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Music Therapy: an Introduction

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The aims and historical development of music therapy are briefly described. Various approaches to research into music therapy are outlined, including recently developed ethological approaches. Much research has focussed on outcome measures, but there is a greater need for studies which focus on the nature of the therapeutic and musical process itself.

What music therapy sets out to do

Implied in definitions of music therapy are factors such as alleviation, change, music, relationship and personal qualities. Alleviating illness and disorder is fundamentally a humane and therapeutic occupation, Goodman (1981) tracing such a use of music in the history of psychiatry from Arabic-Hebraic traditions. Influencing changes in people's behaviour is central to many definitions of music therapy, Fleshman and Fryrear (1981) writing that "The therapist uses music, in a therapeutic environment, to influence changes in the patient's feelings and behaviour."

Music is used as the central means to the end. It is not used to create a performance or as a form of recreational activity alone. Music therapy is concerned not with degree of musical skill but with personal growth and development at all levels: physical, intellectual, emotional, social etc. In this case music therapy can be regarded as an applied use of music as in Alvin's (founder of the British Society for Music Therapy and the first post-graduate training course in Great Britain) classic definition:

> "the controlled use of music in the treatment, rehabilitation and training of children and adults suffering from physical, mental or emotional disorder." (Alvin, 1975)

A wide range of musical styles is employed in this developing process. Atonal and tonal improvisation, pre-composed music (both 'classical' and 'popular'), folk music and jazz all have their place in different contexts with different client groups. In some countries great emphasis is placed on the music therapist being first and foremost a trained musician able to adapt to include a wide number of musical styles in the work. In other countries music therapy is practised by musical psychologists, physicians and educationalists. Benenzon (1981), for example, feels that a music therapist must be specifically trained as such and need not by necessity be a musician. There are obviously arguments on both sides: on one side we have experienced musicians learning in too short a time to start developing as therapists; on the other highly trained clinicians needing more training in musical skills. A music therapist may be improvising with a group or an

individual client in an interactive way with great emphasis on incorporating clients' musical ideas into the improvisation. Another music therapist may use a lot of pre-composed music either in the form of live music or recorded material, perhaps to stimulate discussion.

The music therapist is using music to alleviate and to change particular behaviours or influence feelings all within the context of a developing relationship. This point permeates the relationship-based approach of, among others, Paul Nordoff and Clive Robbins, two internationally respected pioneers in the field (see Bruscia in this issue). Alvin also writes that "The success or failure of music therapy depends on human as well as musical factors of the relationship." (Alvin, 1975).

A balance needs to be struck between, on one extreme, total emphasis on the music without recognising the importance of the therapist, and on the other, the disregarding of the music in favour of a developing relationship. Schneider and colleagues felt that the discipline evolved through these two extremes in the States before establishing a position between them (Schneider et al., 1968).

A synthesis of the above factors—alleviation, change, music, relationship and personal qualities—appears in the definition published in 1982 by the Association of Music Therapists in Great Britain. Here music therapy is defined as:

> "A form of treatment whereby a mutual relationship is set up between patient and therapist, enabling changes to occur in the condition of the patient and therapy to take place. ... By using music creatively in a clinical setting, the therapist seeks to establish an interaction, a shared music experience and activity leading to the pursuit of therapeutic goals determined by the patient's pathology." (APMT, 1982)

Some applications of music therapy

Traditionally music therapy has been used where there is a major break in communication as a result of profound mental handicap or acute mental illness, for example. Music therapy departments have therefore been set up in the large institutions for the mentally handicapped and the mentally ill. There is a great deal of work with children with special needs including the pre-school language-delayed child, the deaf and hearing-impaired child, the autistic child, the child with emotional and behavioural problems and the child with a mental and/or physical handicap. At the other end of the age spectrum there is an increasing need for work with the elderly both in hospital and local community day centres and small homes.

Music therapists are also exploring the potential of music therapy with neurologically-based disorders such as Parkinson's Disease or Huntington's Chorea and with problems associated with long-term pain and stress. There is some work with offenders and in areas of social deprivation and high unemployment. Such developments are opening out music therapy's relevance and helping people to regard music as a local community resource for health in general.

Music therapy has a tradition of practice in the States. There is increasing work in Great Britain and throughout Europe—France, Germany, Austria, Switzerland, the Netherlands and Italy. A brief introduction must also mention the work in Canada, Australia, New Zealand, Scandinavia, Israel, Japan and Yugoslavia.

The range of theoretical frameworks

During the early part of the century music was introduced into hospitals to boost morale, as a general aid to convalescence and as an interesting diversion (Blair, 1964). Music was played to large groups of patients on the vague assumption that it might activate certain metabolic functions and relieve mental strain and stress (Feder and Feder, 1981). The early literature abounds with anecdotal accounts, Podolsky (1954) cites, for the example the case of a schizophrenic musician being administered "daily doses of Chopin."

After the Second World War, with the ever-increasing influx of war veterans, hospital authorities began to employ musicians in hospital teams in more earnest. The medical and scientific communities were not satisfied by anecdotal stories of music's inherent power to do good and challenged the musicians to assess the influence of all types of sound and music on behaviour, examining efficacy in specific treatment plans.

There are many differing styles of music therapy practice all contributing their own particular quality to the overall development of the discipline. In some ways there are as many different styles as there are practising music therapists. Nevertheless there are certain philosophical positions that group certain music therapists together. Much of the early work was dominated by observations that music appears to affect changes on a physiological and very basic level of functioning. Music therapists have referred to such studies as, for example, those by Weidenfeller and Zimny (1962a, 1962b) who carried out a series of experiments with children, depressives and schizophrenics, hypothesizing changes in the electrical resistance of the skin relating to calming or exciting music. They discussed how different music could be used to modify general emotional levels.

Although there is no clear theory of the psychodynamic meaning of music (see Noy, 1966–1967) there is a group of music therapists who relate music therapy processes to psychoanalytical theory. Mary Priestley uses a psychoanalytical approach in her specialised form of Exploratory Music Therapy. Here the client is encouraged to talk through the area to be explored in the traditional analytical way. This is then enacted in the musical improvisation perhaps with the therapist and client each taking on a particular role or stance. The session is completed by the playback of the tape recording and integration of the musical material into the final discussion (this simple description is given a fuller elaboration by Professor Bruscia in this issue). Gerwirtz (1964) used music therapy as a form of supportive psychotherapy and Grossman (1978) used music as a projective technique when children with emotional problems were invited to relate stories to different musical stimuli.

Various pioneers in the States repeatedly called for an objective and scientific approach to evaluation, regarding music therapy as a 'science of behaviour' (Madsen and Madsen, 1970). Learning procedures are clearly involved in music therapy interventions and it appeared possible to link both short and long-term aims with specific musical activities and needs, the range of both music and needs being so varied. There is an important body of work that clearly aligns itself with a behaviour therapy standpoint. These studies stress the importance of well-thought out experimental design with much use of control groups and statistical analysis. Emphasis is placed on developing appropriate baseline measures and systems for detailed recordings. One strength of all this work is that no claims are made for the efficacy of any specific intervention save those clearly itemised in the aims and objectives of the particular study. An elegant study by Steele, for example, can serve as an example. She used recorded music as a means of controlling the aggressive, self-directed behaviour of a retarded eight-year old. The procedure ranged from the availability of favourite music being contingent on the child remaining in a designated circle where the therapist was positioned to the gradual introduction of the instruments which could be played at the direction of the therapist. Steele reported positive changes in behaviour with periods of cooperative interaction with the adult increasing from four to twenty-three minutes (Steele, 1968).

Criticisms of the medical, psychodynamic and behavioural approaches come from therapists with a more humanistic and eclectic standpoint. They feel that the behaviourist's examination of small 'bits' of behaviour is too narrow and that research into underlying causes, emotions and consciousness too problematical (Feder and Feder, 1981 and see Ruud, 1980 for an extensive review of all the standpoints discussed above). The humanistic psychologist's emphasis on work in the present 'here and now', development of the person's full potential and whole being etc. are areas that are beginning to be critically analysed and researched. These objectives do give rise to behaviours that can be observed and measured over time.

An ethological approach to music therapy

Ethologists can be helpful to the music therapy researcher in helping to establish more rigour. According to the ethologists every new discipline needs to carry out extensive periods of direct observation with clear descriptions and classifications (e.g. Hinde, 1976 and Richer, 1979). From direct observation, categories can be selected and more specific questions asked. Further sub-categories may need to be made before any inferences can be drawn from the data. In moving towards a clearer description of interpersonal relationships (e.g. Hinde, 1979) ethologists do not exclude the use of introspective evidence as a way to establish meaning. More supportive and subjective data have a place besides the more reliable quantitative data.

Such is the background for a series of outcome studies recently carried out at The City University, London. The three studies described by Hoskyns in

this issue, Bunt, Oldfield and Odell, are all attempts to describe clearly the effects of intervention with three patient groups: children with handicaps, adults with profound mental handicap and the elderly with problems of dementia. The studies make use of control groups either by comparing an equal period of time with or without music therapy or by comparing with an alternative intervention such as play, occupational therapy or reminiscence therapy. All three projects used clear measures that reached acceptable levels of inter-observer reliability. Video analysis was also extensively employed. Bunt, for example, used time-based measures to examine changes over time in such areas as vocalisations, contact with instruments, looking behaviour, imitation and initiation of ideas, turn-taking, amount of adult support or direction (measures incorporating both quantitative and qualitative aspects). Using statistical analysis he consistently found highly significant results particularly regarding changes in vocalisations, amount of turn-taking and adult support in the music therapy (Bunt, 1985). In one of his studies he compared behaviours over time between a period of music therapy and an equal period of no music therapy, each child acting as his or her own control. In a more extensive project he compared longer periods of music therapy both with equal periods of no music therapy and individual play activities with a well-known adult. The entire study was able to clarify some of the similarities shared between music therapy and other developmentally-based interventions such as play and also indicated some of the features that appear special to music therapy and music making in general, such as the development of vocalisations and the antiphonal and synchronous balance in the musical activities.

The music therapist's dilemma

Such studies help to further the profession's external validity yet by the very nature of their design do not add much to our understanding of the processes by which the outcomes are reached (see discussion between Clarke et al. in this issue). One possibility is to explore the potential of self-evaluation, encouraging clients to itemise the central aspects of the music that may have had any effect (see Hoskyns and Odell in this issue). Reporting clients' statements verbatim can provide a rich source of information that can be a starting-point for further investigation (e.g. Bunt, Pike and Wren, 1987). Such approaches appear to be even more relevant as music therapists begin to explore music's potential in areas of more general medicine and in less traditional settings such as small community-based day centres, youth clubs etc. (e.g. see Troup, 1986 on music as a resource for mental health in the community). Issues such as social desirability effect when people may respond in a positive way in order to please the people running the project and observer bias need careful consideration. Careful handling is also needed of the case study which is increasingly being used to gain access to the more private mental states that are at the core of the music therapy process (see discussion between Clarke et al. in this issue).

There is a fundamental need to focus more on the musical material. Evidence has been and is being collected evaluating the outcome of various

music therapy interventions, evaluations that tend to use measures-physiological, behavioural, psychological etc.—that are comprehensible to other members of the para-medical teams with whom music therapists usually work. Every practising music therapist also carries with her/him experiences of numerous cases both of individual and group work—there is no shortage of descriptive material. We do need to look more closely at the musical strategies which lead to the various therapeutic outcomes. Analysis of such strategies can also benefit by recent developments in psychology of music. The discussion in this issue between two music therapists and two music psychologists highlights how, for example, recent developments in cognitive psychology could benefit the music therapy researcher. Perhaps we can begin to look at affect, for example, and try to explore some of the issues that for many years have been felt to be too rich and complex. It is surely here that there is much potential for collaborative research between the disciplines of psychology of music and music therapy. We may then begin to understand more of the processes by which, for example as one client recently wrote, "Music Therapy has provided an alternative avenue to the areas of my personality and social interaction closed off, mainly through fear of disapproval." (Bunt, Wren and Pike, 1987).

Personal viewpoint as summary

The success of any music therapy intervention is a subtle blend of both the human and musical facets of the relationship. If music therapy is to develop alternative strategies to a behaviourist application of recorded music (recorded music seems to predominate this research) and to shed some of its early cosiness and general assumptions of inherent worth then it will have to address itself to questions regarding the evaluation of the live use of all types of music in a fundamentally interactive setting with client and therapist on equal terms. Perhaps music therapy will then be closer to the stage when it will be able to step outside of existing models and be respected as a unique discipline in its own right (see also Ruud, 1980 and Bunt and Hoskyns, 1987).

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