

## **A Music Therapy Approach in Mental Health**

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The article aims to describe an approach to music therapy in mental health. It looks at the work of a music therapist who is based in a psychiatric hospital but works in community based units such as a Day Clinic and Young People's Unit in Cambridge. It also aims to make some general points about music therapy in this field in Britain, based on historical and theoretical perspectives in the literature; and on discussions with other music therapists. The discussions with other music therapists led to the production of a document "Music Therapy and Mental Health" (1986) which also acts as a source for this article. The clinical material which illustrates a specific approach taken in Cambridge is drawn from a group run over a period of four years at the Cambridge Day Clinic.

### **Definition and background**

At present there is a music therapy team based at Fulbourn Hospital, Cambridge, and the service has been developing since 1980. There are future plans for more music therapy input, particularly into new units in the community. This has come about because the music therapists have documented work systematically, carried out research and consistently explained benefits of the treatment to the multidisciplinary team. Music therapy is one form of therapy available within the mental health service in Cambridge, and is specifically provided in the following areas: Psychiatric Services for the Elderly; Rehabilitation Services; Day Clinic; Young People's Service; and Acute Admission Units.

Music therapy sessions take place either in the Music Therapy Department, or in the unit concerned, if this is a more appropriate place. A brief definition of the overall approach to music therapy in the mental health service in Cambridge is as follows:

"Music therapy in the field of mental health is the use of music to allow an alternative means of communication and expression where words are not necessarily the most effective way to fulfil therapeutic aims for the client. These aims are worked towards through a developing relationship between client and therapist with practical music-making as the primary medium. Formal musical ability is not necessary for the client, but imperative for the therapist. Clinical aims are determined in consultation with other team members, together with clients. Work is undertaken individually and in groups. Assessment and review take place when necessary. Some common aims in music therapy are:

Encouraging motivation, providing a forum for exploration of feelings, developing social skills, self awareness and awareness of others, and stimulation of movement through improvisation and spontaneous music-making."

(Fulbourn Hospital Music Therapy Annual Report 1986).

Information about differing aims in various client areas is available in the document entitled "Music Therapy and Mental Health" (Scott, Odell & John, 1986).

### **Historical perspective**

The diversity of music therapy approaches in Great Britain and elsewhere is such that it is important to understand what approach is being taken in Cambridge. Present trends in Britain show that music therapists emphasise two main features in their work in psychiatry—that of "live music" and "interaction with the therapist".

As indicated by the definition above, the music therapy approach in Cambridge involves using live interactive methods where improvisation is used as a focus to make relationship with clients which may reflect other relationships in their lives, and thus enable an awareness and understanding of difficulties to take place. It is also important to recognise that the way clients improvise may reflect their current states, and can therefore lead to an understanding of changes which may need to take place.

These points are emphasised because in other countries, and elsewhere in Britain, there has been a trend towards the use of recorded music. This in the author's opinion, by definition cuts down the intensity of the interaction between patient and therapist, and thus misses what this author regards as a central key to the success of treatment. It is less possible to deal with immediate formation of relationships and interaction if a remote source of music e.g. a record player, is part of the focus for therapy.

Reinhardt (1982) and Dickens and Sharpe (1970) describe the use of recorded music in group music therapy, and others are critical of the use of recorded music (Priestley, 1975). Priestley writes "To reach out only for records or cassettes is to cheat oneself of a profound inner experience of strengthening growth."

At present in Britain, mainly as a result of music therapy having its roots in music, improvisation has become the most prevalent element in the interaction between client and therapist. Elsewhere, pre-composed music has been more widely used as a pre-determined concept, for example in America (Riegler, 1980; Shapiro, 1969; Schoenberger & Braswell, 1977; and Palmer, 1977) although trends are now changing, particularly in New York and Philadelphia (Odell, 1985; Bruscia, 1987). Pre-composed music can be used within improvisation, but what separates out differences in approach is whether the therapist adapts the music because of the therapeutic process (as concerns us here), or expects the music to be adapted to by the clients involved in the process. This is not to put a "value" on the success of music therapy which does not use improvisation as its central focus, but to clarify the approach concerning us here. As shown in the clinical case example later, what is emphasised here is that working with a direct relationship with the therapist is often one of the primary elements of effecting change.

The following two statements reinforce the points being made:

“Music therapy provides a framework in which a mutual relationship is set up between client and therapist. The growing relationship enables changes to occur, both in the condition of the client and in the form that the therapy takes. The Music Therapist works with a variety of clients of all ages in group and individual settings. Their problems and handicaps may be emotional, physical, mental or psychological in nature. By using music creatively in a clinical setting, the therapist seeks to establish an interaction, a shared musical experience leading to the pursuit of therapeutic goals. These goals are determined by the therapist’s understanding of the client’s pathology and personal needs.”

(Association of Professional Music Therapists, 1986).

“Music therapy is the use of predominantly improvised music to fulfil therapeutic aims for the client.”

(Hoskyns & Odell, 1986).

Before proceeding further it is important to define what is meant by improvisation. The Association of Professional Music Therapists in “A Handbook of Terms Commonly in use in Music Therapy” (1985) define as follows:

*“Musical Improvisation: (general definition)*

Any contribution of sounds and silence spontaneously created with a framework of beginning and ending.”

*“Clinical Improvisation: (general definition)*

Musical improvisation with a specific therapeutic meaning and purpose in an environment facilitating response and interaction.”

Many music therapists work on the pretext that musical interactions and musical behaviour are a reflection of what is happening internally for the patient. Some would say that a patient’s music is understood as a metaphor (Katsh & Fishman, 1984). However one interprets the sounds and music, it seems clear in Britain that music therapists respond to the patients’ music by using music themselves, emphasising the need for skilled musicians to do the work. If one is to be involved in a musical improvisation, and enable shifts and changes to take place through the musical relationship, the therapist must have a thorough understanding of rhythm and harmony, and be able to respond immediately with what is needed. This calls for skill and training as a musician and therapist. Both are of equal importance, in this author’s opinion.

### Verbal elements

The question of the importance of dealing with verbal material in music therapy is in constant debate amongst music therapists. The following questions are particularly common—“should all verbal material brought into the session by clients be looked at through musical interactions?”—“at what point does the therapist use words to comment; if at all; on the verbal or musical material of the session?”—“how is the understanding of musical

behaviour approached by the therapist and also other elements such as the verbal, dramatic, movement orientated?" These questions are constantly grappled with particularly by music therapists working in psychiatry (Woodcock, 1987).

The importance of an interactive relationship using music is born out by paying attention to psychoanalytic theory and practice. Ruud (1980), Priestley (1975) and Feder & Feder (1981) pay such attention when discussing music therapy, and give importance to the inclusion of verbal material, and links between music and meaning within the musical interactive relationships. These aspects are covered in the literature both by music therapists and others, but as yet no conclusive overall theory of the links between music and other human elements in music therapy has been developed (Meyer, 1956; Noy, 1966, 1967). Katsh and Fishmann use verbal material within Metaphoric Improvisation Therapy, and see it as important in their Gestalt-based method (Katsh & Fishmann, 1984).

Priestley (1975) pays attention to analytic music therapy extensively, and also to counter transference specifically (Priestley 1976).

### Developments

Before illustrating some of these points with a description of a particular way of working in one unit, it is important to link the general emphasis on improvisation and interaction in British music therapy in mental health, with changes in Cambridge.

For example, there is a growing acceptance of the importance of the musical material in relation to the therapist's understanding of what processes are taking place with clients. Eight years ago, music therapy at Fulbourn Hospital, Cambridge, was established and at first, techniques were being explored and developed, particularly in group work together with other professionals. This meant at times an emphasis upon the *use of* music within existing models such as verbal psychotherapy (Odell, 1982), rather than working *through* music and applying relevant psychotherapeutic models within appropriate contexts. These gradual changes have been possible owing to increased understanding and acceptance from other professionals; increased opportunities for exchange between music therapists on an experiential level e.g. Association of Professional Music Therapists' Annual Weekend Conference; changes in training; and influences of music therapists from varying standpoints. This has led to a greater richness and sophistication of improvisation in music therapy.

### Evaluation

This study describes work specifically with clients who have long term problems associated with mental illness.

There is much evidence to suggest that social skills and interactive or socialisation-based therapies are helpful in the rehabilitation of those with long term mental illness such as schizophrenia (Hollin & Trower, 1986). In

his chapter "Social Skills Training and Schizophrenia" (Hollin & Trower, 1986) Shepherd concludes, that increased abilities in relating, and socialising resulting from social skills training (SST) are helpful in recovery, and in dealing with long term social difficulties. However, he also writes: "Regarding treatment methods, since we actually have very little evidence that SSI is significantly superior to a number of plausible alternatives, the therapeutic potential of a wide range of treatment techniques might be explored e.g. psychodrama and gestalt." This has implications for music therapy.

This paper is not designed to fully prove or evaluate the outcome of music therapy, but is a descriptive study. However, this author has carried out a research project with the elderly mentally ill looking at the differences in levels of engagement in a verbal group, and a music therapy group in a controlled "scientific" way. Time sampling methods were used, and it was found that levels of engagement—including interaction with the therapist and between group members—were higher in the music therapy group than in the verbal group, although not statistically significant. However, a significant increase in levels of engagement was found over a three month period in a music therapy group held consistently (weekly), than in one held intermittently. There are problems in relating outcome (as described in the clinical example to follow), specifically to music therapy treatment itself, and in this study, the aim is not to do this, but to point out the likelihood of connections, made from observations by clients, therapists, and other team members. It is recognised that these observations can be seen as "biased", in traditional scientific research terms, but the philosophy of this study is that it is the whole person, and whole life pattern during the time that a client attends music therapy of this nature, which contributes to recovery and outcome, and that music therapy is important as one component of this. Exactly how important the music therapy process is, can be understood in many different ways, and the case example is one way of describing this anecdotally.

### **Cambridge Day Clinic**

To illustrate the approach taken in Cambridge, the work of the Cambridge Day Clinic will be described.

The clinic is in new premises in Cambridge which opened in January, 1986, and has a music room with a piano as one of its features. A group is set up for clients who have problems connected with living at home or in hostel accommodation. Clients are suffering from a variety of psychological problems such as loneliness, depression, those associated with schizophrenia, lack of assertiveness, lack of awareness and ability to relate to others easily, difficulty in remaining outside the psychiatric hospital, social, emotional and others. The group is for those who feel they can benefit by using music as a means towards coping with these various problems, and is for those who do not find verbal ways of doing this easy or appropriate. Commitment is important, and clients are expected to attend weekly and to let the group

know if they cannot do so. Referrals are made on a form, and clients carry out their own assessment in that they discuss their lengths of attendance regularly at their discretion within the group. However, the therapists will advise and encourage as they feel necessary as to whether a client should be thinking about leaving the group, or remaining. The music therapist facilitates the group with a co-therapist who is a member of the Day Clinic staff. The group lasts for 1½ hours and is reviewed afterwards by the therapists.

### *Method*

Instruments used are tuned and untuned percussion, violin and piano, and these are set up in the music therapy room before the group begins each week. The group is based on a psychodynamic model, using music as the main medium, with clients making their own verbal comments about what is happening in the music, as well as the therapists commenting on how they perceive improvisations.

The psychodynamic model used here is one based upon the work of Yalom (1970), and others such as de Mare & Kreeger (1974). These therapists developed group analytic theories set up by Foulkes & Anthony (1957) and other post Freudians, in a way which enables group interpretations and a focus on the dynamic interaction within the group, to be worked with concurrently. The word psychodynamic is sometimes used to distinguish between an organic approach, and an approach which takes all factors concerning the clients, their family and relationships into account. De Mare & Kreeger (1974) in the introduction to their book, describe the emergence of a psychodynamic approach to mental illness, after the work of Freud; in contrast to other previous organic physiological approaches to mental illness.

Thus, as described here, the music therapy group focuses on what is happening within and between members of the group, and this can be heard in the music, and worked with in a dynamic way to help clients understand more about themselves. Improvisation therefore forms the basis of the group.

Issues are brought to the group by the clients, because the main overall aim for all clients at the Clinic is to be able to live a life reasonably self-sufficiently outside the psychiatric hospital. Thus, a large amount of work is concerned with allowing clients to take responsibility for what happens. Owing to this, the music therapist takes a facilitating role which is verbally and musically non-directive at times. By this, it is meant that methods include clients leading the group musically, thus being able to experience their own music without the therapist always taking a leading or dominant role. The therapist has found that in some cases, her harmonic in-put from the piano, for example, can inhibit the clients from being able to work through their own problems. However, there are times when just the opposite is true and the basis for someone exploring a problem is that a musical dialogue with a supportive or more dominant role taken by the therapist is necessary. Only then will the client be able to develop musically

and thus in other areas, such as initiating and leading. The music therapist and co-therapist place emphasis on the processes within relationships between group members and with the therapists.

It is not always necessary to make verbal comments. For example, individuals, or the group as a whole, have been able to work towards resolution of conflict on a musical level. Transference relationships are explored musically and verbally, and the therapists receive regular supervision with other creative arts therapists in a group led by a consultant psychotherapist.

#### *Breakdown of events which may happen*

- looking at a particular client's problem musically;
- looking at a group aspect musically;
- talking in between about what people have learned and perceived about themselves and others;
- silence, owing to resistance, preparation, relaxation, "stuckness", sadness, thoughtfulness;
- movement in order to generate energy;
- improvisation;
- role play of a particular situation.

#### *Outcome*

Benefits of the group have been described by clients in many ways, or have been perceived by the therapists when the verbal element is absent for a particular client. They have also been observed and followed by other Day Clinic team members. General examples of these are:

- overcoming difficulties in socialising and building relationships;
- becoming more confident generally and as a leader;
- learning to respect, appreciate and support others;
- becoming more able to follow musically what others are doing, e.g. following someone else's rhythm, tonality, mood;
- becoming more adventurous, e.g. after spending months only ever playing one instrument in a set personal style or rhythm, moving to others and developing musically;
- enabling personal change to occur either in mood, during one group, or over a period of time in more complex ways such as becoming less domineering and insensitive;
- finding support from other members;
- enabling those who find it difficult to relax in the company of others to do so;
- releasing tension and frustration through musical expression.

#### *The case of Anne*

A brief summary of one lady's experience will make these points clearer: Anne is a lady of 40 years old with a diagnosis of manic depression. In the past she has had several admissions to hospital, but for the last 5 years has

not needed to be admitted. She lives at home and has attended the Day Clinic for treatment; recently only for music therapy. She also has a part-time job. She chose to refer herself to the weekly music therapy group which is set up for those who feel they can benefit by using music as a means towards coping with various problems, and who do not find verbal ways of doing this easy or appropriate. She has had no previous musical ability or training, and her own job is as a dressmaker. During the 3½ years of attending the present music therapy group, Anne has often arrived looking angry, upset and feeling helpless. One of her main problems is of feeling worthless, and unable to assert herself. She has been able to use the session to explore how to deal with these feelings, particularly by unleashing angry feelings previously unexpressed. A pattern for her has been that she will be able to talk about what is worrying her after loud, often violent playing on the bass xylophone, drum or cymbal; where the music therapist supports and encourages musically from the piano. Gradually, the therapist has been able to withdraw musical intervention for longer periods, and sometimes Anne can assert herself with no help from the therapist or other group members. She has become more confident in herself by being able to lead with an instrument while others follow, thus feeling a sense of importance in a safe setting. This she has been able to use outside the group by finding that she can now have the "upper hand" with her sons who previously, she has felt have had too much control over her. Recently, she has begun to explore her relationship with the music therapist further, which has enabled her to begin to understand her feelings about her mother who committed suicide when Anne was eight. This understanding has been manifest in a wish to move on and reject the group, but also in a need for the music therapist to tell Anne it is time to leave rather than her being able to do this herself. Musically, this has involved Anne withdrawing from the improvisations by behaving in a way which she hoped would lead to being "thrown out", i.e. walking round in front of those playing instruments, peering out of the window, and refusing to use instruments altogether. The music therapist did not of course throw her out or reprimand her. It seems that the deep hurt and rejection Anne felt when her mother committed suicide is connected with her wanting to be rejected now by the therapist, and she has acknowledged this. She has now finally been able to leave the group rather than be "thrown out", and has left of her own will after a period of coming; not coming; being less involved with others musically and verbally in the group; culminating in a 'phone call saying she has definitely decided to leave. She has found help on an individual level of her own accord, and has said that she can now benefit from "talking" therapy on a one to one basis as a result of her time in the music therapy group and as a result of the root of her problems coming more to the surface. The music therapist and co-therapist feel that she has benefitted as much as she can from the group, and that it is now the "right" time for her to be looking at her issues on a one to one level, something she could previously not tolerate. She has also arranged this herself away from the Day Clinic as a member of the community in Cambridge, rather than as a "patient" needing psychiatric help.



### Conclusion

It should be clear from the discussion and case study, that the approach taken is one where an understanding of the client's music, i.e. what it might mean within the therapeutic relationship, is of prime importance. This leads to an understanding of what is important for the client at the time of the session, and subsequently in the continuing process. It does not always mean that a client needs to move to more therapy as in the case of Anne.

The approach taken can form the entire basis of therapy treatment in itself for some people, particularly because all elements are dealt with rather than only musical behaviour.

Each area of work in the Mental Health Service in Cambridge demands a different approach, although the basic philosophy remains the same. The essential feature is that the therapist and client find the particular way in which music therapy can help, depending upon the nature of the developing relationship within the music therapy sessions.

### Acknowledgement

Special thanks go to colleagues and clients at Fulbourn Hospital; particularly those at The Cambridge Day Clinic.

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