



## 'Naming the unnameable and communicating the unknowable': Reflections on a combined music therapy/social work program

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### ABSTRACT

Spinal cord injury (SCI) is the sudden onset of a traumatic disabling condition. It impacts on people with SCI physiologically, psychologically and socially. People face major life changes and the lifelong challenges of disabilities that affect every aspect of their lives. This paper is a reflection on the impact of individual music therapy sessions and combined social work and music therapy group sessions, the music therapy program (MTP), on adjustment to SCI. Reflections focused on data drawn from group discussions, semi-structured satisfaction interviews of 13 men with SCI, who had undergone primary rehabilitation in the Royal Talbot Rehabilitation Centre, Melbourne, Australia; findings from an independent evaluation of MTP; and practitioner perceptions. Three themes were identified during this reflection. These were: Music as a conduit; Music and the body; and Music as a connector. Reflections identify a number of benefits of incorporating the MTP in rehabilitation programs for men with SCI.

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### Introduction

This paper is a reflection on the music therapy program (MTP) at the Royal Talbot Rehabilitation Centre (RTRC) in Melbourne, Australia and its capacity to assist men to adjust to spinal cord injury (SCI). The program utilises a combined music therapy/social work approach. The inspiration for the MTP came from a young man with a recently acquired brain injury (ABI) who was undergoing inpatient rehabilitation at RTRC. He was a musician and member of a band that toured Australia. His friendship circle included a music therapist who suggested that music therapy would greatly assist him with the adjustment difficulties he was experiencing. Using skills and confidence gained in twice-weekly individualised music therapy sessions delivered by a qualified music therapist, he was eventually able to perform with his band again on a regular basis. As credited by him, music therapy significantly contributed to his physical and cognitive recovery, engagement in rehabilitation, emotional adjustment and self-expression. Music therapy sessions were subsequently provided to a second person with an ABI. Following considerable interest by the multidisciplinary rehabilitation team in the impact of music therapy on these two young men, the integration of music therapy into rehabilitation practice was supported. The MTP became an established program within the Social Work Department. It was incorporated into the com-

prehensive RTRC therapy program provided to five clinical units: SCI, ABI, amputation, neurology and orthopaedics. The funding provided for an independent evaluation of the MTP (Montague, 2005). As Bernstein (1976, p. 140), musician, composer, conductor and author, said: '[Music] can name the unnameable and communicate the unknowable' and, as argued in this paper, a sentiment highly relevant to the role of music as a therapy for men recovering from acquired disabilities.

### Literature review

The literature review provides the backdrop for combined music therapy and social work programs for men with SCI undergoing rehabilitation by exploring the consequences of SCI and how it affects people; the use of music therapy with people with SCI; group work in this context; and social work and music therapy.

### SCI

Many types of accidents and illnesses can cause SCI and the physical, psychological and social effects of the injury can vary greatly between individuals. SCI results in the loss of movement and sensation in the limbs and trunk of the body (Zedjlik, 1992). Quadriplegia or tetraplegia is an SCI that results in the loss of sensation and movement in all four limbs and trunk. Paraplegia is SCI that results in loss of sensation and movement in the legs or the entire trunk (Zedjlik, 1992).

While SCI is a catastrophic traumatic event for the injured person, it also profoundly changes the lives of families and significant

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others. Physical consequences are sudden and traumatic usually resulting in permanent lifestyle changes (Galvin & Godfrey, 2001), with different implications when compared to the usually slow onset of chronic illness. Considerable changes alter every aspect of the person's life at the time of injury. These include paralysis of limbs (so that they cannot be moved or felt), balance, and the inability to control the function of bladder, bowel and sexual organs (Nielson, 2003). Emotional turmoil and psychological difficulties related to these catastrophic changes have been reported. These include rates of depressive disorders up to 40 percent, anxiety disorders up to 30 percent and a suicide rate up to six times higher than the general community (Galvin & Godfrey, 2001). SCI also impacts on the person's social life, involves multiple stressors, radically changed roles and financial difficulties that impact heavily on spouses (North, 1999). Persons with SCI also face a lifetime of possible health complications such as pressure sores, and respiratory and urinary tract infections that can lead to further extended stays in hospital (Dorsett & Geraghty, 2008). Men in Australia incur a higher rate of SCI than women (AIHW: Norton, 2010).

#### *Adjustment to SCI*

A major interest in how people with SCI and their significant others adjust to acquired disability is identified in the literature (Dorsett, 2001). Adjustment is defined as "adapting to a new condition" according to the *Spinal Cord Injury Information Network website (SCIIN)*. Adapting well is critical to the quality of life for an individual post injury. The significance of adjustment to SCI is that the individual is forced to adapt to an unplanned, life-changing event. Time is needed to adjust to the realities of acquired disabilities and changed lifestyles. People whose lives are disrupted by SCI may experience this as loss of control, physical function, dignity together with loss of usual social and family roles (Dorsett, 2001). Physical and emotional recovery and adjustments that occur as a result of SCI is a continuing process, unique for each person. An individualist, client-centred approach is essential for good client outcomes.

A significant contribution to knowledge concerning adjustment processes for persons with SCI is the distinction between rehabilitation and recovery. Rehabilitation includes the 'services and technologies' used to help people with disabilities adapt, while recovery is 'the lived or real life experience of persons as they accept and overcome the challenge of the disability' (Deegan, 1988, p. 11). A positive recovery can create a new sense of self and purpose as the person accepts what he cannot do and starts to discover who he can be and what he can do (Deegan, 1988). Recovery involves the individual accepting the diagnosis of SCI and regaining some control over the situation through this acceptance, which should not be confused with hope for improved functional outcomes (Dorsett, 2010). Adjustment may be viewed as a more passive process until the more active concepts of recovery and acceptance are considered.

Recovery from SCI that requires ongoing psychological adjustment and support for the adjustment process is an important aspect of rehabilitation. Unresolved negative emotions or social behaviours may impact on the patient's capacity to participate in rehabilitation (Tamplin, 2006). North (1999) lists number of factors that may predict a more successful adjustment to SCI. These include being younger, female, having a sense of control over one's situation, good quality support from others and the community, and good communication with and information from health professionals. In addition, strategies such as problem solving and active coping, as well as range of other resources to draw on have been linked to better adjustment (Galvin & Godfrey, 2001). Another study found that coping mechanisms used by people who are better adjusted to SCI included protective strategies

of emotional self-control, acceptance, positive re-evaluation and ignoring the problem by living as before. On the other hand, people using coping mechanisms of escape or avoidance, confrontation and self-blame were more vulnerable to psychological distress or depression (De Carvalho, Andrade, Tavares, & De Freitas, 1998).

Quality of life (QOL) research is particularly important for persons with SCI. In a meta-analysis of 22 such studies, Dijkers (1997) found that the average person with a SCI experiences a lower QOL than one without such injury. Although not a surprising finding, Dijkers (1997) went on to highlight the need for knowledge of the factors that contribute most to QOL after SCI and the importance of obtaining this information from persons with SCI themselves to inform and assist the awareness of policy makers and service providers. A subsequent study of 15 persons with SCI provided some insight into this and identified nine themes relevant to QOL for persons with a SCI: physical function and independence; accessibility (to places); emotional well-being; stigma; spontaneity; relationships and social function; occupation; financial stability; and physical well-being (Manns & Chad, 2001).

Although each person's situation is different, SCI commonly causes multiple losses which continue to unfold over time. As well as primary losses in physical function and mobility, there are often secondary losses in areas such as relationships, occupation and accommodation (Manns & Chad, 2001). Grief is the emotional response to loss (Golden & Miller, 1998). For a man with SCI, the loss of physical function induces feelings such as vulnerability, weakness and fear that can create inner turmoil by threatening perceptions of manhood (James, 2001). Feelings of helplessness, vulnerability and weakness are not necessarily private concerns. In many cultures, men have been socialized to keep such emotions to themselves, however, evidence exists that feelings not expressed in words or actions may be expressed through physical pain or illness (O'Neil, 1982).

Golden and Miller (1998) have provided theoretical perspectives on the less commonly understood masculine side of healing as distinct from the more explored feminine mode. While Golden and Miller (1998) point out that men and women can use both masculine and feminine methods of coping, their theories concerning masculine methods of coping are relevant to the participants in the MTP. Men are discouraged within certain western cultures from openly expressing emotions as a measure of strength and independence and their roles of protector and provider require them to defend themselves and to be alert to the safety, well-being and needs of significant others (Golden & Miller, 1998). However, for men dealing with personal loss, a grieving state may reduce their ability to defend, protect and provide for themselves and others (Golden & Miller, 1998). Characteristics of a masculine style of healing from loss can include an initial sense of chaos, a more cognitive, action-oriented and independent approach with a preference to spending time alone to connect with the loss (Golden & Miller, 1998).

Although men may be less inclined to express their emotions verbally, it does not mean that the intensity is less acute than that felt by someone more able to express feelings verbally, and so it is important to accept a man's silence and to be an effective listener if and when he chooses to speak (Golden & Miller, 1998). It, therefore, becomes important to seek more practical and active ways to respond to their losses. Some men may respond to creative activities including drawing, painting, sculpting, poetry, writing and music composition that provide safe but potentially powerful, active and practical ways to express and manage emotional vulnerability. Golden and Miller (1998) stress the importance

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