HOLISTIC ASPECTS OF REHABILITATION POST-CARDIAC SURGERY IN THE BONNY METHOD OF GUIDED IMAGERY AND MUSIC

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CERTIFICATE

CERTIFICATE OF AUTHORSHIP / ORIGINALITY

I certify that this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Candidate

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ABSTRACT

This thesis has set out to investigate the role of music therapy in the form of the specialist Bonny Method of Guided Imagery and Music (GIM) with a view to exploring how meanings related to adjustment from a health crisis (such as cardiac surgery) are depicted in music-supported imagery. Factors shaping clinical interpretations of verbal and musical responses in music therapy practice are often unclear or undelineated. A systematic interpretive process relevant to clinical health care was developed using the Bonny Method of Guide Imagery and Music (GIM), providing a means for exploring the emotional difficulties of coronary bypass patients, who typically recover quickly from physical surgery but often experience residual symptoms such as depression, pain, and anxiety. The interpretive process accessed both verbal and non-verbal texts, playing them against each other in order to find significance for music therapy practice in rehabilitation.

A Bonny Method of Guided Imagery and Music (GIM) series was undertaken by patients recovering from coronary artery bypass grafting (CABG), with each session audiotaped and transcribed. This narrative data was analyzed thematically, and grand themes were used to focus further intertextual (semiotic) and Jungian perspectives, in the process of deriving substantial clinical meanings. Results suggested that participants used a wide range of personal, cultural and archetypal texts to convey meanings about their health care situation, including images of the music during the therapeutic process. Clinical change in the rehabilitative process was suggested by grand themes comprising “Looking through the frame”, “Feeling the impact”, “Spiralling into the unexpected”, “Sublime plateau”, and “Rehearsing new steps” and the further music-related grand theme of “Sounding the changes”. This project highlights the value of GIM as a vehicle to track clinical change with cardiac patients, based on a systematic interpretive process sensitive to the interweaving verbal and non-verbal texts evident in the music therapy context.

INTRODUCTION

Imagine that listening to music could make a difference to your physical health. Imagine that music could tap into your emotions and help express your feelings. Imagine that you could find solace in sound. Imagine that you could imagine.

This unique research project uses a specific method of music therapy to address the experiences of cardiac patients post-surgery during their rehabilitation process. The Bonny Method of Guided Imagery and Music (GIM) is an effective tool to evoke and support the experiences of participants, providing a narrative text which is analyzed thematically and semiotically, further placing the material within a Jungian context. This project creates deep understanding about the experiences of patients as they recover from heart surgery and seek to resume their life in its fullness and entirety, and carries implications for the broader health care field.

This project grew out of a long history of training and experience in the professional field of music therapy, and of careful observations of responses by clients in my therapeutic care to health care problems. There was a nagging feeling that there was something more about the way that physical and emotional issues dovetailed in the music and imagery process. As early as 1990, I was seeking to understand such relationships, working on a "physical marker" model linking holistic responses to a physical onslaught with the internally generated imagery process as supported by the specific music of Bonny Method the Guided Imagery and Music (GIM). I continued to practise and observe. When the opportunity of further research and study arose, it was to this area of broader reactions to healthcare issues that I was drawn. Looking from within another therapeutic discipline (Nursing), I now had the opportunity to re-view and re-think my approach to professional music therapy. This had the advantage of stepping outside of accepted jargon and patterns of thinking, and to develop new understandings of this unusual but highly effective modality. In doing so, I went right back to the roots of how meaning occurs in the clinical situation, and re-built new understandings of foundational theory, research approach, research method, implementation, analysis process and therapeutic implications with regard to the Bonny Method of Guided Imagery and Music (GIM).

This large and extended project has provided challenges at times seemingly beyond that which was manageable. However, perseverance has led to a richly complex and valuable addition to the literature of the Bonny Method of Guided Imagery and Music (GIM), which has implications for research and practice in the wider field of music therapy, and indeed for other areas of the health care endeavour via the development of innovative theoretical and methodological constructs.

This research project has sought to always keep the clinical perspective in view. But the nature and complexity of information available in the practical setting has led to the challenging exploration and piecing together of how this may be understood from within a research framework. It was clear from the beginning that the answer would no doubt relate to handling narrative text in some way, since this is what is generated in the therapeutic session, but a conventional thematic analysis was insufficient to bring out the richness of the data. Therefore, a conventional thematic analysis eliciting themes and grand themes formed the basis of the study, but a second stage of analysis was required to provide further understandings. In order to define and handle the additional texts available in researching the Bonny Method of Guided Imagery and Music (GIM) session, an exploration of semiotics led to the employment of the concept of intertextuality. Therefore, I was able to work with the different aspects of language texts and access material related to shifting imaginary behaviour, by using the academic tool of a formal language structure. The intertexts addressed (circumtext, intratext, intertext) merged, and were woven into a three-dimensional view, rather than split analytically. This served the purpose of doing more justice to the challenging task I was facing, of trying to analyze imagery, using a qualitative textual analysis.

Although it became clear that the Jungian approach that I was familiar with from my clinical work was equally applicable to the research process, the manner in which this would occur did not become clear until during the analysis process (as is often the case with qualitative analysis). I was accustomed to working with archetypes by checking for patterns in the imagery produced by clients in the Bonny Method of Guided Imagery and Music (GIM) process. In the current project, I likewise reviewed client productions, this time in the form of emergent themes and grand themes, and this most strongly suggested to me the archetype of the Hero's journey. Therefore, the typology

of the Hero's journey was not predetermined, but just "fell out" of the data when I was involved with reading and analysis of the data.

This archetype in fact provided an overall therapeutic viewpoint which links well to the experience of recovery from cardiac surgery. Thus, I was able to utilize the archetype as a tool to develop theory, deriving a greater depth of understanding of the experiences of people recovering from cardiac surgery. In doing so, it expanded the knowledge base of the experiences of cardiac patients and their needs in rehabilitation, and likewise extended thought regarding the most useful approaches needed in rehabilitation, bringing greater clarity to the health care endeavour with regard to cardiac rehabilitation.

This study has helped define for me what I do as a clinician, of how I combine text and music in an intricate and flowing manner to explore the experiences of the patient, not extracting proofs or looking at clear cause-and-effect, but maintaining a range of therapeutic possibilities which are continually checked and adjusted according to the responses of the patient. This is, for me, the essence of excellence in music therapy practice – an open-minded and client-centered application of music to achieve therapeutic benefits for the participant.

Notes about terminology and scope of the study

In this study, matters regarding terminology and the scope of the study relate to the naming of participants and of the Hero, to consistent notation adopted, and to naming and the scope of reporting interventions and music used in the Bonny Method of Guided Imagery and Music (GIM). These notes are essential to an understanding of this study and the way that it has been written into the current format.

Participants

Although for the most part, the use of the word, "participant" is favoured and used consistently in this thesis, at times it is more appropriate in the context for the words "patient", "cardiac patient", "the cardiac patient", and "client" to be used. These usages do not imply a hierarchical view of the therapeutic relationship, but merely reflect current clinical usages and are aimed at promoting clarity for the reader.

Bonny Method of Guided Imagery and Music (GIM)

Some confusion exists about terminology referring to the specialist music therapy technique of the Bonny Method of Guided Imagery and Music (GIM), as has been already noted by Bruscia & Grocke (2002). In this thesis, a number of terms will be used interchangeably to describe this technique, including "GIM", "music therapy (GIM)", "GIM (music therapy)", and "the Bonny Method of GIM".

Hero

For ease of reading, in this thesis the character in the archetype of "Hero" will be referred to consistently as "he", but nevertheless considered to cover both genders. This decision has been made in order to promote ease of reading, and in order to circumvent the cumbersome and distracting nature of "he/she" or "s/he" when this is used repeatedly.

Notation

Sections of the GIM session will follow terminology developed in Figure 1-2, namely Investigative Discussion, Music and Imagery Treatment Phase (M&I), and Cumulative Discussion.

In quotations, the participant's words will appear in plain text, and therapist interventions in italics. Information in square brackets and italics relates to observable responses and other relevant information.

Sessions will be referred to by a coding system, where the participant number occurs first (based on order of entry into the research project), followed by session number of that participant. For example, Pat2-5 would indicate the fifth session of participant number two. Such a system helped keep track of the data in an organized manner and protected participant confidentiality. It was not intended in any way to de-humanize the people concerned or the data they kindly and enthusiastically provided.

As in standard literary practice, in imagery quotations "…" indicates that something was left out, and " – " indicates a pause in speech. As later noted, "Mm's" by the researcher were removed, for ease of reading (known as "clearing the text"), given that

this is a frequent and repetitive intervention in GIM (see Chapter 3). "Mm's" were not removed from participants' texts.

GIM interventions

This research project focuses primarily on the texts generated by the participant, in particular the narrative text of their reported imagery. It does not substantially address the nature of GIM therapist interventions during the process of the participant reporting their imagery, such interventions, however, followed standard GIM practice. Some interventions are noted in textual examples quoted in this thesis, in order to provide clarity, however the main focus of this research project is on the participant's text.

Music

For clarity of reading, each individual quote in Chapters 4-8 will not additionally carry information regarding the music selection occurring as the participant was reporting their imagery, as this becomes too cumbersome to read and interpret in the written thesis situation. This does not mean that the music is not important, but merely that for pragmatic purposes not all information could be reported simultaneously to the reader. General information about the music used for each session is carried in Appendix 7 and Appendix 8. In contrast, in Chapter 9 where participant quotes referred to the music, the music playing is noted according to the title and composer of the music playing at the time of the reported imagery.

CHAPTER 1. CLINICAL APPLICATIONS: MUSIC THERAPY AND HEALTHCARE

1.1 Overview

Music has a fundamental role in the life of the individual and society. The use of music is an exciting, but sometimes underestimated or misunderstood, way of addressing the needs of people within the clinical situation.

This study uses music therapy as a clinical treatment modality to address the needs of the patient after cardiac bypass surgery. In an era of increased interest in a range of treatment options, its particular value lies in it being a non-threatening and user-friendly modality which is helpful emotionally and physically, and which may be accepted by people who are suspicious of traditional therapies. Music therapy promotes relaxation and may elicit responses which are not seen elsewhere, and therefore adds another facet to the health care endeavour.

In looking at music therapy, I will first address the nature of music as a phenomenon to be applied in therapy, then follow its development into music therapy and thence on to the clinical field and the interpretive process. Therapeutic theories affecting this particular study are based on Jung's understandings and in particular the importance of imagery and archetype will be discussed. This leads to a full outline of the specialist music therapy method of Guided Imagery and Music (Bonny Method) and its relevance to the needs and problems of cardiac patients in this research project.

1.2 The role of music

1.2-1 The importance of music

Taking a global view, it is noteworthy that all societies have music in some form (Blacking, 1995). This suggests that music is an essential and basic expression of the person and society (Hodges, 1996b). The multifunctional nature of music has been evidenced in the rituals and rites in primitive cultures, including, for example, a strong emotional role in the frightening away of animals, enemies and bad spirits, and in

uplifting and sustaining the community. As such, it has formed a powerful societal and emotional force.

In addition, some people call music a "universal language", although this is not strictly correct, as it clearly does not have the same syntactic and semantic structures of formal communicative language as we know it. However, music does share some characteristics with language. Some writers consider that music has grown to be an extension of speech, especially with regard to intonation and articulation (Arieti, 1976). Music may have grown out of, or been strongly related to, movement, rhythm and dance (Arieti, 1976). Calmative lullabies from mother to baby are common in many cultures and suggest the nurturing characteristics of music. Music has also commonly been seen as expressing the ineffable, thereby linking music to spiritual experiences which transcend normal communicative words (Khan, 1959). The social function of music is demonstrated in numerous cultures at ceremonies and rites of passage, such as marriage and death, and in a more general way related to other social occasions such as courtship, celebrations, and homecomings. Recent thinking suggests that music also performs a role in highlighting individuality and individual expressions, and in this respect may reinforce personal identity and emotional expression, at the same time giving voice to inner psychological processes.

1.2-2 Influence of music

Since ancient times, music has been considered to have an effect on the person and subsequently a role in health care. It is often quoted that in Biblical times, David used to play his harp for Saul when he was "troubled" (1 Samuel 16: v.14-23, NRSV). The Greeks derived a whole system of the effects of music, stating that certain musical modes, similar to scales, inspired people towards war or were calmative (Davis, Gfeller & Thaut, 1998). More recently, music psychology has explored the interface of music with emotional and cognitive reactions, for example, in order to gain further perceptual understandings (Radocy & Boyle, 1997). Ethnomusicologists have explored the role of music within prescribed societies, often non-Western in character (Blacking, 1995), and some studies have looked at the role of music within Western society or societal groups (Dees & Vera, 1978). The nature of the role of music in our society as a whole is complex. Suffice to say that currently there is a great range of styles and modes of

music freely available in many forms, and that the sheer pervasiveness of music in society makes it a relevant therapeutic tool.

1.2-3 Music and the senses

Music affects our senses, especially visual and auditory senses. At a concert or when considering a compact disc, we respond not only to sounds, but also to the visual impact of the performer and their motions, the colour and title of the compact disc, and so on. If actually playing (performing) music oneself, the tactile sense is very much in evidence, as is the kinaesthetic sense based on the movements involved in the production of music, and of course auditory awareness. When listening to music, all the senses can be additionally involved via the imagery process, and this can even involve sensations of smell and taste, in addition to auditory, visual and tactile senses.

The way that information can be transferred between the senses is intriguing. Many people have, or develop, a synaesthetic awareness whereby they can translate and correlate information between one set of senses and another, for example the "colour" of a sound, or the "harmony" of a building (Rader & Tellegen, 1987). Such a transfer of sensory meanings assists in trying to understand and depict time-bound and ostensibly transient music. It is postulated that such meaning transfer happens via the imagery process (Rader & Tellegen, 1987), and this has important implications for the study of music and its interaction with the individual.

1.2-4 Imagery

The type of imagery in question in this research project is commonly known as "mental imagery". It may be described and defined in this way:

> We can hear the sound of our child's voice, see a loved one's face, smell a fish, taste a lemon, feel our feet buried in warm sand, and sense our bodies swimming in cool water. Imagery is mental representations of both reality and fantasy, including not only mental "pictures", but also mental representations of hearing, touch, smell and taste, and movement (Zahourek, 1998, p.203).

> The term 'mental images' applies to images of memory and imagination as distinguished both from material images such as paintings and from optical and other sensory images... Mental images, although they include 'pictures in the mind', are not all pictorial; some, for example, are musical and some are verbal (Goodman, 1990, p.358).

Imagery is also, according to Horowitz, "memory fragments, reconstructions, and reinterpretations or symbols which stand for objects, feelings or ideas which enable us to create, to dream, and to know" (Horowitz, cited in Zahourek, 1998, p.203). Imagery is apparent in everyday life in the form of dreams, daydreams, metaphoric representation, imagination and the like. Imagery is also often linked to visual, dramatic and performing arts. Imagery may occur in conjunction with moments of meditation, relaxation and reflection, and its evocative nature and connection to everyday life makes it a valuable therapeutic tool.

1.2-5 Music and imagery

As already suggested, music forms a natural link with imagery. Relaxing and sedative effects of selected music have been demonstrated (Guzzetta, 1989; Taylor, 1997). This naturally leads to the possibility of imagery occurring when the person is in a very relaxed state, often with the eyes closed. The major external sensory stimulation becomes the auditory, since in this situation, outer visual input is halted. Therefore, the musical stimulus will have a significant effect on any associated visualization or other aspects of the imagery process.

Composers and listeners alike know that music may conjure up images of recognizable natural sounds (onomatopoetic effects), for example, running brooks, waterfalls or birdsounds, often referred to as sound painting or sound effects. But it may also, through activating similar pathways to the sensory system (Decety, 1993), conjure up much more abstract and personalized images, related to sensations, feelings, and memories (Deschenes, 1995). Some music has an increased capacity to evoke imagery, even if not deliberately intended by the composer or overtly programmatic in nature. In addition, the ability of the individual to respond with imagery in the musical context varies considerably, with some people being labeled as "high imagers" and others as "low-imagers" (McKinney, 1995b), and Lem has further investigated the nature of connections between imagery and music (Lem, 1999).

1.2-6 Soundtracking

The image-enhancing nature of music is well demonstrated in the way that it is often used alongside the visual arts such as film and related media. In fact, historically, music developed alongside silent films as a means of communicating emotional and other

effects in order to enhance the visual image (Dees & Vera, 1978). The temporal nature of music was effective in supporting the ongoing and unfolding message or story of the film.

In our culture, the pervasive nature of film music is frequently overlooked, since the visual sense is generally predominant and therefore most noticed by people. Regardless of the person's awareness or not, music has an impact. Consider a scary scene, or a love scene – what would it be like without the music? As Dees & Vera point out, "Music conceived as a soundtrack implies that the sounds, the musical theme, become another element in the environment, and a potential object of attention." (Dees & Vera, 1978, p.135).

The study of the music soundtrack is an area which cannot be fully addressed in this thesis. However, in general terms the music contributes to the unfolding of the film, at times supporting the film plot and at other times providing tension indicating underlying emotional currents and so on. As such, it contributes to the overall product by combining visual and auditory information, and using both to enhance an underlying story or message (Chion, 2000). The music assists in making meaning in a culturally acceptable multi-sensory imaginal artform. This meaning may be at a cognitive, emotional or cultural level, and seeks in some way to impact on the person/listener. Further to this, it is suggested that people may use music to soundtrack social and cultural events in their own lives (Dees & Vera, 1978). Also, "Everyday life events can be made special by the addition of music…music has become an artifact that people can utilize to literally provide a soundtrack to their actions." (Dees & Vera, 1978, p.135). This begins to suggest ways that music may be useful in the therapeutic arena.

1.3 Music as therapy

In modern times, music has become integrated into not only cultural, but also health and clinical areas. Parallelling the modern age of medicine and medical understanding, interest in music therapy has largely developed in the twentieth century, with major interest in its research and professional application occurring mostly post-second world war (Davis, Gfeller, & Thaut, 1998). Music therapy has become a world-wide phenomenon, developing professionally around the world in many places including Australia (Erdonmez Grocke, 1996). In Australia, music therapy developed in the mid-

50s in Sydney and Melbourne (Barber, 1984; Bright & Grocke, 2000; Erdonmez, Bright & Allison, 1993). Emphasis from the beginning was on psychiatric care, and was immediately incorporated into the clinical care team as a legitimate treatment modality (Barber, 1984**,** Bright & Grocke, 2000; Erdonmez, Bright & Allison, 1993). Later applications have addressed an unlimited range of clinical populations, including special education, hospice, palliative care, elderly care, and hospitalized children (Lem, 1993).

Definition

Music therapy may be defined as "the planned and creative use of music to attain and maintain health and well-being." (AMTA, n.d.). Defining music therapy is by no means an easy task, as shown by Bruscia's entire book of definitions (Bruscia, 1998). Music therapy may address any or all of physical, psychological, emotional, cognitive and social needs of the patient/client, by using music within a therapeutic relationship (AMTA, n.d.).

Activities

Activities used in music therapy may include, but are not limited to, singing, discussion, playing of instruments, movement, relaxation techniques, song-writing, and other creative activities, and may include improvisational techniques where appropriate (Short & Cameron, 1999, p.18). Practising music therapists are highly trained musicians, using improvisation, transposition, and instantaneous creation of accompaniments in their everyday work. All music therapists are proficient on a portable musical instrument, for purposes of approaching patients in an appropriate location in their clinical setting, for example, if they are in bed or chair-bound.

Effects and responses

Music used as a therapeutic medium has the potential to access different and additional thoughts, feelings and bodily reactions compared to pure conversation or other activities. Research continues as to the reason for this. People have often pointed to hemispheric lateralization as an important aspect in the perception and therapeutic application of music, a notable example being the way that stroke patients can sometimes sing when they have lost the power of speech (Baker, 2000; Cohen, 1994). Literature suggests that the way that music is processed in the brain is very complex and

forms an important focus of brain research (Azar, 1997; Kosslyn & Koenig, 1992; Pascual-Leone, 2001; Sergent, 1996; Toga & Mazziotta, 2001).

Music has commonly been understood as having "sedative" and "stimulative" characteristics (Staum & Brotons, 2000). Sedative music usually has a slow rate of change, a clear melody, predictable rhythm in the bass, and is often slow in tempo. It may involve flutes or a soothing female voice, for example. It is often softer in dynamics (volume). In contrast, stimulating music is usually fast in tempo and with a stronger sense of rhythm, it does not necessarily have a clear melody, and is often louder or with strong and sudden changes in dynamics. It may have a variety of instrumentation, often featuring percussion or instruments with a strong “attack” if analyzed acoustically.

Such simple definitions as “sedative” and “stimulating” frequently fail in the face of complex and temporally changing music, and it is clear that there is still much to learn when considering the manner of classifying music (Taylor, 1997). Clinical measurement of physiological effects of a certain selection of music on, for example, heart rate, galvanic skin response, and endorphins, are interesting, but it is still a challenge to reliably interface these with personal choice and socio-cultural factors to produce reliable stress management (Hanser, 1988). There is not a "universal panacea" of particular music, we can't say "take three concertos and call me in the morning", it is just not that prescriptive! Burns, Labbe, Arke, Capeless, Cooksey, Steadman & Gonzales (2002) highlight the lack of current research into the effects of different types of music on stress, and also point to the need to allow for individual choice when considering music for relaxation (Burns et al., 2002).

Music may work to promote therapeutic change in many ways. The understanding of how this occurs is based particularly on clinical and theoretical orientation and the clinical population being addressed. For example, therapeutic change may be evidenced in the playing of music itself, as in many of the improvisational approaches (Alvin, 1975; Nissenson, 1986; Nordoff & Robbins, 1977). It may be evidenced in the client’s approaches to the instrument or activity, and their choices within the therapeutic context (Short, 1992c). Relationship changes resulting from music therapy may be evidenced with regard to relating to the therapist, others in the group, and applications to daily life

and the broader community, with the music playing a role in enhancing such social interactions (Bright, 1997). It should be noted that the amount and style of verbal interventions in music therapy varies considerably, however some verbal processing, at a short or longer length, is generally necessary in order to evidence and consolidate changes occurring, such as new insights or awarenesses of the client about themselves.

Unlike the social stigma often attached to psychiatric treatment, music is generally a socially acceptable modality of therapy, often promoting a differing range of clinically interesting responses from the person. Because of this, it may be considered as another system deriving information helpful for treatment of clients with their potential range of psychological, emotional, physical and social problems.

1.3-1 Music and imagery in the therapeutic setting

Music has been used in conjunction with (mental) imagery in the therapeutic context for a range of clinical purposes. It has been applied by not only qualified music therapists but also by other practitioners (for example, Bolwerk, 1990; Guzzetta, 1994, 1989; Davis-Rollans & Cunningham, 1987; White, 1992; Zimmerman, Pierson, & Marker, 1988). The sedative and imaginal effects of music combined with specific relaxation and imagery techniques together promote imagery useful to the therapeutic context. Music used in this way increases the depth and involvement in imagery production by the person. One specific music and imagery technique is the Bonny Method of Guided Imagery and Music (GIM), and this is the clinical technique used for the current research project.

Bonny Method of GIM

The Bonny Method of Guided Imagery and Music is a specialized music therapy method that has been systematically and specifically developed by Helen Bonny in the United States since the 1970s (Bonny, 1978b, 1994; Bonny & Savary, 1990; Goldberg, 1995). It seeks to enhance spontaneous inner exploration and development of the person, combining imagery and selected music to promote psychodynamic change. The patient/client reports their imaginal experience as it actually occurs, like a waking dream, and the therapist responds with open-ended comments designed to promote active working with the image as it occurs, in conjunction with the musical stimulus. Thus, there is interaction between the client, the music, and the therapist. For example,

if the client reports that they imagine a tree, the therapist may respond with, “what do you notice about that tree”, or, “would you like to go closer to the tree”. In the Bonny method, the focus is on the client’s unfolding and spontaneous imagery process, which occurs in conjunction with carefully selected classical music. Pre- and post-music therapeutic discussions maximize the clinical impact of this method. This promotes appropriate therapeutic tailoring to the clinical situation, and the participant’s integration of the material evoked. Further details of the clinical method will be discussed later (Section 1.11-1).

Personal experience and documented clinical cases suggest that the Bonny Method of GIM is an exciting area of music therapy which has a great potential application in the health care field. To date, the Bonny Method has been under-researched in the formal sense (McKinney, 2002; Toomey, 1996-7), a situation which is being remediated somewhat by the current study. Clinical application of GIM also has the potential to derive further client material of relevance to other health care disciplines.

1.4 Relationship to health care disciplines

Music therapy does not stand alone as a new discipline in the clinical health care field. A range of medical and paramedical fields have also extended or developed at a similar time as the development of music therapy. Occupational therapy and psychology, social work, pastoral care, and nursing (with an expanded view of its role in health care) may all connect with the practice of music therapy in one way on another. Music therapy is also closely related to the other Creative Arts therapies such as art therapy, dance therapy, drama therapy, and so on. In some clinical areas, creative arts therapies are rapidly becoming a treatment of choice due to their evocative, non-verbal and emotionally relevant techniques (Van der Kolk, 2000).

Clinical teamwork is recognized as being essential in any health care situation. It involves a range of health care professionals, in order to maximize benefits to the client/patient. Practitioners from an array of disciplines all share an experienced approach to deal with the day-to-day recovery, rehabilitation and development of the person, working cooperatively, although using different skills. Their shared experience and expertise provides relevant health care decision-making with regard to the patient/client.

1.4-1 Clinical health care

The nature of clinical practice and the role of the clinician in the decision making process will now be further explored, which is relevant to the later analysis process in the current research study.

> *An elderly person enters an aged care psychiatric unit of a large suburban hospital, refusing to eat, eyes downcast, mostly unresponsive to verbal approaches, disoriented, lethargic and at times crying or showing aggressive behaviour. Her accent and age suggests that she may have been in Eastern Europe during wartime, and she clutches at a picture of herself and a man, presumably her spouse.*
>
> *The clinical team proceeds to unravel the range of presenting clinical material. Routine tests are taken to rule out acute medical conditions such as pneumonia, social workers investigate the previous living situation and talk with the family. Psychologists test for cognitive deficits, interpreters may be called to help with language and communication, nurses provide day-to-day care and nurturing encouragement, dentures are checked, and family is contacted for further information. As part of the team, the music therapist follows up with culturally appropriate music and notes responses to this, as well as promoting appropriate and social behavior with other residents. Following and during all of this activity, the clinical team meets, discusses, reviews, and tries new strategies where necessary, until finally a clear picture of the problem emerges and appropriate treatment is applied, in order to enhance the health and well-being of the patient.*

Clinical health care is generally understood to be the hands-on, practical aspects of health care delivery and practice. The word "clinical" means "direct, bedside medical care" (Anderson, Anderson, & Glanze, 1994, p.346), and a clinical diagnosis is based on knowledge gathered from medical history and physical examination rather than laboratory tests or x-ray films (Anderson, Anderson, & Glanze, 1994). It can be more generally thought of as "anything associated with the practical study or observation of sick persons" (Thomson, 1979, p.204).

Extending the definition of clinical care beyond physical health care and medical practice, we find the term employed by psychologists. In this field, clinical practice is clearly separated from the laboratory situation. In some ways this reflects the level of control exercised by the practitioner – the laboratory worker has total control of his environment and experiment, based on clearly defined theoretical principles and an agreed research area and research strategy. In contrast, the clinical practitioner, from whichever discipline, often has little control over the focus of his/her work, since they

must take and find solutions for whichever client/patient appears for treatment. Although they use known theory, research and principles of practice, clinicians always need to find individualized solutions for the client/patient in question, usually characterized by complexity, in contrast to the streamlined simplification often found in the laboratory. Thus, a clinician is a health care practitioner who may be considered to have "direct contact with and responsibility for patients, as distinct from one concerned with laboratory or theoretical work" (Simpson & Weiner, 1989, p.328). In the nursing field, the clinical practitioner may be variously described as a "nurse practitioner", "clinical nurse specialist", "nurse consultant" or "nurse clinician" (Woods, 1997, p.823).

A clinician from any recognized health care discipline may share a range of characteristics with other clinicians, including engaging in practical reasoning, an openness to the current circumstance, a grasp of particular similarities and differences based on experience, watchful reading of the patient, awareness of potential problems and issues, a focus on informed action, and an attunement to the given situation (Benner, Tanner, & Chesla, 1997). This description of a clinician easily and equally applies to the field of music therapy, therefore a subsequent discussion of the role and functions of the clinician is clearly relevant to the qualified music therapy practitioner, and hence to the current research project.

1.4-2 Clinician as decision-maker

In everyday health care practice, the clinician frequently must make speedy and decisive judgements based on evaluating a range of evidence, in order to provide for the most appropriate care and treatment for the patient/client in a particular situation. Clinicians often do not have the luxury of time for reflection and philosophical thought: they must react to life-and-death situations, from severe bleeding and immanent collapse to attempted suicide. Gaining a quick (but accurate) picture and understanding of the patient and their health care situation is essential (Benner, Hooper-Kyriakidis, & Stannard, 1999). The ways in which clinicians make decisions may vary according to levels of experience and practice, depending on whether they are novice, advanced beginner, competent, proficient, or expert, as defined by the Dreyfus Model of Skill Acquisition (Dreyfus & Dreyfus, 1986). It is thought that clinical practitioners are largely functioning at proficient or expert levels, thereby decision-making goes beyond

analysis to synthesis and intuition, with increasing ability to zero-in on a problem and handle the unexpected. As Benner notes, "Clinical judgment requires moral agency (the ability to affect and influence situations), relationship, perceptual acuity, skilled know-how, and a narrative reasoning about particular patient transitions" (Benner, 2000, p.103).

In summary, a clinical practitioner is one who has hands-on practice with people, makes use of substantial experience and has the knack of putting it all together to make sense of a new situation. The type of evidence or information relevant to the clinician, and the meanings that are subsequently interpreted from such evidence, will vary according to the health care discipline, and based on the nature of their therapeutic media. For example, loud yelling may suggest pain to the doctor, or antisocial behaviour to the social worker, or uncontrolled vocalization to the speech pathologist, but in the music therapy context it may be indicative of an attempt at singing, with positive, engaged and expressive participation in the therapeutic process.

1.5 Clinical evidence

I will now turn to look more closely at the broad areas of clinical evidence available in music therapy, particularly in relation to the Bonny Method of Guided Imagery and Music, as relevant to the current study. The first and most obvious place to look is at the responses of the patient to the musical millieu.

1.5-1 Music

In music therapy, patients can show a wide range of responses to the music itself, of relevance to the clinical situation. This may include toe-tapping, vocalizing, and emotionally charged musical responses, for example. When patients express their views about the music in words, they may be conveying additional information about their own feelings as they talk about the music. Certain characteristics such as the complexity of music, especially Western orchestral and classical music, promote projection, that is, putting one's thoughts or feelings onto the music, and this is especially relevant to the current project. Onomatopeia, where music echoes and depicts sounds in the real world, also creates useful therapeutic material and is an essential characteristic of a great deal of music, where the music itself tends to echo gestures, movement and some of the syntactic and semantic patterns of language itself.

1.5-2 Imagery

The patient's imaginal responses (in the musical context) form another interesting area of clinical data, with important cross-disciplinary implications. In recent years, there has been an explosion of popular interest in a range of non-traditional phenomena, particularly mental imagery. Imagery features strongly in the popular self-help, so-called New Age culture, and has influenced clinical practice in many fields of endeavour. Its widespread use and promotion as having significant clinical effects occurs as a substantial countertheme to more formal academic and laboratory research. Not only this, but the use of imagery to enhance performance in areas of sports training and physical rehabilitation is widely accepted (Decety, 1993; Hecker & Kaczor, 1988; Jowdy & Harris, 1990; Van Leeuwen & Inglis, 1998; Vealey & Walter, 1993).

Imagery, more commonly known as mental imagery, has increasingly been used to understand health and disease processes during the twentieth century, and, in particular, to relate to emotional issues. Psychodynamic therapy has utilized this inner image-based communication to access underlying meanings that may not yet be part of the person's conscious awareness. In fact, Freud (1965) was the first person to show that there may be underlying, unconscious meanings in a client's narrative, and Jung (1934/54/1968a, 1968b) further extended links between imagery and meaning on many levels. For example, by carefully interpreting the imaginal signs of a client's dream, Jung found that he could correctly diagnose a problem involving blocked cerebrospinal fluid (Jung, 1968b). More recently, writers such as Achterberg (1985) and Simonton, Matthews-Simonton & Creighton (1980) have made further connections between the disease process and the imagery process. It becomes increasingly evident that imagery has the capacity to communicate additional meanings as relevant to health and recovery.

At this point, it should also be noted that there are certain contraindications for the use of mental imagery in health care. For example, imagery techniques are particularly not recommended for people with psychosis or other mitigating factors affecting the imagery process (Stephens, 1993a, 1993b). The current research study focuses on imagery processes occurring in so-called normal people, in line with standard practice in the Bonny Method of GIM. This leads towards the important question of clinical

interpretation, of how information is gained and understood from the clinical behaviour and responses that the clinician witnesses.

1.5-3 Influences on clinical interpretation

Music therapy practitioners form a unique clinical community, incorporating a wide range of therapeutic orientations. In many cases, music therapy has adopted normative practices and theory of allied disciplines, applying this knowledge to selected clinical settings with a view to optimizing the therapeutic effects of music for patients/clients.

Sensing the need for a definitive typology of music therapy, Wheeler examined the way that music therapy is applied clinically, in order to understand the range of options available for treating a particular problem (Wheeler, 1987). Her model views music therapy applications as being related to three major sets of goals: 1) activities/supportive therapy, 2) insight-oriented with re-educative goals, or 3) insight-oriented with reconstructive goals. Within this schema, the Bonny Method of GIM is noted to have a role to play as an insight-oriented reconstructive therapy (Wheeler, 1987). The current research project focuses on using the reconstructive therapy of GIM to promote integrated inner change in the person, from a teleological (forward change and development) orientation. In fact, GIM is often practised from a Jungian perspective (Short, 1996-7; Tasney,1993; Ventre, 1994; Ward, 2002). The premises of Jungian therapy will now be explored in greater depth, since they are pertinent to the current research study.

1.6 Jungian therapy

Jung's view of therapy saw the person as capable of ongoing change and development as they proceeded through the experience of life, and indeed considered it to be essential that the person adapt and adjust to their circumstances. In view of this, Jung's theory is considered to be optimistic and constructive (Frey-Rohn, 1974/1990), and contains a teleological viewpoint of the person and their development. Thus, the person responds to a range of inner and outer experiences as they grow and develop. Jung finds relevant clinical meaning in imaginative processes and patterns, including the use of dreams and imagination. Therefore, his approach is well suited to the creative arts and imagery approaches.

1.6-1 Jung and Music

Although Jung rarely talked about music, Jung's appreciation of the potential of music as a therapeutic tool is evident in interviews with both a British and an American music therapist (Hitchcock, 1987; Ward, 2002). In addition, Jung's emerging understandings of auditory imagery and connections between music and imagination are also demonstrated by an anecdote from one of his last works (Jung, 1961/1965):

> One evening - I can still remember it precisely - I was sitting by the fireplace and had put a big kettle on the fire to make hot water for washing up. The water began to boil and the kettle to sing. It sounded like many voices, or stringed instruments, or even like a whole orchestra. It was just like polyphonic music, which in reality I cannot abide, though in this case it seemed to me peculiarly interesting. It was as though there were one orchestra inside the Tower and another one outside. Now one dominated, now the other, as though they were responding to each other.
>
> I sat and listened, fascinated. For more than an hour I listened to the concert, to this natural melody. It was soft music, containing, as well, all the discords of nature. And that was right, for nature is not only harmonious; she is also dreadfully contradictory and chaotic. The music was that way too: an outpouring of sounds, having the quality of water and of wind - so strange that it is simply impossible to describe it (Jung, 1961/1965, p.228-9).

Clearly, the auditory sounds and associated musical imagery had a deep effect on Jung, and held implications for the use of music and imagery in the therapeutic situation. There is limited literature connecting music therapy and Jungian approaches (Clark, 1991, 1995; Priestley, 1987; Short, 1996-7; Tasney, 1993; Ventre, 1994; Ward, 2002), and it would seem that this is an area ripe for further development. The connection between music therapy and Jungian theory is enlightened by a further study of Jung's therapeutic method.

1.6-2 Jungian theory

Jung's concept of mental health (or illness) depended on the integration of conscious and unconscious processes during the course of individual development. Therapeutic techniques were developed in order to encourage readjustment when this integrative relationship showed signs of going wrong. Conscious-unconscious interaction was considered to be the basis of all creative activity (artistic, literary or scientific). It was also the foundation for the development of the personality, during which an individual becomes as complete a human being as it is possible for him or her to be. Jung called this "individuation" (Stevens, 1990). Jung saw a sense of meaninglessness as being

responsible for over 30 percent of his patients seeking therapy, and hence a great deal of his therapeutic effort focused on this point (Jung, 1966, cited in Corsini & Wedding, 1989, p.390).

A full explanation of Jung's theory of therapy is beyond the scope of this current thesis; a brief definition of terms is available in Appendix 1.1. Jungian theory is relevant and necessary to this current research project since he further advanced the understanding of the relevance of patient's material to the clinical situation, developing a system for combining not only the person's history and current experience, but also the way they react to and use cultural material in the process of their own growth and development.

Jung's notable contribution to this personal/cultural interface was in examining and understanding the products of culture and how these relate to the person. Jung's understanding of culture derived therapeutic understandings from the embedded knowledge of myth and fairytale (May, 1991), which could be considered "the language of culture". This was related to a universal pool of symbols evident in or accessible to all cultures worldwide, which Jung called the "collective unconscious". These personal and cultural connections were conveyed via archetypes and archetypal patterns.

1.6-3 Archetypes

The concept of archetypes is fundamental to Jung's understanding of the person, and applies to all people in some way. Archetypes may be broadly understood as the person's patterns of interpreting and responding to the world. More formally defined, archetypes are

> patterns of behavior, modes of functioning of the human psyche similar to the instincts, that follow a distinct goal, the meaning of which becomes more and more clear as they unfold in their actual expressions or images (McCurdy, 1991, p.2).

> Jung's theory of the archetypes of the collective unconscious is particularly pertinent to dream analysis... From the evolutionary perspective, developmental processes are structured by principles common to all members of the human species, which are termed the "Archetypes" (Shuttleworth-Jordan, Saayman & Faber, 1988, p.477).

Archetypes may be evident in many of the person's productions, including not only dreams, but also active imagination, artistic creations and anything that accesses the

imaginal realm. The pattern/structure of archetypes may appear similarly to myth and fairytale (Short, 1996-7).

> Throughout the inhabited world, in all times and under every circumstance, the myths of man have flourished; and they have been the living inspiration of whatever else may have appeared out of the activities of the human body and mind (Campbell, 1968, p.3).

> It has always been the prime function of mythology and rite to supply the symbols that carry the human spirit forward, in counteraction to those other constant human fantasies that tend to tie it back (Campbell, 1968, p.11).

Archetype and myth serve to reinforce and underpin important experiences in the life of the individual. It is not possible to create a definitive list of archetypes and myths, due to their pervasive nature, however they may be described in this way:

> This collective substratum is independent of historical moment, culture, sex, or race, although there is a synergetic interaction between these factors and genetic potential. Thus, human ontogeny implies "critical, nodal points of transition in biopsychosocial situations common to humanity such as birth, relating to a father, mother, child, birth of a sibling, separating from parents, adolescence and middle-age crises, preparation for death, and so on (Kaplan, Saayman & Faber, 1981, p.228, cited in Shuttleworth-Jordan, Saayman & Faber, 1988, p.477).

In the clinical context, the person has the capacity to use the symbols of society and culture in order to express something more about their ongoing experience in the form of archetypes, via myths and fairy tales. In particular, the imagery produced by the therapeutic application of Guided Imagery and Music in the current study may be interpreted in terms of imagery patterns relating to myth, archetype or imagery schemas, where noteworthy characteristics themselves become signs or summaries of the myth itself and indicate a certain meaning behind it, as relevant to the clinical situation.

1.6-4 Archetype of the Hero

A particular archetype which is very pervasive worldwide is that of the "Hero". This appears mythologically in many forms, and occurs in many cultural stories and productions. Following on from the work on Jung, some writers have particularly addressed the "hero" archetype (Campbell, 1968; Johnson, 1974; Pearson, 1989).

This archetype is fundamentally about meeting a problem and changing as a result of it. The hero archetype may follow the stages of responding to the call (to change, of new

experiences), of being challenged to change (letting go of the old), of seeing self/life differently, and of taking these new learnings into the world, to be applied to one's life and to other people (Campbell, 1968; Johnson, 1974).

The potentially gendered nature of this archetype does not appear to detract from its usefulness - the "hero" archetype is thought to hold true for women as well as men, even if in slightly different manifestations (Noble,1990; Pearson, 1989). The fundamental message of the hero archetype is about facing (overwhelming) difficulty and transforming oneself in order to cope and develop new understandings and insights, which is equally true regardless of gender. Indeed, the hero archetype is about exploring and integrating increased aspects of oneself.

> Every heroic characteristic finds its analogy among the virtues necessary to vanquish chaos and overcome the temptations offered by the forces of darkness…in the life destined for the hero, the historical and the symbolic are one and the same thing. The first object of the hero is to conquer himself (Cirlot, 1971, p.148).

> The passage of the mythological hero...fundamentally…is inward – into depths where obscure resistances are overcome, and long lost, forgotten powers are revivified, to be made available for the transfiguration of the world (Campbell, 1968, p.29).

The hero archetype has great relevance to the health care endeavour. It may well be evoked in conjunction with any serious challenge to the individual and their lifestyle, in the process of being challenged to undergo a process of personal transformation (Halstead, 2000). Both physical and emotional problems may trigger the beginning of a hero's journey, as suggested by case material (Halstead, 2000; Noble, 1990). The hero archetype is relevant to the current study because of the nature of cardiac disease and its associated treatment via surgery as a severe health challenge to the individual, requiring both emotional and physical adaptation.

In his work, Jung was part of the movement which placed increased credence on the reported experiences of the patient, thereby empowering them, and changing the focus of therapy towards insight and the developing of skills such that the person had their own capacity to cope in their everyday life.

1.7 Incorporating patients' experiences into health care

It has not always been the case that the reported experiences of patients have been a primary focus of attention in the therapeutic arena. In fact, they have often been neglected or discredited. Despite the earlier integrated views of the Greeks, the theoretical basis of established medical, or biomedical, practice, has been strongly influenced in recent centuries by the work of Descartes, who proposed a philosophical viewpoint of separation of the mind and body (Cottingham, 1987). His work has influenced the development of modern technology and many complicated procedures with their associated life-saving benefits. However, the resultant mechanistic view of the body has had important societal influences. Belief systems about health and illness are now being challenged by a more holistic view of the interaction of mind and body is becoming increasingly popular.

As a response to this, support for alternative medicine has evolved out of a perceived need for a change to current medical practice through exploring new ways of conceptualizing health and illness and for incorporating recognition of the patient's experiences into the health care endeavour. As an example of their popularity, a study published in the *New England Journal of Medicine* indicates that one in three Americans uses therapies considered "unconventional" (Eisenberg, Kessler, Foster, Nortack, Calkins & Delbanco, 1993, cited in Keegan, 2000). Alternative medicine has been described as "an unrelated group of non-orthodox therapeutic practices, often with explanatory systems that do not follow conventional biomedical explanations" (U.S. National Library of Medicine, Medical Subject Headings). An alternative therapy is therefore one that is used instead of conventional or mainstream therapy (Keegan, 2000). Alternative medicine often seeks to connect with traditional and ancient non-medical approaches, based on distinctive belief systems. In fact, the main reason people become involved with alternative medicine is their health-related values and beliefs (Siahpush, 1999). Such alternative therapies may make use of media such as the creative arts and techniques of multi-sensory input, with a view to engaging the emotions.

Amongst some thinkers in the field of alternative medicine, it has become popular to consider that Western biomedical care treats ***only*** the physical side of illness, trauma

and the like. Such a clear-cut statement runs contrary to the author's almost 20 years of observation, interaction and experience as a team music therapist in clinical care. Many people would agree that good medical practice takes a great many factors about the person into account, and is as much an art as a science. This holistic nature of both nursing and medical practice has been noted by many authors (Owen & Holmes, 1993). As more moderate areas of alternative medicine have been researched and absorbed into the health care field in specific instances, so its name has begun to change to "complementary" medicine, reflecting a new partnership in health care. As Keegan (2000) points out,

> A complementary therapy may be an alternative therapy, but becomes complementary when used in conjunction with conventional therapy. It helps to potentiate the effect of the conventional therapy (Keegan, 2000, p.94).

And as Rankin-Box points out, "complementary therapies challenge western perceptions of health, but the premises on which many are based are not irrational, simply different" (Rankin-Box & Campbell, 2000). Furthermore, "the intent of complementary medicine is to support and encourage a state of physical, mental and social well-being, as well as an absence of disease" (Freeman & Lawlis, 2001, p.4). Summer (1997) cautions against incautious acceptance of so-called holistic therapy, stating that seemingly holistic treatments may in fact have the same prescriptive treatment regime as an antibiotic and pay no attention to individual differences, or social or emotional factors (Summer, 1997).

The holistic model is not foreign to the field of music therapy. The processes of music therapy were addressed by Sears (1968), writing in the first, and for many years the only, established text in music therapy. He classified and offered constructs fundamentally addressing the question of "What does music therapy offer the individual?" His answer included attention to physical, emotional, cognitive and social needs in the development of the person (Sears, 1968). Therefore, this may be considered as laying the foundations for a holistic practice of professional music therapy. This trend has continued with regard to clinical practice and theoretical teaching (see Davis, Gfeller & Thaut, 1998), however, it has frequently not been evident in regard to established music therapy research. Clinical case material has often highlighted a range of aspects of the person (for example, physical, psychological,

social), however research in the past has frequently focused on narrow behavioral parameters (Bruscia, 1991; Wheeler, 1995). This trend is now changing, as music therapy research once again seeks to investigate the holistic nature of music therapy practice.

The Bonny Method of GIM has been recognized as a complementary therapy capable of having significant effects on the body (Short, 1991), particularly in the way that working with emotions, music and imagery can impact on physiological measures (Freeman & Lawlis, 2001). Even more importantly, the application of GIM foregrounds the experiences of the client/patient, and encourages them to spontaneously and openly express their feelings, thoughts, perceptions and sensations in an ongoing and in-depth manner. In doing so, the client/patient becomes empowered to tell their (own) story to the clinician, and in turn to themselves.

1.8 Telling the story

The medical field as a whole has recently paid increased attention to the viewpoint of the patient, and alongside this has developed the field of qualitative research (Miller & Crabtree, 1998). Qualitative research is largely based on self-report and other (generally) non-numerical data. This has led towards an expanded view of clinical interpretation, to encompass the views and experiences of the patient, not just those of the clinician. As already mentioned, patients report their experiences in the form of stories, and the nature of this narrative data will now be explored further.

1.8-1 Narrative

A narrative is "any extended segment of talk in which an interviewee is telling a story (Lucas, 1997, p.116). Narrative may also be defined as "an organizational scheme expressed by language in story form" (Eberhart & Pieper, 1994, p.43), which represents "real or fictitious events and situations in a time sequence" (Prince, 1982, p.1). Narratives fulfil a communicative and functional purpose. "Making stories... is one way we bring the past into the present, communicate our own experiences to others, make sense of events" (Lucas, 1997, p.116).

Narratives help create a composite linking actions and events, and also help make sense of changing situations occurring over a period of time. The temporal, or time-based,

nature of narrative is sensitive to ongoing change and development in the person, and parallels the forward moving nature of human experience (Eberhart & Pieper, 1994).

In the clinical situation, narrative is most usually the raw data of clinical evidence. Narrative conveys information about the patient's viewpoint/perception as they experience and re-experience themselves. The importance of the person's viewpoint has been shown in the development of the entire school of person-centered therapy (Raskin & Rogers, 1989; Rogers, 1961, 1980), including those focusing on the way that the patient draws meaning from his circumstances (Frankl, 1963; Viney & Bousfield, 1991).

> Narrative case reports can help physicians look past existing interpretations and examine the contexts in which patients' actions make sense. They can help bring into consciousness the knowledge that experienced clinicians use daily in their interactions with patients (Ventres, 1994, p.146).

Ventres points out the need for physicians "to listen for and be responsive to multiple patterns of communication" (Ventres, 1994, p.145). In regard to the current study, the importance of the person's emotional responses to what is happening or has happened to them should not be underestimated, and demands the use of a method, such as narrative, which is conducive to eliciting material from the patient's point of view.

The trend towards focusing on the patient's viewpoint has also spread to the music therapy field. Early research by Amir involved conducting in-depth interviews with music therapy clients (Amir, 1992). A more recently published and innovative edited book looks at music therapy from the patient's perspective (Hibben, 1999), where a wide range of circumstances and applications are explored in different ways in order to access the client's views. The manner in which music is used to access the client's material in music therapy, and to clinically enhance the health care and recovery experience of the patient/client, is pertinent to the current research project.

1.9 Clinical music therapy in general health care

Music therapists may use a range of musical or music-related media in everyday professional practice, depending on the needs and backgrounds of the clients concerned, as already noted. The range of techniques of music therapy have been very effectively

applied in many settings and with many populations, including the general hospital (Davis, Gfeller & Thaut, 1998; Erdonmez, 1991).

In music therapy, the application of even a simple activity such as singing, for instance, may involve a very complex clinical decision-tree related to the use of one song as opposed to another, and musical factors in the therapeutic context may strongly influence the nature of its rendition (Short, 1992c). Music therapists are trained to be aware of and take account of individual taste and preference in music, reflecting the cultural mix of society and individual upbringing. Unsuitable or unacceptable music is not imposed on the client. Major methods and processes of music therapy have been developed, particularly relating to the context in which the music therapy is practiced. These include, for example, the specialist areas of Nordoff-Robbins improvisational music therapy (Nordoff & Robbins, 1977), analytical music therapy (Priestley, 1995), and Guided Imagery and Music (Bonny, 1997; Goldberg, 1995). Despite incomplete understandings of the mechanisms involved, music therapy has nevertheless been observed, verified and accepted as an important clinical discipline (Pratt & Grocke, 1999). There is clearly a need for further research to confirm observed positive responses in the clinical setting and extend such understandings.

Historically, music therapy practice has focused on long-term institutionally-based disabled populations, with limited attention to community based short-term treatments for the otherwise-healthy person who may be addressing situational life crises or health incidents. Across health care, the current trend is now towards reducing inpatient stays to as short a time as possible. This is also true of general hospital admissions, where stays have become as brief as possible and recovery from illness and surgery takes place largely in the community. As broader societal attitudes to health and illness increasingly change, so the trend is away from institution-based music therapy. There is increasing literature regarding the use of music therapy in general hospital and recovery (Dileo, 1999; Kennelly, 1999; Nolan, 1992; Spintge, 1999). Practitioners in other clinical fields, such as nursing and psychology, have also noted or researched the value of music in this setting. They have often paid disappointingly little attention to understanding and describing the music used (MacDonald, Ashley, Davies, Serpell, Murray, Rogers, & Millar, 1999), its individual relationship to the person, and further implications from the musical as well as clinical point of view. Toomey's review of

literature in the specific area of Guided Imagery and Music highlights the need for extensive research in many applications (Toomey, 1996-7). Cardiac care is an area not yet specifically addressed by GIM research.

In the global view, the application of music therapy to the treatment of medical conditions has in the past focused particularly in the areas of pain management (White, 2000), reduction of stress and anxiety, and emotional support and adjustment in acute and rehabilitative phases (Davis, Gfeller & Thaut, 1998; White, 2000), however it is now extending further into additional areas (Dileo, 1999; Pratt & Grocke, 1999).

Looking towards cardiac care, selected clinicians from a range of disciplines other than professional music therapy have experimented with the use of some form of music in coronary care and rehabilitation (Bolwerk, 1990; Davis-Rollans & Cunningham, 1987; Guzzetta, 1994, 1989; White, 1992; Zimmerman, Pierson & Marker, 1988), finding its use effective in mediating some physical parameters. Aldridge describes " an absence of valid clinical research material from which substantive conclusions can be drawn" in the medically oriented application of music therapy (Aldridge, 1996, p.83), and clearly there is an increased need for systematic research into the use of professional music therapy in cardiac care in the clinical setting. This is addressed by the current project. The areas of anxiety and stress, pain management, and rehabilitation and adjustment will now be further explored.

1.9-1 Anxiety and stress

The nature of stress and anxiety

Stress is literally any emotional, physical, social, economic, or other factor that requires a response or change. Some would suggest that an optimal level of stress is necessary for growth and development, but that either too little or particularly too much stress can undermine health. "Stress-adaption theory" is a concept wherein stress depletes the reserve capacity of individuals, thereby increasing their vulnerability to health problems. (Anderson, Anderson, & Glanze, 1994, p.1491).

Anxiety is a condition which incorporates both subjective (emotionally felt) and objective (physically observable/measurable) characteristics (Anderson, Anderson, &

Glanze, 1994, p. 108). The physical and emotional effects of anxiety are largely based on an activation of the sympathetic division of the autonomic nervous system (commonly described as an urge towards "fight or flight"). Characteristics of anxiety may include tension, feelings of inadequacy, uncertainty and helplessness, worry, fear, cardiovascular excitation, restlessness, insomnia, trembling, increased perspiration, and expressed concern regarding change in life events (Anderson, Anderson, & Glanze, 1994, p.108).

In contrast, the parasympathetic division of the autonomic nervous system counteracts the adrenergic action of the sympathetic nerves, promoting effects such as slowing the heart, releasing secretions and relaxing muscles (Anderson, Anderson, & Glanze, 1994, p.1162). Engagement of the parasympathetic division is related to relaxation, and as such is considered to be like an "antidote" to the activation of the sympathetic system. Therefore, the promotion of relaxation has an important role to play in health care, not only emotionally but also physically, in addressing stress and anxiety.

Clinical applications

In clinical practice, music therapy has been used effectively to reduce anxiety with children hospitalized for surgery (Dun, 1995; Winter, Paskin & Baker, 1994), to change cardiovascular-respiratory parameters with chronic back pain patients (Abel et al., 1996), with adults recovering from physical and sexual abuse (Slotoroff, 1994; Ventre, 1994), and with Vietnam veterans recovering from post-traumatic stress disorders (Blake,1994a, 1994b). Imagery, breathing and relaxation techniques have been used in conjunction with music chosen by the patient to reduce pre-anaesthetic and pre-surgical stress and anxiety (Cowan, 1991), and to reduce stress and anxiety in the surgical holding area (Winter, Paskin & Baker, 1994).

Music which promotes relaxation may have consistent and discernible rhythm, a fairly repetitive melody, moderate harmonic rhythm, a balanced texture (Pratt, 1999), and have a relatively lower volume (Staum & Brotons, 2000). Innate musical characteristics and personal associations also contributes to the effectiveness of music used for relaxation.

> The precise nature of how music communicates meaning and emotion is a topical and sometimes controversial area…The precise mechanisms involved,

> and whether these are intra-musical (i.e., structural) and/or extra-musical (i.e., learned and associational), remains to be explored in more detail (MacDonald, Ashley, Davies, Serpell, Murray, Rogers, & Millar, 1999, p.16).

The individual variability which is a factor in the effectiveness of music used for relaxation (Staum & Brotons, 2000) contribute to the assertion that the most effective results in promoting relaxation arise from studies which are both individualized and involve elements of personal choice (Hanser, 1988; MacDonald et al., 1999).

Links to cardiac care

Music therapy has been used to address individual needs related to anxiety, terminal illness and rehabilitation in paediatric cardiac care, however, major differences between the aetiologies of paediatric and adult problems are noted (Dun, 1995). The use of music therapy for stress management in cardiac rehabilitation has been addressed by Mandel (1996). Bonny has also reported lessened anxiety and decreased heart rate with regard to selected music listening in a preliminary study in the Intensive Coronary Care Unit (Bonny, 1983).

1.9-2 Pain management

There has been a great deal of interest in the use of music therapy as a cognitive pain control strategy. It is relevant to the current study as an issue that has arisen as a result of researching cardiac patients recovering from bypass surgery.

The nature of pain

Pain is a subjective experience of the presence of severe discomfort. It may relate to noxious stimulation of the sensory nerve endings, which could be due to biologic, chemical, physical or psychologic agents (Anderson, Anderson, & Glanze, 1994, p.44). Responses to pain vary widely among individuals, which is one of the inherent difficulties with regard to management. For patients who have undergone cardiac surgery, pain may be initially focused around wound healing. In addition to this, residual pain and discomfort may occur for a length of time, related to the nerves affected by the sternotomy, structural changes related to opening the thorax, and nerves affected in the removal of the vein used for the bypass (particularly from the leg).

The action of music therapy in alleviating pain may be explained by the Gate Control Theory of Melzack & Wall (1983), which suggests that the experience of pain is mediated by descending influences from the brain, for example, the higher CNS processes of attention, anxiety, anticipation and past experiences (Lanceley, 1995). As already noted, music can address anxiety via the relaxation process, and hence music therapy in pain management has clear links to Gate Control Theory (Good, 1996).

Clinical applications

Music therapy has been applied to a range of pain management situations (Davis, Gfeller & Thaut, 1998; MacDonald et al., 1999; Standley, 1986), and can act in various ways, for example, as a distraction for children undergoing painful debridement of burns (Edwards, 1994, 1998), and as a means to promote changes in cardiovascular-respiratory parameters (Abel, Geier, Pratt, Spintge & Droh, 1996). Magill has noted the diversity of music therapy to offer a range of benefits in addressing, the complexity of pain management (Magill, 2001). Short (1991) noted evidence of reported pain and its relationship to imagery and the health care context for a patient recovering from ovarian cancer, using the Bonny Method of Guided Imagery and Music.

Links to cardiac care

Bonny's preliminary study of the effects of listening to specific music in an Intensive Coronary Care Unit reported greater tolerance of pain and suffering by those using the music treatment. There were also some reports of spontaneous imagery with the music, although this was outside of the main focus of this preliminary research (Bonny, 1983).

1.9-3 Rehabilitation and adjustment

The nature of rehabilitation

Rehabilitation is a broad term which may be applied to many phases of recovery from a range of circumstances of illness, trauma or other factors. It is defined as,

> the process of assisting individuals with disability or chronic illness in recovering to the highest possible level of independence and well-being. The need for rehabilitation arises when a person's previous way of life is changed by illness or injury… Depending on the type of disability, the physical, mental, vocational, social and economic aspects of a person's life may be altered (Harkness & Dincher, 1999, p.405).

The rehabilitation process is targeted to work with both physical and emotional aspects of illness or injury, seeking to restore normal function, prevent complications, and promote adaptation to current circumstances (Harkness & Dincher, 1999). Even after surgery, these circumstances may be substantially altered. "Adaptation is the process of adjusting to life changes that occur with disability… Patients need to make some degree of adaptation, otherwise rehabilitation may be incomplete or unsuccessful." (Harkness & Dincher, 1999, p.405)

Impaired adaptation or adjustment may occur when the individual is unable to modify his or her lifestyle behavior in line with the change to their health status (Anderson, Anderson, & Glanze, 1994, p.41). This may be evident in lack of movement towards independence, lack of future-oriented thinking, extended periods of shock, disbelief and anger regarding health status change. Related factors include a disability requiring lifestyle change, an assault to self-esteem, altered locus of control, or incomplete grieving (Anderson, Anderson, & Glanze, 1994, p.41). Depression is another effect often found in the rehabilitative and adjustment process.

Clinical applications

Music therapy has been applied to the area of rehabilitation, in order to facilitate expression of emotions (Davis, Gfeller & Thaut, 1998), to promote adjustment and to encourage change (Cohen, 1994; Erdonmez, 1991, 1992). Music therapy has been used to assist the coma patient (Baker, 2000; Tamplin, 2000). A role for music therapy in physical rehabilitation is also emphasized by Sandness (1995) and Staum (1992). McKinney investigated the effects of GIM on depression, using a formal research approach to find a link with beta-endorphin levels (McKinney, 1995a). Elizabeth Jacobi has also substantially studied the effects GIM on the management of arthritis, using questionnaires and quantitative measurements (Jacobi, 2002).

Other anecdotal and case reports suggest that spontaneous imagery leading towards physical or emotional healing of a medical condition typically may include ventilation of emotions, insight into often-longstanding relational problems or negative patterns of behaviour, emergence of an archetypal guide figure, symbolic transformation of body part(s), and increased feelings of physical and mental health or rejuvenation (Hale, 1992; Merritt, 1993; Pickett, 1987).

Aspects of loss, related to physical trauma, may also appear spontaneously in imagery during GIM treatment, which can then be addressed according to standard GIM practice (Goldberg, 1988; Pickett, 1996-7). This may also include emotional reactions related to self-concept resulting from physical disability (Moffit, 1991). Recovery from the physical trauma of sexual abuse may require the addressing of images related to fear and the archetypal hero, in turn leading to empowerment and the development of inner strength by the client (Tasney, 1993).

Investigating the range of physical and emotional effects commonly suffered by Vietnam veterans, Blake (1994a, 1994b) looked at the role of GIM in relation to post-traumatic stress. Her study suggested that imagery was effective with regard to relaxation, ventilation of emotions, accessing of traumatic memories, and achievement of insight, with associated increased positive feelings and empowerment by clients. Somatic responses with regard to difficult emotional material are an interesting area requiring further research. Such reported somatic responses may include headaches, body tension, pain, numbing of body parts, sweating and temporary paralysis (Blake, 1994a).

Short explored emotional and physical adjustment to a stressful pregnancy through a series of GIM sessions (Short, 1993a, 1993b), suggesting that the client was responding positively and appropriately to a new view of herself, her body, and her new baby (Short, 1996-7). The spontaneous imagery generated in the GIM session related to both physical and emotional aspects of this health-related condition.

GIM has also been used clinically to explore the emotional and physical problems of long-term physically disabled elderly residents (Short, 1992a), the emotional and physical effects of Post-Traumatic Stress Disorder (PTSD) (Blake, 1994a, 1994b), palliative care (Marr, 1998) and cancer rehabilitation (Short, 1991).

The way that both physical and emotional reactions and adjustments may be evidenced via imagery in the practice of GIM has been considered by Short (1990, 2002a), putting forward a model proposing that any physical problem is likely to promote a range of reactions and responses in the person. Such reactions may be evidenced through the

data produced in the GIM session, that is to say, the reported imagery and accompanying discussion. This model is depicted diagrammatically in Figure 1.1. Individual aspects of the spontaneously generated imagery conglomerate may be considered separately, but are understood to form part of an integrated whole. These individual aspects may occur in the imagery as "markers", in turn linked to the range of responses (psychological, social, and so on) experienced by the person as a reaction to the physical event. Markers may be a clue that delineates and carries further information about the physical and emotional status of the person.

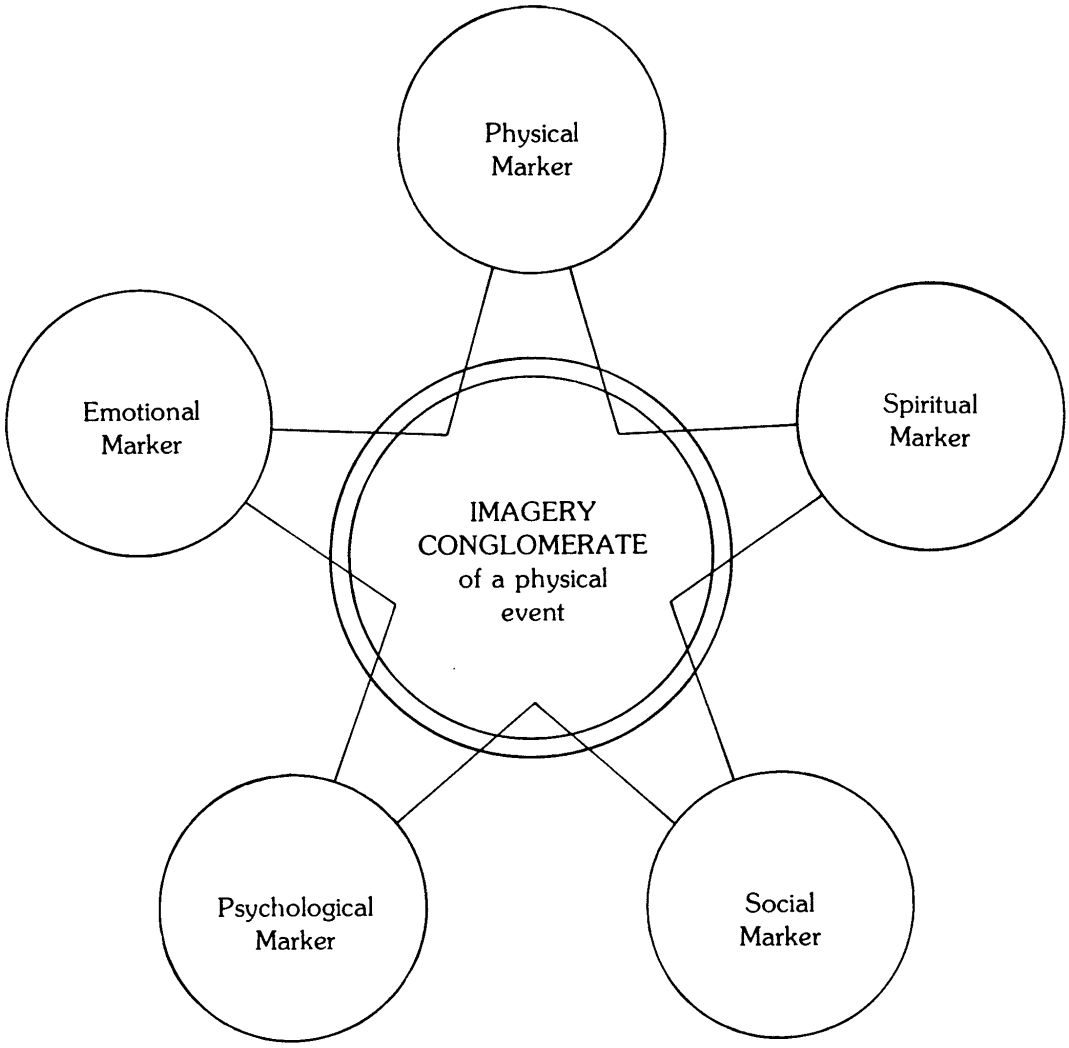


Figure 1-1. Schematic diagram of the imagery conglomerate generated by a physical illness or trauma, and the imagery markers left by this event.

Assuming that such imagery markers occur, it is important to consider how they may convey useful clinical information, capable of contributing to assessment and the

diagnostic endeavour (Short, 1991), and in turn, provide opportunities for contributing to effective clinical practice, as part of the clinical team. Examples suggest how imagery spontaneously produced by clients undergoing GIM sessions can be carefully examined for clinical and diagnostic information (Short, 1991). In deriving such information, significant factors include a) recognizing possible mind-body links via appropriate imagery, whether images of past or present situations, traumatic or rehabilitative processes, b) applying interventions to pinpoint processes in the imagery and screen out unnecessary data, and c) following through with discussion and validation of the imagery processes with the client in the post-music discussion section of the GIM session (Short, 1991). The concept of the broad-based responses to physical problems and recovery having an influence on the spontaneous imagery process is relevant to the current study, which seeks to explore such connections with regard to cardiac rehabilitation.

Having explored the area of general hospital and medical care, discussion of music therapy literature will now be further targeted towards cardiac care.

Links to Cardiac care

Music therapy has been reported to promote rehabilitative gains, as part of a cardiac exercise programme (MacNay, 1995). Programmed listening to selected music in the Intensive Coronary Care Unit suggested that such an intervention using music may reduce depression (Bonny, 1983). Research in related fields supports such findings (Bolwerk, 1990; Davis-Rollans & Cunningham, 1987; Guzzetta, 1994, 1989; White, 1992; Zimmerman, Pierson & Marker, 1988).

Anxiety and stress, pain management and the rehabilitation process are all relevant to the cardiac patient after surgery, however there have been no reports of the use of Guided Imagery and Music with this population. In order to further understand the nature and needs of cardiac patients, and the aetiology and other clinical factors related to cardiac surgery, attention will now focus on these issues.

1.10 Clinical problems of the post-surgical cardiac patient

1.10-1 The nature of heart disease

Heart disease, also known as coronary heart disease (CHD) is a leading cause of death in Westernized societies, including Australia (Harkness & Dincher, 1999; National Heart Foundation of Australia). Coronary artery disease is "an abnormal condition that may affect the arteries of the heart and produce various pathologic effects, especially the reduced flow of oxygen and nutrients to the myocardium" (Anderson, Anderson, & Glanze, 1994, p.397). Cardiovascular disease is now widely accepted to have both physical and emotional aetiology. The broad aetiology of cardiovascular disease may involve many predisposing or risk factors, including reactions to stress (National Heart Foundation of Australia).

A range of treatment options exist for coronary heart disease, depending on its stage, particular manifestation and other complicating factors. One treatment, of relevance to the current research project, is cardiac bypass surgery, the most common heart operation (National Heart Foundation of Australia). It is also known as coronary artery bypass grafting (CABG). Coronary bypass is described as "open heart surgery in which a prosthesis or a section of blood vessel is grafted onto one of the coronary arteries, bypassing a narrowing or blockage in a coronary artery" (Anderson, Anderson, & Glanze, 1994, p.398). Another type of open heart surgery is that of valve replacement, or valvotomy, which involves the repair or replacement of a heart valve, with generally a somewhat longer recovery time than CABG surgery (Anderson, Anderson, & Glanze, 1994, p.1630).

After bypass surgery, patients usually return to physical health very quickly, and are generally discharged from hospital at six days post-surgery (Harkness & Dincher, 1999; National Heart Foundation of Australia). In fact, some hospitals have a benchmark for discharge as early as five days (Clinical Pathway for CABG, 2002). If there are no complications, patients are largely physically healed by six weeks after the operation.

There is little doubt that emotional and psychological factors, as well as physical and genetic factors, may have a strong impact on the health and well-being of people with heart disease (Cornett & Watson, 1984). Optimal treatment, such as revascularization

via coronary artery bypass grafting, involves an interdisciplinary team approach (Cornett & Watson, 1984). This broader-based treatment involves a holistic and multifaceted approach, complementary to the medical treatment. Music therapy is one such treatment.

1.10-2 Stress and anxiety in cardiac care

Health problems, including cardiovascular problems leading to myocardial infarct (heart attack) and other coronary blockages or near-blockages, may be related to stress and anxiety. In addition, the process of diagnosis and treatment of heart disease in itself creates a certain level of stress and anxiety. It seems that this reaction to diagnosis and treatment can lead to a feeling of helplessness in the face of overwhelming odds in regard to the illness itself, the dependency of hospitalization and treatment, and existential issues of facing death (Denber, 1995).

Studies suggest that anxiety prior to surgery is very common. The effects and occurrence of pre-operative stress have been addressed by a number of writers. For example, Kay (1992), points to overwhelming loss of control, and concerns about diagnosis and death, as having a major impact on patients awaiting coronary bypass surgery. Denber writes:

> Cardiac surgery can be considered a major stress…There is a basic fear inherent in cardiac surgery. The uninterrupted heartbeat is accepted universally as evidence of life, and its cessation means death. Cardiac surgery disconnects patients from the past and places them in both an inexistent present and in a future without meaning until they reawake. Some patients believe they are dead during cardiac surgery, that their heart has been removed elsewhere to be operated on and repaired, or that their brain has been deprived of oxygen (Denber, 1995, p.160).

In fact, Denber (1995) elaborates on existential issues with these patients, suggesting that the impact has been underestimated. In some ways, one might even consider that patients are trapped in their body by their disease, and that they then have to endure the treatment.

1.10-3 Pain in cardiac care

One of the defining characteristics of a heart attack is pain, which is popularized as a clutching at the chest but may in fact appear in a variety of manifestations. After bypass surgery, when the disorder of narrowed arteries has been repaired, patients may

experience unexpected pain, both in the chest due to the sternotomy and/or in the leg or other area from which the bypass graft has been removed. Such post-operative pain may last for an extended period of time, causing anxiety and irritation, most likely due to disturbed nerve endings as a result of the procedure. The pain in itself has the capacity to promote worry about a recurrence of angina or heart attack, and at times such pain limits participation in rehabilitative activities such as physical exercise.

1-10-4 Adjustment and rehabilitation in cardiac care

As the cardiac patient adapts and adjusts in the rehabilitation phase after surgery, they may experience anxiety and depression related to their health (Cornett & Watson, 1984). Further to this, they may have issues of coping and adaptation (Kerson, 1985), and concerns of a spiritual nature regarding life, death and use of time (Denber, 1995).

Denber points out that a changed view of oneself is necessary for full rehabilitation to occur (Denber, 1995). Clinically, it is noted that there is a need for the psychological impact of illness to catch up with the physical reality of increasing health – the person may see themselves as worse than they now are, and the person needs to come to terms with their increased/increasing health.

In order to understand the significance of heart surgery for the patient, it is helpful to investigate the metaphorical aspects of people's view of the "heart". The heart is well known to be a vital organ that must continue to work in order to survive. The heart and its workings may be understood, from the client's perspective, as, for example, a) a Black Box, it is there and it works but we know nothing about it, b) a Pump, a mechanical gizmo that has a job to do, as efficiently as possible, c) an Emotional centre, a source of love, joy, pain, sorrow, fear, d) a source of Transcendent values, sacrifice, compassion, mother-love, and e) a Chakra, part of an integrated whole bodily energy system.

Additional cultural meanings relate to celebrating the heart on Valentines Day, and at Engagements and Weddings, as part of the interpersonal bonding process related to love. Many phrases and sayings in common usage also incorporate the idea of the heart (Short, 1997), for example:

at the heart of the matter
abscence makes the heart grow fonder
heart-broken
heart of gold
black-hearted
cold-hearted
has a big heart
my heart nearly stopped
my heart was pumping, pounding
haven't the heart to go on
take heart (have courage)
his heart isn't in it
heart of oak
heartfelt (greetings, sympathy)
in your heart you know...
win a person's heart
dear heart
after one's own heart
by heart (memory)
from the bottom of one's heart
have a change of heart
have a heart (be compassionate)
one's heart in one's mouth
have one's heart in the right place
heart and soul
set one's heart on
to one's heart's content
wear one's heart on one's sleeve
with all one's heart
heartache
heartland
heart rending
hearts and flowers
heartless
heartsick
heartstrings
heart throb
heart-to-heart
heartwarming

In addition, the heart may be referred to in different ways, such as a "dicky ticker", with implications of rhythmic and regulatory aspects similar to that of a clock.

Metaphorical aspects of people's view of the "heart" may impact on the rehabilitative experience of the patient. The heart is well known to be a vital organ which, if not working, will rapidly lead to death. So there is a life-threatening aspect of response to surgery. It would seem that there is a overwhelming sense of fear - of self, of body, of

future - likely to manifest itself both pre- and post-surgery. This clearly needs to be acknowledged and dealt with in order to prevent possible undermining of the positive effects of the surgical procedure itself. Fear is liable to engage the sympathetic nervous system, which is directly linked to the heart (Anderson, Anderson, & Glanze, 1994), and thus possibly delay the healing process and adaptation towards an increasingly healthy lifestyle. There is not only a physical trauma, but also a psychological/emotional/spiritual trauma that must be addressed in the wake of bypass grafting, in order for full healing and a return to a positive lifestyle to occur. In fact, there are reports of clients being physically well post-surgery, but still feeling unwell and unwilling to engage in life again, thus although the physical surgery is successful, the client appears to remain substantially disabled (J. Donoghue, personal communication, November, 1996). Clearly, this matter needs addressing, in order to enhance the care and recovery of the patient.

1.11 Appropriateness of music therapy to cardiac care

As cardiac patients recover from surgery, there is a need for re-experiencing self, as increasingly healthy and capable, not disabled. It is also necessary to address anxiety and promote relaxation, to assist with pain management, and to support the rehabilitation process of increasing health and adaptation. An acceptable, non-threatening form of therapy such as music therapy may be individualized to the needs of the patient. It may be used to comfortably bring to the fore emotional issues and communicate additional clinical information. Music therapy is an excellent choice for these purposes.

The therapeutic value of music therapy, in the form of GIM, is the way that it supports the unfolding of inner awareness and insight, via the music and imagery context. As such, there is a supportive environment in which reflection may occur, thus leading to inner-directed changes in self-concept. At the same time, this creative milieu provides support for deep and difficult feelings, encouragement to confront difficulties and ultimately moves towards empowerment of the person and towards making and understanding positive changes in their life, in line with Jungian principles.

The open-ended nature of the Guided Imagery and Music technique (Bonny Method), based as it is on the patient's narrative of their experience, is very appropriate to cardiac patients, who have most likely not participated in talking (psycho-)therapies before.

In addition, the concomitant emphasis on relaxation is clearly appropriate to increased health for cardiac patients. GIM provides a therapeutic vehicle for inner change, and the nature of music itself is useful in helping people gain insight into their feelings and experiences.

Clinically, the GIM technique is closely related to relaxation, to meditation, and to the use of imagery, which have clear benefits for cardiac care (Achterberg, 1985; Bolwerk, 1990). In addition, its ability to reflect and promote change in the recovery and rehabilitation process after major surgery is clearly of value in the practical setting (Cornett & Watson, 1984). We now look more closely at the nature of the Bonny Method of Guided Imagery and Music.

1.11-1 Guided Imagery and Music (Bonny Method)

The Bonny Method of Guided Imagery and Music (GIM) (Bonny, 1997; Goldberg, 1995; Short, 1991) has been chosen for the current research study. This method is officially defined by the Association for Music and Imagery as:

> A music-centered, transformational therapy, which uses specifically programmed classical music to stimulate and support a dynamic unfolding of inner experiences in service of physical, psychological and spiritual wholeness.
>
> The GIM therapist/guide maintains an active dialogue with the listener throughout the session, providing encouragement and focus for the emotions, images, physical sensations, memories and thoughts which occur (Association for Music and Imagery, 1990).

It is a specific and specialist method of music therapy, with separate and extensive training requirements at advanced academic levels (Lewis, 2002; University of Melbourne, 2003), leading to practitioner qualifications such as Registered Guided Imagery and Music Therapist (RGIMT), Australia, and Fellow of the Association for Music Therapy (FAMI), USA.

GIM is practiced within the context of an accepting therapeutic situation conducive to promoting imagery. Therapeutic benefits to the client are not dependent on their own musical experience or musical training. Classical music is known to be very effective in promoting and maintaining imagery and relaxation in the clinical setting, which is standard practice in the Guided Imagery and Music (Bonny Method). Bonny originally designed eighteen music programmes for use in the GIM process (Grocke, 2002b); other practitioners have designed additional programmes for use with this method (Bruscia & Grocke, 2002).

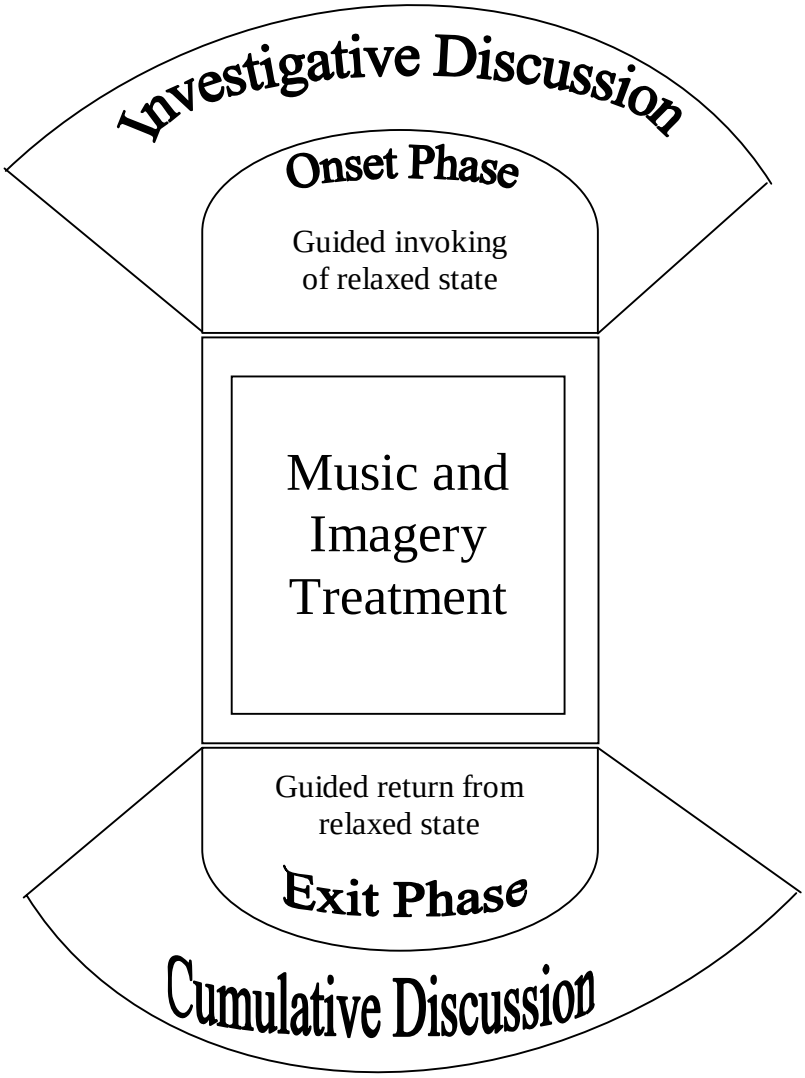


Figure 1-2. Schema of GIM sessions (Short, 2002b), based on Bonny (1978b)

Structure of session

The GIM session is outlined diagrammatically in the Schema of GIM sessions (Figure 1.2). Whilst this model is essentially the same as Bonny's, the terminology has been changed to provide clarity and clinical focus in view of the current thesis. The GIM session typically begins with therapeutic discussion, called Investigative Discussion in the current study, followed by a relaxation procedure and a focusing image, called the Onset Phase, leading to the Music and Imagery (M&I) Treatment, usually 30 to 45 minutes in duration depending on the music programme used. The relaxation procedure in the Onset Phase is chosen by the GIM therapist to relate to the client's therapeutic issues, to both the physical and emotional states, and to the music to be played. The relaxation and focusing image of the Onset Phase promotes a smooth transition from a normal waking state to the altered state of consciousness necessary for effective use of the GIM method. During the Music and Imagery Treatment phase, the GIM therapist, in conjunction with the music itself, assists in deepening and moving the imagery forward in a manner that encourages spontaneous experience of the imagery by the client. The GIM therapist makes resonant verbal interventions - often in the form of specific or open-ended questions, supportive comments, or reflective statements - to which the client may or may not respond, according to needs at that moment. At the completion of the music and imagery segment, there is an Exit Phase, and then time is allotted for processing and integration of insights and awarenesses (Short, 1991), called the Cumulative Discussion in the current research project. A time space of 2 hours is usually allowed for the entire session, although this may vary considerably. A verbatim transcript is usually taken by the GIM therapist during the Music and Imagery Treatment, the GIM therapist seeking to notate all relevant data.

In standard practice, GIM participants are encouraged to lie down during the music and imagery. This is the position most likely to promote and enhance full bodily relaxation: Bonny and Savary note, "Most people find they relax best by lying supine on a floor, sofa or bed" (Bonny & Savary, 1990, p.24). In addition, most GIM practitioners would follow the oral teaching that a sitting position may reduce the depth and effectiveness of the imagery process. In contrast, the current author has found imagery with music to be very effective both in terms of evocation, depth and quantity when working with a

group of elderly people with physical difficulties who remained in seated position (Short, 1992a), thus suggesting that either position may be used effectively.

Types of imagery

During active listening in the music and imagery segment of the GIM session, many types of imagery may emerge for the client. These may include (a) reminiscence and association, (b) affective awareness, (c) interactional imagery, (d) somatic and kinaesthetic sensations, (e) auditory imagery (f) abstract and concrete visual imagery, (g) photographic images, and (h) transpersonal and spiritual experiences (Short, 1991).

These types of images may alternate and interweave throughout the course of each music and imagery segment, while the depth of psychological work being undertaken by the client may oscillate between the profound and the seemingly superfluous, with many gradations in between (Short, 1991). The interpretation of imagery cannot be successfully addressed via cause-and-effect, rational methods, but needs to be approached by the imagination and intuition of the observer, exercised in a careful and professional manner. Any symbolic image may have implications at various levels of experience and must be considered within its imagery context (Short, 1991).

Music used

In the technique of Guided Imagery and Music, the specific music used in each session is carefully selected by the music therapist, according to the psychological and emotional needs of each client as they present in the session. Bonny suggests that the multilayered nature of the music used in GIM allows psychodynamic movement at different levels chosen consciously or unconsciously by the client (Bonny, 1989; Grocke, 2002a). Since each client's background and issues are unique, the same musical selection played to a cross-section of clients may produce differing responses. Professional training in GIM provides further clinical insights into the appropriate use of music in the Bonny Method in order to achieve maximum therapeutic benefit. Selected clinicians have sought to determine the manner in which the individual elements of the music affect the overall imagery process (Grocke, 1999; Marr, 2001; Ventre, 1990).

1.12 Research Questions

This chapter has explored an introduction to music therapy, its place within wider clinical therapy, the nature of the clinical information gathered in the music therapy context, the relevance of an overarching psychotherapy discipline, the nature and role of narrative within the health care context, applications of music therapy to clinical and cardiac care, the nature of heart disease and bypass surgery, and finally an understanding of the Bonny Method of Guided Imagery and Music (GIM). This therapeutic method forms the basis of the current study, and it is towards the method that the fundamental questions of this research project apply.

The general focus of this research project seeks to clarify how meanings related to adjustment from a health crisis (such as cardiac surgery) are depicted in music-supported imagery. Not only that, but related questions seek to find out 1) how patients may use the imagery to depict their experience of themselves and their body, 2) how this sense of themselves can change, to adapt to their new circumstances post-surgery, 3) how they respond emotionally to these views of themselves and their circumstances, and 4) how the music may contribute to the depiction of the emotional and physical meanings, underscoring the entire rehabilitative process.

Having now explored clinical and therapeutic theory in the current chapter, the next chapter takes a research viewpoint towards the clinical/therapeutic situation, seeking to investigate how understanding is gained in clinical practice.

CHAPTER 2. APPROACHING RESEARCH: CLINICAL AND THEORETICAL ORIENTATION

2.1 Approaching research

Music therapy is a very difficult area to research using conventional methods, especially due to the transient, abstract and intangible nature of music, which presents difficulties in quantification and description. Responses to music are also heavily influenced by personal taste, preference, and other cultural factors, and such individual factors add another level of complexity to the research process. Moreover the nature of therapy itself, across a broad range of healthcare disciplines, tends to elude controlled quantitative research strategies. As with many others areas of healthcare, qualitative research has been applied to music therapy since the early 1990s. Studies founded on qualitative research principles have addressed experiential aspects of music therapy (Langenberg, Aigen & Frommer, 1996), often from the perspective of the researcher/music therapist.

One of the first music therapists investigating alternative research approaches was Michele Forinash, who developed the phenomenological approach to explore the whole picture of a clinical music therapy exchange (Forinash, 1992, 1993; Forinash & Gonzalez, 1989), influenced by the work of Ferrara (1984). Kasayka (1991) also used qualitative research to derive detailed clinical understandings. In recent years, there has been an increasing focus on qualitative research methods in music therapy, as shown by Wheeler (1995) and other writers (Aigen, 1991, 1993, 1995; Amir, 1993; Bruscia, 1995; Edwards, 1999), including investigations of cultural aspects of applied music (Brodsky, 1991). Patients have been interviewed (Hogan, 1999; O'Callaghan, 2001), as have their visitors and staff members (O'Callaghan, 2001), in order to derive further understandings about music therapy. In addition, researchers have reflected on interactions between practical and theoretical knowledge in music therapy (Ansdell, 1996). Much of the early research in GIM is in the form of individual case studies, showing a strong clinical focus (Grocke, 2002c). Qualitative research methodology based on carefully noting and later reviewing a lengthy series of adapted-GIM sessions with elderly residents, subsequently deriving themes related to the experience of the participants was used by Short (1992a, 1992b). Grocke's study of "pivotal moments",

based on interviews with both clients and therapists, demonstrated a systematic approach to qualitative analysis (Grocke, 1999). Bonde combines both quantitative and qualitative methods to explore relationships between music and image (Bonde, 1997), and Moe explored qualitative themes in order to further understand the therapeutic process (Moe, 2002). In addition, phenomenological studies of the music have been undertaken, for example, Kasayka (1991), Grocke (1999) and Marr (2000). Additional applications of qualitative methodologies to GIM have further extended the field (Bonde, 2002). Despite considerable understandings of GIM, it is clear that research is still needed in order to fully explicate the Bonny Method of Guided Imagery and Music (GIM).

The current study is based on a qualitative approach applied to clinical GIM (Bonny Method). As already noted, this specialist music therapy method combines music and imagery in the therapeutic context. Each of these aspects will now be explored further from a research perspective.

2.2 Music

Research into music has typically focused on musical characteristics such as harmony, melody and historical place in the repertoire. A few writers have sought to understand the nature of the music language (Coker, 1972; Tarasti, 1994). However, some have even rejected the possibility of music research in itself. A pervasive philosophical viewpoint is that of "art for art's sake" (Bell-Villada, 1986-7), suggesting that music cannot be understood via anything except music itself. Hence, talking or writing about it is pointless or irrelevant. Although words will often be insufficient in describing music, in the viewpoint of the current author, it seems equally pointless to suggest that since we cannot know everything about music, we had better not try! Since communicating the nature of the therapeutic function of music lies at the heart of developing the professional status of music therapists amongst other therapies, research is mandatory. As Aldridge notes, "the music therapist who says listen to my work as a work of art alone, without concern for its clinical relevance, imposes an individual tyranny apart from indulging in solipsism" (Aldridge, 1996, p.17).

Formal and academic approaches to studying music, or musicology, have often seemed remote and unemotional, with "a disembodied abstract structure" (Ansdell, 1997, p.37)

based substantially on cognitive or historical approaches. Macarthur (1995) highlights the dehumanized and disembodied nature of music research,

> A score-driven discipline, musicology has developed analytical systems to test music for internal coherence. These focus on syntax and structure (the way the composer has put the notes together), and their findings can be presented in graphic and numerical form. The performative and experiential aspects of music as a temporal art capable of having an intimate relationship with the human body have been ignored (Macarthur, 1995, p.121).

If musical understandings are to be applied to clinical music therapy, they will clearly not be enhanced by a disembodied approach. Emotional and experiential aspects of music are fundamental to music therapy practice, and hence essential to researching music. At the same time, the focus of musicology as whole is changing to encompass a broader range of topics and understandings (Ansdell, 1997; Hodges, 1996; Ruud, 2000).

Outside of formal musicology, some research into the cultural and associative effects of music has occurred via soundtracks, or film music. Chion (2000) suggests that the relationship between sound and image creates "added value", which is responsible for creating impressions, tapping immediate and remembered experience, and providing a sense of natural flow and connection in the information carried by the image itself. This creates, "an immediate and necessary relationship between something one sees and something one hears" (Chion, 2000, p.112). The emotional effects of music have an important role to play in film music. In a clinical health care situation, the eliciting of emotions is clearly for different purposes, and in this situation the emotional health of the person and clinical goals are important considerations.

Music psychology research has given further insights into the way that people respond to music, however, this remains a complex area (Hodges, 1996a). McMullen outlines the importance of adopting a new interpretative paradigm to link affective and aesthetic behaviour with music, and notes the difficulties of empirical research with regard to music and musical experience (McMullen, 1996). Taylor also notes the difficulties in understanding the nature of music, such as relaxing music (Taylor, 1997).

The results of clinical music therapy have increasingly been treated to a formal music analysis (Arnason, 2002), and to ways of combining analysis of music and therapy (Ansdell, 1996). Personal construct methodology has been used by the music therapist

to understand their own responses to listening to music, thereby adding to an understanding of subjectivity in the music therapy setting (Aldridge & Aldridge, 1996).

Research into the effects of the music in the Bonny Method of GIM has been addressed initially by Kasayka (1991) and more recently by Grocke (1999) and Marr (2000; 2001). Grocke developed the Structural Model of Music Analysis (SMMA), and Marr used event structure analysis in order to further explicate understandings about the effect of music used in GIM therapy (Grocke, 1999; Marr, 2000, 2001). .

Bonny talks in particular of the multilayered nature of the music in Guided Imagery and Music which helps the process move forward (Bonny, 1989; Grocke, 2002a). Such comments, based on her experience as a practitioner, go part-way to explaining how different imagery can be generated or supported by the same music. The current study incorporates attention to the music via self-report data of participants, however, the main focus of this study remains the clinical implications based on and derived from the music-generated imagery.

2.3 Imagery

The notion of "imagery", used in this study to mean "mental imagery", presents difficulties in conceptualizing, understanding and evidencing the nature of imagery and the imagery process. This is well described by Goodman,

> What *are* these pictures in the mind? They are pictures not painted, drawn, engraved, photographed - not in any material medium. And they are invisible, intangible, altogether insensible. A visual image cannot be seen (for seeing requires looking at something before the eyes); an auditory image makes no noise, and the pain in my toe I can now imagine does not hurt. Again, whatever mental images may be, where are they? There is no small theater in the head where these images are projected on a screen, and there is nobody there to look at them anyway. When we are asked what or where mental images are, we falter. Our answers are negative and self-defeating. When the mental image goes on trial, testimony for the defense is itself enough for conviction. The mental image seems to be unimaginable, a mere figment of the imagination! Or in words less minced, the inevitable conclusion seems to be that there are no mental images (Goodman, 1990, p.359).

Despite the supposed complexity of finding evidence to support the existence of imagery, research into imagery has been approached in several ways, including elaborate laboratory experiments, a search for neuropsychological bases, and close

examination of unusual cases. It is worthwhile noting that this has generally not addressed spontaneously generated imagery, which is the type of imagery evoked in the current study. It is clear that objective measures are not adequate, and hence a more personal and individualized research approach needs to be developed which is relevant to everyday experience, and to clinical practice methods focusing on mental images.

In the area of dream analysis, anecdotal and clinically oriented research has occurred, focusing generally on the therapist's interpretation of events in the clinical situation. This leads towards a further consideration of how clinical research may be approached.

2.4 Approaching clinical research

In addition to basic understandings of research principles, clinical research demands a very careful consideration of the clinical area to be researched, in order to best adapt to and complement the practical needs of the setting. This also means considering the possibility of utilizing routine clinical practices as part of the research plan itself (if appropriate), thus eliciting and recognizing relevant embedded method rather than changing the clinical situation to suit an imposed protocol. As Miller & Crabtree point out, "A fundamental tenet of the proposed vision of clinical research is that *the question and clinical context are primary; methods must adjust to the clinical setting and the clinical question [sic]"* (Miller & Crabtree, 1998, p.298). It is important that links between the method of practice and the method of research are streamlined as much as possible, in order to fit the circumstances in the clinical field. This, in turn, promotes integration of both clinical and research endeavours.

In the current study, this required a great deal of thinking and reflection, as the link between application and research is not at all clearly defined or laid out by previous researchers. It involved considering what format and data collection modes are ordinarily available in the GIM session, and enhancing and using these for the research endeavour. It is well to note that there has been little formal research with regard to applied GIM, most likely due to a lack of funding available for research, and to the complexity of the clinical method.

2.4-1 Clinician-Researcher

In this study, the researcher also functions as the clinician, due to the lack of any other qualified practitioners in the Bonny Method of GIM in the broad metropolitan region of this study. Hence, the clinician-researcher role was a necessary pragmatic decision. Indeed, the multiplicity of roles that can occur for the clinician-researcher is outlined by Cartwright & Limandri (1997), where a nurse researcher went into people's homes to interview care-givers. The clinician-researcher may have many advantages over "outside" researchers, such as a pre-existing knowledge and experience base which aids with design, implementation and analysis of the study, and a "synergistic insight" into useful and appropriate topics (Robson, 1993, p.447).

Some music therapy writers suggest that research into the dynamic practice of music therapy can only be fully attempted and understood if the clinician is also the researcher (Aigen, 1991; Wheeler, 1995). Certainly the current clinician's lengthy prior experience has helped shape the most appropriate design of the current study, based on deep and complex understandings regarding the nature of GIM therapy and client's responses to the applied technique.

2.5 Researching the patient's viewpoint

Traditionally, research and investigation in music therapy has focused on clinical observation and/or assessment scales. Increasingly, the client has been directly consulted as part of the research (Amir, 1992; Grocke, 1999, Hogan, 1999; O'Callaghan, 2001), leading to better understandings of their experience of music therapy. Further indications of this changing trend have emerged with a new book entitled "Inside music therapy: Client experiences" (Hibben, 1999), and recent conference material also supports the trend of reporting verbal interviews after music therapy sessions (Stige, 1999). Music therapy outcomes may be verbal or musical or a combination of both, and the current project seeks to find ways to investigate the client's self-reports in order to further understand the clinical impact of GIM.
Other selected health care fields have focused a great deal of interest in the patient's verbal report and how this narrative may be understood. The area of narrative analysis has been approached in many ways, from a complete structural analysis to a broader analysis of themes (Mishler, 1986; Polkinghorne, 1988), and this in turn has contributed

to richer clinical understandings, where narrative serves as a vehicle for communicating experience.

The current study follows the work of Ingram (1994), analyzing narrative in terms of a thematic analysis of the text. In doing so, it may access information about the patient's use of narrative to convey meaning via text, themes and grand themes. Such a thematic analysis has been applied effectively to the therapeutic context (Aronson, 1994; Ingram, 1994). As Aronson notes:

> From the conversations that take place in a therapy session or those that are encouraged for the sake of researching a process, ideas emerge than can be better understood under the control of a thematic analysis. Thematic analysis focuses on identifiable themes and patterns of living and/or behavior (Aronson, 1994).

A thematic analysis can be applied to psychotherapy, using a six-stage process to emically derive and map a hierarchical structure of themes in order to understand what the client was saying in therapeutic context, as demonstrated by Ingram (1994); the details of this will be further discussed in Chapter 3.

In the specialist GIM field, patients communicate by reporting their experiences of the imagery during the music, and this forms important clinical data. The experiences of GIM clients typically have contributed to the research endeavour, via field notes and/or researched recollections of clinicians (Grocke, 1999), and sometimes via post-session interviewing (Grocke, 1999). The current study is thought to be the first research project in GIM involving the audiotaping of entire sessions in order to transcribe patient's comments word-for-word in all parts of the session. Such a clear procedure lends not only greater accuracy than field notes or post hoc recollections, but effectively shifts the emphasis from etic to a substantially emic analysis, where the experience of the participant, not the researcher, is of paramount importance and structures the analytical frame.

In the GIM session, there are several narrative texts. The obvious narrative text of the self-reported experience of the imagery during the music (Music and Imagery Treatment) is supplemented by additional pre-and post- music texts (Investigative

Discussion, Cumulative Discussion respectively) which contribute further clinical information. Given that several narratives are present, it becomes increasingly difficult to figure out how to deal with these together, using a purely narrative analysis framework. With a number of competing narratives apparent, there is a need for a process for relating them one to another in some way, in order to undertake a systematic analysis. What is needed is a further way of deriving knowledge in the situation of multiple narrative or sources of information, in order to address the needs of the clinically applied music therapy method of GIM.

2.6 Researching the clinically applied situation

In turning attention to the way that a range of narrative texts from the client may be documented and interpreted within the clinical setting, it is useful to review how clinical medical information has been derived from client texts. This is relevant to the current study because of its stated focus on responses related to the physical event of bypass surgery within the context of cardiac care. Going back to the origins of Western medical thought, Hippocrates considered medical symptoms to be signs relating structurally to other symptoms, to the doctor, and to the patient.

> The Hippocratic corpus reveals an awareness of phenomena as symptoms which are part of a structure. Relations are found among the symptoms themselves and among the symptoms and the signifieds, the interpreter or doctor, and finally the medium for the symptoms, the patient. The latter is not only passive, but with the doctor's help, he or she can use a code, the language, to give information necessary for the determination of the symptom (Sebeok, 1986, p.309).

This begins to indicate an interaction of several texts, which is relevant to the several texts elicited in the practice of clinical GIM. A text may be considered to be a collection or set of signs around a particular code or set of codes (Scholes, 1982); this will be further discussed in Section 2.7-3.

Following the Hippocratic approach, the patient was understood to use language as a sign, in order to convey information necessary for the understanding of the symptom. Similarly, medical personnel today obtain clinical information about what is going on for the patient, both physically and emotionally with regard to health issues, in this case with regard to cardiac care. Such information must be gained systematically and in an accountable way. This is known as medical semiology.

Semiology, or semiotics, relates to the analysis of disease and illness as a communicative structure which allows for the recognition of the analogies existing among the seemingly unrelated fields of art, literature, biology, and the social and medical sciences (Staiano, 1986). This leads to an expansion of the pool of relevant signs produced by the patient. Staiano explains this by addressing non-physical signs which appear to run parallel to the physical signs, encompassing an understanding of the imaginal realm (or imagery) as it appears in the patient's narrative, and of the social, cultural and communicative purposes of illness.

> The signs and symptoms which indicate illness and disease have communicative functions. They express culture and are culturally expressed. They provide a mode for the articulation of stresses and conflicts which might otherwise be inexpressible. They mobilize and reconstitute the social group. They verify, challenge, and, ultimately, reconcile basic cultural assumptions. They provide one means of revealing "significant truths" ... They inform the afflicted individual, the social group, and the diagnostician, and provoke actions or reactions, both behavioral and physiological, which constitute the therapeutic process (Staiano, 1986, p.8-9).

As already noted, early medical foundations of semiotic thought have been traced to the Greek medical tradition, but outside of health care, semiotic thought has also formed part of a broader mode of understanding and perceiving the world. It is noted that medical semiotics (or semeiotics) has remained separated from the linguistic and philosophical semiotic traditions as recently as the late 1700s (Staiano, 1986), and only recently have thinkers such as Barthes sought to further develop and reunite them. He describes the sign-based communication regarding disease in the clinical setting as follows:

> Disease is in fact made intelligible as a person who is first of all in the body's secret, under the skin, if I may say so, who emits signs, messages, which the physician must receive and interpret rather like a deciphering soothsayer (Barthes, 1985/8, p. 213).

In doing so, Barthes showed that the linguistic/philosophical tradition had further insights to offer medical science. This recent medical/philosophical integration, based on recognized similarities of approach, has occurred particularly in the writings of Staiano (1986). The manner in which semiotics contributes to an understanding of the clinical situation is harnessed in the current research, based on its ability to relate several sign-based texts together in order to derive meaning.

2.7 Semiotic thought

So far, semiotic thought has been approached from (largely) the medical framework in this discussion, however a broader look at semiotic ideas and principles promises to bring an additional depth of understanding to the current research project. Historically, John Locke introduced the importance of the nature of signs into philosophical discourse at the end of the seventeenth century. He developed a doctrine of signs as one of three branches of science (Sebeok, 1964). Further writers developed a theoretical base for an understanding of the nature of the sign. The two founders of modern semiotics, or semiology, are generally considered to be Ferdinand de Saussure and Charles Sanders Peirce. Although approaching the idea of semiotics from different directions and with different points of view, their work shows considerable similarities as well as some differences. Saussure particularly emphasized the social and language function of the sign, whilst Peirce was particularly interested in its logical function (Guiraud, 1971/75).

2.7-1 The nature of the sign

Semiotics, or semiology, is based on seeking to understand the nature and implications of the sign. The process of communication itself involves the use of signs. Saussure described the sign process in terms of "signifier" and "signified", which is basically about the sign and its meaning (Guiraud, 1971/75; Scholes, 1982), whereas Peirce described a three-part model of the sign (Guiraud, 1971/75). Peirce incorporated not only the sign and its underlying message, but also the notion of the receiver of the sign as important to the process of semiotic communication. He described the communicative nature of semiotics as, "something stands to somebody for something else in some respect or capacity" (Peirce, cited in Eco, 1985a, p.176). That is,

something

- a sign of some sort, be it verbal or non-verbal etc.

stands to somebody

- somebody is on the receiving end of the sign, the communication

for something else

- the direct/concrete object or idea is not there, but is being referred to

in some respect or capacity

- may be very similar or very different to the object or idea referred to

For example, seeing a drug being drawn up into a syringe and having their skin swabbed with alcohol may signify to a patient that the next event may be painful, to a greater or lesser extent! Likewise, a steadying hand under their elbow while walking may signify to a patient that dependable help is available during the rehabilitation process. Or in another example, the sound of a bell ringing within the music may stand to a GIM client for the experience of being in church, related to childhood attendance at school-based Mass.

The communicational aspect of a sign is hard to avoid. Signs of all types abound in daily life and signs are produced in order to be understood by others. For communication to occur, however, there needs to be not just a generator of signs but also a receiver and a message. Here, Guiraud's model, which he acknowledges to be based on Roman Jakobson's (1960) work, is useful in further clarifying the semiotic communication process (Guiraud, 1971/1975).

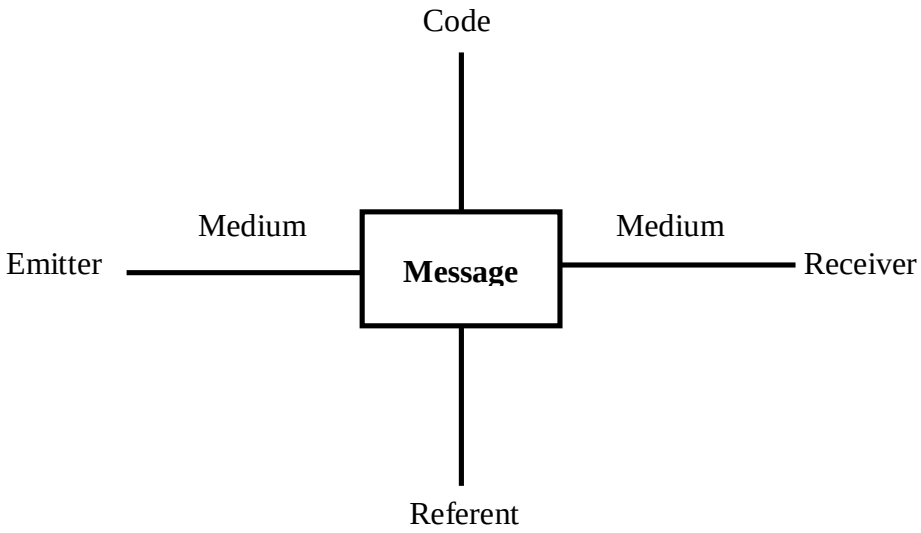


Figure 2-1. Functions of the sign (Guiraud's adaptation of Jakobson (1960), Guiraud, 1971/1975, p.5.)

This model involves both the generation and production of a sign which is conveyed to a receiver through a medium, and which refers to an object/idea by way of a coding system.

For example, in the previous example of the patient about to receive an injection, the patient is sent a message emitted by the nurse via medical equipment, and receives the message via visual and tactile senses within the medical context, thereby indicating imminent pain, within the code of medical procedures.

2.7-2 Genres and applications

Signs, often gathered together as texts, may be verbal, in fact, language is considered to be a major semiotic (sign) system, where a word may stand for an object, an idea, or a thought. The example (above) also indicates that signs may be non-verbal, including gestures and facial expressions, diagrams, artwork and music. Semiotic research has extended into communication based on spoken and written language, film, TV, advertising, ethnography, philosophy, law, medicine, art, music, feminism, mysticism and more.

The semiotic approach has been applied to many areas of the research endeavour across a broad spectrum of investigative areas. For example, the use of signs in one fast-food industry hamburger chain has been semiotically analysed in terms of menu information and service presentation for its messages to the consumer (Manning & Cullum-Swan, 1994). Advertising of several soap and cleaning products in India has been analyzed for cultural overtones in words and visual presentation (Kaushik & Sen, 1990). In the dramatic arts, semiotic meaning has been analyzed in terms of plot, scenery, gesture and lighting (Esslin, 1987) and also applied to the medium of television (Fiske & Hartley, 1978). Many researchers have looked at the sign-system of spoken or written language, with varying complexities of structural, semantic and pragmatic analysis (Sebeok, 1986). Others have semiotically considered cultural beliefs and practices via the role of signs in fashion (Barthes, 1985/1988; Cullum-Swan & Manning, n.d.), analysis of colours (Eco, 1985b) and non-verbal and body language (Sebeok & Sebeok, 1994).

2.7-3 Interpretation of signs

Signs may be encoded in different ways in order to produce meaning. Moreover, a collection of signs around a particular code or set of codes may be considered to be a "text" (Scholes, 1982, p.149).

> Whenever we "make sense" of an event, it is because we possess a system of thought, a code, that enables us to do so... Human languages are the most developed instances of codes that we know, but codes exist that are sublinguistic (facial expression, for instance) and supralinguistic (literary conventions, for instance). Interpretation of complex human utterances involves the appropriate use of a number of codes simultaneously (Scholes, 1982, p.143).

> That which provides the social connection among the components of a sign, a set of signs clustered as texts, and even assembled as discourse, is a code (Manning & Cullum-Swan, 1994, p.466).

This understanding of the word, "text", does not necessarily mean a written text. As Voelz points out, "it is best to understand "text" as a set or complex of signs, which is to be interpreted against the background of other signs or set/complexes of signs" (Voelz, 1995, p.150).

For example, taking the previous example of the patient about to receive an injection, a text could be observation of the whole range of medical equipment available for interventions, or the range of quiet and soothing verbal statements offered by the nurses when pain is imminent, or the repertoire of memories of painful procedures carried by the patient into this new situation.

Much of the modern study of semiotics has been based on structuralist principles, that is, the idea that the sum is the total of the discrete building-block parts. The one-to-one mapping of signs and meanings has been a task for many semioticians, and this is possible in some applications. However, the structural nature of semiotic thought has been severely challenged by the turn to postmodernism, and early signs of such a post-structural challenge grew out of the codification system itself.

Codes form their own text, or sign system, of themselves, and in turn generate more signs and codes. This is called semiosis, or Peirce's "infinite regress" of the sign, that is to say, meaning arising from the endless play of signifiers (Gottdeiner, 1995, p.23). Thus, the idea of only one meaning tied to one sign has come under serious threat as a result of postmodernist ideas, and has led to a greater appreciation of polysemy, the awareness of many meanings, as related to single sign (Gottdeiner, 1995, p.21). According to Gottdeiner, several thinkers especially contributed to an understanding of polysemy, most notably the later work of Roland Barthes. Polysemy addresses multiple

meanings inherent in a sign, thereby acknowledging that there is no longer a direct, linear or exclusive relationship between a sign and its meaning, which in turn implies that multiple codes are in operation.

For example, the syringe used in the (above) example may carry meanings of pain, but also of hopefulness, assault, intrusion, and medical relief from illness. The nurse's voice may have meaning for the patient as soothing, dictatorial, motherly, remote, musical, or cunning and deceptive. Polysemy allows for all of these competing meanings to co-exist.

As Morgan points out, "the signs and codes in a text are presumed to be capable of interrelating in an unforseeable number of ways, so that semiosis is always open, actually infinite" (Morgan, 1985, p.8). The extreme extension of the sign via polysemy into infinite regress and the open text has undermined structuralist approaches and the one-to-one mapping of signs and meanings, leading to a much heavier reliance on the interpretive integrity of the individual researcher. It has also led to an even greater emphasis on the nature of texts and interrelations between texts.

2.8 Multiple texts

The interrelationship of multiple texts has developed via Bakhtin's interest in context, dialogism and polyphony (Bakhtin, 1981; Kristeva, 1969/1986), and the nature of the sign as having multiple meanings. This is described by Kristeva, where "[the sign] does not refer to a single unique reality, but *evokes [sic]* a collection of associated images and ideas" (Kristeva, 1970/1986, p.72). This has more recently evolved into the concept known as intertextuality. The term, "intertextuality", comes from the Latin, intertexto, meaning to intermingle while weaving (Sebeok, 1986, p.387), and was first used by Kristeva in the later 1960s (Moi, 1986). Intertextuality is a way of thinking about the confluence or juxtapositioning of different sign-systems (texts). It refers to the ways that signs may transfer or expand meanings from one sign-system to another, via the semiotic process (Scholes, 1982).

> Intertextuality reminds us that all texts are essentially plural, reversible, open to the reader's own presuppositions, lacking in clear and defined boundaries, and always involved in the expression or repression of the dialogic 'voices' which exist within society (Allen, 2000, p.209).

> Just as signs refer to other signs rather than directly to things, texts refer to other texts... Thus, an intertext is a text lurking inside another, shaping meanings, whether the author is conscious of this or not... Parallel to the unlimited semiosis of signs we have the infinite regress of texts as well (Scholes, 1982, p. 145).

In a literary example of intertextuality, a modern author of a novel may have a character say,

> "To be or not to be, I wondered if that was the question?"

Clearly, in saying this, he is referring to Shakespeare's Hamlet, but in a way that suits the purposes of the current character and advances probably a quite different story. In this instance, one text is directly referred to by another text. It is actually a quite clear-cut example, where a reader can easily specify the text it has come from and compare the different circumstances of its use.

From another intertextual point of view, a particular message can be conveyed via a range of sign systems, or texts, both verbal or non-verbal, and accessing a range of sensorimotor information. For example, conveying of the message: *"It's time for tea (dinner)"* could access sign systems or texts related to:

Body - hunger pang, inner sensation - rumbles

Visual - look at the clock => decided it is or isn't time for tea

Auditory - sounds of kitchen pots and pans

Imagery - imagine food that you would like or could expect (meat, vegies etc.)

=> can lead to salivation

Language - being "called" for tea (explicit message being conveyed and understood)

Motion/visual - someone setting the table for tea

Smells (olfactory) - the smell of tea cooking

Earlier conversation - that tea would be at 6 pm

=> some expectation?

=> setting the scene (and use of memory)

Temporal - increasing smell, sounds, pots being scraped, sound of cutlery (it's getting closer) watching the clock tick closer to the "appointed hour".

Many semiotic writings apply intertextuality, whether they are aware of it or not, since the basis of semiotics is about a sign or sign-text intersecting with a reader/receiver (another textual opportunity) to convey a message sent by an author/sender. For example, when Manning & Cullum-Swan discuss their study of a McDonald's fast-food store, they touch on competing texts related to colour and organization of signage, negative association by diners including smells and childhood illness, the rhetoric of spaciousness, promotion of an image of fun and friendliness, ritualistic behaviour in the greetings of workers, and the dramatic production in terms of cast, costumes, props and setting (Manning & Cullum-Swan, 1994). Whilst the notion of intertextuality is not mentioned, that is clearly what it is!

Although theoretical writings are plentiful, empirical studies using applied intertextuality are difficult to locate, especially in relation to the clinical situation. This may reflect fundamental difficulties in the practical application of such systematic devices in real-world situations, given the complexity of textual information generated. As in the first example of a literary text, it is tempting to look for one-to-one correspondences and direct quotations when beginning to look at the field of intertextuality, however Fiske encourages a far deeper perspective,

> Intertextuality is not a system of allusions between specific texts, or of references between one text and specified others: rather it is located in that space between texts to which all texts and readers/writers refer more or less equally, but which all activate differently (Fiske, 1987, p.144).

Not only that, but the multiple texts involved in intertextuality may indeed cross borders of genre and appear in a broad variety of forms, often building on each other.

> Indeed, *culture* itself, or the collection of signifying practices in a society, is *radically intertextual [sic]*. For instance, we cannot explain music except through verbal language; we probably use hand gestures to support our discourse about music; we wear clothes that affect our interlocutor's response to our discourse, and so on (Morgan, 1985, p. 8).

The range of texts surrounding or relating to a given text is addressed by Barthes.

> A feature of discourse *refers[sic]* to another text, in the almost infinite sense of that word... In what is called inter-textuality, we must include texts which come *after*: the sources of a text are not only *before* it, they are also *after* it*[sic]* (Barthes, 1985/8, p. 230).

Barthes gives the example of Levi-Strauss's comments on the Oedipus myth relating to both Freud and Sophocles It becomes clear that intertextuality may be operating at different points in the semiotic process - with the text of the sender/author, the text of receiver/listener, the code and referent, the medium or genre - and actually underpins the elements of sign-based communication (see Guiraud's model, 1971/75). Further examination will begin by exploring these different focuses of intertextuality, beginning with the author/sender.

2.8-1 Creating the message

The author speaks through text(s) in order to convey a message, fulfilling a role as sender in the semiotic communicative act. A great deal of semiotic thought has been concentrated on finding detailed understandings of the author's message, from a structural point of view. For example, Manning & Cullum-Swan consider the messages generated by deliberate use of colour, grouping and placement of signs in a McDonalds fast-food store, in order to understand the carefully constructed message presented to consumers (Manning & Cullum-Swan, 1994).

Viewed intertextually, the author may also actively use a range of texts to create a unique text, a pastiche of his/her knowledge and experience. Barthes had an inkling of this with his concept of "the self as an intertextual site" (Barthes, cited in Morgan, 1985, p.18), however, he did not further develop this application of intertextuality. Hanninen explored the way that the author deliberately chooses texts, at a certain time and in a certain way, to convey their message, and is not just a passive voice (Hanninen, 1999). Hanninen comments on Ackroyds's analysis of Thomas Chatterton:

> For Ackroyd the author is still a meeting point between various texts and discourses; he is the crossroads where numerous texts "blend and clash"… but the radical poststructuralist emphasis is re-shifted when he shows through Thomas Chatterton that a poet or an author does not have to be at a total mercy of these discourses; he can still adapt, assimilate, transform, alter, reshape, revise or misread the precursor's texts as his own text ... Intertextuality for Ackroyd is still a feature of all writing, but an artist can assert his strength and even independence by active intertextuality and open plagiarism (Hanninen, 1999, p.5).

Clinical viewpoint

In the clinical situation, the patient is seen to be the creator/author, using a variety of texts to express themselves (Nessa, 1996). The patient's telling of illness in the clinical setting uses a range of voices (or texts) within the narrative context (Charon, 1993).

> Sickness tells many stories; the sick person's choice of a narrating self through whom to tell a story reveals much about the meaning of the entire illness. Because suffering persons have a depth of contradictory responses to their experiences, different features will emerge at different times in the illness or in front of different care-givers: the stoic accepter, the fearful cringer, the retaliatory blamer, the generous nurturer of others. These multiple contradictory voices must be heard and recognized, each an implied author, each a patient, who together compose the person who suffers (Charon, 1993, p.89).

The textual, and indeed intertextual, nature of such communication is very evident when more rigorous semiotic understandings are applied.

> The signs delivered by the patient may be regarded as a text, a story embedded in a body language. The patient is both telling and showing what is his or her sufferings and agenda. Hence, we perceive the sum total of the patient's signs by both listening to, seeing, feeling, touching and tasting the complex message from the patient. Symptoms experienced and expressed can also be regarded as cultural and communicative acts, attempts to translate subjective sensations into signs that are understood in the medical consultation (Nessa, 1996, p.374).

Thus, the function of the patient as author/sender in the clinical setting in the context of the research framework of intertextual communication is a notion which is clearly supported within the literature.

2.8-2 Minimizing the Author

Another viewpoint, developed as a reaction to the extreme structural complexity of sender-focused semiotics, brings to the foreground the role of the receiver. The receiver is also known as the listener, the reader, or the "subject". This viewpoint suggests that the author is less important than the reader/interpreter, where it was said that the message and meaning of the author had succumbed as a victim of cultural semiotics and the reader's intertextual interpretation.

> [Barthes] reinstates the individual subject at the very center, in the act of (re-) *[sic]* writing the text. After all, it is the subject – author, reader, analyst – who must make the intertextual connections that constitute the open text. "Interpretation", then, depends on the subject's ability to gather up a variety of intertexts and bring them to bear on the given text (Morgan, 1985, p.19).

In this framework, the reader is aware of multiple texts (intertextuality) and brings them to the text under consideration, creating a unique reading emerging from their individual interpretation. "We may say from an intertextual position, that, through the presence of a multiplicity of texts, both written and non-written, the meaning of a text ***arises*** *[sic]* in the presence of an interpreter" (Voelz, 1995, p.150).

This leads to the possibility of multiple and varied interpretations, in line with postmodern thought, where "each reader discovers a different text within any one work, the interpretation of a text telling about the reader as well as about the author or characters" (Charon, 1993, p.86).

Clinical viewpoint

In the clinical situation, the clinician is seen as the reader/receiver. The clinician looks at a whole range of texts produced by or related to the patient and uses intertextuality to "read" the patient, to make sense of varied and competing information, in order to find a satisfactory interpretation, in turn acted upon and applied to the clinical situation.

The notion of intertextual readings by the listener/receiver of the message fits well with psychotherapy/medical theory, where the client/author expresses themselves uniquely and is interpreted by a therapist/doctor with additional knowledge and experience that is brought to the situation, thereby "reading" the patient according to their own knowledge and experience – in fact, this is the basis of knowledge in medicine as handed down from the ancient Greeks (Nessa, 1996). The advantage of using literary theory to further enlighten the clinical situation is noted by Charon (1993).

> In the telling discovery and in the listening creation, the clinical contract potentially gives to doctor and patient great powers of understanding and accuracy. By describing the work of doctors and patients in terms of their writerly acts, their narrative contract, their sequencing, and their reader responses, hidden elements of medical work may become clear (Charon, 1993, p.87).

Charon further addresses the multiple levels of information being produced by the patient and interpreted by the clinician.

> The doctor reaches an understanding of the patient and the patient's problems by synthesizing multiple codes of information and sources of data – reading, that is,

> on many levels at once and then telling the patient what he or she has learned. The professional role, then is not one of solely diagnosis and intervention but one of recognition, of astute listening toward useful interpretation, and of reflection… The doctor, then is implicated in the process of discovering meaning in clinical events (Charon, 1993, p.93).

The notion that further layers of social and emotional information relevant to the clinical situation may emerge via intertextual understandings is also noted by Charon, who states that "A clinically useful and personally true medicine requires recognition of patients in their own lives – recognition of their health problems, recognition of their social and emotional realities, and recognition of their stories" (Charon, 1993, p.95).

In fact, turning to psychoanalysis, we find that Freud was aware of and influenced by an (Biblical) intertextual interpretation strategy in shaping his own approach to interpretation, through the practice of "midrash" (Handelman, 1978).

> Midrash is a search for the inner meaning of a given Biblical text as Freud's method was a search for the inner meaning of a dream text or a symptom. The Bible was considered an all-inclusive storehouse, with meaning for every aspect of life. The dream, likewise, for Freud was the "royal road to the unconscious", the great repository of the psyche containing archaic individual and collective treasure for man (Handelman, 1978, p.101).

Later, Jung also used an intertextual process in dream analysis, using interpretative techniques such as amplification and focusing not only on the patient's own interpretations, but also bringing to bear the therapist's awarenesses of social and cultural meanings as part of the interpretive process (Mattoon, 1984).

2.9 Discrimination of intertextual areas

Intertextuality in the clinical area is also strongly related to the idea of "context". As Linell writes,

> Any discourse or text is embedded in a *matrix of contexts [sic]* made up from an array of different *contextual resources [sic]*: prior discourse, concrete physical environments, people (and assumptions about people) with their interpersonal relations, various kinds of background knowledge, situation definitions (frames), models of topics talked about, etc. Different genres, discourse communities and communication situations will make use of contextual resources of different kinds and in different combinations (Linell, 1998, p.144).

A significant aspect of intertextuality involves looking at the other work of the author of a text. The texts prior to or surrounding the current or main one under study have been

described using varying terminology. Genette talks of the "peritext" being spatially situated in or around the text itself, with the "epitext" comprises all those additional external items that can be generated in relation to a text, for example, reviews, interviews with the author, relevant correspondence, and so on (Genette, cited in MacLachlan & Reid, 1994, p.104). Keller-Cohen & Dyer refer to the relationship of other texts to the main text in three ways - as historical, antecedent authorial, and anterior stream of text (immediately before) (Keller-Cohen & Dyer, 1997, p.148). Morgan suggests concepts of "intertext", "intratext", and "autotext" (from Morgan, 1985, p.20). Amidst the confusion engendered by such a multiplicity of terminology, MacLachlan & Reid suggest functional terms such as "circumtextual" and "intratextual", where circumtextual refers to "those framing items that strike a reader as prefixed or suffixed to the text (for instance information on a book cover)" and intratextual refers to "those items that seem to disrupt internally the reading process (for instance a play within a play, or subsectional titles)" (MacLachlan & Reid, 1994, p.104). The current research project adopts the terms "circumtextual", as meaning other texts surrounding the main text in question, "intratextual", meaning distinct and deliberate references to other texts from within the main text, and "intertextual", referring to broader cultural readings.

A further aspect of intertextuality, put forward by Voelz (1995), is that of a specific "interpretive community", where this brings to bear even more experiential meanings on the main text. This concept incorporates the broad understanding of a specific belief system in relation to the text in question. In Voelz's case, this was with regard to Biblical interpretation within the overarching belief system of the Christian interpretative community (Voelz, 1995) but in the current project, the "interpretive community" relates to the viewpoint of the community of therapists, particularly the principles and beliefs surrounding Jungian therapy.

2.10 Therapeutic change

In the process of therapy, change is expected to occur as a result of the application of treatment. This is equally true for the use of music and imagery in the therapeutic context, and the basis of this will now be explored.

As we experience life, we imbue symbols (words/music) with meanings, based on our experiences and who we are, and even a few words, images or notes of music may have deep or significant meaning. As therapists, we aim to use the music/images (in the context of language) to work back the other way – to unlock personal meanings for the person, and help them explore, enrich, expand these meanings as relevant to their current situation.

The way that meanings are imbued and imbedded is substantially based on semiosis. One meaning of a sign is then reflected on, to become a new (combined) sign for the next layer of meaning to be embedded onto it, thereby accessing concepts of polysemy (multiple meanings) and the infinite regress of the sign (Section 2.7-3). Concepts of semiotic thought and interpretation are needed to show/explain how this can happen, which occurs particularly in the telling and re-telling of narrative. Such telling and re-telling leads to a distillation of meanings into sign and symbol, such as that which we see in myths and archetypes (Jung, 1934/54/1968a).

Likewise, therapeutic change may be evident in the modifying and development of texts, stemming initially from the patient's own narrative process in the context of a therapeutic relationship.

> A story, even if it is a story about the teller himself or herself, is heard anew as it is told. Psychoanalytic theory rests on the belief that telling a story is a path towards understanding it. When patients tell about themselves, whether about physical or emotional or social matters, they put into words that which until then they have experienced only nonlinguistically; "the self," in other words, "is a telling"… Their telling, even more so than the novelist's writing, "constitutes the self"; the act of telling, like the act of writing, can mobilize memories, clarify connections among events, and articulate feelings that otherwise would have remained hidden. When patients tell about themselves, then, they are using narrative powers to order otherwise chaotic events (Charon, 1993, pp. 88-89).

In the process of creating their own text, the patient/author is encoding their experience for subsequent reading, both by themselves and by the clinician. The patient gains further insights by looking at areas of life/experience simultaneously, and being questioned about it. As reflexive readers, they see/hear their created text and seek to find additional ways that it applies to their own lives.

> As readers read, they read not only the signs of a given text in intertextual relationship, also with their own life-experiences as sign, to obtain a meaning for the text – but they read also and simultaneously their own life-experiences as

> textual sign and relate them and their potential meanings to the signs and to the meanings of those signs at the various levels which comprise the given text, to make sense of their own life-experiences as textual sign, i.e. to "apply" the text to themselves (Voelz, 1995, p.156).

Therefore, the patient continues to reinterpret their own texts, in the context of the clinician also interpreting and eliciting further textual information during the therapy session. As Adler notes, "we find that our experience changes in the very act of talking about it because we are re-experiencing the narrated events as we imagine that they are being perceived by the listener" (Adler, 1997, p.56).

This is yet another instance of the manner in which intertextual understandings may assist in elucidating processes in the therapeutic context. It explains why and how meanings may change during the course of therapy, and is relevant to the current study, given the undertaking of six ongoing music therapy sessions by particiapnts, allowing for potential change and adaptation to emerge.

2.11 Medium/Genre: The music text

The presence of music itself forms a text which may be considered in the light of its intertextual interaction with analysis of the reported imagery text. This shares a historical relationship with the patient's narrative (Keller-Cohen & Dyer, 1997), since it occurs at the same time. Temporal (time-based) aspects of the music interact with the temporal aspects of the reported imagery text. In fact, the presence of music in the music therapy session may act as an intertextual "trigger", promoting access to a range of further information. Music forms a particular type of text, which hints at, or directly involves, further texts or images.

In an earlier example, the sound of a bell ringing within the music may signify to the patient the experience of being in church, related to childhood attendance at school-based Mass. Expanding this intertextually may suggest even more possibilities. For example, if choir music is also present, it may easily be incorporated as angels, congregation, or an actual choir, and as the music moves on it may provide a genuine uplifting quality or promote a strong emotional reaction based on issues of "forced" religious attendance or alternatively grief related to the funeral of a loved one.

In the current clinical context, the music promotes and enhances the imagery text, and in doing so, lays the foundations for further clinical material to emerge.

2.12 Jungian interpretation

The nature and beliefs of the Jungian therapeutic community have already been substantially outlined in Chapter 1. However, at this point, the process of such research and analysis is relevant. In employing a Jungian approach to imagery, in particular dreams, some procedures are suggested, and generally initially approached from the narrative viewpoint of the patient but also take into account a broad range of social, aesthetic and cultural genres and texts. This is achieved particularly though amplification. Amplification is defined by Jung himself as "elaboration and clarification of a dream-image by means of directed association and of parallels from the human sciences (symbology, mythology, mysticism, folklore, history of religion, ethnology, etc.)" (Jung, 1961/1965, p.391). Such amplifications by both the client and the therapist result in insights and with clinical conclusions being drawn, which are then further examined in the light of subsequent data (Mattoon, 1984).

In order to interpret a dream, it is essential to gain a clear understandings of the exact nature of the dream, in order to "minimize dangers of reductionism" (Hall, 1983, p.34). Not only that, but associations and amplifications need to be gathered on the personal, cultural and archetypal levels, and the amplified dream then needs to be placed within "the context of the person's life situation and process of individuation" (Hall, 1983, p.34). Hall has thus provided a structure for interpreting dreams, which will be further discussed in Chapter 3 (Section 3.4-3).

2.13 Summary of research understandings/strategy

This chapter has taken the clinical focus of the previous chapter and moved it towards a research framework, based on the clinical health care endeavour of music therapy, namely, application of the specialist Bonny Method of Guided Imagery and Music. Although limitations of established information and literature are evident, nevertheless research findings relevant to understanding music, imagery, clinical research, the patient's viewpoint, basic and applied semiotics, interpretation of signs, and how to deal with multiple texts within the framework of intertextuality have been described and considered in terms of the current research project. In particular, the process of

intertextuality has been explored as an applicable framework to the current study, including concepts such as circumtext, intratext, intertext and interpretive community. In the next chapter, these research concepts will now be further explored and applied in order to arrive at a systematic process of applied analysis.

This upcoming chapter will also consider the role of the research paradigm, the process of thematic (textual) analysis, and the details of the current research project in terms of participants, equipment and so on. All these will serve to further address the research focus, which seeks to clarify how meanings related to adjustment from a health crisis (such as cardiac surgery) are depicted in music-supported imagery.

CHAPTER 3. APPROACHING RESEARCH: IMPLEMENTATION AND ANALYSIS

3.1 Introduction

This research project has focused on applying music therapy, in the form of the Bonny Method of Guided Imagery and Music (GIM), to the clinical population of patients recovering from heart surgery. This population provides a fertile ground for research due to physical and emotional health care issues which may be assisted by appropriate therapeutic intervention. In the current project, the narrative evident in the clinical GIM session lent itself well to a qualitative research process, in which the patient tells the ongoing story of their experiences, employing narrative in doing so, thereby creating their own text(s). This data can subsequently be analyzed for thematic and additional textual information, and then placed in a therapeutic context, in order to derive insight and understanding. The current chapter will begin with a broad outline of approach, followed by specific details of the research and implementation process, and conclude with an outline of the systematic analysis system developed for this study.

3.2 Focus and Research Approach

This project sought to clarify how meanings related to adjustment from a health crisis, such as cardiac surgery, were depicted in music-supported imagery. Not only that, but related questions sought to find out 1) how patients may use the imagery to depict their experience of themselves and their body, 2) how this sense of themselves can change, to adapt to their new circumstances post-surgery, 3) how they respond emotionally to these views of themselves and their circumstances, and 4) how the music may contribute to the depiction of the emotional and physical meanings, underscoring the entire rehabilitative process.

In considering the process of researching these questions, it became clear that distinctions exist between the different modes of applied research, and are each best suited to answering particular types of questions (see, for example, Morse & Field's comparison of a range of research strategies and associated questions, Morse & Field, 1995, Table 2.2). As Morse & Field note with regard to the selection of research modality, "it depends on what one wishes to know, what the expected outcomes of the

research will be, the constraints of the setting, the subjects, and, to a lesser extent, the resources available to the researcher (Morse & Field, 1995, p. 36).

In this current study, an interpretive approach is best suited to the open-ended and non-directional questions being asked in seeking to derive beginning information in the use of GIM with cardiac patients in recovery phase from the participant's perspective. Without specifically tailored theory or substantial previous studies on which to base further research, the current research is novel and innovative in almost every aspect, and thus best served with an interpretive approach.

3.2-1 Research Paradigm

Building theoretically on a synthesis of constructs in a range of clinical and other disciplines, as already shown in Chapters One and Two, it is first necessary to consider broad methodological issues in proceeding from this background theory towards the implementation of this research project.

According to Paton (1990), two major research paradigms currently exist. Each paradigm may be considered to be "a worldview, a general perspective, a way of breaking down the complexity of the real world" (Patton, 1990, p.37). These research paradigms may be defined as "logical-positivism, which uses quantitative and experimental methods to test hypothetico-deductive generalizations" (Patton, 1990, p.37), and "phenomenological inquiry, using qualitative and naturalistic approaches to inductively and holistically understand human experience in context-specific settings" (Patton, 1990, p.37). The latter is also known as an interpretive research paradigm.

The advent of this latter interpretive research paradigm into health care has provoked a profound re-thinking of the basis of research, amidst positivist, empirically-oriented research protocols, commonly inappropriately divided as quantitative and qualitative methods. Some researchers consider that these two paradigms form a continuum in the research field (Thomas, 1990). The situation becomes even more complex, when one finds that positivist researchers may examine interviews qualitatively as part of their research, and interpretivist researchers may examine transcripts for numerical data in addition to looking for meaning. Clearly, both qualitative and quantitative methods may be used to some extent in either approach. What differs more radically between these

two approaches is the philosophical approach to, and general understanding of, the question or area being investigated, which is the basis for the paradigm. There also may be differences in the type of reasoning engaged, that is, inductive versus deductive reasoning (Morse and Field, 1995), as will be discussed later in this chapter.

Links to epistemology, the study of theories of knowledge or ways of knowing, have been explored, with a view to establishing the value of interpretive research. In doing so, the entire nature of research inquiry, both positivist/empirical and interpretive frameworks, perspectives and understandings have been questioned. Philosophers such as Husserl (1913/1931) and Heidegger (1927/1962) laid the groundwork for the interpretive paradigm. This approach has been described as humanistic, interpretive, naturalistic, constructivist, phenomenological, hermeneutic, heuristic and historical (Lather, 1991), and recognized the need to preserve and notate the entirety of the experience for the person, with the researcher involved in the research process. Interpretive qualitative methods use in-depth, open-ended interviews, direct observation, and written documents (Patton, 1990, p.10), generating transcripts and field notes for review as a whole, in order to derive understanding and meaning of the experience/research question for the person. Patton describes the process as follows;

> Extensive field notes are collected through these observations, interviews and document reviews. The voluminous raw data in these field notes are organized into readable narrative description with major themes, categories and illustrative case examples extracted though content analysis. The findings, understandings and insights that emerge from fieldwork and subsequent analysis are the fruit of qualitative inquiry (Patton, 1990, p.10).

> Qualitative methods permit the evaluator to study selected issues in depth and detail. Approaching fieldwork without being constrained by predetermined categories of analysis contributes to the depth, openness, and detail of qualitative inquiry (Patton, 1990, p.13).

The nature of the research questions, the characteristics of the clinical technique of GIM, and the proposed mode of analysis suggested that an interpretive qualitative enquiry is indeed a most appropriate method for the current study. In fact, a range of interpretative approaches now exist in addition to phenomenology (Patton, 1990). For the current study, the overarching philosophy of narrative principles were applied together with a thematic analysis, given the storied nature of the music therapy method

of GIM, and later further explored via semiotic intertextuality and a Jungian perspective.

In the choosing of a research paradigm, and the approach within this paradigm, it should be noted that one type of inquiry is not better than the other, but serves different purposes and answers different questions (Morse & Field, 1995). Therefore, it is wise to take a pragmatic approach to choice of research paradigm (Patton, 1990), as has been done in the present study. This in turn influences the manner in which data is obtained and the planning of the process of systematic analysis.

3.2-2 Obtaining information

An interpretive approach also well suits the data to be gathered in the clinical situation, as it relates to the current study. Applied GIM promotes a spontaneous and open-ended (non-directed) generation of imagery with the music, and likewise encourages spontaneous narrative of both imagery and issues relevant to the client, in line with other methods of psychotherapy. This forms what may easily be considered to be an open-ended interview, with the only addition to normal clinical practice being the need for auditory recordings to assist with accurate research. The open-ended interview forms a major mode of data collection in interpretive research. As Patton notes, "an open-ended interview… permits the respondent to describe what is meaningful without being *pigeonholed [sic]* into standardized categories" (Patton, 1990, p.46).

The open-ended self-report data of this study was captured by the audiotaping of the entire GIM session (both the music and imagery treatment section and surrounding discussion sections), following the work of Kasayka (1991) and Irgens-Møller (1995). This was then transcribed to form the raw data for the analysis process. The two types of data collected were 1) reports of imagery with music, and 2) surrounding discussion, including both before and after the music and imagery experience.

3.2-3 Systematic analysis

In logical-positivist quantitative inquiry, a research instrument is typically and carefully devised to measure a certain parameter, with the instrument being then applied in a prescribed and standardized manner in the research and analysis process. In contrast, in qualitative inquiry, the researcher themselves becomes the instrument or research tool.

(Patton, 1990, p.14), and develops the research process fully during the course of analysis. Typically, this involves inductive reasoning as part of the analysis process, as is the case in the current study. Inductive reasoning develops knowledge by working from the specific to the theoretical, unlike the more common deductive reasoning.

> Inductive reasoning proceeds from specific observations (data) to general principles (laws). The observations may suggest a generalisable pattern which if repeatedly tested and confirmed can lead to the discovery of a lawful relationship… Deductive reasoning, by contrast, proceeds from a general law to specific examples. Deductions can be used to test a theory by generating specific predictions which can in turn be verified by observation (Smith, Connole, Speedy, & Wiseman, 1990, p.25).
>
> The strategy of inductive designs is to allow the important analysis dimensions to emerge from patterns found in the cases under study without presupposing in advance what the important dimensions will be (Patton, 1990, p.44).
>
> In short, the inductive approach to evaluation means that an understanding of program activities and outcomes emerges from experience with the setting. Theories about what is happening in a setting are grounded in direct program experience rather than imposed on the setting a priori through hypotheses or deductive constructions (Patton, 1990, p.44).
>
> Where the focus is on individuals, an inductive approach begins with the individual experiences of those individuals, without pigeonholing or delimiting what those experiences will be in advance of fieldwork… general patterns across cases may be identified when case materials are content analyzed, but the initial focus is on full understanding of individual cases before those unique cases are combined or aggregated. This means that the findings are grounded in specific contexts: theories that result from these findings will be grounded in real-work patterns (Patton, 1990, p.45).

The way that inductive reasoning has been used in the process of data analysis has been variously described by several researchers as unitizing and categorizing (Rudestam & Newton, 1992, p.114), coding and thematizing (Ingram, 1994), and developing themes and a code (Boyatzis, 1998, p.29). This process basically involves the careful separation of the data and its re-combination in order to derive new associations and patterns of understanding, as described by Rudestam & Newton (1992):

> Making sense of the data in the naturalistic sense means processing the data through some technique of inductive analysis. One approach involves two essential subprocesses that compose the basis of inductive analysis, unitizing and categorizing. *Unitizing* is essentially a coding operation that identifies information units isolated from the text. In the second subprocess, *categorizing*,

> information units derived from the unitizing phase are organized into categories on the basis of similarity of meaning (Rudestam & Newton, 1992, p.114).

Decisions made about processing the data into units and categories may be based on external or internal viewpoints. Terms commonly used to describe this are emic and etic, the originally coming from the areas of language and culture, and anthropology, and initially coined by Pike (1954, 1967). Whilst etic analysis observes and measures behaviour from a viewpoint external to those being studied (Tripp-Reimer, 1984), an emic approach to analysis involves "an attempt to discover and describe the patterns of that particular language or culture in reference to the way in which the various elements within that one system are related to each other" (Pike, 1967). Tripp-Reimer extends this, suggesting that "the emic approach yields a description of a cultural system from the inside, from the point of view of the participant, not the observer" (Tripp-Reimer, 1984, p.103). Such an emic approach well suits the questions being asked in the current study, seeking to discover the experiences and meanings that the participant is experiencing while undergoing music therapy, in the form of GIM, as they recover from cardiac surgery.

Approaching analysis of the self-reported data generated in this study, it is found that textual analysis looks at particular elements of the text, and the relationships between them, in order to construct meaning (Davis & McKay, 1996, p.152). Commonly, a thematic analysis process is used in order to do this. A thematic analysis of qualitative data may use one of several ways to move from the textual data towards developing a thematic code. This process may be driven 1) by theoretical constructs, 2) by prior data or prior research, or 3) inductively from raw data (Boyatzis,1998). The current analysis followed the latter approach to thematic analysis, an emic approach, where the data shapes the analysis. The (inductively driven) thematic analysis then formed the basis of material which was then also viewed from intertextual (semiotic) and Jungian perspectives, thereby extending interpretations from individual self-report right through to relevance into the clinical domain.

3.2-4 Credibility and qualitative research

In quantitative research, there is great emphasis on credibility parameters such as internal and external validity, reliability and validity, and objectivity. However, such

matters of credibility are treated differently within the field of qualitative research, and are subsumed under the concept of "trustworthiness"(Rudestam & Newton, 1992).

> Rather than requiring statistical generalisability from the findings, the issue here is more about recognizing significant patterns and recurring themes within the context of a natural setting, which can then become catalysts for further research… Results are less concerned with statistical accuracy than with emerging concepts and categories that propel the researcher continually to test and update theory (Anderson & Poole, 1998, p.28).

> Qualitative researchers, while not relying on scientific measuring apparatus, must demonstrate reliability and validity by different means. Their credibility is confirmed to the extent that data are collected ethically, that any personal biases are kept in check, and that interpretations are sound. Because of the interpretative nature of the work, replication is not the issue that it is in scientific experiments and often replication is virtually impossible (Anderson & Poole, 1998, p.28).

In qualitative research, researchers themselves are an important tool in the analysis process, as already mentioned. In qualitative research, the researcher is required to suspend their own belief and assumptions as much as possible, in a technique known as "bracketing". As Anderson and Poole point out, "The main danger in interpretive data analysis is that interpretation is a personal process and the researcher must be careful to distance themselves to a certain extent" (Anderson & Poole, 1998, p.29). Thus, in the current study, personal preconceptions were put aside in order to focus in a fresh and unbiased way on the material that the participant was producing. Although this concept is based in research ideology, putting aside one's personal self and preconceptions is what every good therapist must do in any case, in order to fully enter into and engage with the experience of the client, and so this phenomenological concept fits well with the study of a therapeutic field such as music therapy and GIM.

3.3 Implementing the Research Project

Basic research decisions were made regarding the implementation of the research design and method. These related particularly to the selection of participants, ethical considerations, research plan, setting, equipment and materials, data collection and recording, data analysis and trustworthiness.

3.3-1 Selection of participants

In this study, the clinical population of cardiac patients in recovery after coronary surgery formed the basis of the data and consequently the systematic analysis

undertaken. This population was chosen primarily because of a clear (physical) intervention and well-defined recovery trajectory. This homogeneity was helpful in the exploration of consistent information. The large pool of potential recruits, due to the high incidence of bypass surgery, made recruitment of participants pragmatically easier.

The selection of participants in this study is based on principles of "purposeful" sampling, using information-rich cases for in-depth study (Patton, 1990, p.169). This is sometimes also called purposive sampling. Participants also were selected to be representative of age, ethnicity, gender. To be selected, they needed to be fluent in the English language, such that they could express themselves comfortably and effectively on the majority of occasions. This was determined by an initial phone conversation after they had stated interest in the current study.

In order to be part of this study, participants were required to be progressing well with their rehabilitation, as determined and approved by the cardiac rehabilitation coordinator (contact-person) at their hospital. Participants were required to have no pre-existing psychiatric problems of a psychotic or longstanding nature. They were also required to not be on medication likely to affect the relaxation and imagery process. Participants needed to be comfortable with the use of classical music in this study, although no actual knowledge was required regarding this type of music.

Recruitment of participants for the current study was initially by cardiac rehabilitation programme staff in two tertiary hospitals. However, following difficulties in obtaining recruits, a brief (five minute) seminar presentation within the cardiac rehabilitation programme was trialled, and found to immediately increase recruitment numbers.

3.3-2 Ethical considerations

It is important to consider ethics in the planning of a research study, in order to protect the rights of participants and in order to obtain data of good quality. Approval from the ethics boards of both hospitals and university was completed before contact with any participants was made or data gathered.

In line with National Health and Medical Research Council guidelines, participants gave signed consent to their involvement in this research project (see Appendix 2). Prior to

this, the project was explained in initial phone contact, and again in detail before participants were asked to sign consent forms, with adequate time for questions.

Potential participants were informed of the use of classical music in this study. Both initial phone conversation and written information conveyed to the participant that the broad category of "classical music" was to be used, but that a knowledge of classical music was not required in order to participate in the study. Participants who then chose to participate were deemed to be aware of and comfortable with the broad style of classical music (see Information and Consent forms, Appendix 2).

It was explained to all participants that their participation was voluntary, that they were free to withdraw from the study at any time, and that their experiences would form the basis of the postgraduate study currently being undertaken by the researcher. They were also informed that the data would be collected via audiotaping, using clip-on microphones.

As part of an explanation of the clinical method of GIM, information was given about the structure of the session, the types of images that may occur (for example, visual, kinaesthetic, auditory) and a description of the way that reporting of the imagery process may function in ongoing interaction with the GIM therapist (see Appendix 3).

It was explained to participants that their anonymity was ensured. Use of a chronological coding system, based on order of entry into the study and session number, concealed each participant's actual identity from any reader of transcripts, thus protecting each participant's privacy.

The task of transcribing the audiotaped text of sessions was completed by the researcher only, and audiotapes were not made available to any other person. None of the transcriptions carried a public identifier that could be linked to a particular participant. All names of hospital staff or family, as referred to by the participant, were removed from the written text. Audiotapes of the conversations were kept in a secure place. It was confirmed for participants that any published work that arose from the study would not include their names.

3.3-3 Description of study participants

Six patients who were attending or had recently attended the cardiac rehabilitation programme at one of two major teaching hospitals participated in the research project. An overview of participants is presented in Table 3-1.

From this, it will be seen that ages of participants in the programme varied from 55 to 69 years, with the average age being 62 years. Equal numbers of males and females participated in this study. Two participants came from non-English speaking backgrounds (NESB), one Greek born in Egypt (Participant 4) and the other of Hispanic background from Chile (Participant 5). They had each lived in Australia for a long time - the former for 44 years and the latter for 35 years. Consequently, their command of the English language was competent and expressive, with only occasional difficulties concerning accent or word choice.

Table 3-1

Summary of participant data regarding participation in current research study

	Gender	**Age**	**No. of sessions completed**	**No. of weeks since surgery, at 1st GIM session**	**NESB (Yes/No)**
Pat.1	F	57	1 (withdrew from project due to family emergency)	9 weeks (quadruple bypass)	N
Pat.2	F	69	6	11 weeks (Valve replacement) (8 years ago, triple bypass)	N
Pat.3	M	62	6	6 weeks	N
Pat.4	M	64	6	15 weeks	Y (Egyptian/ Greek)
Pat.5	M	55	6	13 weeks (5 bypasses)	Y (Chile)
Pat.6	F	66	6	?6 weeks	N

Five participants had had recent first-time coronary artery bypass grafting (CABG). One participant had had a recent heart valve replacement, with a prior CABG surgery some eight years previously (Participant 2). This participant's recovery process from the current valve replacement was deemed (after consultation with the cardiac rehabilitation coordinator) to be very similar to recovery from CABG, with the valve replacement possibly having a slightly delayed recovery time by a matter of several weeks, but nevertheless following a similar trajectory.

One participant reported a pre-existing longstanding chronic pain condition (Participant 5). He had also had post-operative physical complications, including a severe chest infection after his bypass surgery, necessitating readmission to hospital in order to attend to the difficulties.

Most participants reported that they were involved in emotionally supportive relationships, however for one participant, the fact that her husband had been clinically "screened" by cardiac staff and consequently diagnosed with Alzheimer's disease while she was in hospital recovering from her bypass surgery led to an emotionally stressful relationship (Participant 6). Therefore, in addition to her own recovery, she was coping with the additional emotional burden of facing her husband's increasing ill health and confusion, with the associated responsibility for his welfare.

Attendance at music therapy sessions in this study was planned, where possible, to fit in with each participant's other visits to the hospital, where necessary, in order to make it logistically simple for participants to engage in and complete the study. For example, Participant 5 was seeing a psychologist, Participant 4 was attending a "Fat programme" (dietary advice and information), and Participant 6 an exercise programme.

One participant completed only the first session of her participation in the music therapy programme due to personal and family-based reasons outside of her control (Participant 1). All other participants completed their full quota of clinical GIM sessions.

Previous participation in any research programme was indicated by only one participant (Participant 3). He reported that he was happy to participate in any research

endeavours, and this was thought to relate to his comfortable connection to the health care area due to his field of work prior to retirement.

A further clinical summary of each participant appears in Appendix 4.

3.3-4 Research Plan

Research intervention occurred during the extended rehabilitation phase when physical recovery from cardiac surgery was almost complete. As physical recovery tended towards completion, emotional issues were now likely to come to the fore, thus providing the physical/emotional data sought in this study. Pragmatically, at six weeks post-surgery, participants were generally allowed to return to driving a car, and hence transport themselves independently to appointments such as the music therapy sessions in the current study.

A series of six GIM sessions was the time-scale chosen for this research project. This is generally considered an appropriate length of time for clients to learn, relate to and begin to use the GIM technique therapeutically (Bonny, 1978a). Six weekly sessions also formed an acceptable and not too onerous length of time to be involved in a research study, thus encouraging participation and preventing attrition of the research sample.

Participants commenced the research project at 6 to 15 weeks post-operatively, with the average being ten weeks (see Table 3-1). Generally, sessions occurred on a weekly basis, with some slight variations in the frequency of sessions occurring due to pre-existing commitments and holidays/vacation (see Appendix 5). Only once did sessions occur at a longer spacing than seven days (Participant 2). In fact, 76% of sessions were at seven days exactly, and the average number of days between sessions was 6.72.

All participants in the study chose to remain seated during the GIM session, due particularly to pain and discomfort resulting from their sternotomy, even though in standard practice, GIM participants are generally encouraged to be in supine position (that is, lying down), however this did not appear to negatively influence the imagery process.

In standard GIM practice, sessions generally occur for a time period of approximately two hours, depending on clinical and situational factors (including the health status of the participant, concentration, and how quickly they became tired). Although it was anticipated that many sessions in the current study may frequently be shorter than two hours due to health and tiredness, this did not eventuate, and sessions were more inclined to be over-time than under-time in this research study with these participants.

An initial set of broad questions formed a conversational framework which was covered in every beginning GIM session in this study. It did not constrain the flow of interaction and discussion, but ensured that important question areas were not neglected. This covered information about illness/surgery, experiences with imagery and music, awareness of own needs, and participant questions regarding the music therapy process and the research project (see Appendix 6).

3.3-5 Setting, equipment and materials

Setting

Music therapy (GIM) sessions in this research study were held in a quiet and conducive room in the hospital. Practical considerations for the use of such a room in the hospital included the availability of medical help should any incident occur related to their cardiac recovery process. Several rooms were used, being Meeting, Seminar or Examination rooms. Any existing medical equipment in the room was removed or covered, in order to make it less "medical" and conversely more conducive to relaxation. The relaxation experience was enhanced by dulled lighting, and the availability of a comfortable chair (or chairs), blankets and pillows. Sundry items such as tissues were also available, with drinking water and restroom facilities close by. The room was booked by the researcher to be without interruption for the duration of the session (approximately two hours).

Some problems impacted on the implementation of the GIM sessions. These related to the setting, and included interruptions by people (staff) and miscellaneous noises. Both of these proved to be distracting in the therapeutic situation, and had the potential to challenge the private and inner-directed nature of the therapeutic context. In one

instance, a medical staff person entered the room, disputed the room booking, and asked the music therapist to leave. Following his checking with the room booking office and returning for further discussion, the correctness of the music therapist's booking was confirmed, but since the other room (incorrectly booked by him) was in fact more familiar and suitable to the GIM research programme, the participant agreed to an immediate relocation across the corridor to the other room (Pat5-2). The session had been interrupted at the early stages of the relaxation procedure, and was then recommenced. In another instance, a workman knocked and entered the room, and following brief discussion attended to plumbing pipes in the wall. This took less than five minutes, and occurred just as the participant started to settle down for the music and imagery (Pat4-5).

Other interruptions included stray noises which were frequently not only audible but loud and distracting. This included a jackhammer (Pat4-2), gurgling and swishing water pipes (Pat5-3), loudly squeaking doors (Pat3-4, Pat5-2), emergency vehicle sirens (Pat2-3, Pat2-4, Pat5-1, Pat5-4), rainstorm or thunderstorm (Pat2-1, Pat 2-4, Pat2-5**),** or people talking loudly outside (Pat4-2, Pat6-6*;* Pat5-2). These distractions challenged the auditory focus required for effective GIM therapy, and the therapist took appropriate clinical steps, such as raising her voice or increasing the volume of the music, where necessary, in order to maximize the effects of the GIM session above the other distractions.

Equipment

Research equipment included a high quality audiocassette recorder, two lapel microphones, an auditory signals mixer/plug, and a selection of blank audiotapes which were used for data collection. The lapel microphones were necessary in order to clearly record the sound of the two voices above the sound of the music.

Additional analysis tools included a dictionary and a thesaurus, in order to further define and bring to the fore the researcher's lexicon, with a view to finding the best word to describe themes and thematic groupings.

Standard equipment for GIM therapy sessions included a compact disc/cassette player. The standard set of over twenty precisely formulated pre-recorded GIM programmes,

and also additional appropriate classical music, were available for use by the GIM therapist, and in this study.

Clinical materials

The Bonny Method of GIM formed the research tool of this project. This clinical method has already been fully described in Chapter One. At this point it is important to note specific details of application to participants in the current research study.

Music

The music used in this study was programmed in such a way as to promote initial relaxation, enhance the production of mental imagery as the imagery progresses, and assist in completion of the imagery process, thereby enhancing exploration by the participant of a variety of internal experiences.

Each music programme consisted of 30-45 minutes of carefully selected Western "classical" music, including music form Baroque, Classical, Romantic and Twentieth Century eras. Many programmes have been designed with specific purposes in mind (for example, "Grieving" (Keiser Mardis), "Positive Affect" (Bonny)), and these were utilized as appropriate in the clinical/research situation. The music may be described as complex and multi-layered in nature (Bonny, 1989), providing opportunities for idiosyncratic responses by each participant.

Individual choices of music used for each participant's session was additionally determined by clinical information such as energy levels, perceived therapeutic issues, personal factors, and information about responses to music, as in standard GIM practice.

In accordance with standard practice, established GIM programmes (or parts thereof) were used in all music therapy sessions except one. A total of eleven different programmes were used for the six participants in various configurations (see Appendix 7; Appendix 8). In addition, one new GIM programme was used ("Reconciliation", as cited in Bruscia & Grocke, 2002, for Pat6-6) since it was considered to be the best choice relating to the person's issues. In another instance, non-programmed, but suitable, music was used for the last session of the series, and in order to reduce the

possibility of newly emergent client material which might have required substantial further therapy (Gluck: Dance of the Blessed Spirits; Pat5-6).

The most commonly used music programmes in this music therapy research project were “Quiet music”, “Peak experience”, “Nurturing” and “Creativity 2”, with lesser use of “Mostly Bach”, “Grieving” and “Transitions”, and only occasional use of other programmes or additional music, as outlined in Table 3-2. In only one case was a programme changed, and in this case parts of two music programmes were used.

Table 3-2

Ranking of music programmes in order of frequency of use in this project

Name of programme	**Frequency of use (Total = 31 sessions)**
Quiet music	6
Peak experience	6 (twice for 2 participants)
Nurturing	4
Creativity 2	4
Mostly Bach	3
Grieving	3
Transitions	2
Relationships	1
Emotional expression1	1
Dance of the Blessed Spirits (Gluck)	1
Reconciliation	1

In the current research project, all participants began their first session with the “Quiet Music” programme, unless it was clinically contraindicated, in order to promote initial consistency. It should be noted that until the process of music and imagery is undertaken for the first time, individual differences are often less apparent, and a good general-purpose programme is quite acceptable. This programme, “Quiet music”, is known to be a good introductory programme (Grocke, 2002), and is suitable for people who may have low energy or physical problems (Ventre, 1990). For this reason, it was a very suitable choice for the first session of participants from this clinical population.

Only one participant did not begin with this music programme in the first session. This was because of a hearing problem, where the wide contrasts in timbre, volume, and tessitura may have been difficult for the participant to hear with consistency. In this instance, the "Nurturing" programme was chosen since the music was a little more homogenous in character. Information about her hearing loss problem was provided casually by the participant, at the last moment, immediately prior to the commencement of the music and imagery segment, and hence sudden clinical decisions had to be made to accommodate this stated difficulty. This was based on reported experiences of not being able to hear a facilitator's voice when it dropped in volume during a meditation session (Participant 2).

Relaxation Procedure

The imagery experiences of GIM therapy are generally preceded by a relaxation procedure, in order to prepare the client for using the music and imagery experience. As in standard GIM practice, the relaxation procedure was utilized to be appropriate and relevant to the individual participant's current status, based on their preferences and experiences, health status and energy levels, and any issues discussed or apparently emerging from prior discussion. It should be noted that the "progressive relaxation" technique (Jacobson, 1942) was contraindicated, since it encourages severe clenching or cramping of muscles which may impact on physical pain and circulation problems in this particular clinical population. Such a view by the researcher was indeed endorsed by clinical rehabilitation nurses in informal discussion; therefore the "progressive relaxation" technique was not used at all in this current research study. A range of other suitable and appropriate individually-tailored relaxation techniques were used, mostly based on the autogenic method (Schultz & Luthe, 1959) untilizing imagery of colour, light and so on. These were effectively used in order to achieve the relaxation necessary as a prerequisite for unfolding of the imagery in the GIM process. Consistency of initial approach was also achieved by having all participants begin their first session with a relaxation procedure based on their choice of colour, unless it was contraindicated due to clinical data or personal preference.

Other clinical considerations

Clinical choices for GIM practice with this population and in this context included giving participants the option of lying down or sitting up during the music and imagery

segment, since it was unclear to what extent their sternotomy may produce physical discomfort (including pain) in the supine position. Obviously, discomfort and pain work against the ability to relax. Therefore, each participant was encouraged to choose their preferred bodily relaxation position (that is, supine or upright). If sitting up, participants were encouraged to raise their feet on an additional chair, and to use pillows and blankets to make themselves as comfortable as possible.

The fact of sitting up, not so common in GIM therapy, did not appear to impair the imagery and relaxation process in this research project, as shown by reported imagery that was vivid and relaxation which was often very deep. Only one participant reported physical discomfort directly linked to relaxing in the sitting-up position. This consisted of temporary neck pain after the music and imagery segment, which he spontaneously relieved himself in a matter of minutes by simple self-massage and gentle movement of the affected part (Pat4-4).

3.3-6 Data Collection and Recording

In this research project, entire GIM sessions were audiotaped and transcribed verbatim, preserving as much information as possible. In line with qualitative principles, a research journal was kept by the researcher, which included a range of information, thoughts and impressions, and also served to enhance trustworthiness.

The audiotaped recordings obtained from the music therapy sessions were generally of clear sound quality, with voices of both the participant and the researcher/music therapist as well as the backgrounded music captured well by the clip-on microphones. This meant that the sessions were relatively easy to transcribe. Due to technical problems, some material was unfortunately lost from tape recordings in three sessions (Pat4-3, Pat5-3 and Pat6-3), and the research journal was utilized to help fill in the gaps and add further perspectives, where necessary.

All transcribing was undertaken by the researcher herself. Although this was a time-consuming activity, it promoted a familiarity with the data that would have been difficult to achieve in any other way. Such familiarity also added clarity to the understanding of the text, due to recollections of the participants' voices, accents, emphases and inflections.

Following the transcribing process, the text was "cleared" (Ingram, 1994, p.276). Clearing the text involved the removal of superfluous material and, for the current project, particularly meant removing the "Mm's" and "Mm hm's" frequently uttered by the music therapist during the session in order to support and encourage the participant's imagery process.

For volunteers from a non-English speaking background (NESB) who participated in this study, and in instances where in the spoken text the meaning was clear but when written would lead to confusion, there was some minimal adjustment of the grammar in order to preserve clarity, for example, resolution of occasional disagreement of grammatical tenses and verb endings.

Data collected could be clearly divided into several data sets. The main text consists of imagery reported by the participant, stimulated by the music therapy context, rather like a waking dream with a soundtrack. This was the central part of the GIM (Bonny Method) session, defined as "Music and Imagery Treatment" (see Figure 1-2, p.43), and therefore formed the main text for the analysis process.

This central text was surrounded by both pre-music and post-music discussion texts, known as Investigative and Cumulative Discussion respectively (see Figure 1-2). The Investigative Discussion accessed information such as comments about previous sessions (as applicable), about experiences of imagery, relaxation and music, current and past health status, and current feelings and awarenesses. Cumulative Discussion focused on the preceding imagery and music experience, and on any links or insights of which the participants may have become aware. It also accessed further information about the meanings and associations for the participants, including cultural information.

Additional data was also derived from two standard imagery dictionaries (Cirlot, 1971; Cooper, 1978), in order to access and explore intertextual aspects of images, and other specific informational sources were tapped when necessary, in order to further understand an image or concept put forward by the participant.

3.4 Data Analysis

> To analyze is to find some way or ways to tease out what we consider to be essential meaning in the raw data; to reduce and reorganize and combine so that readers share the researcher's findings in the most economical, interesting fashion. The product of analysis is a creation that speaks to the heart of what was learned (Ely, Anzul, Friedman, Garner & Steinmetz, 1991, p.140).

The analysis of this research project reflected a three-stage process. Firstly, the text of participants' narrative during the Music and Imagery Treatment phase was coded to derive themes and grand themes, according to a thematic analysis.

At a second stage, the semiotic process of intertextuality was applied. In doing so, this analysis sought to understand how the person was using imagery as a sign to convey meanings about their adjustment process and to draw links between emotional and physical phenomena.

Thirdly, viewpoints derived from the Jungian interpretive community were brought to bear on the emergent thematic and intertextual material, giving rise to interpretive patterns (known as archetypes), in order to explore how participants were currently approaching adjustment and reformulation of meanings, given their changing and changed circumstances following cardiac surgery. Each of these three stages of analysis will now be explored in further detail.

3.4-1 Stage 1: Thematic analysis of narrative

The first stage of the analysis focused solely on the client's reported experience of the music and imagery, seeking to understand meanings that the client was communicating via their imagery narrative, using the clinical research tool of the Bonny method of Guided Imagery and Music (GIM). At the second stage of analysis, pre- and post-music texts were further examined, as will be noted later in Section 3.4-2.

The narrative resulting from the Music and Imagery Treatment therefore formed the main text, which was analyzed thematically (Polkinghorne, 1991). Such a thematic analysis has been applied affectively to the therapeutic context (Ingram, 1994; Aronson, 1994).

> From the conversations that take place in a therapy session or those that are encouraged for the sake of researching a process, ideas emerge that can be better

> understood under the control of a thematic analysis. Thematic analysis focuses on identifiable themes and patterns of living and/or behavior (Aronson, 1994).

Thematic analysis also involves

> the search for and identification of common threads that extend throughout an entire interview or set of interviews. Themes are usually quite abstract and therefore difficult to identify… The theme may be beneath the surface of the interviews but, once identified, appears obvious. Frequently, these themes are concepts *indicated [sic]* by the data rather than concrete entities directly described by the participants(Morse & Field, 1995, p.139).

A thematic analysis can be applied to psychotherapy, using a six-stage process to emically derive and map a hierarchical structure of themes in order to understand what the client was saying in therapeutic context, as demonstrated by Ingram (1994). These stages involved 1) transcibing the text, 2) clearing, which involves making the text more manageable, 3) coding, the first level of analyzing textual content, 4) blocking, to identify the single best representative statement related to the text, 5) thematizing, including the derivation of initial, higher order and central themes, and 6) depicting relationships between content areas, themes and higher order themes through a graphic "map". Ingram also notes that "some texts may include content areas only, with no relations explicated between segments of content. Some texts may include themes without yielding higher order themes" (Ingram, 1994, p.278).

The current analysis was based on the structure outlined by Ingram (1994). It should be noted that the concept of blocking, in order to use a piece of text only once, was not used in this study, and thus a piece of text was allowed to be placed within more than one theme when absolutely necessary. The analysis followed this process:

1) transcribing the text,
2) clearing the text, which involve making the text more manageable,
3) coding, the first level of analyzing textual content, by breaking it into sections
4) thematizing, including the derivation of higher order and grand themes, and
5) depicting relationships between content areas, themes and higher order themes through a graphic schematic diagram or "map".

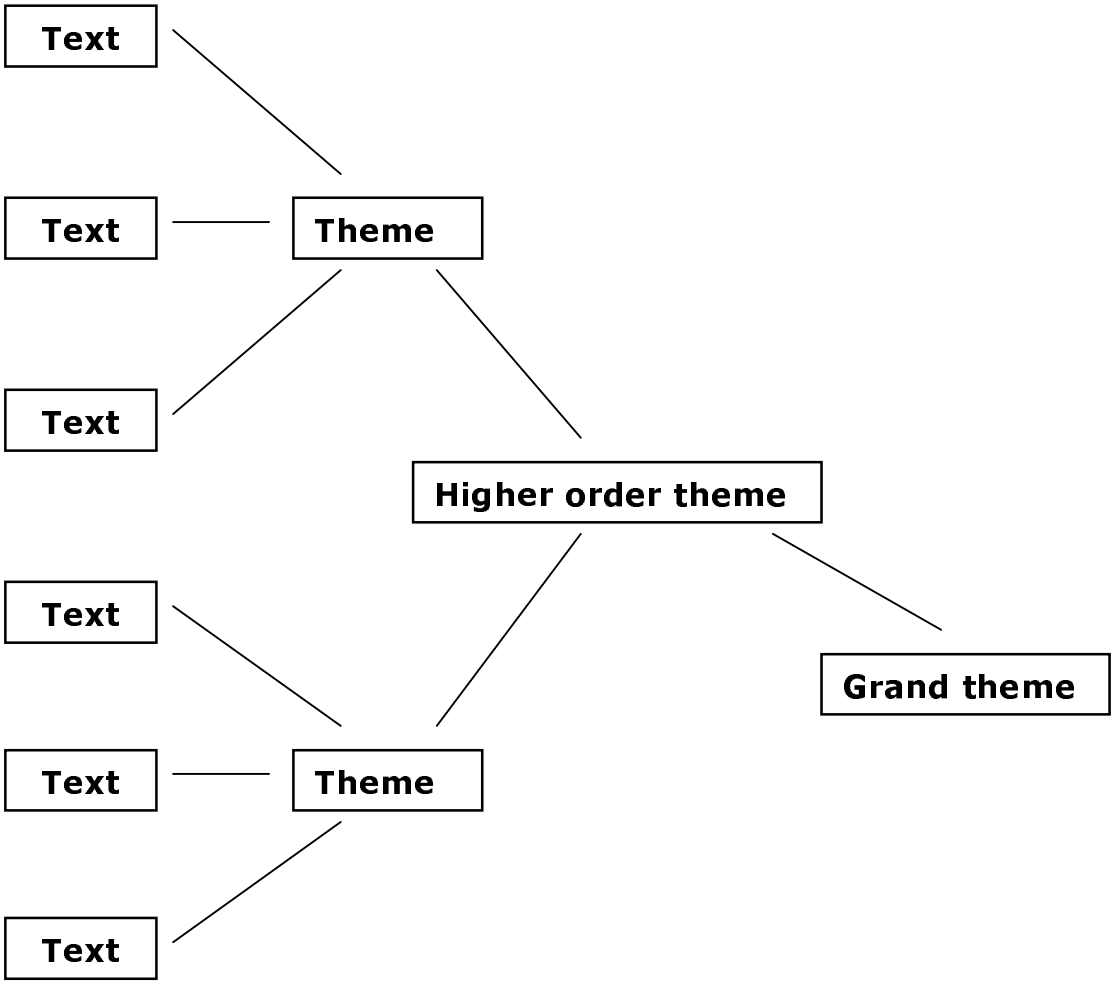


Figure 3-1. Schematic diagram of coding and thematizing in the analysis process

The different phases of thematic analysis are depicted schematically in Figure 3-1, and will now be further addressed, noting that transcribing the text and clearing the text have already been addressed above (Section 3.3-6).

The thematic coding process.

A thorough knowledge of the text was required in order to commence the thematic coding process. This had already occurred to some extent during the transcribing of the text, whereby the researcher gained a deep understanding by transcribing all her own audiotapes. Relevant insights or observations generated during the transcribing process were noted, for later consideration. Once written transcripts were available, they were read repeatedly by the researcher and reflected upon, with a view to generating a deep understanding by the researcher of what the person was attempting to convey to the

clinician. These texts were broken into relevant small units and coded for individual themes based on the text. Text was coded under more than one theme when necessary. At the initial level of thematic coding, data was grouped under themes that were fairly close to the text. At the same time, clinical insights were noted, compared to the groupings, and then adjusted and reworked as necessary so that there was the potential for apparent connection in subsequent levels of analysis.

Thematizing for higher order and grand themes

The thematizing process involved reviewing the individually coded themes in order to collect them together into higher order themes. However, the real value of qualitative research lies not only in discovering individual themes, but also in searching for broader themes across participants, in order to gain a better and deeper sense of what is going on. In this process, "themes that emerge from the informants' stories are pieced together to form a comprehensive picture of their collective experience" (Aronson, 1994, p.1).

Following derivation of the higher order themes from the initially coded themes, these were pooled, and reviewed emically, exploring similarities and differences in thematic material and thus extending it to a further level of analysis, in order to determine grand themes which represented the narrative text. In this study, there were five grand themes emerging. These themes were, "Looking through the frame", "Feeling the impact", "Spiralling into the unexpected", "Sublime plateau", and "Rehearsing new steps". An additional grand theme, "Sounding the changes", was derived from text referring specifically to the music. Each of these themes will be further outlined, described in more detail, and discussed in the light of research data in subsequent chapters of this thesis.

3.4-2 Stage 2: Semiotic analysis

At a second stage of interpretive analysis in the current research study, the emergent Grand themes from the thematic analysis became the focus of an exploration of the range of other texts occurring at the same time as or interacting with, the Music and Imagery Treatment text. In this process, additional texts were brought to bear on this primary text, thus expanding understandings of messages being conveyed by the Grand

themes. As already noted, these additional texts and references to other texts naturally occurred within the structure of the standard GIM session.

Investigative and Cumulative Discussion texts carried a wide range of information about the experiences and reactions of participants, the personal meanings of images, and their responses to and understandings of music in general and the particular music used in GIM. These additional texts were understood from a semiotic perspective as part of the intertextual process. Expansion towards cultural associations and understandings proceeded via the use of additional printed material such as two standard imagery dictionaries, and other relevant specific sources, in order to look for cultural associations to the reported imagery in question (Cirlot, 1971; Cooper, 1978).

Intertextual viewpoint

In order to shed further light on the thematic analysis, this current project has adopted the concepts of Intratext, Circumtext, Intertext, and Interpretative community, based on the work of MacLachlan & Reid (1994) and Voelz (1995). "Interpretative community" will be treated separately, and forms the Stage 3 analysis process in the current study. At the Stage 2 level of analysis, "circumtextual", refers to other texts surrounding the main text in question, "intratextual" refers to distinct and deliberate references to other texts from within the main text, and "intertextual", refers to broader cultural readings. The researcher's further reading and interpretation of the text of the patient involves the use of intertextual understandings. Each of these three intertextual areas will now be further defined and explored for relevancy to the current research project.

Intratext

The term "intratext", refers to another whole text or set of signs of some sort (MacLachlan & Reid, 1994; Voelz, 1995). This may be, for example, a movie, a piece for art, or a piece of music, and in this intratextual phase of the current analysis such a reference must be actually stated in the main (reported imagery with music) text. Actual examples include the film, Fantasia, Michelangelo's sculpture of the Pieta, or references to theme parks such Disneyland and Luna Park. For clarity of analysis, references to the music text by the patient from within the main text will be individually treated in a separate chapter (Chapter 9).

Circumtext

The circumtext refers to the range of texts produced in discussion by the participant, surrounding or related to the main (reported imagery with music) text. In particular, this refers to discussions before and after the music, namely, Investigative Discussion and Cumulative Discussion. It also includes references to previous or subsequent sessions. This in turn sheds light on the meanings of the main text via the way that these other texts directly interact with the primary text.

Intertext

In this analysis circumtance, the word "intertext" is specifically used to address the broader cultural look at the themes arising from the primary text, in particular by looking at other literary and cultural texts. This includes the direct use of two dictionaries of symbols (Cirlot, 1971; Cooper, 1978), which incorporate cultural knowledge in the understanding of symbols, and other relevant specific sources, for example, reviews of movies or written reflections on the nature of the relationship of golf to life in general.

Music-based text

Up to this point, and for purposes of simplicity, we have chosen to separate the music text, for ease of analysis. A full musical analysis, in terms of scores, will not be attempted in this thesis, although productive information has been obtained from a focus on the role of the music in GIM (Grocke, 1999; Lem, 1998; Marr, 2000). In fact, the current thesis is aimed towards answering clinical rather than musical/aesthetic questions. A broad outline of musical considerations occurs in Chapter 9.

Analysis of the data with regard to an understanding of the impact and role of the music was explored in similar fashion to the rest of the analysis process. Narrative text produced by the participants referring specifically to the music during the Music and Imagery Treatment was subjected to thematic analysis, and then subsequently explored via intertextuality, using surrounding discussion and related material in order to derive information about the role of the music in applying the music therapy technique of Guided Imagery and Music to the cardiac population recovering from bypass surgery.

3.4-3 Stage 3: Interpretive community

At the third stage of the analysis process, the intertextually-informed emergent Grand Themes were reviewed from a Jungian perspective in order to identify fundamental patterns and archetypal material. This in turn suggested understandings to be applied back to the cardiac rehabilitation population, in order to further enhance the client's rehabilitative experiences, within the clinical framework.

At this level, the interpretive community (Voelz, 1995) with its shared belief system, is brought to bear in the analysis. In this case, it involved using the Jungian belief system to derive further understandings of the textual material presented by the client, especially in terms of archetypal patterns and their relevance to life, personal development and health care. It also provided the rationale for looking at therapeutic change and development – the teleological endeavour.

For the current study, Hall's method of dream interpretation has been adapted as a framework for deriving understandings. Since an ongoing spontaneous imagery can be seen as a form and inner process similar to a dream, and the GIM session has often been described as being like a waking dream, this procedure seemed appropriate to the current process. Hall (1983) outlines three general stages of dream analysis, which include finding a clear understanding of the exact details of the dream, followed by the gathering of amplifications progressively at personal and cultural levels, a consideration of archetypal dimensions, and putting the amplified dream in the context of the participant's life situation.

This fits well with the foregoing analysis plan: the narrative transcribing and thematic analysis has most definitely sought to gain a clear understanding of the exact details of the dream, which the process of standard GIM therapy has supported via the manner in which the GIM therapist asks clarifying questions during the Music and Imagery Treatment phase.

In addition, surrounding discussion sheds further light on the exact nature of the specific imagery in question. This discussion also provides a forum for exploring personal and

cultural amplifications and associations, which has been addressed in the foregoing consideration of the intertextual nature of the clinical situation.

What remains for the Jungian perspective of this analysis is to explore the archetypal aspects of the imagery reported by the participant, in a way which puts the entire amplified (and associated) aspects of this research project within the context of the participant's life situation, which in this instance especially addresses aspects of rehabilitation and healthcare. In doing so, it has the capacity to encapsulate the experiences of participants into a meaningful pattern, promoting understanding of the tasks involved in recovering from serious cardiac surgery.

3.5 Trustworthiness

Aspects of trustworthiness of the data and the analysis process, as relevant to the current study, have already been mentioned at various points in this chapter, and such issues will now be further considered.

3.5-1 Data gathering

Participants were approached ethically regarding all aspects of the study, and the data was gathered with accuracy via the use of audiotapes. It was gathered over a number of sessions (six), and participants were asked in each successive session to further comment on previous sessions, thereby clarifying and expanding on topics, issues, images generated, and promoting elements of corroboration between sessions. Field notes were kept, in order to enhance data, and written transcripts were checked carefully for accuracy.

3.5-2 Data analysis

The process of coding of the raw data has already been addressed in this chapter. The qualitative research concept of the audit trail was also followed, aimed at establishing the credibility of qualitative research, by showing that processes are clear, systematic, well documented (Robson, 1993). In the current project, the audit trail consisted of elements shown in Table 3-3.

Table 3-3

Examples of categories of information in the audit trail of the current study (derived from Robson, 1993, p.406).

Category of information	Examples
Raw data	Audiotapes, transcribed sessions, field notes
Processed data and analysis products	Reflections on data, write-ups, summaries
Data reconstruction and synthesis products	Codes, patterns, themes, and the final report
Process notes	Reflections on procedures, implementation plan
Materials relating to intentions and dispositions	Original proposal, personal notes, intentions, expectations, etc.
Instrument development information	Initial trial analysis, schedules

3.5-3 Relevance

As Anderson & Poole note, in regard to qualitative research, "it is also important that researchers do not over-generalise from small scale studies" (Anderson & Poole, 1998, p.29). Qualitative research typically uses a relatively small number of participants within the context of a specific setting. For this reason, care was taken with regard to generalizations to other subjects and situations, and were "always modest and mindful of the context of individual lives" (Rudestam & Newton, 1992, p.39).

3.6 Overview of research method

In this chapter, the focus has been on harnessing the foregoing theoretical basis with the research questions in order to apply a systematic research approach and method to the implementation of music therapy sessions with the chosen population of participants recovering from cardiac bypass surgery.

This analysis was designed to proceed from the inside out, emically, rather than imposing categories on the information derived. Working from an accurately reported and transcribed text (from audiotape), the actual words of the person were developed through careful and systematic analysis to reach a deeper level of understanding, though increasing levels of carefully controlled abstraction.

The analysis also brought into play other relevant information, both from surrounding discussion and from broader culturally-based material. This wealth of broad and expanded understandings, was placed within a Jungian and archetypal framework in order to bring further light to bear upon the participant's experience of and reactions to cardiac surgery and rehabilitation.

CHAPTER 4. SYSTEMATIC ANALYSIS

Overview of analysis

According to the foregoing plan and based on qualitative principles of inductive analysis, transcribed narrative data of GIM sessions were separated into suitable units for coding and then analyzed for themes and grouped together to form grand themes. At this level, the emergent grand themes arising from the data were “Looking through the frame”, “Feeling the impact”, “Spiralling into the unexpected”, “Sublime plateau” and “Rehearsing new steps”.

As will be demonstrated, each of these grand themes was built up from lower order themes emerging from the data. A thematic “tree” diagram indicating the relationships of themes and grand themes is presented in Figure 4-1.

As demonstrated schematically, themes emerging from the data of reported imagery in the music therapy session led to subsequent grand themes at a higher level of textual analysis. Each of these grand themes will now be addressed individually. Following each grand theme, additional intertextual material will be discussed, in order to offer further semiotic perspectives on the nature and meaning of the grand themes, as relevant to the participant’s experiences and within the context of recovering from cardiac bypass surgery.

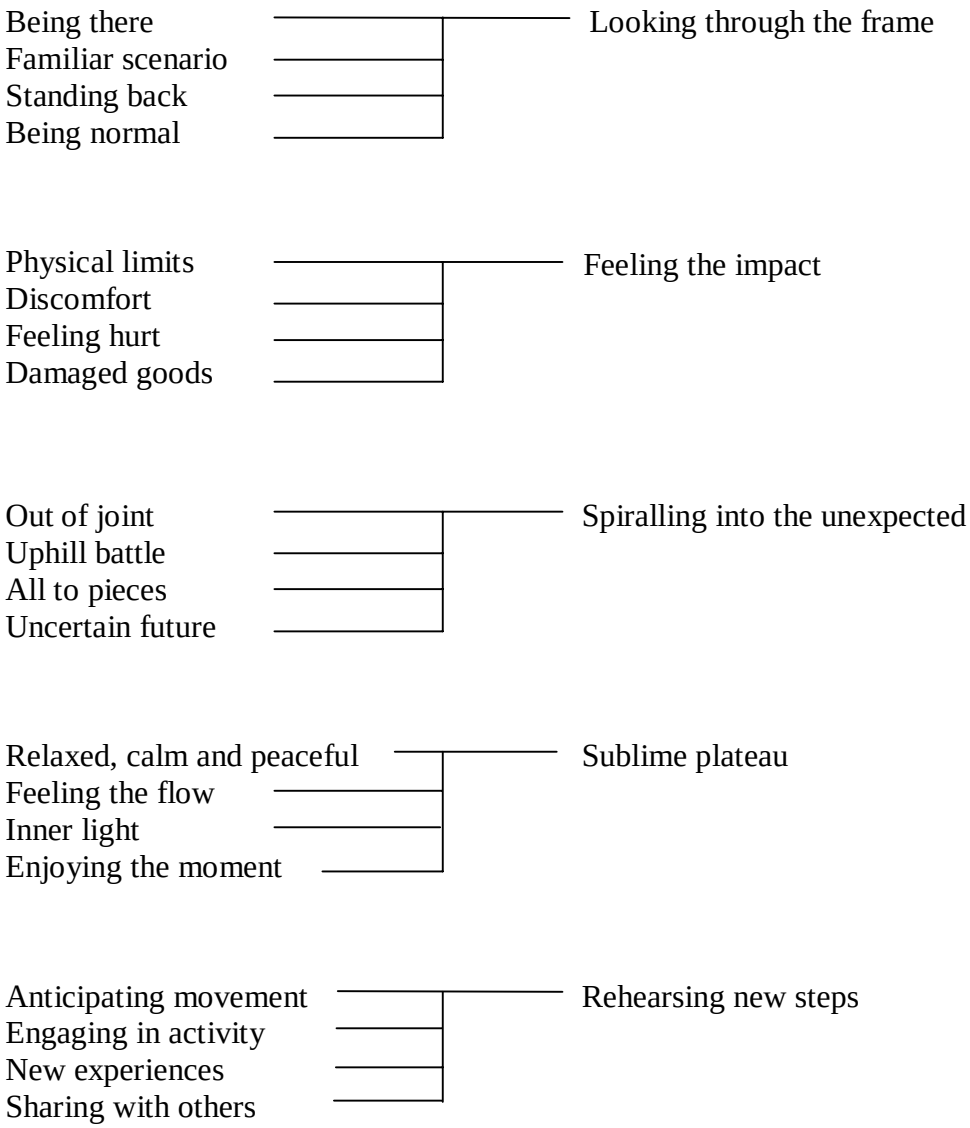


Figure 4-1. Thematic tree diagram of themes and grand themes emerging from music therapy research data.

GRAND THEME 1. LOOKING THROUGH THE FRAME

4.1 Textual analysis

The act of looking suggests a gaze in a particular direction, and carries the sense of seeking, searching, examining, watching and reviewing (Urdang & Flexner, 1968, p.790). It also suggests observation and attention to what is really there, in front of the one who is looking. The place from which the looking takes place is likely to be familiar to the person. They look around and see what is there, which conveys something about how they see the world and their place within it. Extending this, looking from where the person is becomes their foundation, from which to move forward, their base level, the person's home camp or launching pad.

A frame, as in, for example, a picture frame, adds definition to what is being viewed, it puts a clear edge around it and draws attention to what is inside (Urdang & Flexner, 1968, p.524). A frame can also be used to provide a sense of foreground and background, thereby providing a highlighting function, leading to a focus of attention on what is important. Thus, it tends to also add a sense of perspective.

The overall structure of themes contributing to the Grand Theme, "Looking through the Frame" is shown in Figure 4-2, and is now explored in detail via supporting thematic and textual information.

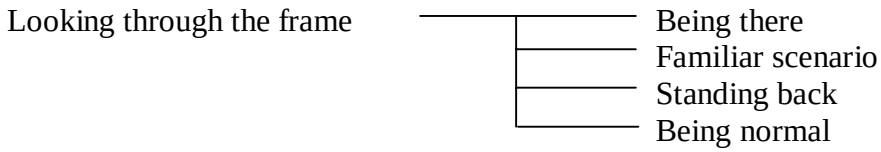


Figure 4-2. Thematic tree diagram of Grand Theme: Looking through the frame

4.1-1 Being there

"Being there" encompasses a sense of being close to the action, of the plot of the imagery narrative, and of how it felt to be there. All participants had many themes indicating this type of involvement. For example, Participant 2 experienced being close to the piano.

> *Are you close to the piano?* Yes, I'm close to it. And I can see hands, slim fingers. *Slim fingers…* Now there's a pinkish glow around the piano (Pat2-2, M&I).

In another example of "being there", Participant 4 reported being at a real orchid exhibition and being part of the judging panel, including awareness of complex interactions and feelings (Pat4-1).

> Yes, the judges having, to select the best in a class *[sic]*. Or the champion of all the plants in the show. It is very, very difficult for them. And the decision they have to make is amongst them. Not from only one person. Communication plays a big role. And understanding the breeding line of that particular hybrid. It will help a lot to make a good decision about it. *So are you with the judges, in your imagery?* Yes. *Are you a judge too?* Yes. Finally, a lot of worry comes out, of all judges, because they have selected a good plant that it's worth to be a champion. And the feeling is good (Pat4-1, M&I).

And in another type of "being there" experience, Participant 3 marvelled at the vibrancy of a particular blue colour as he looked closely at paintings by the painter, Titian.

> Oh, there's very nice. A couple there by Titian… A couple paintings there by Titian. *Titian.* And "Carlorov". That's vibrant, the blue. It looks like he specialized in blue. Because the "Madonna in the field" is dominated by the blue veil (Pat3-3).

> The blue is absolutely - it reminds me of that "Blue-o". *Like Blue-o?* Blue-o. That people used to use to whiten clothes, years ago. *I remember that.* That's the colour of blue. Very vibrant! Also, the other Titian painting… And the people with Bacchus - there's those blues again! - He must specialize in a special blue (Pat3-3, M&I).

The direct experience of imagery as being there in the here-and-now is important, and indicates something about the level of participation by the individual in the whole music and imagery experience. In fact, the participants in this study overwhelmingly embraced the imagery experiences, typically placing themselves actively in the imagery scenario.

4.1-2 Familiar scenario

Themes relating to familiar scenarios or situations where the "action" took place were frequently reported by participants throughout the imagery reported with the GIM sessions in this music therapy programme. Such scenarios could be either real memories or other composites or impressions that seemed familiar, even at times related to familiar movies and other culturally-based material. The self-report of participants as to what they felt was familiar remained of paramount importance, with the "real" accuracy of such familiarity being of only limited value in the therapeutic situation.

There were many different types of familiar scenarios. Sometimes the familiarity was with nature, either real or imagined. It could often be a favourite place, for example, in the bush (Pat3-1; Pat2-5; Pat5-6). Participant 2 gave an example of walking through the bush with her friends.

> I'm walking up the track, through the bush. We know that once we get up to the top of this hill. And we sort of walk through from the present where this house is, with Betts, Ada, and we've walked through there and the area is as it used to be when we were kids. *How does that feel?* It's low scrubby bush, and there's bush flowers. I think there's native boronia, and eggs-and-bacon, which is a yellow flower, which I thought grew very low there, but I've seen it in bigger bushes. But maybe it's because it's a windswept hill, not far from the ocean. There's little pink flowers. And we just keep wandering around. And then we're at the top, and you can see the ocean. There's a little sheltered area, that we called a "cave" in the rock. It wasn't really a cave, it was just an indentation, I think. And you could sit there, and look down (Pat2-3, M&I).

The sense of familiarity with a scenario also extended to overseas locations, for example, imagining being in New Zealand (Pat6-2, Pat3-3), in the United Kingdom (Pat2-2; 2-3; 2-4; 2-6; Pat3-6), in Fiji (Pat1-1) and in the United States of America (Pat3-4). Participant 2 and Participant 1 both give examples of being in familiar overseas locations, in New Zealand and Fiji.

> I went to Mt. Cook, and I was out early, and not many people were around. But then I realized there's a helicopter and an aeroplane up there, and there are skiers. It's very busy. Everyone else is going up the mountain. *The skiers.* And there's a little glacier there, too, which is quite noisy (Pat6-2, M&I).

> I'm going to Fiji next month, I've been there before, so I think I might go to the island. It's much more relaxing. *Can you imagine what it will be like there*? Yes. It's different. Very different to Maroubra beach. I love beach, I love water and sand. But where Maroubra's the wild surf, this is just a calm, blue lagoon. And the white sand (Pat1-1, M&I).

Sometimes the sense of familiarity was with other people, for example, when the participant was imagining playing and being with childhood friends (Pat2-3, Pat2-2, Pat2-4). Other familiar people could also be involved in the imagery, for example the postman with a cloak (Pat2-2), the "Mr Whippy" ice-cream man (Pat2-2), an aunt (Pat2-3), fellow orchid judges (Pat4-1), and an Irish woman thought to be like Molly Malone (Pat2-3), as shown by these examples:

> And there's the "Mr Whippy" van. And there are still children running up to "Mr Whippy". He's on the corner, outside a school. He's gone now. *[deep breath] How does that make you feel?* I wasn't real happy about "Mr Whippy". *You weren't?* No, I've always heard lots of funny stories about how the local "Mr Whippy" used to deal in drugs as well (Pat2-2, M&I).

> She's got a basket. And she's filling it with cockles and mussels, or something like that. Something that grows there naturally. *Is she finding a lot?* Yes, I can't see them, but she's bending down and picking them up. And, um, she's wearing a scarf over her head. And wearing a skirt which is sort of bunched up, so that it's not getting terribly wet. And she's got, she's wearing bare feet, or sandals. It's not very modern… I think, I think we're in Ireland. There's a dirt road. I'm kind of getting mixed up with Molly Malone! *[laughs]* And a wheelbarrow full of cockles and mussels. *[laughs]* Ah. There's a church in the distance. She's not going there. She's going along this little dirt road, which is closer to the ocean now. But she's still got the shellfish from beside the lake (Pat2-3, M&I).

Sometimes the sense of familiarity of the familiar scenario was with the activity being undertaken, covering a whole range of activities, from tasks as simple as making a clover chain (Pat2-3), paying greens fees and playing golf with his brother and son (Pat3-2), orchid judging (Pat4-1), bringing home the cows (Pat 6-5), and learning and reciting poetry (Pat6-5). Participant 2 was involved with the familiar activity of playing with a billy-cart with her friends:

> We've got a billy-cart painted red. And are we game to go down the hill? Are we game to go down there on the billy-cart? No, we pull it back up to the top of the hill. No, we're going around to the next street, to where we always run down a bit of the slope. Which was cobblestones. *Cobblestones.* Yes. This bit of the street didn't get bitumen on for years and years and years. Which was good as far as we were concerned. It was rough but, well, a very short ride. I haven't quite got there yet - *Yes.* It must be my turn to push. And the other girls are twins, they're both in the billycart. No, that's not fair, because I couldn't push the two of them. But we're going along the level part of the street before you come to this cobblestone bit. Ok. Somebody's pulling the billycart up to the bit of the top of the bit of the slope (Pat2-3, M&I).

In contrast, Participant 4 expressed his intimate knowledge of the activity of judging orchids flowers at a show, which was a very familiar pursuit for him.

> Plenty, plenty of colours. A lot of different plants, which makes the show so interesting. *Which things catch your eye?* Mm. It's very hard for me to pick one up. The reason is because I know how to judge it, and every little fault, it counts. It's not only the colour, or its shape, or its substance or any other feature that has to do with the flower. It's the complete quality of the flower that the flower has to offer. And the decision I have to make for it (Pat4-1, M&I).

> The other thing we see, and we are very, very careful, is that every single plant that has been put on a bench to be judged, it must be judged and not ignored. And the reason is the grower, that grew up that plant to bring it to flowering, it took quite a few years. So, if it is a good flower, or not, it still has to be judged and show respect to that grower (Pat4-1, M&I).

Sometimes the participant's perceived familiarity was with an object or place. This included a specific china design (Pat2-1), a picture that used to hang in their dining room (Pat2-3), a French palace (Pat3-3; Pat5-1), a garden in New Zealand (Pat6 -2) and the long walk home from school through the countryside as a child (Pat6-5). For example, Participant 2 referred to an item in her extensive china collection in describing the imagery she was experiencing:

> And it's like a still painting of the sunset. It's the sun setting on one of my china plates. And the pattern is called "Sunset and Tall Trees". And now that I bring that to mind, I can see these tall trees next to the sunset. They weren't there before (Pat2-1, M&I).

In another example which was typical of extensively reported familiarity with a known place, Participant 6 talks of her well-known walk home from school.

> Well, during the war when I went to high school in the country, I used to walk home from school to the farm. This of course was through completely natural countryside. Firstly, after I left the school, because I was near a little lane . And there were fewer and fewer houses. Some smaller little farms that were nearer. Then I'd cross the bridge. If it had been raining the water would be running along. But often it would be dry. Up over the railway line and around - I knew every inch of the street. House to house, where the dogs would come out and greet me. The cat would watch, with its tail. And then on, over a hill. Then I'd usually get one of my school books out, and learn some of the lessons that had been given us (Pat6-5, M&I).

Sometimes the reported imagery encompassed all or most of these areas of familiarity, for example, Participant 1 had a picnic birthday party with family in the park, thus encompassing familiarity with a lovely place in nature, with people in the family, with

a favourite activity of picnicking, and finally at a specific and familiar place known as Centennial Park.

4.1-3 Standing Back

It was typical for some participants and in some parts of their GIM therapy sessions that they reported viewing the imagery from a distance, and did not seem to feel directly connected to it. This suggested a sense of review, like a distant or remote movie. Such a sense of review was especially indicated by comments such as “watching from a distance” or “looking down” on the action of the spontaneously unfolding imagery. This was a particularly strong theme for Participant 2. Her imagery with the music included being distant from the ocean or a waterfall.

> I just like watching the water. I think now I am on the balcony of where we used to live, overlooking the ocean. Especially when there was a storm and the waves were dark. I can see the rocky bay now, I’m looking down from the balcony (Pat2-1, M&I).

> I think you could probably walk along the rock. *Would you like to try that?* Um, I think you'd have to find out where you could get to the rocks. Because I'm on the other side of the lake. But you could probably walk underneath the falls. *Do you have a sense of how to find out how to get there?* I think it's a long way round, from where I am (Pat2-3, M&I).

She also felt distant from persons, for example, in the form of a shepherd.

> I just see an outline, but it's a Scottish shepherd. He's wearing a kilt. And there's sheep. And they're little fleecy white sheep. With little black legs. But he's very, very much in the distance. *Do you have a sense of where you are?* He's wearing a kilt, so I've got to be in Scotland. And I think they're - I must have seen sheep with little black legs like that in Scotland. *Do you have a sense of being on the hill too?* No, no. I can see him right in the distance. No. He's gone. The sheep are still there (Pat2-4, M&I).

In a similar way, Participant 5 felt distant from a group of women.

> I can see people, but very far from where I am. Yes. I can see people. The funny thing, that they are, most are women. They are wearing some costume from the "Belle Epoch". *They’re wearing?* Some dresses. The fashion is from the "Belle Epoch". With the very large hat. They wear a very large hat, and some kind of a, they are not umbrella, they are - to protect themselves from the sun. And that's funny, because I don't know what that people doing there with that kind of costume. With their dresses. *Can you ask them?* No, they are far away (Pat5-4, M&I).

Participant 6 watched all the action on the mountain with interest from a distance, at Mt. Cook in New Zealand, noting activities and dangerous activities from afar.

> *And what are you doing now?* Quite frankly, taking it all in, it's such a big scene. I'm not involved in the activities. So there's a lot to watch (Pat6-2, M&I).

The sense of distance inherent in this theme gave participants a sense of space where they were not directly involved, but nevertheless able to observe and consider their position. Such distancing can be adaptive in the face of an overwhelming impact, and may relate to a need to "back off" after the emotional intensity of heart surgery, which had been recently experienced by these participants.

4.1-4 Being normal

Establishing a sense of things continuing on "as normal" was also important for these participants, who had recently gone through the very abnormal experience of cardiac surgery. Within this theme, participants clearly compared their imagery experiences to what was "normal". There was also frequently a sense of comparison about the way memories of the past were recounted into the present. For example, Participant 2 remembered going to a familiar place near her school, and commented, during the music and imagery, on how it had changed from her memories of going there with her friends for a picnic. In another, somewhat quirky response to a therapeutic intervention, Participant 1 commented that she did not normally talk to clouds, after it was suggested in the process of imagery exploration!

> A cloud, a cloud that I'm leaning on, that's supporting me. *Is there anything that you would like to imagine that you can say to the cloud?* No. Because I don't... I don't talk to clouds *[laughs]* (Pat1-1, M&I).

Playing an imaginary game of golf, Participant 3 frequently commented on what was normal, appearing to constantly compare his current (imagery) experiences with memories of previous (real) games played. The "being normal" theme focused on a normal day, normal shots being played, normal feelings being evoked, and normal scores eventuating in the game. Several examples illustrate this:

> I'm having a go with my driver this time. "Easy" I tell myself "don't hit it too hard". "Easy". Yeah that's not too bad it's drifting out to the right a bit. About where I normally go. That's not too bad (Pat3-2, M&I).

> Yeah, that's typical, a normal shot, I'm on the green. On the dance floor, on the dance floor (Pat3-2, M&I).

> My brother tees his ball up and as usual he got out of turn. He does that quite a bit. I don't say nothing because there's no advantage. *Does it bother you?* It does in a way because he should know etiquette better than that. *Is there something you could say to him?* Well I'm sick and tired of telling him. My son and I just pass a quiet comment "there he goes again"! But we let it go (Pat3-2, M&I).
>
> So, I'm a couple over, so is my brother, so's my son. He's only 2 over. And that sounds about right, where we normally are (Pat3-2, M&I).

4.1-5 Summary

In summary, the grand theme, "Looking through the frame", was characterized by the participant assuming a perspective on something in their lives. The type of imagery contributing to this emergent grand theme generally occurred in conjunction with a sense/feeling of actually being there, sometimes as an active participant and sometimes as a more remote observer, and frequently involved a place that seemed familiar. It sometimes carried a sense of comparison, from the past into the present.

4.2 Semiotic Expansion via Intertextuality

Up to this point, thematic analysis has focused on the participants' reported imagery with the music. However, further clinical insights may be gained by using principles of semiotics to shed further light on the grand theme, "Looking through the frame". This is achieved by using material derived via intertextuality, notably the surrounding discussion and sessions (circumtexts), direct referrals to particular texts (intratexts) and accessing cultural symbols or idioms (intertexts), as approached via the interpretations of the researcher. These will now be explored in greater depth, moving from emergent thematic materials to related texts.

For example, as was previously noted, Participant 1 reported imagery of the familiar family occasion of a picnic birthday party, which was her 57th birthday. Using intertextuality, broader circumtextual material gave further understandings of the meaning of this event for the participant. In particular, the surrounding material brought into focus the participant's understanding of familial links to heart disease and the death of her grandmother at the age of 56.

> And my Mum had a heart attack in her 50s and my Dad died having a third one at 63. My grandmother died in her 50s with a heart attack, actually was 56, the

> same age I was when I had the Op. So I sort of feel, yes, when you think about all that - *You've beaten the odds!* I really have beaten the odds! (Pat1-1, Investigative Discussion).

Imagery of her own birthday brought to the fore the question of her age. And her grandchild spoke the obvious existential question - was she going to die soon too?, as she states:

> I actually had a birthday the week before last, and my little grandson, he's 4, he said to me "How old are you, Nan?" and I said, 57. And he said, "Oh, Wow! That's a lot of numbers!" I said, "Yes, it is a lot of numbers". He said, "I can't even count to 57", he said, "you're probably going to die very soon!" *[she laughs] Oh, that was encouraging!* Well it was very encouraging *[laughs]* but I said, "No, not now, but I might have". But I sort of feel like I've really been given a second chance (Pat1-1, Investigative Discussion).

Thus, she was able to look at and frame her life within the context of not only what might have been, but also in terms of the reality of post-surgical health and the sense of a "second chance". This material demonstrates that the simple memory of a birthday picnic with family during the music and imagery part of the session held additional meanings for the participant, and for her understanding of her future health and prognosis, as well as enhanced appreciation of her own life as she reviewed it at this point.

In another example, reporting imagery of the familiar context of an orchid show, Participant 4 used intertextual information to communicate additional information about his own experiences. Growing things, especially of the complexity of orchids, was very important to this participant, as shown by his comments in his surrounding discussion, and he treated this activity with the same dedication as a career or profession. This retirement activity related well to his previous work in the florist industry, thereby maintaining some sense of meaningful continuity and useful knowledge base, which he then used in the process of orchid judging.

> I grow orchids, different kinds of orchids. *Oh, right!* Yes, I show them, and I judge them as well. *Yes.* So I'm involved, very, very deeply. *Well, that's a very particular skill.* Yes. I do it as a hobby, now, because I am fully retired. And that keeps me busy, and keeps my way of thinking nice and clear, you know. *Well you need something to do!* Oh God, yes! *[laughs]* And this is the only time I sit down, probably early in the morning, after my walk, you know. If the weather is bad, I sit and study a bit, to refresh my memory. Because we've got to remember so many things, when we judge. Ah, during the day, I work outside in the yard, with the plants, you know. And that's 12 months, you can work 12

> hours a day if you want to, you never end. *[joint laughter]* Yes, it's, er, your brain works, your body works, everything works for you. And it's a beautiful hobby, you know (Pat4-1, Investigative Discussion).

During his reported imagery with the music, Participant 4 cited a particular type of orchid flower as the "champion" of the show, a cattleya orchid (Pat4-1). He further describes it in circumtextual material after the reported music and imagery.

> *So what colours were in the one [orchid] that you imagined, the one that you chose as the champion?* A lot of colours. *Yes.* Probably with spots on it. *Right.* Or what we call, "peloric spots". They're huge in size. And actually, when you see them, you understand that you have an improvement from the parents. Probably the parents had small spots, both of them, but their hybrids, or their kids, they had "peloric". So that's an improvement. *So, it seemed like in the imagery, that you had selected one as the champion, you were going through that idea of selecting one.* Mm hm. *Um, and I just wondered what that one was like.* There was only one flower, actually. Not a lot of flowers. One only flower. *And the overall effect of the colour? I mean, I can understand it has lots of shading and different colours in it.* Er, yes, I - *Did it have an overall sort of whitish, or pinkish, or greenish, or* - Yes, it's a whitish colour, with a very light pinky colour on the edge of the segment, and the lip had a very, very deep pink again, that matched the light pink and the white and the dark pink. And when I say a big flower, on a cattleya orchid. Because it's big, if it hasn't got a good substance, the flower folds, or, you know, drops (Pat4-1, Cumulative Discussion).

On further investigation into the nature of the cattleya orchid, it is found that it is the most "typical" orchid shape, as shown in Figure 4-3**,** and producing a beautiful one is what many orchidists aspire to. "Cattleyas are some of the most commonly grown orchid plants, and their culture is often used as the basis for comparison with other types of orchids" (American Orchid Society Education Committee, n.d.). Peloric spots are clearly one of the aspects of an orchid flower which affect the judging of its overall quality and value.

Such intratextual information leads on towards broader intertextual texts, where the orchid may symbolize harmony, beauty, love, refinement and scholarship, and is also said to represent the concept of the "Perfect Man" (Cooper, 1978, p.123). As a flower, the orchid may relate to the evanescence of life, the transitoriness of the body, or spiritual unfolding (Cirlot, 1971; Cooper, 1978), and it is important in many worldviews as symbolizing the possibility of personal growth and development. Many of these

concepts seem to be very appropriate to the needs and understandings of the post-surgical bypass patient.

Figure 4-3. Illustration of cattleya orchid (Boehm, n.d.).

Embracing and assuming the feelings of growth, along with a relationship to nature, vegetation and flowers, in a later session Participant 4 himself became part of the photosynthetic process in his imagery, feeling the intake and out-flowing of the process. This will be further discussed under Grand Theme 4 (Chapter 7). Even at this point, it is apparent that Participant 4 was able to use his familiar hobby, growing orchids, to express more about how he was feeling and to reinforce the feeling of relaxation and balance in the intake and outflowing of air and nutrients. This had important implications for relaxing and nurturing his physical body. The sense of current health and bodily status and the potential for further growth and development engendered by these multiple texts added another dimension to the review process of "Looking through the frame".

In contrast, Participant 2 imagined being on a path in her fifth session, and clearly felt a need to correctly identify this seemingly familiar path, in her later (circumtextual) discussion and in the initial discussion of her subsequent session.

> *What stands out in your mind, from the imagery you had here?* That when you first suggested a path, I immediately saw this path that you, I'm not even terribly sure where you get onto it because it's something I've never done. And it winds along Narrow Neck, and it is like a clay-coloured winding path, with bush on either side. [excited tone] I know where it appeared! In "Oscar and Lucinda" - did you see the movie? (Pat2-6, Investigative Discussion).

Here, Participant 2 specifically pointed to another intratext, Oscar and Lucinda. On further examination, it was found that the plot of this movie focuses on the relationship between an Anglican priest and a headstrong woman who is heavily involved in gambling, leading to the biggest gamble of their lives together. Further exploration reveals themes that "everything in life is a gamble" (Berardinelli, n.d.), and that "life has many unexpected twists and turns" (Koplinski, n.d.).

Looking to the broader cultural intertext, the significance of the path in broad terms is understood to include a sense of direction and implies forward movement, carrying a sense of passage from one place to another (Cooper, 1978, p.126) and can incorporate a feeling of pilgrimage (Cirlot, 1971, p.255; Cooper, 1978, p.130). "The pilgrim is one who follows a direct and purposeful path… he is the seeker after a goal" (Cooper, 1978, p.130), however that path may be fraught with dangers, difficulties and unexpected twists along the way.

Combining these additional textual insights, and linking them with the experiences of the post-surgical bypass patient suggests that even one's health is unpredictable and somewhat of a gamble, and things may change unexpectedly as one goes along. Learning to live with this is a challenge for the patient.

Another use of the image of a path was by Participant 6, where she identified a place that she had visited near Christchurch in New Zealand, and sought her own path.

> Now I think there's small bushes, and I'll have to find a path through them. *What are the bushes like?* Just bushes. A few flowers. *Are they easy to get through?* Oh yes. *Are you finding the path you need?* Yes, the trees are a little smaller. I must be somewhere near an open clearing (Pat 6-1, M&I).

The use of texts relating to the "path" by participants suggested the need for finding a way forward from where they currently were, and a sense of looking for a sense of direction, an important function of "Looking through the frame".

In another instance, a favourite and familiar place to holiday, in the Southern Highlands of NSW was reported by Participant 3 in his first session. Leaving the session later, he mentioned that his operation had happened at the time he would have been holidaying, and that he really missed this once-a-year occasion. Such circumtextual information highlighted the impact of surgery on his life and lifestyle, and re-framed his experience of surgery as interrupting the normal sequence and progression of routine activities, at the same time reinforcing in his imagery the remembered enjoyment of this familiar activity, especially walking in the Australian countryside.

One place which had become familiar to all participants in this study was the cardiac rehabilitation group context, as noted in pre-music and post-music circumtextual material. Here, participants related to and shared with others about their experiences and in doing so gained new information. Such exchange of information included not only health professionals but also, and perhaps just as importantly, interaction between members of the group, as they talked about their experiences. The pre-music comments of Participant 1 demonstrate the important function that this rehabilitation and support group served in the communicative process.

> This is where I found this group discussion quite good, because different people were having experiences that they thought were uniquely theirs. Like this man when I was talking to him later on, he said something about being cold, and I said, oh, that being cold feeling, I said we discussed it in - because he's only, it's only his second week- I said, that happens to all of us, for weeks afterwards you're cold, you really can't get warm. He said, I didn't know that, I've been freezing and I just didn't know why. I said, we're all the same, because of the heart-lung machine they think, but he didn't know (Pat1-1, Investigative Discussion).

Based on many comments from participants, it became clear that this rehabilitation group functioned to provide additional perspectives and viewpoints on their current health care situation, through both formal and informal interactions, and to provide a familiar context for this exchange. This socially familiar context provided a place where review of their current situation was encouraged among the attendees, and by incorporating memories of this into their GIM session, participants were harnessing the further reflective resources of this group into their own experience of "Looking through the frame".

Even imaginary places had the capacity to seem familiar to the participant, such as the French palace experienced by Participant 5. After the music, he described it in this way:

> It was so beautiful, there. *Yes, yes.* The Salon. *Had you imagined anything like that before? Or seen anything like that before?* No. This is the first time in my life that I have been inside a palace. *Yes.* I've never been in one. *How about that! It sounded lovely.* Yes. It is so real, everything (Pat5-1, Cumulative Discussion).

Growing up in South America, it is not surprising that this participant had had no direct ("real") contact with images such as these he was imagining, and yet the sense of familiarity was maintained, possibly based on reading (he was an avid reader) and television/film sources. Interestingly, another participant also had imagery of a French Palace, naming it directly as the Palace of Versailles, and had familiar memories of being there on his European travels (Pat3-3). This participant continued on to describe his experience of visiting the palace and reflecting on life inside the palace prior to the French revolution.

> But the Palace of Versailles was, as I say, excellent. That was what led to the French Revolution. *Yes.* And when you tie it up with the decadency, when you see it there, you can say that this is it. Because, you want to walk around like this *[indicates]*, you don't want to touch anything, even the floors and the work of, masterpieces of woodwork, all designs in the floor. And the furniture and stuff. *Yes.* And when the guide explained to us that the bedroom, it would be about as big as this room, I suppose, and her bedroom, the Empress's bedroom. And there was always about 10 people there, seeing her go to bed. Alright? *It would be a different way to live, wouldn't it!* Then they showed us, next to the bed is a big mural thing, a country scene or something. And she went over and pushed *[indicates]* pushed a secret door. The Palace of Versailles. Yes, something happened there. Some, I don't know it is was a United Nations charter was there, or world war. *They signed some agreement there* - Some big thing in World War I or II or something there. *I think they did, actually. Yes, it must have been one of the treaties.* Something like that, yes, was signed there (Pat3-3, Cumulative Discussion).

Such reflective comments seemed to raise further issues of privacy and independence, which were clearly of importance for this participant.

Producing imagery of other lifestyles, such as that related to a French palace, brought participants not only a sense of a beautiful and somewhat familiar location to explore,

but also a time to review what it might be like to live there, and to reflect on this in terms of its personal impacts, such as privacy and peace. As such, it continued the sense of reflection on their life based around the grand theme, "Looking through the frame".

Spontaneously arising imagery of familiar objects also tended to carry additional textual information. For example, Participant 2 talked about a particular design in her china collection, which she utilized to describe the imagery in her first GIM session. She later commented on this pattern.

> Well, I collect Shelley china, and there's a pattern called "Sunset and Tall Trees". And it's definitely a reddy-orange sun with the rays, traditional look of the setting sun, and I could see these tall trees , and I though well, yes, that's definitely that particular pattern (Pat2-1, Cumulative Discussion).

This pattern, "Sunset and Tall Trees" is demonstrated in Figure 4-4. It is characterized by striking colours and strong contrasts. The concept of "sunset" in indeed an interesting one, as the sense of the setting sun is often used to refer to the end of life (consider, for example, "the twilight years" as referring to old age). For this client, it was definitely the "sunset" of her life, as she grappled with living with a malfunctioning heart valve.

Figure 4-4. Illustration of "Sunset and Tall Trees" (Charleston Antiques, n.d.).

Interestingly, in the next session, she corrected her naming of the china pattern as being "Tall trees and sunrise", which was similar in design (see Figure 4-5). The change of naming itself could be seen as carrying further implications based on the sense of new life and new beginnings resulting from the revascularization process. It is unlikely that such ambivalence with regard to sunset/sunrise and beginnings/endings of life was deliberately intended by this participant, however, it does suggest to the interpreter an uncertainty of viewpoint and may parallel an ambivalence in framing the events surrounding cardiac surgery.

Figure 4-5. Illustration of "Tall trees and Sunrise" (Charleston Antiques, n.d.).

In another instance, Participant 2 directly referred to the text of a well-known song in order to bring extra meaning to her imagery experience. Imagining an Irish scenario, she specifically referred to "Molly Malone", a character in a well-known song "Cockles and mussels". Turning to this intratext, we find the words of the first verse of this song are as follows:

Cockles and mussels

In Dublin's fair city
Where girls are so pretty
Twas there that I first met
Sweet Molly Malone
As she wheeled her wheelbarrow
Through streets broad and narrow
Crying,
Cockles and mussels, alive, alive oh

Alive, alive oh, alive, alive oh
Crying,
Cockles and mussels, alive, alive oh

(Taylor, n.d.)

According to Taylor (n.d.), this song was first published in 1884, and is an unofficial national anthem of Dublin. Although there has been speculation about the existence of an actual Molly Malone, all evidence suggests this character is allegorical rather than based in fact. The manner in which this song may have relevance to the participants in this study can be considered by looking at the words of this song with its refrain, "alive, alive oh". This is indeed what the heart surgery had done, made the participant more alive. Also, it is not unusual for there to be a play on words and metaphors in the imagery process, and here we find the unusual word "cockles", ("warm the cockles of your heart"?) and mussels (sounds like muscles, and the heart is indeed a muscle which is now more alive after the surgery). Whether such additional meanings were deliberately meant by the participant is debatable, but as the clinician "reading" and interpreting her text, these additional texts may be a factor in understanding the person's view of themselves in the clinical situation.

4.2-1 Final summary, Grand Theme 1

The process of generating a grand theme emically from thematic material and based on the text has been demonstrated for the Grand Theme, Looking through the frame". For this grand theme, "Looking through the frame", constituent themes emerged of "Being there", "Familiar scenario", "Standing back" and "Being normal", each of which served to convey information about the participant's view of themselves, where they are starting from and the sense of normality it entails.

At a further level of analysis, the semiotic concept of intertextuality has been applied in order to explore the manner in which additional texts (circumtext, intratext and intertext) may shed further light on understanding the meaning for the patient, based on reported music-generated imagery, in the light of recovery from bypass surgery. It appeared that participants were further framing their lives within the context of not only what might have been, but also in terms of the reality of post-surgical health and well-being, and with an added view towards growth and development in the future and a

sense of direction. They did this via a range of additional familiar texts, encompassing history, film, nature, community groups, collectibles, and song lyrics, producing a richly interwoven juxtaposition of texts and experiences related to the grand theme, “Looking through the frame”.

The next grand theme will now be explored, which is “Feeling the impact”.

CHAPTER 5. SYSTEMATIC ANALYSIS: GRAND THEME 2. FEELING THE IMPACT

5.1 Textual analysis

An impact results from the influence or effect of a force colliding with, striking forcefully or impinging upon something such as a "body" (Urdang & Flexner, 1968, p.665). This suggests a direct impact on the body, and carries a sense of corporality. An impact goes beyond pure awareness towards direct and deep feeling, tending towards promoting a response. The sense of impact also carries implied suddenness, or deepness, and a significant effect on something even as profound as existence itself.

In this current study, a major impact for the participants was the bypass surgery itself, whereby their body was physically cut, stretched, sewn up, and which led to responses and feelings such as pain. Participants had also experienced a range of other impacts prior to the cardiac bypass surgery, such as the diagnosis of heart disease, the statement of the need for surgery, and in addition one participant had a pre-existing condition causing chronic pain (Participant 5).

The themes contributing to the Grand Theme, "Feeling the impact" are now discussed in depth. The overall structure of such themes is shown in Figure 5-1.

Figure 5-1. Thematic tree diagram of Grand Theme: Feeling the impact.

5.1-1 Physical limits

The sense of physical or bodily limits took a number of forms in the reported imagery. This ranged from a simple feeling of tiredness and a need to rest from the current

activity, to a broader sense of being prevented from doing something that they wanted to do or had been accustomed to doing prior to surgery, due to health considerations.

It should be noted that when participants reported in a number of instances that they were feeling tired within their imagery experience, this was carefully monitored, according to standard GIM practice. Thus, participants were encouraged to remain aware of their own needs in an ongoing manner and follow their natural responses to this. For example, Participant 5 and Participant 3 each felt tired at different points in their imagery experience.

> Behind the greenhouse, there is a, some kind of gazebo, or - *Some kind of -?* I think it's a gazebo. *Right.* With some bench, something to sit on, so I am going to sit on that. *You're going to sit on that?* Yes, I feel tired (Pat5-4, M&I).

> Yes, I'm going back to the bench. I want to sit at. *How's your body feeling?* Very tired (Pat5-4, M&I).

> Now I'm coming to a little ravine - shall we say- there's some running water, and I think I'll sit on a rock here and rest awhile. *Yes. How does it feel to sit and rest?* Very good. Because after that walk, you feel like a rest (Pat3-1, M&I).

In addition to tiredness, the limiting effects of the surgery on life activities was demonstrated by Participant 3, who reported not being able to swing a golf club like he used to, during the music and imagery segment.

> Well I can't hit very far these days. *You can't?* No, I think it's because of having my surgery, and I'm not strong enough yet. But I accept that. I'll get better. I'll get better. *You'll get better.* When I do I'll have a harder swing. I don't want to swing too hard, anyway, in case it does upset things (Pat3-2, M&I).

In another instance, Participant 6 felt unable to match a perceived physical requirement with regard to the walking pace that she interpreted from the rhythm of the music (Vaughan Williams, Norfolk Rhapsody No.1, middle section). In fact, the pace of the music was 108 beats per minute, as determined by metronome, which would generally be considered a fast walking pace, almost at a "quick march" pace. Marching pace is generally considered to be 120 beats per minute. In her imagery, Participant 6 obviously felt that her body was unable to match and keep up with the speed of what was "required", as she says with typical understatement:

> I suppose the music's saying that we can walk more quickly because we have seen this. But it isn't necessary to go that fast. *How does your body feel, to be*

> *walking quickly?* Not particularly keen about hurrying. *Can you walk at the pace you need?* Oh yes (Pat6-2, M&I).

In this case, the therapeutic intervention by the music therapist assisted the participant to re-focus away from the musical tempo in order to pay attention to her current physical needs and capabilities.

Another physically challenging activity, running around with her grandchildren, was felt to be beyond her current capabilities by Participant 1, and she ultimately chose to leave this activity and setting.

> Normally when we go to the park, I do play ball and, but I wasn't able to do that last time, so maybe that's why I'm seeing myself doing that. *How does that feel?* Good, good. I guess it's like lying on the beach without the scar hurting. It's seeing how things are going to be *[begins to cry quietly]* – soon. It's just that I'm not quite strong enough yet, to do the things that I'm so used to being able to do. I'm going to leave the park, because I can't relax with all the children (Pat1-1, M&I).

Participant 5 experienced a limitation of a different sort, describing it as a "blockage" in his reported imagery as he experienced it. Although this seemed initially to be in the nature of a cognitive/emotional rather than a physical limitation, this may possibly have been related to physical factors such as pain medication, or even the pain itself.

> It is hard, I cannot concentrate well on that, what I really see there. *You can't concentrate.* No. *Is there something else that gets your attention?* The image is not clear. I, something is, I have a blockage in my mind. But I don't know what is it *[sic]*. *Can you get a sense of what the blockage is like?* No, I have no idea. *If it had a colour, can you imagine what it would be like?* Yes. *Can the blockage have a colour? [sigh]* I see the water colour, some kind of blue-green. And the sand is white. But that's all. I don't see anything. I try to penetrate more, but I cannot. Is a blockage, a big block there. I cannot. Can it be the medication that I took this morning? Can it be? (Pat5-2, M&I).

Despite efforts to work with this blockage and even a change of music, as in standard GIM practice, this blockage recurred later in the same session, after some spontaneous and relaxing imagery of being at the beach.

> I'm trying to see far away, but I cannot. A long way. I used to enjoy it. Looking far away, but now it's a blockage. Is nothing there. *Yes.* And I know there is some - *Is nothing there?* Yes. I think I cannot concentrate. It's a blockage there. *Yes. Would you like to finish now?* Yes. *Ok, well, we'll leave the music for now. Is that alright with you?* Yes, I think so, Alison. *Yes. [opens eyes]* I cannot penetrate that blockage (Pat5-2, M&I).

Of particular interest is the fact that the reason for cardiac surgery is usually an imminent blockage, which in itself in turn limits the flow of blood. Here, Participant 5 has used the concept of blockage as limiting the flow of imagery, and it is interesting to consider these parallel limitations.

In another instance focusing on physical limitations, Participant 2 identifies strongly with the feeling of "running out of breath", with an image of the wind which is blowing hard.

> And the wind looks like a picture of a wind blowing, like a child's book. And it keeps blowing and all the daisies have blown away over the hills. *Do you have a sense of what the wind's face looks like?* It's, um, the cheeks are fat, and I feel as though I've seen it in a book. Perhaps when I was a child. He's definitely blowing, you could see the air being blown out of his puffed-up cheeks. And yet… *Do you feel the wind on your body?* No, because I'm watching. And now I think he's run out of breath and there's sort of trailing vapour, behind the wind (Pat2-2, M&I).

As is well known, breathing difficulties are also frequently associated with heart disease. In fact, this participant reported that she had had difficulties with breathing related to exertion prior to the operation, which formed a significant limitation on everyday life. Again, there are interesting parallels between the imagery process and physical symptomatology.

5.1-2 Discomfort

In a number of instances, participants in this study described sensations of discomfort resulting from their cardiac surgery, ranging from tightness and "pulling"(Participant 1) through to "botheredness"(Participant 4), and even real pain (Participant 4, Participant 5). These sensations occurred in the music and imagery segment, and were at times resolved comfortably within the imagery process itself.

Feelings of discomfort were reported as being "zipped up" or "too tight" by Participant 1. She expressed a desire to open up, and to gain greater flexibility, from the zipper-like constriction and tightness that she felt as a direct result of her sternotomy (Pat1-1).

> I just wish I could open it up a little bit... as I mentioned to you before, if I could just open it, pull the zip down an inch just to give my shoulders a bit more flexibility, because it does get a bit tight. But that will come with time. I quite often feel, yes, if I could just open that up a little bit. But it isn't like it all the

> time, but tends to be mostly when you're in bed, and I think that's more uncomfortable because of lying down (Pat1-1, M&I).

At the same time, themes emerging suggested that she expressed surprise at not feeling discomfort from the scar as she lay down on the beach in her subsequent and ongoing imagery, contrasting the normal discomfort with a new current perception. This will be discussed further under Grand Theme 4, "Sublime Plateau" (Chapter 7).

Participant 4 described his discomfort as a sense of "botheredness" in his chest during the music and imagery segment.

> My chest feels good. There is a beautiful "botheredness" in my chest. *There is a beautiful - ?* A "botheredness", in my chest. The pain, it's only very slight (Pat4-4, M&I).

It is interesting to note that he did not seem to find this "botheredness" a negative experience, in fact describing it as "beautiful". Perhaps he had become accustomed to it since the surgery (at this point, nineteen weeks previously), and hence identified it as being part of his routine experience at the moment.

5.1-3 Feeling hurt

At times, participants reported actual physical pain occurring during the GIM sessions. For example, Participant 4 commented on pain related to exercising, during the imagery.

> I can see myself doing my both feet, exercising both feet. A bit hard! Muscles, they seem to pull quite a bit. *Muscles pull?* Yes. It hurts a bit (Pat4-5, M&I).

Participant 5 was especially subject to chronic pain resulting from a number of pre-existing health issues, in addition to recovery from cardiac surgery. He reported such pain a number of times during the music and imagery segment of several GIM sessions. On two occasions, he spontaneously terminated his imagery process before a natural completion, due to the experiencing of severe pain (Pat5-2, Pat5-4). Despite this, Participant 5 was able to find a way to resolve the pain within the imagery in a subsequent session (Pat5-5), which will be further discussed under Grand Theme 4 (Chapter 7).

In his fourth session, Participant 5 imagined walking in a garden, but then chose to sit down for awhile because of pain.

> Still I keep the seat. I quite - *You prefer to sit?* Yes. I am with some pain, and I will keep sitting on that. I try to see all the park, but everything is, looks far away (Pat5-4, M&I).

After this, he reported that the pain abated as he walked towards the beach, but then recurred later.

> I am sitting on the bench, in the park. I am in pain. *You're in pain.* I am enjoying the music *You're enjoying the music?* Mm [Yes]. *What do you notice about the music? [no answer] Have you really had enough now? [no answer] [opens eyes] Enough?* I have pain in both knees. *Oh, have you.* I shouldn't! *I'll finish the music now. [he begins to programme the implant]* (Pat5-4, M&I).

In this instance, the pain was sufficient to require re-programming of his pain management implant, thus effectively bringing the imagery to an end as he opened his eyes and set about the precise activity of re-programming a small box, an activity rather like re-setting a complex watch.

5.1-4 Damaged goods

Themes arising from the reported imagery by the participants in this study also reflected a sense of imperfection, damage, or incompleteness. This could be interpreted as being related to the bodily effects of surgery, or a general feeling of physical compromise, and it raises the question as to whether it might reflect a type of emotional or psychological "scarring".

For example, an image of a damaged statue was reported by Participant 5, which was a well-known Greek sculpture called "Venus de Milo".

> There's some statues in the garden too. *Some statues?* Mm hm. *What are the statues like?* I think one is the "Venus of Milo". *Are you close to the statue?* No, I am not (Pat5-4, M&I).

Based on his comments, he obviously felt distanced from this scarred, broken sculpture of a body, and since his own body had been likewise scarred with cardiac surgery and pre-existing conditions it is interesting to note this parallel bodily damage. The implications of this will be further discussed using intertextual expansion (Section 5.2).

The need for, and the effects of, restoration were a focus for Participant 3 in his imagery of the Sistine Chapel. In particular, he commented on the dullness and then the change to brightness of colour during the restoration process (Pat3-3).

> Oh yes, the Sistine Chapel, it's absolutely beautiful. *Let yourself really enjoy that!* Oh, it's been restored. And I'll open the book up to photographs taken of before and after the restoration, and this, it's like chalk and cheese! The colours are so vibrant again, they looked dull before! *What do you notice about the difference?* The colours, mainly. The colours. Just more. The blues are more blue, the brown and more brown, and things like that. It just like someone switched, put lighting on them. It must take a lot of work to restore things like this (Pat3-3, M&I).

It is interesting to consider that restoration is exactly what has happened to this participant's body since the revascularization of cardiac surgery, providing his body with an improved and unimpeded flow of oxygen and nutrients, in a sense also making it more vibrant or full of energy.

5.1-5 Summary

This theme encompassed a sense of physical and emotional limits, as well as aspects of pain and discomfort, possibly linked in some way to the surgery and rehabilitation experience. It also carried a sense of damage, with unpleasant or unwelcome residual effects, in some ways paralleling the scarring that frequently is associated with wound recovery. The reported imagery within this grand theme often carried a sense of woundedness. The sense of being hurt often crossed both physical and emotional levels, and actual experiences of physical pain during the imagery and music were reported by some participants.

5.2 Semiotic Expansion via Intertextuality

Up to this point, thematic analysis has focused on the participants' reported imagery with the music. However, further clinical insights may be gained by using principles of semiotics to shed further light on the grand theme, "Feeling the impact". This is achieved by using material derived via intertextuality, notably the surrounding discussion and sessions (circumtexts), direct referrals to particular texts (intratexts) and accessing cultural symbols or idioms (intertexts), as approached via the interpretations of the researcher. These will now be explored in greater depth, moving from emergent thematic materials to related texts.

For example, Participant 1 used the intratext of the zipper to convey further information about how she was feeling. This concept was borrowed from another text, that of clothing and its construction, relating the sense of the sternotomy and the tight feeling of the metal clips intratextually to being like a zipper. The term, sternotomy, refers to the opening of the sternum by the surgeon to gain access to the cardiac area in order to perform surgery. It is subsequently secured with metal wire after surgery. Clinically, many patients experience discomfort from their sternotomy in the recovery phase. Looking at the construction of a zipper (Feibusch, 1996-2000), there are certainly strong structural similarities with that of a sternotomy (North Shore Cardiovascular Education Centre, n.d.), as demonstrated in Figure 5-2.

As with other participants, her sternum had been cut, like an opening caused by a zipper, in order to undertake the bypass surgery, and hence the "doing up" could be conceived as being too tight, as with a piece of clothing. In examining the surrounding texts, we find further comments by the participant, before the music and imagery, which underline the importance of this image of the zipper to the participant.

> I mean, it's uncomfortable, it's still uncomfortable, I still like if I could just unzip that one inch [gestures to neck, top of sternum], it would be so much more comfortable, it feels tight. If I could pull that zipper down one inch, I would sleep better and I would be more comfortable. (Pat1-1, Investigative Discussion).

Although Participant 1 elaborated most about the importance of the zipper as a symbol of the effects of cardiac bypass surgery, other participants also commented on this concept. Participant 2 discussed "joining the zipper club" in post-music discussion, with her comments indicating that this expression was common amongst people recovering from heart surgery (Pat2-4). Further to this, a quick perusal of the internet revealed frequent and varied use of the term "zipper club" to refer to this group in many places around the world. For example, this included a self-help group formed in the 1970s in New Jersey, USA and connected with the American Heart Association (Patient Care Services, n.d.), the British Cardiac Patients Association (NetDoctor, 1998-2001), a post-surgical bell-ringers group in the UK (Zipper Society, n.d.), and reported comments by a prominent Australian football coach who had recently undergone bypass surgery, saying "You'd be surprised how many people are in the zipper club" (Walter, 2002, p.1).

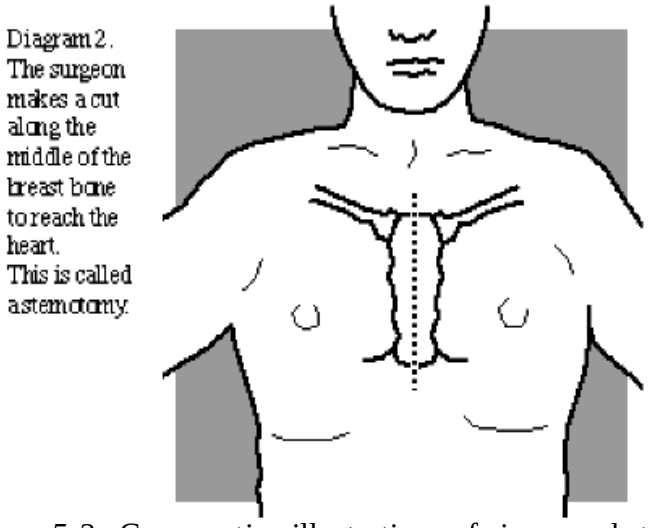


Figure 5-2. Comparative illustrations of zipper and sternotomy (Feibusch, 1996-2000; North Shore Cardiovascular Education Center,

Looking to basic definitions, the zipper, or more correctly, the zip-fastener, may be described as "a fastener consisting of two edges which are interlocked (or separated) when an attached piece sliding between them is pulled up (or down)." (Bernard & Blair, 1989, p.1196). In a broader symbolic sense, intertextually the zipper carries connotations of holding things together or letting things out, as shown by cultural phrases like "zip it" referring to keeping mouth closed and not talking.

The sense of a garment being zipped clearly suggested a sense of how the patients saw themselves after bypass surgery. Along with this, it also carried a sense of feelings being easily "un-zipped", relating to increased awareness of emotional/physical hurt.

> Well, I mean, it did make me realize that I've got this anger there. Not even anger. Frustration, I suppose, is a better word. With myself. Because I can't just do everything that I did before (Pat1-1, Cumulative Discussion).

In another instance, Participant 3 entered the GIM session complaining of a tightness related to his sternotomy. He suggested that it was related to playing lawn bowls two days in a row! After the music and imagery segment, he was asked how this now felt.

> *You came in saying it was a little bit sore, or tight.* It was a little bit tight. *And I just wondered, now that you've had the music, just to check how that is. Because you did the breathing, and sometimes the imagery* - If anything, it's a little better, if anything. *Yes, you think it's a bit better?* Because I find these experiences very relaxing, and very enjoyable, right! (Pat3-3, Cumulative Discussion).

Participant 4 also talked about the impact of the sternotomy, although not depicting it as a zipper. He called his sternotomy a "lousy cut" in the chest bone, with apparent negative connotations despite the improvement in his health status.

> *You said at the end, your scar didn't hurt.* Mm. *Was it hurting when you came in here? Was it bothering you?* It hurts every day. *It hurts every day? All the time? Yes.* It doesn't hurt, it's a sort of a "botheredness". You're not comfortable, you know. *Yes, yes. Sort of like an aggravation?* Yes. And then you're feeling, you know, all that is numb, as well, that's their knife. I don't know how long it is going to be like this, they say for a couple of years… Because you feel it, especially when you lay down, and you try to, when you lay down on your side, *Yes.* Oh, it comes very, you know, whether it's the pressure or whatever it is - it hurts! You know, and you can't sleep, or you can't lie down, your face down. I tried, you know - no way!… You get used to it. Your system gets used to it. But you know it's there. *But you obviously noticed the difference, when you didn't have it.* Oh, yes! You feel it, you feel it. *Has it come back again now?* Just a bit. *Just a bit.* But I don't take too much notice, because it looks like the body - *You try and ignore it anyway.* Yes. *Yes. That's*

> *interesting.* It is interesting. I mean those little things makes the difference, Alison, it does (Pat4-2, Cumulative Discussion).

The difficulties with the sternotomy naturally led to an awareness of current limitations, especially for Participant 1, as she commented after the music and imagery segment:

> I lay down flat on the sand. And I must, I can now lay on my stomach in bed, but it takes me awhile to get comfortable. Because it is, I mean, the scar really does take time. *Oh, you mean you were lying face down?* Mm [Yes]. Oh, right, ok, I didn't realize that. I lay down in the sun, with the sun on my back. And that's been hard to do. *Yes.* But I can do it now. But I still, as soon as you lay down, then you feel the scar straight away. But when I lay down on the beach [referring to imagery], I didn't feel the scar. And I was conscious that I didn't feel the scar when I lay down. Yes. And run - , chasing the children, at the park. Well, I don't chase them - well, I'm starting to, but, yes. *Well, yes, of course, you shouldn't overdo it.* No. *But it does suggest that you'll be able to again in the future.* Yes, well, I think that's half my problem, the fact that I have to accept my limitations at the moment and I don't like accepting them! (Pat1-1, Cumulative Discussion).

The sense of limitations was clearly evident in surrounding and additional texts, and related to the grand theme "Feeling the Impact", where limitations were based on physical health considerations.

Another apparent limitation, of a "blockage", was reported as an inner sensation by Participant 5. Circumtextual material emphasized his inability to address the blockage, where he says "I cannot penetrate that sort of blockage" and "I didn't have anything to penetrate that blockage, that's all. As I say, I'd never noticed it before" (Pat5-2 postmusic). The nature of the blockage and possible reasons for it were explored in discussion between the participant and the music therapist after the music and imagery. This participant emphasized the new and unexpected nature of his experience of "blockage" in the imagery.

> *Imagery is different, and it depends on how you're feeling inside. It depends on what's been going on. Like, I say, it can depend on the fact that we've had a 'broken" sort of session, because we were in the other room. We've talked a lot. You also said that you had taken some medication this morning. Was that the pain medication you're talking about?* Yes. *Yes.* On the top of my regular medication. *So that might have had some effect too. So not to worry, don't feel bad. I'm quite happy with what's gone on today. Do you have this sort of feeling of a "blockage" often? Or was it just for now?* I don't know, but I never noticed it before (Pat5-2, Cumulative Discussion).

Medically, the occurrence of a physical blockage, or more correctly, an occlusion, may lead to a resultant infarction. This is something to avoid with regard to the circulatory system, as it can lead to "tissue anoxia caused by interruption in the blood supply to the area" (Anderson, Anderson, & Glanze, 1994, p.807). The concept of blockage is not to be taken lightly with regard to cardiac care. In some ways, the sense of blockage of the flow of images may parallel fears of a physical blockage of his cardiopulmonary system. As the clinician "reading" and interpreting the text, this provides a fertile juxtaposition of texts and adds to the full clinical understanding of how the participant is feeling, and especially their sense of "Feeling the Impact" of this experience.

The implicit sense of "damaged goods" also emerged from initial thematic material. For Participant 3, further discussion of the sense of damage and restoration resulting from his imagery of the Sistine Chapel occurred between the music therapist and the participant in the surrounding text.

> *I was struck by how struck you were with the restoration of the Sistine Chapel* - Yes. *Compared to the fact that your body has had quite a restoration.* Yes! *I don't know whether that parallel occurred to you?* No, that did not occur to me, no. *Yes, I was really struck by that.* Ah, yes. No, that didn't occur to me. But when you see the two pages like that, "before and after", you will see. I'll bring it up and I'll show it to you. *Yes, that would be interesting.* That would be interesting (Pat3-3, Cumulative Discussion).

Field notes written after this session indicated the interpretation by the clinician, responding to the fact that he had apparently refocused the comments/question into the concrete pages of the souvenir travel book rather than into further personal reflection in the current GIM situation.

> "When I broached the parallel between Sistine Chapel restoration and restoration of his own body, he heard but didn't respond" (Field notes, 7/12/98, Pat3-3).

In fact, he was quite correct in saying that the contrast after restoration was very pronounced, as indicated in the picture (Figure 5-3). Such restoration had clearly taken place delicately and carefully. Interestingly, this Participant also began to talk about the damaged nature of the sculpture known as the Pieta, as he prepared to leave the room, as also noted in field notes (Pat3-3).

> "As we were leaving, he talked about a statue near where you leave the Sistine Chapel or St Peter's Basilica, a famous statue, the Pieta. It has been hit with an axe and restored"(Field notes, 7/12/98, Pat3-3).

(A) before restoration.

(B) after restoration.

Figure 5-3. Illustrations of restoration of Sistine Chapel (Cegur's Chimera Gallery, n.d.).

There are in fact interesting parallels between the participant and this further art-based text of a statue (Figure 5-4). In the current context, as a broken and damaged figure of a body, it suggested the possibility of a parallel to the experience of his body, which had also been broken and damaged by cardiac surgery, and even previously by cancer and

severe arthritis with chronic pain, and both his body and that of the statue had then been restored following the impact. The sense of restoration will be further explored under Grand Theme 4 (Chapter 7).

Figure 5-4. Illustration of Venus de Milo (Artchive, n.d.).

Physical limitations emerging as thematic material related to "Feeling the impact" were also expanded semiotically. Participant 2 expressed themes related to her physical breathlessness via an image of the wind struggling to blow and subsequently running out of breath (Pat2-2) from a childhood storybook image.

Although there is no certainty, the book to which she is referring may well have been "A child's garden of verse" by Stevenson (1885/1989, p.31). This collection of poetry has been popular for generations, including during the time that the participant would have been growing up (the 1930s). In this book, there is a poem about the wind, which is usually surrounded by evocative illustrations (in any edition), and it may have been to these to that the participant was referring. The words of the poem appear as follows:

The Wind

I saw you toss the kites on high
And blow the birds about the sky;
And all around I heard you pass,
Like ladies' skirts across the grass –
O wind, a-blowing all day long,
O wind that sings so loud a song!

I saw the different things you did,
But always you yourself you hid.
I felt you push, I heard you call,
I could not see yourself at all –
O wind, a-blowing all day long,
O wind that sings so loud a song!

O you that are so strong and cold,
O blower, are you young or old?
Are you a beast of field or tree,
Or just a stronger child than me?
O wind, a-blowing all day long,
O wind that sings so loud a song!

(Stevenson, 1885/1989, p.31)

Interestingly, the words of this poetry text also carry additional meanings, including issues of identity, strength, and aging, which may or may not have been intended by the participant. She further describes her imagery in surrounding discussion, where the imagery reported and conveyed seemed to carry a great sense of childish simplicity. Perhaps she was also feeling small and childish in the face of the overwhelming drama of heart surgery.

> Just so many things seem to be as though I had seen it in a book, particularly the wind, and even the green hill with the daisies, it was like a child's drawing, I suppose, where you draw a hill like that *[gestures]* and then another like that *[gestures]*, and the fence, and probably that's where the rainbow (Pat2-2, Cumulative Discussion).

In looking further at broader cultural texts, "wind" may be understood intertextually to be active air (Cirlot, 1971, p.373), and carries the sense of the "vital breath of the universe… sustaining life and holding it together" (Cooper, 1978, p.192). This links surprisingly well with the comments of Participant 2 regarding her prior physical limits of breathlessness, especially in walking up a hill (Pat2-1).

> My main problem was shortness of breath…my problem was getting up hills. And I've realized since, in the last few weeks, I'm not avoiding hills and steps.

> And, you know, I've been kidding myself, I've been avoiding them for a few years (Pat 2-1, Investigative Discussion).

This quote also shows the beginnings of an awareness of a change to these limitations post-surgery, where she now indeed has increased breath to undertake activities. Hence, she has recognized and acknowledged these limitations, related to the grand theme, "Feeling the impact", but also recognized that they are changing towards improvement of health.

In contrast, Participant 1 now actually has more limitations in the wake of cardiac surgery. These limitations, which she did not experience before surgery, engender a sense of emotional frustration, due to a natural expectation to feel better quickly after the bypass surgery.

> I can actually try and deal with it now, and tell myself what an idiot I'm being to be frustrated with myself at this stage. Which is obviously what I'm feeling. Because I can't chase the children around, and I can't do quite what I was doing before. Ah, and that's silly. Because at 9 weeks, you shouldn't be able to do that (Pat1-1, Cumulative Discussion).

Participant 5 also talks about a post-surgical feeling of depression due to the combination of increased cardiac health and increased frustration with other physical limitations based on chronic pain and severe arthritis.

> That's why I fell into depression after the surgery, because of the - . Because of the new heart, I feel, inside, more active. I want to jump, I want to run, I want to do many things. But I have limitations because of my legs. *Yes, yes.* You see, this limitation is. *So you said, that's been making you feel depressed? Is that what you said?* Yes, because I feel so active inside, but I cannot do it. The only thing I do is walk. I walk a lot. But I know I cannot jump, or I cannot run. But I feel like I want to do it. My heart is willing to do it. *Yes, yes*. But my legs say "no". That's it (Pat5-1, Investigative Discussion).

The issue of frustration based on physical limits was further raised by Participant 1:

> Well, I mean, it did make me realize that I've got this anger there. Not even anger. Frustration, I suppose, is a better word. With myself. Because I can't just do everything that I did before. But I also know that that's only time. And it really is silly, when you think about it, to think that I'm that frustrated, after 9 weeks. And I can really virtually do almost everything. Except that I get tired (Pat1-1, Cumulative Discussion).

Here, the sense of "Feeling the Impact" was also acknowledged, in both physical and emotional terms, and ambivalent feelings about post-surgery progress were highlighted via the juxtapositioning of texts.

Residual pain in the shoulders was also discussed by some participants in circumtextual material, and was another aspect of feeling the impact of the surgery as especially noted by Participant 2 and Participant 4. Such pain resulted from the flow-on effects of opening and stretching the sternum in order to undertake the cardiac surgery, thereby putting strain on other bodily structures. Participant 2 had sought further professional help in treating this; Participant 4 describes and demonstrates his experiences quite graphically.

> The doctors want to get at your heart and they don't care what happens to the rest of you. Parts are moved that were never designed to be moved. And, I feel that the soreness in that shoulder which shows up there. *In your right shoulder*. That, that really showed up after I'd finished doing the [cardiac rehabilitation] course (Pat4-2, Investigative Discussion).

> That was one of the worst things I had, in my body, the muscles in the shoulders, after the operation – *[indicates] Behind your back there too?* Yes, because they stretch you, when you are on the operating table, they stretch you and your hands back so much, you know, and after the operation, ooh, it's painful. *Yes. So it was back around, near your shoulder blades, that muscle back there.* Yes, that's right, very sore. And I had days that the pain was twisting my body, I couldn't move, you know, I wasn't feeling relaxed. It didn't matter if I was lying down, or standing up, or walking, or whatever. It took about 4 to 6 weeks to start feeling the recovery. And the exercises, they help a lot, they do help a lot (Pat4-2, Investigative Discussion).

Participant 2 also talked about the residual pain in her shoulders, which had become noticeable since the previous year and most likely linked to her mastectomy some 27 years ago. She had been receiving treatment for this problem from an osteopath; the situation had again worsened as a result of the cardiac surgery. She summed it up thus:

> So all the good work that [the osteopath] did, I'd say has been undone by being split open. Like a filleted fish! *[joint laughter]* (Pat2-2, Investigative Discussion).

In addition Participant 6 also mentioned visiting a Tai Chi instructor, who noticed tightness in her chest, obviously resulting from the cardiac surgery.

> When I went to inquire, and they had me do some of those things. He held my shoulders. And I was only recently, about eight weeks after my operation, and it was sore. But I was doing this for him. And he held my shoulders and he said,

> "Strange", he said, "but your arms are so relaxed but your torso is so rigid!" *[laughs]* He didn't know…*[laughs] He didn't know you'd had the surgery?* No. But he could tell I was all tight and tense in my body - just from touching my shoulders… I was very impressed! (Pat6-6, Investigative Discussion).

Here, further textual information about the impact of the surgery was literally carried in her body, and is clearly of relevance to the grand theme, "Feeling the impact".

In further examples, Participant 5 elaborates on his experiences of pain, in this case focusing on the vagaries and unpredictability of pain. Interestingly, his chronic pain disappeared for two months after his bypass surgery, and then returned not long before his commencement in the GIM research project. As he states,

> After the heart surgery all my chronic pain disappeared. Completely! It was something the doctor couldn't believe, you know. And I know that it was a bonus. And of course they last about 2 months. After that time, it gradually started to come back, all my pain. And you see, I am with pain. The implant's on. *Yes, so that was not too long ago.* No. It was up to February some time. *So it's only just started coming back again.* Up to February some time, yes. Early February. Two months. And the doctors can't explain that. Because it has nothing to do, having surgery, with chronic pain. But, she says, *Something about the change of balance about the things?* She say the nerves, something about the nerves is important too. *Yes.* And they explain to me how some people they are amputees, some leg or arm, and they feel the pain in their limb they don't have. But they feel the pain. *Pain is such a difficult problem, isn't it?* It is. - *for people to understand or do things about.* It is. It is hard to understand. I know a lot now about mine. But I cannot understand completely, you know. But, um, I don't know still how pain works, but I know how pain feels. That's for sure! (Pat5-1, Investigative Discussion).

Participant 5 also commented on the success of his implant in masking pain.

> With the implant on, the minimum pain relief is 50%, which is very good. And I can get a maximum of 70 or 80 %, which is very, very, very good. I'm very lucky because that implant doesn't work on everybody. For some people it doesn't work. That's I say, I'm very lucky. Because I was so upset with the side-effects of the morphine (Pat5-1, Investigative Discussion).

As he reported, his chronic pain also occurred intermittently in the GIM sessions, and was somewhat affected by circumstances such as the type of chair being used by the participant.

> *Well, it seemed like you were quite relaxed, for a while there, in your imagery. And then it changed.* That pain comes and goes, inside the knee. *Inside the knee. Is that the pain you've been getting recently?* Yes. Sometimes it is the chair, but all chair the same. *I can get another chair from over there for you...*

> *I'll get you another chair so that you can choose. This one might be better.* At home I've got four different kinds of chairs! (Pat5-4, Cumulative Discussion).

At this point, it is worthwhile considering the wider implications of pain and what it means, and so we turn to intertextual sources. The word, "pain" may be used to describe sensations or experiences of both physical and/or emotional suffering or distress, and may be related to injury or illness (Urdang & Flexner, 1968, p.955). Likewise, feeling hurt may also have physical and emotional aspects of injury and damage (Urdang & Flexner, 1968, p.647).

It is interesting that in the context of this current recovery from a physical hurt (cardiac bypass surgery), other pain and hurts of a more emotional nature were brought to the fore. For Participant 1, this related to her divorce, seeming to be part of general emotional outpouring, and will be further discussed under Grand Theme 3 (Chapter 6). It is clear that cardiac surgery was often viewed as having a painful and profound physical (and emotional) impact, as related to the grand theme, "Feeling the impact".

In complete contrast, Participant 2 incorporated an ongoing joke about the grafting of her new (pig) heart valve into her new life, combining both film and musical texts to do so, and in the process acknowledged the damage to, and attempts at repairing, her body. In surrounding discussion in session six she referred to a song (an intratext), called "Mame", linking it to the pig valve which has been placed in her heart, via the recent Australian movie about a pig called "Babe" (Pat2-6). She reported utilizing the words of an older popular song, "Mame", and changing them to suit her need to express her current situation. The original words of the song, "Mame", are as follows:

Mame

> You coax the blues right out of the horn, Mame;
> You charm the husk right off of the corn, Mame.
> You've got the banjos strummin' and plunkin'out a tune to beat the band,
> The whole plantation's hummin' since you brought Dixie back to Dixieland.
> You make the cotton easy to pick, Mame;
> You give my old mint julep a kick, Mame.
> You make the old magnolia tree blossom at the mention of your name,
> You've made us feel alive again,
> You've given us the drive again,
> To make the South revive again, Mame.
>
> (Herman, n.d., p.28-30)

Participant 2 comments on how she intends to utilize this song to express her own situation an upcoming Christmas party in a few days time.

> I'm going to sing, "You put the valve back into my heart, Babe!" *Oh, are you?! [joint laughter]* Unaccompanied, because we don't have a pianist there. And I haven't finished writing the parody yet... I think it's from the film that had Lucille Ball, as Mame. There was Roslyn Russell as Aunty Mame, and this was the musical from the book. I think it was "Travels with my Aunt". And then the film was "Auntie Mame", and then Lucille Ball - We did it with this group of senior citizens, and we did it in long dresses and hats and umbrellas, and it's like, she's in the South…
>
> *[sings]* "You make the cotton easy to pick, Mame". "Da,da, dum…Mame".
>
> I really should ring my friend… But my idea was to wear this long dress and hat and the umbrella, and get a "Miss Piggy" mask. I couldn't get a Miss Piggy mask anywhere, so it finished up, I bought a pink, cuddly pig, and I'm going to sing it to the pig. When I finish writing the words. *[joint laughter]* It started off, my daughter started the song off when I was in hospital. And then another friend added some more to it. And I've only just sort of put it together (Pat2-6, Investigative Discussion).

The nature of the film "Babe" – is about an adventurous and caring animal who sets out to use his extraordinariness to save others on the farm, including the farmer himself. Babe is described as "a pig with an unprejudiced heart who takes all other animals at face value and by treating the sheep and all other animals as equals, he irrevocably changes their lives" (Starpet, n.d.). In fact, this participant has had her life irrevocably changed as the result of a pig, which she has now humorously characterized as "Babe".

The fact that both her daughter and her friend joined in with the "Babe" joke promoted a social milieu in which change from the surgery and identity were acknowledged. This no doubt provided a sense of support to the participant and also served to diffuse potentially difficult emotions via humour, thereby assisting the forming of a positive sense of the impact of cardiac surgery, as considered with respect to the grand theme, "Feeling the impact".

Based on the comments of participants, it seemed that the experience of a health crisis of severe dimensions based on damaged or depleted cardiac function often seemed to occur before the operation, following diagnosis and while waiting for treatment to begin. This crisis was usually sudden and unexpected.

For example, one participant described what led to surgery: it had been found, at a routine check-up, that her blood pressure was fluctuating dramatically. She was sent straight to hospital, where it was discovered she had four coronary blockages. When stabilized, she was allowed to go home for just five days, before bypass surgery. She says:

> So I didn't really have time, I had five days. I went home for five days. So it was a sort of mental shock to the system. I mean, I did get a bit upset at first, when he first said, "there's four blockages", I had a bit of a weep, but that was the only time (Pat1-1, Investigative Discussion).

Her shock and worry before the operation was still strongly remembered (now nine weeks later) and from her tone of voice and other comments, it suggested that her words were, if anything, understated, regarding the sudden effect of this almost-emergency surgery. Likewise, Participant 4 expressed comments about his pre-surgical experiences thus:

> I don't let my mind go back, you know, to the hospital, where I had my surgery. *You don't?* No. I try to keep it away. *Yes.* All that time. There was nothing happy about it, you know (Pat4-2, Investigative Discussion).

These comments in surrounding discussion indicate the extremely stressful time of surgery, including the prior experience, and suggest unresolved feelings related to the impact of this cardiac surgery, which again serve to further understand the relationship of the grand theme, "Feeling the impact", to the life and experiences of these participants recovering from bypass surgery.

5.2-1 Final summary, Grand Theme 2

The process of generating the grand theme emically from thematic material and based on the text has been demonstrated for the grand theme, "Feeling the impact". Constituent themes of Grand Theme 2, "Feeling the impact", were "Physical limits", "Discomfort", "Feeling hurt" and "Damaged goods", which together served to convey the impact of the cardiac surgery on the person, physically and emotionally, and their response to this.

At a further level of analysis, the semiotic concept of intertextuality has been applied in order to explore the manner in which additional texts (circumtext, intratext and

intertext) may shed further light on understanding the meaning for the patient, based on reported music-generated imagery, in the light of recovery from bypass surgery.

Participants used further texts to convey the deep, hurtful and limiting effect of cardiac surgery, and to further express both emotional and physical feelings related to this. The possibility of unresolved feelings from cardiac surgery was carried in texts relating to damage and the sudden onset of health crisis, and had an effect on individual identity.

The next grand theme will now be explored, which is “Spiralling into the unexpected”.

CHAPTER 6. SYSTEMATIC ANALYSIS: GRAND THEME 3: SPIRALLING INTO THE UNEXPECTED

6.1 Textual analysis

This theme suggests advancing into difficult or challenging areas, with the movement forming a spiral, a curve generated "by a point moving around a fixed point while constantly receding from or approaching it" (Urdang & Flexner, 1968, p.1267). The enlarging or decreasing spiral can give a sense of being almost out of control, and a sense of dizziness, confusion, and disorientation. There is also a strong sense of forward movement, with the word "into" suggesting no escape, no pulling back, and a need to confront new experiences.

Unforeseen or surprising experiences routinely occur for all human beings, but for participants in this study, unexpectedly severe issues of pure existence, and questions of how to manage in very unfamiliar territory were evident. This included experiences such as being in the hospital and relating to their body and their feelings. Clinically, coping with fear and anxiety was a major issue requiring an individual response, and could be related to the potential development of dependency in the post-surgery and rehabilitation phase.

The themes contributing to the grand theme, "Spiralling into the unexpected" are now discussed in depth. The overall structure of such themes is shown in Figure 6-1.

Figure 6-1. Thematic tree diagram of Grand Theme: Spiralling into the unexpected.

6.1-1 Out of joint

Within the grand theme of "Spiralling into the unexpected", a sense of strangeness, of something not quite right or not fitting properly in the logical scheme of things was

evident. It also involved trying to makes sense of disparate information, or even a sense of risk. Specific examples included a sense of the sun setting in the wrong direction (Pat2-1), a man-made asphalt road seeming to be out of place in the idyllic forest (Pat4-5), and the intake of petrol fumes as a car passed amidst clear country air (Pat4-5). In another example, Participant 4 struggled to understand the effect of night-time on the process of photosynthesis with plants, and reported the sense of something missing due to the lack of daylight.

> I wonder what happens at night time? Plants must act different at night-time. That's right. That cannot act the same, because there is not day-light, there is no sun. So, photosynthesis cannot occur, if one of those elements is missing (Pat4-5, M&I).

Sometimes there was an unusual visual juxtaposition of past and present images and memories which seemed out of joint, as Participant 2 comments:

> And it looks as thought the sun is setting at night. My mind's telling me that that is wrong. *It's wrong?* Yes, you only see the sun rise from here. *So it feels like the wrong direction?* Mm [Yes] (Pat2-1, M&I).

> But that's strange, because streets around there weren't developed then, but there's a big two storey white painted house, which is probably there now, but it certainly wasn't there then, because it's all scrubby bush (Pat2-3, M&I).

Not only a sense of strangeness but also a feeling of riskiness, with its associated ambivalence, appeared in relation to imagery about Mr. Whippy, the ice-cream man and the question of whether he was dealing in other illicit products (Pat2-5). Such a sense of risk was seen even more profoundly in reported memories of risky behaviour when walking in the Blue Mountains (Pat2-5), and more immediately in active imagery of a farmer and a cart in a rustic setting.

> There is a little farmer's cart. I think it's got hay on it. And there's, he's leading a horse. He's not driving the horse, he's just walking along, leading it. I don't know how he's going to get down this steep bit. Because he's got to go down a very steep part, and then up the other side. So what's he going to do there? Oh, he's got a young lad there, who's going to sort of pull back, so that the cart won't rush down and run over the horse. *Is he able to do that?* Um, yes, I think he's - . It seems as though he's got a stick, or a stave to put through the wheel, to - . I don't know how that's going to work. Logically, I can't see it. But, - *But that's what they're doing?* That's what he's doing. *Does that help?* Um, it all looks very dangerous to me (Pat2-3, M&I).

Other themes suggesting some sense of risk emerged from the reported imagery, such as the intake of unhealthy air laden with car fumes (Pat 4-5) and the more general feeling of being out of breath (Pat3-1, M&I).

Sometimes there was an ominous sense of impending gloom, including a sense of heaviness, and in fact dark and ominous clouds appeared several times in the course of the music-generated imagery, and occasionally threatening waves.

> There's clouds passing over the lake. And the water is a bit rough, and then it dies down again (Pat2-3, M&I).
>
> There is a very big wave coming this way now. Oh, it didn't reach me, that wave. *It didn't reach you?* No (Pat5-5, M&I).
>
> Now I can see the, a bit of a storm cloud. And they're all putting up their frilly umbrellas, I don't know if there's much protection from the rain, where they're decorative. *And what happens now?* The rain seems to blow across very quickly. *And how is it now?* Oh, I think they're all going to get wet (Pat2-6, M&I).
>
> Now, it's overcast, there's a black cloud *A black cloud. How does it feel to have that black cloud?* Mm. It's as though there is a storm. *A storm?* Mm. Now my cloud has gone. *How does that feel?* Everything's lighter As though, um, a heavy weight has lifted (Pat2-1, M&I).

The sudden nature of a storm arising in the imagery parallels the sense of "Spiralling into the unexpected".

6.1-2 Uphill battle

At times, participants reported imagery which gave the sense of a barely surmountable challenge, of a struggle for movement or achievement, an obstacle in the way or even an imposed restriction, which led to the theme of an "uphill battle". For example, the sun struggled to shine through the trailing vapour, the silver rain and clouds for Participant 2.

> And now the sun's come out again, or the sun's trying to come out. It hasn't quite come through because of this sort of trailing ray/vapour behind the wind. And there's the sun, it keeps trying to come through. And it can't because the vapour/ray sort of clouds are there. And now it's… *Is there something that the sun would like to do, to the vapour and the clouds?* Yes, it would like to push through, and shine on the fields. *Can it do that?* And when it does that, the daisies will re-appear. But it's still trying to get through, and yet the wind has gone. It's just this grey. And there's some blue sky above the grey. But the sun can't get through, and yet it's, um, it's warmer (Pat2-2, M&I).

> And there's little sprinklings of rain, and the rain is silver. *Silver.* It looks like little silver droplets. And that's coming down, it's coming down out of the clouds. And the sun is probably causing the rain to look silver, but it is still dark, overcast. *Still overcast.* And I'm still on this hill with the white fence. And the sun's just trying to come through a break in the clouds. And as the music lifts a bit, the sun lifts. But it's not like a sunrise or a sunset, it's just that break in the clouds, with the sun showing through (Pat2-2, M&I).

The effort required to surmount an obstacle could be as simple as getting over a stile, and other restrictions could involve not touching the water!

> I think I've got to get over a stile. *You've got to get over a stile?* Yes. It's by the side of a road. Um, the road's a pretty rough sort of a road. But to get nearer to the sheep, I've got to get off the road and get over this stile. I'm still not getting any nearer to the sheep. It's very green (Pat2-4, M&I).

> Then you go on through into another cave, and there's water. *There's water.* Yes. Look down, I suppose you could touch it but you're not allowed to. And it's running along, that's called the river cave (Pat2-4, M&I).

Some images were reported as being very static, such as painted and unmoving rays of the sun (Pat2-1), and "stuck-ness" in the imagery process, such as that reported by Participant 2.

> And the rays of the sun look as though they're painted. *Would you like to paint them too?* No, no. No, I just like looking at them (Pat 2-1, M&I).

> And I'm really stuck on this hill. *I beg your pardon?* I'm really stuck on this hill, I can't… *You're really stuck on the hill?* I can't , um, move – I'm standing. I can't see anything else. *Does it bother you?* I feel as though I should be able to see more than that. Perhaps I'm just waiting for the sun to shine over the whole place and the daisies to come back. And actually I'm getting very bored with this hill, I could, um… Because nothing more is happening there (Pat 2-2, M&I).

The "uphill battle" also included a sense of inadequacy, of not having enough time, of not being strong enough, of fear of weakness, and an inability to relax, especially for Participant 1.

> It's just that I'm not quite strong enough yet, to do the things that I'm so used to being able to do. I'm too independent, I know that, I don't let people help me… I guess I have trouble *[breaks into tears again]* handling not being strong. *It's ok to not feel strong sometimes.* I'm going to leave the park, because I can't relax with all the children (Pat1-1, M&I).

6.1-3 All to pieces

The theme of being "all to pieces" carried a sense of the unseen, the unknown, the physically disconnected or disembodied and the destroyed or pulled apart. It could appear when the participant was seeing another side of themselves that they had not anticipated. As is common in GIM therapy, emotions could arise suddenly in the spontaneous generation of imagery in the Music and Imagery Treatment phase. For example, emotions triggered by a simple memory of a picnic could be perplexing and fragmented for the participant.

> We had like a picnic there, two weeks ago, for my birthday. *Would you like to imagine you are there now?* I'm getting very emotional. *[begins to cry] Oh, are you. Let the feelings out. It's ok to let the feelings out.* I don't know what they are. *Yes. Can you give the emotions a colour? Can you imagine what those emotions would be if they were a colour?* Purple. *Do you have any sense about those emotions?* No, no really. *No?* It's something that we have discussed at the meetings, everyone keeps saying they are very emotional. I guess it's just part of the after effects, but I don't know what I'm feeling emotional about. Because, as far as I know, I've got no fears or anything about the surgery or what's happened to my body, I'm quite relaxed about it all, I think. But I did this with [rehabilitation nurse co-ordinator] when I was talking to her for the first interview. I was as good as gold and then all of a sudden, I started to cry for no reason. But then the other ladies told me they're the same. And emotions, maybe just the music, and the relaxation. But no, I can't put a name to it at all (Pat1-1, M&I).

Sometimes events or actions occurred without the obviously necessary connections in place to make them happen, and this then promoted a sense of disembodiment. This occurred in the way a piano played by itself, and top hat and gloves appeared without an embodied owner, in the reported imagery of Participant 2.

> It's got gold writing. *Can you see what it says?* No. The writing is above the keyboard on the panel there. The lid's up. *Is there anything else about the piano?* I can see the keys moving, but no-one's playing them. It's like a pianola. *What does it sound like?* Oh, it's soft and flowing. And then there's violins in the back. But again, I can't see the people that are playing them (Pat2-2, M&I).

> No, I'm still back to the piano, and, although first of all it looked like a rosewood or a mahogany, now it's black. And it's a graphic, that was [on the piano?] – my daughter used once, on something she printed for me. Yes, you can see the unevenness when it's been copied and copied. And there's a top hat, and it's not going to be Fred Astaire because it's not dancing music *[joint laughter] Is there anyone with the top hat?* No, but there's definitely gloves. White gloves. *Are the gloves on someone's hand, or not?* No (Pat2-2, M&I).

This sense of disorder extended to indefinite and disjoint pieces of vision, a patchiness about what seemed to be there, and a sense of things becoming fuzzy or fading. In particular, Participant 2 experienced a lot of fuzzy, fading and disappearing images. This occurred with respect to a boat on the water, a fountain, a waterfall, a hill, a woman picking shellfish, and some friends and their billycart.

> They've all vanished. And its all gone blur-ry. Hm. There's nothing very definite. *How does it feel to not be very definite?* Sorry? *How does it feel for it not to be very definite?* It just feels as though I'm looking at a picture which has just faded away. There's no definite image at all (Pat2-4, M&I).

> And the rays of the sun look as though they're painted. *Would you like to paint them too?* No, no. No, I just like looking at them. *Let yourself really enjoy that.* Now it's all going fuzzy. *All going fuzzy?* Mm. As though it's just fading away, as though - . I've lost track of the music (Pat2-1, M&I).

> Although her hair is golden. But the gown hasn't got a distinct colour. But everything else is gold. *How does that feel?* It's sort of glowing, but now its fading. It's fading right away (Pat2-2, M&I).

> And now the golden rays are sort of shimmering. Now that's all faded. The pot of gold has faded first, and then the rainbow gradually fading, over the arch of the rainbow. *How does that make you feel, to see it fading?* It's quite calming, because it's all happening slowly. And it's gone. And everything's blank. There's nothing there (Pat2-2, M&I).

It is interesting to note that the reported imagery of Participant 2 frequently disappeared after there were music therapy interventions directed towards enhancing bodily or emotional feelings. This trend of fuzzy, fading, and disappearing in early GIM sessions was discussed gently and openly with her, and she was encouraged to gradually increase her tolerance of and openness to feeling interventions. In fact, her response of avoidance gradually began to decrease, and by session five she was able to relate well to her body and bodily feelings as she walked down the Giant Staircase in the Blue Mountains, with obvious enjoyment and embodiment.

6.1-4 Uncertain future

At times there was a directly felt threat to existence and an uncertain future as a theme arising from the reported imagery. Aspects of danger were suggested by imagery such as a fish being chased by a life-threatening predator, and the fear and difficulties of survival in the wild, or in wild places.

> Now I feel very light. Um, sort of just more swirling images, now than a scene. *What are the swirling images like?* Mm. There's a question mark in blue. There's little dots, little sparkling dots. It's like spots on material (Pat2-4, M&I).
>
> If you walk into there when it's dark, before they turn the lights on, you can feel the roof pressing down on you. But as soon as it's lit up, you find that the roof is, oh, 15 or 20 feet high (Pat2-4, M&I).
>
> Oh, now the water is affecting the boat, it's turning into a whirlpool, that calm patch. But they're still fishing, even though they're going to be drawn into this whirlpool (Pat2-3, M&I).
>
> But there's a wind blowing across, causing ripples over to one side. And a fish jumped. He must be being chased. *Was he being chased?* I think someone wanted him for dinner. *Would you like to see who that someone is?* Just a bigger fish (Pat6-4, M&I).
>
> The birds, they don't take any notice. Probably later. Probably they're scared. I don't know. I can only find out in a little while, if they do come or not. *Is there something you would like to say to them?* I don't know what to say to them. I wish I knew! There is a little one came up. *A little one.* And it's very, very scared. And only sits on the rail, of that balcony. I'm pretty sure he's watching the breadcrumbs. There's another one. They're only little ones. *What are they like?* Pretty ordinary birds, that we see everyday. I don't know their names. *Do they have colours?* Grey-ish-y colour. A dark grey. I don't know what you call them. Anyhow, who cares! *Who cares* - As long as they come around me and feed themselves. Yes, they start feeding now. But they look very, very scared. *They look scared.* They look scared alright! *How can you tell.* They're moving around their heads, they're moving around their bodies. And I'm trying not to move, or make any moves whatsoever (Pat4-2, M&I).

This is an interesting link of not just fear but also immobility related to the fear.

> I just wonder that, I always wonder that birds can look after themselves and their babies so well. They have a lot of difficulties. They must have a lot of intelligence. *Is there something the bird would like to say to you?* I don't know. I think that… he was probably worried we'd frighten things away, that may have been about, for food. Sometimes it's better not to venture into places where animals need to survive. Although it's very beautiful (Pat6-4, M&I).
>
> It takes a lot of time watching everything that is on the mountain. The little avalanches. *Little avalanches.* They're quite dangerous for people skiing in some parts (Pat6-2, M&I).

This sense of uncertainty and threat may have related to the participant's view of an unpredictable body, with an inherent expectation of the body as being unreliable (particularly the heart, which is necessary for survival). The sense of an uncertain

future was brought out even more strongly in other texts as part of intertextual (semiotic) expansion, which will be addressed in the next section.

6.1-5 Summary

The theme of "Spiralling into the unexpected" addressed feelings of things being "out of joint" and unexpected, of being part of a difficult and uphill battle, and the unknown, disconnected and disembodied. It also carried a sense of foreboding, unpredictability, and of a difficult future.

6.2 Semiotic Expansion via Intertextuality

Further clinical insights are now pursued using semiotic intertextuality to shed light on the grand theme, "Spiralling into the unexpected". This brings greater depth to the emergent thematic material by focusing on the related circumtexts, intratexts and intertexts.

As already noted, a prominent theme related to the sense of things being fuzzy, fading, or disappearing. This was especially true for Participant 2, and seemed to occur especially in response to interventions by the music therapist aimed at accessing physical and emotional feelings. In fact, in further textual material, the therapist commented with regard to her imagery and after the second session, that "there is almost no sense of a physical self in the imagery. The imagery seems detached and disembodied". This occurs in field notes recorded after her second session (Field notes, 2/11/98). Such a sense of disembodiment was evident at times for other participants in surrounding discussion. For example, Participant 4 clearly considered mind and body to be separate with regard to relaxation, as he demonstrated in discussion prior to his first music and imagery experience in this music therapy programme.

> *So how does that feel in your body, when you're not relaxed?* Ah - *Do you notice how your body feels, when you are not -?* My body's alright. *Yes.* It's the head that is faulty! *[joint laughter]* It's the head that's faulty! *So you feel it more as a head thing.* Yes. *Because sometimes when people are saying they're not relaxed they're feeling sort of tight in their muscles, or any of those sorts of things.* No, not in mine, no (Pat4-1, Investigative Discussion).

Such an understanding may relate to the unexpected focus on feelings of the body which may be new for the participants; they may have denied and neglected the body prior to surgery and this music and imagery situation.

This perceived disembodiment and disconnection also at times seemed to be related to a sense of loss, of a disappearance of that which was familiar. This is shown by another text, a previously written poem written by Participant 2, which highlights the disappearance and loss of familiar territory from childhood, which she offered to the researcher and reads as follows:

South Coogee – Then and Now

[Participant 2] 1992

We ran up the bush hill
Looked across to the city -
Saw the Harbour Bridge,
The AWA Tower,
Tallest building in Sydney.

Played hidings in scrubland,
Gathered five-corner berries,
Tiny bush bells,
Eggs and bacon,
Boronia and wattle.

We stayed away from the Quarry,
Danger in the deep water,
Caught tadpoles in rock pools,
Found caves in sandstone
With views of the ocean.

Thirty years on – my daughter
Played on the same hill,
Built lantana cubbies,
Pitched a Guide tent,
Lit campfires, boiled billies.

Now million dollar mansions
Crown in three-storeyed splendour.
Sandstone caves, little rock pools
Devoured by Public Housing –
My grandchildren live there.
They can't play in the bush –
The wildflowers have gone.

This highlights an unexpected loss of the familiar, which has again promoted a sense of movement into new or difference experiences.

The further disordered and disparate experiences of themselves, their body and their treatment were noted especially by Participant 4. In discussion prior to the music, he reflects on this as promoting a lack of balance and foundation.

> Well I was asking the cardiologist, I said, "why?", "why me?", you know. I've been exercising, my diet was perfect, no blood pressure, no cholesterol, no this, no that - "Why?", "Why?" "Why did it happen to me?"… And the other question I asked, I said, "alright, if everything goes alright, will that happen again?" And he said, "yes, it can happen again"!… But, you know, you don't have a solid foundation for a proper answer, follow me? It's missing. It isn't there. You're standing with one foot up, Alison. *There's no clear reason.* No. You're always standing with one foot up. Not with your two feet down. And it's a pain, Alison. Because it's in your head that, you know, it could happen tomorrow again, or next year, or the year after. And you got to start all over again, you know (Pat4-1, Investigative Discussion).

This text carries powerful symbolic material, especially "standing with one foot up". In order to bring to light the social/cultural aspects of these symbols, two standard and respected dictionaries were consulted (Cirlot, 1971; Cooper, 1978). From this, we find that "absence of feet, as in the case of fire gods, indicates the instability of flame" (Cooper, 1978, p.66). Cirlot sees the foot as an ambivalent symbol (1971, p.111). He quotes Ania Teillard, who points out that "[the foot] is an essential part of the body and the support of one's entire person" (p.111). It is also pointed out that in Greek legends, lameness usually symbolizes some defect of the spirit, and this is corroborated by Jung (as cited in Cirlot, 1971, p.111).

Therefore, this circumtext points to a sense of instability and ambivalence, a lack of solid support, a residual feeling of disability and a sense of incompleteness. This expanded intertextual understanding points jointly to the physical and emotional experience of this participant, and also points, in turn to the overall grand theme, "Spiralling into the unexpected", where suddenly the familiar "ground rules" have changed to give a feeling of uncertainty.

His conflicting feelings are further reflected as he seeks to understand and make sense of information connecting diet (especially cholesterol intake) and health, where he has a sense of disparate and competing information.

> And the other thing that bothers me a lot, is, er, really does, is the diet I am doing for cholesterol. Which, I've been told that new studies in the medicine,

> shows that cholesterol is not a prime effect to the body to cause you blockages (Pat4-2, Investigative Discussion).

He elaborates further about the effect of this competing and conflicting information he has received with regard to his cognitive and emotional well-being.

> Well, you're mixed up, you see. *Yes.* Not only me, but every one of us, have been in the same boat. *So, that feeling of uncertainty is upsetting?* It is! *Yes.* It is. I mean, now, when I face these people about the facts, like last week, we were taught how to read the food labels, the ingredients and all that, to be careful what to eat, what not the eat, too much salt, too much fat, too much this, too much that – All right, that's an education. But, is it true? If you see a medical study that the cholesterol, you know, it doesn't count so much - which way are you going to think - this way, or that way? You're in the middle, you know, and you had the operation, you know, and you don't know which way to take? You see, that's another frustrating thing. You go to any cardiologist, or to any heart doctor, and ask him about it, and he will tell you, "well look, just keep doing this, you know, and you will be alright" (Pat4-2, Investigative Discussion).

Again, the sense of moving into new and unfamiliar territory with no clear "ground rules" relates this strongly to "Spiralling into the unexpected".

Most of the participants in this study expressed a desire to continue to show strength and ability to cope, but at times this seemed to cover a real sense of feeling as though they were falling apart. For example, Participant 1 felt a strong need to be strong and stoic in her approach to health and relationship problems, and clearly found it frustrating when her own sense of herself crumbled and she felt dependent. She also recognized that this feeling of dependency had promoted her emotional outpouring during the music and imagery session, as well as during prior discussion with the cardiac rehabilitation programme coordinator.

> But I can see, from that, that, that I am angry with myself, because I'm not strong yet, physically. [more tears] *Yes, yes. It must take a lot of patience with oneself to be able to cope with this.* Yes, that's a real failing, I think. Because I'm just, um, my whole family, my mother, my sisters, my children get cranky with me because I'm too independent. I think, because of the marriage break-up to a degree, I made up my mind that I wasn't depending on the children, or anyone, to be my support. I was their support. And I think this is, well, the kids saying, "you won't let us help you", " you won't -". But I can't. I'm just - . And I think this [GIM session] has made me aware that I'm vulnerable (Pat1-1, Cumulative Discussion).

> That's what I did with [Rehabilitation Coordinator]. We'd been talking for an hour. And then right out of the blue, she said something like, "You've always

> got to be strong". Or I was giving this impression. And as soon as she said it, I "lost it" (Pat1-1, Cumulative Discussion).
>
> And I think this is where a little bit of the emotion comes from. The fact that I've had to be dependent on other people. Where up until now, I wouldn't. But I had to be, I didn't have any choice. And I guess that's sort of had a little bit of an effect on me (Pat1-1, Cumulative Discussion).

The frustration and dependency was clearly related to both the physical and emotional effects of the cardiac bypass surgery, again moving the participant into new and unfamiliar territory as part of "Spiralling into the unexpected".

Participant 1 also used surrounding discussion to relate her experience of emotional "falling apart" to the experiences of others. She was obviously able to gain some acknowledgement and support from reviewing the wider experiences of others, both in the form of fellow-rehabilitees and a patient education booklet.

> The "tear part" worried me a little bit. Because as soon as, the minute you put that music on, my eyes filled with tears. But that, I think, really is just the emotional - - *sort of like an emotional discharge?* I think so, I think so. Because this other lady said to me the other day, she said, "I just get so emotional". She said, "just any little thing, I just start to cry". And, well I haven't, I was doing that in the early stages, but I haven't so much lately (Pat1-1, Cumulative Discussion).
>
> *Did they say much about the emotions in your book?* …Ah, it just said about, I think it did say about emotional. It said more the "mood-swings". It was very much stressed that you can have depression, and the mood swings can be very severe. I don't think I've had any of that sort of thing, so far. Emotional, yes, but not mood swings, as in, you know, being miserable and happy and - , I haven't had any of that (Pat1-1, Cumulative Discussion).

Again, Participant 1 appeared to be describing the unexpected and unwelcome emotional experiences of this client population in terms of the grand theme, "Spiralling into the unexpected".

A sense of fragmentation of focus was shown by several participants in this research project who claimed to be unable to relax, which was corroborated by observations of fidgeting and other anxious or restless behavior in discussion prior to the music. Participants commonly viewed themselves as being deficient because of reportedly not being able to relax when they needed to or were asked to. In particular, Participants 4 and 5 commented on this.

> I can’t sleep, Alison, I can’t sleep. I can’t sleep, I can’t relax. *You can’t sit still?* I can’t. I can study, because I do a lot of orchidology (Pat4-1, Investigative Discussion).

> Because my problem has been to really to relax. Sometimes I relax, it’s by accident. But not because I did it because I want to. *So you can't plan to relax, and then relax*. That’s right. *It's just something that happens occasionally what you least expect it.* Yes. I’m not the kind of person, I never learned how to relax. That’s my problem. That’s the reason why everything has been worse, when you don’t know how to relax. At the beginning I used to become very angry for that, because everybody say *[sic]* to you, "relax, relax". And I say but tell me how to relax, I don’t know how to relax. *Yes.* I want to relax, but I don't know how. Teach me and I will. *Yes*. But no-one teaches me. *Did anyone teach you?* Ah, I have, er, three different occasions, psychologists that teach, um, has been working at the beginning, with them, *Yes* but after when I live on my own, it's not working the same. *It didn’t work without them.* I think I lost it. *Yes*. You know. That’s unfortunate. It’s just, I know that I’m that kind of person that is very hard to relax. *Yes*. Something that it is normal in other people. *Yes*. Is not in myself. *Yes*. You know. I don’t have that control, to relax. Sometimes, I wish I can relax. But I cannot. I must say to you, if I relax finally, I don’t know how that relaxation should come. I have not control of it (Pat5-2, Investigative Discussion).

It seemed that the unpredictable nature of relaxation was of great concern. Trying to find information about how to relax assumed a role of great importance for these participants, who were looking for greater control over this process. For example, Participant 4 asked the cardiologist for information at a cardiac rehabilitation group meeting, particularly asking him how he relaxed himself, in order to gain further insights.

> And I asked him that question, "How can I relax myself.?" I said, "I understand that you are a doctor, and you are very busy, and you are under tremendous stress, day and night.. What do you do to relax?" … Oh, the answer was good - *Yes? What did he say?* Drinking coffee! *[joint laughter]* Well, everybody was there. That wasn't good for me. That's what I mean… See, you're waiting for a professional answer, and this is what you get. You know, I didn’t feel good. Not even the other boys [group members] were feeling good about it. Because when we finished, we talked, we chatted (Pat4-2, Interpretive Discussion).

Unfortunately, the information sought, and the sense of control it was likely to bring, was not forthcoming. The flippant reply by the cardiologist caused further emotional upset for the participant, which he obviously addressed by discussion with other participants in the cardiac rehabilitation support group. Therefore, the participant remained in a situation of viewing relaxation as uncontrolled and unexpected, within this grand theme of “Spiralling into the unexpected”.

Looking at further unpredictable and unwanted emotional aspects, emotional frustration and a sense of depression seemed to be linked for some of the residents, especially Participant 5, where his pre-existing chronic pain placed limits on his now increasingly active body (after the bypass surgery).

> Because if I'm - I'm afraid to stop, you know. I say, if I have pain, then I move more than without pain. I don't know for how long I will be able to do that. But so far, the problem is the pain. But, I don't accept that limitation. And that has been worse. That's why I fell into depression after the surgery, because of the - Because of the new heart, I feel, inside, more active. I want to jump, I want to run, I want to do many things. But I have limitations because of my legs. *Yes. yes.* You see, this limitation is. *So you said, that's been making you feel depressed? Is that what you said?* Yes, because I feel so active inside, but I cannot do it. The only thing I do is walk. I walk a lot. But I know I cannot jump, or I cannot run. But I feel like I want to do it. My heart is willing to do it. *Yes, yes.* But my legs say "no". That's it (Pat5-1, Investigative Discussion).

However, finding a way to relax in a routine and controlled manner (according to standard GIM practice) appeared to improve confidence and promote positive feelings, as particularly noted by Participant 4.

> That's why, when you asked me in the beginning, "how do you feel", *Yes* - You know, half an hour ago, *Yes* I feel a lot better, I feel confident, this is what I -*Now, or earlier?* Now, because I found a way that I - how to relax. I might be wrong, I might be right. *Yes.* I don't know. *I don't think it's about "right" or "wrong", I think it's about "what works for you".* But if it works for me, that's it! *Yes, yes.* I'm going to keep doing it, you know (Pat4-2, Investigative Discussion).

Therefore, this participant was able to move beyond the unpredictable nature of relaxation to begin to have some more confidence, which will be further discussed under Grand Theme 4 in the next chapter (Chapter 7).

There also seemed to be established links between pain and fear, where pain indicated a feared limitation to active life. These type of links may have been established and reinforced by anginal pain prior to the bypass surgery, where it is common for exertion to be linked (often unpredictably) with pain, due to narrowing in the cardiovascular system. Participant 5, with his associated chronic pain, talked about his need for movement when in pain, indicating that this served an emotional as well as a physical purpose, in order to address the associated fear of immobility.

> Well, er, when I am in pain, I like to walk. Because if I don't walk, I feel worse. *Right.* It's that's one of the things that I understand, and the doctors understand. *It sort of "walks it off" does it?* Yes. That I guess is some kind of distraction, or is my other "I" or my other half, that is afraid not to move, because of the pain. I have to walk. *So, you walk to fight that fear.* That's right. To see that I can move my leg. That must be the reason. I'm not sure, but it looks like it is that reason. Because when the pain becomes worse, I have to walk. Always that's the reason. The fear not to be able to walk, or to move my leg. Or whatever it is (Pat5-4, Cumulative Discussion).

Here, this participant has addressed fundamental issues of survival, and in talking about his "other half" spontaneously refers to what would be known as the "shadow" side within Jungian therapeutic understandings. This will be further addressed in Chapter 10. However, the unpredictable and unexpected spiralling into feelings of fear were clearly evident, as part of the grand theme.

The sense of the uphill battle and of feelings and images deliberately blocked or rejected by the participant is particularly shown where Participant 3 deliberately switched his focus from emergent imagery and suppressed it in favour of imagery that he felt more comfortable with, as reflected in field notes from that session.

> "He told me afterwards he had started with imagery of being admitted to hospital for the operation, but deliberately switched away from it – and didn't want to talk about it" (Field notes, 27/12/98, after Session Pat3-5).

The obvious question is why he caused this barrier in the imagery to occur, and what purpose it served. Investigative discussion in the following session (Pat3-6) revealed difficult circumstances surrounding going for surgery, where he reported that was fully prepped and ready for surgery when he was unexpectedly left for several hours. He later found out that an emergency had come in and both the operating theatre and the cardiologist were required to deal with this. He related how he had been wheeled back to Ward and then told to come back next week for his operation, frightening his wife by calling her to come and take him home when she was expecting him to be unconscious during the operation. In lengthy discussion, he clearly had mixed feelings about this occurrence, mentioning anger, disappointment but also a feeling of "taking it on the chin" and expressing that "other people" would have been very much more upset than he was. This unpredictable and clearly upsetting experience relating to cardiac surgery was directly related to the grand theme of "Spiralling into the unexpected".

Participant 3 also said during the series of sessions, that he would deliberately look through and look at his stock of travel videos the night before a GIM session, in order to give himself ideas of where to go! This apparent desire for control over experiences in the Music and Imagery Treatment phase may well be a natural response to the out-of-control emotional effects of cardiac surgery, a way of maintaining a sense of one's own agency, and may even link into the "locus of control" literature familiar to the nursing field, where it is understood that the patient's sense of agency and empowerment has a significant effect on their recovery process (Miller, 2000).

6.2-1 Final summary, Grand Theme 3

The process of generating the grand theme emically from thematic material and based on the text has been demonstrated for the grand theme, Spiralling into the unexpected". Constituent themes emerged, which served to convey information about the participants' experiences, including feeling "Out of joint" or facing an "Uphill battle", of feeling fragmented and "All to pieces", and of contemplating an "Uncertain future".

At a further level of analysis, the semiotic concept of intertextuality was applied in order to explore the manner in which additional texts (circumtext, intratext and intertext) may shed further light on understanding the meaning for the patient, based on reported music-generated imagery, in the light of recovery from bypass surgery.

Participants evidenced a range of texts to convey the sense of disconnection and disembodiment, and a loss of foundation. This occurred alongside a sense of ambivalence and mixed emotions, a feeling of fragmentation or restlessness. The need for survival and a sense of control over life was evident in related texts.

The next grand theme will now be explored, which is "Sublime plateau".

CHAPTER 7. SYSTEMATIC ANALYSIS: GRAND THEME 4: SUBLIME PLATEAU

7.1 Textual analysis

The word, “sublime” is used to refer to elevated or lofty language or thought, where the mind is impressed with a sense of grandeur or power, and which inspires awe, possibly carrying a sense of purity (Urdang & Flexner, 1968, p.1309). There is a transcendent sense, suggesting being above or overcoming something. It also suggests a new perspective gained.

A plateau is described as a land surface raised above adjoining land and having a comparatively level surface (Urdang & Flexner, 1968, p.1017). In terms of this grand theme, it implies having reached a particular level of experience, where it is even and comfortable in terrain, where there is time and space to rest. In view of this new perspective, things that seemed big and problematical may now seem smaller, less important in comparison and less overwhelming. It would seem that gaining a new experience and perspective on life, such as this, is part of the rehabilitative and adaptive process.

The themes contributing to the grand theme, “Sublime Plateau” are now discussed in depth. The overall structure of such themes is shown in Figure 7-1.

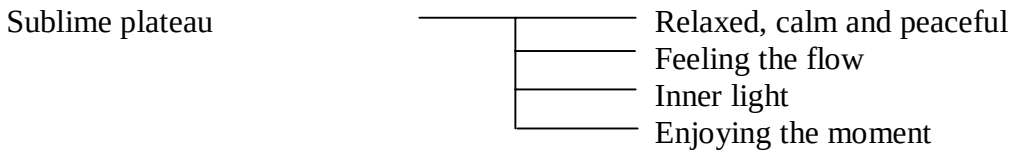


Figure 7-1. Thematic tree diagram of Grand Theme: Sublime plateau.

7.1-1 Relaxed, calm and peaceful

Being able to let go and feel physically and emotionally relaxed, in a way that promoted a sense of calm and peacefulness, was the focus of this theme. Although relaxation was an inherent part of the beginning of the GIM session prior to the commencement of the

music, reported material was placed under this theme when the participant reported feelings of relaxation, calm, and/or peacefulness subsequent to the beginning of the session. Commonly, all participants reported feelings of relaxation during the music and imagery segment, even though several participants indicated beforehand that they frequently had difficulties in achieving relaxation (Participant 1, Participant 4, and Participant 5).

For example, despite indicating in discussion beforehand that she was unable to relax, Participant 1 was able to use the music and imagery to express themes regarding feelings of being relaxed, calm, and peaceful. In consequence of this new-found relaxation, a changed perception of the discomfort of her sternotomy wound arose, which was encouraged and clarified by therapist interventions. In her imagery, she was lying down on the warm sand at her favourite beach.

> I'd like to have a lie on the sand, I think... Stretch out on the warm sand. *How does that feel?* Good. *How does your body feel when you stretch out on the sand?* Very relaxed. Actually, I can't feel the scar. *You can't feel the scar?* No. Normally when I lie down, it's "pulling". *So you don't feel the scar any more?* Not lying down like that, no. *Are you talking about just the scar on you chest or the other scars.* No, just the scar on my chest (Pat1-1, M&I).

This participant experienced relief from bothersome and uncomfortable symptoms during the music and imagery, linking it to a feeling of being relaxed, which was above and beyond her usual experience of her body in this recovery phase from bypass surgery, and as such this was a very important experience for the participant.
Other participants also enjoyed the sense of feeling relaxed, calm and peaceful at the beach, including lying on the sand (Pat5-5), and walking close to the water (Pat6-4; Pat2-1). The sense of feeling calm and peaceful was also reflected by Participant 1 in later imagery of Fiji, relaxing at the beach she loves, and sailing on a tall ship.

> I'm going to Fiji next month, I've been there before, so I think I might go to the island. It's much more relaxing (Pat1-1, M&I).

> I'm actually on the tall - we're going to sail to the island on a tall ship, I've seen photos of it, it's got big brown sails. I was just imagining standing on the deck. It all feels lovely, very relaxing (Pat1-1, M&I).

As with Participant 1, Participant 4 also expressed difficulties in relaxing beforehand, although similarly difficulties did not seem apparent during the music and imagery

segment in his GIM session. Participant 4 also reported relief of discomfort related to his sternotomy during the music, together with relaxation based on both the imagery and the music, which he linked to more comfortable breathing.

> It would be nice to have a house like that in Sydney. To enjoy the beautiful view, and that good feeling. *Let yourself enjoy that.* It's very good. Even my chest is not in pain. *Your chest is not in pain?* No. It's not actually a pain, it's sort of a bothered-ness, a sort of aching. It's probably that lousy cut I've got, when they cut my chest bone. That [music/imagery] seems to be very, very relaxing. You can breath better, a lot better! *A lot better.* Because you feel it's clean. The air is very clean (Pat4-2, M&I).

> Anyway, I feel the air is good. And the view is panoramic. It's very, very relaxing. And there is no heat. It's not hot, as it is during the day. It's a good feeling, a very good feeling. A very good, relaxing feeling (Pat4-2, M&I).

Not only did Participant 5 emphasize an inability to relax in prior conversation, but he also experienced substantial and ongoing chronic pain during all sessions, especially during session two when his usually pain management treatment method was unavailable (due to the batteries of his implant being insufficiently charged). Nevertheless, he was able to transcend both real and potential difficulties and achieve relaxation, even in his first session. For example, towards the end of this first session, he imagined a beautiful and soft (French) chair, which was relaxing and peaceful.

> Oh yes, I love that kind of a - , the seat is very, very soft. It's like velvet, I think. *What colour is the seat, the velvet?* They are green too. But, um. *Would you like to sit in that chair?* Oh, yes! It should be nice, to sit on. Can I? *Yes, you can.* Oh, that feels good…yes! *How does your body feel, to sit in that chair?* I feel myself with no weight. *Is that a pleasant feeling?* It's so peaceful, here… *How is it for you now?* Good, it's beautiful. Everything is nice, everything is, is so peaceful. The place is free of any sound, just music. Music is in the air. *Are you still in the chair?* Yes. I'm in the chair. Enjoying it (Pat5-1, M&I).

Interestingly, he seemed to need to be given permission to sit and relax and enjoy himself, "It should be nice to sit on. Can I?", and that seemed to open up and confirm the possibility of enjoying bodily feelings.

The notion of comfortable breathing as an aid to relaxation was common for many of the participants. This included comments about noticing the air and the atmosphere, as well as the actually experience of feeling the breath entering the body. Participant 4 particularly connected with imagery of air and breathing, and deliberately used it to make himself feel better at certain points in the reported imagery sequence.

> It looks more peaceful, much better. And the air is cooler. It's very peaceful. There's no other people coming (Pat4-4, M&I).

> Breathing makes a difference. It sure does. Big breaths in and out, in and out, relaxes me quite a bit (Pat4-5, M&I).
>
> Big breaths, is the whole secret. It makes you feel relaxed. Your body relaxes you quite a bit (Pat4-5, M&I).
>
> I will take a few breaths again, relax again (Pat4-5, M&I).

Sometimes the feeling of relaxation was related to childhood, especially to feelings of safety, such as when Participant 2 remembered imagery of trips to Luna Park [an amusement park] as a child.

> So it's still that nice relaxing feeling about being a child and, I know it was something where you were quite safe. And it went on, it seemed to go on and on forever (Pat2-4, M&I).

The sense of a calm and peaceful atmosphere frequently occurred in the absence of other people. Two participants spontaneously commented on the disruptive effects of the presence of others during their imagery (Pat4-5, Pat 2-5). Participant 2 comments,

> And it's calm and peaceful, and you hope that you're going to have it to yourself before another crowd of walkers come this way (Pat2-5, M&I).

In the imagery process, participants not only experienced relaxation but also used it to assist with difficulties, in this case providing a sense of support, and blending the unexpected and seemingly unwelcome emotions in a way which provided ongoing support.

> I feel relaxed, really relaxed. That blue was a cloud, that just travelled up. And it's supporting me, it's holding me up, and I feel relaxed and I actually feel quite happy! *[surprised tone of voice]*. So maybe they're happy tears. *Could be. So you said the emotions had a purple colour too.* Yes, I really don't know why. *Can the purple be with the blue?* Yes, yes. I like those two colours. *Can you imagine the blue and the purple together?* Yes. *Can you imagine they might move together, or do anything together?* I can just see them blending in together. Just becoming one. *What's that "one" like?* Just a blue and purple blob! *[laughs]* A cloud, a cloud that I'm leaning on, that's supporting me (Pat1-1, M&I).

A sense of calm and relaxation also occurred in conjunction with images of light and transcendence. Although these will be further explored and discussed under the constituent theme, "Inner light", two brief examples suffice at this point.

> The rowing boat is still there, and it's still calm and light. Just in a circle where the boat is (Pat2-3, M&I).

> It's more like a "sparkler". *Like a sparkler.* It's going, it's lit up the whole of the body, of the outline of the body. *How does that feel?* It's relaxing (Pat2-6, M&I).

7.1-2 Feeling the flow

Another emergent theme, based on the reported imagery, was that of "feeling the flow' Sometimes this involved the sense of a flow of water, but also included the flow of interaction, the flow of increasing energy and health, and the flow of movement in various forms.

Noticing the water-wheel at Luna park and the way that it pumped and propelled the water (Pat2-4), the ongoing clarity of really spotlessly clean water (Pat4-5), the motion of a waterfall with the noise of running water falling over the rocks (Pat4-5), and even seeing the water running "in a very narrow edge, in a very narrow artery like" (Pat4-5) were all examples of "feeling the flow".

In particular, Participant 4 experienced the spray and humidity of the moving water, commenting on the atmosphere created by this flowing water:

> It's very, very early in the morning. It's very, very fresh. *Very fresh. Let yourself smell that air.* The smell is nice. And the sound of the water is nice. I feel like walking (Pat4-4, M&I).

> But it's so humid here, I can feel that beautiful atmosphere again. And all the plants around me, they look alive (Pat4-5, M&I).

> That humidity, it's the one thing that does it. *What plants do you see?* I can feel, and I can see the spray from the water, going upwards. And the wind is taking the spray of water. And I can see it through the rays of the sun (Pat4-5, M&I).

However, this soon extended even more broadly and deeply to an appreciation of the interaction of this moisture with the plants themselves and the delicate and complicated process of photosynthesis:

> I can feel, and I can see the spray from the water, going upwards. And the wind is taking the spray of water. And I can see it through the rays of the sun. And that's, and I think the worry I'm thinking about, the respiration of the plants. How it works, I can see it in front of me now. When the leaves perspire, the water comes out, from the leaves, and the new water is absorbed through their roots, to be perspired again from the leaves. And that's energy. I can see that in front of me, in "black and white". It is really a good picture. Because you cannot see it in videos. You can only see it and read it in books. And sometimes you don't understand it properly. And where I am sitting, I can see it, really see it. The perspiration of the leaves. It's beautiful, it's magnificent! *Let yourself really absorb that.* It's really a beautiful thing (Pat4-5, M&I).

> And I really want to see that photosynthesis again. Which is a thing you don't see every day. I can see the leaves about me perspire. This is a really good picture (Pat4-5, M&I).

Feeling the sense of flow also extended towards the experience of touching the water, and thereby interacting with this flow.

> There seems to be something like a rockface, where you can just scoop it up with your hands. And it's really, oh, fresh. And it's really crystal clear. *How does it taste?* It tastes like water should taste *[brief laughter – possible reference to recent Sydney Water contamination problems!]*. It's fresh and it's cool. *Let yourself really enjoy it.*… Yes… And I want to stand there and just watch the falls (Pat2-5, M&I).

> It's so clean the water, it's so clean, you can really see the bottom of those pebbles, or rocks. It's spotless clean. I think I might have to try to drink that water. If it's clean, fresh water. And it looks like being fresh, clean water. I am trying the water, and it's beautiful! It's really cold water, really cold water. *How does that feel?* It feels good! It feels terrific! (Pat4-5, M&I).

"The flow" also implied a sense of increased energy and health, a sense of "waking up" and feeling better.

> So, I'm going to wet myself, as much as I can. My head, my face, my arms, my feet. Whatever I can. The water is cold, it's really cold, that water! How come I'm not feeling cold? I'm still wearing my shorts. Anyhow, the feeling is good. I'm not going to think about my shorts. I'll wet myself as much as I can. I feel a lot better, and a lot wet. *You feel better.* I feel better. I feel awake. *You feel awake.* Yes, I feel awake. I think the water did the job (Pat4-5, M&I).

> I feel like wetting myself again. I wish there was a place to dip in to the water. The feeling is so good. *Let yourself enjoy that.* I'm going to wet my head again (Pat4-5, M&I).

> I'm going to get up, wet myself again. It looks like that water does the job for me (Pat4-5, M&I).

The sense of flow is evident in a feeling of connection to other living things, in this case birds.

> They seem to feel happy too. *They feel happy too?* Yes, they seem to enjoy what I enjoy. *Do they have anything to share with you?* I think, the same feelings. They enjoy the freedom, too. They probably enjoy the quietness of the morning. They probably enjoy the quietness of the lake, and the quietness of the water. Well, they've got their own lives, which they enjoy. And it seems to me that we are just one thing. They are living things as well (Pat4-2, M&I).

The quality of "flow" also extended to the type of movement experienced in an activity. For example, Participant 1 talks of rolling straight out of her burée (in Fiji) and into the water, seemingly in one simple movement (Pat1-1, M&I).

> And we're going to have a burée right on the beach. I'm going with my mother and sister. We all love the water, the sun. And we're just going to roll out of our burée into the lagoon. And relax (Pat1-1, M&I).

Participant 5 also enjoyed feeling movement with an inner sense of flow, in his case by participating in doing ballet in his imagination. This was a new feeling of comfortable, coordinated and enjoyable movement, with flowing ease of movement and pleasant body sensations (Pat5-3). This pleasant fantasy was unrealistic in real terms but nevertheless served to provide a sense of overcoming and transcending difficulties, and of enjoying flowing movement, which had been long denied him due to chronic pain.

7.1-3 Inner light

Another theme derived from the reported imagery consisted of the emergence and use of light to promote a transcendent feeling. Reported imagery included glowing, gleaming, shimmering, and prismatic effects, related to a range of different images and in a variety of settings. This included golden rays, rainbows, sun and clouds, jewels, water diffraction, sparkling and glowing music and surroundings, as shown by a range of examples.

> It's very delicate sounds, I can see a harp. And that's gold, And that's golden rays. *Golden rays?* Shining down. And the harp and the piano are near each other. And there's a girl with long golden hair. And she's in a long flowing gown. *Do you have a sense of what colour her gown is?* No, it isn't. Although her hair is golden. But the gown hasn't got a distinct colour. But everything else is gold. *How does that feel?* It's sort of glowing (Pat2-2, M&I).

> There's the rainbow again. The rainbow is coming down into the pot of gold. *What's the pot of gold like?* Oh, it's a traditional end of rainbow pot of gold, it's gleaming, and it's got golden rays shining out of it. And now the golden rays are sort of shimmering (Pat2-2, M&I).

> Now the sun's rising. Oh, and there's a cloud. *A cloud.* With a glow around it. *Would you like to be with the cloud.* No. It's, the cloud's now - the edges are tinged with pink. And its floating over a hill (Pat2-4, M&I).

> Now there's a sort of a pinky glow beyond the hill. *A glow.* It's still as though it's that sunrise sort of, where the sky's now all pink and blue, but I can't see the sun. It's just getting lighter (Pat2-4, M&I).

> And the only light comes from the little, um, it's like jewels. As though there were jewels stuck on all around the side of this cavern. *Let yourself enjoy that.* Sorry? *Let yourself enjoy that!* Yes. You can, as you go through there, everyone is saying, "Oh, isn't it lovely" (Pat2-4, M&I).
>
> *What's the waterspout like?* It's like a fountain, it's just shooting straight up. And now it's curling over the top, and droplets are falling from the waterspout. And the whirlpool is just still, yet the waterspout is still shooting up. And the little droplets are sort of dancing, and they're creating a rainbow effect, like prisms. *A rainbow effect* (Pat2-3, M&I).
>
> But now the sparkler, it's like a sparkling ball of light, and it's held by a fairy. *Held by a fairy*. Like, um, like Tinkerbell. It's Tinkerbell music. And she's dancing. She's pirouetting on one foot, on one toe. *Does she know that you are there?* Ah, she's now left me, and I'm still, there's still the figure that's outlined with light. No, she's dancing, flying, up over a hill. *Would you like to go with her?* No, she's too light, she's flying. She's just twirling and whirling until, just sort of vanished into a swirl of dust and light. And it's right up into the sky. *How does that make you feel?* Well, it's pleasant, as well, because there's a glow coming from the sky (Pat2-6, M&I).
>
> Now there's just more light. Waves of light. *Does the light have a colour?* Um, golden sun coloured. Now, there's a - , the glow now is all over this mountain. Um, it's got a very high peak. And it's getting higher and this golden glow, sort of like a halo, around the top of the mountain. And there's a - , I'm just getting the glow. It just keeps coming in with the music. And there must be a choir there. *A choir.* A choir. And they're walking, in white robes. And they're walking from the top of the mountain as though they are going right around it, or in a zigzag pattern. *In a zigzag pattern.* Yes. So across, and then back. And they look, I know they are in white robes, but they look like monks (Pat2-6, M&I).
>
> Is not telling what I see, is to what I feel. I feel the music inside of me. It is all that beautiful glow, beautiful furniture, carpet. It can't be named. It must be a palace (Pat5-1, M&I).

Imagery of light is often associated with sublime and transcendent experiences, and was particularly shown by this range of examples.

7.1-4 Enjoying the moment

This theme extended from a sense of feeling good about nature and other beautiful things, towards an experience of enjoying these things, right through to an inner feeling of increasing health and well-being, and a sense of being able to surmount problems due to feeling good.

> Now I've come through, still in a boat, but out into the sunlight, out of the cave. *Into the sunlight.* Mm. And it's into a lake, and the sun shining down from up

> above. *How is that?* It's a very pretty place. It's not where I started out. There's a palm tree there, sort of like a desert island. So I expect to see Dorothy Lamour in a sarong! *[joint laughter]* And it's warm (Pat2-4, M&I).

Enjoyment of beauty and nature extended from a simple sense of good feelings of standing on the sand at the beach with bare feet (Pat2-1), to noticing the sun showing through the clouds and lighting up the grass with associated pleasant and warm feelings (Pat2-2). Such enjoyment often gave a sense of increased health and well-being.

> It makes me feel good, because there is no fumes, from the cars. You can only see the water, you can see the birds. You can sees the trees. You can feel the air. - It's beautiful! (Pat4-2, M&I).

> And I think I'm going to lay down. Take a few breaths. *How's your body feeling?* The body feels good, after all these exercises. Not so bad. It feels very, very good (Pat4-5, M&I).

> Even the houses that are around it, around me, they're beautiful. They're nice and clean. And they're so peaceful. It's probably because it's early in the morning. I don't know how it's going to look like afterwards. It's a very peaceful moment, very, very peaceful. *How does your body feel?* Very, very relaxed. Very, very relaxed. *Do you notice where in your body it feels relaxed?* The whole system feels relaxed. I don't feel that urge to get up and go. I feel the urge to sit and relax. The view, the air, the atmosphere, as much as I can. Because I know it doesn't last very long (Pat 4-2, M&I).

> It seems to me that there is nothing bad comes into my mind while I imagine those things, while I see those things in front of me. It looks like the view, or the birds, or whatever it is, the air. They have such a big power, for you brain, not to let anything else come into your mind, or any problems. It's very, very relaxing (Pat4-2, M&I).

In his fifth session, Participant 5 reported enjoying imagining being at the beach.

> I feel more breeze. *How does the breeze feel?* Oh, beautiful. It feels nice and cool. I'm glad I left the bench, because what I see now is the beach, that the breeze comes from. *The beach.* Yes, it was the beach. Oh, it is nice. There is no body on the beach. Just water, sand. And some rock, very far away. Two small boats on the water, but very far. They look small, maybe they are large. But they seem very small to one. And the breeze is very beautiful, too. *Let your self enjoy that breeze.* I stand on the wet sand. I like that sensation. It is nice, that. I'm going to walk on the beach. I feel like it. I like the noise of the water. *The noise of the water.* Mm. That's really relax me. I think I will be the happiest man on earth, if I can live in a place where I can see , where I can smell, or where I can touch the water. I will be there for the rest of my life. I like to hear the sea. To touch it. And just smell. I love the sea so much. *So, can you touch the water now?* Yes. Is cool, is fresh. It's nice to touch. *[deep breath]* I am going to walk to the dry sand, to sit down there. I have to walk about 20 or 30 metres. To be on the dry sand. *How is it, walking on that?* Oh, the walking is ok. I'm sitting on it, and I lie down. But I keep my leg bended. I

> feel the sun on my back. Oh, that's a very nice sensation. *Let yourself enjoy that.* I can be hours like that, you know, lying on the sand. I have no cold, no hot. I can hear the perfect music (Pat5-4, M&I).
>
> *So what would you like to be doing now?* Oh, still, will I will lie down on the sand. Because the music is very nice too. I lay down on my back now. It will be worse for me after, to move, but never mind. I will enjoy the moment. You know, I hear, lay down on my back. I hear the sea. I see the sky, at the same time I feel the sand, and I feel the sun. What else can I ask for? I've got it all! Oh, it feels beautiful. It comes to my mind, that the best things in life are free. The sun is free, the sand is free. The sea is free. You don't need money to enjoy that (Pat5-5, M&I).

And later:

> I feel so good, about everything. Life is beautiful. When you can enjoy all these things. It makes me feel so good about myself. I feel that I've got everything. At this moment, nothing will spoil my happiness. No pains, no worries, nothing. Just enjoying myself. *Let yourself enjoy that.* I'm so lucky, to have all that (Pat5-5, M&I).

After the session, this participant spontaneously reported that he felt like a "new person". It is apparent from what he was saying that something had changed about the way he was thinking about and experiencing himself and his body. His apparent anxiety and depression appeared reduced, and he now had increasingly positive experiences of his body. He reported an absence of pain after the Music and Imagery Treatment phase, and in the next session commented that he was deliberately using music to assist with his pain management at home.

Participant 4 also described an overwhelming feeling of well-being in his body, including clear sense of improved circulation.

> While I'm walking I feel my chest very, very easygoing. I breathe the fresh air, and I feel the oxygen going through my chest. Breathing in and out, while I'm walking - it's excellent. *Would you like to look inside, to see what's happening in your chest?* Not really. Because the feeling I've got is good. And I can imagine a lot of oxygen goes through it. Which helps everything in my body. If blood circulation is good, you feel good. If enough oxygen goes through your veins, you <u>must</u> feel good! You see, if you've got a good feeling about yourself, why worry about it! If I wasn't feeling good, and even the best oxygen, it wouldn't do me "well". It probably do me "feel good". But I feel all the way good! *You feel all the way good.* I feel all the way good. I feel extremely good. I'm walking fast now. I feel the muscles in my legs, I feel my waist, I feel my abdomen, I feel my back, I feel my spine. I feel everything in my body. Everything is feeling good (Pat4-6, M&I).

And a little later:

> That promenade looks long enough. It looks very big to me. I'm going to walk as much as I can, because I feel good. And I'm not going to bring anything into my mind, any problem whatsoever, to solve it. Just because I feel so free. I'm going to enjoy that moment as much as I can. *Let yourself do that, really deeply.* I can realize what I see in front of me is like a million dollar view. And I consider myself very lucky. Being healthy enough to enjoy that view, and to walk that long promenade. And I wish it never ends! It's really magnificent (Pat4-6, M&I).

Thus, participants showed a sense of being able to surmount problems utilizing their enjoyment of the moment, often with a new sense of themselves, and with a sense of completeness where nothing could spoil their happiness.

7.1-5 Summary

This theme, "Sublime plateau", incorporated feelings of being "Relaxed, calm and peaceful", a sense of "Feeling the flow", of experiencing "Inner light", and of fully "Enjoying the moment".

7.2 Semiotic Expansion via Intertextuality

Further clinical insights are now pursued using semiotic intertextuality to shed light on the grand theme, "Sublime plateau". This brings greater depth to the emergent thematic material by focusing on the related circumtexts, intratexts and intertexts.

Relaxation, and their response to it, in the context of the GIM sessions was frequently a topic of discussion for participants, and the desire for, and achievement of, such relaxation was a major theme within the grand theme, "Sublime plateau". Surrounding discussion indicated that some participants had been taught formal relaxation techniques prior to their experiences in the current research project. For example, two participants talked of previous learning or experiences of relaxation, one using the Dr Grantly Dick-Read "natural childbirth" method (Anderson, Anderson & Glanze, 1994, p.1336), which occurred for her many years ago (Participant 6), and another outlining informal personal experimentation with relaxation over lunchtime in his very busy workplace; he had now been retired for several years (Participant 3). Neither participant still regularly practiced these techniques. In addition, Participant 5 had undertaken formal instruction in relaxation with regard to pain management, and had been given a practice tape for use at home. He felt that this had not been successful for him.

In the current research project, many participants talked of difficulties with relaxing, and this appeared to occur regardless of whether or not they had been taught relaxation

techniques. One participant had recently experienced a single session of group relaxation teaching in the cardiac rehabilitation programme, but was very upset about her perceived inability to relax and consequently claimed that she felt like a "failure". She speaks of it thus:

> And it was nothing deep, but I really had problems keeping my normal thoughts out of it. Like I was supposed to be relaxed, and [the leader] was - it was just a talk one, [the leader] read the thing, and I was trying to concentrate on [the leader's] voice, but something had happened before we started, one of the gentlemen who's new to our group, it really bothered me, because we discovered that he had never, talking to him, discovered that he didn't know what the heart-lung machine was, he didn't know his heart had been stopped during the machine, during the operation. He was very worried about himself, but he didn't know. There's a bypass book that they should give you before you start, that explains all the things that happen to you, so you're expecting them when they happen. This guy hadn't been told any of these things, and he was so concerned about himself, and so I told him I would bring my book next week. But this happened just before [the leader] started. And I'm trying to relax, and I kept thinking, "Oh, how could you have this operation and not even know any of these details", no wonder the poor guy was worried about short-term memory loss and all this sort of stuff. But I just couldn't get his problems out of my head…Yes, and all these thoughts kept popping in, and I thought, "Concentrate! What's that word again that I'm supposed to be thinking about?!" (Pat1-1, Investigative Discussion).

Although Participant 5 had had a great deal of instruction in relaxation with a view to pain management, he still claimed that he had great difficulty relaxing by himself. This was confirmed by clinician/research observations of non-verbal cues and frequent and agitated movement by the participant in the GIM session. This is how he described himself and his situation:

> I'm not the kind of person, I never learned how to relax. That's my problem. That's the reason why everything has been worse, when you don't know how to relax. At the beginning I used to become very angry for that, because everybody say to you, "relax, relax". And I say, "but tell me how to relax, I don't know how to relax". *Yes.* "I want to relax, but I don't know how. Teach me and I will". *Yes.* But no-one teaches me. *Did anyone teach you?* Ah, I have, er, three different occasions, psychologists that teach, um, has been working at the beginning, with them. *Yes.* But after when I live on my own, it's not working the same. *It didn't work without them.* I think I lost it. *Yes.* You know. That's unfortunate. It's just, I know that I'm that kind of person that is very hard to relax. *Yes.* Something that it is normal in other people. *Yes.* Is not in myself. *Yes.* You know. I don't have that control, to relax. Sometimes, I wish I can relax. But I cannot. I must say to you, if I relax finally, I don't know how that relaxation should come. I have not control of it. And I say, the music helps me. Sometimes I go to the beach, and the sea sound helps me to. I've got at home a tape of, sometimes Japanese music. It really helps, it's beautiful. I feel float, I

> feel that I fly, you know, I feel without any heavy (Pat5-1, Investigative Discussion).

Participant 5 was not the only participant seeking help with relaxation. Participant 4 was also looking for information. He reported questioning his cardiologist in a cardiac rehabilitation group session, without apparent success.

> You ask a cardiologist, can you tell me a way to relax… Because you feel stressed after the operation, you see. And we had one cardiologist here, on our last session, that's two weeks ago, …and I asked him that question, "How can I relax myself?" I said, "I understand that you are a doctor, and you are very busy, and you are under tremendous stress, day and night.. What do you do to relax?"… Oh, the answer was good – *Yes? What did he say?* Drinking coffee! *[joint laughter]* Well, everybody was there. That wasn't good for me. That's what I mean… See, you're waiting for a professional answer, and this is what you get. You know, I didn't feel good. Not even the other boys were feeling good about it. Because when we finished, we talked, we chatted (Pat4-2, Investigative Discussion).

This participant was aware that whistling helped him relax a little bit, but he was looking for something more than that. This participant had looked for other ways to relax, including a relaxation tape, however the effects of this were not helpful in the long-term.

> Um, I've been looking, myself, for a different way. And my daughter-in-law, she brought me a tape. Er, that was a study that was made, I don't know where, and I've heard the tape. It was good, you know, for the first few hours, but after that it was boring. I don't even now, today, remember what it was all about. I'm telling you the truth, Alison (Pat4-2, Investigative Discussion).

During the series of GIM sessions, it became clear that being able to shut out current concerns in order to relax was indeed possible for all of these participants despite their being convinced that they could not relax! Despite emphasizing his inability to relax prior to the music and imagery segment, Participant 4 comments on his relaxed feelings immediately after the music finishes in his second GIM session.

> It was good! *Yes… How's your body feeling now?* Oh, very relaxed. *Very relaxed.* I couldn't care less about this Fat Programme! *[laughs]* (Pat4-2, Cumulative Discussion).

> *I was pleased to see how easily you went with the imagery today, and with the music.* Mm. *I felt you were doing very well with it.* Yes. I let myself, you know, completely relax. *Yes.* I let go. *Yes.* It depends what you put into that image, you know. *Yes.* I don't want to put any, er, life dreams or anything like that into my head. Because you find troubles, you find good times, you find a bit of everything. So, when I try to relax, you know. That, I know now, say, a way to relax, I always put something of a good picture in front of me, something

> that relaxes me. It doesn't matter what it is. It doesn't matter what it is! As long as I get that, you know, that floppy feeling! *[laughs] That floppy feeling, yes!* Like a dog in the shade, you know. If that makes me feel good, I'll do it! *[laughs]* (Pat4-2, Cumulative Discussion).
>
> Oh, I'm relaxed, now! *Yes.* Like a dog sitting in the shade, you know! *[laughs]* (Pat4-2, Cumulative Discussion).

Not only did Participant 4 relax so deeply that he felt free of time constraints and requirements, but he describes it by putting forward the new image of "a dog sitting in the shade", mentioning it twice. This is a very potent Australian, and perhaps universal, summertime image! This image may have been similar to that depicted in Figure 7-2, by Cece Chatfield (n.d.). The fact that a deep sense of relaxation finally occurred for this seemingly anxious participant indicated that he had achieved an increased sense of himself at a new level, and thereby contributed to the grand theme, "Sublime Plateau".

Figure 7-2. Illustration of "dog in the shade" (Chatfield, n.d.).

The peaceful feelings evoked by experiencing panoramic views were commented on by Participant 4 as the music finished in his fourth session, together with feelings of happiness and relaxation, and other participants also commented on their feelings of relaxation.

> *Let yourself really drink in that view, and remember it.* It's very peaceful (Pat4-4, Cumulative Discussion).
>
> *How is it for you now?* I feel very, very good. And very, very happy. I feel very, very relaxed (Pat4-4, Cumulative Discussion).

> *I just wanted to check in with how you're feeling now. Are you feeling ok? Your body's feeling ok?* Yes. *Is there anything that I should know about there?* Yes, I feel nice and relaxed (Pat2-1, Cumulative Discussion).

Evidence from reported imagery with music and surrounding discussion suggested that relaxation was clearly attainable for all participants during the GIM session. In addition, some participants actively and spontaneously commented on improved sleeping patterns at home, even following only their first GIM session.

> No, really, I say, nothing unusual happen to me. Just my normal routine, the same everyday. I feel quite happy this last week. Because I've been sleeping well. I have no problems at all. I had a nice talk with my daughter. Going to Newcastle tomorrow. There is nothing, that, is no worry (Pat5-2, Investigative Discussion).

> *So, I wondered, did you have any thoughts or comments after last week. Did anything stay with you - ?* I did notice that that night, um, I went to sleep very easily and very soundly, so whether it - *Is that unusual?* Well, it's been varying lately… I've never had trouble sleeping. But, it took me a long time for my sleeping pattern to settle down again, after the operation. *Just this last operation?* Mm, yes (Pat2-3, Investigative Discussion).

The ability of participants to achieve relaxation and apply it to assisting with an aspect of normal life indicated the attainment of a new "Sublime Plateau".

The effects of sheer and transcendent beauty were also further commented upon in surrounding discussion. For example, Participant 5 further described his experience of the French palace.

> It was so beautiful, there. *Yes, yes.* The Salon. *Had you imagined anything like that before? Or seen anything like that before?* No. This is the first time in my life that I have been inside a palace. *Yes.* I've never been in one. *How about that! It sounded lovely.* Yes. It is so real, everything (Pat5-1, Cumulative Discussion).

Growing up in South America, and later coming to Australia, this participant had not ever had the chance of seeing a French palace in reality. He was, however, an avid reader and would have gained information in this manner. He further described his particular imagery experience of the palace alongside new and surprising bodily sensations, contrary to his usual chronic pain.

> And when I was sitting there I was feeling no weight on my body, like I was floating. And you know, that's a very strange sensation. But that was when I was seated on it. I was sitting on air. It was a new sensation. *Have you ever had that feeling before?* No. I don't know if that implant had something to do with it. Because it's a permanent tingling. *Yes, yes. Could be.* But I never before have any experience like that. *Yes, that your body didn't have that - I*

> *gather that your body must often feel quite heavy, with the pain.* Of course, yes, of course. Because what happens is you, when you are in pain, you feel not control of you body, and doesn't make your body happy. Because you cannot control, I guess. That is - *And maybe because pain tends to make muscles contract, isn't it. You tend to feel like this [demonstrates] when you feel like pulling together, because of pain.* You feel more. *And to relax and let it be is very hard with pain.* Yes
> (Pat5-1, Cumulative Discussion).

The issue of pain and finding comfort sitting in chairs resurfaced for Participant 5 in the Cumulative Discussion of his fourth session, and after he had experienced a sensation of pain whilst sitting down in his reported imagery with music. This was linked to a consideration of the type of chair to be used.

> That pain comes and goes, inside the knee. *Is that the pain you've been getting recently?* Yes. Sometimes it is the chair, but all chair the same. *I can get another chair from over there for you. I'll just take this off [microphone]. I'll get you another chair so that you can choose. This one might be better.* At home I've got four different kinds of chairs! *[laughs] Well you can try this one, and here's another one!* I searched until I found - *You can try - like Goldilocks and the three bears!* Yes! *[laughs]* (Pat5-4, Cumulative Discussion).

The symbolism of a chair clearly relates to the symbolism of the throne. This is understood to be "the seat of authority, knowledge and rule, both spiritual and temporal" (Cooper, 1978, p. 171), which makes it even more interesting in the light of his comments about control of pain (as above). The throne also embraces concepts of "support, exaltation, equilibrium and security" (Cirlot, 1971, p.341), which are also relevant in the light of his relaxing and supportive imagery, and clearly relates to the grand theme of "Sublime plateau" via an achievement of uplifting and enjoyable bodily experiences.

The experience of relaxation also led at times to an awareness of the absence of pain for the participant.

> *You said at the end, your scar didn't hurt.* Mm. *Was it hurting when you came in here? Was it bothering you?* It hurts every day. *It hurts every day? All the time?* It doesn't hurt, it's a sort of a "botheredness". You're not comfortable, you know. *Yes, yes. Sort of like an aggravation?* Yes. And then you're feeling, you know, all that is numb, as well, that's their knife. I don't know how long it is going to be like this, they say for a couple of years. *Yes. So, you sounded surprised when you noticed that.* Yes. *The music had actually just finished, but, for you to notice that the pain was not there. I'm curious, because I've heard other people say this too.* See - it does help! *It's very interesting, yes.* Yes. Because you feel it, especially when you lay down, and you try to, when you lay down on your side, *Yes.* Oh, it comes very, you know, whether it's the pressure

> or whatever it is - it hurts! You know, and you can't sleep, or you can't lie down, your face down. I tried, you know - no way! *You can't do that. Yes.* No way! Not yet - probably later on. *Yes, yes. And to have that constant pain, or if not quite pain, that aggravation, must be very wearing after a while.* You get used to it. Your system gets used to it. But you know it's there. *But you obviously noticed the difference, when you didn't have it.* Oh, yes! You feel it, you feel it! (Pat4-2, Cumulative Discussion).

Here, the participant highlights the (presumably enjoyable) feeling of lack of pain, evoking a new "plateau" of feeling, and relates to the grand theme, "Sublime plateau". The surprising nature of the spontaneous imagery which was found to be relaxing imagery was also commented on by participants in this study. For example, Participant 1 commented with incredulity about the emergence of her blue cloud in surrounding discussion.

> Yes, the cloud's still… It was funny, because as soon as I said blue, I became a cloud. I've never seen a blue cloud drift around in my life, I don't know where it came from! (Pat1-1, Cumulative Discussion).

This reflected the surprising nature of achieving a new awareness and a new way of seeing things, as related to the grand theme, "Sublime plateau".

All participants had enjoyable moments which often carried a sense of the superlative, and of great beauty. Participant 2 especially had imagery of a golden harp, golden rays of sunshine, a girl with golden hair, and everything else being gold.

> It's very delicate sounds, I can see a harp. And that's gold, And that's golden rays. *Golden rays?* Shining down. And the harp and the piano are near each other. And there's a girl with long golden hair. And she's in a long flowing gown. *Do you have a sense of what colour her gown is?* No, it isn't. Although her hair is golden. But the gown hasn't got a distinct colour. But everything else is gold. *How does that feel?* It's sort of glowing (Pat2-2, M&I).

Turning to further textual sources, gold is described as a "mineral light" (Cirlot, 1971, p. 119). Gold is also, "the essential element in the symbolism of the hidden or elusive treasure which is an illustration of the fruits of the spirit and of supreme illumination (Cirlot, 1971, p.120). The sense of gold as a reward is indeed a strong one, and can be reflected in even the gold medals of Olympic and other achievement. This sense of gold as reward is further underlined by imagery of the pot of gold at the end of the rainbow (Pat2-2).

> There's the rainbow again. The rainbow is coming down into the pot of gold. *What's the pot of gold like?* Oh, it's a traditional end of rainbow pot of gold, it's

> gleaming, and it's got golden rays shining out of it. And now the golden rays are sort of shimmering (Pat2-2, M&I).

The associated meanings attached to "gold" clearly give a sense of achievement of something special and of treasure to be valued, and relates to the grand theme of "Sublime plateau".

Another significant image was that of "light", which occurred in many forms in the reported imagery of these GIM sessions. Light is traditionally linked with the spirit, creative forces, illumination and knowledge (Cirlot, 1971; Cooper, 1978). As Cirlot notes, "Psychologically speaking, to become illuminated is to become aware of the source of light, and, in consequence, of spiritual strength." (Cirlot, 1971, p.188). This image-based experience of light may then serve to enlighten, to "give intellectual or spiritual light to…impart knowledge to" (Urdang & Flexner, 1968), and links to the broader concept of enlightenment and the generation of insight.

The sense of the beauty of life as a whole, a feeling of satisfaction with such beauty, and links with insight were related by Participant 4.

> As you get older, life is more beautiful, believe me! *More beautiful?* Yes, it's more beautiful. Because, you remember what you were doing, you know, for living. Struggling, you know, for life and trying to earn a bit of money to do something for you family. And you've done all that. And today, you can see your kids doing the same thing for their kids. And it's, it's nice. That's beautiful! *And you can feel that it's been handed down* - Yes, that's right. It was a good cause. *Like something still growing from what you started?* That's right! I mean, if you can see the sacrifices that you have done in life work for good, and it was worthwhile doing it, it's a good, good feeling inside you, Alison. It's beautiful, you know! (Pat4-4, Investigative Discussion).

The sense of a flow and balance in nature was shown by many of the participants in this study. Participant 4 had especially interesting imagery, which included the concept of photosynthesis, as already noted. The role and nature of photosynthesis are described by Vermaas (1998) and illustrated by the California Rice Commission (2001).

> Sunlight plays a much larger role in our sustenance than we may expect: all the food we eat and all the fossil fuel we use is a product of photosynthesis, which is the process that converts energy in sunlight to chemical forms of energy that can be used by biological systems (Vermaas, 1998, p.1).

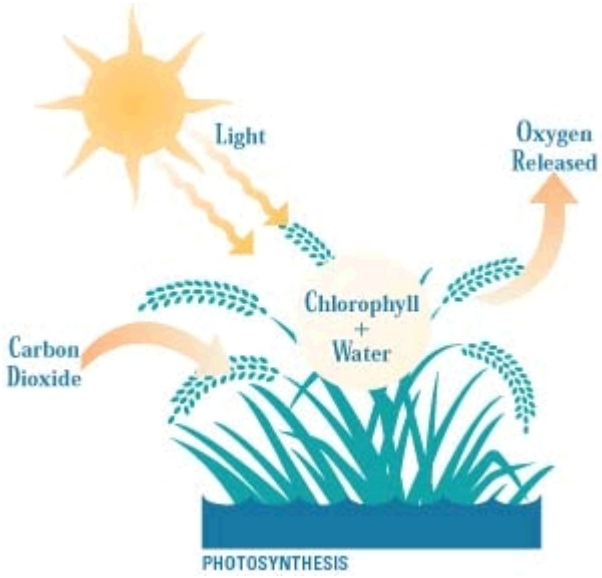


Figure 7-3. Illustration of the process of photosynthesis (California Rice Commission (2001).

In terms of the experience of the participants in this study, this process is both a metaphor for the balance of nature, and a realization of the intake and giving out which is essential for life to be maintained.

> *So, you saw the whole process of photosynthesis laid out in front of you - how amazing!* Honest of God, I mean, I understood it, perfectly (Pat4-5, Cumulative Discussion).

This seems to be not just a matter of the flow, but also of increased understanding. In doing so, a new plateau of insight and understanding is reached, thus clearly relating to the grand theme, "Sublime plateau".

Increasingly during the course of the sessions, Participant 4 deliberately practised breathing techniques to help his body relax, and to overcome rising pain, tiredness, and tension. He also used the image of water, and of applying water to help his body feel better, and even to help wake himself up, thereby implying assistance with cognitive abilities.

> So, I'm going to wet myself, as much as I can. My head, my face, my arms, my feet. Whatever I can. The water is cold, it's really cold, that water! How come I'm not feeling cold? I'm still wearing my shorts. Anyhow, the feeling is good. I'm not going to think about my shorts. I'll wet myself as much as I can. I feel a

> lot better, and a lot wet. *You feel better*. I feel better. I feel awake. *You feel awake*. Yes, I feel awake. I think the water did the job (Pat4-5, M&I).

As a sequel to Grand Theme 2, "Feeling the impact", Participant 3 hinted at issues of physical restoration in imagery and comments about the Sistine Chapel, and makes additional comments about a sculpture called the Pieta. He had already talked about restoration of the paintings, but as a "by the way" after the tape was off and before he left the room he also talked about the statue called the Pieta by Michelangelo, which "has been hit with an axe and then restored" (Field notes, after Pat3-3). This well-known artwork by Michelangelo is shown in Figure 7-4, where the sculpture depicts the broken body of Christ in his mother's arms.

Figure 7-4. Illustration of the Pieta by Michelangelo (Olteanu, 1997).

This underscores the idea of damage to a body, and its need for restoration, which again parallels aspects of the bypass surgery experience, and provides a rich juxtaposition of texts relevant to the clinical situation. The fact that such restoration can actually take place, thereby achieving a new sense of himself, is particularly relevant to the grand theme, "Sublime plateau".

Finding a way to transcend pain on an ongoing basis was one of Participant 5's greatest tasks. This varied considerably. In his last session, he commented:

> It's not - the implant is not working today. *Yes, so you've been feeling very good.* It hasn't been used since yesterday or today. *Yes.* I've been very good yesterday and today. *Yes, so you've been feeling very good.* So I keep my fingers crossed. *Yes, yes.* Because suddenly the pain go, it can come back any time. But so far, yesterday and today. *Yes. Is that unusual?* Very unusual. Because I haven't used nothing at all. *Yes.* Yes, it's been very good (Pat5-6, Investigative Discussion).

This may have been related to his experience of feeling like a new person in the previous session, with "no pain or worries" that could bother him (from Pat5-5). Thus, he had a new sense of himself, with nothing to spoil his happiness, and a sense of being able to transcend problems, which was clearly linked to the grand theme, "Sublime plateau".

7.2-1 Final summary, Grand Theme 4

The process of generating the grand theme emically from thematic material and based on the text has been demonstrated for the grand theme, " Sublime plateau". Constituent themes included "Relaxed, calm and peaceful", "Feeling the flow", "Inner light", and "Enjoying the moment".

At a further level of analysis, the semiotic concept of intertextuality has been applied in order to explore the manner in which additional texts (circumtext, intratext and intertext) may shed further light on understanding the meaning for the patient, based on reported music-generated imagery, in the light of recovery from bypass surgery. Participants used a range of texts to convey information about achieving and having control over the relaxation process, and of feeling it deeply in their body as a pleasant and enjoyable sensation. They also allowed new sensations, often pain-free, to emerge, including superlative experiences with meanings related to gold, light and a sense of flow. They also experienced a sense of restoration and of feeling like a new person. The next grand theme will now be explored, which is "Rehearsing new steps".

CHAPTER 8. SYSTEMATIC ANALYSIS: GRAND THEME 5: REHEARSING NEW STEPS

8.1 Textual analysis

Rehearsing is about practising something prior to its performance (Urdang & Flexner, 1968, p.1112). It suggests the sense of trying out something new, of developing, improving and training. Rehearsing occurs in areas such as music performance and sports training, and may link to sports training literature.

Steps commonly go forward, therefore stepping out in a new direction implies trying on a new way of being, going "out there" with it. For participants in this study, the steps are "new", because things have changed, since bypass surgery – the body is much fitter and healthier now. "New steps" also implies a sense of being active, rather than sedentary, and in this grand theme the focus is particularly on rehearsing physical abilities as part of the rehabilitation effort.

The themes contributing to the grand theme, "Rehearsing new steps" are now discussed in depth. The overall structure of such themes is shown in Figure 8-1.

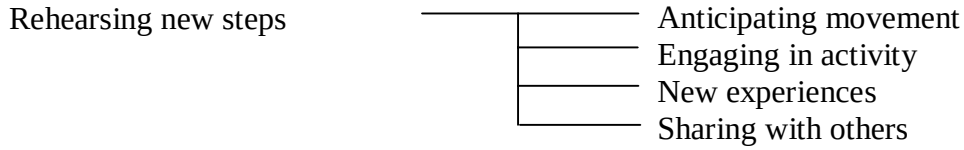


Figure 8-1. Thematic tree diagram of Grand Theme: Rehearsing new steps.

8.1-1 Anticipating movement

The beginning of an urge towards rehearsal involves wanting, planning or preparing to attempt physical activity. Based on an analysis of their reported imagery, participants showed many instances of wanting or planning to attempt physical activities, providing a sense of preparation and anticipation of activity. For example, Participant 1 felt the need to "get up and move on", after lying relaxed at the beach feeling relaxed (Pat1-1).

> *Are you still on the beach?* Yeah, but I think it's time to get up. *Time to get up*. Well, I've been lying down. *Yes.* Get up and move on. *Do you have a sense of*

where you would like to move on? Yes, I might go to Centennial Park (Pat1-1, M&I).

.

More actively, Participant 2 saw a rustic stile which she needed to climb over in the course of the imagery, and investigated what was necessary in order to achieve this.

So, does the stile have a shape to it? Ah, I know you've got to go up a couple steps on one side, and then you step over the fence, and down a couple steps on the other side (Pat2-4, M&I).

Not only this, but participants in the study spontaneously imagined a range of different activities in which they could participate. The down-to-earth comments of Participant 2 as she was imagining the possibility of a long walk added a touch of realism.

How does it feel to imagine being there and that you won't have to rest this time? I'm hoping that I can do a very brisk walk, just as prescribed in the "Healthy Heart" course! (Pat2-5, M&I).

In fact, the desire to walk was quite common amongst participants in their reported imagery, as shown by Participant 4, Participant 5 and Participant 6.

Do you have a sense of where the road goes? I don't know where it goes. But I'm going to walk, till I feel I've had enough. I'll just make sure I've got enough strength to get back. *Do you have enough strength?* I feel very good, except my legs, they feel a bit tired. But I won't let myself worry about that. I know I'll be a lot better, after a little bit of a walk. If I don't, I'll go back (Pat4-4, M&I).

I feel that we are walking on the path to a forest. *What's the path like?* It's somewhere in Newcastle, where I was before. Called, I think, Rankin Park. With very tall trees, and you can hear the birds, and that nice forest. Eucalyptus, I think. It is so nice, at this time of the year (Pat5-6, M&I).

They're tall shade trees. There's plenty of room to walk below them. *Do you feel like walking?* Oh yes, I am walking, yes (Pat6-1, M&I).

Not only that, but the walk that was planned and anticipated was sometimes challenging, even uphill, as shown by Participant 4.

I can see the road. It's not asphalt anymore. And I can see an uphill. Not a big one. *An uphill?* An uphill. And I think I'm going to go through it, and find out if it will affect the muscles of my feet. It's not a steep one, and I can make it. I don't think I'm going to have any troubles. If I do find troubles, I'm going to sit down a couple minutes and relax, and start again. I'm going to give it a go. It <u>is</u> worthwhile, because it is so beautiful (Pat4-4, M&I).

Walking was not the only challenging physical activity that was planned and anticipated by participants in the reported imagery. Participant 4 felt a great urge to try a range of

physical exercises, planning to undertake these, and Participant 5 tried a gentle activity tailored to his current physical abilities.

> I intend to do a lot of different ones [exercises]. In short breaks. And I'm going to take deep breaths after every one of them. That will help my heartbeat, and my blood circulation. And my breathing that beautiful fresh air - oh boy, it's going to be good! It wouldn't be the same one like I am doing every morning at home (Pat4-5, M&I).

> I'm going to lay on my back. And exercise my body. Half way up. And exercise all my, all the joint*[sic]* of my feet and my knees. And try to lift my body as much as I can (Pat4-5, M&I).

> I cannot swim yet, but I just float on the water. It's very easy for me to keep afloat. I move my feet and my arms like that *[demonstrates a sculling motion]* and I keep afloat. Still my chest hurts to swim, you know. I cannot move around. But I enjoy just floating on the water (Pat5-5, M&I).

8.1-2 Engaging in activity

In the participants' reported imagery experiences, there were reports of not only a desire to attempt physical activities, but also the ability to follow through on this urge in order to engage in activity.

> There are quite a few trees around, and there's shadows shining through them. Or some light shining through, casting shadows. A few leaves falling. *What are the trees like?* They're tall shade trees. There's plenty of room to walk below them. *Do you feel like walking?* Oh yes, I am walking, yes. *How is it for you now.* I was wondering how far I would go, if I would come back onto the grassy slopes again. But not yet. *What's the ground like, that you are walking on?* Very grassy. And there are little mushrooms, toadstools I suppose. *Are you still walking?* Yes, but not very quickly (Pat6-1, M&I).

Participant 2 was able to see and plan how to get over the stile, as already noted, and then to achieve this physical activity.

> Ah, I know you've got to go up a couple steps on one side, and then you step over the fence, and down a couple steps on the other side. *Are you able to do that?* Yes, I can do that. So I'm now on the same field, or the same area as the sheep (Pat2-4, M&I).

For Participant 2, achieving this simple physical activity of climbing over a stile, which in fact resembles the steps used in physical rehabilitation activities, seemed to be a precursor to trying further physical activities. In fact, in the next session she imagined climbing down the Giant Stairway in the Blue Mountains, a strenuous and lengthy walk, and recognized that it was now achievable given her improved health.

> And now I'm on the path which is on the other side of the valley from where I started. And I can walk along. *What is the path like?* It's quite a distance, but I can walk along this path. I think it's because it's something that I will do again. Because last time I was very short of breath. So it's something that I can see these seats to sit on, which last time I went along there, I had to have quite a few rests (Pat2-5, M&I).
>
> And I'm still following the path, which I think may have been paved now, but I can see it as it used to be a sort of yellowy clay. *Are you on the path?* Yes, I'm on the path. *How do your feet feel?* I feel very light, so it's easy to walk along. *Let yourself enjoy that lightness.* And I even think I might be able to – I stop and look at the view, where you look down to the first Sister [rock formation], and I feel so well that I think I can go down the first few flights of steps. And walk across the little bridge or whatever it is, where you're actually – you can sit under the rock face (Pat2-5, M&I).

In fact, Participant 2 continued, in her imagery, down the entire flights of steps to reach the bottom of this valley and then continued on to walk a distance to the tourist "skyway" vehicle, thereby undertaking a long and strenuous walk in her reported imagery.

Participant 4 was also able engage with and succeed in his desire to walk, and felt the satisfaction of his achievement, experiencing it as comfortable and enjoyable.

> I'm walking now. I can hear the water. I can hear a few birds. And I can see some big trees in front of me. It's nice and cool. *It's cool.* And the air is very, very fresh. I think this is good! My hands, they feel very comfortable. My whole body is very comfortable. My breathing's very, very relaxed. My head is very, very clear (Pat4-4, M&I).

Not only this, but he was able to undertake his previously planned uphill walking, an imagined activity which provided an even greater cardiovascular challenge to his body.

> I'm walking the hill, now. *How does that feel?* Not too bad. Not too bad. It's not very steep. But the air is so good. The atmosphere smells good. Who cares about the hill? … My feet are strong, I'll just keep walking, and put my mind to the view. And get my mind away from my feet. That will be the best way (Pat4-4, M&I).

Thus, Participant 4 was able to engage with and achieve the physical challenge he set for himself. He likewise was able to follow through on a range of spontaneously created exercises in his reported imagery.

> I think I started doing my exercises (Pat 4-5, M&I).
>
> I am doing shoulder exercises (Pat 4-5, M&I).

> I might do some neck exercises as well (Pat 4-5, M&I).
>
> I'm going to do my waist exercises (Pat 4-5, M&I).
>
> I'm doing my knee exercises. My knees are a bit sore, the muscles are a bit sore (Pat 4-5, M&I).
>
> I'm going to lift my half-body up and down. As much as I can. It feels good. The tummy of the muscle*[sic]* looks a bit tight. I can feel it stretching. That is good
> (Pat 4-5, M&I).
>
> I think I started doing my exercises. *How does that feel?* It feels good. I think the water did the job. Of making me feel awake, and I <u>feel like</u> doing those exercises. I don't feel like that I "have to", I feel like doing them. And probably, this is the difference of the fresh air. And the water. And the humidity. And the sun. And the atmosphere, the whole atmosphere around me. *Let yourself really feel that.* It's really great! (Pat4-5, M&I).

For Participant 5, walking at all was often painful, even at the best of times, due to pre-existing chronic pain. During one GIM session, he reported pain in the imagery and a desire to sit down for awhile, but then this participant was spontaneously able to get up and walk comfortably, even on the presumably shifting sand of the beach, which is a challenging terrain for walking.

> I am going to walk to the dry sand, to sit down there. I have to walk about 20 or 30 metres. To be on the dry sand. *How is it, walking on that?* Oh, the walking is ok. I'm sitting on it, and I lie down. But I keep my leg bended. I feel the sun on my back (Pat 5-4, M&I).

Participant 6 imagined engaging in the activity of riding a bicycle, which rather interestingly was another type of activity promoted in the cardiac rehabilitation programme.

> I think it's quite open countryside. And I was riding a bicycle, with my hair blowing. Just it's all very beautiful and lots of scenery. So I'm not in a hurry. *Let yourself enjoy that.* And the road's easy-going. *How does it feel to ride a bicycle?* Oh, I grew up on one, I'm quite comfortable there. *How does it feel to ride it now?* Well, it's a good idea (Pat6-4, M&I).

Another challenging physical activity was imaged by Participant 3, who undertook an imaginary game of golf with his son and brother during the music and imagery segment. In the imagery, he commented on how he felt to be doing this.

> So now we join up together again, for the walk down the middle of the fairway. They both ask me what it's like to be back playing golf. And I say "it's great"! "Am I feeling any pain?" "No, not like I used to". We comment about that,

> about no angina pain. And that's, that makes me feel, good, that's a good feeling (Pat3-2, M&I).

Becoming even more physically active, Participant 1 imagined enjoying running around and playing with her grandchildren, at a family picnic in Centennial Park.

> The children are running in and out of the trees. *Do you have a sense of what you are doing?* Running around with them. Which I really can't do. *I beg your pardon?* Which I really can't do at the moment. No. Normally when we go to the park. I do play ball and, but I wasn't able to do that last time, so maybe that's why I am seeing myself doing that. *How does that feel?* Good…good. I guess it's like lying on the beach without the scar hurting. It's seeing how things are going to be *[begins to cry quietly]* – soon (Pat1-1, M&I).

Just as with Participant 3 and his golf, Participant 1 used this activity to reflect not only on prior abilities (and disabilities) but also to imagine prospectively the recovery and reinstatement of such abilities as a direct result of the cardiac bypass surgery. Participant 5 also returned to the manageable and enjoyable physical activities of sculling/floating, in anticipation of swimming in the future.

> I cannot swim yet, but, I just float on the water. It's very easy for me to keep afloat. I move my feet and my arms like that [demonstrates sculling motion] and I keep afloat (Pat5-5, M&I).

8.1-3 New experiences

Based on reported imagery, participants not only planned or anticipated exercising, and imaged engaging in such activity, but they also experienced in the imagery what it felt like to do this. In doing so, they reflected on both emotional and physical aspects of their experiences. For example, Participant 3 remarked on the relationship between his surgery and his game of golf.

> Well I can't hit very far these days. *You can't?* No, I think it's because of having my surgery, and I'm not strong enough yet. But I accept that. I'll get better. I'll get better. *You'll get better.* When I do I'll have a harder swing. I don't want to swing too hard, anyway, in case it does upset things. Well, we're just walking down the fairway, together, chatting again (Pat3-2, M&I).

Feeling good inside, and feeling a sense of achievement with greater health merged with the participant's experiences of what it was like to undertake physical activity. Participant 2 commented on her feelings of getting to the bottom of the Giant Staircase in the Blue Mountains.

> And thinking, well I'm down here and I didn't think that I'd be able to ever do this. *How does that make you feel?* Very pleased with myself! *Let yourself*

> *really feel that inside, feel that pleased feeling.*…. Mm. I'm just able to walk nice and steadily, and enjoy the feeling of being in the bush. It's quite a fair way to walk (Pat2-5, M&I).

Participant 4 also experienced pleasurable feelings from walking, and even minor problems still seemed enjoyable.

> I think I started doing my exercises. *How does that feel?* It feels good. I think the water did the job. Of making me feel awake, and I feel like doing those exercises. I don't feel like that I "have to", I feel like doing them. And probably, this is the difference of the fresh air. And the water. And the humidity. And the sun. And the atmosphere, the whole atmosphere around me. *Let yourself really feel that.* It's really great! (Pat4-5, M&I).

> I just keep walking and enjoy whatever is in front of me. My chest feels good. There is a beautiful "botheredness" in my chest. *There is a beautiful…?* A "botheredness", in my chest. The pain, it's only very slight. I'll just take a few breaths, I might send it away. The air is very, very clean (Pat4-4, M&I).

> I'm going downhill now. Geeze I feel good! My whole body feels good! (Pat4-4, M&I).

> I'm going to breathe, take big breaths, before I start doing it. And I feel, if I feel myself tired, I'm going to do the breathing exercises. While I am going up the hill. This will help me. I'm pretty sure. I walk differently uphills. I probably feel tired on my feet. But that's about all. I don't feel short in breathing. So why worry about it? I find myself walking the hill. *Yes.* And I'm going to keep looking at the water, as much as I can. I will try to whistle a bit, and try to get my mind off the hill. It's only a hill! I'm going to do it! I'm whistling a bit. I sing to myself. And I feel good. I'm going to take a few big breaths. This time I'm going to put my head down. And I'm going to keep walking, walk that hill. It's only a hill, nothing else. And I feel I'm prepared to do it. I feel good about it, I'm not going to give up. It's only a hill. *How far have you got now?* Just about half-way. I can see the water. I have no problem. My feet feel a little bit tired. It's only the muscles. And nothing else. The power is there. Big breaths seem to relax me a bit. And take my brain thinking about my fit[ness]. The tiredness of the muscles. Big breaths. Big help. Good song, good view. I still feel good. I'm walking strong enough, and I feel strong enough. I'm going to keep doing the same thing until I come up the top. The idea that comes into my mind is a good picture. To relax me. When I get up the hill, up the top of the hill, I'm pretty sure I'm going to feel very, very relaxed. I'm almost there, very, very little to go. I still find myself good. The muscles of my feet, they feel a bit tired. I still haven't run out of breath. So, what the hell, I'm going to keep walking. The greenery seems to come closer to me. My God, I'm up the top! It's only very, very narrow. Sort of a promenade. Maybe about 10 or 12 feet wide, that's all. But the view, that view, is extremely excellent! (Pat4-6, M&I).

Other participants also experienced the pleasure of movement in their reported imagery.

> The lawn is very soft. I feel like I walk on carpet, very soft and thick carpet. *Can you feel it with your feet?* Yes (Pat5-4, M&I).

In addition, a sense of deliberate active challenge and improvement, and of enhanced ability to problem-solve, was present for some participants during the spontaneous imagery process, particularly Participant 4.

> I probably look for, if I had a problem to solve, maybe this is the best time to solve it. *Do you have a problem to solve?* I can't see any problem (Pat4-4, M&I).
>
> Big breaths again. I'm going to try my two feet at the same time. It looks a bit harder than doing them only one by one. Oh boy, it's hard! But it's good! I think I improve myself. *You think you improved yourself?* I do. And I'm happy with myself, because I wasn't able to do that a few two weeks back. And I'm doing them now. Not as an athlete, but as a patient, getting better. It's good for me (Pat4-5, M&I).
>
> I'm going to walk that hill! I've got the power to walk it. And I've got the feeling to walk it. And I've got the will to walk it. It's a big one, too (Pat4-6, M&I).

The sense of active improvement indicated the potential for further development of activities, especially with regard to physical rehabilitation.

8.1-4 Sharing with others

An increasing awareness of relating to other people marked a possible change in identity, involving a new way of putting oneself forward into the world after bypass surgery. For example, Participant 4 spontaneously felt a desire to share, after his experiences in understanding the nature of photosynthesis (Pat 4-5), and his feelings while walking in nature (Pat4-4).

> I think I am going to talk to my friends about it. What I did see in front of me, in view, they might want to do it themselves, or they might want to see for themself. Unless you see it, you don't realize the real thing (Pat4-5, M&I).
>
> I can see other people coming towards me, too. *Yes. Other people?* There's a couple of people coming towards me. They probably look, or feel like I feel (Pat4-4, M&I).

In another instance, Participant 3 was on a paddle-steamer cruise on the Mississippi river at New Orleans, joining with his wife and others in looking at the sights and listening to the captain's commentary. He also obviously felt a desire record and potentially share his experiences, as evidenced by imagery of videotaping his experience.

> They are sister ships. *Would you like to take a look at them?* Yes, we're just going past, very slowly. I'm doing some video work now. And I'm letting the commentary come on the tape, instead of using my voice. Hm. That's nice, we've gone past there. And the captain has brought our attention to a huge factory, shall we say. *A huge factory.* Yes, a big factory. He explains, it's a sugar mill or factory, for the processing of sugar. They must grow a lot of sugarcane around here (Pat3-4, M&I).

He also recorded a visit to a historic property with his wife, using exclamation and voice tone to summarize his experience and convey his enjoyment.

> But if you go up on the first floor, you can get a good view of the lot. All the oak trees that line the driveway. I'm going to get a video shot of all this. "Country life"! (Pat3-4, M&I).

This outward-looking connection to other people and lifestyles was also an important part of the rehabilitation process.

8.1-5 Summary

This theme is about trying again, re-experiencing something, or perhaps experiencing it in a new way. In particular, about planning to do something physical that needs practice and certain abilities or skills in order to achieve it. It is about re-tackling a problem, or gaining a new perspective on it. This could include another view of themselves and their body, and of how it feels to exert themselves. It also included a sense of extending and improving themselves into greater health and well-being, and of sharing insights with other people.

8.2 Semiotic Expansion via Intertextuality

Further clinical insights are now pursued using semiotic intertextuality to shed light on the grand theme, "Rehearsing new steps". This brings greater depth to the emergent thematic material by focusing on the related circumtexts, intratexts and intertexts.

In relation to the grand theme, "Rehearsing new steps", participants frequently reflected on abilities or disabilities prior to surgery in surrounding discussion. For example, Participant 2 commented in her first session about problems with hills and steps.

> Um, no, my problem was getting up hills. And I've realized since, in the last few weeks, I'm not avoiding hills and steps. And, you know, I've been kidding

> myself, I've been avoiding them for a few years (Pat2-1, Investigative Discussion).

That her cognitive realization of reinstated physical abilities was later demonstrated in her imagery becomes even more interesting in the light of such a statement. Her ability to plan and then achieve the stepping over of the stile (Pat2-4) and her descent down the Giant Staircase in the Blue Mountains (Pat2-5) were even more significant given such a profound change in her abilities and circumstances. The stile also carried overtones of the step-up-and-down required by physiotherapy exercises in the rehabilitation programme. Since she had stated that steps were a real problem before her surgery, this also underscores the rehabilitative process. Her emphatic and surprised post-imagery comment sums up her feeling :

> Yes! I think I've done my walk for today! (Pat2-5, Cumulative Discussion).

She also commented on how it now felt to walk from the bus to home.

> But then I realized that, well, I must be walking more. Although even before I had the bypass, I didn't find that a difficult five minutes. But it certainly got easier after I had the arteries un-blocked. And so I'm definitely walking much easier (Pat2-6, Investigative Discussion).

The way her abilities, such as walking, were reviewed and undertaken in the light of cardiac rehabilitation clearly related to the grand theme, "Rehearsing new steps".

In contrast, Participant 1 was coming to terms with her current temporary disability, since her physical abilities were reduced as a result of the surgery. She describes it like this:

> I haven't got that, "Oh wow, I feel wonderful now, because I wasn't able to walk before", because I was walking and doing all those things. So it's sort of been a bit of a different situation for me than most people do, I think, who have it and have been really ill beforehand. And now they can do things that they couldn't do before. I still can't do things that I could do a week before the operation! (Pat1-1, Investigative Discussion).

This is a difficult situation for her, because she didn't really feel sick or unable to do things before the operation. However, in the course of the GIM sessions, she began to experience her body as it is going to be, with no pain, and with reclaimed energy. She had the sense of the possibility of new or reclaimed physical abilities, even if she was not yet able to engage them as fully as she would like, as shown by her reflective

imagery about running around and playing between the trees with her grandchildren in Centennial Park.

> *It seems like you did some things in the imagery that you couldn't normally do now. Which was interesting. You were saying about lying on the beach, with your chest not hurting…* Yes, yes, I lay down flat on the sand. And I must, I can now lay on my stomach in bed, but it takes me awhile to get comfortable. Because it is, I mean, the scar really does take time. *Oh, you mean you were lying face down?* Mm [Yes]. *Oh, right, ok, I didn't realize that.* I lay down in the sun, with the sun on my back. And that's been hard to do. *Yes.* But I can do it now. But I still, as soon as you lay down, then you feel the scar straight away. But when I lay down on the beach [referring to imagery], I didn't feel the scar. And I was conscious that I didn't feel the scar when I lay down. Yes. And run-, chasing the children, at the park. Well, I don't chase them - well, I'm starting to, but, yes. *Well, yes, of course, you shouldn't overdo it.* No. *But it does suggest that you'll be able to again in the future.* Yes, well, I think that's half my problem, the fact that I have to accept my limitations at the moment and I don't like accepting them! *[joint laughter]* (Pat1-1, Cumulative Discussion).
>
> Yes, and then I can actually try and deal with it now, and tell myself what an idiot I'm being to be frustrated with myself at this stage. Which is obviously what I'm feeling. Because I can't chase the children around, and I can't do quite what I was doing before. Ah, and that's silly. Because at nine weeks, you shouldn't be able to do that. I mean, mm. *Well, I'm sure it will improve over time.* Oh, absolutely! It's just time (Pat1-1, Cumulative Discussion).

Here, this participant was using the imagery and surrounding discussion to anticipate positive change in the rehabilitative process, as part of the grand theme, "Rehearsing new steps".

In fact, many of the participants anticipated activities that they had not yet undertaken since the bypass surgery. This included familiar activities such as riding a bike or taking a walk. For Participant 3, golf was the one last thing on his list of "normal recovery" that he was still waiting to achieve, and he comments about this as a result of an open-ended question by the music therapist.

> *How's it been for you?* Good, good, yes, good. Everything's going along very nicely. And improving very nicely. So, ah, I'm almost back to normal, shall we say. Not far off it. A few more things - the physical…*So what things can't you do?* Play golf yet. *Yes. Because that puts quite a strain with the swing?* That's right. It'll be another couple weeks for that before I even try it out, to see how I go. I've got to be careful pull-starting the lawn-mower (Pat3-2, Investigative Discussion).

> No, now it's looking forward to playing golf, but I'm not frustrated with it because I know that it's a time thing (Pat3-2, Investigative Discussion).

This sense of rapidly increasing abilities was also seen with other participants, who were anticipating such activities as riding a bicycle.

This sense of mounting anticipation with regard to deliberately pursuing imagining physical activity was indicated by Participant 3 in discussion prior to the music and imagery segment.

> Just one little question. About, should I be thinking about tranquil scenes, and doing tranquil things, rather than physical things? *Whatever you would like to do. What do you mean "other than physical things"? Like that you were walking around last time?* Walking around, just enjoying the scenery. That was very relaxing. Ah, what about if I played an imaginary round of golf? Which would be physical. *You could, you could.* Oh, I see. *You can do whatever you like.* So, I could let the music do it to me? And see what happens? *Well, it's not just the music doing it. It's the inside of you, responding to the music, too.* That's it. That's what I meant. That's exactly what I meant! (Pat3-2, Investigative Discussion).

This participant did indeed launch right into imagery of playing golf, even without any further formal relaxation or image-focusing assistance by the GIM therapist. This indicated a natural and spontaneous desire to be involved in physical activity, and clearly relates to the grand theme, "Rehearsing new steps".

Participants also expressed a level of satisfaction and sometimes surprise after their physically active imagery generated in conjunction with the music.

> Well, it was good, that. Well, I didn't mind that. That game of golf was ok. *It was interesting the comments you made at one stage, that they asked how you were feeling, and you said that you didn't have angina, and you were feeling really good.* Yes. *Or something like that, that's not the exact words.* Well, that's the way I want it to happen. *Yes.* That's what I want to happen. Well, I shouldn't get the angina pain, anyway (Pat3-2, Cumulative Discussion).

> Because I can't believe I've been 45 minutes. The whole thing felt like 15 or 20 minutes to me. *[joint laughter] So do you feel tired after all that?* No, I feel beautiful! *Good!* I feel a lot better than when I walked in. Well that's good, too, That's the way, to me, that's what I'd hoped to get out of it. But I felt good last week. I think I felt good last week too. So, I do find the whole thing relaxing (Pat3-2, Cumulative Discussion).

This participant also considered the incongruity of his imagery experience, where he was both sitting in a chair and being active at the same time, and where discrepancies could appear between imagination and reality.

> [Referring to the current research project] *Yes, something a bit different with this one, isn't it? You don't get asked to do this every day!* No! *[joint laughter]*. Sit in a chair with the music and have a game of golf in your mind. *And enjoy yourself!* Yes. *Probably a lot of the other [research projects] are taking blood, or doing this, or doing that, that mightn't be so much fun.* I still played well, didn't I? That's the trouble. You play well in your mind. *Well, you probably will, in practice too!* Well, that's positive thinking. But you do muck things up. Like that happened [referring to imagery] *But the interesting thing in the imagery is that even when you mucked up, you said, "oh, well, that's ok", "that's ok". "I'm just getting back into it".* Yes, it'll take time (Pat3-2, Cumulative Discussion).

He even planned and altered his imagery experience to fit successfully within the known (and realistic) constraints of the current GIM session.

> Well, isn't it funny how we discussed the golf thing, and I said, "this is where I'm going to go"? *So you just "went for it"*. And I thought to myself, I'm going to have to play quickly, because otherwise we're going to run out of time. *You had that in mind already* - So I knew what to do. So I thought, I'll get off the tee. The greens are ok, we'll cut the fairway time down. That part, I thought we played in 6 minutes, that should have been about 15 or 20 minutes or more. *[joint laughter]* But, I was way out! [in time calculation] *(joint laughter). Sorry I can't oblige with several hours of sessions!* Oh no, I'm not sorry over the whole thing. I'm just totally surprised! Totally surprised! That's right - you're right! *[joint laughter] I see you looking at your watch in disbelief! [joint laughter]* … Well, it was good, that. Well, I didn't mind that (Pat3-2, Cumulative Discussion).

Thus, this participant used the creative planning aspect of the grand theme "Rehearsing new steps" to apply not only to his physical health but even to the "new" setting of the music therapy session, using it to rehearse abilities according to his own needs.

The fact that this participant spontaneously rehearsed in his mind his physical re-entry into his passion of playing golf suggested similarities to other areas where imagery is been used deliberately utilized in order to train physical abilities, for example, sports training, nursing education, and stroke rehabilitation, as has previously been discussed (Section 1.5-2).

Not only this, but his reported imagery carried a sense of integrating pre-operation and post-operation experiences. This participant's sense of regaining a feeling of mastery

and control in the recovery process also suggests links to literature about “locus of control”, where personal agency is seen as an essential coping strategy.

Using imagery of playing a simple and very ordinary game of golf, this participant addressed some of the hurdles of rehabilitation, such as anxiety related to anticipation of resuming normal life, in order to experience the enjoyment and motivation of his favourite physical activity. He used the music and imagery situation to link what had happened with his future activities, and in doing so experienced deep relaxation and an increase in confidence, which was clearly related to the grand theme, “Rehearsing new steps”.

In her last session, Participant 2 reflected further on her imagery from the previous session, which was about walking the Giant Staircase in the Blue Mountains.

> And then thinking the last time I'd been to the Mountains. And it was just a week before I'd had a scan, and the doctor had found the valve was partially blocked. And , um - *So that was not all that long ago?* No. So that was earlier this year, it was June, that's right. And I think that's when we just strolled along, to the Three Sisters [rock formation], which is on the other side of the lookout. And that's what made me feel that , "Yes, I want to be able to do that again, and just see what I'm confident in doing, as far as walking." *Did you think, even back then when you actually did it, did you have in mind that you were going to come back feeling better and do it again? Or do you mean only from now, at this perspective?* It's only from now. I didn't think of it then (Pat2-6, Cumulative Discussion).

She also elaborated on the significance of the Blue Mountains and the township of Katoomba for her personally. In doing so, this formed a positive connection with her familial foundations.

> I think I've probably said to you, I'm sure I was conceived at Katoomba (Pat2-6, Investigative Discussion).

> And Mum thought I'd become pregnant while we were on holidays there [at Katoomba]. And she said, "Oh, ah”, she said, “Well, we were always there in January”, and she said, “We didn’t know that we were carrying you around with us, up and down the Giant Stairway”. And I was born the following September! *[joint laughter]* (Pat2-6, Investigative Discussion).

A number of participants undertook activities that could be seen to carry broader cultural meanings. For example, walking along a path could be more than just a favourite or familiar place, with implications of a sense of journeying, of future, and of moving forward (for example, Pat2-5, Pat4-4). Walking also involved having both feet

on the ground. A path can mean a physical path but also a sense of direction and purpose, as has already been suggested under Grand Theme 1 (Chapter 4), and here the sense of forward movement into new experiences was an essential element of the grand theme, "Rehearsing new steps".

Other activities carried even broader cultural meanings. For example, the game of golf was clearly important to Participant 3. This is a game which has developed its own "culture", and with it an associated "philosophical" approach. Corbett (1996,1997) outlines some aspects of this, which seem very relevant to the current situation.

> Golf and life are a lot alike. Sometimes, even when you do everything that you are supposed to do, and you do it perfectly, and you expect to be rewarded with greatness, you can end up the butt of some colossal cosmic joke… The thing to remember is to not let it get you down… And we still have to play our best, at golf and at life, so that when those opportunities present themselves, we are ready to step up and hit our best shot (Corbett, 1997, p.2).

> It would be a sad thing to quit the round, just because you didn't want to risk having another hope dashed. You have to reach into your bag and grab another one. Even if that one may not be as bright and shiny as the one you started out with. Maybe this one has been used before, maybe it's one you found along the way, but don't worry. It keeps you moving forward and it keeps you in the game. There is no way to play the game of golf without that ball, and there is really no way to play the game of life without hope. If your hopes don't work out the way you planned, it's a good idea to have plenty of others in reserve. You know, back-up plans or "fall-back" positions… See, as we go through life we have to constantly adjust our goals depending on the circumstances. Flexibility is the key. If you lose a ball out there on the course, you can't let it put you out of the game (Corbett, 1996, p.2).

Participant 3 further outlined his own views on playing golf in surrounding discussion, which seemed to parallel and reflect much of what Corbett was saying:

> *Sometimes people play perfectly in their mind, and have to stay perfectly all the time.* No, you know that can't happen, right. Ah, plus the fact that if you make a bad shot either in your mind, or in real life - playing bowls or playing golf - you've got to put it behind you. You've got to look to the next one. That's gone - the next one. Try and analyze what you did wrong. Not to repeat. *It sounded like the first shot on the first hole was important to you. To get that one away right.* Well, it sets the mood of the game. If you put the first in the rough - er - you feel down. But because you're out on a nice day and the sun's shining, what better place can you be? And you say, what are the "poor people" feeling? What are the "poor workers" feeling? You know! *(joint laughter)* (Pat3-2, Cumulative Discussion).

Although this participant did not express it, informal discussion with clinical staff suggests that many people with cardiac disease have an enormous fear of collapsing on the golf course, and here, and contrast, we have seen the participant actively and spontaneously enjoying playing without apparent fear.

In addition, it is interesting to note that the concept of rehearsal is basic to survival, from babies and children up to premier athletes. The ability to not be afraid to try again, and to tolerate the possibility of lack of success as well as anticipate success is essential to the organism. However, it would seem that when the body is under severe stress, there is a tendency to not move it, in case it hurts (see Melzack and Wall, 1983) or is compromised in some way. Thus, there is a tendency to withdraw from normal physical activities, and to not rehearse them with a view to positive outcomes.

The way that people used their imagery to relate it to their life has been shown in this study by evidence of spontaneous (not directed) rehearsal of things which they had not yet done since the surgery, and hence it clearly supports the grand theme, "Rehearsing new steps".

8.2-1 Final summary, Grand Theme 5

The process of generating the grand theme emically from thematic material and based on the text has been demonstrated for the grand theme, "Rehearsing new steps". Constituent themes included "Anticipating movement", "Engaging in activity", "New experiences", and "Sharing with others".

At a further level of analysis, the semiotic concept of intertextuality has been applied in order to explore the manner in which additional texts (circumtext, intratext and intertext) may shed further light on understanding the meaning for the patient, based on reported music-generated imagery, in the light of recovery from bypass surgery.

Participants have used a range of texts to indicate the importance to them of resuming physical activities. They have also shown positive anticipation, and a natural desire to be physically involved. For some, this links to their philosophy of life, of getting up and trying again, even (or especially) after something as major as bypass surgery. In

doing so, these additional texts serve to underscore the rehabilitative focus after cardiac surgery.

In the next chapter, attention turns to look at reactions of the participants to the music used in this music therapy research project.

CHAPTER 9. SYSTEMATIC ANALYSIS: GRAND THEME (MUSIC): SOUNDING THE CHANGES

Introduction

In the chapters now completed, we have endeavoured to understand more about the participant's reported imagery with music and the range of texts evident in the GIM session, and begun to understand meanings with regard to health care. This has occurred via the range of texts which intersect and interact, using the principles of intertextuality, based on a semiotic approach. Up to now, for purposes of simplicity, only brief comments related to the music have been included.

However, it is clear that in some instances comments about the music have become integral to the analysis, for example, when Participant 6 contemplates the difficulties of physically hurrying and relates it to the pace of the current musical stimulus. Such direct references to the music in the Music and Imagery Treatment phase, and likewise in the surrounding Investigative and Cumulative Discussions are clearly of great interest. Direct references to the music by participants are now the specific focus of this chapter, in order to see what light this can shed on the GIM experience and how it relates to their cardiac surgery experience of themselves and their bodies. Research into reports by clients regarding their views of the music in GIM therapy is limited, with examples being Short and William (1999) and Grocke (1999). It appears that looking at reported words ***during*** the music itself in GIM sessions has not yet been undertaken in the research literature.

By looking at this, the current research project may provide information about how the music contributes to or interacts with the imagery process in the current context of music therapy as related to cardiac rehabilitation, using the perspective of the participant as a starting-point.

Although it is beyond the scope of this thesis to undertake a full musical analysis, comprising a review of scores and musicological features, such an approach has recently provided new insights into the role of the music in GIM (Grocke, 1999; Lem, 1998; Marr, 2000, 2001). In contrast, this current project extends thematic textual

analysis towards the music within a clinical qualitative analysis. In line with the research project up to this point, it focuses on the narrative reports of the participants, both during the Music and Imagery Treatment phase and in surrounding (Investigative and Cumulative) discussion, in order to derive further information about the role of the music in applying GIM to the cardiac population recovering from bypass surgery. A brief outline of the actual music used for the GIM sessions in this study appears in Appendix 7 and Appendix 8.

In the narrative reports of the participants, there have been many references to the music, and these have been separated out, for ease of analysis. As in the foregoing chapters, analysis will proceed by first examining the music and imagery narrative text, seeking a new emergent grand theme related to the music, in the light of the healthcare experience of the patient/participant, and based on text and constituent themes.

In fact, the grand theme which emerged from the reported data was "Sounding the changes". This grand theme is now further described and explored with its constituent themes. Additional intertextual material will be discussed, in order to offer further semiotic perspectives on the nature and meaning of the grand theme, as relevant to the participant's experiences, before re-situating this analysis of the music text within the foregoing and ongoing research process and research questions.

GRAND THEME: SOUNDING THE CHANGES

9.1 Textual analysis

A sound is something which may be heard, the result of a disturbance (of the air), and possibly the result of an utterance (Urdang & Flexner, 1968, p.1255). It involves auditory perception and stimulation. A sounding board not only reflects and amplifies sound but also refers to a "concerted" reflection and examination of ideas by a group of people in order to reveal the effectiveness of the ideas put forth. The substance of something may also be described as "sound" if it has a good foundation, and the unknown may be examined and determined by "sounding", using measurements taken in exploring the depth of a body of water such as a lake. In addition, the act of sounding may involve giving forth, announcing or expressing (Urdang & Flexner, 1968, p.1255), such as the ringing-out of bells, and may typically be used to define important

transitions in cultural life. In this sense, the grand theme "Sounding the changes" suggests the way that the music may assist in tracking the changes experienced by these participants recovering from cardiac surgery.

The overall structure of themes contributing to the grand theme, "Sounding the changes" is shown in Figure 9-1, and will now be explored in detail via supporting thematic and textual information.

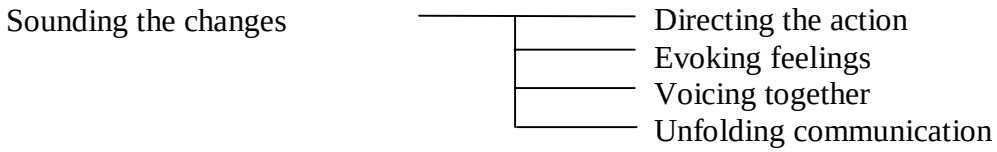


Figure 9-1. Thematic tree diagram of Grand Theme: Sounding the changes.

9.1-1 Directing the action

The issue of how, or why, the action was occurring was frequently linked to the music by participants during their reported imagery. In some instances, participants commented that they felt that the music was directly telling them what they should imagine or do in their imagery. At other times there was the sense of the music acting as a companion, with the music travelling alongside within the imagery experience. In contrast, sometimes the music was felt to be "not right", and was felt to be withholding the action in the imagery (Pat5-2, Pat 3-3), including a feeling of not engaging in the imagery that they either wanted or expected!

There were frequently comments about the music being felt to dictate what the imagery should do. The music related with regard to place and location, person or characters, and action within the imagery sequence. There were many references of music related to place, for example, a scene at dawn, a favourite mountain, and a childhood school.

> I'm wondering if it's going to be dawn. *Dawn. Do you think it will be?* Yes, but I'm waiting to see what the music will do (Pat6-1, M&I) *[Music: Debussy: Danses Sacred and Profane]*.

> *Are you able to find a place?* Yes, I was waiting for the music to decide which of one or two I would pick. *Do you have a place picked out now?* I think so. *What's your place like?* The music's going up the mountain (Pat6-2, M&I) *[Music: D'Indy, Symphony on a French Mountain Air, Movement 1]*.

> That was Mount Cook. *Yes.* I changed it to suit the music! *[laughs]* (Pat6-2, M&I) *[Music: Silence at end of M&I]*.
>
> The music's now taken me to what it was like before the high school was built (Pat2-2, M&I) *[Music: Vaughan Williams, Fantasia on Greensleeves]*.

There were also references to person, with regard to the music, for example, the postman who turned into "Mr Whippy" because of the music, and sense of it "not being Fred Astaire" due to the music.

> No, now you're turning him into "Mr Whippy" with that music *[joint laughter]*. *So would you like an icecream?* No, but I'll never, ever hear Greensleeves without thinking of "Mr Whippy". The garden's gone. And there's the "Mr Whippy" van. And there are still children running up to "Mr Whippy" (Pat2-2, M&I) *[Music: Vaughan Williams, Fantasia on Greensleeves]*.
>
> And there's a top hat, and it's not going to be Fred Astaire because it's not dancing music! (Pat2-2, M&I) *[Music: Debussy: Danses Sacred and Profane]*.

References to the action in the imagery were also related to the music, as reported by the participants, for example, the speed of walking (as already discussed under Grand Theme 2, Chapter 5), the spreading and scattering of daisies, and the sound of running water to help with exploration.

> I suppose the music's saying that we can walk more quickly because we have seen this. But it isn't necessary to go that fast. *How does your body feel, to be walking quickly?* Not particularly keen about hurrying. *Can you walk at the pace you need?* Oh yes. There are lots of birds again, by the lake, perhaps we've disturbed them (Pat6-2, M&I) *[Music: Vaughan Williams, Norfolk Rhapsody No.1]*.
>
> Um, there's daisies scattered over, it's just as though they are being spread over this hill. And it's the music that's scattering them. *Do you have a sense of why that is happening?* No. It's all because of the music. It's just that delicate and shimmery feeling, and there's another hill, behind that one, and it's green (Pat2-2, M&I) *[Music: Debussy, Afternoon of a Faun]*.
>
> Very nice, I can hear the water running. In fact, the music helps. Cause that's what it reminds me of - running water *Let yourself use the music when you need to…* That's exactly what I'm doing. *Are you still with the creek, or are you somewhere else?* I've just climbed up a small hill, and with that music I was looking for miles up this valley. *How did that feel?* Excellent. So peaceful. So I'll walk along this ridge for awhile, just following the creek, because I know that leads me back to where I want to be (Pat3-1, M&I) *[Music: Debussy, Afternoon of a Faun]*.

In many cases the references to the music itself seemed to be integrally related to the imagery. Sometimes there were references to actual instruments, to an orchestra, to a choir, to the stage, to performance, the nature of performance, and the composer.

> I can see the keys moving, but no-one's playing them. It's like a pianola. *What does it sound like?* Oh, it's soft and flowing. And then there's violins in the back. But again, I can't see the people that are playing them. *Are the violins moving, are they making a sound?* Um, not now. *Are there any other instruments there?* No, it's the piano that's standing out all the time, I can't get beyond that (Pat2-2, M&I) *[Music: Debussy: Danses Sacred and Profane]*.

> Yes, I'm close to [the piano]. And I can see hands, slim fingers. Now there's a pinkish glow around the piano (Pat2-2, M&I) *[Music: Debussy: Danses Sacred and Profane]*.

> A choir. And they're walking, in white robes. And they're walking from the top of the mountain as though they are going right around it, or in a zigzag pattern. *In a zigzag pattern.* Yes. So across, and then back. And they look, I know they are in white robes, but they look like monks (Pat2-6, M&I) *[Music: Vivaldi, Gloria :Et in terra pax]*.

> But there is a choir there, rehearsing (Pat2-6, M&I) *[Music: Bach, Toccata, Adagio and Fugue in C]*

> And we'd walk up past the Cathedral before we went to the park. So we'd hear the organist practising, which was always very, very beautiful. And then it would be in the distance, as we walked on down to the river (Pat6-6, M&I) *[Music: Handel, Concerto Grosso Op.3 No.2]*.

> It's very delicate sounds, I can see a harp. And that's gold, And that's golden rays. *Golden rays?* Shining down. And the harp and the piano are near each other. And there's a girl with long golden hair. And she's in a long flowing gown (Pat2-2, M&I) *[Music: Debussy: Danses Sacred and Profane]*.

Some participants reported sounds in their imagery process as being integrally related to their experience, for example, loud talking by people walking along a path. It is interesting to note that at this point the music was loud and busy, in the middle of the *"Allegro non troppo"*, from the Brahms, Piano Concerto No.2, which seemed to parallel the imagery taking place.

> It won't be long until I meet these people face to face. We might have to exchange "Good Morning's". And see their faces as well. *Are you close to them now?* They're very, very close. They're actually two women. And they talk very, very loud. *Yes. Very loud.* I don't know why they talk so loud. *Is there something you would like to say to them?* No, I'd just like to say, "Good

Morning" (Pat4-4, M&I) *[Music: Brahms, Piano Concerto No.2, Allegro non troppo]*.

Sometimes the imagery was reported by participants to have occurred ahead of the music, with the music apparently secondary and lagging.

> *Do you notice what you are doing?* Yes, I've been walking around, observing the wildflowers. And the water running, trickling into… areas. And a waterfall on one side, which is, I can't hear it in the music though. *You can choose what you have there. If you want a waterfall, that's fine.* Yes, I've got it there, but the music hasn't found it yet! (Pat6-2, M&I) *[Music: D'Indy, Symphony on a French Mountain Air, Movement 1]*.

Sometimes there was also the sense that the selected music might not be "right" or appropriate for the unfolding imagery process, as reported by the participants in particular instances. It could be that the parameters of the music were uncomfortable, or that other factors led to a sense of it being problematical. Near the beginning of the imagery, Participant 3 found the music to be too loud or disturbing, which was then addressed by the music therapist, however this did not appear to cause an ongoing problem.

> Getting a club out. Now we're deciding who's going to hit first. I'm stopped now, because the music seemed to be a little bit - *The music seemed to be…?* A little out of context. Perhaps if it were softer. *[Turns it down a little] Is that better?* Yes. The music did not seem to go with… playing golf. But I'm going to try to ignore the music and get on with my golf game. My brother's decided to hit off first. And as usual, he's gone out to his left. I'm going to hit next (Pat3-2, M&I) *[Music: D'Indy, Symphony on a French Mountain Air, Movement 1]*.

Participant 5 experienced a feeling of "blockage" in his imagery process in his second GIM session, and one of his first questions after noticing the blockage included the possibility that the music could be responsible. After being allowed to choose, the music was changed.

> Can it be the medication that I took this morning. Can it be? *Yes.* Or can it be the music too? Or? *It could be the music. Would you like to try some different music?* Yes, you know, might as well have a try (Pat5-2, M&I) *[Music: Britten, Simple Symphony, Sentimental Saraband]*.

Sometimes the music was only barely noticed or acknowledged by participants within the imagery process.

> It's just that I'm not quite strong enough yet, to do the things that I'm so used to being able to do. I'm too independent, I know that, I don't let people help me.

> And clouds! *[laughs] Can you let the music help you?* The music's good, but I sort of, I don't even really feel like I need help, I just feel that I just need another couple months and I'll be back to normal (Pat1-1, M&I) *[Music: Debussy, Afternoon of a Faun]*.

On the other hand, sometimes the music proceeded along with the imagery in a very comfortable sense of partnership, accompanying the unfolding imagery process and enhancing the scope of forward movement and change. This happened, for example, with music related to clouds, waves, and a sense of moving along.

> And as the music lifts a bit, the sun lifts. But it's not like a sunrise or a sunset, it's just that break in the clouds, with the sun showing through. *How does that feel?* There's warmth. *How does that feel?* It feels pleasant. And it's lighting up the green field again. It seems as though as the music, um, changes and moves, so the cloud moves across the sunlight (Pat 2-2, M&I) *[Music: Holst, The Planets: Venus]*.

> It's waves on the shore. *Yes. And how are the waves?* Just watching them. *Just watching them?* Hm. The waves are in time with the music (Pat2-1, M&I) *[Music: Britten - Simple Symphony, Sentimental Saraband]*.

> It's a lovely day. And it's a vast flat valley, with hills across the distance. So I could just keep going on and on, with the music (Pat6-4, M&I) *[Music: Marcello, Oboe Concerto in C minor, Adagio]*.

In still further instances, sometimes the music was linked to memories of childhood, which was also integrally linked to the imagery process. This could include memories of rote learning, music practice, relaxed games, and singing in the household.

> Frequently, we'd have to learn pages of prose. And that's what I thought of as the music started, of all this. Lines I had to be learning (Pat6-5, M&I) *[Music: Bach, Pasacaglia and Fugue in C minor]*.

> I can remember one of the senior girls at school, she had a beautiful soprano voice, and she used to practice singing (Pat 6-6, M&I) *[Music: Purcell, Dido and Aeneas, Dido's Lament]*.

> I was just remembering that we used to play under the pepper trees behind the school assembly hall. And that would be where the singing would be in there. It was in the distance, and we used to, we had lots of games we played under the pepper trees (Pat6-6, M&I) *[Music: Purcell, Dido and Aeneas, Dido's Lament]*.

> I can only remember voices like that [male voice] during the War. My father had to return, because he was a Primary Producer. He was made to come home. I think the man who'd, the elderly man who'd replaced him became ill. And my

> father could only get away, because he was a Primary Producer, when that man was there. And when he had a heart attack, I think, my father came home (Pat6-6, M&I) *[Music: Purcell, The Fairy Queen, If love's a sweet passion]*.

This constituent theme of "Directing the action" related to a range of emergent data linked with the way in which the music influenced or directed the focus of the imagery process.

9.1-2 Evoking feelings

Another emergent theme from this study, based on the reported imagery of participants and within the grand theme "Sounding the changes", concerned the evoking of feelings by the music. These included calm and peaceful feelings and a sense of beauty, but also sometimes provided the impetus for deeper emotions to emerge.

Sometimes there were comments that the music promoted a sense of beauty and of peacefulness and calmness, which included experiences of the music itself, of the countryside, and of the beach.

> This is very beautiful! *Let yourself enjoy it.* I think the music must be European (Pat6-6, M&I) *[Music: Mozart, Sinfonia Concertante K.364, Andante]*.

> It's very "floaty" sort of music (Pat2-5, M&I) *[Music: Marcello - Oboe Concerto in C minor, Adagio]*.

> *How is it for you now?* Good, it's beautiful. Everything is nice, everything is, is so peaceful. The place is free of any sound, just music. Music is in the air. *Are you still in the chair?* Yes. I'm in the chair. Enjoying it (Pat5-1, M&I) *[Music: Debussy: Danses Sacred and Profane]*.

> I think the music was peaceful, just like the quiet countryside used to be (Pat6-5, M&I) *[Music: silence immediately after music]*.

> Mm, it is very relaxing there. The noise of the sea. I like that very much, I can be hours there. *Let yourself really feel that relaxation.* I used to go there with my walkman, and lie on the sand. And watch the sea, and enjoy the Fifth Symphony of Beethoven, at the same time. That's a beautiful experience! Sometimes I was so relaxed that I fell asleep (Pat5-2, M&I) *[Music: D'Indy, Symphony on a French Mountain Air, Movement 1]*.

> I can be hours like that, you know, lying on the sand. I have no cold, no hot. I can hear the perfect music (Pat5-4, M&I) *[Music: Grieg, Holberg Suite, L'Air]*.

> It's very lovely music, isn't it. *[Piano comes in, in apparently different key] Let yourself enjoy it* (Pat6-6, M&I) *[Music: Ravel, Piano Concerto in G minor, Adagio assai]*

Sometimes the music tapped into deeper emotional and physical feelings, for example, deeply relaxed feelings in the body.

> *How does the music seem to you?* Nice and soft, it has quality. I do appreciate it. It's relaxing music, very relaxing music. *What's happening for you now?* It relaxes me a lot. I feel relaxed. It seems like the music attracts me more now. *Does the music affect your body?* It affects my feeling actually. *Your feeling?* Mm. *How is that?* I don't know how to explain it, but the feeling is good. You have to concentrate a lot… *You have to concentrate?* To the music. To appreciate it more - you have to give it more attention (Pat4-1, M&I) *[Music: Debussy, Afternoon of a Faun]*.

> The music's involving me completely. *Do you feel it in your body.* Yes, I feel the music inside me. Everywhere. *How does that feel? [no answer] How does that feel?* No, I think this is the first time that I hear this music. It's a beautiful sensation (Pat5-1, M&I) *[Music: Debussy, Afternoon of a Faun]*.

> Is not telling what I see, is to what I feel. I feel the music inside of me. It is all that beautiful glow, beautiful furniture, carpet. It can't be named. It must be a palace (Pat5-1, M&I) *[Music: Debussy, Afternoon of a Faun]*.

> *So what would you like to be doing now?* Oh, still, will I will lie down on the sand. Because the music is very nice too. I lay down on my back now. It will be worse for me after, to move, but never mind. I will enjoy the moment. You know, I hear, lay down on my back. I hear the sea. I see the sky, at the same time I feel the sand, and I feel the sun. What else can I ask for? I've got it all! Oh, it feels beautiful. It comes to my mind, that the best things in life are free. The sun is free, the sand is free. The sea is free. You don't need money to enjoy that! (Pat5-5, M&I) *[Music: Faure, Requiem, In Paradisum]*.

Sometimes this sense of peaceful beauty and the sensation of the music led to a sudden awareness of the absence of feelings of pain. Participant 4 talked about relief of discomfort related to his sternotomy, together with relaxation based on both the imagery and the music.

> It would be nice to have a house like that in Sydney. To enjoy the beautiful view, and that good feeling. *Let yourself enjoy that.* It's very good. Even my chest is not in pain. *Your chest is not in pain?* No. It's not actually a pain, it's sort of a bothered-ness, a sort of aching. It's probably that lousy cut I've got, when they cut my chest bone. [now referring to the imagery/music:] That seems to be very, very relaxing. You can breath better, a lot better! *A lot better.* Because you feel it's clean. The air is very clean (Pat4-2, M&I) *[Music: Wagner, Lohengrin: Prelude to Acts 1, 3]*.

At times, the participants used the music and imagery situation to comment on the feelings of the composer, which may also have carried a sense of projecting their own feelings onto the image or idea of the composer.

> I think the music was composed by someone who lived in the countryside, I don't think they lived in the city. I think they were trying to express the peace of the countryside (Pat6-6, M&I) *[Music: Mozart, Sinfonia Concertante K.364, Andante]*.

> I think he's expressing a mood, more than anything else *[End of Mozart. Silence.*
>
> *Beginning of Ravel]* And now he wants to express a calmer feeling (Pat6-6, M&I) *[Music: Mozart, Sinfonia Concertante K.364, Andante; Ravel, Piano Concerto in G minor, Adagio assai]*.

> He's obviously feeling much more at peace with himself. Perhaps he had a break, had something to eat. I think he's been for a walk. And he's come back and tried to express the peacefulness of the experience (Pat6-6, M&I) *[Music: Ravel, Piano Concerto in G minor, Adagio assai]*.

The music was sometimes also related to comfortable, energetic and enjoyable movement in the imagery, such as walking or dancing.

> It's very, very early in the morning. It's very, very fresh. *Very fresh. Let yourself smell that air.* The smell is nice. And the sound of the water is nice. I feel like walking (Pat4-4, M&I) *[Music: Brahms, Piano Concerto No.2, Allegro non troppo]*.

> But now the sparkler, it's like a sparkling ball of light, and it's held by a fairy. *Held by a fairy.* Like, um, like Tinkerbell. It's Tinkerbell music. And she's dancing. She's pirouetting on one foot, on one toe. *Does she know that you are there?* Ah, she's now left me, and I'm still, there's still the figure that's outlined with light. No, she's dancing, flying, up over a hill (Pat2-6, M&I) *[Music: Beethoven, Piano Concerto No. 5: Adagio]*.

Therefore, the music appeared to evoke a range of feelings, as shown by imagery reported during the music and imagery segment of the GIM session, including relaxation, deep enjoyment, and deeply peaceful moods.

9.1-3 Voicing together

The theme of voicing together incorporated the sense of joining together in music-making. It included listening and working "in concert" (that is, with a concerted effort), and also planning, rehearsing and bringing things together in conjunction with the music, as reported in the imagery segment.

For example, Participant 6 envisaged the plan being made by the composer, and how he created the musical score.

> *Can you imagine what the composer was like?* No, I can't really. I have an idea that he was, he worked on his own. Trying to write the score and comparing the instruments, to bring them together. *How is it for you now?* I was thinking of how he would plan for the different instruments to, for their "turn". He'd probably work for a very long time without resting (Pat6-6, M&I) *[Music: Mozart, Sinfonia Concertante K.364, Andante]*.

Participant 2 reported in her imagery that she was listening to a choir and to its rehearsal, which was obviously a situation where voices were blending together.

> Now I just want to sit, and sit in one of the pews, and listen to the choir. *[female choir singing]* (Pat2-6, M&I) *[Music: Faure, Requiem, In Paradisum]*.

> But there is a choir there, rehearsing. *[choir singing]* (Pat2-6, M&I) *[Music: Bach, Toccata, Adagio and Fugue in C]*.

The sense of bringing things together and blending, which is part of joint music-making, was reflected in reported imagery about the composer in other examples by Participant 6.

> He's very conscious of the blending of the chords of the different instruments (Pat6-6, M&I) *[Music: Mozart, Sinfonia Concertante K.364, Andante]*.

> He has to bring all the instruments together again (Pat6-6, M&I) *[Music: Ravel, Piano Concerto in G minor, Adagio assai]*.

The sense of "voicing together" occurred in a range of different contexts, but expressed a sense of blending and bringing together, listening and rehearsal. This sense of integration may well have been very important for these participants recovering from bypass surgery, as they sought to bring together and makes sense out of their recent

experiences. Here, the music seems to reflect a similar process to what is happening psychologically and emotionally.

9.1-4 Unfolding communication

The unfolding process of communication with others and the relationship of this communication to the music was reflected in emergent material based on the reported imagery. This included images of interactions with livestock, such as the way that Participant 6 sang to the cows as she worked with them on the farm, which she reported during the imagery.

> The cows would come back always very lazy, never hurried. Not even the dogs made them run, just walked back slowly, slowly. I used to sing when I'd bring them in. I used to sing while I milked them (Pat6-5, M&I) *[Music: Bach, Geistliches Lied, Mein Jesu]*.

Communication with human beings was not always clear, as shown by the same participant (Participant 6) in the next session.

> It's very lovely. This choir of people, standing under some trees, in a circle. And they're by the riverside too. I can't understand what she's singing. *Do you have a sense of what she wants to sing about?* No, I don't. I can't understand this song at all, I don't know what… I don't know what they're saying (Pat6-6, M&I) *[Music: Boulanger, Les Sirenes]*.

Participant 4 used images of music, singing and whistling to communicate to himself positive messages about keeping on walking, which was so important for his overall rehabilitation, thereby distracting himself from implied internally generated negative messages.

> I will try to whistle a bit, and try to get my mind off the hill. It's only a hill! I'm going to do it! I'm whistling a bit. I sing to myself. And I feel good. I'm going to take a few big breaths. This time I'm going to put my head down. And I'm going to keep walking, walk that hill. It's only a hill, nothing else. And I feel I'm prepared to do it. I feel good about it, I'm not going to give up (Pat4-6, M&I) *[Music: Faure, Requiem, In Paradisum]*.

The theme of unfolding communication encompassed the sense of interaction within the imagery, in conjunction with an awareness of music. It also paralleled the participant's experience, of an unfolding communication via the GIM process in this research project, and this will be further discussed in the next section.

9.1-5 Summary

The emergent grand theme, “Sounding the changes”, comprised the sense of how the music fitted in with directing the action, as well as its role in evoking feelings, in voicing together and in promoting and unfolding the communicative process.

9.2 Semiotic Expansion via Intertextuality

Up to this point, thematic analysis has focused on the participants’ reported imagery with the music. However, further clinical insights may be gained by using principles of semiotics to shed further light on the grand theme, “Sounding the changes”. This is achieved by using material derived via intertextuality, notably the surrounding discussion and sessions (circumtexts), direct referrals to particular texts (intratexts) and accessing cultural symbols or idioms (intertexts), as approached via the interpretations of the researcher. These will now be explored in greater depth, moving from emergent thematic materials to related texts.

In this study, the participant’s view of themselves in relation to music and music-making was interesting and informative. Some participants had some connections with music but most were not currently actively involved with it. Some had played instruments in the past (Participant 4, Participant 2), or sung in a school choir, even if not successfully (Participant 2), and some felt a connection to classical music (Participant 5). Some participants had no particular connection at all with music (Participant 1, Participant 3). The connections of participants with/to music, as reported in surrounding discussion, are outlined briefly in Table 9-1.

Table 9-1

Participant's reported connection to and experience with music (instrumental, vocal, classical)

	Played instrument	**Experiences of singing**	**Connection to classical music**
Participant 1	No	Like to sing at home with radio	None
Participant 2	Yes. (chord organ, in later life)	School choir (told not to sing)	Minimal. Granddaughter gave her some impressionistic music to relax to
Participant 3	Yes, a little (organ "Easy to read" music).	No	
Participant 4	Yes (trumpet)	No	Yes. Very comfortable with classical music
Participant 5	No	No	Yes Loves classical music
Participant 6	No	No	Likes to relax to classical music

Some participants felt very comfortable with relating to music, including Participant 4 who used to play trumpet in a Latin Band, and Participant 5 who had an extensive collection of recordings of music of many styles. However some participants also expressed their inabilities and discomforts related to music. For example, Participant 2 had a very negative view of her abilities regarding music making, as she reported in discussion before the music and imagery segment.

> Well I've always been told I don't have a musical bone in my body. *Oh, really? That's a bit rude!* Well, I was told by a boyfriend once, "there's so many keys on the piano, why do you sing between the cracks" *[joint laughter]* And, in fourth class in school, someone was out of tune, it was me. In the days when we used to have the music in the back of the school magazine (Pat2-1, Investigative Discussion).

> *So you've never played an instrument* - When my husband retired. Oh no, once, some years ago, he bought an organ. He must have done some overtime, or got a bonus, or something or other. And, ok, he could play that, and I was going to learn. And when it came to playing the chords, "Oh, I'm never going to learn this". And then subsequently we traded that in on a Hammond. Now, this had "cheating" chords, you only had to hit one key - *Yes, press one note and it*

> *does "doodely, doodely, doodely do"!* Yes. And that was great, and I did, you know what came with it was free lessons. Which you really didn't learn anything, but it was a lot of fun. And I think I did two series of those. And you could buy lots of easy-playing music. So, for a few years, yes, I had a lot of fun on my own, playing. Ah, but then something went wrong with the organ, and, oh, we spent ages trying to get it repaired. And finally we got someone, a few years ago, and he did the best he could, but there's just so many parts to it, and all computer operated. And the "cheating" bits that I used would no longer work! (Pat2-1, Investigative Discussion).

> And I know if I am singing something, that the last note is going to come out flat. I can feel it, but I can't do anything about it! (Pat2-1, Investigative Discussion).

Her difficulties in regard to music also extended to a current hearing impairment, which limited her auditory and musical perception, as noted in surrounding discussion.

> *So your best ear is your right ear, is that right? Have I understood it right? [laughs]* The deaf ear is my left ear. And the other one, the right ear, isn't so good (Pat2-1, Investigative Discussion).

This hearing impairment was also evidenced by her (incorrect) naming of an instrument during the music and imagery, where (actual) harp music was named by her as piano (Pat2-2), which was most likely related to hearing capabilities. Even in her last session, in the context of a general review of the six sessions, she referred to this music quite emphatically as being played on the piano. There seemed to be no clinical advantage in challenging her opinion.

> *In the second one you started with a lot of musical instruments, do you remember, the piano?* Yes, I remember that. *I think there might have been a violin and a few things.* There was a, yes there was definitely a grand piano. Yes. That was one of the definite, it was linked directly to the music, wasn't it! (Pat2-6, Investigative Discussion).

Familiarity with, and relationship to, classical music, as used in the Bonny Method of GIM, was an issue for some participants. For example, Participant 1 mentioned that she did not usually listen to classical music, although she liked "easy listening" music and enjoyed "singing along" with it at home. In addition, she was not aware of ever having had imaginal responses to music, although she had realized the importance of relaxation and was interested in exploring this application of music in the current study.

Other participants frequently listened to classical music and were very familiar with it, especially Participants 5 and 6. Participant 6 especially described the importance of this music as it related to her life and her activities via a radio programme.

> Yes, well when my children were growing up, I always used to put Margaret Throsby on in the afternoon, and drag the ironing board out into the hallway where I got a through-draught in the summer, and she helped me enjoy ironing, because I had to iron about, more that two dozen shirts a week, with all the children going to school and my husband going to work, you know, clean shirts every day. So I had a draught, and Margaret Throsby with all her beautiful music. So I used to look forward to my hour of ironing. And keeping it under control. But it was the music that made it possible (Pat6-1, Cumulative Discussion).

Exploring the range of experiences of the participants in relation to music and music making together gave a fuller sense of their usual connections with music, and was clearly relevant to the grand theme, "Sounding the changes".

Participants often described the music as directing or having a strong influence on their imagery and experiences in discussions before and after the music and imagery segment. For example, after the music and imagery was completed, Participant 1 reported that immediately as the music had come on, she felt ready to burst into tears. She spontaneously came back to this point again later in the discussion, indicating the ability of the music to stir emotions in the imagery process.

> Because as soon as, the minute you put that music on, my eyes filled with tears. But that, I think, really is just the emotional - … And it just brings a tear. And I think music is another thing, that, you know, it's an emotional type of thing (Pat1-1, Cumulative Discussion).

This was typical of the way that participants felt that the music itself was directing their experiences, as part of the grand theme, "Sounding the changes".

In this particular method (GIM), the music serves as like a soundtrack, to promote spontaneous imagery and to keep it moving along temporally. The carefully selected music stimulates imaginative processes, and is designed to allow the client to choose a range of responses in whatever way is pertinent to their situation. In fact, one participant commented on the difficulty of keeping the imagery going, without the

accompanying music. This was at the end of the Music and Imagery Treatment phase, and after the music ended he was encouraged to continue to completion with the imagery, without the music. He finished the seventh hole of golf, and then said in a very surprised voice:

> Would you believe, it's getting harder to do imagery and concentrate without the music, isn't it! (Pat3-2, M&I) [No music].

Participant 4 commented particularly on the role of the music and how it affected him.

> Mm. That music was nice. Have you noticed something with music? *What? What have you noticed?* It always finishes up like an answer. *Yes?* It never finishes up like an interrogation mark. *Right. About the music I'm using, or just generally with music?* Generally. *Yes, there's usually a sense of completeness, the questions are asked early on and there's some sort of resolution by the end, isn't there?* Yes. If they had to diminish, they might change (Pat4-5, beginning of Cumulative Discussion).

> *You look different to when you came in, you just look glowing!* Yes! I think that thing does it *[pointing to audio player]. Yes? The music made the difference?* Yes. *That's lovely music on that particular tape.* It's really good. *Yes, yes.* And you're always reaching for scales, aren't they going up. *The scales? Yes, so there was a lot of upward movement in the music?* Yes. Especially when they were finishing. *Especially that last piece, yes. [referring to Massenet Scenes Alsaciennes; Sous les Tilleuls]* (Pat4-5, Cumulative Discussion soon after the above).

> But music relaxes me, It doesn't matter if it is Japanese, or Chinese, or Indian, or Egyptian, or Greek, you know. *It's just got to be the right thing in the music.* Yes. I love it. Classical - beautiful! Even better, you know! *[joint laughter]* Oh God. I love it, classical. It doesn't matter what it is (Pat 4-6, Investigative Discussion).

Participant 4 commented about what it was like to settle into using the music in his first session.

> *How did it feel, or how was it for me to say, can you listen to the music?* Well, it took me awhile. For the music to attract me. *Yes, you said that it was attracting you more, I think.* Yes. *Yes. And that it affected your feelings.* I did? *Yes.* Yes. It took me a bit of a while, I don't know why, that's how it came out (Pat4-1, Cumulative Discussion).

In discussion after the music, the therapist commented on the relationship of the music to the imagery.

> *Well, it seems like you were very tuned to the music too, I noticed a number of times, you commented on the music, or the things that you did matched-in very*

> *well with what was happening in the music…*Well that was a game that - I should remember the name of the conductor, he came to Adelaide and played for children, he did a lot of - Eugene Goossens, was it, was that many years ago? *Yes, it would have been.* Well he, this conductor came to Adelaide and I went to wherever the orchestra was, and he played the different instruments for the children. And the music he played, he taught us that "this was a storm", and "this was a lovely autumn day', the different scenery that he described. And then we listened to the music, and of course the music was telling me those things. So I have always looked for what the music was saying. And that's why a lot of modern music doesn't say anything! (Pat6-1, Cumulative Discussion).

Such discussion also brought forth comments about how the music related to perceived changes of feelings and emotions, such as the comments by Participant 4 and Participant 1.

> *So, did you feel that that music worked alright for you?* Yes, especially the last, er, the last ten minutes or so. *The last bit there where you really noticed it?* It was very, very good. I really felt the difference, from the first five or ten minutes or whatever (Pat4-1, Cumulative Discussion).

The role of emotions and its connection with the music was also evident as Participant 1 began by talking about another person in the cardiac rehabilitation programme, progressing to talk about her own strong feelings.

> This other lady said to me the other day, she said, "I just get so emotional". She said, "just any little thing, I just start to cry". And, well I haven't. I was doing that in the early stages, but I haven't so much lately. But as soon as this Ad. comes on [television], I do, I fill up with tears. And just the - and it's not a sad thing. It's just wonderful. I love the song. And it's all the images of all over the most wonderful places in the world. The great wall of China, and these kids are standing there singing, "I still call Australia home". I'm a real soppy sentimentalist. *Yes.* And it just brings a tear. And I think music is another thing, that, you know, it's an emotional type of thing (Pat1-1, Cumulative Discussion).

In their imagery process, participants sometimes referred to specific pieces of music, thereby creating an intratextual relationship from the imagery text to a musical text.

For example, Participant 5 commented on his memories of using Beethoven's Fifth Symphony for relaxation whilst lying on the beach.

> Mm, it is very relaxing there. The noise of the sea. I like that very much, I can be hours there. *Let yourself really feel that relaxation.* I used to go there with my walkman, and lie on the sand. And watch the sea, and enjoy the Fifth Symphony of Beethoven, at the same time. That's a beautiful experience!

> Sometimes I was so relaxed that I fell asleep (Pat5-2, M&I) *[Music: D'Indy, Symphony on a French Mountain Air, Movement 1]*.

In fact, the music playing at the time of this imagery was by D'Indy: Symphony on a French Mountain Air, Movement 1, with this imagery occurring some way into the piece, after the piano has entered and interacted with the rest of the orchestra. It is not clear what the connections might be between both of these pieces of music (D'Indy and Beethoven) if one looks at musical similarities. Perhaps similarities occur via a forceful and rhythmic theme which is confidently explored, broadly, in a variety of instrumentation and via extensive thematic development.

In another interesting example of the participant directly referring to specific music and thereby creating intratextual musical relationships, Participant 2 cited the music of the Walt Disney film, "Fantasia", as an intratext during her imagery of an approaching storm. Later, she identified this music as part of the Beethoven Pastoral Symphony, which occurs during the "ponies" animated sequence in Fantasia (Pat2-1, Cumulative Discussion), which also has an animation of a storm.

> Yes, I just wondered at one stage, there was something that reminded me of Fantasia [Walt Disney film]. *Yes?* Ah. *Oh, they have some water stuff in "The Sorcerer's Apprentice"* No, it wasn't that! *[joint laughter] It wasn't the buckets of water!* Um, it was part of oh, the "Rite of Spring", no, it was the Beethoven. *Right.* The storm clouds come over and - *That's the little Pegasus sort of horses isn't it?* Yes, yes. And I thought at the time, oh dear, am I just connecting this with that particular scene in "Fantasia" *Well, it's ok if you do!* (Pat2-1, Cumulative Discussion).

In addition to the imagery link (via "storm" images), it is interesting to pursue a brief exploration of the links between this music, the Pastoral Symphony by Beethoven, and the music playing at the time, Britten's Simple Symphony, *Sentimental Sarabande*, in order to derive more understandings.

The music at this point of the imagery was the middle section of the Britten, Simple Symphony, described in analysis notes as having a deeper sound with a deep bass melody and shaky tremolo-type figure, with an upper string figure and then a decrease in tension as the music becomes quieter. A subsequent exploration of writings about the corresponding section of the Pastoral Symphony describes features showing some similarities:

> The celli and basses are asked to play very rapid notes in their lowest range. In no way will this, based on the capabilities of the instruments, be heard cleanly. What one hears, instead, is a deep rumbling resembling distant thunder. We see the brilliant flash of lightning in the rapid ascending notes of the violins, and hear the rain and swirling winds in the arpeggiated tremolo string writing (Lindholm, 1998-9).

Beethoven talks himself about his desire to connect feeling with musical depictions of images in his music, as he states in notes on his sketches for this Symphony: "the listeners should be allowed to discover the situations themselves… people will not require titles to recognize the general intention to be more a matter of feeling than on tone painting" (Kramer, 1988, p.91).

Continuing on from this, further investigation suggests that the manner in which the power of natural forces, such as a storm, can be converted into music and thence portrayed in visual effects was fundamental to the deliberations of Disney and Stokowski as they worked together to produce the film, "Fantasia", as outlined by Allan (1999).

> The viewer is lurched from beauty to pathos within the same frame and at the same time in a complicated, layered struggle to present visually, 'to create a whole new feeling' for the audience, one of the most sublime pieces of music in the Western world (Allan, 1999, p.149).

The juxtapositioning of two different musical "texts", of Britten's Simple Symphony and Beethoven's Pastoral Symphony, and the further overlay of the aims and impact of Disney's film, Fantasia, provide rich insights into the participant's experience of the combined music and imagery during music therapy treatment.

Progressing further into the participant's broader intertextual and circumtextal information, it is noted that the film, Fantasia, was possibly this participant's first experience of combining imagery and music together. She also goes on to tell of the social importance of this film in her life, for example, sharing it with her husband, going to see it with friends and family, and in turn wanting to show it to her children and grandchildren. This parallels Disney's stated motivation as "a conscious effort to make classical music acceptable to a popular audience" (Allan, 1999, p.91).

> But, um, well I do like the Pastoral. And, um, I think it's probably the, I think when we were first married, we bought the Pastoral Symphony. And it must have been 6 records in the album. And now we've got the whole of Fantasia on

> a CD! *[laughter]* But perhaps that would have been my first experience of imagery in the music (Pat2-1, Cumulative Discussion).

> Actually, my husband only mentioned, not long ago, that he once wagged school to go and see Fantasia. *Yes, it's a lovely film, isn't it.* And, um, it used to be on regularly every year at a little theatre, in Bligh Street, I think it was. The theatre's no longer there. But, um, from the time, oh well, I first saw it as a kid and I thought, oh, it's stupid. And then I read that it wasn't successful the first time that it was released. *Well, it was for you, by the sound of it! [joint laughter]* Well, not that first time. I think I was too young. And then, well I had no musical interest really. And then by the time I was about 16 we used to go every year, and um, we didn't see it for years and years. Until it appeared again, ah, and my daughter remembers going to it, the Metro at Kings Cross, to see it. And now our grandchildren , you know, they just watch the video! *[joint laughter]* (Pat2-1, Cumulative Discussion).

Another example of musical intratexts included a more indirect reference to the music in the imagery with the reference being to the musical film version of "South Pacific".

> It's a very pretty place. It's not where I started out. There's a palm tree there, sort of like a desert island. So I expect to see Dorothy Lamour in a sarong! *[joint laughter]* And it's warm (Pat2-4, M&I).

In these several instances of referrals to specific music texts within the imagery, it shows that intertextual relationships can exist even between the music used for GIM and music reported to occur as part of the imagery process, suggesting interesting and fertile links related to the grand theme, "Sounding the changes".

Participants also reported using the music themselves outside of the GIM therapy context, to help themselves and to promote an imagery experience. This was not always successful, due to a range of possible factors.

> Because the other morning, or evening, I was very wide awake. And I thought, well, I'll see, by playing a tape, if I can see any imagery myself. And I really couldn't. *What sort of music were you playing?* Ah, it was Debussy (Pat2-6, Investigative Discussion).

Participant 5 reported an absence of pain after the music and imagery, and in the next session commented that he was deliberately using music to assist with his pain management at home.

> *So, if we turn our attention to thinking of these last five sessions, um, is there anything you want to comment about that? Any thing you've noticed, that might have changed? Or not changed? Or anything that was interesting, or different. Or unexpected?* Oh, I tell you it has been a very, very good experience for me,

> because I experienced something that I haven't experienced before. I learned something new, that I guess I can use it. I don't know for how long. But I can use it. *So, when you say you learnt something new, do you mean about the relaxation, or - ?* That's right. The relaxation imaginary *[sic]* with the music. I haven't had any kind of experience similar to that before. *So you hadn't tried the imagery with relaxation. Is that right? And with the music?* Yes. And that's good, it's a good experience. *Have you tried doing it at home?* Yes, a few times. But lately I've been keeping so busy, that I, you know, I'm glad for that because time flies, for a start. For me it is very important that time flies. Don't ask me why, I don't know why. But I think it's just there to keep me busy. If I'm busy, I'm enjoying what I'm doing, then not much thought, you know, that is a way that I find [found] out to avoid my depression very good (Pat5-6, Investigative Discussion).

By the end of their series of sessions, several of the participants were planning to continue their renewed connection with music into everyday life. For example, Participant 2 and Participant 3 were planning to try playing the electronic/chord organ again, Participant 6 was planning to find ways to listen to the music she liked (even though husband doesn't like it!), and Participant 5 was attempting more relaxation with a view to pain management, including experimenting with compiling his own music selections/tapes.

> But, the music is the key…Yes. You give me a great idea, I'm going to *[sic]… I don't know how much classical music you know. But a lot of the slow movements of concertos, or of symphonies, are the right sort of music for this type of relaxation. They're often called Adagio, or Andante, or something like that.* That is one of the things that I am willing to have a list very soon, I want to speed it up. I want to check past, through all my music. That will take me months! CDs, about 80 classical. *Oh! Right, so you've got lots… of classical music.* Cassette, I've got about 20 or 25 classical. *Yes.* I have to go all through that, and I'm going to select - *See what works?* That's right. *Oh, I should ask you to let me know what you find, because you might find some things I don't know about!* And make [=find] other ones. Yes. Because, I usually, I hear the flute Concert[o], you know. But sometimes there's a part you like more than others. Many people just go and hear just that part. No, I go through all the Concert[o], to get the part I like. And even after that part passes, I continue with the concert[o] until it's finished. You know, that is my way. But, at the same time. *But if you just want to do the imagery, then you might want to just pick out some of those.* That's right. Because it take me *[sic]* too much time to do that. If I select, I will hear, in less time, more music. *Yes, yes.* That is what I've been thinking about, you know. *Yes.* It would be something good. But as I say, I have to go through all my music. And, um, then select, I'll make my own tape (Pat5-6,Cumulative Discussion).

> Yes, it has to be, I'm thinking about my experience. I like classical music, that makes it easy for me. But I can't imagine, if I don't like it, you know, how that music will me to makes *[sic]* images in my mind, if I hear something that upsets

> me, doesn't like me. [= I don't like]. My mind will be not happy, it will do nothing good (Pat5-6,Cumulative Discussion).

Thus, it appeared that participants had become empowered to in use the positive and creative aspects of music to assist in everyday life.

In her last session, Participant 6 identified with the composer, and the way that he has expressed his emotions through the music. She uses the music to express herself, and at times it has a projective sense. The composer is bringing together, blending, which is an interesting parallel to the way that her body is now blending together, after the major cut of the sternotomy. Thus it seemed that, based on her reported awareness, the music was actually echoing and tracking changes, thus clearly relating to the grand theme, "Sounding the changes".

The issue of the participant feeling that the music was in some way "wrong" for their experience is actually a very complex issue, and taps into the broader issue of client involvement in directing their own therapeutic process and the way that clinical perspectives intermesh with this. For example, in standard GIM practice, when a client declares that the music is "wrong", clinical factors will be carefully and quickly reviewed with regard to such things as the range of imagery possible with any given piece of music, the rate and type of imagery occurring, and to what extent the need for "control" by the client is in itself the predominant therapeutic issue. It had been well noted from clinical practice that in the latter case no amount of changing of music will solve the problem! Such an understanding is relevant to Participant 5's second session, where, despite the change of music, it still did not assist the participant in breaking through the "blockage" (Pat 5-2).

However, negative comments about the music by participants were certainly addressed by the music therapist, for example in Participant 3's third session.

> *You didn't like the music at first, did you?!* No, I tell you, when it started getting loud and what-have-you, I thought, "No, no, I'm don't want it". *Well I'm glad you were able to say about that, 'cause it seemed like turning the music down was enough for comfort.* Yes, it did. *I know that it did that loud bit and then it calms down a little bit more, and yet it was giving you some motion and some energy.* It nearly stopped the imagery, too! Because that was taking over my concentration. Listening to that (Pat3-2, Cumulative Discussion).

As in standard GIM practice, if the music was really judged to be wrong by the GIM therapist, it would have been changed, but the fact that the imagery process continued indicated that it was not inappropriate, just a bit loud. In fact, clinically, much of what he was doing in the imagery process seemed to fit well with the music, as the session unfolded, and there was no further dissatisfaction with the music reported (Pat3-3).

9.2-1 Final summary, Grand Theme (Music)

The process of generating a grand theme emically from thematic material related to the music and based on the text has been demonstrated for the grand theme, " Sounding the changes". Constituent themes included "Directing the action", "Evoking feelings", "Voicing together", and "Unfolding communication".

At a further level of analysis, the semiotic concept of intertextuality has been applied in order to explore the manner in which additional texts (circumtext, intratext and intertext) may shed further light on understanding the meaning for the patient, based on reported music-generated imagery, in the light of recovery from bypass surgery.

Participants in this study came from a range of different backgrounds and music interests, and hence their responses to the music and musical texts varied considerably. Through a range of texts, they expressed their connections to music, and the ways in which it related to their experience of the imagery process. Likewise, participants commented about the way in which the music related to their body, including inner experiences of the music and connections to emotional responses. The music at times connected to other music, and thereby accessed memory-related information and the social context. Music also appeared to have a role in pain management, and in underscoring the effects of surgery on the body. Finally, connections to music provided an avenue for the planning of ongoing musical activities for some participants, thereby extending the effects of the study into their everyday lives.

In the next chapter, attention turns to the viewpoint of the Jungian interpretive community, seeking to consider text, themes, grand themes and intertextual (semiotic) expansion of participants' reported imagery in the light of its archetypal significance.

CHAPTER 10. JUNGIAN INTERPRETIVE APPROACH

Introduction

In seeking to understand not only what is happening for patients, but also what this means for them in the broader therapeutic and health care setting in recovery from cardiac bypass surgery, the viewpoint of the therapist/clinician is continued in this chapter. This started with the intertextual semiotic exploration but is now extended towards "interpretive community" (Voelz, 1995), based on Jungian principles. This is achieved by utilizing the extended pool of textual and intertextual data already generated in preceding chapters and combining it with Jungian interpretive knowledge, thereby deriving further clinical and therapeutic understandings.

Hall's process of dream analysis was applied to the study of imagery in the current project (see Chapter 3, Hall, 1983). In this process, the initial analysis has led to clarifying and understanding the exact details and information carried by the images using textual analysis, followed by the gathering of amplifications progressively at personal and cultural levels, achieved via the approach of semiotic intertextuality. An exploration of textual references to music and its effects has also been undertaken as an additional thematic and intertextual (semiotic) analysis. In order to now proceed to a Jungian interpretation, archetypal dimensions arising from the preceding analysis are considered, and then the amplified imagery is placed in the context of the participant's life situation (Hall, 1983, p.34). Therefore, this chapter focuses on the possibilities of archetypal significance emerging from the previous textual and broader semiotic analyses, as it moves the analysis into the area of the Jungian interpretive community.

Archetypes can be understood in many ways (McCurdy, 1991; Short, 1996-7), and a range of interpretations are possible from any archetypal material. In fact, training in GIM leads to an awareness of archetypes in many forms. It is not unusual to see archetypal patterns played out in the imagery of a single session or over a series of sessions. Such archetypes may relate to gods and goddesses, religious figures, or classic films or stories (for example, Dorothy from The Wizard of Oz).
The archetypal material may include a direct and stated connection between the imagery and the archetype, or be more veiled and be based on the nature of events and

interactions as relevant to the story and archetype. GIM therapists are trained to be aware of a great wealth of potentially archetypal material.

In view of this, the data of the current study was reviewed for archetypal material, with an expectation of seeing some new or different archetype emerge as relevant to cardiac surgery and its recovery. It came as a great surprise to the researcher to see the Hero's journey archetype emerge from the thematic material, given that this archetype had usually only been applied to deep emotional (not physical) problems, and had been seen to operate at an abstract rather than a concrete level. Suddenly, the focus reversed, and emotional "wounding" was seen as resulting from the literal physical suffering related to cardiac surgery and recovery. This then led to a more thorough exploration of the entire Hero's journey story, in the light of the emergent data from this study.

The nature of the hero's journey is described particularly succinctly by Pearson (1989).

> Heroes take journeys, confront dragons, and discover the treasure of their true selves. Although they may feel very alone during the quest, at its end their reward is a sense of community: with themselves, with other people, and with the earth (Pearson, 1989, p.1).

The Hero's journey archetype has previously been noted to occur in GIM therapy, based on clinical practice and has been reported briefly in the GIM literature (Clark, 1995). However, such a consideration has only occurred in regard to emotional tasks and inner development. The hero's journey archetype has not been discussed at all in GIM literature with regard to surmounting literal physical problems. Therefore, prior to this study, it was not anticipated that the hero's journey archetype would play a significant role. However, from a "post hoc" point of view, such an interpretive pattern maps clearly over the constellation of grand themes, as will be shown in further discussion. The emergent Hero's journey archetype from this study especially referred to the physical side of confronting physical pain and difficulties, together with the associated uncertainties of heart disease and the life-threat of possible recurrence of acute episodes, in turn finally finding a way to build new insights and understandings and overcome this health situation. It is interesting to note that further evidence of the Hero's journey archetype related to physical problems and rehabilitation has been found in other healthcare fields (Halstead, 2000; Noble, 1990). Such examples demonstrates the appropriateness of the current study's innovative interpretation of the Hero's journey

into physical healthcare in the clinical situation, based on the use of the Bonny Method of Guided Imagery and Music (GIM).

10.1 Hero's journey vs emergent grand themes

This section commences by re-examining the emergent grand themes, as discussed in previous chapters, in the light of their contribution to the archetype of the hero and the stages of the Hero's journey.

The hero archetype is fundamentally about meeting a problem and changing as a result of it, and may follow the stages of responding to the call (of change, new experience), of feeling hurt and being challenged to change (letting go of the old), of seeing self/life differently, and of taking these new learnings into the world, to be applied to one's life and to other people (Campbell, 1968; Johnson, 1974).

The process of the Hero's journey, and its proposed relationship to emergent grand themes in the current study, is summarized in Table 10-1.

Table 10-1

Summary of stages of the hero's journey, as related to emergent grand themes in the current research project

Grand themes (emergent from current research)	Stage of Hero's journey (based on Campbell, 1968; Johnson, 1974)
Looking through the frame	Call to adventure Crossing the threshold
Feeling the impact	Woundedness
Spiralling into the unexpected	Tests and challenges
Sublime plateau	Apotheosis and reward
Rehearsing new steps	Returning to the world

As noted in Table 10-1, the Hero prepares for the journey, which includes the call to action. This includes recalling the past and life review, such as is evident in the Grand Theme 1, "Looking through the frame". This provides grist for personal development

and in fact setting the scene for further action. In this sense, it is the preparation for the hero's journey. The call to action also occurs as a response to heart disease and imminent surgery and the changes which this embodies. Following this, the hero has to confront physical and emotional woundedness, such as may be evident in Grand Theme 2, "Feeling the impact", which may include the actual cut to the body in bypass surgery and its emotional and physical effects. The Hero faces severe fears and threats which test and challenge, as may be evidenced in Grand Theme 3, "Spiralling into the unexpected". The Hero also experiences internal change and finds a reward, as may be evidenced in Grand Theme 4, "Sublime plateau", and this may appear as physical change such as deep relaxation and emotional appreciation of beauty and the divine. The hero is able to bring the reward back with him as he returns to his world, from whence he started out, as may be evidenced by Grand Theme 5, "Rehearsing new steps", which reintegrates current health experiences. In fact, the sense of trying again and rehearsal appears to complete and epitomize the entire hero's task – to leave an old way or an old life behind to face challenges, and find a new way of being, existence and functioning, and thence incorporate this into his old life in a new way. The further Grand Theme, "Sounding the changes", generated in relationship to the music, suggests an overall trajectory of increasing awareness, interaction and communication via reported responses to the music, which follows alongside and supports the Hero's journey.

10.2 Stages of the Hero's journey

Each of the stages of the hero's journey, as outlined in Table 10-1, will now be examined in detail, exploring how it was manifested in this research project via the themes, grand themes and further intertextual (semiotic) information.

10.2-1 Call to adventure/Crossing the threshold

As the hero's journey begins, there is a prelude which involves the "setting of the stage" looking around, an assessment, of asking the apparent question, "where am I?" This can involve recalling the past, and life review, which in itself provides further grist for personal development. In doing so, it allows for an evaluation of what is good, meaningful and important in life. As Campbell describes it, the prelude to the hero's journey carries with it the beginnings of change. "The familiar life horizon has been outgrown; the old concepts, ideals, and emotional patterns no longer fit; the time for the

passing of a threshold is at hand" (Campbell, 1968, p. 51). This sense of standing at the threshold is the preparation for the hero's journey, and sets the scene for further action, which moves towards a call to adventure, where suddenly everything begins to change.

> This first stage of the mythological journey – which we have designated the "call to adventure" – signifies that destiny has summoned the hero and transferred his spiritual center of gravity from within the pale of his society to a zone unknown (Campbell, 1968, p.58).

The call to adventure challenges the hero to change with the onset of difficulty. In the case of the participants in the current study, this occurred in the form of the medical diagnosis of blockages and the need for surgery, most likely following the earlier challenge of diagnosis of heart disease and related tests.

In the current research project this initial stage of the hero's journey was supported in analysis by Grand Theme 1, "Looking through the frame". As we recall, "Looking through the frame" is about a gaze in a particular direction, suggesting observation and attention to what is really there, in front of the one who is looking. It provides a foundation from which to move forward, conveying a sense of how I see the world and my place within it. A frame adds definition, providing a sense of foreground and background and highlighting what is important.

The first stage of the hero's journey is supported in even more detail by constituent themes. "Being there" and "familiar scenario" provide a strong sense of wanting to identify where the participant is, from a favourite Australian bush track to an exotic overseas location, and of finding a sense of familiarity. For example, finding the pathway indicates a sense of a forward direction. The constituent theme of "standing back" provides a sense of taking stock, of standing back to review and assess the situation, prior to engaging in direct interaction, and this is also a necessary part of the commencement of the hero's journey. And finally, the sense of comparison with previous (existing) knowledge in the theme of "being normal" begins to allow for the possibility of change in the future, as the threshold begins to appear.

How the hero responds to the "call to adventure" and crosses this threshold into the new "adventure", as related to cardiac surgery, is further suggested by what the patients tell us now, as they reflect on the process. For each person, the timing and story is different, based on individual variations of their circumstances and their reactions to

them, however they commonly recognize the need for change in their lives as this threshold is approached.

For example, Participant 1 highlights the shock of the diagnosis and the subsequent surgery, given that she was feeling well up to that point.

> But I wasn't sick. I'd been doing things right up until - I've always had blood pressure, and I've always had blood pressure tablets. Since I had the first baby really. The tablets have always controlled it, and it just got out of control... [Doctor] said, "I don't like that, it shouldn't be like that, and then like that", he said "I think you should go straight to a cardiologist". He rang [name of cardiologist] and I got a cab straight to [cardiologist]. And he didn't like it either. He said, "I think I would prefer to work this from hospital", and so I said, "I'll go home and pack a bag". And he said, "No you won't, my wife will put you in the car and drive you straight to [the hospital]". So his wife drove me up. They did a - spent 24 hours getting it stable, and once it settled down it was really good, and they did the angiogram, and found four blockages. And he brought the surgeon down and he said, "I'll operate next Wednesday". So I didn't really have time, I had 5 days. I went home for 5 days. So it was a sort of mental shock to the system. I mean, I did get a bit upset at first, when he first said, "there's four blockages", I had a bit of a weep, but that was the only time (Pat1-1, Investigative Discussion).

And Participant 4 talks of the frustration and anxiety before his operation, at the same time suggesting an additional role for music and relaxation.

> *So, were you then rushed into surgery quite quickly?* No, I was waiting for 7 weeks, because the surgeon was on holidays for two weeks, then he came back, then he had to go away for another week, it was very, very important to him to go away. This is what I've been told by him. And everything was the lie, you know. *Was that frustrating to have to wait?* It was terrible! Because one morning I really was in pain, when I was doing my walk, and I got fed-up, you know, and I picked up the phone and I had a talk with the cardiologist. He didn't like it. And I said to him, "look, you told me when I am in trouble, to give you a ring, while I am waiting for the surgery. So there is no need for you to get upset. If you want me to get a check-up and go somewhere else, no worries. And then he got in touch with the surgeon. I don't like to mention names. *No, of course, You don't need to mention names.* And he said to me, "[name of Participant 4], I'll do you up in two weeks". *Yes.* And he done me up 4 days later (Pat4-1, Investigative Discussion).

> *But as a preparation, [music and relaxation] would have been useful…* That's right, that's right. Because if you would have put these things into my head before the operation, you got me trained. *But do you think you would have been ready for it then? Do you think you would have been open to it then?* Oh yes! I needed that. I really needed that. That waiting time, you know, for you to be operated [on], could be 5, 6,7, 10 weeks. 3 weeks, 3 months, I don't know. This is where you suffer, Alison. Not after the operation. *I just wondered to what extent some people, and I mean, who knows in your case, but I wonder to what*

> *extent people would be so worried that it would be so hard for them to relax.* Oh my God, I've seen them! *Yes. And at a certain point you can be so worried that you just <u>can't</u> relax. But it would be worth the try, I agree.* Yes. Alison, it depends, from what you are going to go through. If you go for an appendix, you still worry, but you wouldn't worry the same as if you're going to have a major operation. It's not the same thing, follow me? *Right.* Or you're going to do your bump up, because something happened to your bump. Alright, it's not the same thing that something happened to your heart. *Right.* It is a tremendous amount of difference. And you need that help. You need somebody, you know, to put you back, or put you back somewhere, to feel a bit secure. And that's missing, Alison. *Yes, yes.* And you suffer. And then you got the other worries, of your family, because they're the worrying type, and you can see them, you know, struggling. And you don't know how to relax yourself, to make them relax as well! (Pat4-6, Investigative Discussion).

Participant 3 had imagery of the Southern Highlands (geographical area) and then says afterwards that that's where he would have been at the time of the operation (Pat3-1) thereby juxtapositioning his call to adventure with his usual activities at that time of year and emphasizing it through his imagery. His further comments at the beginning of the next GIM session emphasize this.

> *It was interesting what you said as we walked out last time, that you usually have a holiday this time of year in the Southern Highlands?* Yes, yes. *And did I understand right, that just at that time, that you would have been holidaying, was when you were in hospital with the operation.* Yes, exactly right. *Oh, well, that's not much fun, is it!* And that's probably the reason why I chose the spot I did do. *It may well be. Because you were hoping to have gone there.* Yes, in the back of my mind. You know, that spot, oh, I like being up there. *Well, it was obviously a relaxing place for you* (Pat3-2, Investigative Discussion).

> Yes. Probably because, you see, it was in the back of my mind, being up the Southern Highlands. It was in the back of my mind. It was like, at this time of year, I'd normally be up there. Or was up there. Right. And they're the sort of things I would have been doing. So it probably did make it easier for me to go there (Pat3-2, Investigative Discussion).

How participants have responded to the impending challenge of heart surgery once they knew that it was inevitable is also significant, and will be further discussed under "Tests and Challenges" (Section 10.2-3).

10.2-2 Woundedness

As he commences on the hero's journey, the archetypal hero may experience a sense of woundedness. A manifestation of this mythological story is particularly typified in the

legend of the Holy Grail, which includes the wounded Fisher King (Johnson, 1974). We are told, of the Fisher King, that:

> His wounds are so severe that he cannot live, yet he is incapable of dying. He groans, he cries out, he suffers all of the time. In fact, the whole land is in desolation. The cattle do not reproduce, the crops won't grow, knights are killed, children are orphaned, maidens weep, there is mourning everywhere – all because the Fisher King is wounded (Johnson, 1974, p.8).

Other examples of the wounding of the hero are present in many initiation legends (see Campbell, 1968, for a range of examples). In the current study, this stage of the hero's journey was supported by Grand Theme 2, "Feeling the impact". This theme related to a direct impact on the body, and carried a sense of corporality, with direct and deep feelings and responses. The sense of impact, with its implied suddenness and deep effect on existence, related primarily to the bypass surgery itself, whereby their body was physical cut, stretched, sewn up, and experienced responses such as pain. Participants had also experienced a range of other impacts prior to the cardiac bypass surgery, such as the diagnosis of heart disease, the need for surgery, and pre-existing conditions causing chronic pain.

This second stage of the hero's journey is supported in detail by constituent themes. The hero is constrained by "physical limits", restricting the easy flow of activity, walking, playing golf, and running around with grandchildren, and as such may constitute a "wound" to normal physical abilities. The constituent themes of "discomfort" and "feeling hurt" point directly to both the results of the physical wound and the emotional effects of such an impact. The sense of damage and the need for restoration further supports the sense of woundedness related to the hero, which is a spur towards further development via the hero's journey archetype.

Currently there is no way to undertake routine cardiac bypass surgery without creating a wound, given that access to the heart is required. This woundedness can be frightening for the patient to contemplate, and likewise potentially creates ongoing discomfort. The person is literally wounded, in terms of the cut (sternotomy) and their circumstances of (temporarily) reduced health and physical abilities. This clearly takes an emotional toll. This surgery itself may be experienced negatively as a threat on life as well as positively in terms of its life-giving forces.

The ongoing pain and discomfort becomes a reminder of trauma, of woundedness, of being less than fully well and normal. This woundedness has been a circumstance where it was for their own good, not a negative or destructive type of trauma, which sets it apart from many other instances of traumatic stress. But all the same, it has been a severe stress. It seems to be a situation where there is the potential for overwhelming pain, stress and lack of personal control in the treatment and recovery process.

The traumatic and stressful nature of cardiac surgery is highlighted by Denber (1995).

> Cardiac surgery can be considered a major stress…There is a basic fear inherent in cardiac surgery. The uninterrupted heartbeat is accepted universally as evidence of life, and its cessation means death. Cardiac surgery disconnects patients from the past and places them in both an inexistent present and in a future without meaning until they reawake. Some patients believe they are dead during cardiac surgery, that their heart has been removed elsewhere to be operated on and repaired, or that their brain has been deprived of oxygen (Denber, 1995, p.160).

Interestingly, one participant in the study later reports deliberately "blocking" memory-imagery related to the surgery with regard to being admitted to hospital, and instead escapes to Disneyland in his imagery (see research notes, Pat3, 27/12/98). Such apparent denial is typical of the cycles of intrusion and denial commonly seen with post-traumatic stress problems (Johnson, 1987). Participants frequently talked about being brought face-to-face with their own mortality, with regard to the cardiac surgery, related to the fact that their heart was actually stopped on the operating table. So indeed it could be considered a situation of imminent death in unpredictable circumstances, which carried traumatic overtones.

In addition, issues of existence, "I almost died", "why me?" also connected to questions of "will it happen again?" This had underlying messages of "am I safe?", "can I trust the future", which are also common responses of people with post-traumatic stress disorders.

> Well I was asking the cardiologist, I said, "why?", "why me?", you know. I've been exercising, my diet was perfect, no blood pressure, no cholesterol, no this, no that - "Why?", "Why?" "Why did it happen to me?"… But, you know, you don't have a solid foundation for a proper answer, follow me? It's missing. It isn't there. You're standing with one foot up, Alison. *There's no clear reason.* No. You're always standing with one foot up. Not with your two feet down. And it's a pain, Alison. Because it's in your head that, you know, it could

> happen tomorrow again, or next year, or the year after. And you got to start all over again, you know (Pat4-1, Investigative Discussion).

Interestingly, cardiac staff have commented in informal discussion that patients commonly overestimate the rate of recurrence of problems, and this may possibly be related to feelings of woundedness. Woundedness often happens within the myth and likewise emotionally at the time of major change and/or challenge, and appears to be an indicator of such a change. In order to overcome the sense of seeing oneself as incomplete or inadequate, a way has to be found by the hero to incorporate the sense of woundedness into the wholeness of their self.

Following this, in particular Participant 2 finds a way to incorporate the operation of implanting a pig valve into her body by recognizing its effects in terms of known characters such as "Babe" and "Miss Piggy", utilizing a sense of fun to promote a change in physical conceptualization of her body and her experiences of cardiac surgery. Therefore, although wounded, this participant at this point has incorporated this woundedness into her new self, with a subsequently more positive view.

10.2-3 Tests and challenges

The sense of woundedness in the hero's journey may be related to, or closely followed by, the tests and challenges typically experienced by the hero.

> Once having traversed the threshold, the hero moves in a dream landscape of curiously fluid, ambiguous forms, where he must survive a succession of trials. This is a favorite phase of the myth-adventure. It has produced a world literature of miraculous tests and ordeals (Campbell, 1968, p.97).

In facing texts and challenges, the hero also faces severe fear and threat. This may be seen as the shadow side, the hidden challenges, the things often thought of as "bad' or "negative". This is part of the hero's challenge, of facing difficulties, of coping with the ominous and the threatening. The hero's challenge for the participants in the current study may come from fear of possible death and dismemberment in the process of the surgery. This is a total threat to the being of the person, where the heart is literally stopped with its subsequent uncertain future. There is additionally the obvious threat of survival of heart disease itself.

This third stage of the hero's journey was supported by Grand Theme 3, "Spiralling into the unexpected". As already noted, this theme is about moving forward, into difficult or challenging areas. At times this spiral carried a sense of being almost out of control, even dizzying, confusing, and disorientating. The strong sense of forward movement suggested no escape, no pulling back, and a need to confront new experiences. For participants in this study, unexpectedly severe issues of pure existence, and how to manage in very unfamiliar territory were evident. This included experiences such as being in the hospital and relating to their body and their feelings. Clinically, coping with fear and anxiety was a major issue requiring an individual response.

The sense of being "Out of joint" related to a sense of confusion and disorientation in the midst of challenging circumstances, whilst an "Uphill battle" encapsulated the high level of difficulty felt to be experienced by the participant. "All to pieces" represented the feeling of fragmentation also typically experienced by the hero as he faces tests and trials, and the fear inherent in an "Uncertain future" is in many ways the supreme test of the hero – how to survive in unfamiliar territory and under unfamiliar circumstances.

For Participant 5, one of his greatest challenges was a fear of physical immobility, which he responded to by an urge for movement when he was in pain. He clearly outlined the role of this inner fear in his actions, describing it as part of another "I', giving a clear sense of parallel to the Jungian concept of the "shadow".

> Well, er, when I am in pain, I like to walk. Because if I don't walk, I feel worse. *Right.* It's that's one of the things that I understand, and the doctors understand. *It sort of "walks it off" does it?* Yes. That I guess is some kind of distraction, or is my other "I" or my other half, that is afraid not to move, because of the pain. I have to walk. *So, you walk to fight that fear.* That's right. To see that I can move my leg. That must be the reason. I'm not sure, but it looks like it is that reason. Because when the pain becomes worse, I have to walk. Always that's the reason. The fear not to be able to walk, or to move my leg. Or whatever it is (Pat5-4, Cumulative Discussion).

The fundamental way that this pain and fear challenge his natural feeling of comfortable movement, turning it into a seemingly almost insurmountable challenge, is conveyed by the participant very succinctly, and at the same time indicates his new insights into his actions and the reasons for it. Here we see the real process towards individuation in action: becoming more aware of the shadow side, and incorporating the wisdom it brings into everyday existence.

Participants may not always respond in a heroic way to threats or challenges, and may choose not to embrace such tasks. One example of this may involve apparent avoidance behaviours in the reported imagery, for example, the manner in which Participant 2 frequently had disappearing, fuzzy, or fading imagery, forming part of the theme, "All to pieces".

It is also important to note that this participant was the only one who had had previous bypass surgery, and then a recent valve replacement, and to what extent this previous (possibly emotionally unresolved?) surgery could have been a factor in this case is debatable. Nevertheless, over the series of six GIM therapy sessions, the participant was encouraged to engage with images as much as possible and to persevere through fuzzy/fading images even when related to physical and emotional feelings. Substantial changes occurred during the course of the therapy demonstrating that Participant 2 was indeed able to develop new coping strategies. In doing so, she was able to change the initial avoidance in order to respond to the call and the challenges of the Hero's journey. In many ways, this is what therapy is really all about: loosening the bounds of a routine pattern or way of reacting/interacting, in order for a new, more adaptive behaviour to occur. In turn, this promotes growth and development of the person, resulting from the challenge to change as part of the Hero's journey.

10.2-4 Apotheosis and reward

In the fourth stage, following a range of tests and challenges which have forced him to grow and develop, the hero has a fundamental transformation of perception and discovers his reward. Such a reward may appear in many forms.

As Campbell notes,

> The agony of breaking through personal limitations is the agony of spiritual growth. Art, literature, myth and cult, philosophy, and ascetic disciplines are instruments to help the individual past his limiting horizons into spheres of ever-expanding realization… Finally, the mind breaks the bounding sphere of the cosmos to a realization transcending all experiences of form – all symbolizations, all divinities: a realization of the ineluctable void (Campbell, 1968, p.190).

In the hero's journey archetype, the reward is usually some sort of "boon", something that will help him along in some way. As Campbell notes, "the boon is simply a symbol

of life energy stepped down to the requirements of a certain specific case" (Campbell, 1968, p.189).

The participants recovering from cardiac surgery in the current study needed to find (or claim) a "health boon", which could be felt and enjoyed both emotionally and physically. The obvious "boon" from the heart surgery was literally increased life, however in the context of the GIM sessions, participants seemed to be searching for and claiming an additional boon, in the form of a deeper sense of relaxed enjoyment, and a sense of things being "right". This included a sense of wholeness, of deep enjoyment, of relief from pain and suffering, and of exploring "good feelings". As part of the individuation process, it was also seen as a recognition of a natural flow and balance between positive and negative forces.

This stage of the hero's journey was supported by Grand Theme 4, "Sublime plateau". As already noted, this theme focuses on a transcendent sense of awe, suggesting being above or overcoming something, and the possibility of a new perspective to be gained. A plateau implies having reached a particular level of experience, where it is even and comfortable in terrain, where there is time and space to rest. In view of a new perspective, things that seemed big and problematical may now seem smaller, less important in comparison, and therefore less overwhelming.

The peaceful, calm enjoyment of relaxation was a very important "reward" for these participants, many of whom expressed difficulties in relaxing, and indeed seemed to require a heroic effort in order to overcome pre-existing anxieties and relax fully.

Relaxation and anxiety reduction were suggested in inner experiences of "Feeling the flow", "Inner light" and deeply "Enjoying the moment", with additional related feelings of increased health and vigour.

Thus, the "health boon" was both emotional and physical, and embraced feelings of well-being and positive self-image. It was the culmination of efforts to deal with and resolve the woundedness, tests and challenges of the heroic journey.

> This was another happy experience. I mean, all these sessions, it's strange how you want to recall happier things, rather than sombre or bad things that happen to you. It's – it seems to be easier to recall happier things than it is to recall nasty things. *I guess you've had your share of the not-so-good things too* -Well,

> I think everybody has. Well, er, you can recall them if need be. But why not, if you're going to recall something, recall something nice. It makes you feel good too! (Pat3-6 Investigative Discussion).

> Well, I wasn't feeling myself, in simple words. I wasn't feeling, you know 3 or 4 weeks ago, I wasn't feeling myself, - *You weren't feeling yourself* - Yes, I was felt like - I felt tired, I felt a bit low, you know. I wasn't feeling myself, like I am now. And I put your way of relaxing to be mine, and the results were good. The results were good! *Right.* I mean, I've done what we were doing here. And I've done it as a test, if it works or not, even without seeing you. *Right, so you've tried it at home?* I tried it, 2 times, and it worked! *Yes? Good!* Oh God yes, it worked, honestly! Honestly, it did work! *Yes.* But because I'm so busy all day, you know, I don't get the chance to feel, you know, the same thing again. So I have to do it. But if it comes, I know how to relax. *Yes.* It's the same thing, you know, when you do exercises, you're taking big breaths. With so much oxygen in it. The same thing! *Yes, yes.* So to me, it was a good experience, and I think I have benefited from it, Alison. And if I go, if I feel low again or anything happens to me, I've got something to face it. *Right. So you've got a tool that you can use now.* That's right! (Pat4-6, Investigative Discussion).

> *So, if we turn our attention to thinking of these last five sessions, um, is there anything you want to comment about that?*…Oh, I tell you it has been a very, very good experience for me, because I experienced something that I haven't experienced before. I learned something new, that I guess I can use it. I don't know for how long. But I can use it. *So, when you say you learnt something new, do you mean about the relaxation, or - ?* That's right. The relaxation imaginary with the music. I haven't had any kind of experience similar to that before… And, um, all the pains I think related to the surgery are gone. The situation have changed, after 4 months. The operation. And all these things together have made the change that- er- I feel better about myself. I don't feel depressed. I enjoy my life, I don't, I cannot do what I want to do, but that is because maybe I want to do too much. And I know, I - *We were discussing that last time. That you want to do more than -. You feel the energy, but you want to do more than perhaps your legs can manage.* That's right. I have to control that. I have to slow down. And I've been thinking, you know, very seriously that to slow down. Because, I said, it's no point to being in a hurry. Everybody's in a hurry. When, of course, to my belief, there is an eternity waiting for me! (Pat5-6, Cumulative discussion).

10.2-5 Returning to the world

At the final stage of the Hero's journey, and following the gaining of the reward or "boon", the hero then takes this reward back to the real world, to the life from whence he was originally called in order to pursue the hero's adventure. As Campbell notes,

> The final work is that of the return. If the powers have blessed the hero, he now sets forth under their protection… At the return threshold the transcendental

> powers must remain behind; the hero re-emerges from the kingdom of dread…The boon that he brings restores the world (Campbell, 1968, p.246).

In conjunction with this process of returning with the boon, there is a time for reassessment of the hero's "world". This encompasses what is important, what is possible, and how the hero's experiences may be integrated and incorporated into the old life. For the participants in the current study, it was particularly important to integrate their new, post-surgical feelings and abilities with their "old" self. In doing so, the differences of "now" and how that feels, compared to "before" or at the beginning of the hero's journey, were considered. This urge to incorporate the new self, new abilities, and a working towards becoming free and integrated to go on with life and reconnect with new experiences was fundamentally important as part of the rehabilitation process.

This final stage of the hero's journey was supported by Grand Theme 5 "Rehearsing new steps". As previously noted, this theme is about practicing and trying out something new, of developing, improving and training via rehearsal. It also involves stepping out in a new direction, an active sense of being out and about, rather than drawing into oneself, and of sharing with others.

"Anticipating movement" embodied a positive attitude and approach to movement and exercise, which is so essential to the cardiac rehabilitation effort, in conjunction with "Engaging in activity", which was the culmination of implementing such plans into physical activity. This is essential to the hero's journey as the person emerges from the challenging physical and emotional effects of cardiac surgery and recommences their newly invigorated life (via revascularization), converting their desire for physical movement into active imagery. Participants also reflected on these "New experiences", and incorporated them into improving themself and their own health, and into beginning "Sharing with others", thereby taking their new learnings and insights thoroughly into "the world" as their final transition in completing the hero's journey archetype.

10.2-6 Summary and implications

This last stage of the hero's journey, with its sense of trying again and rehearsal, in fact epitomizes and embodies the entire hero's task – to leave an old way or an old life behind, and find a new way of being, existence and functioning, forming a composite as

it is integrated into his original life. We have seen that the hero must typically respond to a call to change and surmount a series of obstacles and unexpected situations in order to grow, develop and become whole (Campbell, 1968).

In fact, this myth of the Hero's journey can be applied very successfully to assist understanding of the process of the person's recovery from life-threatening and stressful health problem, to continue to try again, day by day, thereby addressing both physical and emotional problems (for example, inertia, anxiety and depression).

Broadly, we may consider that the hero archetype/myth as applied in this current thesis links inward growth with outward action, and as such mobilizes both physical and emotional aspects of recovery. In many ways, then, it can be seen as a manifestation of psychic activity into physical recovery.

In doing so, participants who have undergone heart surgery have been called on to apotheosis-ize, to change their world view and view of themselves. This has brought new insight and understanding of what life is really about and how they are going to live it. They have then found ways to incorporate this knowledge and the rewards it brings into going about their everyday life.

10.3 Music and archetype

In the current study, the music has provided a forum to support the unfolding of archetypal imagery, via the Bonny Method of Guided Imagery and Music (GIM). The Grand Theme "Sounding the changes" suggested that the music may assist in tracking the changes experienced by these participants recovering from cardiac surgery. This theme notes how auditory perception and stimulation may function as a sounding board, which not only reflects and amplifies sound but also ensures a good foundation for looking at the unknown and exploring the depths, likewise expressing and defining important transitions in cultural life.

The hero often feels the pull of an external force, forming a catalyst which stimulates the need to change. In the current study, the music appeared to serve this purpose, being especially related to a sense of "Directing the action". The music also served to assist with "Evoking feelings", which is often an area of new and challenging experience in the hero's journey, as the hero learns to contend with feelings of all types.

The music also promoted the sense of integration with "Voicing together", which forms part of an important consolidation as the hero progresses through the journey. The sense of "Unfolding communication" via the music, also leads towards the sense of sharing with others, which in turn forms part of the return to the world, as the Hero's journey is completed.

10.3 Final comments

A Jungian analysis has brought out further meanings about the struggle towards and health and adaptation following cardiac bypass surgery. Much of Jungian therapy is based on teleological principles of forward growth and development, and on the naturally occurring tendency towards individuation, which is about exploring and integrating more of oneself in an ongoing manner. Participants in this study have shown this through the archetypal pattern of the hero's journey, a very potent myth which is common through many cultures and in many forms, and appears to fit well with the challenges and demands of cardiac bypass surgery. In doing so, they are responding to a call to change and develop, to incorporate change and new insights into their lives. Even when initially unable to meet the hero's challenge, in the course of the GIM treatment they were finally able to meet this challenge.

Looking to the broader cultural context of this study, we find that the concept of the hero is also strongly enshrined in Australian folklore (Davey & Seal, 1993). In fact, it is noted that "the tough, independent bushman pioneer is a recurring image in much of our folklore and is celebrated in a very large body of songs and poems" (Davey & Seal, 1993, p. 130). An example of this is shown in the classic poem by Henry Lawson, "Andy's gone with cattle".

Andy's gone with cattle

Our Andy's gone with cattle now –
Our hearts are out of order –
With drought he's gone to battle now
Across the Queensland border.

He's left us in dejection now;
Our thoughts with him are roving;
It's dull on this selection now,
Since Andy went a-droving

Who now shall wear the cheerful face
In times when things are slackest?
And who shall whistle round the place
When Fortune frowns her blackest?

Oh, who shall cheek the Squatter now
When he comes round us snarling?
His tongue is growing hotter now
Since Andy crossed the Darling.

Oh, may the showers in torrents fall,
And all the tanks run over;
And may the grass grow green and tall
In pathways of the drover;

And may good angels send the rain
On desert stretches sandy;
And when the summer comes again
God grant 'twill bring us Andy.
(Lawson, 1918/1984, p.44-45)

In this classic and well-known Australian poem, we note the beginning of the hero's journey into unknown territory, the pain of loss and uncomfortable emotions, the tests and challenges of drought, boredom, fear and vulnerability, and a developing sense of anticipation of positive reward, arriving at its completion with an improved view of the future and what this may bring. In many ways, this poem may be seen to encapsulate the hero's journey, as has already been discussed based on both analysis of participant material and Jungian understandings.

We may equally re-write this poem (with apologies to Lawson), as referring to recovery from heart surgery.

<u>Andy's gone to town</u>

Our Andy's health is rattled now
His heart is out of order –
Disease has made a battle now
Across the healthcare border.

It's left him in dejection now;
His body's not like normal
Under the knife and in pain now,
Since surgery in Crookwell.

Who now shall wear the cheerful face
In times when things are slackest?
And who shall whistle round the place
When Fortune frowns her blackest?

Oh, may the peaceful feelings flow,
And relaxation ponder;
And may the healing process know
Recov'ry all the fonder;

Then may good angels send the "boon"
To cope with life's exchanges
And when the future comes again
God grant 'twill bring great changes!

(Adaptation of Lawson, 1918/1984, p.44-45, by Alison Short)

Davey & Seal (1993) sum up the role of the hero and its place in Australian folklore in terms of the sense of battle:

> What is essential for the attainment of folk hero status is not success but struggle. It is the spectacle of men or women battling against what they know to be the overwhelming power of fate or authority that generates the folklore about most heroes and heroines…the individual ultimately wins by displaying the courage to resist them (Davey & Seal, 1993, p.131).

This, then, is the task of the patient recovering from bypass surgery – to battle against the overwhelming nature of what has happened to them, due to heart disease and subsequent surgery, in order to discover their own inner courage and find a new way of surviving both physically and emotionally amidst, and in spite of, their circumstances and life situation.

CHAPTER 11. RESEARCH OVERVIEW: RESULTS, DISCUSSION AND IMPLICATIONS

11.1 Overview

In this research study, analysis of results reflected a three-stage process. Thematic analysis of reported imagery derived themes and grand themes, to access meanings conveyed by the participant, this being the initial thematic analysis stage. At a second stage, this project used an intertextual (semiotic) analysis to understand how the person was using imagery and related texts to convey meanings about their adjustment process, especially using intertextuality to draw links between emotional and physical phenomena. And at a third stage, this project used a Jungian perspective to understand how such thematic and textual material contributed to interpretive patterns (known as archetypes), indicating how the participant was currently approaching adjustment and reformulation of meanings in the light of their changed circumstances following cardiac surgery.

Participants used a wide range of meaningful personal, cultural and archetypal texts to convey information about their responses to their health care situation. Clinical change in the rehabilitative process was suggested by grand themes comprising “Looking through the frame”, “Feeling the impact”, “Spiralling into the unexpected”, “Sublime plateau”, and “Rehearsing new steps”, and the further music-related grand theme of “Sounding the changes”. Intertextual expansion indicated the use of a wide range of texts, shedding further light on meanings for the participants as related to their health care situation. Examples of this included the concept of “unzipping” in both physical and emotional terms, and the way that a song, “Mame”, became related to the film, “Babe”, conveying further information about the physical rehabilitation process.

The archetype of the Hero’s journey emerged as a major archetypal pattern, which was fundamentally about meeting a problem and changing as a result of it. The use of the archetype in this context linked inward growth with outward action, and as such mobilized both physical and emotional aspects of recovery. The Hero experiences his life as it is and prepares for the journey. The patient recalls the past and enters into life review through the Grand Theme 1, “Looking through the frame”, setting the scene for

personal development and further action. The Hero is called to action. The patient receives knowledge of their disease, is called to imminent surgery and is told that changes must be made to their life and lifestyle. The Hero confronts physical and emotional woundedness. The patient's body is cut during bypass surgery and its effects ensue, as shown by Grand Theme 2, "Feeling the impact". The Hero faces severe fears and threats which test and challenge. The patient faces unknown territory, anxiety and confusion, as shown by Grand Theme 3, "Spiralling into the unexpected". The Hero experiences positive internal change and finds a reward. The patient experiences physical change such as deep relaxation and emotional appreciation of beauty and the divine, as shown by Grand Theme 4, "Sublime plateau". The Hero brings back the reward and returns to the world. The patient integrates physical and lifestyle change into their current health experience, as shown by Grand Theme 5, "Rehearsing new steps". The sense of trying again and rehearsal completes and epitomize the entire Hero's task – to leave an old way or an old life behind in order to face challenges and ultimately find a new way of being, incorporating old experiences into a new sense of life and well-being. The patient's rehabilitation process incorporates changes to body and lifestyle in an ongoing attempt to live with cardiac disease. Music assists in an overall trajectory of increasing awareness, interaction and communication, as shown by the further Grand Theme, "Sounding the changes". Across the research project, patients collectively created and describe their own heroic journeys, as they moved through the rehabilitative process, using the therapeutic technique of GIM as a vehicle to track physical and emotional change.

11.2 Exploding the focus

This qualitative, narrative research set out to investigate how meanings arising from adjustment to a health crisis such as cardiac surgery were depicted in music-supported imagery. More specifically, it sought to find out 1) how patients may use the imagery to depict their experience of themselves and their body, 2) how this sense of themselves can change, to adapt to their new circumstances post-surgery, 3) how they respond emotionally to these views of themselves and their circumstances, and 4) how the music may contribute to the depiction of the emotional and physical meanings, underscoring the entire rehabilitative process. These questions and the way that the current research project shed light on each of these areas will now be explored in further detail.

11.2-1 Depicting experiences via imagery

Despite the fact that participants were new to GIM, were often demonstrating considerable anxiety, and were entering the study as a "novelty" trial participant rather than an intense desire for therapy or music therapy, the imagery produced by participants in this study was generally strong and deep, and carried a great wealth of material. This is in direct contrast to clients who may in other circumstances use the imagery to stall the process of personal growth and change, and show considerable resistance to the GIM process (Ventre, 1990). Even when imagery may have seemed superficially simple and pedestrian, analysis resulting from the current study brought out a great wealth of information about how participants were feeling (both physically and emotionally), and the manner in which they were experiencing and coping with the recovery process.

It is often thought by people new to the area that imagery must be of a "fantasy" nature or be of transcendent character in some way for it to be effective. This is not necessarily the case. In fact, participants in this study frequently used simple imagery of concrete and familiar settings or processes, such as a "travelogue" within an ordinary narrative structure, to convey further meanings about their current experiences. Such imagery provided the participant with a sense of control and familiarity, but at the same time, this reported imagery had the scope and flexibility to access a range of meanings about the way the person was feeling, based on the very imagery produced and the experiences being felt and reported in the GIM setting. Even simple imagery such as a game of golf, remembering walking home after school, or lying on the beach carried a great wealth of meaning about their views of themselves, their health and their relationship to their body, as has been noted in previous chapters.

Due to its ability to adapt to and make use of such simple and seemingly pedestrian, concrete imagery for therapeutic benefit, the GIM technique formed a "user-friendly" modality for eliciting further information about what was happening for the person. This included meanings that would have been difficult to access via standard verbal means. This was further emphasized by the surprise that cardiac staff expressed when hearing about the ease with which participants produced imagery, including some

participants known and observed by staff to be very "concrete" in their thought processes. "Concreteness" was clearly no barrier to the imagery process!

The music clearly enhanced the process of generating imagery, and the manner in which it did so deserves further comment at this point. The application of the music is considered by GIM therapists to be part of the therapeutic milieu, which the client uses and responds to as relevant to their own inner process, based on Bonny's concept of the multi-layered function of the music (Bonny, 1989) and suggesting its role as a projective technique, perhaps like a Rorschach or Thematic Apperception test (Ackerman, Hilsenroth, Clemence, Weatherill & Fowler, 2001), thereby providing access to non-verbal or hidden material. In contrast, participants in this study frequently reported the music to be **directing** the imagery in some way. Recent studies suggest that the role of the music may have been underestimated or perhaps even misunderstood in its impact on the imagery process (Marr, 2000, 2001). An investigation of this discrepancy of musical impact on the imagery process, and its implications with regard to agency and locus of control, is well beyond the bounds of the current study, but clearly demands more extensive research into the relationship between the imagery and the music.

11.2-2 Undertaking change and adaptation

For therapy to be effective, change must occur in some way. In the rehabilitation process, this change occurs as related to increasing health and adaptation to current circumstances. The GIM technique promotes changes in imagery and the imagery process, which in turn may be translated into everyday life in some way via discussion or the images themselves.

For participants in the current research project, change was clearly evident in both imagery and surrounding discussion during the process of GIM therapy. Participants used the imagery to highlight changes, such as what they **could not** now do after the surgery (for example, swing a golf stick fully, or run and play with the grandchildren), or what they **could** now do (for example, enjoying playing golf without pain, or walk the physically strenuous Giant Staircase in the Blue Mountains).

Such changes in physical ability were also supported by increasing enjoyment of physical movement in the imagery, for example, walking, exercising, and imagining doing ballet, providing a comfortable feeling of physical movement and a sense of flow. This possibly provided the mind and body with a new set of normal sensations, after the physically invasive and initially debilitating effect of surgery or even pre-surgical limitations.

Emotional and cognitive changes were also evident, with Participant 4 in particular talking about changes to cognitive abilities and issues of uncertainty and personal confidence, both prior to and following surgery. Unexpectedly, participants also spontaneously used the music and imagery treatment to assist with pain management and the rehearsal of physical abilities in looking towards the future.

This study revealed the importance of the Hero's journey as an archetypal pattern used by cardiac patients to assist with the process of change and recovery from bypass surgery. This archetype mobilized inner strategies and insights to assist in facing difficult situations related to their health. This change, which is suggested to be a change from a victimic to an agentic life-plot (Polkinghorne, 1996), was achieved via the narrative process of GIM therapy.

The extended impetus of the GIM programme into everyday life was evident in 1) participants' plans to re-connect with musical activities, in 2) participants deliberately using music for relaxation and sleeping, and 3) participant's comments about having increased tools to address anxiety and pain if/when it should occur in the future. Thus, change extended beyond the GIM programme itself into enhancing the broader life context of participants.

11.2-3 Responding emotionally to circumstances

Emotional responses to physical circumstances are known to interact with and affect the healing process. The GIM technique encourages awareness of feelings and feeling states attached to images. For participants in this study, such emotional responses frequently occurred "unexpectedly" (from their point of view) and were seen to form part of the "tests and challenges" of the Hero's journey, as shown especially by the emotional discharge experienced by Participant 1. Challenges to the hero also took

place during the frustration and anxiety of waiting for surgery to occur (as noted particularly by Participant 4).

In fact, anxiety was reported frequently as an emotional response to the cardiac surgery, and an inability to relax was cited as a symptom requiring help in the GIM setting, particularly by Participants 4 and 5, and was addressed within the context of the GIM sessions. Encouraging participants to be involved in choices with regard to the relaxation techniques to be used was a very important aspect of the current study, empowering participants and promoting a successful experience, and in turn providing reinforcement such that they felt even more able to relax on subsequent attempts.

Anxiety and the emotional effects of the physical surgery are reflected in symptoms such as difficulties with sleeping patterns (Redeker, Mason, Wykpiaz & Glica, 1996). Relaxation is known to counter anxiety, most likely via the mechanism of the sympathetic and parasympathetic nervous systems. Consequently, promoting relaxation was an important therapeutic component of the rehabilitation process in this GIM research study. An improving ability to relax was increasingly reported as part of the music and imagery process and in post-music discussion. Some participants suggested that now they had an increasingly useful tool to approach anxiety-provoking situations, and some spontaneously used newly learned or reinforced skills of relaxation to assist with night-time sleeping problems. This was in stark contrast to the sense of failure initially mentioned by several of the participants in regard to approaching or achieving relaxation.

The series of GIM sessions provided a context in which to learn relaxation, individually tailored to the needs of each participant. Over the series of sessions, such relaxation was explored and reinforced such that the participants were able to absorb these techniques and apply them when necessary. Although not possible within the framework of the current study, it is suggested that perhaps just a small “maintenance” dose (perhaps a monthly relaxation group?) would potentially be helpful to these participants undergoing anxiety related to heart disease and its treatment.

11.2-4 Exploring the contribution of music

Music assists with evoking imagery in the GIM technique, as has already been noted (see Chapter1). In this study, it provided a context in which awareness and change was fostered and promoted. Specifically, it promoted a relaxed state, allowed imagery to occur, and encouraged its ongoing unfolding, allowing for a range of clinically relevant information to emerge.

As part of the GIM context, the music gave the focus for therapy to occur, promoting a non-threatening setting for these participants who had (almost all) not attended formal "therapy" before. In line with the general population, participants were most likely wary of psychology, psychiatry and psychotherapy, especially since they did not see themselves as having a particular psychological "problem". The use of music in therapy had a role as a user-friendly "screening" therapy, with the obvious potential to refer on to other members of the clinical team where necessary.

11.3 Contributions of this research

This study has examined the use of GIM in an actual health transition (recovery from cardiac surgery) to investigate how GIM may enhance the rehabilitation process and contribute to the clinical team, incorporating the viewpoints of both the practitioner and the patient into the research process. This research is innovative in many aspects, as will now be discussed.

Music therapy research in cardiac care is limited, and indeed music therapy positions in this area are rare, with children claiming more attention than adults. This study suggests benefits in helping patients use music therapy, in the form of GIM, to deal with physical and emotional effects of the surgery in the recovery process, thereby contributing to building up a body of knowledge about the way that music therapy in the form of GIM may assist in this field. In doing so, it sought to provide a rationale for the use of music, and of imagery, by cobbling together a broad range of literature in order to provide a firm foundation for the discipline and for this research project. Although a range of principles related to theory and practice have over the years been generated and absorbed by the established discipline of music therapy, and more recently the specialist area of Guided Imagery and Music, such material has largely been based around case

study reports, with some formal research also available. The current study has contributed additional systematic qualitative research to the literature base.

Approaching a clearly complicated and multifaceted topic, this project has developed innovative methodology, utilizing a research approach combining narrative and semiotics. In doing so, this project has developed new analysis tools to investigate the complicated interactions of music, imagery and text, and found ways of incorporating both imaginal and discussion material, as is generated in the GIM session. Basing research on the standard (largely unmodified) GIM session format, this study provides immediate links to standard GIM practice and to the clinical situation, thereby making the results easily understandable to practitioners and potentially applicable to a range of other situations.

In a broader sense, this study explored the nature and derivation of clinical understandings of how the patient and their productions are interpreted, and the manner in which such additional and creative texts, such as those related to music and imagery, may impact on further understandings of what is happening in clinical care. Longstanding applications of semiotics to medical care, even as far back as the Greeks, have led to seeking to understand health care implications that may be derived from a range of media, and the process whereby the practitioner "juggles" a range of information from various sources (or "texts") may be more easily understood and investigated using semiotic principles of intertextuality. This is clearly an innovative approach to such clinical understanding.

The analysis procedure used in this study is also new to the GIM field, focusing particularly on the text generated by the client, rather than the interpretation and belief system of the practitioner. This study has found a new way to distill information from the client's text, based on the grouping of themes and the formation of constituent themes and grand themes, showing new aspects of the phenomena of how people relate to and utilize the GIM setting. The voices of the patients, carefully recorded and transcribed, speak about both therapeutic and musical aspects of their experience of music therapy. It is no longer sufficient to hear only the therapist's trained music-and-therapeutic assessment of what is going on, there is also a need to understand the experience for the patient, to check if the music therapy is doing what we want it to do

and to perhaps be influenced to change practice as the result of this feedback. After all, clinical therapy is about meeting the needs of the patients and helping them grow, develop, change -whatever the creative arts or verbal modality may be - and so it is encumbent upon the therapist to receive information about the patient's experience, so that the best possible treatment may be provided.

This research project has highlighted an interesting discrepancy by carefully analyzing and distilling comments and insights of patients offered with regard to the music in GIM about the nature of the music and how it affects the imagery process. Whilst practitioners would say that in general the chosen music provides the context for the imagery to unfold based on the needs and wishes of the client, rather like a soundtrack, the participants in this study convey a strong sense of the imagery being directed, and perhaps controlled, by the music. There is no doubt that the application of music in the GIM setting is a very complex process, and still requires a great deal of research. The competing voices of practitioner and participant heard in this current research project challenge assumptions about the basis of the profession, the music itself, and is clearly a matter urgently needing further exploration.

In addition, cultural aspects of music have been highlighted in this study. Fundamental theory of music therapy talks about the need to meet client's cultural needs. This has been explored, for example, with regard to music therapy improvisation techniques by Ruud (1998), and with regard to issues in palliative care (Forrest, 2000). More examples of formal research into cultural meanings and associations using applied music therapy are needed in order to build a full body of knowledge. The current research has not only elicited such culturally-based material via the GIM process, but sought to find a way to systematically study these cultural aspects of music, for example, references to music in films such as Disney's "Fantasia". In doing so, it has adapted and developed new methodology to investigate connections between musical texts, using semiotic intertextuality as a way to study the complex nature of music and its associations. This has broad implications for further study of the role of music in music therapy in a variety of applications and settings.

This research project has also contributed new information with regard to understanding the rehabilitative process after cardiac surgery, and the role of GIM therapy within this

process. It is clear that patients generally recover well physically after bypass and similar surgeries, however it is equally clear that new ways need to be found to access and assist with the residual emotional effects, such as depression and anxiety, which are commonly found after such surgery and most likely relate to the major impact and threat of these procedures (Denber, 1995). Not only this, but using the Bonny Method of Guided Imagery and Music has accessed texts and meanings not generally seen in the cardiac rehabilitation literature. In this study, the emotional implications were especially noted under Grand Themes 2 and 3, relating to the impact of the surgery and the unexpected tests and challenges. For example, the sense of the zipper, named as a simile for the sternotomy, and the nature of joining the zipper club becomes a cultural and social aspect of the physical effects of surgery. When this example of the zipper was mentioned to a range of staff at an in-service at one of the hospitals concerned in the study, as backed up by both themes and direct quotations, it was met by some surprise and dawning insight by the staff present, obviously beginning to see more in the personal experiences of patients and how it may be characterized into the lives and lifestyles of these patients.

Thus, this study has promoted and produced more clinical insight into the experience of a classic treatment process at the level of cultural meaning. The classic treatment processes of bypass surgery and valvotomy have been undertaken for a long time, and therefore a great deal is known about theoretical and practical aspects of this physical intervention, however, there appear to still be limits on the amount of information available about client's emotional and broader psychological reactions to this surgery, the subsequent recovery process, and how best to treat such reactions.

According to this study, the GIM therapy technique assisted in mobilizing both physical and emotional recovery, converting psychic activity into physical recovery. This was seen especially in Grand Themes 4 and 5, where Grand Theme 4 showed the promotion of both physical relaxation and positive, calm feelings, and Grand Theme 5 included mental rehearsal of physical abilities, as relevant to everyday life and rehabilitation goals, for example, incorporating an exercise programme into daily life.

In this research project, the combination of physical and emotional recovery and the tasks involved in the recovery process have been encapsulated into the archetype of the

hero's journey. To date, this archetype has occurred in the literature largely in relation to emotional problems and arose rather surprisingly with regard to physical recovery. This new application of the Hero's journey to healthcare promises a rich area of investigation.

This study has validated the significance of the archetypal journey of the hero as an important tenet of the imagery process in relation to health care and rehabilitation, as shown by the way themes emerged emically and in the interpretive process formed easily into the Hero archetype. The significance of the hero's journey extends beyond GIM therapy into the broader literature, and is something that could well be incorporated into a range of healthcare disciplines, including the field of nursing.

Based on this research project, the Hero's journey is not purely a theoretical construct emergent from speculation and belief systems related to a particular therapeutic orientation, but in fact has been seen to emerge in a systematic manner from data via a systematic analysis process. This then adds further weight to the important role of the Hero's journey as a principle for understanding experiences and progress via a creative art-form such as the Bonny Method of Guided Imagery and Music.

The sense of the Hero's journey has appeared from time to time in the GIM literature with regard to emotional and psychotherapeutic tasks (for example, Clark, 1995), however this research, focusing on emically generated themes, has demonstrated how the hero's journey may be equally applicable to physical health as patients recovery from the serious impact of heart surgery. This archetype can both give the practitioner a deeper understanding of the tasks the patients is facing in the rehabilitative process, but also potentially suggest ways of helping patients who are "stuck" at various points along the way.

In fact, it may be that the hero's journey archetype and the way that people connect with their heroic nature, thereby enhancing and supporting natural instincts to move towards change, forms some type of "template" or basic response with regard to post-surgical recovery, just as Kubler-Ross and other writers have noted a series of basic stages in approaching death and life-threatening illness (Doka, 1995; Kastenbaum, 2000; Kubler-Ross, 1969). It may be that all post-surgical patients need to see themselves as a Hero,

in order to recover properly. In doing so, they are meeting problems head-on and coping, finding a new life (both inside and outside), and relating internal change related to external change, in the process of rehabilitation. As such, a technique such as GIM which accesses these inner processes has a great deal to offer in supporting and encouraging the rehabilitation effort which is put forward by other health professionals in cardiac rehabilitation programmes. This seems to relate to Polkinghorne's concept of the change from victimic to agentic narratives (Polkinghorne, 1996), and also most likely relates to the "locus of control" concepts.

The literature on locus of control as related to chronic illness suggests that such a need for personal agency and control is evident in many circumstances, including cardiovascular disease (Miller, 2000). In exploring the broader concept of overcoming powerlessness, Miller has indicated that the use of personal productions are an important link towards enhancing control, including such modalities such as bibliotherapy, with inherent narratives, and imagery with likewise strong self-expressive characteristics. Based on the current study, the use of music therapy in the form of GIM clearly has an important and relevant role to play in fostering self-expression, insight and empowerment, and as such has important contributions to make to both the patient and the clinical team in enhancing the health care effort.

11.4 Limitations of the research project

The scope of the current research project was limited to those patients who were deemed to be recovering well from surgery, as determined by cardiac rehabilitation staff at each hospital. Whilst the vast majority of patients do indeed recover well and in a timely manner, those needing even more medical and therapeutic attention with regard to the recovery process have been excluded from this study. Whilst it is assumed that their experiences may well reflect further aspects of the heroic journey, or even a sense of hiatus in this journey, without data support this it is merely speculation.

More specifically, clinically tailored decisions such as the standard two-hour length of GIM sessions may well have been appropriate to patients recovering well, but for those with further difficulties this length and type of session may still be too intense and demanding, given factors such as physical tiredness, depression, cognitive deficits and

pharmacological effects. Hence, the GIM process may need to be modified in these circumstances. Again, this is based on speculation and requires further investigation.

The nature of music therapy technique applied in this specific study using the Bonny Method of GIM has utilized only classical music. GIM as a technique is oriented towards insight and reconstructive goals (see Wheeler, 1987). Some members of this client group may be better served by other music therapy applications focusing towards supportive or re-educative goals. This may included group rather than individual applications, and perhaps involving music activities such as singing, playing of instruments, active listening to prerecorded music and discussion, group relaxation, song-writing and so on. Forms of music therapy other than GIM may be appropriate at different stages of surgery and recovery or in other circumstances, and may serve as a millieu from which to further direct more needy people to a psychologically deeper therapy such as GIM.

Another important limitation of the current study was the perceived tension generated between the assumed chronology of the hero's journey in terms of stages, and the disordered nature of imagery in the practical setting, where thematic information occurred intermittently and interspersed throughout the text. Even though for the major part the development of the phases of the hero's journey did keep in with the chronology of the session, whereby initial sessions were inclined to be exploratory and carried a sense of starting the journey, moving to deeper and more profound issues and insights, culminating in a sense of insight and reward, there were also instances where imagery and understanding went forward and then backed off unexpectedly, or when initial insight was achieved quite suddenly without a long and intense struggle. In fact, imagery has its own development process, and complex dimensions of progress are often not easy to map in a linear fashion (Reid, 1988).

It is interesting to note that this is not a unique example of this type of tension developed between a stage model and individual non-linear variation within it in relation to health care. In fact, this has appeared especially in literature related to coping with a life threatening illness. Kubler-Ross, in her now classic work, "On Death and Dying (Kubler-Ross, 1969), proposed clear stages, however, "her model allows that not all individuals move through each stage and that some individuals may move back

and forth or even jump between stages" (Doka, 1995, p.112). Not only this, but her model has led the way towards the development of further stage models, as discussed by Kastenbaum (2000). In particular, Doka (1995) proposes a phase model based on the tasks involved, but at the same time these stages may show considerable fluctuation. As he writes,

> These phases should not be viewed as stages that every individual must experience. These phases simply represent different points in the ways which many individuals experience illness. Depending on the trajectory of the illness, individuals may experience one or more of these phases… However, the use of phases emphasizes that individuals have to cope with distinct challenges and issues at different points in life-threatening illness (Doka, 1995, p.116).

Thus, it seems that a precedent has already been set for the idea of a stage model which combines both an overall linear/chronological movement, whilst still maintaining the flexibility and variability of individual response, as depending on both inner and out circumstances, such as in the case of the archetype of the Hero's journey. The clinical implications of this are obvious.

> First, understanding the illness experience as a series of phases with distinct tasks can provide effective models for helping individuals with illness assess, understand, and cope with the issues that cause concern… The model reaffirms individuality by reminding clinicians that each individual will find different tasks more or less difficult. To some adhering to a medical regimen will be extremely difficult, to others it may not pose a problem. While individuals may have to deal with the same issues, certain tasks will be more problematic for different people (Doka, 1995, p.120).

11.5 Final proposals for the future

Based on this study, the application of the specialist music therapy method of GIM forms an effective and acceptable first approach to clients unfamiliar with psychological or emotional therapies, assisting them in processing verbal and non-verbal material related to cardiac surgery. This community-based, "normal" population typically recovers well physically, but may well benefit from further assistance to access emotional responses to the physical surgery. Music therapy may in fact be a "treatment of choice" in some circumstances, as noted in traumatic stress studies (Van der Kolk, 2000), and the importance of and role for music therapy extends to the area of cardiac rehabilitation. Despite limited studies, music therapy seems to promise a user-friendly clinical therapy which can aid emotional rehabilitation linked to physical recovery. It has the potential to address, and perhaps even prevent, symptoms such as depression,

anxiety and pain, which are common in this population. In addition, it provides a context for harnessing innate coping mechanisms in the patient, helping them rethink, review and integrate their currently improved health, and thereby reinforcing and encouraging healthy activity and a sense of motivation. The exact mechanism by which this all occurs demands further study, in order to highlight the manner in which this discipline may contribute to the health care team.

The music therapy session may be seen as a context for exploring creative problem-solving, which is required in everyday life in order to solve or resolve difficult situations. A parallel exists between responses in the music therapy session and creative responses in life, such that the music therapy setting supports and mirrors creative problem-solving. Such a testing-ground for creative responses is similar to concepts in fundamental group therapy theory, where the group is seen as a microcosm of the real world and therefore a useful context where relationships and responses may be safely explored. In this study, participants have manifested such creative exploration into the archetype of the "Hero's journey" archetype, echoing how able they feel to meet life creatively in order to solve the mix of problems or circumstances which may occur.

In a broader sense, the addressing of emotional effects of physical problems and procedures, and the fundamental and integral relationship of these two contrasting aspects of disease and illness, is yet to be explored to its fullest. Clearly, music and imagery is one avenue. GIM is not just a technique for those who are "art-y" or "creative". In fact, even people who had very "concrete" in their thinking and initially would not have seemed so open to insight still were able to use the GIM sessions effectively to express how they were feeling and adjusting, such as the man who played golf. So this method may be especially effective in working with people even who do not seem initially so open and able to achieve insight. Further research is needed to explore and support such an assertion.

Music therapists need to know and articulate essential aspects of music therapy practice, in a similar way to nurses looking deeper into their chosen profession (LeVasseur, 2002). Given the increasing range of new health care products and practitioners, some of whom may be seen as less-than-professional in approach, it becomes even more

important that goals and outcomes of professional music therapy are clearly articulated and provided with a solid theoretical and methodological basis.

This study has considered participants' responses to cardiac rehabilitation as a health transition of concern to music therapy. The results seen in this study show that music-supported imagery, in the form of GIM, has the capacity to provided meaningful and clinically useful information to music therapy practice and practitioners, and in turn has important contributions to make to the entire clinical healthcare team, in this instance with regard to cardiac rehabilitation.

If we can clearly define what it is that music therapists achieve with cardiac patients in the rehabilitation process, it will be more likely that agencies and institutions will begin to value these achievements as significant health care outcomes. This study also represents a step forward in defining how music therapists can help patients move forward into uncertain futures. The voices of both patients and clinicians in this study are important in that they point to ways in which music therapists may make a significant and unique contribution to patient care utilizing the exciting and innovative modality of music therapy.

APPENDIX 1. JUNGIAN APPROACH

[based on Stevens, (1990), Corsini & Wedding (1989), Ventre, (1990), Jung (1961/65; 1934/54/1968a; 1968b) and related readings]

Jung presents a teleological view of change and development, including adaptation to circumstances. His therapeutic approach incorporates the view of the client/patient as integral to the therapeutic endeavour and re-center's the action towards empowerment of the client and encouragement of the ability to act on their circumstances. In Jung's view, clients use their own patterns of behaviour to grow and develop and to achieve insight from reflection and integration of new ideas related to life as they experience it. The linking of conscious and unconscious processes of the inner and outer world is reflected in the principles of Jung's therapeutic understandings and treatment modalities.

Conscious self and shadow

Jung's view includes both conscious and unconscious parts of the psyche, particularly focusing on the "shadow", an area holding unconscious processes and often rejected from awareness by the conscious self (Stevens, 1990). A strong reaction of disapproval or strong rejection towards other people or objects is often evidence of a "shadow" reaction. Consciousness and shadow can work at cross-purposes and undermine the person's sense of their own self. The task of individual human development is to begin to connect to this shadow and integrate it into the personality, over time, thus leading towards the process of individuation, a concept which will be further discussed below.

Spontaneous generation of material

In depth-oriented techniques such as those of Freud and Jung, the emphasis is always on spontaneous generation of material from the unconscious level, be it images, slips of the tongue or other expressions. The process of Jungian therapy then uses images and ideas and elicited from the patient rather than imposed by the therapist. In this way, it differs significantly from some other therapies and current societal uses of imagery, such as for pure relaxation or stress reduction, where a particularly image is deliberately held in mind to the exclusion of others. In the depth-oriented techniques under discussion, the client is encouraged to produce their own images without restriction, in an effort to access underlying unconscious processes, which tend to appear in spontaneous rather

than “forced” circumstances. Once the spontaneous image is elicited, it can then be reviewed, discussed and worked with in various ways. The spontaneous image is fundamental to the process, and is used to reveal unconscious processes.

The unconscious has a different language, which is that of imagery and symbol. It cannot be easily approached by normal, grammatical language, therefore this is why Freud developed “word association” and other techniques. In doing so, it became obvious that signs can carry both conscious and unconscious meanings.

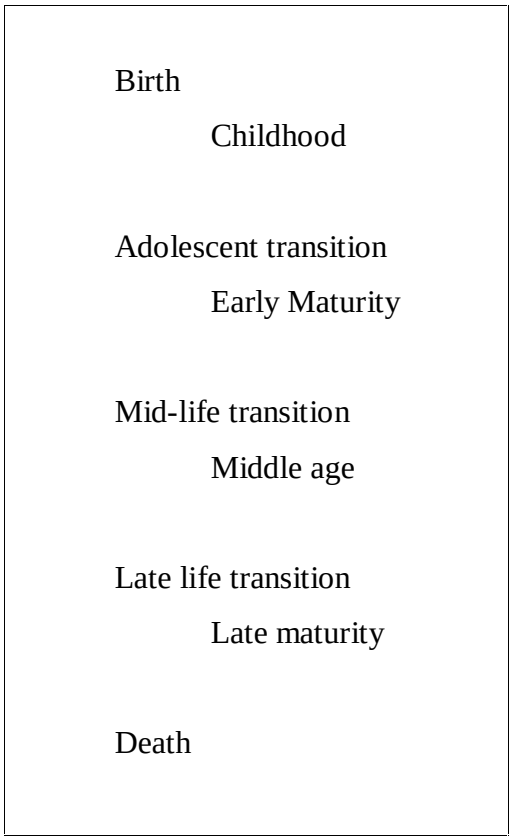
Psychic imbalance

Reacting to the problems or events of life within the life cycle stages, the person may sometimes experience difficulties in the resolution and integration of such problems within themselves. This can lead to psychic imbalance, as inner defensive mechanisms which may no longer be appropriate seek to hold back the forward-moving developmental forces of integration and individuation. This may manifest in a range of ways, such as depression, lethargy, anxiety and hyperactivity. Assisting the client to look at the problems or events causing the distress can help release the client’s own psychic energy to rebalance, in order to develop and move forward.

> Neurosis is really an attempt at self-cure, just as any physical disease is partly at attempt at self-cure. We cannot understand a disease as an *ens per se* any more, as something detached which not so long ago it was believed to be. Modern medicine - internal medicine, for instance - conceives of disease as a system composed of a harmful factor and a healing factor. It is exactly the same with neurosis. It is an attempt of the self-regulating psychic system to restore the balance, in no way different from the function of dreams - only rather more forceful and drastic (Jung, 1968, pp.189-190)/

Life cycle development

In conjunction with the idea of individuation, Jung put forward the idea of stages of development throughout the life cycle of the person, extending Freud’s idea of the importance of childhood to encompass the concept of significant stages throughout the entire life of the person (Stevens, 1990, p.263). In each of these stages, certain problems or types of problems were likely to arise. In the current study, the latter stages are the most pertinent, since a crisis of health is likely to trigger awareness of problems and consequent changes relating to the process of individuation.



Stages of development throughout the life cycles of the person (Stevens, 1990, p.62)

Individuation

As one begins to integrate more of the conscious self with the shadow, one begins to recognize more of one's own self, about the origins of motivations, reactions and so on, but now having a choice about one's life. This integration of unconscious and conscious material so that they are not working against each other forms the major part of individuation. In doing so, there is increased awareness of the self. Individuation is a life-long process, and since it is never entirely complete, it is THE task in psychic development and progress.

> In the Jungian view, mental health (or illness) depends on the functional relationship, achieved in the course of individual development, between conscious and unconscious processes. Progress in the therapeutic application of depth psychology has resulted from study of this relationship and the creation of techniques designed to bring about its readjustment when the relationship shows signs of going wrong. Moreover, conscious-unconscious interaction is important not only in the maintenance of mental health but also in the achievement of all creative activity, whether artistic, literary or scientific, and on it depends what Jung came to regard as the highest of all human attainments, the development of the personality, whereby an individual becomes as complete a

> human being as it is possible for him or her to be. He called this "individuation" (Stevens, 1990, p.9).

It is interesting to note here the difference between Freud and Jung. Freud saw the person as substantially affected by forces outside their control, whereas Jung proposed (based on his experience) a force within the person which included self-determination and self-realization, a concept also echoed in humanistic therapies in the from of self-actualization (Rogers, 1961, 1980; Corsini & Wedding, 1989).

> Whereas Freud espoused the principle of causality and proposed an almost mechanistic form of determinism, Jung insisted on the freedom of the will, which he defined as free psychic energy at the disposal of the ego. Where Freud's orientation was causal, Jung's was teleological (Stevens, 1990, p.263).

Information from the unconscious may be conveyed via symbols and sign-based information, and which form patterns known as archetypes. Therapy helps this process of conveying information to occur in a more timely manner, and allows new perspectives and insights to occur.

> The images anticipate the dreams, and so the dream-material begins to peter out... Then you get all the material in a creative form and this has great advantages over dream-material. It quickens the process of maturation , for analysis is a process of quickened maturation. This definition is not my own invention, the old professor Stanley Hall invented this term (Stevens, 1990).

Imagery and archetypes

The concept of archetypes is fundamental to Jung's understanding of the person, and applies to all people in various forms.

> The fundamental distinction between the two schools is the view that each adopts of the unconscious. Whereas Freud assumed that most of our mental equipment is acquired individually in the course of growing up, Jung asserted that all the essential characteristics that distinguish us as human beings are with us from birth and encoded in the collective unconscious (Stevens, p.262).

> Successful psychological development and adaptation require the satisfactory negotiation of these critical phases of life. Conversely, psychological maladjustment, or, at the least, problems of living, are encountered when the archetypal developmental blueprints are frustrated or impeded. It is in these circumstances that the "archetypal" dream, as distinct from the "personal" dream … assumes particular importance. These vivid, emotionally charged dreams reflect developmental problems that are not only of individual but also universal relevance (Shuttleworth-Jordan, Saayman and Faber, 1988, p.477).

The happy ending to the fairy tale, the myth, and the divine comedy of the soul, is to be read, not at a contradiction, but as a transcendence of the universal tragedy of man. The objective world remains what it was, but, because of a shift of emphasis within the subject, is beheld as though transformed (Campbell, 1968, p.28).

The passage of the mythological hero...fundamentally…is inward – into depths where obscure resistances are overcome, and long lost, forgotten powers are revivified, to be made available for the transfiguration of the world (Campbell, 1968, p.29).

APPENDIX 2. CONSENT FORM, INFORMATION FORM.

South Eastern Sydney Area Health Service - Eastern Section
Prince of Wales Hospital

"An investigation of the process of recovery in post-surgical cardiac patients using music and imagery"

Information Statement

My name is Alison Short and I am currently enrolled as a Doctoral Student at the University of Technology, Sydney. I am also a qualified professional music therapist. You are invited to participate in a study investigating the use of music and imagery (the Bonny Method) with people who are recovering from heart bypass surgery. It is hoped that this study will shed light on emotional issues associated with physical changes brought about by cardiac surgery. It will also explore a role for music and imagery in the recovery process. You were selected as a possible participant in this study because you are recovering from heart bypass surgery.

People volunteering and being selected for this study will have six (free) sessions of music therapy at the hospital (or the researcher's office), and will be free to withdraw from the research and/or the music therapy at any time and without giving a reason. Each music therapy session will involve general open-ended discussion, assistance with relaxation, encouragement to produce imagery with the (classical) music, reporting of imagery as it occurs (with comments by the therapist), and final discussion of experiences. Each session will last approximately one and a half hours, and will be audiotaped.

The data from this study will be stored on file, personal computer and audiotape for five years and then disposed of by shredding or erasure. You will be encouraged to participate actively in the research by reviewing the information gathered, by openly discussing drafts during the analysis process, and by a further final meeting with the researcher to express a personal evaluation of the role of music and imagery in your recovery process.

We cannot and do not hold out that you will receive any benefits from this study. Whether you take part in this study or not, it will not make any difference to the medical care you will receive from Prince of Wales Hospital. If you decide to take part in the study, you can still withdraw at any time and this will not make any difference to your medical care either. You will be given a copy of this form to keep.

As a participant, your name will not be used in any published format, and you may choose to have a copy of the final results of the study if you wish.

South Eastern Sydney Area Health Service - Eastern Section
Prince of Wales Hospital
"An investigation of the process of recovery in post-surgical cardiac patients using music and imagery"
Information Statement (continued)

You will be given a copy of this Information Statement form to keep. Your signature indicates that you have read the information provided above.
If you have any further questions or concerns regarding this research, please feel free to discuss them with me (Ph. 9514 5708), or my Supervisor, Professor Heather Gibb at the Health and Aging Research Unit, War Memorial Hospital (Ph. 9369 0288).

Alison Short, RMT, RGIMT

Signature_____ Signature of witness_____

Please PRINT name_____ Please PRINT name_____

Date_____ Nature of witness_____

Signature of researcher_____

South Eastern Sydney Area Health Service - Eastern Section

Prince of Wales Hospital

"An investigation of the process of recovery in post-surgical cardiac patients using music and imagery"

Consent Form - Student Research

I,_____ (participants name) agree to participate in the research project, "An investigation of the process of recovery in post-surgical cardiac patients using music and imagery", being conducted by Alison Short, Faculty of Nursing, University of Technology, Sydney, P.O. Box 222 Lindfield, 2070.

I understand that I have been invited to participate in a study investigating the use of music and imagery (the Bonny Method) with people who are recovering from heart bypass surgery. It is hoped that this study will shed light on emotional issues associated with physical changes brought about by cardiac surgery. It will also explore a role for music and imagery in the recovery process.

I understand that this research will involve undergoing six (6) sessions of music therapy treatment using music and imagery, which will include discussion, relaxation, classical music and further discussion. These sessions will be audiotaped, and all materials will be kept confidential except as required by law. The sessions will last approximately one and half hours. Further to this, I will be asked to participate actively in the research by reviewing the information gathered, by openly discussing drafts during the analysis process, and by a further final meeting with the researcher to express a personal evaluation of the role of music and imagery in my recovery process. In understand that the data from this study will be stored on file, personal computer and audiotape for five years and then disposed of by shredding or erasure.

I understand that the researchers cannot guarantee that I will receive any benefits from this study.

I am aware that I am at liberty to contact Alison Short (Ph. 9514 5708), or her Supervisor, Professor Heather Gibb at War Memorial Hospital, Waverley (Ph. 9369-0288), if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish and without giving a reason, and may still continue with the six sessions of music therapy if I so choose, without any prejudicial effects to the medical care and treatment I receive from Prince of Wales Hospital.

South Eastern Sydney Area Health Service - Eastern Section
Prince of Wales Hospital
"An investigation of the process of recovery in post-surgical cardiac patients using music and imagery"

Consent Form - Student Research (continued)

I have been provided with and read the Information Statement about this research, and I will be given a copy of both the Information Statement and this Consent Form to keep.
I agree that Alison Short has answered all my questions fully and clearly.
I agree that the research data gathered by this project may be published in a form which does not identify me in any way.
I am making a decision whether or not to participate. My signature indicates that I have decided to participate having read the information provided above.

Signature_____ Signature of witness_____

Please PRINT name_____ Please PRINT name_____

Date_____ Nature of witness_____

Signature of investigator_____

NOTE: This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research you may contact the Ethics Committee through the Research Ethics Officer, Ms Susanna Davis (ph: 9514 1279). Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Revocation of Consent

I hereby wish to withdraw my consent to participate in the research proposal described above and understand that such withdrawal WILL NOT make any difference to my medical care or my relationship with the University/Hospital or my medical attendants.

Signature_____

Please PRINT name_____

Date_____

The section for Revocation of Consent should be forwarded to Professor Heather Gibb, Health and Aging Research Unit, 125 Birrel Street, Waverley 2024.

APPENDIX 3. VERBAL EXPLANATION OF GIM PROCESS (EXAMPLE)

Are there any questions that arise from the consent form?
Not really, no, that's all quite straight-forward.
No? Ok . And we talked a little on the phone about it. So I think I mentioned quite a few of the things. I guess the most important thing to bear in mind is that whatever imagery might arise, it's all ok, it's not like there's a special thing that you have to be doing, or a special thing that you have to be saying, or that something's right or something's wrong. The general aim is to do some imagery with the music, whatever comes, whatever comes from inside you, not forced types of things -
Imagery, meaning what I am imagining? At the time, from the music?
Yes, what you are imagining. People sometimes think it's rather like just before you go to sleep. You know - sometimes you have ideas of what you should have done during the day or what you should have said to the boss, or something [joint laughter]. Or it just seems like a creative sort of moment when you are still aware of what's around you but something's a bit more on the imaginal side, just before you go to sleep.
Mm, hm.
Of course, once you're asleep and dreaming it's a bit harder to control what's going on, you just get what you've got! [laugh]
That's right.
But in that in-between state you're aware of the world and have a certain amount of control over what is going on, but at the same time can allow some of that material to come up. Some people suggest that we have a sort of a stream of images going on in us all the time, and that there's just various times when we tap into it, and we might notice it if we are daydreaming, or we might notice it if an Ad. on TV attracts us,
Yes, mm.
We're using all different sorts of images and so forth. And we might notice it when we are sleeping, we might notice it if we do meditation, or relaxation - different times like that. So, some people would suggest that that's going on pretty much all the time, as a background type of thing, and this is just one occasion to be able to tap into this.
It is very much from your point of view, whatever you need to do, it's not about me imposing what I think you should or shouldn't do -
Hm.
So, it's not imposed in the way, that some people might think of therapy as being "do the right thing", or "say the right thing".
So, just to explain what actually's going to happen - you're just going to put music on...
Yes. Well, first we'll talk for a little while, like this, and maybe I'd like to hear a little more about your experiences with your heart surgery and so forth, and anything else that is particularly happening in your life, that's good or bad, whatever amount you would like to say about that. Then, when you're ready, we'll move to a spot, either we'll stay in the chairs, re-organize a little, or - you don't want to lie down, so that's alright. [Note: This refers to previous conversation before the taping, where she indicated that due to arthritis and also pain from the chest scar she thought that she would be more comfortable sitting up].

But we'll get comfortable, ready, and then I'll talk you through a relaxation type of thing, and we can talk about what sort of relaxation might be good for you, and what [Rehab. Nurse] did on Friday with you, and at the end of that relaxation I will suggest an image to start with and we can even discuss now what you would like, but it might be your favourite place or something like that, that you would like to go, that is relaxing.
Mm.
So I suggest the area of that first image, and then once the music comes on, after that, it's up to you what you would like to do. So you might stay with that place, or you might go somewhere else, and it might change a lot, it doesn't have to be just one story. And as you say something, I will respond in some way at various times. So, for instance, as I was saying on the phone, you might say, you know, "I see a tree", and I might say, well, "what do you notice about that tree", or "would you like to go closer to that tree", and you might say, "No I'm not interested in the tree, I'm off over the hills somewhere! [joint laughter]. Or you might say that "I feel like hugging it", or "I want to climb it", or, you know, whatever! So, it's there as a sort of a sounding board, just to help the imagery progress, not to say right or wrong.
Mm.
So, again, you can ignore me any time you'd like to, it's your experience, not mine! If I wanted it to be mine, I could have stayed home and done this! [joint laughter] So, yes, and we'll see from talking and from how you're going with that how long the music will go for, it could be 15 minutes, it could be half an hour, it could be a little more depending how things are going. Sometimes people tire very easily and that sort of thing. I've done this type of work for quite a long time so I know what to look for -
Do you ever find people don't see anything? *[laughter].*
I do find that people are worried about not seeing anything, but it's very rarely that they don't. And I also find, as you said [Note: before the taping] you might go to sleep - I find that almost everyone says that, when they're starting! (Pat1-1, Investigative Discussion).

APPENDIX 4. SUMMARY OF PARTICIPANTS

Note: All clinical details are based solely on the self-report of the participant.

Participant 1

A 57-year-old woman appeared in her first music therapy session (at nine weeks post-bypass surgery) to be empowered, actively involved with a supportive family, and had been divorced several years prior to our meeting. Her surgery had been sudden and unexpected, based on clinical information gained at a routine Doctor's checkup for hypertension. She was apologetic that she did not have any problems, saying that everything had gone well for her. She was positive and upbeat about her experiences of cardiac surgery (quadruple bypass) whilst discussing other people she knew who had had a "bad time" with cardiac surgery. This contrasted remarkably with her reactions once the music began, where she abreacted with tears. Many emotional issues, often apparently conflicting, emerged during the music and imagery and were thought to be have been very "close to the surface". This participant also specifically complained of the discomfort of her chest pins (sternotomy), and chose to relax in sitting position because of it.

Participant 2

This 69-year-old woman had had a heart valve replacement eleven weeks prior to entering the current study, and a coronary bypass operation some eight years previously. She reported that her main symptom which had bothered her prior to surgery was shortness of breath, especially when walking. She also talked of how much harder it was beforehand, facing a second major heart operation, knowing what would happen and fearing some of the unpleasant procedures, including a breathing tube.

This participant had participated in Tai Chi and Yoga prior to the current study, and seemed easily able to relax. A prior problem with a swollen her arm (from breast removal) meant that she was careful to make herself comfortable, and she used the pillow and blanket as a support for this arm. She also reported having a hearing impairment. Her imagery with the music included many instances of going to specific places, and images of actually places and things, such as a favourite tea-set or memories of being with her aunt.

Participant 3

Participant 3 was a 62-year-old retired man who had had bypass surgery six weeks prior to entering the current study. He did not usually listen to classical music, and would not be considered musically sophisticated in any way. But he enjoyed music in the average way that many people do, and enjoyed extending his mind with new ideas. Although retired, his work had involved trade skills at an advanced level, and he was comfortably familiar with the healthcare setting as part of his work. This participant had practised self-devised relaxation procedures over some years , but the fact that he had no difficulty relaxing and imaging with the music nevertheless surprised him, He reported that he reviewed his old travel videos prior to GIM sessions, which tended to suggest a

level of anxiety and a need for control. He appeared to have a very positive and pragmatic approach to his recovery from bypass surgery.

Participant 4

Participant 4 was a 64-year-old man who had had bypass surgery some 15 weeks prior to entering the study. He was from a non-English speaking background (NESB), his original language being Greek and he had come to Australia from Egypt some 44 years ago. He spoke fluent, if sometimes "picturesque", English and used it well to express himself. Originally arriving with very little money, he had worked to become a very successful small-business man. He was deeply connected to music, and when he first arrived in Australia had worked as a professional musician for many years playing Latin music, before later turning to other non-music-related pursuits. His instrument was the trumpet, although he had not played it for many years. He reported difficulties with anxiety both prior to and following surgery, and was clearly anxious in early GIM sessions. Once he was able to relax, his imagery flowed easily and he particularly used it to connect emotionally with his body.

Participant 5

Participant 5 was a 55-year-old man who had had bypass surgery some thirteen weeks prior to entering the current study. He was from a non-English speaking background (NESB) with his original language being Spanish. He had come to Australia from Chile some 35 years previously. He spoke fluent and expressing English, having at one time worked as a librarian, and any difficulties cause by his strong Hispanic accent were resolved by further questioning to ensure accuracy and mutual understanding.

This participant also had had chronic pain for some 13 years, following from an operation for cancer and arthritis. Following his bypass surgery (five bypasses), this participant was readmitted to hospital with pneumonia and a collapsed lung, where he reported experiencing great pain due to the coughing (due to the sternotomy). At the time of the study he also had anaemia, related to an "excess of antibiotics" and his asthma was aggravated. He was on medication for the depression resulting form chronic pain, and had attempted to use relaxation tapes, with limited success. He attended a pain clinic and saw a psychologist regularly. He also reported a surprising effect, of no chronic pain for two months after his bypass operation. He did not use his pain-control implant for that length of time, then the pain came back. This participant reported an inability to relax, which was very evident during discussion, however once he relaxed the imagery process was well engaged and flowed easily.

Participant 6

Participant 6 was a 66-year-old woman who had had bypass surgery six weeks prior to commencing in the current study. Whilst the surgery had gone well, her time in the hospital had led to observations and comments by staff and consequently to diagnosis of her husband with Alzheimer's disease, a matter which provided increased stress for this woman as she tried to look after herself in the recovery phase and at the same time had to look after her husband and his forgetfulness. It seemed that the full extent of his problem was not evident to other people, including family and especially himself, this providing much grounds for conflict. In fact, he stayed in the first two GIM sessions,

before it was gently suggested to the participant that it might be better to have sessions by herself. She was happy with this idea, and made other arrangements, seeming to be relieved at having a time when she could speak about her progress and difficulties. This participant was very familiar with relaxation, having used the Dr Grantly Dick-Read method of childbirth many years ago, and she had a great lover of classical music. She relaxed well and imagery flowed easily for her with the music in the GIM session.

APPENDIX 5. DATES OF SESSIONS AND FREQUENCY

Dates of sessions for each Participant

	Pat 1	Pat 2	Pat 3	Pat 4	Pat 5	Pat 6
Session 1	14/9/98	26/10/98	25/11/98	10/3/99	11/3/99	12/3/99
Session 2	-	2/11/98	30/11/98	17/3/99	18/3/99	19/3/99
Session3	-	9/11/98	7/12/98	24/3/99	25/3/99	26/3/99
Session 4	-	23/11/98	14/12/98	31/3/99	31/3/99	30/3/99
Session 5	-	25/11/98	21/12/98	7/4/99	7/4/99	6/4/99
Session 6	-	2/12/98	28/12/98	14/4/99	14/4/99	13/4/99

Number of days between sessions for each Participant

	Pat 1	Pat 2	Pat 3	Pat 4	Pat 5	Pat 6
Session 1	0	0	0	0	0	0
Session 2	-	7	5	7	7	7
Session3	-	7	7	7	7	7
Session 4	-	14	7	7	6	4
Session 5	-	2	7	4	7	7
Session 6	-	7	7	7	7	7

APPENDIX 6. INITIAL QUESTION AREAS TO BE COVERED.

Can you tell me how you feel about this illness/surgery?

How your body feels about this illness/surgery?

Have you had any experiences with imagery or relaxation before?

What is your relationship to music? To classical music?

What do you think you need in order for things to improve?

What do you hope might come out of a session like this?

Is there anything else that you think I should know?

Any questions or concerns?

APPENDIX 7. MUSIC PROGRAMMES

Music programmes used for each participant, in each GIM session

	Pat.1	Pat.2	Pat.3	Pat.4	Pat.5	Pat.6	Times used
QM (1st 2 cuts) QM (whole)	1-1	 2-2	3-1	4-1	5-1	6-1	6
Nurturing		2-1 (part)	3-3	4-5	5-2 (part)		4
Relationships (Pierne)		2-4					1
Grieving		2-5 (end of Dvorak)			5-4	6-4	3
Reconciliation						6-6	1
Creativity 2		2-3	3-3		5-2 (part)	6-2	4
Peak Experience		2-6	3-6	4-2 4-6	5-3 5-5		6 (four clients)
Mostly Bach			3-5	4-3		6-5	3
Emotional Expression 1				4-4			1
Dance of Blessed Spirits					5-6		1
Transitions			3-4			6-3	2
							Total: 31 sessions

Abbreviations:

QM = Quiet Music
N = Nurturing
Cr2 = Creativity 2
Rel = Relationships
Gr = Grieving
P = Peak Experience
Tr = Transitions
MB = Mostly Bach
EE1 = Emotional Expression 1
Recon.= Reconciliation
DBSp. = Dance of the Blessed Spirits (Gluck)

APPENDIX 8. GIM PROGRAMMES

Quiet Music (Helen Bonny)

Debussy: Danses Sacred and Profane	9.07
Debussy, Afternoon of a Faun	11.34
Holst, The Planets: Venus	8.38
Vaughan Williams, Fantasia on Greensleeves	4.15

Creativity 2 (Linda Keiser Mardis)

D'Indy, Symphony on a French Mountain Air, Movement 1	11.43
Vaughan Williams, Norfolk Rhapsody No.1	10.12
Mendelssohn, "Scottish Symphony no. 3, Vivace non troppo	4.25
Faure, Pavane	6.04
Ravel, Daphnis and Chloe, Suite No.2 (portion)	12.25

Nurturing (Helen Bonny)

Britten, Simple Symphony, Sentimental Saraband	7.52
Vaughan-Williams, Prelude to Rhosymedre	
Berlioz, L'enfance du Christ - Shepherd's farewell;	5.17
Chorus	5.46
Puccini, Madame Butterfly: Humming Chorus	2.54
Massenet, Scenes Alsaciennes; Sous les Tilleuls	4.06
Canteloube, Songs of the Auvergne - Brezairola	3.34

Peak Experience (Helen Bonny)

Beethoven, Piano Concerto No. 5: Adagio
Vivaldi, Gloria :Et in terra pax
Bach, Toccata, Adagio and Fugue in C.
Faure, Requiem, In Paradisum
Wagner, Lohengrin: Prelude to Acts 1, 3

Relationships (Helen Bonny)

Pierne, Concertstuck for harp and orchestra	14.48
Rachmaninov, Symphony No.2, Adagio	14.11
Respighi, Fountains of Rome,	
Villa Giulia at Dawn, Villa Medici at Sunset	9.02

Transitions (Helen Bonny)

Strauss, A Hero's life (excerpts)	8.24
Brahms, Symphony No. 3, Poco Allegretto	5.49
Beethoven, Symphony No.9, Adagio Molto	15.59
Brahms, Piano Concerto No. 2	12.14

Grieving (Linda Keiser Mardis)

Marcello, Oboe Concerto in C minor, Adagio	4.19
Rodrigo, Concierto de Aranjuez, Adagio	9.59
Grieg, Holberg Suite, L'Air	5.16
Dvorak , Four Romantic Pieces, Larghetto	6.25
Bach, Prelude in E flat Minor	5.06
Dvorak, Czech Suite, Romanze	4.36

Mostly Bach (Helen Bonny)

Bach, Pasacaglia and fugue in C minor	15.00
Bach, Come Sweet Death	4.54
Bach, Geistliches Lied, Main Jesu	5.27
Bach, Fugue in G minor BWV 578 The Shorter	4.02
Brahms, Violin Concerto, Adagio	9.44
Bach, Concerto for two violins and orchestra, Largo	7.25

Emotional Expression 1 (Helen Bonny)

Brahms, Piano Concerto No.2, Allegro non troppo	17.58
Brahms, Requiem, Part 1, Selig sind, die da leid tragen	8.48
Brahms, Requiem, Part 5, Ihr hapt nun Traurigkeit	6.30
Brahms, Symphony No.4, Andante Moderato	12.12

Reconciliation (Alison Short)

Handel, Concerto Grosso Op.3 No.2 (selection)	2.56
Kreisler, Concerto for Violin in the style of Vivaldi	4.05
Purcell, Dido and Aeneas, Dido's Lament	4.06
Purcell, The Fairy Queen, If love's a sweet passion	2.40
Mozart, Sinfonia Concertante K.364, Andante	11.56
Ravel, Piano Concerto in G minor, Adagio assai	9.26
Boulanger, Les Sirenes	5.49

Extra music

Gluck, Dance of the Blessed Spirits

REFERENCES

Abel, H-H., Geier, J-S., Pratt, R.R., Spintge, R. & Droh, R. (1996). Effects of selected music listening on cardiovascular-respiratory parameters of chronic back pain patients. In R.R.Pratt & R.Spintge (Eds.), MusicMedicine Volume 2 (pp. 193-205). Saint Louis, MO: MMB Music.

Achterberg, J. (1985). *Imagery and healing: Shamanism and Modern Medicine*. Boston: Shambala Pubs. Inc.

Ackerman, S.J., Hilsenroth, M.J., Clemence, A.J., Weatherill, R. & Fowler, J.C. (2001). Convergent validity of Rorschach and TAT scales of object relations. *Journal of Personality Assessment, 77* (2), 295-306.

Adler, H.M. (1997). Towards multimodal communication theory of psychotherapy: The vicarious co-processing of experience. *American Journal of Psychotherapy, 51* (1), 54-66.

Aigen, K. (1991). The voice of the forest: A conception of music for music therapy. *Music Therapy. 10* (1), 77-98.

Aigen, K. (1993). The music therapist as qualitative researcher. *Music Therapy, 12* (1), 16-39.

Aigen, K. (1995). Principles of qualitative research. In B.Wheeler (Ed.), *Music therapy research: quantitative and qualitative perspectives* (pp.283-312). Phoenixville, PA: Barcelona Publishers.

Aldridge, D. (1996). *Music therapy research and practice in medicine: From out of the silence.* London: Jessica Kingsley Publishers.

Aldidge, D. & Aldridge, G. (1996). A personal construct methodology for validating subjectivity in qualitative research. *Arts in Psychotherapy, 23* (3), 225-236.

Allan, R. (1999). *Walt Disney and Europe: European influences on the animated feature films of Walt Disney*. London: John Libbey &Co.

Allen, G. (2000). *Intertextuality*. New York: Routledge.

Alvin, J. (1975). *Music therapy* (2nd ed.). New York: Basic Books.

Amir, D. (1992). *Awakening and expanding the self: Meaningful moments in the music therapy process as experienced and described by music therapists and music therapy clients*. Unpublished Doctoral Dissertation, New York University.

Amir, D. (1993). Research in music therapy: Quantitative or qualitative? *Nordic Journal of Music Therapy*. Retrieved 14 July, 2002, from http://www.hisf.no/njmt

American Orchid Society Education Committee (n.d.). *The orchid house: Cattleya culture*. Retrieved February 4, 2002, from http://retirees.uwaterloo.ca/~jerry/orchids/cnotes/cattleya.html

Anderson, K.N., Anderson, L.E. & Glanze, W.D. (Eds.). (1994). *Mosby's Medical, Nursing, & Allied Health dictionary* (4th ed.). St. Louis, MO: Mosby-Year Book Inc.

Anderson, J. & Poole, M. (1998). *Assignment and thesis writing* (3rd edition). Milton, Qld, Australia: Jacaranda Wiley Ltd.

Ansdell, G. (1996). Talking about music therapy: A dilemma and qualitative experiment. *British Journal of Music Therapy, 10* (1), 4-16.

Ansdell, G. (1997). Musical elaborations: What has the New Musicology to say to music therapy? *British Journal of Music Therapy, 11* (2), 36-44.

Arieti, S. (1976). *Creativity: The magic synthesis*. New York: Basic Books.

Arnason, C.L.R. (2002). An eclectic approach to the analysis of improvisations in music therapy sessions. *Music Therapy Perspectives, 20* (1), 4-12.

Aronson, J. (1994, Spring). A pragmatic view of thematic analysis. The Qualitative Report, 2 (1). [http://www.nova.edu/ssss/QR/BackIssues/QR2-1/aronson.html]

Artchive (n.d.). *Venus de Milo*. Retrieved on 11/11/02 from http://www.artchive/G/greek/venus_de_milo.jpg.html

Association for Music and Imagery (1990). *Definition of the Bonny Method of Guided Imagery and Music*. Approved at the Annual Conference of AMI, Blue Mountain Lake, NY.

Australian Music Therapy Association, Inc. (n.d.). *Music therapy: A sound practice* [Brochure]. Turramurra, NSW.

Azar, B. (1997). Musical studies provide clues to brain functions. In J.N.Reich, E.Q. Bulatao, G.R. Vandenbos & R.K. Farberman (Eds.), *Close up on psychology: Supplemental readings from the APA Monitor* (p.10-13). Washington DC: American Psychological Association.

Baker, F.A. (2000). Modifying the melodic intonation therapy program for adults with severe non-fluent aphasia. *Music Therapy Perspectives, 18*, 110-114.

Bakhtin, M. (1981). *The Dialogic Imagination: Four Essays* (C Emerson & M Holquist, Trans.). Austin, TX: University of Texas Press.

Barber, E. (1984). Red Cross music therapy service: Part 1. *AMTA Bulletin, 7* (4), 8-13.

Barthes, R. (1988). *The semiotic challenge*. (R.Howard, Trans.). Oxford, UK: Basil Blackwell (Original work published 1985).

Bell-Villada, G.H. (1986-7). The idea of art for art's sake: Intellectual origins, social conditions, and poetic doctrine. *Science and Society, 50* (4), 415-439.

Benner, P. (2000). The wisdom of our practice. *American Journal of Nursing, 100* (10), 99-105.

Benner, P., Hooper-Kyriakidis, P. & Stannard, D. (1999). *Clinical wisdom and interventions in critical care: A thinking-in-action approach*. Philadelphia, PA: W.B. Saunders Co.

Benner, P., Tanner, C.A., & Chesla, C.A. (1997). Becoming an expert nurse. *American Journal of Nursing, 97*(6).

Bernard, J.R.L. & Blair, D. (Eds.).(1989). *The pocket Macquarie dictionary* (2nd ed). Milton, Qld: Jacaranda Press.

Berardinelli, J. (n.d.). *Oscar and Lucinda*. Downloaded February 4, 2002, from http://movie-reviews.colossus.net/movies/o/oscar.html

Blacking, J. (1995). *How musical is man?* (Reprint edition). Seattle: University of Washington Press.

Blake, R. (1994a). Vietnam veterans with post-traumatic stress disorder: Findings from a music and imagery project. *Journal of the Association for Music and Imagery, 3*, 5-18.

Blake, R. (1994b). The Bonny Method of Guided Imagery and Music (GIM) in the treatment of post-traumatic stress disorder (PTSD) with adults in the psychiatric setting. *Music Therapy Perspectives, 12* (2), 125-129.

Boehm (n.d.). *Boehm flowers: Cattleya orchid*. Retrieved on 11/11/02 from http://www.someonespecial.com/cgi-bin/someone/boehm24.html

Bolwerk, C. (1990). Effects of relaxing music on state anxiety in myocardial infarction patients. *Critical Care Nursing Quarterly, 13*(2), 63-72.

Bonde, L.O. (1997). Music analysis nad image potentials in classical music. *Nordic Journal of Music Therapy, 7* (2), 121-128.

Bonde, L.O. (2002). Guided Imagery and Music and Beyond? *Nordic Journal of Music Therapy, 11* (2).

Bonny, H. (1978a). *Facilitating Guided Imagery and Music sessions*. Baltimore, MD: ICM books (GIM Monograph No.1).

Bonny, H. (1978b). *The role of taped music programs in the Guided Imagery and Music process*. Baltimore, MD: ICM books (GIM Monograph No.2).

Bonny, Helen (1983). Music Listening for Intensive Coronary Care Units: A pilot project. *Music Therapy, 3* (1), 4-16.

Bonny, H. (1989, December). *Music in the Guided Imagery and Music process: A substantive look*. Workshop presented at Molloy College, Rockville Center, NY.

Bonny, H. (1994). Twenty-one years later: A GIM update. *Music Therapy Perspectives, 12* (2), 70-74.

Bonny, H. (1997). The state of the art of music therapy. *Arts in Psychotherapy, 24* (1), 65-73.

Bonny, H L, & Savary, L.M. (1990). *Music and your mind: Listening with a new consciousness*. Barrytown, NY: Station Hill Press.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage Pubs. Inc.

Bright, R. (1997). *Wholeness in later life*. London, UK: Jessica Kingsley.

Bright, R. & Grocke, D.E. (2000). *Twenty-five years on: Music therapy in Australia, the early history of AMTA.* Wahroonga, NSW: Music Therapy Enterprises.

Brodsky, W. (1991). A personal perspective of the power of music and mass communication, prior to and during the Gulf War crisis in Israel: Implications for music therapy. *Music Therapy, 10* (1), 99-113.

Bruscia, K. (Ed.) (1991). *Case studies in music therapy*. Phoenixville, PA: Barcelona Publishers.

Bruscia, K. (1995). Differences between quantitative and qualitative research paradigms: Implications for music therapy. In B.Wheeler (Ed.), *Music therapy research: quantitative and qualitative perspectives* (pp.65-78). Phoenixville, PA: Barcelona Publishers.

Bruscia, K. (1998). *Defining music therapy* (2nd ed.). Gilsum, NH: Barcelona Publishers.

Bruscia, K.E. & Grocke, D.E. (Eds.). (2002). *Guided Imagery and Music: The Bonny method and beyond*. Gilsum, NH: Barcelona Publishers.

Burns, J.L., Labbe, E., Arke, B., Capeless, K., Cooksey, B., Steadman, A. & Gonzales, C. (2002). The effects of different types of music on perceived and physiological measures of stress. *Journal of Music Therapy, 39 (2),* 101-116.

California Rice Commission (2001). *California rice: Nature's gift.* Retrieved on 11/11/02 from http://www.calrice.org/carice/natures_gift.html

Campbell, J. (1968). *The Hero with a thousand faces* (2nd ed.). Princeton, NJ: Princeton University Press.

Cartwright, J. & Limandri, B. (1997). The challenge of multiple roles in the qualitative clinician researcher-participant client relationship. *Qualitative Health Research, 7* (2), 223-235.

Cegur's Chimera Gallery. (n.d.). *Michelangelo: Section of Sistine Chapel before/after restoration*. Retrieved on 11/11/02 from http://www.cegur.com/Michelangelo/RestorationBefore.html & http://www.cegur.com/Michelangelo/RestorationAfter.html

Charleston Antiques (n.d.). Shelly:Sunrise and Tall Trees. Retrieved on 11/11/02 from http://pages.charlestonchina.com/258/PictPage/1218488.html

Charon, R. (1993). Medical interpretation: Implications of literary theory of narrative for clinical work. *Journal of narrative and life history, 3* (1) 79-97.

Chatfield, C. (n.d.). Northern Michigan Artist/Northern Michigan Journal. Retrieved on 11/11/02 from http://www.leelanau.com/nmj/views/artist1.html

Chion, M. (2000). Projections of sound on image. In R.Stam and T. Miller (Eds.) *Film and theory: An anthology* (pp.111- 124). Oxford, UK: Blackwell Pub. Ltd.

Cirlot, J.E. (1971). *A dictionary of symbols*. New York: Philosophical Library.

Clark, M. (1991). Emergence of the adult self in Guided Imagery and Music (GIM) Therapy. In K. Bruscia (Ed.), *Case Studies in music therapy* (pp.321-331). Phoenixville PA: Barcelona Publishers.

Clark, M. (1995). The hero's myth in GIM. *Journal of the Association for Music and Imagery, 4,* 49-66.

Clinical Pathway for CABG (2002). Royal Prince Alfred Hospital, Camperdown, NSW Australia.

Cohen, N.S. (1994). Speech and song: Implications for music therapy. *Music Therapy Perspectives, 12* (1), 8-14.

Coker, W. (1972). *Music and Meaning: A theoretical introduction to musical aesthetics.* New York: Free Press.

Cooper, J.C. (1978). *An illustrated encyclopaedia of traditional symbols.* London: Thames & Hudson.

Corbett, J. (1996). *Hope is like a golf ball.* Retrieved November 30, 1998 from http://www.mrgolf.com/hope.html

Corbett, J. (1997). *Even when you do it right…* Retrieved December 1, 1998 from http://www.mrgolf.com/right.html

Cornett, S. & Watson, J. (1984). *Cardiac rehabilitation: An interdisciplinary team approach*. New York: John Wiley & Sons.

Corsini, R. & Wedding, D. (1989). *Current psychotherapies.* Itasca, Illinois: F.E. Peacock Publishers, Inc.

Cottingham, J.C. (1987). Descartes. In R.L. Gregory and O.L. Zangwill (Eds.), *Oxford companion to the mind* (pp.189-190). Oxford: Oxford University Press.

Cowan, D.S. (1991). Music therapy in the surgical arena. *Music Therapy Perspectives, 9,* 42-45.

Cullum-Swan, B. & Manning, P. (n.d.). *Codes, chronotypes and everyday objects*. Retrieved 14 July, 2002 from http://www.aber.ac.uk/media/Sections/textan07.html#8

Davey, G.B, & Seal, G. (Eds.). (1993). *The Oxford companion to Australian folklore*. Melbourne: Oxford University Press.

Davis, W., Gfeller, K. & Thaut, M. (1998). *An introduction to music therapy: Theory and practice* (2nd ed.). NY: McGraw-Hill.

Davis, L. B. & McKay, S. B. (1996). *Structures and strategies: An introduction to academic writing*. South Melbourne, Vic., Australia: Macmillan Education Australia.

Davis-Rollans, C., & Cunningham, S. (1987). Physiologic responses of coronary care patients to selected music. *Heart and Lung, 16* (4), 370-378.

Decety, J. (1993). Should motor imagery be used in physiotherapy? Recent advances in cognitive neurosciences. *Physiotherapy Theory and Practice, 9,* 193-203.

Dees, D.R. & Vera, H. (1978). Soundtracking everyday life: The use of music in redefining situations. *Sociological Inquiry, 48* (2) 133-141.

Denber, H. (1995). *Cardiac Surgery: Biological and psychological implications*. Armonk, NY: Futura Pub Co. Inc.

Deschenes, B. (1995). Music and symbols. *Music Therapy Perspectives, 13* (1), 40-45.

Dileo, C.D. (1999). *Music therapy and medicine: Theoretical and clinical approaches*. Silver Springs, MD: American Music Therapy Association.

Doka, K.J. (1995). Coping with life-threatening illness. *Omega, 32* (2), 111-122.

Dreyfus, H.L. & Dreyfus, S.E. (1986). *Mind over machine: The power of human intuition and expertise in the era of the computer*. New York: Free Press.

Dun, B. (1995). A different beat: Music therapy in children's cardiac care. *Music Therapy Perspectives, 13* (1) 35-39.

Eberhart, C. P. & Pieper, B.B. (1994). Understanding human action through narrative expression and hermeneutic inquiry. In P.L Chinn (Ed.), *Advances in methods of inquiry for nursing* (pp. 41- 58). Gaithersburg, Maryland: Aspen Publications.

Eco, U. (1985a). Producing signs. In M. Blonsky (Ed.) *On Signs: A semiotics reader* (pp.176-183). Basil Blackwell: Oxford, UK.

Eco, U. (1985b). How culture conditions the colors we see. In M. Blonsky (Ed.), *On Signs: A semiotics reader* (pp.157-175). Basil Blackwell; Oxford, UK.

Edwards, J. (1994). The use of music therapy to assist children who have severe burns. *Australian Journal of Music Therapy, 5*, 3-6.

Edwards, J. (1998). Music therapy for children with severe burn injury. *Music Therapy Perspectives, 16* (2), 13-23.

Edwards, J. (1999). Considering the paradigmatic frame: Social science research approaches relevant to research in music therapy. *Arts in Psychotherapy, 26* (2), 73-80.

Ely, M., Anzul, M., Friedman, T., Garner, D. & Steinmetz, A.M. (1991). *Doing qualitative research: Circles within circles*. London: Falmer Press.

Erdonmez, D. (1991). Music therapy – the evidence. *Australian Journal of Music Therapy, 2*, 12-24.

Erdonmez, D. (1992). Clinical applications of Guided Imagery and Music, *Australian Journal of Music Therapy, 3*, 37-44.

Erdonmez Grocke, D. (1996). *Directory of Music Therapy Training Courses World-Wide*. Complied by Denise Erdonmez Grocke, WFMT.

Erdonmez, D., Bright, R. & Allison, D. (1993). Music therapy in Australia. In C.D. Maranto (Ed.). *Music therapy: International perspectives* (pp.37-61). PA: Jeffrey Books.

Esslin, M. (1987). *The field of drama: How the signs of drama create meaning on stage and screen*. London: Methuen.

Ferrara, L. (1984). Phenomenology as a tool for musical analysis. *The Musical Quarterly, 70* (3), 355-373.

Feibusch, A. (1996-2000). *The structure of a YKK zipper*. Retrieved June 24, 2002, from http://www.zipperstop.com/faq.htm

Fiske, J. (1987). *Television culture*. London: Routledge.

Fiske, J. & Hartley, J. (1978). *Reading television*. Methuen: London.

Forinash, M. (1992). A phenomenological analysis of Nordoff-Robbins approach to music therapy: The lived experience of clinical improvisation. *Music Therapy, 11* (1), 120-141.

Forinash, M. (1993). An exploration into qualitative research in music therapy. *Arts in Psychotherapy, 20*, 69-73.

Forinash, M. & Gonzalez, D. (1989). A phenomenological perspective of music therapy. *Music Therapy, 8* (1), 35-46.Forrest, L. (2000). Addressing issues of ethnicity and identity in p[alliatiev care through music therapy practice. *Australian Journal of Music Therapy, 11*, 23-37.

Frankl, V. (1963). *Man's search for meaning: An introduction to logotherapy*. New York: Pocket books.

Freeman, L.W. & Lawlis, G.F. (2001). *Complementary and alternative medicine: A research based approach*. St. Louis, MO: Mosby.

Freud, S. (1965). *The interpretation of dreams*. New York: Avon Books.

Frey-Rohn, L. (1990). *From Freud to Jung: A comparative study of the psychology of the unconscious*. (F.E. & E.K. Engreen, Trans.). Boston: Shambhala. (Original work published 1974).

Goldberg, F. (1988). Music and imagery as psychotherapy with a brain injured patient: A case study. *Music Therapy Perspectives, 5*, 41-45.

Goldberg, F. (1995). The Bonny Method of Guided Imagery and Music. In T. Wigram, B. Saperston, and R. West (Eds.), *The art and science of music therapy: A handbook* (pp.112-128). Chur, Switzerland: Harwood Academic Publishers.

Good, M. (1996). Effects of relaxation and music on postoperative pain: A review. *Journal of Advanced Nursing, 24* (5), 905-914.

Goodman, N. (1990). Pictures in the mind? In H.Barlow, C. Blakemore and M.Weston-Smith (Eds.), *Images and understanding* (pp 358-364). Cambridge University Press.

Gottdeiner, M. (1995). *Postmodern semiotics: Material culture and the forms of postmodern life*. Oxford, UK: Blackwell.

Grocke, D.E. (1999). *A phenomenological study of pivotal moments in guided imagery and music (GIM) therapy*. Unpublished Doctoral Dissertation, University of Melbourne.

Grocke, D.E. (2002a). The evolution of Bonny's music programmes. In K.E.Bruscia & D.E. Grocke (Eds.), *Guided Imagery and Music: The Bonny method and beyond* (pp. 85-98). Gilsum, NH: Barcelona Publishers.

Grocke, D.E. (2002b). The Bonny music programmes. In K.E.Bruscia & D.E. Grocke (Eds.), *Guided Imagery and Music: The Bonny method and beyond* (pp. 99-133). Gilsum, NH: Barcelona Publishers.

Grocke, D.E. (2002c). Qualitative research in GIM. In K.E.Bruscia & D.E. Grocke (Eds.), *Guided Imagery and Music: The Bonny method and beyond* (pp. 467-480). Gilsum, NH: Barcelona Publishers.

Guiraud, P. (1975). *Semiology*. (G. Gross, Trans.). London: Routledge & Kegan Paul. (Original work published 1971)

Guzzetta, C. (1989). Effects of relaxation and music therapy on patients in a coronary care unit with presumptive acute myocardial infarction. *Heart and Lung, 18* (6), 609-616.

Guzzetta, C. (1994). Research for practice: Soothing the ischemic heart. *American Journal of Nursing, 94* (1), 24.

Hale, S.E. (1992). Wounded Woman: The use of Guided Imagery and Music in recovering from a mastectomy. *Journal of the Association for Music and Imagery, 1*, 99-106.

Hall, J.A. (1983). *Jungian dream interpretation: A handbook of theory and practice*. Toronto, Canada: Inner City Books.

Halstead, R.W. (2000). From tragedy to triumph: Counselor as companion on the hero's journey. *Counselling and Values, 44* (2), 100-106.

Handelman, S. (1978). Freud's Midrash: The exile of interpretation. In J.P. Plottel & H. Charney (Eds.), *Inter-textuality: New perspectives in criticism* (pp.99-112). New York: New York Literary Forum.

Hanninen, U. (1999). *Rewriting Literary History: Peter Ackroyd and Intertextuality*. Retrieved on 13/02/01 from http://ethesis.helsinki.fi/julkaisut/hum/engla/pg/hanninen.

Hanser, S. (1988). Controversy in music listening/stress reduction research. *Arts in Psychotherapy, 15*, 211-217.

Harkness, G.A. & Dincher, J.R. (1999). *Medical surgical nursing: Total patient care* (10^{th} edition.). St Louis, MO: Mosby Inc.

Hecker, J.E. & Kaczor, L.M. (1988). Application of imagery theory to Sport Psychology: Some preliminary findings. *Journal of Sport and Exercise Psychology, 10*, 363-373.

Heidegger, M. (1927/1962). *Being and time.* (J. Macquarrie & E.Robinson, Trans.). New York: Harper and Row (Original work published 1927).

Herman, J. (n.d.). *50 Super Blockbusters for '72*, p.28-30

Hibben, J. (Ed.). (1999). *Inside music therapy: Client experiences*. Gilsum, NH: Barcelona Press.

Hitchcock, D. (1987). The influence of Jung's psychology on the therapeutic use of music. *Journal of British Music Therapy, 1* (2), 17-21.

Hodges, D.A. (Ed.) (1996a). *Handbook of music psychology* (pp.29-68) (2nd edition). San Antonio, TX: University of Texas.

Hodges, D.A. (1996b). Human musicality. In D.A. Hodges (Ed.*), Handbook of music psychology* (pp.29-68) (2nd edition). San Antonio, TX: University of Texas.

Hogan, B. (1999). The experience of music therapy for terminally ill patients: A phenomenological research project. In R.R. Pratt & D.E. Grocke (Eds.), *MusicMedicine 3: MusicMedicine and Music Therapy: Expanding Horizons* (pp.242-252). Parkville, Victoria, Australia: University of Melbourne.

Husserl, E. (1931). *Ideas: A general introduction to pure phenomenology*. (W.R Boyce Gibson, Trans.). London: George Allen and Unwin Ltd. (Original work published 1913).

Ingram, J.L. (1994). The role of figurative language in psychotherapy: A methodological examination. *Metaphor and Symbolic Activity, 9* (4), 271-288.

Irgens-Møller, I. (1995). Guided Imagery and Music: Discovering personal resources. Unpublished Masters Thesis (Music Therapy), Aalborg University, Denmark.

Jacobi, E. (2002, July). *Guided Imagery and Music (GIM) in the treatment of rheumatoid arthritis.* Paper presented at the 10th World Congress of Music Therapy, Oxford, UK.

Jacobson, E. (1942). *Progressive relaxation*. Chicago, University of Chicago Press.

Jakobson, R. (1960). Closing Statement: Linguistics and Poetics. In T. Sebeok (Ed.), S*tyle in Language* (pp. 350-77). Cambridge, MA: M.I.T. Press.

Johnson, D.R. (1987). The role of the creative arts therapies in the diagnosis and treatment of psychological trauma. *Arts in Psychotherapy, 14*, 7-13.

Johnson, R. A. (1974). *He: Understanding masculine psychology*. King of Prussia, PA: Religious Publishing Co.

Jowdy, D.P. & Harris, D.V. (1990). Muscular responses during mental imagery as a function of motor skill level. *Journal of Sport and Exercise Psychology, 12*, 191-201.

Jung, C.G. (1965). *Memories, Dreams and Reflections.* (A. Jaffe, Recorder and Editor). (R. & C. Winston, Trans.). (Rev. Ed.). New York: Random House. (Original work published 1961).

Jung, C.G. (1968a) *The archetypes and the collective unconscious (R.F.C. Hull, Trans.)*. London: Routledge. (Original work published 1934/54)

Jung, C.G. (1968b) *Analytical psychology: Its theory and practice (The Tavistock lectures)*. New York: Pantheon.

Kasayka, R. (1991). *To meet and match the moment of hope: Transpersonal elements of the Guided Imagery and Music experience*. Doctoral Dissertation, New York University.

Kastenbaum, R. (2000). *The psychology of death* (3rd edition). New York: Springer.

Kaushik, M. & Sen, A. (1990). Semiotics and qualitative research. *Journal of the Market Research Society, 32* (2), 227-242.

Kay, S.-E. C. (1992). *Patients awaiting coronary artery bypass graft (CABG) surgery: The patient's experience*. Unpublished Masters Thesis (Nursing), University of Technology, Sydney.

Keegan, L. (2000). Protocols for practice: Alternative and complementary modalities for managing stress and anxiety. *Critical Care Nurse, 20* (3), 93-96.

Keller-Cohen, D. & Dyer, J. (1997). Intertextuality and the narrative of personal experience. *Journal of Narrative & Life History, 7* (1-4), 147-153.

Kennelly, J. (1999). "Don't give up": Providing music therapy to an adolescent boy in the bone marrow transplant unit. In R.R. Pratt & D.E. Grocke (Eds.), *MusicMedicine 3: MusicMedicine and Music Therapy: Expanding Horizons* (pp.228-237). Parkville, Victoria, Australia: University of Melbourne.

Kerson, T. (1985). *Understanding chronic illness: The medical and psychosocial dimensions of nine diseases.* NY: Free Press.

Khan, I. (1959). *Music*. New York: Samuel Weiser.

Koplinski, C. (n.d.). Letting it ride with Oscar and Lucinda. Retrieved February 4, 2002, from http://www.8am.com/welcome/film/oscarluc.htm.

Kosslyn S.M. & Koenig, O. (1992). *Wet mind: The new cognitive neuroscience*. New York: Macmillan.

Kramer, J.D. (1988). *Listening to music: The essential guide to the classical repertoire*. London: Schirmer Books.

Kristeva, J. (1986). Word, Dialogue and Novel. (A. Jardine, T. A. Gora & L. S. Roudiez, Trans.). In T. Moi (Ed.), *The Kristeva Reader* (pp.34-61). Oxford, UK: Basil Blackwell. (Original work published 1969).

Kristeva, J. (1986). From symbol to sign. (S. Hand, Trans.). In T. Moi (Ed.), *The Kristeva Reader* (pp.62-73). Oxford, UK: Basil Blackwell. (Original work published 1970).

Kubler-Ross, E. (1969). *On death and dying*. New York: Macmillan.

Lanceley, A. (1995). Wider issues in pain management. *European Journal of Cancer Care, 4* (4), 153-157.

Langenberg, M., Aigen, K. & Frommer, J. (Eds). (1996). *Qualitative music therapy research: Beginning dialogues.* Gilsum, NH: Barcelona Publishers.

Lather, P. (1991). *Feminist Research in Education: Within/against*. Deakin University, Geelong, Vic.

Lawson, H. (1918/1984). *Poetical works of Henry Lawson*. Sydney, Australia: Angus & Robertson.

Lem, A. (Ed.). (1993). *Music therapy collection*. Braddon, ACT: Ausdance.

Lem, A. (1998). EEG reveals potential connections between selected categories of imagery and the psycho-acoustic profile of music. *Australian Journal of Music Therapy, 9*, 3-17.

Lem, A. (1999). Selected patterns of brainwave activity point to the connection between imagery experiences and the psychoacoustic qualities of music. In R.R. Pratt & D.E. Grocke (Eds.), *MusicMedicine 3: MusicMedicine and Music Therapy: Expanding Horizons* (pp.75-87). Parkville, Victoria, Australia: University of Melbourne.

LeVasseur, J. J. (2002). A phenomenological study of the art of nursing: Experiencing the turn [Health Transitions]. *Advances in Nursing Science, 24* (4), 14-26.

Lewis, K. (2002). The development of training in the Bonny Method of Guided Imagery and Music (BMGIM) from 1975-2000. In K.E. Bruscia & D.E. Grocke (Eds.), *Guided Imagery and Music: The Bonny method and beyond* (pp. 497-517). Gilsum, NH: Barcelona Publishers.

Lindholm, E. (1998-9). *Beethoven: Symphony #6, "Pastoral"*. Pomona College Orchestra. Retrieved on 28/11/02 from http://pages.pomona.edu/~elindholm/bee_6.htm

Linell, P. (1998). Discourse across boundaries: On recontextualizations and the blending of voices in professional discourse. *Text, 18* (2), 143-157.

Lucas, J. (1997). Making sense of interviews: The narrative dimension. *Social Sciences in Health, 3* (2), 113-126.

Macarthur, S. (1995). Keys to the musical body. In B. Caine & R. Pringle (Eds.), *Transitions: New Australian feminisms* (pp.120-133). St. Leonards, NSW: Allen & Unwin.

MacDonald, R.A.R, Ashley, E.A., Davies, J.B., Serpell, M.G., Murray, J.L., Rogers, K & Millar, K. (1999). The anxiolytic and pain reducing effects of music on post-operative analgesia. In R.R. Pratt & D.E. Grocke (Eds.), *MusicMedicine and music therapy: Expanding horizons* (pp.12-18). Parkville, Vic., Australia: University of Melbourne.

MacLachlan, G.L. & Reid, I. (1994). *Framing and interpretation*. Carlton, Vic.: Melbourne University Press.

MacNay, S.K. (1995). The influence of preferred music on the perceived exertion, mood and time estimation scores of patients participating in a cardiac rehabilitation exercise programme. *Music Therapy Perspectives, 13* (2), 91-96.

McCurdy, J. (1991). The structural and archetypal analysis of fairy tales. In M. Stein & L. Corbett (Eds.), *Psyche's Stories* (pp.1-15). Wilmette, Illinois, USA: Chiron Publications.

McKinney, C. (1995a). The effects of Guided Imagery and Music on depression and beta-endorphin levels in healthy adults: A pilot study. *Journal of the Association for Music and Imagery*, *4*, 67-78.

McKinney, C.H. (1995b). Differential effects of selected classical music on the imagery of high versus low imagers: Two studies. *Journal of Music Therapy, 32* (1), 22-45.

McKinney, C. (July, 1996). Personal communication. Vancouver, Canada.

McKinney, C. (2002). Quantitative research in Guided Imagery and Music (GIM): A review. In K.E. Bruscia & D.E. Grocke (Eds.), *Guided Imagery and Music: The Bonny method and beyond* (pp. 449-466). Gilsum, NH: Barcelona Publishers.

McMullen, P.T. (1996). The musical experience and affective/aesthetic responses: A theoretical framework for empirical research. In D.A. Hodges (Ed.*), Handbook of music psychology* (pp.387- 400) (2nd edition). San Antonio, TX: University of Texas.

Magill, L. (2001). The use of music therapy to address the suffering in advanced cancer pain. *Journal of Palliative Care, 17* (3), 167-172.

Mandel, S.E. (1996). Music for wellness: Music therapy for stress management in a rehabilitation program. *Music Therapy Perspectives, 14* (1), 38-43.

Manning, P. & Cullum-Swan, B. (1994). Narrative, content, and semiotic analysis. In N.Denzin and Lincoln, Y. (Eds.), *Handbook of qualitative research*. (pp.463-477). Thousand Oaks, CA: Sage Publications.

Marr, J. (1998). GIM at the end of life: Case studies in palliative care. *Journal of the Association for Music and Imagery*, 6, 37-54.

Marr, J. (2000). *The effects of music on imagery sequence in the Bonny Method of Guided Imagery and Music (GIM).* Unpublished Masters Thesis (Music Therapy), University of Melbourne.

Marr, J. (2001). The effects of music on imagery sequence in the Bonny method of Guided Imagery and Music (GIM). *Australian Journal of Music Therapy, 12*, 39-45.

Mattoon, M.A. (1984). *Understanding Dreams*. Woodstock, CT: Spring Publications.

May, R. (1991). *The cry for myth*. New York: Dell Publishing.

Melzack, R. & Wall, P.D. (1983). *The challenge of pain*. NY: Basic Books.

Merritt, S. (1993). The healing link: Guided Imagery and Music and the body/mind connection. *Journal of the Association for Music and Imagery, 2,* 11-28.

Miller, J.F. (2000). *Coping with chronic illness: Overcoming powerlessness* (3rd edition). Philadephia, PA: F.A. Davis Co.

Miller, W.L. & Crabtree, B.F. (1998). Clinical research. In N.K. Denzin and Y.S. Lincoln (Eds.), *Strategies of qualitative inquiry* (pp. 292-314). Thousand Oaks, CA: Sage Publications.

Mishler E. (1986). Research Interviewing: Context and narrative. Cambridge, MA: Harvard University Press.

Moe, T. (2002). Restitutional factors in group music therapy with psychiatric patients based on a modification of Guided Imgagery and Music (GIM). Retrieved on 25 February, 2003 from http://www.musictherapyworld.net/modules/archive/programs/mtfxd02g.htm

Moffit, E. (1991). Improvisation and Guided Imagery and Music (GIM) with a physically disabled woman: A Gestalt approach. In K. Bruscia (Ed.) *Case Studies in Music Therapy*. (pp. 347-356). Phoenixville, PA: Barcelona Publishers.

Moi, T. (1986). Introduction. In T.Moi (Ed.), *The Kristeva Reader* (pp.1-22). Oxford, UK: Basil Blackwell.

Morgan, T.E. (1985). Is there an intertext in this text? Literary and interdisciplinary approaches to intertextuality. *American Journal of Semiotics, 3* (4) , 1-40.

Morse, J.M. & Field, P.A. (1995). *Qualitative research methods for health professionals* (2nd edition). Thousand Oaks, CA: Sage Publications.

National Heart Foundation of Australia, Deakin ACT. Retrieved on 14 July, 2002, from http://www.heartfoundation.com.au

Nessa, J. (1996). About signs and symptoms: Can semiotics expand the view of clinical medicine? *Theoretical medicine, 17*, 363-377.

NetDoctor (1998-2001). Support Groups: British Cardiac Patients Association (Zipper Club). Retrieved June 24, 2002 from http://www.netdoctor.co.uk/directory/support_groups/sg.asp?PID=296

Nissenson, K. (January-May, 1986). *Advanced clinical piano improvisation.* Seminars contributing to Music Therapy Masters' Degree, New York University.

Noble, K.D. (1990). The female Hero: A quest for healing and wholeness. *Women and Therapy, 9* (4) 3-18.

Nolan, P. (1992). Music therapy with bone marrow transplant patients: reaching beyond the symptoms. In R.Spintge & R.Droh (Eds.), *MusicMedicine* (pp. 209-212). St. Louis, MO: MMB Music.

Lem, A. (1999). Selected patterns of brainwave activity point to the connection between imagery experiences and the psychoacoustic qualities of music. In R.R. Pratt & D.E. Grocke (Eds.), *MusicMedicine 3: MusicMedicine and Music Therapy: Expanding Horizons* (pp.75-87). Parkville, Victoria, Australia: University of Melbourne.

Nordoff, P. & Robbins, C. (1977). *Creative Music Therapy*. New York: John Day.

North Shore Cardiovascular Education Centre (n.d.). *Types of heart surgery*. Retrieved 24/6/2002 from http://www.clininfo.health.nsw.gov.au/hospolic/CVascEdCent-CIAP/Booklets/Surgical/surgical3-09.htm

O'Callaghan, C. (2001). Bringing music to life: A study of music therapy and palliative care experiences in a cancer hospital. *Journal of Palliative Care, 17* (3), 155-160.

Olteanu, M. (1997). *Basilica di San Pietro: Michelangelo, Pieta*. Retrieved on 11/11/02 from http://www.christusrex.org/www1/citta/B1-Pieta.html

Owen, M. & Holmes, C. (1993). "Holism" in the discourse of nursing. *Journal of Advanced Nursing, 18* (11) 1688-95. Pascual-Leone, A. (2001). The brain that plays music and is changed by it. In R.J. Zatorre & I. Peretz (Eds.), *The biological foundations of music (pp.315-329)*. Annals of the New York Academy of Sciences, Vol 930.

Patient Care Services (n.d.). *Zipper Club History*. Retrieved 24/6/2002 from http://www.deborah.org/consumer/clubs/zipper/zipper0.html

Patton, M.Q. (1990). *Qualitative evaluation and research methods (2nd Ed.)* Newbury Park, CA: Sage Publications.

Pearson, C.S. (1989). *The hero within: Six archetypes we live by*. San Francisco, Harper & Row.

Pickett, E. (1987). Fibroid tumors and response to Guided Imagery and Music: Two case studies. *Imagination, Cognition and Personality, 7* (2), 1987-88.

Pickett, E. (1996-7). Guided Imagery and Music in head trauma rehabilitation. *Journal of the Association for Music and Imagery, 5*, 51-60.

Pike, K.L. (1954). *Language in relation to a unified theory of the structure of human behavior*. Glendale, CA: Summer Institute of Linguistics.

Pike, K.L. (1967). Etic and emic standpoints for the description of behavior. In D.C. Hildum (Ed.), *Language and thought: an enduring problem in psychology*, (pp.32-39). Princeton, NJ: D.Van Norstrand Co.

Polkinghorne, D.E. (1988). *Narrative knowing and the human sciences*. Albany, NY: State University of New York Press.

Polkinghorne, D.E. (1991). Narrative and self-concept. *Journal of Narrative and Life History. 1* (2&3), 135-153.

Polkinghorne, D.E. (1996). Transformative narratives: From victimic to agentic life plots. *American Journal of Occupational Therapy, 50* (4), 299-305.

Pratt, R.R. (1999). Music and infant well-being. In R.R. Pratt & D.E. Grocke (Eds.), *MusicMedicine 3: MusicMedicine and Music Therapy: Expanding Horizons* (pp.101-119). Parkville, Victoria, Australia: University of Melbourne.

Pratt, R.R. & Grocke, D.E. (Eds.). (1999). *MusicMedicine and music therapy: Expanding horizons*. Parkville, Vic., Australia: University of Melbourne.

Priestley, M. (1987). Music and the shadow. *Music Therapy, 6* (2), 20-27.

Priestley, M. (1995). Linking sound and symbol. In T.Wigram, B. Saperston & R.West (Eds.), *The art and science of music therapy: A handbook* (pp 129-138). Chur, Switzerland: Harwood Academic Publishers.

Prince, G. (1982). *Narratology: The form and function of narrative*. Berlin: Walter de Gruyter & Co.

Rader, C.M. & Tellegen, A. (1987). An investigation of synesthesia. *Journal of Personality and Social Psychology, 52* (5), 981-987.

Radocy, R. & Boyle, J. (1997). *Psychological foundations of musical behavior (3rd ed.)*. Springfield, Illinois: Charles C. Thomas.

Rankin-Box, D. & Campbell, K. (2000). Is there a rational basis underlying alternative medicine? *Nursing Times, 96* (23), 18.

Raskin, N.J. & Rogers, C.R. (1989). Person-centered therapy. In R.J. Corsini & D. Wedding. *Current psychotherapies* (4th ed.) (pp.155-194). Itasca, IL: F.E. Peacock Publishers.

Redeker, N.S., Mason, D.J., Wykpiaz, E. & Glica, B. (1996). Sleep patterns in women after coronary artery bypass surgery. *Applied Nursing Research, 9* (3), 115-122.

Reid, M. (1988). Towards an epistemology of the imagination. Special issue: Metaphor and human understanding. *Saybrook Review, 7* (1), 21-33.

Robson, C. (1993). *Real world research: A resource for social scientists and practitioner-researchers*. Oxford, UK: Blackwell.

Rogers, C.R. (1961). *On becoming a person*. Boston: Houghton Mifflin.

Rogers, C.R. (1980). *A way of being*. Boston: Houghton Mifflin.

Ruud, E. (1998). *Music therapy: Improvisation, communication and culture*. Gilsum, NH: Barcelona Publishers.

Ruud, E. (2000). *"New musicology", music education and music therapy*. Retrieved on 25 February, 2003 from http://www.hisf.no/njmt/artikkelruudnewmusic.html#top

Rudestam, K.E. & Newton, R.R. (1992). *Surviving your dissertation: A comprehensive guide to content and process*. Newbury Park, CA: Sage Publications.

Sandness, M.I. (1995). The role of music therapy in physical rehabilitation programs. *Music Therapy Perspectives, 13* (2), 76-81.

Scholes, R. (1982). *Semiotics and interpretation*. New Haven, CT: Yale University Press.

Schultz, J.H. & Luthe, W. (1959). *Autogenic training: A physiologic approach to psychotherapy*. New York: Grune and Stratton.

Sears, W.W. (1968). Processes in music therapy. In E.T. Gaston (Ed.), *Music in therapy* (pp.30-44). New York: MacMillan Pub.Co.

Sebeok, T.A. (Ed). (1964). *Approaches to semiotics*. The Hague, The Netherlands: Mouton & Co.

Sebeok, T.A. (Ed.). (1986). *Encyclopedic dictionary of semiotics*. Berlin: Mouton de Gruyter.

Sebeok, T. & Sebeok, J. (Eds.). (1994). *Advances in visual semiotics.* Berlin: Mouton de Gruyter.

Sergent, J. (1996). Human brain mapping. In R.R.Pratt & R.Spintge (Eds.), MusicMedicine Volume 2 (pp. 24-49). Saint Louis, MO: MMB Music.

Short, A. (1990). Physical illness in the process of Guided Imagery and Music. *Australian Journal of Music Therapy, 1*, 9-14.

Short, A. (1991). The role of Guided Imagery and Music in diagnosing physical illness or trauma. *Music Therapy, 10* (1), 22-45.

Short, A. (1992a). Music and imagery with physically disabled elderly residents: A GIM adaptation. *Music Therapy, 11* (1), 65-98.

Short, A. (June, 1992b). Memories and inspiration: Music and imagery with elderly physically disabled residents. *Proceedings of 21st Conference of the American Association for Music Therapy,* (pp. 57-71). Cape Cod, MA: AAMT.

Short, A. (1992c). Isoprinciple: The group approach. *Australian Journal of Music Therapy, 3,* 57-62.

Short, A. (1993a). GIM during pregnancy: Anticipation and resolution. *Australian Journal of Music Therapy, 4*, 7-18.

Short, A. (1993b). GIM during pregnancy: Anticipation and resolution. *Journal of the Association for Music and Imagery, 2*, 73-86.

Short, A. (1996-7). Jungian archetypes in GIM therapy: Approaching the client's fairytale. *Journal of the Association for Music and Imagery, 5,* 37-49.

Short, A. (1997, 17 July). *Messages from the heart*. Paper presented at Graduate Seminars, School of Nursing, Midwifery and Health, UTS, Lindfield, Sydney, Australia.

Short, A. (2002a). Guided Imagery and Music (GIM) in medical care. In K.E. Bruscia & D.E. Grocke (Eds.), *Guided Imagery and Music: The Bonny method and beyond* (pp. 151-170). Gilsum, NH: Barcelona Publishers.

Short, A. (2002b, July). *Clinical and music texts in counterpoint: Researching the basis of GIM with cardiac patients.* Paper presented at the 10th World Congress of Music Therapy, Oxford, UK.

Short, A. & Cameron, F. (1999). Music therapy A sound practice. *Geriaction, 17* (3), 18-20.

Short, A. & William (1999). Review of GIM Sessions: William's story. In J. Hibben (Ed.), *Inside music therapy: Client experiences* (pp. 153-161). Gilsum, NH: Barcelona Press.

Shuttleworth-Jordan, A., Saayman, G. & Faber, P. (Oct.,1988). A systemized method for dream analysis in a group setting. *International Journal of Group Psychotherapy, 38* (4), 473-489.

Siahpush, M. (1999). Why do people favour alternative medicine? *Aust.N.Z.Public Health, 23* (3), 266.

Simonton, O.C., Matthews-Simonton, S. & Creighton, J.L. (1980). *Getting Well Again*. New York: Bantam.

Simpson J.A. & Weiner, E.S.C. (Eds). (1989). *The Oxford English dictionary* (2nd edition). Oxford, UK: Clarendon Press.

Slotoroff, C. (1994). Drumming techniques for assertiveness and anger management in the short-term psychiatric setting for adult and adolescent survivors of trauma. *Music Therapy Perspectives, 12* (2), 111-116.

Smith, B., Connole, H., Speedy, S. & Wiseman, R. (1990). *Issues and method in research: Study guide*. Adelaide, SA: South Australian College of Advanced Education.

Spintge, R. (1999). MusicMedicine: Applications, standards, and definitions. In R.R. Pratt & D.E. Grocke (Eds.), *MusicMedicine 3: MusicMedicine and Music Therapy: Expanding Horizons* (pp.3-11). Parkville, Victoria, Australia: University of Melbourne.

Staiano, K.V. (1986). *Interpreting signs of illness: A case study in medical semiotics.* Berlin: Mouton de Gruyter.

Standley, J. M. (1986). Music research in medical/dental treatment: Meta-analysis and clinical applications. *Journal of Music Therapy, 21*, 184-193.

StarPet (n.d.). Babe. Retrieved 28 June, 2002 from http://www.starpet.com/movie_babe.html

Staum, M.J. (1992). The role of music therapy in physical rehabilitation. In R.Spintge & R.Droh (Eds.), *MusicMedicine* (pp. 267-270). St. Louis, MO: MMB Music.

Staum, M.J. & Brotons, M. (2000). The effect of music amplitude on the relaxation response. *Journal of Music Therapy, 37* (1), 22-39.

Stephens, R. (1993a). Imagery: A strategic intervention to empower clients: Part 1 - Review of research literature. *Clinical Nurse Specialist, 7* (4), 170-174.

Stephens, R. (1993b). Imagery: A strategic intervention to empower clients: Part 2 - A practical guide. *Clinical Nurse Specialist, 7* (5), 235-240.

Stevens, A. (1990). *On Jung.* London: Penguin Books.

Stevenson, R.L. (1885/1989). *A child's garden of verse*. Chicago, IL: Kipling Press.

Stige, B. (1999, November). *Hypertext in music therapy.* Paper presented at the 9th World Congress of Music Therapy, Washington DC, USA.

Summer, L. (1997). Considering the future of music therapy. *Arts in Psychotherapy, 24* (1), 75-80.

Tamplin, J. (2000). Improvisational music therapy approaches to coma arousal. *Australian Journal of Music Therapy, 11*, 38-51.

Tarasti, E. (1994). *A theory of music semiotics.* Bloomington, Indiana: Indiana University Press.

Tasney, K. (1993). Beginning the healing of incest through Guided Imagery and Music : A Jungian perspective. *Journal of the Association for Music and Imagery, 2*, 35-47.

Taylor, B. (n.d.). Cockles and Mussels. Retrieved February 4, 2002, from http://www.contemplator.com/folk/cockles.html.

Taylor, D.B. (1997). *Biomedical foundations of music as therapy*. Saint Louis, MO: MMB Inc.

Thomas, B.S. (1990). *Nursing research: An experiential approach*. St. Louis, Missouri: C.V. Mosby Co.

Thomson, W.A.R. (1979). *Black's medical dictionary* (32nd ed). London: Adam & Charles Black.

Toga, A.W. & Mazziotta, J.C. (2001). *Brain mapping: The systems.*

Toomey, L. (1996-7). Literature Review: The Bonny Method of Guided Imagery and Music. *Journal of the Association for Music and Imagery, 5,* 75-103.

Tripp-Reimer, T. (1984). Reconceptualizing the construct of health: Integrating emic and etic perspectives. *Research in Nursing and Health, 7,* 101-109.

University of Melbourne (2003). *Graduate Diploma in Guided Imagery and Music.* Retrieved on 23 February, 2003, from www.unimelb.edu.au

Urdang, L. & Flexner, S.B. (Eds.). (1968). *Random House Dictionary of the English Language: College Edition*. New York: Random House.

Van der Kolk, B. (2000, March). *If the body keeps the score, who keeps score of the body?* Paper presented at 3rd World Conference for the International Society for Traumatic Stress Studies, Carlton Crest Hotel, Melbourne, Australia.

Van Leeuwen, R. & Inglis, J.T. (1998). Mental practice and imagery: A potential role in stroke rehabilitation. *Physical Therapy Reviews, 3,* 47-52.

Vealey, R.S. & Walter, S.M. (1993). Imagery training for performance enhancement and personal development. In J.M. Williams (Ed.) *Applied sport psychology: Personal growth to peak performance* (2nd ed.) (pp.200-221). Mountain View, CA: Mayfield Publishing Company.

Ventre, M. (1990). *Level Two GIM training lectures.* Unpublished manuscript. New York University/Creative Therapies Institute, NY.

Ventre, M. (1994). Healing the wounds of childhood abuse: A Guided Imagery and Music case study. *Music Therapy Perspectives, 12* (2), 98-103.

Ventres, W. B. (1994). Hearing the patient's story: Exploring physician-patient communication using narrative case reports. *Family Practice Research Journal, 14* (2), 139-147).

Vermaas, W. (1998). *An introduction to photosynthesis and its applications*. Center for the study of early events in photosynthesis: Arizona State University. Retrieved June 28, 2002, from http://photoscience.la.asu.edu/photosyn/education/photointro.html

Viney, L.L & Bousfield, L. (1991). Narrative analysis: A method of psychosocial research for AIDS-affected people. *Soc. Sci. Med., 32* (7), 757-765.

Voelz, J.W. (1995). Multiple signs, levels of meaning and self as text: Elements of intertextuality. *Semeia 69/70,* 149-164.

Walter, B. (February 21, 2002). *Anderson happy to be one of the boys again*. Retrieved 24/6/2002 from http://old.smh.com.au/news/0202/21/sport/sport7.html

Ward, K.M. (2002). A Jungian orientation to the Bonny Method. In K.E. Bruscia & D.E. Grocke (Eds.), *Guided Imagery and Music: The Bonny method and beyond* (pp. 208-224). Gilsum, NH: Barcelona Publishers.

Wheeler, B. (1987). Levels of therapy: The classification of music therapy goals. *Music Therapy, 6* (2), 39-49.

Wheeler, B. (Ed.). (1995). *Music therapy research: Quantitative and qualitative perspectives*. Phoenixville, PA: Barcelona Publishers.

White, J. (1992). Music therapy: An intervention to reduce anxiety in the myocardial infarction patient. *Clinical Nurse Specialist, 6*(2), 58-63.

White, J.M. (2000). State of the science of music interventions: critical care and perioperative practice. *Critical Care Nursing Clinics of North America, 12* (2), 219-25.

Winter, M.J., Paskin, S. & Baker, T. (1994). Music reduces stress and anxiety of patients in the surgical holding area. *Journal of Post Anesthesia Nursing, 9* (6), 340-43.

Woods, J. (1997). Conceptualizing advanced nursing practice: curriculum issues to consider in the educational preparation of advanced practice nurses in the UK. *Journal of Advanced Nursing, 25* (4), 820-828.

Zahourek, R. (1998). Imagery. *Alternative Health Practitioner, 4* (3), 203-231.

Zimmerman, L., Pierson, M., & Marker, J. (1988). Effects of music on patient anxiety in coronary care units. *Heart and Lung, 17* (5), 560-566.

Zipper Society (n.d.). *The zipper society*. Retrieved June 24, 2002, from http://www.bellringing.freeserve.co.uk/zipper