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36 Rhizomatic Networking Leading to Co-musicking Processes: A Case Study of a Boy with Adrenoleukodystrophy (ALD)

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1. Introduction

In the medical model of music therapy, music has been regarded mainly as the core entity for treatment. On the other hand, in recent sociocultural oriented models (contextual models), the metaphor of music has been radically changing: music is perceived as encompassing a broader range of activities from psycho-biological core-musicality to sociocultural musicking activity (Stige, 2002) (Pavlicevic and Ansdell, 2004, 2009). These musical concepts, however, are still regarded in the modernist view of humanity as progressive subjects who individualized and then grew up in relation with society since the Enlightenment.

Considering the actual musical-therapeutic processes on clients who have unusual ways of communication, such as those with autism, and those in a vegetative state, there seems to be a minor deliberation on the category of clients that cannot be apprehended with the modernist view of treatment. I believe postmodern thoughts, non-Western musical conceptions or contemporary arts, including music and dance, could offer valuable insight for realizing and attaining a broader understanding of music in music therapy. In this paper, I would like to discuss an alternative way of improvisational music therapy processes through a retrospective case study of a boy with

Adrenoleukodystrophy (ALD), whose condition deteriorated rapidly until he reached a vegetative state.

2. The case study of Naoya

Naoya was diagnosed with ALD at 11 years of age; this diagnosis was prompted by his increasingly poor performance at school. According to the Japan Intractable Diseases Information Center, ALD is a genetic disorder that leads to progressive brain damage, failure in adrenal gland function, and eventually death (http://www.nanbyou.or.jp/sikkan/109_2.htm). Patients often reach a vegetative state within 1 to several years after the onset of ALD symptoms, and there is currently no cure for the disease. Naoya has only received supportive care because of the rapid deterioration of his condition.

One year after the onset of the disease, improvisational music therapy sessions were started. However, his condition seemed to deteriorate rapidly, and I wondered how I would interact with him musically. The music sessions comprised 30 turns of 30-minute individual sessions at the music room of the Medical Welfare Center in Hyogo prefecture. The 3 key episodes of the case study will be presented in the following sections.

2-1. Manifestation

At the beginning of the 8th session, Naoya beat the drums and hammered the piano keys messily and impatiently. As I wanted to introduce a constructive and organized activity for him, I started to play the piano, moving my body in a way that simulated the movements of a gymnast. He soon began to follow me, and I expected improvement in his technique. However, between a brief pause, he blew a vivid bird whistle at me. Listening to the intensive quality of the sound, I hesitated for a moment.

The sound of the whistle made me realize my tacit premise with regard to understanding music therapy. I unconsciously intended to “develop” the client’s expression “musically” or “therapeutically” from a one-sided view of order. In my interpretation, Naoya’s impatient beating of the drums represented a state of “disorder” musically and therapeutically, whereas, my body movements represented a state of “order.” This might strengthen my

views on music therapy. However, the sound of his bird whistle was, for me, "the bare sound" itself. It had a kind of strong intentionality which was something that I did not expect.

The German music therapist Gustorff asserts that breathing and involuntary movements of coma patients can be seen as signs of their *manifestation* (Gustorff, 2002). She tries to regard the patients' condition as not a deficit but rather as their offer and a starting point for therapeutic activities. She says that their manifestations should be received without judgment, as a gesture. She suggests that we can regard clients' manifestations as their own unique expressions. Following her suggestions, the sound of Naoya's bird whistle can be regarded as his manifestation, and it has become the starting point for our new musical-therapeutic relationship.

2-2. Impossibility of understanding

By the 24th session, Naoya's condition worsened. His voice and facial expression deteriorated, and he became slightly hyperactive. Thereafter, he showed a disturbance of gait and an impairment of coordination. It became increasingly difficult to understand his current feelings and actions.

In the 24th session, Naoya was leaning against the piano and swinging haphazardly. I tried to swing with him to experience his world. I improvised attentively to his moving, breathing, mood, and so on. However, I was not able to understand how he felt, or whether he played the piano intentionally. As the sessions progressed, I could hear a sound that I was unable to identify. It was actually a harmonic overtone caused by Naoya putting his hands on the piano. The sound inspired me to play the pentatonic chords, which are the black keys on the piano, so as to make the sound resonate more. Soon, his swinging movement changed to a side to side movement, and our shoulders touched occasionally. I started to spontaneously sing "Naoya is here". I felt his presence strongly, and feeling of togetherness.

This process might be seen as a possible intersubjective experience for a client and therapist from the state of mismatching towards the interactional state of coordination. Pavlicevic points out that a music therapist's task is to "read" the *vitality affects* of the client (Pavlicevic, 1997). According to Stern (1985), *vitality affects* are an "amodal" form of perception that describes the amodal dynamic, kinetic quality of our experiences. It is perceived as an innate capacity of perception that infants can "encode" the shape, intensity

level, motion, number, and rhythm into amodal representations.

However, Naoya's inner state was difficult to "read." Nevertheless, I had been led to believe that we were in together. At that time, I believed that all I could was react to his actions without knowing his inner state. This shows that "reading" and "knowing" a client's inner state may not be necessary. Rather, the impossibility of understanding others seems to be a more useful point of view. It does not mean absolute *impossibility, but being open* in the future to understanding by bracketing a client's expression.

2-3. Art of living

After a 6-month interval, at session 27, Naoya's medical condition worsened, and I was shocked to see him. He had begun using a reclining wheelchair and was fed by a tube, but his subtle musical sense remained the same. In session 27, I focused on his breath, arousal level, mumbling, eye blinking, eye and body movement, muscle tone, and so on as musical parameters. I improvised with him regarding these focus points as his expression.

In this regard, Naoya's physical reaction comprised not just a simple physical reflex but a reaction in response to an action. German music therapist Herkenrath considers a coma patient a living person in possession of his/her most essential characteristic, consciousness, and who lives a form of life that for him/her is normal, although the music therapist is unable to perceive or understand it (Herkenrath, 2005). By relating Naoya's expression to his active reaction, we can see him not only as passive patient but as living existence in specific forms of life. Herkenrath call it *art of living*. To regarding client's life as *art of living* means the collaboration and the cooperation in music making process where the client and therapist perform as expressive subject each other.

3. Rhizomatic networking leading to co-musicking processes

As a result of the examination of this brief case study, 3 viewpoints, *manifestation*, *impossibility of understanding*, and *art of living*, have been further discussed. The common point among these 3 points is how the client's expression can be treated under the unstable and difficult conditions of self-expression. It might be necessary to regard each client's expression as a

singularity, and treat it as it is. Therefore, these viewpoints suggest that the music therapist does not always need to direct the client's expression towards a fixed musical-therapeutic goal. Rather, we may regard it as singular, omnidirectional potentiality.

Therefore, it is debatable how the client and the therapist collaborate and co-create a common musical time-space while retaining their different cultures and musicality. In an attempt to describe it, I would like to introduce Deleuze-Guattari's ideas of music (Deleuze-Guattari, 1980). For them, music is not only a human-specific art but is regarded as a transversal phenomenon penetrating a whole living thing in its natural world. It seems to be open to heterogeneity and oriented towards the alternative of the modern Western view of music, therapy, and human beings.

Following them, the music therapy room can be seen as a *milieu* in which the client and the therapist are both present. There is no presupposed understanding of "music" between them. Each of them exists also as a *milieu* consisting of a variety of their internal-external *milieus*/conditions. The client and the therapist continue to communicate and pass into their ever-changing *milieus* through their musical/nonmusical interaction. As I mentioned above, *impossibility of understanding* is a viewpoint in which the therapist communicates the client's action without interpreting her/him by bracketing the client's expression. In practice, however, it cannot be perceived without any interpretation. Thus, the therapist perceives the *milieus* including the client's performance as individual musical parts and makes a countermelody by temporal interpretation that may be cut off at any time. When it is cut off, a *rhizomatic* transition seems to occur. *A rhizome* is like a subterranean stem, and any point of it can be connected to any other heterogeneous object. Every time this transition occurs, components of *milieus*, created by each other's musical performances, have been reorganized and have opened different musical phases. As such a process is repeated, the sound and gesture of the client and the therapist becomes "a sound" and "a gesture" that has escaped from a previously given meaning and function. At the same time, all the "noise," the sounds not given a specific musical function and thus eliminated, emerge as possible musical elements here. The music therapy room is becoming a singular musical time-space where both the client and the therapist are becoming expressive subjects beyond their assigned role and relationship.

What I have attempted to describe in this paper is that improvisational music therapy processes are continuously making and re-making networks in/with their multiple *milieus* by more than just a one-way or two-way mode of communication between a therapist and client. Improvisational music therapy processes can be more open to heterogeneity, in which the client can be an active part of the co-musicking process despite her/his diseases and disorders.

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