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Reflections on Working With a String Quartet in Aesthetic Music Therapy

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Abstract

Aesthetic Music Therapy (AeMT) is a music centred approach to clinical practice. This essay describes the beginning experiences of sessions with a professional string quartet. Using clinical improvisation the therapist and quartet explored inter-musical and inter-personal relationships. Questioning the importance of musical quality in clinical improvisation this paper proceeds to examine the parameters of clinical practice with musicians. Through the therapist's reflections on the inspirational aspects of sessions, questions are raised for future work and research.

Pushing the Musical Limits

During my early years of teaching I used the metaphor of swimming. Being poised on the edge of a pool before jumping in is not unlike the courage it takes to begin an improvised music therapy session. The learning of diverse musical resources and clinical techniques, like the learning of different swimming strokes will give the therapist the ability to conduct their work with confidence. As a student's learning matures so their potential to remain above water and become stronger swimmers effectively transmits an assuredness in their developing work with clients.

Defining a new approach to clinical practice requires a balance of courage, focus and daring to dive into a sea of not knowing. Aesthetic Music Therapy (AeMT) came from a need to articulate the artistry of music therapy without compromising clinical intent:

Aesthetic Music Therapy (AeMT) considers music therapy from a musicological and compositional point of view. Looking at theories of music to inform theories of therapy, it proposes a new way of exploring clinical practice. AeMT is in part a natural continuation of Paul Nordoff's philosophy of music, aesthetics, and music therapy. AeMT is also a reflection of my own personal philosophy and life experiences and the writing of other theorists.

AeMT can be defined as an improvisational approach that views musical dialogue as its core. Interpretation of this process comes from an understanding of musical structure and how that structure is balanced with the clinical relationship between client and therapist. The therapist must therefore be a clinical musician. Clinical musicianship includes:

- clinical listening
- clinical applications of aesthetics, music analysis and musicology
- clinical form and musical form
- clinical understanding of seminal works
- clinical relationship and aesthetics

- clinical analysis from a composer's perspective (Lee, 2003 pp. 1-2).

As AeMT crystallized so my clinical work found an equality between client and therapist that allowed a greater understanding of the potency of clinical improvisation. Looking at the seminal works of composers I began to further understand the connection between composed and improvised music and discovered that both processes had much in common. By analysing composed music that inspired me I was able to extract specific musical constructs that could be taken directly into sessions through improvised thematic material. The leap between these two polarities became clear. Taking this idea one step further I assigned my graduate students the task of choosing a composer. Through the detailed investigation of specific compositions students were able to discover the musical essence of each piece and the overall style of the composer. These resources could then be taken into sessions as the clinical direction dictated. The building of such resources thus becomes limitless and adds a never ending palette from which we can draw. We are bound only by the limits of our own creativity and knowledge of music.

AeMT is the culmination of eighteen years clinical practice, research and thinking on how music is used in music therapy. It is based on the need to understand the qualities, theories and biological make-up of music. Being music centred is to glimpse into the world of music, sound and meaning; to articulate music in terms of itself rather than attempting to extract its meaning from the extra-musical ideal of words. By listening clinically we begin to separate that which we think we hear from that which is actually heard and played. Through the analytical aural identification of musical components the beginnings of a theory of therapeutic musical science begins. It is this developing musical science to which I dedicate my life's work.

The written word cannot capture what occurs musically between client and therapist. Contemporary texts are now beginning to include video/audio archives as critical to the written text (Aigen 1998, Ansdell 1995, Lee 1996, 2003 Wigram, Pedersen & Bonde 2002). Music like the human spirit, should be free and unfettered. Just as we cannot understand a clients' psyche until we know the inner workings of their internal world so we cannot know their creative potential until we understand the inner workings of their music. To present one without the other is to deny the essence of what music therapy is striving to achieve. Providing both music and words through publication advocates a collective knowledge of music therapy that is, I believe, the core of beginning possibilities for a music therapy theory from within.

Musical Quality

One of the tenets of AeMT is that the quality of the therapist's improvising will affect the quality of the client's input and thus the therapeutic outcome. It could be argued that effective clinical music is not about quality, but rather the intent with which the therapist interprets the direction of the work. The counter argument is that every note the therapist improvises should be introduced with the greatest of care. The smallest of musical ideas should have a clearly defined clinical and aesthetic structure. To consider musical content as equal to clinical direction defines a standard of practice that all therapists should attempt to attain. Thus aesthetic and clinical direction go hand-in-hand.

Music Therapy With a String Quartet

The idea of working in AeMT with a string quartet came as a flash. The beginning two sessions are documented in my recent publication: *The Architecture of Aesthetic Music Therapy* (Lee 2003). The Penderecki String Quartet is the quartet-in-residence at Wilfrid Laurier University, Ontario, Canada. Their international profile and level of playing made them the ideal musicians to work with on such a project.

Working with musicians is an area that has fascinated me since my work in HIV/AIDS (Lee, 1996). AeMT with musicians has the potential to:

- broaden the musical limits of clinical improvisation
- further understand the balance between therapy and art
- explore a new way of assessing the musical/therapeutic relationship.

My question was how can sessions with a string quartet be defined as music therapy? I struggled with this at length prior to the initial session. Was I excited because I felt working with a string quartet could mature my understanding of the therapeutic process or was I

supporting my need to work at a more sophisticated musical level as a clinical improviser? In truth I think both considerations were true. Reflecting on the inter-personal and inter-musical dynamics during their concerts I began to speculate on the possibilities of how the therapeutic process may be useful to the quartet's concert work, as members of a group and their individual needs. What direction might the sessions take and how important would it be to find a clinical focus to the work?

Evaluating my experience as a clinical improviser and therapist I began to formulate boundaries of clinical practice that would enable this work to be identified as music therapy. The potential for new areas of practice are found in the most unlikely of places and it is these places that often provide the richest of material. This is the only way contemporary initiatives will be found that will allow the profession to grow openly and creatively. What would be the potential health benefits for the quartet and what learning experiences could I as clinician gain from the sessions? A professional string quartet has many pressures both in terms of concert schedule and the intimate interpersonal relationships they must acquire. These pressures bring with them potential physical and emotional problems. It was my hypothesis that music could be used as a specific tool to deal with and aid these tensions. Through this work I saw opportunities for a broadening that would perhaps challenge the boundaries of what commonly constitutes clinical practice.

Once the sessions had started the therapeutic level found its own natural balance. Two main questions appeared:

- Could clinical improvisation affect the quartet's concert playing outside sessions?
- How might the interpersonal relationships of the quartet be explored through the musical dialogue? (Lee, 2003, p. 205)

Music therapy and the string quartet may be closer allies than we would at first assume. The string quartet is one of the most intimate and spiritual forms of music making. Are we not seeking to find that same spiritual centre in the therapeutic alliance? Could the music therapy process therefore learn from the precise processes of string quartet music making? Observing the physical, emotional and physical cues during rehearsal and performance is not unlike the subtly of communication between client and therapist. The musical relationship for both is about the smallest and delicate of responses. How then might we begin to understand the mechanisms of each and the links that may be possible? For some these connections may seem tenuous but for me, as I hope for others, relating clinical practice to the practice and performance of chamber music may be one of the richest resources music therapy has yet to harvest.

Inspiration

In the first session I arranged the quartet around the grand piano as in a group session and as a piano quintet would perform. In the first improvisation of the second session the quartet requested their need to move freely and in the second improvisation they sat surrounding the piano. These physical changes were important as they allowed the quartet to foster different musical/therapeutic relationships.

When listening to the audio recording of sessions (for extracts please listen to: Lee 2003, CD 2, tracks one and two), I am able to accurately recall the inspiration of being part of such dynamic music making. From the moment the first sounds began I instinctively realized the potential of this work. I remember my concern that I would be able to provide the level of musicianship necessary to explore the possible intricate workings they might need. How would I translate and understand their music in terms of a possible therapeutic process? It was important that my role in the music was one of therapeutic supporter/interpreter. I listened and played as a music therapist and not as an art performer. I wondered how difficult it would be to retain my role as therapist. These worries soon dissolved as the improvisations found their own natural musical/therapeutic balance.

Reflecting on these two sessions as a music therapist, composer and improviser I remember the revelation of improvising alongside these accomplished musicians. Once my concerns with regard to my abilities had been overcome I was able to freely dialogue. It seemed as if our music had become one voice. The structure and form of the music found its own life; as if the music had already been created. We seemed to be uncovering huge dynamic structures that were truly therapeutic in content.

The Work Begins

What conclusions can I draw thus far, what of future work and what can music therapy learn from this new area of practice?

Music therapy is on the brink of great change. As we develop new clinical theories, present more research and writings, and create new perspectives in health care and community, we must also be open to the possibilities of practice outside the bounds of what we now consider professional practice. The argument against this work could be that its referral comes from an ostensibly musical core. Could this negate the understanding and bounds of what we consider clinical practice? The counterarguments are that the complexities of communication are unquestionably therapeutic and that the detailed investigation of such processes can add to our understanding of the music therapy relationship.

Future work with the Penderecki quartet is to include a series of ten concurrent sessions in partnership with my colleague Dr. Ahonen Eerikainen. This new initiative will amalgamate a music centred and music psychotherapeutic foci. The first part of each session will continue to based on AeMT, with myself as therapist and the quartet as clients. Dr. Ahonen Eerikainen will be present and for the second part will take on the role of group psychotherapist by verbally exploring the musical experiences. Both parts will be recorded and analysed to look at the correlation between music analysis and psychotherapeutic outcome.

Exploring and defining the sessions with the Penderecki String Quartet has generated some of the most significant and revealing work of my career. Allowing the roles of music therapist and composer to merge has played a crucial role in the developing perspectives of AeMT. The delicate and ever shifting balance between the intricate musical components of improvisation and its therapeutic significance is never more clearly articulated than in this work. It is my hope that music therapy will embrace the idea of AeMT with other differing groups of musicians. Perhaps one day every symphony orchestra, chamber group and opera company will have its own resident music therapist to help its members face the day-to-day personal and musical challenges of ongoing professional work.

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