choice everyday: are we going to be fully alive? (Heath, 2008).

Turry (2005) also described a case in which a performance with his client made a powerful statement:

She no longer felt she had to hide her struggles, doubts and fears, and this was extremely liberating. It gave her an opportunity to participate and share with others more deeply what she was going through and that helped her to feel less isolated. As she connected with members of the audience, they in return, felt moved and wanted to connect with her (p. 4).

I have had conversations with audience members following community performances featuring individuals with disabilities, and the spectators have told me of the range of emotions they experience. To summarize, it begins with fear at witnessing the extent of a person’s challenge. Seeing someone in a wheelchair, with slurred or labored speech, odd appearance or behavior, or obvious illness or fragility tends to frighten people because they are not used to it. As Hunt (1966) put it: “They represent everything that the “normal world” most fears - tragedy, loss, and the unknown” (p. 155). Audience members may be emotionally defending against the possibility that this could happen to them or a loved one. They are ambivalent; attending the event while another part of them really doesn’t want to deal with this. After awhile, fear turns to sympathy: “that poor person - it’s so sad.” Then the music, the artistic expression, begins to come through and becomes predominant. Sympathy transforms to rooting for the performer evolving into identification, shared experience, intense immersion, tears, elation, passionate applause. What more do we want from a performance? I have seen audience members actually line-up to talk to a “disabled” musician following a performance, someone with whom they would have previously had no point of contact.

Contemporary rehabilitation methodologies stress the principle of “inclusion,” meaning the individual is incorporated into the community regardless of disability (Condeluci & Mc Morrow, 2004). But this is not mere bottom-line inclusion as in the case of someone in a wheelchair at a museum or social event seeming uncomfortable and out of place; possibly not communicating with anyone other than those with whom he or she came. This is creating an opportunity for a person with a disability to be front and center, have their voices and ideas heard, and be the very reason people are at an event. Writer Melvyn Bragg (2007) quoted artist Yinka Shonibare commenting on the role of disabled individuals in the arts as the last remaining avant-garde movement. Bragg also referred to Ju Gosling, artist in residence at the National Disability Arts Collection, who pointed out that such work helps people to understand that we can only really be happy when we accept the reality of the human condition as being vulnerable and imperfect.

**“Speechless”: A Case Example**

George was admitted to a residential rehabilitation facility following a stroke. Additionally, George was found to have a heart defect that would shortly necessitate surgery. Prior to his stroke at age 46, George had been a healthy, single man who was employed full-time doing computer work. He was also an accomplished piano player and singer who played some professional engagements and had aspirations for furthering his career as a musician. His musical interests leaned towards jazz and classical and he told me that he sang “like Pavarotti.”

At the time of his admission, George was wheelchair dependent with impairments involving speech, motor skills including the use of his hands, and other complications. Emotionally, George was struggling with adjustment issues related to his condition including depression with significant bouts of anger, frustration, and sleep difficulties. George dabbled in some music therapy sessions; however, he was embarrassed by his slurred, labored voice and laughed self-mockingly after any efforts at singing. His piano playing was even less functional and he refused to make any serious attempts. George shortly had to endure further surgery and medical complications returning in an extremely debilitated condition.

As George slowly regained his strength, he did not want to attend music sessions anymore. I maintained our relationship and continued to encourage George to resume some form of music therapy when he was ready. As we continued to discuss the matter, George made it clear that he did not wish to take part in group sessions, saying he felt uncomfortable participating with those less musically accomplished than him. That there were, in fact, quite a number of talented musicians participating in the program seemed to make no difference to him. Eventually, George said he was interested in being musical again, but he would accept only an individual session.

I arranged a weekly co-treatment session with his occupational therapist (OT). The original idea was that we would work on some adaptive techniques for George’s piano playing. There is evidence pointing to music as a rhythmically coherent experience of time and space, facilitating improved sensorimotor control and goal directed movement (Hurt, Rice, McIntosh, & Thaut, 1998; Dileo & Bradt, 2005). We began some sessions, improvising in an exploratory fashion with
George on piano, his OT helping with his physical positioning while I usually played bass. George shortly consented to allow another client to join us, a quite wonderful conga player and so we had a little jazz combo. Although there was some progress in George’s fine motor control and piano playing, it did not appear significant enough to be sufficiently satisfying or motivating for him. However, his musicality was soon engaged in a more comprehensive manner as George began to compose a chord pattern to accompany his improvisations. It was primarily based on a minor blues progression; however, it contained several “jazzy” chord changes that George said were influenced by jazz great, John Coltrane.

In terms of the “Elements of Well-Being” (Soshensky. 2010), George’s key areas of need for progress related to Self-Efficacy with regards to improved sense of competence and autonomy and Self-Expression with regards to his need to express his artistic voice beyond the limitations of his disability. I suggested to George that he might want to consider composing a complete song, adding some lyrics to his changes. George liked this idea and hit on the central idea of “Speechless” almost immediately, referring to his difficulty with communicating clearly. The first verse of “Speechless” came very quickly:

Speechless
I'm speechless
I know what I want to say but the words get in the way
And it ain't no joke when all your words get choked
Speechless

The next verse took a few more weeks. I was in favor of the song taking a wider view of George’s feelings regarding his situation but George remained adamant that the song was only about his being “Speechless” and needed to remain focused on that. George’s strength of character came through as he held fast to his artistic vision, disregarding and overriding numerous suggestions and ideas by me and his OT until he arrived at a second verse that satisfied him:

Restless
I'm so restless
All my thoughts and feelings are still there
I just can't get them in the air
And I need to reveal what I'm forced to conceal
Speechless

The final section was pure inspiration. He accepted my suggestion that perhaps the song could use a bridge, and he spent a brief time in a creative writing program, arriving at:

When Moses talked to God
He said, speaking for me is hard
God said, don't worry about it
Your brother will speak for you

Musically, this lyric was applied to a standard blues bridge beginning on the subdominant chord and resolving on the dominant. But if the music of the bridge was rather traditional, it was nonetheless effective as the power and profundity of George’s lyric gave the piece a quantum leap into the mythopoetic. George was, of course, referring to the Biblical quotations from ‘Exodus:’ (4:10-16).

And Moses said unto the Lord, ‘O my Lord, I am not eloquent; neither heretofore, nor since thou hast spoken unto thy servant but I am slow of speech and slow of tongue.’

And the anger of the Lord was kindled against Moses and He said, ‘Is not Aaron the Levite thy brother? I know he can speak well...And he shall be thy spokesman to the people.’

In discussing his imagery, George said that Moses had been one of his major heroes even prior to his stroke. The fact that Moses was someone who, like George, was considered to have had a speech impediment and yet became known as the greatest prophet of all time signified to George that his disability did not preclude his ability to do important work. George believed he had a purpose yet to be revealed.

When George’s song was finished, he wanted it to be recorded. This necessitated moving into a wider community context. I thought it would be a profound statement for George to challenge the content of the lyric by singing his own song, but he refused. He insisted that it would sound “horrible” and no argument about how the therapy involved in singing it himself outweighed conventional aesthetic considerations could change his mind. George’s choice of vocalist for the song—his “Aaron”—was Alan, another client and fellow jazz and blues lover. Alan was emerging as an extremely talented singer although he had never known this about himself and had never sung prior to coming to music therapy sessions.

A group of client-musicians assembled to begin working on the song with George as musical director. As the rehearsal started to take shape and then transition into a recording session, the energy and ambiance generated by the music of this little group caught the attention of the facility’s Public Relations Director. She wanted to take a picture documenting the session but George disallowed it. He wanted no pictures of himself. Although George’s song explored a wide-ranging coping response to his current life crisis, some of his emotional conflicts related to his trauma were clarified. A talented singer, he refused to sing (although I was able to encourage him to provide a little backing vocal part) and a proud and handsome man, he refused to be photographed. Nevertheless, the recording of his song proceeded well and George was extremely pleased with the results.

With the success of his musical vision behind him, George seemed happier and more comfortable with himself. We began to discuss the possibility of filming a music video to accompany his song. At first, George said no, until he had an idea for an image that appealed to him: throwing a rod down on the ground and having it turn into a snake, as Charlton Heston did playing Moses in The Ten Commandments. We considered this possibility but realized it did not seem realistic, given our limited technical capabilities. However, his artistic sensibilities stirred, George remained interested in the project, developing cinematic ideas and then, allowing himself to be filmed, something he would not permit less than a month previously. George donned a makeshift Moses costume for the shoot and later said that he felt honored having the opportunity to play Moses. He said he felt as if he connected with the spirit of Moses who represented to him perseverance as well as accepting the loss of royalty to achieve a higher purpose. George said, “Moses was someone who was willing to walk through...
the desert until he couldn’t walk anymore and like Moses, I will fight to the very end.”

As George began to make plans for his upcoming discharge, it was apparent that his self-acceptance and sense of empowerment were improving. He became willing to attend open group music sessions and he sang “Speechless” and other songs publicly in groups as well as during in-house performance situations on multiple occasions. Through his CD recording, video-making process and live performances, George came to express pride in himself and his accomplishments rather than simply self-derision as he had done earlier in his treatment. Although George never had the opportunity to sing his song at an outside community venue, Alan and others performed his song numerous times in concert. His recording was also played on the radio a few times, and his video was screened at a consumer-oriented conference and placed on several professionally-oriented websites. His creative work took on a life of its own with his blessing as it went forward even if he was not always present.

In preparing to return to community life, George would certainly require supportive services, and he reflected on his future and the changes he’d been through. Formerly a self-described arrogant, independent person, he accepted people taking care of him more then he allowed before. “The World is my brother,” he proclaimed. “I’m more humble and pious than I was before. It’s OK that I need help. I’ve made some peace with what has happened to me and an important part of this healing came from being taken seriously as an artist. I wasn’t ready to sing on the lead vocal on the recording of “Speechless,” but I do hope to get back to my singing. I want to sing in local opera, who knows, maybe even the Metropolitan! I want to be the first wheelchair impresario!” ‘Well,” I said, “that would be about as far away from being speechless as one could go.” And George just laughed.

Conclusion

Turry (2005) has discussed the healing journey of a (previously non-musician) woman named Maria who, upon being diagnosed with a serious form of cancer, chose to express herself in music therapy, eventually writing songs and ultimately, recording and releasing them and then putting together a nightclub act. In the liner notes of her self-released CD, writer, poet, musician, Gary Keenan (2002) wrote:

This is soul music of the highest order. The songs are acts of witness to the ordeal of living … All of them express a transformation of the soul, from passive victim to creative artist, and of the body from sickness to health. Her discovery of her true voice is recounted in these songs, and their real power is not that they portray a personal confession but that they enact a fundamental spiritual process. In order to be whole, each of us must find our own voice, whether we are singers, poets, accountants or bus drivers. By so boldly stepping forth in an act of faith, Maria not only changes herself but is the agent of change in her audience. She has chosen to face death singing her particular duende, the flamenco singer’s fierce devotion to life in spite of loss – and by doing so transcends the fear that silences too many of us daily.

As our clients discover themselves, as they re-create themselves, in fact, through their creative efforts, their songs, their recordings and public performances bear witness to the faith, the optimism, and the indomitability of the human spirit in seemingly the most afflicted and traumatized among us. Aigen (1991) proposed that creative acts have as their archetype the creation of the world and our presence in it. To embrace creation and creative activity, then, is to embrace life. In this course, our clients have much to teach us. As we help to empower those who might otherwise be marginalized to project their presence and voices proudly into the world, we have the privilege of assisting them in their personal “heroes journey” and, in the process, as Nordoff and Robbins (2005) observed, we give the art of music a new moral reality in the world.

REFERENCES


Community Music Therapy


