

PART ONE: MUSIC THERAPY IN MENTAL HEALTH

Roundtable presenters:
Pedersen, Grocke, De Backer

Discussion group members
Odell-Miller, Lindvang, Storm

Moderator: Hannibal

A reflexive introduction

Music therapy in mental health

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The three lecture papers by Inge Nygaard-Pedersen, Jos De Backer (paper not submitted for this article) and Denise Grocke are diverse, which is not surprising given the expansive music therapy practice in the 21st century. There are cultural, educational and theoretical differences. This is a healthy state of affairs, as one approach does not suit all our populations of both service users (patients or participants) and therapists. The papers also contain some similar themes, and our mutual reflections draw out both similarities and differences from all three papers. This part is both a reflection on the three lectures and an introduction to the two lecture papers presented here in part one of the article. Part one finally presents a reflection on the three lectures and the two questions from another perspective by the moderator of this roundtable for mental health care, Niels Hannibal.

Adult mental health in the 21st century covers a large field, comprising populations with diagnosed mental health problems, and those within public health services who have, for example, addictions, personality disorders and other functional mental health disorders. In modern times mental health is sometimes considered as emotional imbalance rather than illness, yet a medical diagnostic model is still in place in many services. At the same time, inclusion, recovery approaches and dispelling stigma are central to mental health agendas for people experiencing psychiatric disorders and less severe mental health problems.

Both Pedersen and De Backer discuss the importance of the qualities of music to enable connection: synchronicity, a shared language, and a place for non-symbolic linking. Pedersen discusses a possible trajectory for hospitalised

people with acute mental illness: later, in the recovery stage perhaps, a music therapist may not be needed and community musicians or teachers may suffice. Pedersen also highlights that music therapists are uniquely placed within an improvisational framework to decide when harmony and dynamic musical interaction are needed; or that grounding using a monotone might be more appropriate. Grocke focuses upon the use of song with composition and lyric analysis, highlighting research and the importance of songwriting for people with enduring serious mental health problems, no longer in the acute phase of their process.

In reflecting upon the question *'Why and when is a music therapist needed?'*, people with long and enduring mental health problems may need music therapy throughout their journey through mental health services. Specific models or interventions can move from a more introspective approach (as in De Backer's sensorial play prior to musical form) right through to the use of musical structure and creative uses of harmony, melody and, of course, meaningful lyrics.

It is important to mention recent research here. Carr et al. (2013), and Carr (2014), report in-depth research investigating music therapy models on acute psychiatric wards. This research highlights participants' feedback reporting enjoyment of the use of known song structures, and structured improvisation, and also reports a preference for a directive attitude of the qualified music therapist in groups. The social element of music therapy, being present in music therapy groups, can enable insights and the development of relationships for adults with mental health problems. This point is also mentioned by Grocke and Pedersen in their papers. Furthermore, Carr's recent research (looking at over 100 participants in group music therapy) found that participants reported they enjoyed seeing their fellow group members actively singing, playing and participating in a whole group event – or excelling in solo parts of the group. The idea of music as a collective social and creative medium, with the music therapist using their psychological and musical training to create music which is either new or based upon pre-composed songs, really resonates with Grocke's findings in a different cultural setting. Currently, Carr et al. (2016) are investigating the use of song and improvisation approaches in music therapy for out-patient groups for people with depression in a new

feasibility randomised controlled trial.

Individual music therapy approaches are also described as important for people with personality disorders by both Pedersen and De Backer. They each draw upon psychoanalytic theory, using music as an intense connection where the therapist listens, contains and facilitates growth through free improvisation with the therapist using verbal and musical interpretation/reflection/interaction.

This highlights that a music therapist is needed to link psychological and musical thinking – and that the music therapist should always be a highly trained musician who can therefore work musically at any level required. Music therapists frequently interact with music, reflecting back to the client, verbally and musically, in the same way a psychoanalyst uses talking and thinking (Hannibal 2014, 2016; Odell-Miller 2016).

A music therapy approach for people with serious mental health problems is focused upon by Pedersen, De Backer and Grocke. They each emphasise the importance of the unique expertise of the music therapist as improviser, composer, singer, songwriter, instrumentalist, musical interpreter and listener. Music therapists focus upon the unique intense musical relationship, especially with people who are not ready to use words but can 'think' and work musically. Pedersen provides a service-wide document where she is clear about what is needed when and why, and she touches upon the ambiguous nature of music suggesting that it is a kind of language but may never actually represent anything too concrete. She believes music can have a meaning for something that cannot be expressed in words – 'tacit meaning'. All authors touch upon affect regulation as a major factor in music therapy in this field.

The function of the music therapist in different roles, such as therapist, advisor, supervisor and educator is also crucial to the question about why and when a music therapist is needed. There is consensus about the important element of listening; both the music therapist's ability to listen to the non-verbal, musical cues but also an ability to simply allow space and listen to patients. In contrast, the psychoanalytically-informed music therapist might also use words following and between music-making to interpret, investigate, and so on.

In the future, music therapists will probably apply the role of educator or consultant even more to further share their expertise and knowledge, and

to teach other professions to use music to benefit the users of mental health care. This is a process that has started in several areas of music therapy and also in psychiatry. Here, music therapists are functioning as consultants who teach the staff how to use, for example, music pillows, and apps like the Music Star (Lund, Bertelsen & Bonde 2016), in order to facilitate relaxation and better sleep quality among patients.

Research and evaluation is important here, and a consideration of the most helpful ways to communicate about the impact of music therapy. How important is it to communicate about music therapy to multidisciplinary teams from a musical perspective, for example, showing musical examples rather than only talking about music therapy? How much do we need standardised research measures in research? Clearly both are needed, and clarity about the effects of music therapy is needed for the multidisciplinary team.

The profession needs to develop this area to improve understanding about the benefits of music therapy, and for whom. In short-term music therapy, for example in modern acute admission ward settings, a period of only two weeks is available for treatment before patients are discharged. This can be a challenge. We also need to recognise when music therapy is contra-indicated.

In summary, thinking forward, we need to continue rigorous research in this area, including standardised psychological and physiological measurements, and musical measures. We do have these now to some extent, as demonstrated by many research projects. The music therapist's self-agency, through working in the transference and countertransference, is known to be crucial, but more research about the music therapist's process is needed. Qualitative quantitative and mixed methods research which focuses upon diagnostic aspects, user and carer's needs, the context and environment, and specific music therapy elements within sessions, is needed.

Finally, the relationship between music therapy and other experiential arts therapies is worthy of further research. There are many similarities between the different arts therapies, but so far there is not a huge body of research demonstrating which arts therapies might be suitable for which situations and needs, and when and how it should be delivered. In conclusion, music therapy has a specific emotional, intellectual, psychological, physiological and social relevance for adults with

mental health issues, and there is convincing research to substantiate this. In the future, more knowledge is needed about specific beneficial outcomes and new research is continuing to investigate these questions.

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Lecture 1

Music therapy in psychiatry/mental health

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Introduction

In this lecture paper, I will offer some perspectives from primarily my personal experiences in clinical practice in mental health with different patient populations spanning 20 years – primarily people suffering from personality disturbances, schizophrenia and depression. These perspectives will be illustrated through a case study. They have been documented in multiple publications (Pedersen 1999, 2002, 2002a, 2003, 2007, 2012, 2014a, 2014b). I am aware that there can be a range of perspectives on these topics.

Why music?

I will start by going back to some statements on what could be a therapeutic understanding of music, which was first described by my colleague, Lars Ole Bonde, firstly in 2002, then in 2011 and 2014. I want to step back to some of these formulations as I think they are long-lasting and still important today. I do agree with them and I think they are especially important for the understanding of why music is applicable in mental health care.

One of his statements is that although music is a type of language it is:

“[...] not an unambiguous, discursive language, and it can never represent or designate phenomena of the external or internal world with the exactness of verbal, categorical language. Music can be characterized as an ambiguous, representative, symbolical language” (Bonde 2002: 39).

I think this is a very important explanation as to why music is applicable in mental health care. The

patient cannot be ‘interpreted’ directly from the musical expression, and the patient is the agent of his/her experiences in musical expressions and during music listening. Still, these musical expressions and experiences can be shared with a music therapist who is carefully listening and interacting without interpretation, unless this is mutually understood as a positive opportunity for the patient to understand specific developmental steps.

Another description from Bonde is:

“[...] music can contain and express meaning beyond the pure musical or aesthetic content - music can be a direct expression of a client’s emotions, or a musical representation – symbolic or metaphorical – of spiritual or complicated psychological states and conditions, or the musical expression can be an analogy to the client’s being-in-the-world” (Bonde 2002: 39).

This second important statement clarifies why music is therapeutically meaningful in mental health care. It underlines that music can mirror patterns in the therapist/patient relationship both explicitly and implicitly experienced, and that it can offer a mutual, musical space to develop and try out new relational patterns.

Bonde also claims that:

“[...] music can have a meaning, even if this can’t be expressed in words. This ‘tacit knowledge’ or ‘inexpressible meaning’ can be found at different levels” (Bonde 2009: 39).

A former patient of mine, who would tend to intellectualise when talking with other people, exclaimed – after having played the piano for the first time in the first music therapy session, and after a deep sigh – “I have no words!”. He had never played music before. As his music therapist I thought this was a very important moment for him as he was someone who usually avoided deeper contact with other people through the expression of words which he did not seem to be emotionally connected with.

Understanding clinical work in mental health

My etiological and pathogenic understanding of mental health problems is based on a biopsychosocial understanding with an emphasis on

the vulnerability-stress model. This understanding is combined with an understanding of clinical practice as unfolded in a phase-specific case work. This is in line with other clinicians and researchers in music therapy such as Bradt (2012), who claims that instead of examining the benefits of a specific music therapy treatment, investigators can rather employ a stage approach to researching. My theoretical foundation draws on a psychodynamic, existential, relational and psychoanalytical understanding of mental health. To sum up my understanding of music therapy in mental health, the following statements (summaries gathered from different publications) provide important guidelines:

- Different music therapy interventions are often needed in different phases of the case work (phases are not always linear – they are most often circular) (Pedersen 2014a, 2016).
- The timing of the music therapy interventions is of essence (Pedersen 2002, 2012, 2014a, 2016).
- Following the process of the patient is more important than following a specific approach in music therapy (Pedersen 2012, 2014a, 2016).
- The music therapist needs to apply a state of *disciplined subjectivity* in the relationship to stay open-minded to the life world of the patient at the same time as stay grounded in her/his own life world (Pedersen 2007).

Phases in understanding developmental steps in mental health problems in clinical work

If I consider some phases in the progression of mental health illnesses – independent of specific diagnoses – I would start with the *phase of acute conditions*, phase A. In this phase the patient will often experience much chaos and be suspicious of being misunderstood or misinterpreted, since this phase includes being interviewed and observed for a diagnosis. Here the understanding of music being an ambiguous, representative, symbolic language is important in music therapy offered as a complementary intervention. The patient can express him/herself in music in a way that can't be exactly interpreted. This form of expression can release tensions – tensions built up from a state of keeping back personal expressions due to a strong

anxiety of not being understood.

The music therapist is important as a supporter and a mirror for the patient in this phase. In addition, the music therapist is important as a stable and empathic listening person outside the inner chaos of the patient – an anchor for the patient when playing music/listening to music.

One of my music examples from clinical work with the patient mentioned above (see CD track 3 in Wigram, Pedersen & Bonde 2002), illustrates that the patient (diagnosed with personality disturbances, being obsessive compulsive and highly intellectualising) is playing quite fragmented music at either the lower or the upper range of the piano while I, as the music therapist, am playing one tone in the middle range of a second piano, in a stable heartbeat rhythm. The patient had never played the piano before. The music mirrors the relationship patterns between us here and now, where the patient takes turns in a) slightly moving towards the stable sounding centre I am offering in my musical interplay, and b) moving away from it. The patient tells me that he is not able to be in a stable contact with either himself or with anyone else. The harmonies, however, which emerge in the music when the patient moves towards the sounding centre, loosens tensions and anxieties around this problem. The musical interaction encourages the patient to seek contact due to these harmonies emerging between the tones when he moves towards this stable sounding centre. In this phase of an acute condition, an important role of the music therapist can also be to introduce supportive music for the patient and other team members to listen to. This can help the patient listen to such music, selected by music therapists, when needed and possible. So: *music can serve as a constant, safe place* both actively as (a stable sounding centre) and receptively (when listening to a piece of music over and over again).

In a following phase, which could be titled as the *phase of identifying symptoms*, phase B – the focus is on identifying a diagnosis or recognising patterns of the person suffering from mental health problems. Here the music can offer a safe place and can function as a regulator and as a container for reactions to the situation. The music therapist is needed to ensure and mirror a safe place for this sensitive process, and an empathic listening attitude of the music therapist is important here. The music therapist needs to listen to the depth of the suffering of the patient – listening through

empathic identification with the patient. I like to reflect that I am listening to myself listening to the patient in the music. The role of the music therapist in this phase is also to assure the patient that strong reactions and emotions are perfectly acceptable. They can be contained and accepted and expressed in the music; the therapist needs to be a mirror of hope.

In another clinical music example with the same patient (see CD track 4 in Wigram, Pedersen & Bonde 2002), he describes himself – when entering the music therapy room – as being totally restless and anxious. He is not able to concentrate at all or to sit down. He follows the encouragement from me to express this condition, just as it is, in music. I follow his strong expressions and aim at containing them at the same time, as I am aware of keeping a stable pulse to continue the function of a stable sounding centre from phase A.

In the third phase, a *phase of developing and building up capacity to cope with chaos, anxiety or hopelessness*, phase C is unfolded, and the music arena and the music therapist can be partners regarding the experiencing of struggles and receptions. In this same phase music can also be a language of expression through which the patient can feel strengths and resources not so easily experienced elsewhere (music can be an agent, a promoter, and a possible transformer). The role of the music therapist is to be a stable partner who shares and participates in these processes. The music therapist has to be aware of, understand and – with careful timing – react on countertransference experiences either musically or verbally if possible, to raise the understanding of the therapist/patient relationship in the ‘here and now’. How are we related? What is my contribution to the relationship and what is the perspective of the other partner? The music offers a *potential space* (Hansen 2007; Winnicott 1990) for mutual development of the relationship – and literally playing with and exercising new relational capacities.

In the next phase, a *phase to identify possible limitations of being in the world and possible new resources for the future*, phase D, the music can help to establish a new identity with more stable inner resources (e.g. through creations of own songs or through listening to preferred music). Musical form can offer a structure in which the patient can be in flow with an emerging integrated identity. Music can be an important carrier of identity in this phase. In a third clinical music

example with the same patient (see CD track 8 in Wigram, Pedersen & Bonde 2002), he has come to a phase where he no longer needs a stable person outside and related to himself to avoid chaos and anxiety. He can now understand that his former need of controlling others in a relationship due to anxiety and a poor feeling of coherence of identity is no longer prevailing. The patient can act more freely in the musical interplay and can join a common flow in the improvisation, and this can be understood as an analogy of how he now has the capacity to relate to other people in a more flexible way.

I want to present a short statement from the same patient – from a report he wrote to a medical journal based on his experience of the benefits of music therapy as his primary treatment in mental health care for one-and-a-half years. He refused medication throughout the whole period; this was accepted by his psychiatrist. The report was written three years after music therapy was terminated:

“Although music therapy officially has ended, I feel that it is still going on. All the experiments, notes and themes that I played out in the music, I now use in different encounters with other people, and it gives me a great feeling of freedom; freedom understood in the way that I have many different keys to play in – many different ways to tackle situations” (Wigram, Pedersen & Bonde 2002: 168).

A music therapist in this fourth phase, phase D, is needed to encourage, to mirror and to challenge the patient (beyond comfort zones) and to be a stable interplaying partner. Music therapists in this phase may have to move from a position of being a more supportive mother figure to being a more challenging father figure.

The last phase, a phase which for some patients means a *phase to learn to live with mental challenges outside the mental health system*, phase E includes the process of being an equal part of coherence in life (family, friends, society etc.). Here the interplay with other partners is in focus. Music can be a language for the former user of the mental health system to steadily be in contact with both inner resources and challenges. The same patient also wrote the following:

“About three years have gone by since the music therapy ended – I still do voice exercises to become aware of how I feel right now, deep inside.

This is a good tool for me to relax knots and tensions that are forming” (Wigram, Pedersen & Bonde 2002: 168).

In most cases a music therapist is no longer needed as the core person in this phase. The music therapist is not indispensable but may be the important link to other interplaying partners. The music therapy case experiences can be kept alive as internalised experiences – as supportive memories by the former mental health patient.

Music therapy – in spite of low motivation

People in this last phase, when suffering chronic mental health problems including those who experience negative symptoms of schizophrenia (such as low motivation to participate in life activities), can still benefit very much from music therapy as an offer of timely encouragement and possibly a vitalising quality of life (Gold et al. 2013). At the moment, we, the staff at the Music Therapy Clinic at Aalborg University Hospital (regarding the area of psychiatry) are working on a randomised, controlled, double-blinded national inquiry (comprising approximately 120 participants) on the effect of music therapy towards negative symptoms for people suffering from schizophrenia (Pedersen 2015). The study is carried out together with head doctors at the Centre for Psychosis Research. To apply such a challenging design in the inquiry is a demand from the health system to hopefully have music therapy recognised and listed as a part of standard care for this population. Our experiences from the study suggest that the biggest challenge is to recruit the participants. This is because either they automatically refuse to enter new challenges and cannot face the idea of attending 25 weekly sessions of music therapy, or their contact persons think that they are not able to manage such challenges. When the participants come to start music therapy, they mostly attend all 25 sessions and express their enthusiasm of being part of this project.

I think music therapy should be a part of standard care for many more populations in mental health care.

Flower figures of ‘Why music?’ and ‘Why and when is a music therapist needed?’

I have tried to collect the different perspectives on ‘Why music in mental health?’ in the form of a flower figure, as I do think music therapy is a flourishing and vitalising offer in the mental health system (Figure 1).

For most people it is obvious why patients are referred to physiotherapy (problems with the body) or verbal psychotherapy (psychological problems), but why is music therapy needed? From the examples presented here, I think music therapy is needed when patients have problems with verbal communication, with low self-esteem, identity and poor contact to the body and difficulties in entering spiritual experiences. Music therapy is offering relational meetings in a span between early nonverbal communication and spiritual self-experiences (Figure 2).

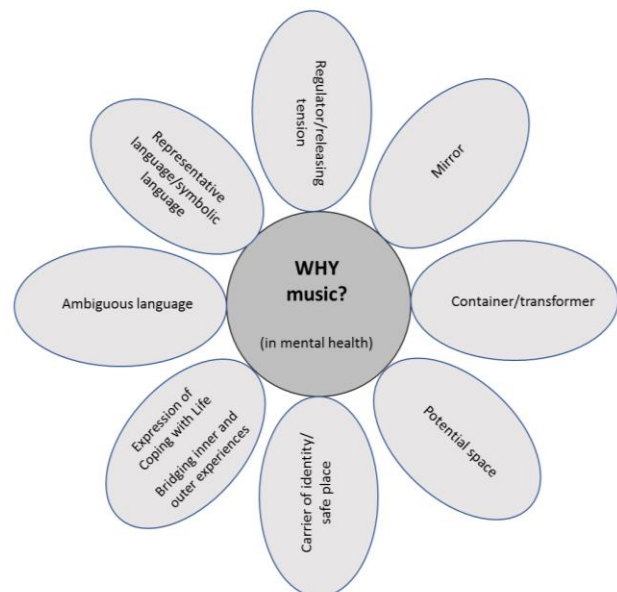


Figure 1: Flower of music

I have also collected my perspectives on ‘Why and when music therapists are needed in the mental health system?’ in the form of a flower.

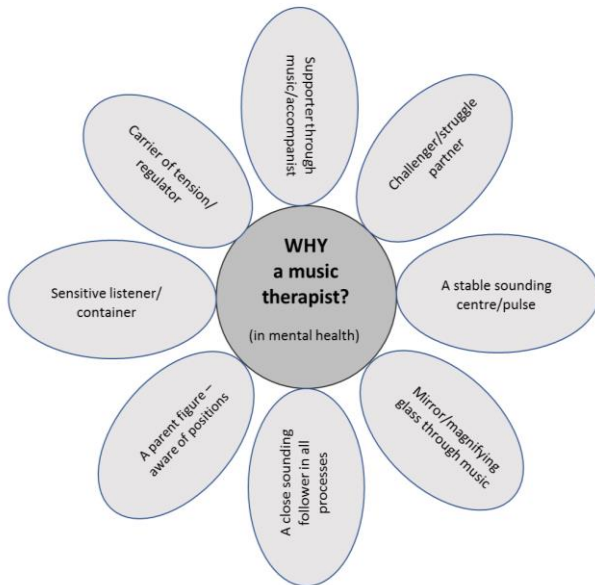


Figure 2: Flower of music therapists

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Lecture 2

‘Songs for life’ – A group songwriting research study for participants living with severe mental illness

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From the time of the great Greek philosophers, music has been recognised for its therapeutic applications. Plato believed that

“[...] rhythm and harmony find their way to the inmost soul and take strongest hold upon it (the soul) [...] imparting grace [...] to foster its growth” (Hamilton & Cairns 1961: 646).

Music provides an alternative means of communication to verbal language, it can be a means of expression of emotions that are difficult to articulate, and can bypass the need for cognitive organisation of thought. This is important for many of our participants who have difficulty in managing emotions, and processing cognitive concepts.

Music is ubiquitous; we can sing music, play music, listen to music deeply, and dance or move to it. We may create and compose our own music. The basic elements of music (rhythm, melody, harmony and dynamics (light and shade)) create a musical architecture on which we build these music experiences. As music therapists, we enable these experiences for people in the community who are the most vulnerable due to physical or mental health challenges.

In recent years, meta-analyses of controlled studies have confirmed the efficacy of music therapy for people with schizophrenia and similar illnesses, and for depression. A Cochrane review demonstrated that music therapy can increase motivation, social functioning, and global state in persons with severe mental illnesses with greater effect when 20 or more sessions are provided (Mössler et al. 2011). Similarly, individual music

therapy comprising ten to 20 sessions has been shown to improve symptoms of depression and anxiety, and to enhance general functioning (Erkkilä et al. 2011).

People who are living with severe mental illness are often subjected to stigmatised attitudes, resulting in social isolation that curtails recovery. We know that singing in groups enhances quality of life, reduces stress and increases emotional wellbeing (Clark & Harding 2012; Clift et al. 2008). Anyone who sings in a community choir will have experienced that first hand.

It follows that, when we as music therapists offer music experiences (particularly singing original songs) with people who have severe mental illness, we offer a modality that enables participants to experience the same benefits, and to express their emotions through lyrics and music. As one participant in our research study (to be described below) said:

Singing brings joy to the heart and the mind, you know.

Songwriting is recognised as an effective and compelling form of music therapy, whether applied to individual sessions with clients or with groups. Within the group context, songwriting calls on the music therapist's skill to harness ideas for themes and lyrical content and to facilitate decisions about the musical structure of the song (including stylistic features and elements of melody, harmony and rhythm), alongside therapeutic skill required to make the group experience rehabilitative (Baker 2015; Baker & Wigram 2005).

When music therapists use songwriting in groups they draw on the potential of music to enhance socialisation. Research participants in a songwriting study (Grocke et al. 2014) valued this particular aspect and commented about the final product (the song):

B: I enjoyed the collaborative part of it: Working together with other people to create something... the creative part of it was to actually write a song.

H: It was good because we all had an input, so that made it (the song) ours. Our song and a team effort, we all had something in the song. You feel good if you're in a team and you've contributed too. It's given me more confidence to try new things.

L: I'd like to say that it gave me a new lease on life.

'Songs for life' study

The 'Songs for life' study was funded by an Australian Research Council Discovery Grant (Grocke et al. 2014). The research group investigated whether group music therapy positively impacted on quality of life, social enrichment, self-esteem, spirituality and psychiatric symptoms of participants with severe mental illness, defined as an enduring illness of more than a duration of two years. A qualitative component of the study explored their experiences of group songwriting through focus group interviews and song lyric analysis.

Ninety-nine adults (of whom 57 were female) were recruited, with participants randomised to either: weekly group music therapy (over 13 weeks) followed by standard care; or standard care (for 13 weeks) followed by group music therapy. The music therapy group comprised writing the lyrics for the song, and contributing to the music architecture of the song – the genre, major-minor key, ascending or descending melody line etc. In week 12, the songs for each group were recorded in a professional studio and copies of the CD given to participants at the focus group interview, conducted in week 13. There were 13 groups of four to six members. Results showed a significant difference between group music therapy and standard care on quality of life ($p=0.019$, with a moderate effect size ($d=0.47$) and spirituality ($p=0.026$, with a moderate effect size ($d=0.33$), with greater benefit for those receiving more sessions. Moderate effects of group music therapy for global severity of illness (BSI) ($d=0.36$) and self-esteem ($d=0.35$) were found, but did not reach statistical significance ($p=0.061$ and $p=0.054$ respectively).

Focus group interview and song lyric analyses suggested that group music therapy was enjoyable; self-esteem was enhanced; participants appreciated therapists and peers; and although challenges were experienced, the programme was unanimously recommended to others.

Why and when is a music therapist needed?

In order to respond to the question of why and when a music therapist is needed, I will draw on the

comments offered during the focus group interviews, as they illustrate and describe what the participants noticed about the music therapists.

The focus group questions were very broad as we did not want to influence what the participants said. The questions were also balanced drawing out both positive and negative experiences of the group songwriting project. The questions in part were:

1. What did you like about the project 'Songs for life'?
2. What didn't you like?
3. What was it like to write a song in a group?
4. Were there aspects you didn't like?
5. Would you recommend this project to others?

Theme 1: What was liked: Accomplishment and satisfaction

N: It was a very positive experience... what I did like, was extending myself... and a sense of accomplishment, doing something that you've never done before. I wouldn't be able to do this on my own.

KS: I just enjoyed being around people who were positive and really happy and willing to take part. There was a good energy with everyone... and a feeling of satisfaction afterwards that we achieved what we set out to do.

AN: I found it to be a very positive experience. I was able to put in words some of the innermost feelings, which normally I would keep hidden. In the song I was able to express some feelings not only I have myself but a lot of other people, I believe, experience as well.

Theme 2: Reclaiming a love of music

Group music therapy also enabled participants to reclaim their love of music:

J: I always wanted to be a musician, and I didn't know how good I was till I heard myself.

D: It was fun making the CD and now I've got proof that I can sing really well.

H: It was great being in the group. I enjoyed the singing and trying to play the instruments... I enjoyed it more than I thought I would.

J: The sessions proved to be a great creative outlet, a means for self-expression and an opportunity for me to focus on more positive things in life, such as music.

T: I think [singing] gives you more confidence. Singing is something that I don't think people are particularly encouraged to do. I think we listen but we don't participate in music, and so it builds your confidence that you can actually participate in it.

J: I just love singing. I mean, I've never been a professional singer, but I've come from a family that sings all the time and I've been brought up with music and I just love it. It's very therapeutic.

Theme 3: Qualities of the music therapists

We did not ask the participants any questions specifically about the music therapists themselves, however the following comments were made spontaneously in answer to the question what they liked about the programme.

J: I liked working with the other group members and I thought Jason was a great music therapist, caring, engaging and talented.

D: Damien and Janet [the name of the therapists] were really good. They didn't put any pressure. So we could come out with the best stuff, you know. Just really supportive. When you're stressed too much you can't be creative if somebody's dominating, and saying you must do this, then you're not very creative.

H: I'm stunned that it came together so well. I'm a bit stunned how that happened, you know. I try and write words and bits and pieces and everything, but Lucy encouraged you and supported you in the way that you needed, and made me think, because she wanted some input from everybody, not just me. I mean, she did the same to everybody. It was really good listening to her sing, she's got a really good voice, and she conducted it that we all had input, you know what I mean, and it wasn't necessarily one person taking over, you know, you got your fair share.

Je: I think the music helps you, um, makes things clearer and it helps you get your thoughts out better. And I want to say Jason was very good... professional. I said to my doctor he was very good because he included everybody and he included everybody's ideas and made everybody feel valued and worthwhile... and that was a big thing... and the end result is something very special.

P: I think Emelia gave us space to do our own thing... she didn't pressurise us into playing it a certain way or singing it a certain way. I think she gave us leeway for our own creative belief.

Al: I got to use the voice, you know, and to sing around the house. I got to drum and sing and Emelia was wonderful and supportive, and she gave space and, um, made it fun even if you were having a bad day – I appreciated that.

P: And there was an acceptance. You know, we didn't have to put on anything because everyone accepted each for who we were.

V: (tearfully) I felt a part of a family here (in music). Emelia was very approachable and down to earth, and I don't know what the word is – open-minded?

P: We couldn't have done it without her.

Theme 4: What was not liked

Aspects that were not liked in the project included that a one-hour session was too short, and a 13-week project was too short, and that there was nothing at the end of the project to enable participants to continue their singing.

Participants commented they would have liked the music group sessions to be held in a neutral place, like a church hall, instead of at the clinic, where they are reminded of medication and difficult questions from the case managers. They wanted a creative space for their songwriting. Participants also were sometimes daunted by their experience recording the song in a studio.

Reprise: Why and when is a music therapist needed?

In summary, the qualities of the music therapists appreciated by the participants included that they were caring, supportive, encouraging, engaging, and wanting input from everyone, making people feel valued and worthwhile, giving leeway for each person's creativity, being open-minded, and accepting each person for who they were. While many of these qualities can be found in musicians who are sensitive to others, music therapy training instils the importance of drawing out members of a group who are not contributing, by encouraging them to make a contribution so that they feel valued. This requires skill and the ability to wait, to be comfortable in silence, and to create an open

space that allows time for reflection.

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Reflection paper

Why music? Why and when is a music therapist needed in mental health care? What have we learnt?

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Background

After the symposium at Temple University in April 2015, I thought there was a need for taking this shared process a step deeper or to take it in a slightly different direction. My idea of suggesting the targeted topic of ‘*Why music? Why and when is a music therapist needed?*’ for the next symposium at Aalborg University in April 2016, was to invite presentations of thoughts and rationales about why music is a good intervention in a therapeutic context, and why we need a music therapist to administer the intervention. My view was, and still is, that explaining this to ourselves as a profession and, more importantly, explaining it to interdisciplinary teams, to politicians and to clients and users of music therapy, has been an ongoing agenda and struggle for a long time. We need to be more expressive and clear in our communication with the non-music therapy community. The diversity and complexity of music therapy makes this kind of thinking a huge challenge. The idea was to invite some of the ‘state of the art’ thinkers in music therapy, and give them an opportunity to present their thoughts and most recent knowledge within the topics.

In the invitation letter, the task for the presenters was described as follows: to present arguments and explanations as to why music is an agent in the chosen clinical area, and why a music therapist is required. My expectations of this day were huge. I fantasised that hopefully we would now be able to explain much clearer and precise, what is the rationale for using music and for the need of a

music therapist. So what happened and what answers did we get in this roundtable?

The answers

The obvious learning from the roundtable and overall from the day was two things: 1) there are many more ways to address these questions than I had imagined, and 2) we are far away from a unified rationale as to why music and why and when a music therapist is needed. I will now reflect on these two statements.

There are many ways to address these questions. They may, for example, be seen as a claim – i.e. we *claim* that music and a music therapist *are* needed. That is implicit in the topic. Music therapy researchers are there to support this statement. Moreover, in order to do so we, as academics, have different options; we can refer to research, to theory, to case material or a combination of these.

Pedersen gave a theoretically-focused presentation even though she also referred to RCT studies and meta-analysis. When addressing the issue of why music, she used Bonde's writings (Bonde 2002, 2011, 2014). She presented music "characterised as an ambiguous, representative, symbolical language" as a rationale for using it in mental health. This is how music differs from verbal language and how it provides different options for mental health patients. When addressing the topic of the music therapist she used her own writings as a basis for describing a rationale for music therapy with this population. Pedersen has made some very important contributions over the years. Her presentation revealed how complex it is to describe what is important in a therapeutic endeavour and, in a way, it showed why answering the questions as to why music and why and when a music therapist is needed are not so straightforward. We can even answer these questions by referring to research and/or by using a more theoretical-based rationale and/or by describing the process of music therapy in a case-focused perspective.

Grocke referred to research findings when talking about group music therapy and songwriting with a group of patients with severe mental health problems. This is a classic way of supporting the idea of music therapy (and indeed any other treatment for that matter). Grocke's presentation, however, does not offer a coherent rationale concerning the two core questions. The argument

is that the research shows improvement and the participants express their appreciation for the treatment, and that in itself is a rationale. There may be obvious reasons for choosing such a strategy for the presentation; there is a time limit, and giving a more in-depth rationale for songwriting as a method in music therapy is a considerable task.

In his presentation, De Backer used a more theoretically-based approach in his argument. He talked about music as something beyond words. Something that at the same time is present in the preverbal interactional context of therapy and also in the personality of the therapist. The music therapist has a psychotherapeutic ego that *is* music. We meet the world from a musical position. According to De Backer, how the therapist thinks and feels about music influences the therapy even when there is no music being played. This also reflects his belief that all music therapists need to be musicians. Enhancing this music-focused perspective suggested a different way in which to build a rationale for why music and why a music therapist. What is unique about 'us' as a profession is the ability to express ourselves through music, to experience our self and the other through music, and the ability to listen, observe and respond in a relationship through music. De Backer advocated for more individual case studies in order to investigate interventions, and studies focusing on the music itself during treatment.

In that respect the presentations revealed that, in my view, a simple and clear rationale for why music and why a music therapist is needed is not easy to produce and not present in our thinking and talking about music therapy in mental health.

As presented here, there are many different ways to address these questions and we listened to very different ways of handling this challenge. All presentations were based on research and some on theory and clinical experience. There was not, however, one unifying understanding; perhaps there will never be such a unified rationale.

This leads me to the second part of my answer. We are, as stated, far away from a unified rationale for music therapy. Yet stating this based on the presentations from this afternoon is unjust. There are intense writings and thinking about why music is a good idea in mental health care and why a music therapist is needed. After the presentations, however, I have come to realise that we might be asking the wrong questions. You would never

investigate the rationale for psychotherapy by asking the question ‘*Why applying words?*’ It makes no sense to simply focus on language itself in order to understand the process of psychotherapy. Words are, of course there; how else can someone convey how they feel or what they think? My point here is that what is difficult for politicians, for example, to understand is how music can convey anything other than aesthetic beauty and perhaps some pleasure and distraction. There is a lack of an understanding and appreciation of what music ‘brings to the table’ that has therapeutic value. This raises the question if talking about music itself, as something that stands alone, makes more sense than talking about words. My own initial thought was, in a sense, doomed.

I believe that we, as music therapists, possess knowledge about music in a therapeutic context that is based on self-experience as clients and on clinical experience as therapists. We have knowledge that, to some degree, is implicit and beyond verbal language. We know what playing with someone is like. We know, for example, how writing a song can empower you and how listening to music can influence your state of mind. This is what I call a deeper understanding. In order to build a solid rationale for music in music therapy and the need for a skilled music therapist, I believe that we need to address this deeper understanding which we, as music therapists, possess and which makes great sense to us when engaged in conducting the process of treatment.

Another important issue is founded in the idea or notion that it is possible to talk about and describe music therapy from one model. It would, referring back to my word analogy, be equal to postulate that it is possible to make one rationale for using language in treatment. No one would ever try to do that. Language can be used as an agent in many different ways: to enquire, to support, to explore, to negotiate, to argue, to understand, to make fun etc. We know this. We do not need to say it. But it is not clear when it comes to music. My point is that a rationale for using music in therapy must focus on what we use it *for* – i.e. the function and the purpose of the intervention. What do we want to achieve by the interventions we perform? Do we want to build relationships with the other person through music? Is it to provide opportunity for self-expression and self-exploration? Or do we want to help regulate internal states? Do we want to form and build new identity and self-perception? This

way of talking about *why music* must include a purpose. There is a reason for doing it and it is related to the needs and problems of the client in front of us. When that becomes clear, the need for a trained music therapist in contrast to a skilled musician becomes obvious.

In my humble opinion any rationale for applying music is connected to the therapeutic situation and the needs of the client. And these differ. This is also mentioned in the Postlude by Bonde. He stated in his concluding comments the following: there do not seem to be a few simple common answers to the questions; there are many good and possible answers to the questions within the specific clinical areas; and they are always influenced by who you ask and in what context.

Diversity and complexity were also reflected in the discussion following the presentations. These included issues such as how we talk about music, how we describe what music does and the different ways music can be used in relation to different phases in treatment. We also considered whether music therapy was ‘only’ about music, or also words or art and so on. Finally, questions of how to talk about mental illness were also introduced.

The presentations and the discussion both revealed that music therapy research supports the *why* questions. Yet we have not found a way to talk about music in music therapy that can be described as one rationale for using music and for needing a music therapist. I do not think we ever will. I think we need to focus on the needs of users who we, as music therapists, aim to help, more than focusing on the element of music itself. Having said that I think there is a great need for more theory and rationale for why music in the hands of a music therapist can, for example, establish a relationship with an isolated person, help regulate arousal, form identity and self-perception, help build group cohesion and heal trauma.

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