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The Practice Of Music Therapy For Adults With Mental Health Problems: The Relationship Between Diagnosis And Clinical Method

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THE PRACTICE OF MUSIC THERAPY FOR ADULTS WITH MENTAL HEALTH PROBLEMS: THE RELATIONSHIP BETWEEN DIAGNOSIS AND CLINICAL METHOD

By Helen Odell-Miller

A thesis submitted in partial fulfilment of the requirements for the degree of PhD at Aalborg University

Declaration: This thesis, in part or in its entirety, has not previously been submitted for assessment with a view to being awarded a degree or prize at any institution of higher education in Denmark or abroad.
Signed:………..
Date:…………..

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ABSTRACT

This Doctoral study is in two parts: Part I includes five published research articles by the author. These relate to the author's quest for defining how music therapy is placed in the field of adult psychiatry, both clinically and theoretically, and to how it defines itself in relation to psychoanalytic theory within its own community, and in the external world of health care services. Part II includes a survey-based research project carried out across five established music therapy clinical centres in Europe designed to answer the main question: 'How are different approaches and techniques of music therapy defined in adult psychiatry, for people between 18-65 years old, which link diagnosis to treatment?' The research design includes statistical and qualitative analysis. Main findings show that music therapy centres in the study variably define what they do and why they do it, linked to diagnosis. Outcomes show that reasons for this are linked to training and clinical judgement. Specific findings show that there are some distinct differences between techniques used for psychotic disorders and non-psychotic disorders. Techniques involving symbolic thinking are more prevalent for non-psychotic disorders, for example. Outcomes also show a prevalence of use of approaches drawing on psychoanalytic theory with a strong emphasis on techniques of free and structured musical improvisation for all diagnoses. The study concludes that there is a need for further research and changes in attitude towards music therapy training, in order to more clearly define music therapy treatments for adults with mental health problems.

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CHAPTER 1
INTRODUCTION TO THE THESIS

1.1 Introduction to the thesis

This thesis is in two parts. Part I includes five published articles by the author which form the starting point, historical background and thinking for Part II. The author is an experienced clinician and researcher. She completed an MPhil in 1989, which, together with a long history of research and publications, led to the opportunity offered by Aalborg University to include publications in Part I of the thesis. Parts I & II are linked in that the research study in Part II arose from main questions and themes emerging from the publications, mainly in the field of adult psychiatry and looking at links between music therapy and psychoanalysis.

The articles or chapters in books included in Part I were all publications that were submitted to peer reviewed journals or edited books, and have undergone systematic review as a part of that process. They were identified as proposed publications for inclusion when applying for registration within the Graduate School at Aalborg University and were then submitted in full as part of the elaborated proposal, which was confirmed by the PhD Board in 2003[1]. In order to establish the context of each publication in the overall thesis, in Part I a short introduction to each publication is given, highlighting any links between them, resulting in some conclusions after each publication. Each publication is included here in the thesis in the format and font in which it was published.[2] This includes, in two cases, a pdf format where the final version after final proof corrections was undertaken by the publishers. A bridge to Part II is made in which the thinking about the survey in Part II begins which makes links with the publications, and this leads to the literature review in Part II.

The main themes relate to the author's quest for defining how music therapy is placed in the field of adult psychiatry, both clinically and theoretically and how it defines

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[1] The publication Odell-Miller at al 2001 was a locally published document about a research project, and originally submitted for inclusion in Chapter 6. It has now been substituted for Odell-Miller 2006 et al, which is a shorter up-dated version of the same project and includes further data analysis. This is published in an internationally peer reviewed journal *Psychotherapy Research.*

[2] Elsewhere in the thesis a standard version of the Harvard system of referencing is used consistently throughout.

itself in relation to psychoanalytic theory within its own community and to the external world such as employers, and purchasers. The main themes within the publications also address the search for a research methodology that is suitable for answering questions about how beneficial and effective music therapy is in psychiatry, and for which diagnostic populations. This then leads onto a more detailed set of questions about which techniques and approaches are suitable for diagnoses and situations, which arises not only from a study of literature, but from the author's thirty years working as a clinical music therapist.

Following the presentation of the publications and a short discussion about their relevance to the author's questions, Part II follows with a survey-based research project designed to answer the main research question in the thesis.

What research studies, clinical reports and current practice, both published and unpublished, describe guidelines, approaches and techniques used in the practice of music therapy in adult psychiatry (18-65yrs) which link diagnosis to practice? The research design is both quantitative and qualitative and involves some statistical analysis and qualitative analysis arising from a purposeful survey.

1.2 Introduction to Part I

Five publications by the author will form Part I of the thesis. The publications form the basis of the author's thinking which led up to doing a new piece of research which is in Part II of this thesis. The ideas underpin the rationale for the more recent research described in this thesis. There are three main themes which draw these publications together and which make them a suitable introduction to this thesis.

These three main themes are:

-The search for an effective research methodology for music therapy (and other related arts therapies), with adults with severe mental health problems.

-Articulation of appropriate approaches to clinical practice, including some mention of links to diagnosis, and an examination of ways of defining this.

-The question of the relationship between psychoanalysis and music therapy

The main research question in the thesis is:

"What research studies, clinical reports and current practice, both published and unpublished, describe guidelines, approaches and techniques used in the practice of music therapy in adult psychiatry (18-65yrs), which link diagnosis to practice?"

The sub-questions to this main research question are:

- How can different techniques and approaches of music therapy be defined in adult psychiatry, by comparing what is described about current practice in the literature, with the results of an in-depth survey from a small sample?

- Can existing methods and techniques of treatment practice be linked to, and respond to the relevant areas of clinical treatment in the mental health act, in the UK?

- Can implicit levels of practice be clearly documented in the wider context for use by practitioners?

While the submitted publications by Odell-Miller(1999, 2001, 2002, 2003, 2006) do not specifically address the research questions, they have been selected because they form the background and original thinking which led up to the creation of the research questions. The findings from these earlier papers began to address these three issues relating to the research question for this study, and in the discussion links were made between the papers and with the main research question. The new study used a survey method to elicit responses from five music therapy centres in psychiatry in order to answer the main research question. It also addressed more specifically the sub-questions of the thesis following analysis of data.

In order to address the main question, the author carried out a literature search to explore evidence from current and past publications documenting clinical and research reports, and also selected well-established music therapy centres for adults with psychiatric problems. A questionnaire based survey was implemented to obtain more focused and specific information on guidelines, protocols and methods for detailed analysis. In this survey there are questions designed to draw out the above themes which link the publications with new and existing literature. Clinical practice, research and theoretical approach are central to the thesis as a whole and thus these publications form a fitting first half of the thesis.

It is notable that one of the most recent publications, 'Are Words Enough? (Odell-Miller 2003) was commissioned by two psychotherapists, (the editors), in the initial planning stages of their book about radical and future developments in psychotherapy practice. This is important because until now there has been more emphasis in the direction of psychoanalytic theory as an influence upon music therapy theory. For example music therapy has treated psychotherapy and psychoanalysis as its 'patriarchal' figure, rather than music therapy being seen to have influential 'power' within the field of psychotherapy. This phenomenon is reflected in the published literature on music therapy and psychoanalysis, Streeter (2000) and within literature striving for new directions such as community music therapy, for example (Ansdell 2002). The first article discussed here formed the basis of thinking and debate about music therapy in psychiatry, examining theory and approach. The question of what people do in sessions and why, particularly in terms of how much talking and how much music is used, underpins the first article (Odell-Miller 2001).

CHAPTER 2
MUSIC THERAPY AND ITS RELATIONSHIP TO PSYCHOANALYSIS

2.1 Introduction to the publication in Chapter 2

The publication in this chapter represents theory-based research exploring the relationship between music therapy and psychoanalysis within the field of adult psychiatry. The focus of the chapter is a detailed historical and current overview of the relationship between music therapy and psychoanalysis, and an argument resulting in a combined model of psychoanalytically informed music therapy ensues by analysing the author's own case work and ideas, and by a detailed look at the literature prior to 2001 within the field of music therapy within adult psychiatry and its reference to psychoanalytic influence. The material that was included to underpin the place of music therapy in a psychoanalytic framework consists of sections at first introducing music therapy. These are quite introductory to the informed reader because this book was for a non-music therapy audience, for psychiatrists, psychotherapists and psychoanalysts, as well as other arts therapists. The article develops a theory of psychoanalytically informed music therapy on the basis that thinking about unconscious processes and the music are equally important. It argues with the term 'music psychotherapy', suggesting that this concept can mean the psychoanalytic theory drives the music therapy rather than being of equal balance. Odell-Miller discusses the danger of music becoming lost in too rigid theoretical integration of psychoanalytic ideas into music therapy. The chapter is set in a multi-disciplinary context, and as such has influence within the other arts therapies fields and the field of psychotherapy and psychoanalysis. Research for this chapter involved identifying the role and function of music therapy within the field of adult psychiatry, and the processes that are defined and the conclusions drawn are significantly influenced by discussion of clinical approaches with other professionals at psychotherapy conferences, and conferences (The Society for Psychotherapy Research), and conferences at The Royal College of Psychiatrists in the UK.

2.2 Music therapy and its relationship to psychoanalysis

Helen Odell-Miller

> "If a few bars of music are played and someone comments that it is from Mozart's *Marriage of Figaro* (as happens in *Don Giovanni*) a number of recollections are roused in me all at once, none of which can enter my consciousness singly at the first moment. The key-phrase serves as a port of entry through which the whole network is simultaneously put into a state of excitation."
>
> <div align="right">Freud, 1900a, p. 497</div>

This chapter focuses on the relationship between music therapy and psychoanalysis, from a historical, theoretical, and clinical point of view. I first give a brief introduction to music therapy and then address two major areas where the disciplines meet. The first is found in the actual structure of the two disciplines, in that free improvisation in music therapy can be seen as similar to the aspect of free association and free-floating attention in psychoanalytic work The second area is concerned with aspects of psychoanalytic theory and practice which have informed music therapists. Theoretical frameworks such as transference and countertransference have clearly helped music therapists understand meaning within the therapeutic relationship, and these concepts have been developed to encompass music therapy (e.g. Odell-Miller, 1996; Streeter, 1999a). Aspects concerning music and the unconscious are important, as clearly the spontaneous abilities of musical processes to stir the emotions and help bring issues to consciousness are central to the topic. Psychoanalytic theory has also enabled music therapists to understand the context in which they are working and the unconscious forces that may be in operation in the external world in which the music therapy treatment is taking place.

What is music therapy?

"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. . . . 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" (APMT, 1995).

Music therapy is used effectively with many patient groups, particularly for those with communication difficulties. Through making music with people in settings such as schools and prisons, the early pioneers of music therapy realized that it sometimes resulted in a new and different way of communicating.

While this chapter draws on work in the mental health field, psychoanalysis has been very influential in the work of music therapists in the field of learning difficulties, particularly through the work of Sinason (1992), who has supervised many music therapists. The work of Stern (1985) has also been influential, particularly for therapists working with young, developmentally delayed patients. Stern in his mother–infant work has linked theories concerning early interaction together with theoretical perspectives from the psychological and psychoanalytic fields. Bunt (1994), Bruscia (1987), and Wigram, Saperston, and West (1995) discuss music therapy more extensively. The task of the current chapter is to give an introduction to the practice of music therapy. Music therapists are now registered and established in the United Kingdom under the Council for Professions Supplementary to Medicine (CPSM) and have their own advisor to the Department of Health. There are six professional training courses at the time of writing, all of which have to be validated jointly by the CPSM and the university in which they are situated, and all of which are at postgraduate level. There is a body of research, both qualitative and quantitative, to be found in the texts referenced in this chapter.

The practice of music therapy

The following description illustrates what might take place with a group of patients with Alzheimer's disease, who are not necessarily able to use spoken

language. The innate qualities of music (Moog, 1976) are pertinent, because a more spontaneous uninhibited form of relating often emerges as part of the dementia process.

Musically, members have the chance to choose their individual way, using a particular instrument or some other musical means, of introducing themselves to the rest of the group. This is usually done with the therapist's support through improvisation, following the patient's rhythm, metre or pulse, often with musical harmonic structures provided by the therapist on the piano.

Sessions involve encouraging interaction, awareness, and movement using instruments and voice, building improvisations from the sounds and music expressed by group members. At times, this involves developing pre-composed material (such as songs, or instrumental material) in improvisations between different members in pairs, in threes, in small groupings, or as a whole group. For example, if a member begins humming or beating in a particular way, the therapist would listen and would subsequently interact musically in order to build on this. The therapist identifies the needs of the patients by observing and getting to know patients as the treatment progresses and the therapeutic relationship develops. Different types of musical interactions are made according to assumptions about what would be helpful. For example, when a patient who has previously shown withdrawn, frightened behaviour begins to beat in a triplet-type rhythm quietly on a metallophone, the therapist might see this as something that could be encouraged musically and perhaps could lead to the patient feeling more able to communicate in other ways. The musical intervention by the therapist is, therefore, made in a way that would help this. For example, here the therapist supports from the piano with soft but firm melodic improvised phrases in the right hand, and octaves in the bass in the left, providing a harmonic structure. The therapist follows the patient's rhythm but does not repeat it exactly, as this could be intrusive. It can be seen

from this example that the therapist must be both a highly trained musician and a therapist.

Why music?

A full answer as to why music is therapeutic is beyond the scope of this chapter, but it must be touched upon. There will, of course, be many questions that cannot be answered. However, the important underlying factors are that four main elements of sound—pitch, volume, duration, and timbre—are all found in the human voice. A collection of sounds made up of these elements leads to the formation of music. Rhythmic and harmonic factors are particularly important, as the previous example shows and as discussed extensively by music therapists (Bruscia, 1987; Nordoff & Robbins, 1971, 1977).

The most important stages in voice development of the child are discussed by Moog (1976). He illustrates how important the human voice is in musical terms and shows that, from inside the womb onwards, children have natural responses to music that are not "taught"—for example, smiling (as distinct from what some believe to be the very early "reflex") and spontaneous movement of the body when music is played.

It is indicative of how important the voice is that often children will immediately recognize a nursery rhyme when it is sung, whereas it may take them a while to recognize it when played on an instrument such as chime bars. More specifically, Moog's research articulates developmental stages in relation to music. For example, from 5 to 8 months, after turning to listen to music and being still, children begin motor movements that are often not related to the tempo of the music but are regular movements in themselves. After making movements, vocalization occurs in form of babbling. The distinction between two types of babbling is important here, as babbling is the precursor of speech. Speech babble is understood to be in response to speech directed at the children. They will usually babble more on a monotone than in a varying pitch. Musical babble precedes the development of speech, and

children will musically babble in response to music (usually vocal music) with varying pitch. This and other developmental stages are not dependent on musical training but are part of natural development. They are significant here in supporting the rationale that, when other faculties deteriorate, a natural musical innate instinct often remains (Sacks, 1985).

Non-verbal and pre-verbal phenomena

While calling myself an analytically informed music therapist, I should also add that in my view psychoanalytic theory *per se* has its limitations in relation to the actual practice of music therapy. This is because some of the general therapeutic qualities of music are physiologically, rather than psychologically, orientated.

A large group of people for whom music therapy is most effective is that of people who find talking difficult, where verbal elements as in ordinary fluent speech and language are missing. Music can be an alternative means of expression and communication because a language of music and sound, often improvised, provides an accessible language. Here, the developmental and neurological aspects of understanding music therapy are important, because it is now well known and well researched that when brain damage occurs, musical functioning often remains intact, and can be the last faculty to deteriorate (Alajouanine, 1948; Basso & Capitani, 1985; Gordon & Bogen, 1974; Sacks, 1985; Smith, 1966). Spitz (1959) in his work concerning the early development of the ego, repeatedly emphasizes that emotion plays a leading role in the formation of organizers of the psyche. He believes that during the first 18 months of life an affective behaviour precedes development in all other sectors of the personality by several months.

This is important because music therapy concentrates on an expressive "affect" as well as talking and thinking, and if the latter are absent (e.g. because the patient is too regressed, or not ready, or unable to speak or think), then the language of music is important. This can be equally relevant when working with people with dementia, who may regress and revert to pre-

verbal infant-like speech and behaviour. In the following case study, some of these points are explored further.

Case study: Martin

Martin is a man in his late 50s with early onset dementia. He was referred for music therapy by the psychiatrist, who had a clearly defined area of work in mind. Significantly, Martin had been a lecturer and composer in music. In her referral letter, the psychiatrist wrote: "We wondered whether it would be possible for you to assess Martin and see if it would be possible to help him work through some of the emotional implications of his diagnosis." In later letters, once the therapy had been underway for several months, the psychiatrist wrote that Martin often seemed depressed, with almost "too much insight into his condition", but also that "although he has considerable difficulty expressing himself he did explain to me that he found weekly music therapy visits very helpful, and his wife has commented that he seemed brighter after these sessions". All those in the team, including his wife, believed in the importance of the music therapy. Two other key people providing interventions were the community psychiatric nurse, who visited weekly to help with practical coping strategies and to give support to Martin and his wife, and the psychologist, whose intervention was aimed at trying to help the couple understand his neurological strengths and weaknesses. This case also illustrates the importance of multidisciplinary work, which is essential for people dependent on many different aspects of the service for their needs.

Nine months into the music therapy, Martin was quite cognitively impaired and could not always identify his wife, dress himself, or hold a lucid conversation. He was occasionally aggressive towards his wife but affectionate at other times. He seemed to recognize me, and he often moved immediately to the piano on seeing me. Sessions took the form of improvisations at the piano, during which I also switched to

using my violin or voice. For him, I seemed to represent carer, fellow musician, pupil. Within the transference, I felt that I also symbolized partner, child, pupil, and nurturer at different times. He developed an increasing rapport with me musically, and he once said, while still in command of some spoken language: "I feel this is so good for me—it's just there, music is here—you touch it and you get it." He also began to improvise on his own between sessions, something that he had had no inclination to do when we first met because he was afraid of the piano. He regularly exclaimed: " It comes up to hit me." Gradually, this fear subsided the more our work developed, and through improvising he recognized a way of expressing himself. It is also significant that music is an area in which he feels expert and confident. Throughout the three years of therapy, he became more cognitively impaired and disorientated, often needing me to point him towards the piano or into the therapy-room as if he could not orientate himself to the situation. However, musically we could still communicate in a way that made musical sense.

Where is the place of psychoanalysis in the above case? Transference and countertransference issues are central to understanding the relationship. The case illustrates the particular relevance of these concepts, which are discussed in the more detailed theoretical discussion later in the chapter. In the sessions with Martin, these phenomena could be heard and experienced in the music.

Striving to follow him—his improvisations, his style, his musical flow—always felt like a musical struggle, where each had to be as musically adept as the other. Listening to the tapes, and allowing myself to be honest about what I was feeling, I sometimes felt inadequate and that Martin was wanting to show his musical prowess over mine. I could sense this musically, and once or twice I could anticipate it. He would stop abruptly and say, "Oh no! Why did you do that here!" I suggested that as he was used to

improving, and felt good at it, that he might be feeling towards me as he did towards his former pupils: "Yes—you've got some way to go", he answered. I thought that the powerful feelings that I had in trying to do well, reaching into my innermost musical memory and creativity, in order to be with him in the music was part of my countertransference towards him. He was literally involved in the one medium within which he had some complex skills intact when other skills such as speaking, dressing, and understanding spoken language were receding. I was put in the position of keeping alive the faculties within which he felt most validated; however, at the same time I was put in the role of feeling inadequate—a position that he himself was now in most often in relation to the world. Although his capacity for understanding was receding, it was important to verbalize this to him, and he seemed relieved. This was when he said: "Music is there—you touch it and you've got it."

The historical context

Music therapy was developed by musicians who recognized the therapeutic value of working through this art form not just as an adjunct to something else, but as an entity in itself within which therapy takes place. Thus, there is a distinct emphasis on the therapist being essentially an expert in the art form. The influence of psychoanalysis on the development of music therapy in the early days was variable. While Jung has been a major influence in the work of art therapists, because he believed in the use of drawing and painting in his own psychoanalytic practice, he drew no direct links to music in his work. Freud was puzzled by music, and for music therapists there has been a much less obvious connection with the world of psychoanalysis. Freud (1914b) reveals his attitude to music:

> Whenever I cannot do this, i.e. explain to myself what their [works of art] effect is due to I am almost incapable of obtaining any pleasure. Some rationalistic, or perhaps analytic, turn of mind in me rebels against being moved by a thing without knowing why I am this affected and what it is that affects me. This has brought me to recognise the apparently paradoxical fact

that precisely some of the grandest and most overwhelming creations of art are still unresolved riddles to our understanding. [p. 211]

Freud (1900a) also discusses possible relationships between music, dreaming, and the unconscious, but as in all his references to music there is a suggestion of being puzzled by not quite understanding music. He discusses sleep in connection with "music dreaming" and wonders about the function of music as acting as a stimulus or port of entry into the unconscious, an idea taken up extensively by Priestley (1994). Freud was not a major influence for early music therapists in terms of the therapeutic use of music. Jung also appeared in awe of music; his reactions to music are discussed extensively by Hitchcock (1987), who describes some interesting interactions between Jung and music therapist M. Tilly. Jung apparently told Tilly that he never listened to music any more because it exhausted and irritated him. He was also of the opinion that music deals with deep archetypal material and that those who play do not realize this. Towards the end of Jung's life, Tilly apparently worked with him in music therapy, and Jung subsequently said that music should be an essential part of every analysis.

Tilly (1947) also discusses masculine and feminine qualities in music, and Jung (1963) speaks of making concrete images and understanding them. Although Jung's experience was in art drawing, he supposes that music might be used in a similar way to drawing in order to move from an aesthetic attitude to one of judgement. However, he thinks that this would only be useful if the music were written down once composed, presumably because he was concerned about the transitory nature of the act of making music in comparison to the more permanent act of the creation of art. We must assume here that, today, with the advent of audio technology, music is thought about very differently, particularly in terms of methods of recording.

While Jung here reveals a different idea of process from that employed by modern music therapists, this is partly relevant to the practice of music therapists who very often tape and analyse the improvisations, even if they are not actually transcribed and notated.

Despite this ambivalence shown by Jung and Freud about music, a major early development of music therapy in relation to psychoanalysis is seen in the work of Priestley (1975, 1980, 1994). She developed analytical music therapy, the characteristic feature of which is that the patient's improvising is often stimulated and guided by programmatic titles.

The model is based on the psychodynamic constructs of Freud, Jung, Klein, and Lowen, and in her writings Priestley focuses on the literal relationship between psychoanalytic theory and her music therapy approach. Priestley (1994) gives clinical examples of regression introjection, suppression reaction formation, isolation, undoing intellectualization, and rationalization, among the many other defence mechanisms identified by Freud. She believes, for example, that improvisation could, through playing music on the theme of a difficult experience, help a patient regress and unlock repressed feelings. She thinks that music therapists should strive to find the music in words and the words in music, an idea more fully developed by music therapists in the late 1980s and 1990s (Odell, 1988; Odell-Miller, 1991, 1995; Streeter, 1995). The purpose of analytical music therapy as described by Priestley (1980), is to explore the patient's inner life and facilitate growth by using words and symbolic music improvisations.

In Priestley's pioneering work, there is a specific technique that involves several stages and uses a thematic or metaphoric representation, an "as if". The patient would describe an event or theme to the therapist, and they would both then improvise, then discuss, and then play again. However, for music therapists who believe in the central focus of the musical relationship and the flexible use of this in the clinical setting, Priestley's approach needed to be adapted. I developed my music therapy practice from the experience of putting into practice music therapy concepts and techniques that I discovered were suitable for those patients in a psychiatric setting who were largely able to communicate through words. At this time, in the early 1980s, the only model for working in psychiatry was the work of Priestley, and this seemed a very rigid model, and not always appropriates for group

work. The psychiatric setting where I had the task of setting up a music therapy service had a long history of social therapy and emphasis on group process. Many of the wards were run as quasi-therapeutic communities. Owing to this, and through links with an analytical psychotherapist with experience in the arts therapies and a strong interest in music, we set up an arts therapists' supervision group in the early 1980s. Within this, some of the underpinning theories that led to "analytically informed music therapy" were explored. Now that the profession has developed, there is an emphasis on music therapists being supervised by music therapists. This is particularly reflected in the Association of Professional Music Therapists' post-diploma supervision scheme.

It is important to add here that there are some music therapists practising who would not describe their work as informed any more by psychoanalysis than by musicology, humanistic psychology, or developmental psychology. The uniqueness of music therapy in the United Kingdom is often marked by its emphasis and focus on live improvised music, and early pioneers such as composer Paul Nordoff and cellist Juliette Alvin appeared to have discovered music therapy largely through the influence of musical and developmental phenomena, rather than psychoanalysis acting as a major influence. In these approaches, the musical impact on the patients in therapy was considered of prime importance, rather than understanding the relationship between therapist, patient, and music.

As we have seen, music therapy involves the use of live interactive improvisation, where the therapist finds a way of building a musical relationship with the patient, and a shared musical experience takes place. Its basis is therefore action orientated, rather than being passively orientated. This is particularly significant as the music therapist is commonly involved in the musical improvisation, whereas in some other arts therapies—for example, art therapy—this is less frequently described. (e.g. Levens, 1995).

Despite this focus on the musical process, there appear to be more subtle influences from psychoanalysis in the early days of music therapy than

is at first apparent. Initially, I believed that in my training in the mid–1970s, there had been little emphasis on psychoanalysis. However, to my surprise I read in Bruscia (1987) that Alvin, with whom I trained, showed many features in her work that were influenced by psychoanalysis. Freud's basic concepts appear to have influenced Alvin's practice, rather than concepts being used in a more "technical" way. Her training method was quite educationally orientated, and it focused on cause and effect rather than exploring the unconscious world of the patient. Aspects of analytical concepts are referred to by Bruscia—such as the use of free improvisation as a means of self projection and free association—rather than the process being literally governed or influenced by it.

Alvin (1975) discusses some ideas about the connections between music and psychoanalytic theory in a subjective, rather tenuous way, as reflected in the following excerpt: "Some musical instruments have a phallic shape, others imitate women's breasts . . ." (p. 151).

I have always regarded developments in music therapy in relation to psychoanalytic theory in the United Kingdom as having derived mainly from the work of Priestley and subsequently during the last two decades by other music therapists, (Davies, 1995; John, 1992; Odell, 1989; Odell-Miller, 1991, 1995, 1996; Rogers, 1992; Streeter, 1995, 1999a; Towse, 1991; Woodcock, 1987). These music therapists integrated psychoanalytic theory into the practice of music therapy in varying ways and developed the theoretical debate about whether theory governs practice or vice versa.

Music therapy practice and psychoanalytic influence: music therapy or music psychotherapy?

Music therapists, while historically rooted in the use of live music, increasingly refer to psychoanalysis to inform their work, and there are different levels at which this can happen. My emphasis here is that the music can still remain central, unlike in the model of Lecourt (1992), mentioned below, in which the process could be seen as psychotherapy with music

rather than music therapy. Freud (1900a, 1914b), Bion (1961), and Yalom (1975) were influential in the early days of my work owing to the social psychiatry setting in which I worked (Odell, 1988; Odell-Miller, 1991). The following description of music therapy group-work reflects both a musically and a psychoanalytically informed way of working.

Improvisation is the focus where active music-making reflects the patient's current state. This in turn can lead to an understanding of the internal and external interpersonal and intrapersonal changes that may be desirable. A variety of instruments are used, including violin, piano, and tuned and untuned percussion.

Owing to the time element and rhythmic dimensions of music, an immediate intense experience of the here-and-now is provided by a music therapy group. Interactions can be played out within improvisations, and it is fundamental to this way of working that the therapist responds to this. It is important not to avoid issues that he or she perceives or hears, if patients are ready to look at this. It is also important to recognize when music-making might be encouraging defences, such as becoming lost in steady repetitive duple-time phrases instead of expressing feelings of distress and chaos in a more irregular rhythmic pattern. In this method, free improvisation provides an experience for transference and countertransference relationships to be dealt with between group members as well as with the therapist. In addition, feelings of members about the way others play, and their degree of skill (Odell-Miller, 1991), provide material that can be used by the music therapist to understand more about the group and its members.

The symbolic parental role of the therapist can be used, particularly in terms of carefully offering or not offering one's own music. For example, I have found that in some cases my harmonic input from the piano can inhibit patients from being able to work through their own problems. However, there are times when the opposite is true and the basis for someone exploring a problem is that a musical dialogue with a supportive role taken by the therapist is necessary.

What has always struck me as unique to music therapy, particularly in group work, is that in a group music therapy improvisation people can literally all "talk" at once. This is a very different aspect of relating from that of relating through words, when it is difficult to understand or hear another if a group of people are speaking simultaneously. In music therapy, the very act of playing music all at the same time allows something to be expressed about the group as a whole—in fact, the joint sounds could be said to link together and express something of the essential dynamic within the group. This can be very potent, both in group and in individual work.

Woodcock (1987), who was influenced by Bion, discusses the spontaneity of expression linked to psychoanalysis. He thinks that the musical role of therapist makes the role of therapist more complex, and he compares verbal and musical media. Woodcock is interested in the question of whether musical and verbal dynamics arise from the same source, or whether there are different ways of understanding them. De Backer (1993), also influenced by Bion, discusses the importance of containment in group work.

Psychoanalysis and music therapy: developing the debate.

It is now a requirement in the United Kingdom that music therapy trainees are involved in their own personal therapy, and psychoanalytic training and theories have been influential in this process. There is debate within the profession about what type of therapy this should be. There are some important distinctions to be made according to whether the theory governs practice or is a useful tool in informing the work. Since the recognition that psychoanalysis has essential components that music therapists cannot afford to ignore, particularly the use of transference and countertransference, the concern among some music therapists is that the music could literally be "killed off".

I would stress that in a psychoanalytically informed approach, the relationship with the therapist is of equal value to that of the art form. In my view, a good arts therapist will focus on the person as a whole primarily through the art form but will also pay attention to the aspects of the person shown through talking and thinking. In the field of music therapy there seem to be many areas of confusion; there also seems to be an underlying division between those who feel that music therapy must develop its own theories arising from music therapy practice, and those who feel more strongly that music therapy would be more effective and more easily defined if it were based on already existing theories. Lecourt (1992), a French analyst and music therapist who has developed a particular approach based on Freudian and post-Freudian psychoanalytic concepts, is one example of the latter approach. In her method, there is a set way of working in which the therapist does not play music, the patients improvise for up to 10 minutes at the beginning of the group after introductory "free sounds", and the rest of the 50 minutes is taken up with an analysis, by therapist and group members, of the experience involving verbal interpretation. The music and words are seen here as very separate, rather than the more fluid movement between music, thinking, and words described earlier in this chapter (Odell-Miller, 1996; Streeter, 1999a). John (1992) also implies that a clear theoretical framework governing practice would be desirable, and he goes some way to clarifying and explaining the function of music in therapy in relation to psychoanalysis. Specifically, he writes about the function of music in conscious and unconscious processes, preferring to describe his work as music psychotherapy:

> It seems that when playing music, feelings are often represented without necessarily being consciously felt. I am convinced from clinical experience that when this "preconscious phenomenon" is used in therapy it can be a way of both regulating and controlling the flow of affect, and preparing consciousness to receive and tolerate affect. It is important to stress that the music is half of the management process; conscious assimilation needs words in order that the unconscious material can be managed and thought about. This process of music being literally a medium through which unconscious

material can bypass repression and become conscious in words forms the
basis of music psychotherapy. [John, 1992, p. 12]

While this is a useful theoretical framework for understanding music therapy,
I believe that music therapy is a discrete entity in itself, as illustrated by
Streeter (1995) where she summarizes the central task of the music therapist:

> Aspects of the transference relationship played out in the music can serve as
> pointers for the therapist's understanding of that which the client may be
> struggling to express. Thoughts may then be put into words and used
> constructively to communicate with the client. [p. 1]

She continues later:

> Whether to encourage more playing, allow for more talking or vice versa?
> How to know when playing alone is enough when talking might be more
> meaningful? [p. 3]

Transference, countertransference and interpretation:
words and music

My approach—which I would describe as "psychoanalytically informed" and
not "music psychotherapy"—has grown from years of reading, discussion,
supervision, and thinking, and with ideas from psychoanalysis informing the
work, rather than building the music therapy on other theories. Hence, it is
important to say that I unashamedly integrate concepts that seem to fit into,
and help explain and understand, my music therapy processes. One of the
fundamental concepts that distinguishes my approach is that of interpretation
(Odell, 1989). Questions such as "How does the patient understand the
musical interpretation by the therapist?"—in fact, "Is musical interpretation
possible, and if so, what is meant by it?"—were frequently discussed by
music therapists in the early days and still continue to preoccupy the
profession.

I am aware that often I use spoken words during the process of
interpretation with patients who can understand this way of working, and for
whom verbal interpretation may help towards understanding what happened
in improvisation. The assumption is that this then leads towards more insight

for the patient. The example of Peter at the start of the next section illustrates this point. I believe that it could be difficult for the verbal patient if such issues are not explored through words and interpretation (Odell-Miller, 1997).

Supervision

My first experiences of psychoanalytic supervision from the late Dr Graham Davies, in an arts therapies supervision group, was full of debate about whether thinking could take place without words. Also, there was discussion about the therapist and patient actually making music together—could this be seen as acting-out?

> During one supervision meeting in the early 1980s after listening to a tape from an individual music therapy session with Peter, a man suffering from manic depression, the music was described as being "like intercourse". Unless this was pointed out or interpreted to the patient, it would have been impossible to move on. A dramatherapy colleague in the group succinctly pointed out after hearing the improvisation: *"You are just giving in to everything that the patient is doing and nothing is changing."* We had to become separate. Another way of thinking about this in psychoanalytic terms is in the context of attachment concepts rather than adult-to-adult relating. This was briefly considered in the supervision group, but as therapy was at that time concentrating on life events relating to Peter's developing relationship with his girlfriend, and owing to his fragile state particularly in dealing with this type of interpretation, it was not thought appropriate or helpful to pursue this notion. Thinking was important, but I had to make the negotiation musically as well as making a verbal interpretation.

> There is increasing clarity now among music therapists concerning these issues, although there is a necessary constant tension between talking

and music-making in therapy. This clarity is demonstrated by Streeter (1995) where she uses the term "musical countertransference" and illustrates the process clearly using case examples. She writes:

> creating music means taking responsibility for form and structure rather than being carried along by it. When the client is given the opportunity to determine the musical material the therapist will find that a musical role has been assigned to her within the improvisation. When playing alongside the client the therapist may find herself in the role of the initiator or she may be required to be drowned out or to be instantly challenged or her music may be ignored or she may find herself having to keep things moving along. Any number of different roles may be assigned to the therapist within the free musical improvisation. By allowing this dynamic to evolve it is possible to understand the client at a deeper level. [p. 4]

She draws a parallel with psychotherapy and continues:

> the music therapist can examine her own responses to the role she takes within the music , what we call her musical countertransference, and in this way get a deeper sense of the client's inner experience. [p. 4]

This concurs with the general definition of musical countertransference below (Odell-Miller, 1994), the point here being that examples illustrate that it is possible both to emphasize the particular unique qualities of music at the same time as drawing on psychoanalytic concepts without the meaning of either being lost.

> This [musical countertransference] would take place in a shared clinical improvisation. As the therapist you realise that you are playing in a certain way in response to the patient, which previously you had been unaware (or unconscious) of. You then are able subsequently to make use of this musical experience. This would be by consciously altering your musical style; and/or after the music has finished, making a verbal interpretation during discussion. This interpretation helps the patient understand how they may have influenced your response. [Odell-Miller, 1994, p. 5]

> Hughes (1995) discusses transference in music therapy and

understands it as the playing out of the patient's primary object relations—that is, the mother–infant interaction.

Transference and countertransference are concepts that seem to have the most to offer music therapists in terms of increasing understanding about what dynamically is happening in this very complex process. It is complex, and when I saw a patient for verbal psychotherapy for one year, I became aware of how much more complicated music therapy can be. There were times in verbal psychotherapy when I longed for music and instruments. However, not having them made this process of negotiating the space less complex, although perhaps for some patients an essential component was lacking.

Towse (1991) discusses how musical instruments in a session can highlight dynamics in a vivid way. She links the playing of instruments with allowing the patient and therapist to gain access to the patient's anxiety by the analysis of defence mechanisms that may be heightened by improvising. The significance of the presence and absence of the therapist can also be explored in a way that Towse believes is less accessible in verbal psychotherapy.

Object relations theory, as demonstrated in the work of Klein (Klein, Heimann, & Money-Kyrle, 1955), Winnicott (1971), and Bion (1961) has influenced the work of music therapists. Within the words-and-music debate, Stewart (1996) states that words particularly provide a distilling clarity in terms of (1) eliciting the nature of transference; (2) responding to forms of resistance; (3) providing firm boundaries; and (4) clarifying issues relating to inner and outer realities of patients.

Winnicott (1971) has greatly influenced music therapists with his concept of the transitional space, and there is a belief that music can symbolize this function in music therapy. Music therapists have taken up his idea that the therapy-room acts as a safe containing space that, while not being explicitly symbolic of either the internal or the external world, represents somewhere "in between" both worlds. This also leads music therapists to draw analogies with music that could also act in this way—for example, as a bridge between the internal world and the external world.

An opposing view to this is held by Ansdell (1995), who believes that "music therapy works in the way music works" (p. 173). He is interested in the phenomenological nature of music in which it is understood on its own terms, rather than the hermeneutic nature of psychoanalysis which interprets and translates. In his view, music acts to synthesize rather than to break down, and therefore the heart of the therapy is contained in the music. However, my concern would be that, particularly when patients can speak, half the process is missing if there is no room for talking and thinking.

The debate about the relationship between music therapy and psychoanalysis is endless and has recently been further developed (Aigen, 1999; Ansdell, 1999; Brown, 1999; Pavlicevic, 1999; Streeter, 199b). It is particularly significant at present owing to a point that we have arrived at in the history of the profession where the two disciplines are being cloned together on the one hand (Lecourt, 1992) and split off on the other (Ansdell, 1995). Lee (1992) goes so far as to suggest that interpretative elements in music therapy could be "highly contentious . . . [and] . . . potentially very dangerous" (p. 23). Despite this scepticism, I would argue here that with the right training and experience, an integration of psychoanalytic concepts within music therapy can only serve to enhance the experience of patients.

Psychoanalysis
and the context of the therapeutic relationship

There are many other forces in operation in addition to the music, and this can be highlighted by looking at a particular group of people who need long-term residential care. Music therapy for these residential groups of people is particularly important because verbal elements common to ordinary fluent speech and language are often missing. Those with psychosis often express themselves in unconnected language and have a deep disturbance not always accessible in ordinary ways of relating, and those who are confused or "demented" often express themselves in unconnected regressed speech.

If you could listen to musical examples from such case work, you would hear the importance of instrumental improvisation, vocalizing, and the developing of an improvised way of relating which offers something that the patients can relate to. Within this, a psychodynamic and sometimes psychoanalytic approach to the work is useful. Even if the patient has little insight into him/herself, it can be important and helpful for the therapist to try to understand unconscious processes that may be happening, even if it is inappropriate to reflect these verbally to the patient. This helps the therapist understand not only the patient, but what I have called the disturbance in the institution, as illustrated by the example given below. This is similar to the ideas discussed by Menzies Lyth in *Containing Anxiety in Institutions* (1988), although the term "countertransference" in relation to these unconscious processes is not necessarily made explicit in her book.

Working with very damaged people places enormous demands on the therapist, such that she or he needs to understand the unconscious processes that may be going on. Change may be little and infrequent, and depression may be enormous. This, coupled with the confused or psychotic expression of some patients, requires staying power on the part of the therapist. It can be helped by understanding the transference and countertransference phenomena.

In order to work in a multidisciplinary setting, it is important for the music therapist to understand these phenomena, and to know that there may be unconscious feelings among staff arising from looking after confused people all day; if not understood, these feelings could get in the way of the music therapy process. It helps to understand that perhaps the reason why others forget to bring the patient to a music therapy session, even though she has been coming for twenty weeks at the same time on the same day each week, may be as a result of staff becoming unconsciously forgetful or confused like the patients.

To summarize, we have considered major influences of psychoanalysis in terms of links between free musical improvisation and the unconscious, the

significance of theoretical concepts such as transference and countertransference, and the importance of setting and context, as shown in the previous section.

Case Study: Malcolm

Malcolm, a man in his early 30s, had a diagnosis of manic depression. After assessment, it was felt that reasons for attending individual music therapy would include "coming to terms with my personal problems, as I have some problems expressing myself—I would rather leave a situation than deal with it", because of a constant underlying affect of rage towards everyone coming into contact with him. Perhaps musical expression would be able to help this in a contained therapeutic setting. Malcolm is a bright-looking young man, usually well dressed, and it was striking that his outward appearance did not always reflect his inner deprivation. I first experienced an overwhelming feeling of warmth towards him, juxtaposed with a sense that he immediately "cut off" if I drew attention to any positive affect he may have expressed. The main facts he told me of his early history were that his father died when he was 5 years old, and that later he was looked after in care. His mother a, schizophrenic, was unable to care for him, and he was fostered at the age of 7. He has two brothers, 5 and 6 years older than he. He has a specific learning disability in terms of reading and writing skills. It is debatable whether this is as a result of his deprivation, because he shows quite marked ability to think and have insight at times. He married when he was 19 years old, following his first hospital admission, where he met his wife. This lasted for thirteen years, during which time they had three children, who were all aged under 5 years at the time of therapy. He was violent towards his wife, but never towards the children. It seems that after the children were born, stress in the marriage built up to an unbearable degree. He

had cut off contact with his children and family, but this was changing towards the end of therapy.

Malcolm was very keen to play music and to engage in the fascinating world of creative music-making. In each session, we moved between improvisation and talking; usually I played the piano and he used the metallophone and drum. It was striking how his music sometimes had a different quality to his other interactions, which are quite stilted. He seemed to "delight" in this music-making, and at first that is how we worked, because he could become very circular and repetitive in discussions, complaining endlessly about his medication, and psychiatric involvement. In later sessions, he began to reveal more and we worked at a more intense level.

In Session 4, Malcolm arrived promptly. He was very pleased to see me after the Christmas break, and I would describe the relationship in terms of him having a positive transference towards me. He talked about Christmas in the hostel, which had been fairly quiet, and he said that he was surprised how much he was looking forward to the session. He was very keen to play music and agreed that this represented an imaginary, creative world that made him feel pleased with himself. I suggested that maybe he felt "looked after" by me (particularly while we played symbiotic music), and he voluntarily added "Yes, like my wife looked after me". He went on to describe feelings of abandonment as a child. At this stage in the therapy, he seemed to have little outward remorse about cutting himself off from his children, although he said with a slight smile that as he was not looked after as a child properly by his parents, therefore he couldn't do it now for his children, and "probably they will turn out like me". He was most serious when playing music—lost in his world, it seemed. In the early sessions, he was reluctant to "let go" on instruments but was encouraged by my playing.

In Session 6, Malcolm first seemed to bring some negative feelings into the sessions, and I became aware of the possible dangers of becoming symbolic of an over-idealized mother or wife, as with those outside the therapy (mainly doctors and key workers) who had become the symbolic objects for his rage. It was clear that he needed this safe place, and that it would not be right to force him to reveal other parts of himself. I thought that in order for us to go forward, he may need to understand something of how these feelings could be integrated, and that if he did become angry I would still be there and be able to tolerate it without getting into "a fight".

He arrived promptly, not his usual smiling self, and I had already wondered if this smile masked some real rage and tension. For the whole first 40 minutes, he said that he was not coming any more, that there was no point, that he may as well kill himself, and that he did not trust me. He said that I was bound to be telling doctors bad things about him. He also criticized our music, saying it was "no good" and "rubbish". I said that I recognized he was cross, and that he may want to blame me for helping him get in touch with some difficult feelings. I also suggested that by attacking the music, the therapy session, and me, he seemed to be cutting out the very thing that made him feel good. Also, that he might deny himself this supportive therapeutic situation—a place he finds a pleasurable experience. He seemed to listen when I suggested that he allowed himself to be looked after, but that this was scary, as previously relationships had failed and so maybe it was safer to end this now. He "raged" for a while, as if wanting a fight or for me to reject him by throwing him out. I did neither, and I was about to suggest playing music when he initiated this. He used the cymbal and metallophone very loudly, and I felt that I needed to musically "contain" his playing by playing large chords on the piano, indicating that I was there but listening intently rather than interacting intrusively. In psychoanalytic terms, this could be

explained by me representing a containing holding object (John, 1992). This also illustrates the importance of the equivalent of free association in psychoanalytic terms (free musical improvisation), and an action-orientated experiential approach.

On two occasions I arrived at the clinic and was given information about Malcolm being upset and angry the day before, but on both occasions he never actually told me any facts in the session. However, he was able to express some very strong emotions in music and discuss other aspects of himself in a general way, revealing hurt, frustration, and anger. A particularly important function of music in music therapy is that sometimes it can take the place of verbal expressions of feeling because words are unavailable or may be too specific, or too conscious.

Session 9 represented a significant change in the therapy, and if it were possible to listen to the taped example you would hear an important stage—a departure from the safe, nurturing harmonic "symbiotic" musical space to an independent raging, assertive position. He played the cymbal extremely loudly as if almost out of control, for four minutes. The experience of this was almost overwhelming; however, through understanding my responses in terms of countertransference, I was able to provide musical containment, although at times it was unclear as to whether he could hear my playing. My feelings at first were manifest in not being able to play for a few seconds—I was not necessary, shut out—but I realized that by going along with this I would have been like the rejecting family or absent mother. He needed to play like this *with me*. Also, listening back to the tape, the music sounded as if he was excited in a sexual way. Similarly to the example of Peter given at the beginning of this section, this could be heard in the music by colleagues in a supervision group. I did not reflect this to Malcolm at this stage in the therapy, but it was a useful and relevant theme for much of the rest of the therapy; it had been highlighted by

an exchange that could only have been expressed musically in my opinion, but at the same time it needed to be fully understood and explored in the therapy from that time on, through words and music. In my notes, I had described his playing as a form of "discharge", "he seemed pleased to be with me", and "At the end he almost lost control on the cymbal and he was exhausted". This is an example of how the affect within a person can become activated through clinical musical improvisation.

The following week, he played in a dramatic way and used the cymbal more. I found myself playing passionate-sounding chords, and I thought that it was important that he also played very quietly— listening to me for the first time. It seemed important that I had survived the onslaught from the previous week, and his sadness seemed to be expressed also for the first time, which could be heard in his music.

He said in the discussion afterwards that the improvisation felt like "two people crying over my shoulder with teacups clashing". In subsequent sessions, Malcolm began to reveal more of his "real" self in the sense of acknowledging his sadness, and abandonment during most of his life.

Some considerable change took place during the four and a half years of music therapy. For example, his anger towards others subsided (Odell-Miller, 1999). Other team members noted a direct link between this change and his involvement in music therapy. They reported that Malcolm seemed easier to get on with and less angry. There are other major changes that have taken place over the period of therapy: for example, he has improved his access and relationship to his children. We cannot definitely attribute these changes to music therapy, but as some of the later dialogue shows (Odell-Miller, 1999), the nature of the relationship change, where Malcolm began to interact more

insightfully within sessions, with a new awareness of the relationship. He started to feed back to me things that he had been noticing in terms of my responses to him. Unlike at the beginning of therapy, Malcolm gained insights for himself through the musical relationship, and he seemed to make use of these outside the therapy. He is maintaining his independent lifestyle outside the hospital in-patient setting.

Conclusion

I believe that, within a shared therapeutic space with musical and verbal structures, a patient can discover his or her own needs and desires. I can then concentrate on providing the space and the possibility for change and think about the patient with an open mind, expressing this musically as well as making some verbal interpretations. I consider the function of music in music therapy as sometimes taking the place of verbal expression of feeling because words are unavailable or may be too specific or too conscious, as illustrated in the preceding case example.

By drawing on psychoanalytic concepts to help to understand meaning, this in turn informs and enables the relationship to develop. These concepts are integrally bound up in a method in which music, thinking, and talking are of equal importance and are bound together to produce an emergent music therapy approach in its own right. Music can have a pre-verbal function, a holding function, a supportive function, an "action leading to thought" function, all of which can lead to some change that otherwise may not have occurred without the music.

Music therapy can also be essential for people who do not suffer a verbal impairment or psychiatric illness. I prefer to think of music and words as interconnected. In view of this, I would like to end this chapter with a quotation from a letter sent to me by J. Barrett, a psychotherapist, following a seminar about music therapy given at a meeting of psychotherapists in a training organization for psychotherapy in 1998:

> It tuned me into another way of thinking about what goes on at a less
> conscious level between the two people in a psychotherapy session, in terms

of the music they are making. It made me think again about the way I am different with different people in terms of my tempo, adjusting it to get in tune with the other. The musical metaphor and language of harmony, discord, resonance following and echoing shifts, introducing new themes etc. all seem very helpful and get away from a tendency to be over-focussed on the content of what is said rather than the manner of its saying.

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2.3 Discussion of Chapter 2

At the time of writing the publication included in this chapter, many of the ideas raised involved new thinking on previous theoretical concepts. For example Odell-Miller's definition of musical counter-transference demonstrates her ideas about integrating and re-working some of Freud's (1910) original concepts, such as free association, into a central idea within psychoanalytically informed music therapy. The musical improvisations are described as equivalent to free association in psychoanalysis and this at the time had not been previously discussed in the literature in such detail. The work of Priestley is discussed as a historical precursor to Odell-Miller's work and that of her contemporaries Hughes (1995), Streeter (1995) for example. The case -work describes clinical processes in detail, and illustrates the concepts from a theoretical and practical point of view. This way of working, of understanding more about the patient's unconscious, and about transference and counter-transference, through the way people with adult metal health problems improvise with the therapist, has become common place in the field of music therapy, but was more radical at the time of writing. The debate about how closely music drives the thinking or the thinking drives the music, or indeed whether there is room for non-musical thinking at all, is followed through, culminating in the author's conclusion that

> "By drawing on psychoanalytic concepts to help to understand meaning, this in turn informs and enables the relationship to develop. These concepts are integrally bound up in a method in which music, thinking, and talking are of equal importance and are bound together to produce an emergent music therapy approach in its own right. Music can have a pre-verbal function, a holding function, a supportive function, an 'action leading to thought' function, all of which can lead to some change that otherwise may not have occurred without the music.
>
> Music therapy can also be essential for people who do not suffer a verbal impairment or psychiatric illness. I prefer to think of music and words as interconnected." (Odell-Miller 2001 p. 152)

In considering how this chapter relates to some of the issues which provided a basis for the design of the questionnaire for the new study in this thesis, it is important to refer to the main question, which asks how music therapists define what they do and what methods they use. Whilst the above publication does not address the diagnostic part of the question, it does discuss differences in approaches and the appropriate use of music and words in the treatment of adults. It is critical of approaches where relating through music seems to be dominated by psychoanalytic theory and music becomes less central in the room with the patient (Lecourt (1992). The chapter argues that the clinical rigor of psychoanalysis is helpful to music therapists, and develops an approach where this informs the music therapist at the same time preserving the particular non-verbal tools of the music therapist. These tools are argued to be the essential for people with bi-polar disorder and dementia, and the fact that diagnosis is not specifically focussed upon points to the need for the clarity attempted by the main research question in the thesis.

The link between this and the next published chapter is that the following chapter continues to use case material to illustrate this psychoanalytically informed approach. Furthermore is also goes into specific detail about how such an understanding can be used to inform the progress in therapy of one man over a long period of time in a music therapy group setting.

CHAPTER 3
ONE MAN′S JOURNEY AND THE IMPORTANCE OF TIME

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Editors: Davies, A & Richards, E. Publishers: Jessica Kingsley (2002)

3.1 Introduction to Chapter 3

The research approach for the publication included in this chapter was based on a single case study design that described a long term model of group music therapy treatment with a man with depression. The analysis of case material was undertaken by Odell-Miller, who was also the music therapist. The final material for the chapter was also discussed with the patient who worked in collaboration with the therapist in the final stages of preparation for publication. This form of verification acted as a reliability check and also provided an important participation focus to the case study. The chapter describes long term music therapy over six years with a man with long term problems of depression, psychosomatic problems and anxiety. The research focus was to articulate a detailed example of the approach described in the first chapter above (Odell-Miller 2001), termed then as psychoanalytically informed music therapy, and to identify the relevance of long term work with such patients, who are often offered very short term treatments. It puts forward the argument that the context and long term nature of therapy for people with long term chronic conditions are vitally important to the successful outcome of treatment. The analysis of long-term therapy work was particularly relevant to articulating appropriate approaches to clinical practice, in particular (in this case) the patient showed that he needed time to work through and act out literally some of his difficulties connected with attachment, intimacy in his personal and work relationships, trust, and in dealing with his often overwhelming emotions. Specifically the single case descriptive approach illustrates the musical group processes and interpretations arising from this, together with the real life relevance of the group in the patient's process of rehabilitation and recovery.

3.2 One Man's Journey and the Importance of Time

Music Therapy in an NHS Mental Health Day Centre

Helen Odell-Miller

> The business of the therapist is to hold the meeting at a specific time and place. Within this defined context the patient may explore the space and the limits of its boundaries. (Walshe 1995, p.415)

Introduction

This chapter will explore the music therapy group process for Steve, a man diagnosed with severe depression and anxiety. He attended a music therapy group for people with long-term mental health problems in an NHS mental health day centre. I work within a psychoanalytically informed framework, emphasizing rehabilitation. The long-term nature of the group has led me to consider the significance of time, both during musical improvisations in sessions, and within the lives of the people concerned. Steve attended the group for six years. Consideration of the ending over at least a year was important, owing to his history of difficulty with endings in other relationships in his life. However, I am aware that within the current climate of short-term therapy models such as cognitive analytic therapy (CAT) and cognitive behaviour therapy (CBT) this period seems long. I will describe the therapeutic process for Steve, focusing on issues of time, boundaries and the meaning and benefits of thinking about internal and external space in relation to the group.

What are the apparently simple boundaries needed to enable the 'business' of the group to take place? This is a question for most psychotherapists, but in my view the 'business' is even more complex for music therapists. In addition to the outer boundaries of the group, there is another internal set of boundaries: the movement in time between words, thinking and music.

An important element that I have developed is the use of time frames for improvisations in the group. Winnicott (1971) discusses the 'transitional space' where internal and external reality meet; we could think about musical sounds and silences as symbolic of the wider picture. In this group, starting an improvisation usually involves a crucial negotiation of boundaries. Members decide when and if they are going to play music during the group. My task is to enable meaning to develop through this process, and to think constantly about what might be happening in the playing, as well as when there is no music. I have found that a time boundary is helpful at the outset of some improvisations. A suggestion near the end of a group,

reminding members of the relationship between the internal and external world, can be made in the form of: 'This piece should end by 3.20.' This leaves the group free to end the music any time before this, yet maintains a helpful boundary. At some stages, particularly in the latter stages of the process described here, this might not be so necessary. The general element of timing, however, is central to the work For those with long-term mental health problems, a long period in a group may be significant in reducing, rather than increasing, dependency.

Steve's journey through the group will form the narrative of this chapter and will illustrate these and other considerations, such as the importance of setting and the interface between the therapist, the patient and the multidisciplinary team as discussed elsewhere (Odell-Miller 1991, 1995).

The music therapy group

My approach is not based on one theoretical framework, but has grown from years of clinical practice and supervision. It involves practical music making, using improvisation as the focus. The way clients improvise may reflect their current states and can lead to an understanding of internal and external, intrapersonal and interpersonal changes which may be desirable. A variety of instruments is used, including percussion, violin and piano.

Music therapy provides an experience of the here and now. Interactions are played out within improvisations; the therapist must recognize this and not avoid issues she perceives or hears. The therapist is a musician trained in this way of working, but clients need not have any previous musical skills.

Time boundaries and their meaning

This was a long-term, semi-closed group run weekly at a psychiatric day clinic for 55 minutes. It was important at the outset to set a time scale that was realistic and that would not change . The group was encouraged to explore the use of the time in terms of managing the time boundaries. Talk or improvisations sometimes began almost before the official starting time of the group, and at others continued while the group was officially ending. Musical structures offered a means for these dynamics to be heard musically, rather than through conversation. I listened to rhythmic and harmonic nuance: tempos slowing down, or cadences building up towards a climax. Sometimes the group would discuss these things. In music therapy, some group dynamics, for example, the general mood of the group, who is leading, who supporting and so on, can be heard musically by the therapist and other members.

Summary of the approach

In addition to improvisation, talking, thinking and reflection were also important parts of the process. Members would comment that they heard the music of other group members, or experienced the group's 'piece', in ways that related to a significant aspect of the group or of a particular member. For example, the group explored whether their music was 'together' or not. Sometimes the group could experience a feeling of 'togetherness' more easily through musical expression; at other times feelings of difference and conflict emerged. In general the group might explore the meaning of how these experiences were related to life outside. The group became at

various times symbolic of family, friends, home, community, relationships, work and psychiatric services.

Trust, transition and endings were significant issues for the group. Members thought about what an ending might be like and what might be the 'right' time for it; the manner in which improvisations ended was a recurring theme. Both sudden and prepared endings were usually significant for members and acted as a reflection of internal issues which were not always articulated in words. Musically, the group worked at an intense level where insights were opened up as a result of improvising together. Changes were often made or negotiated in terms of the way members related to each other and the musical interactions seemed particularly to help members to consider one another's positions within the group.

Steve

Steve was referred in April 1994. He was 45 years old and suffered from depression and anxiety. The reasons for referral were to build confidence, to contain anxiety and to enable him to express some of his more inaccessible emotions such as anger. He attended the group until April 2000.

Referral and assessment

In his assessment Steve appeared as a quiet, intelligent, careful person who was interested in thinking in depth about his problems. He seemed lost and to be looking for a safe place to be looked after. There were issues of aggression and somatization manifest in acute anxiety and symptoms of colitis and skin problems. He described childhood emotional deprivation, particularly from his mother, whom he experienced as disapproving, and the subsequent severing of relations with family members. He discussed how he would like to get back to his work in the field of art at some point in the future.

Steve had attended a music therapy group on an acute admission ward and found it beneficial. The referral came from the staff nurse, who had been the co-therapist in that group, with the support of the community occupational therapist (OT) and the consultant psychiatrist. Steve had been admitted following an overdose after moving from the north of England to be near friends. This had followed what he felt was an abrupt end to 13 years of individual work with a female psychotherapist, after which he described himself as feeling angry and 'dismayed'. He had trained as a graphic designer and found his work stressful; he had high expectations of himself. He felt isolated and had few friends. In the group on the ward he had used music expressively, at times seeming dominant or controlling. He had some insight into the effect of this on others, however.

Steve mentioned that he had felt symptoms of nausea and anxiety during the group on the ward, but that often these had subsided in the course of a session. He felt this implied that something important was happening: he would be able to work in music therapy. From this and other aspects of the discussion I felt that Steve had some destructive parts of his personality which he was trying to understand, and that he pushed himself hard. He seemed to have a notion that he must experience pain before getting better. He was keen to talk, yet I felt that he was holding back from speaking about himself, and in particular about the childhood emotional deprivation he had alluded to. It was as if he could not easily function as an integrated person relating to

the world, but instead had to be totally absorbed or else 'cut off.' I also had a sense that he was frightened of something. After the traumatic ending of his psychotherapy it was important not to encourage a repeat of this pattern, so individual therapy was not offered. Steve was offered a place in the music therapy group:

- to provide a place for him to express himself where words were not the major vehicle, offering the possibility for him to find another way of addressing his underlying destructive and aggressive tendencies
- to provide an opportunity for building relationships in a regular contained setting
- to help him work through some of his traumatic experiences and return to a more healthy lifestyle, psychologically and physically.

The first year

This was a settling in period. Steve became engaged in improvisations, but hardly talked. Through comments and interpretations from me and from group members he gradually developed an insightful awareness of the whole group, which led to him starting to trust the situation more and so to discuss issues more openly. After about three months he started to express, mainly through music, some of his inner chaos and disintegration. He had by this time made an identification with the gato drum. He played in repetitive rhythms, sometimes sounding almost perseverative, reflecting the more obsessive aspects of his personality. At other times he played drums and cymbal loudly and a-rhythmically without apparently listening to other people's music. He played for long periods on the gato drum but in short bursts of more chaotic music, as if he was not at ease with his more negative feelings. If attention was drawn to this he seemed inhibited, and appeared quietly regressed in the group at times. As a result of recognizing this and the effect it had upon the group, he gradually began discussing his fear of attachments. He said he was afraid to start to attach himself in the group. Improvisation seemed to help, because when improvising he was often closely interacting with others. Eventually he was able to acknowledge his fears of death and abandonment. A particularly significant moment in this first year was when during the last minute of a session he banged the drum in front of me so loudly that it made me jump. His fears were discussed in the group at the beginning of the following session. This seemed an important symbol of what he was trying to contain; the long time scale of the group allowed the time and space to build up relationships of a kind which elsewhere he had not been able to sustain. The musical process enabled this rage to be expressed as if in essence, allowing everyone to hear, but without having to explain the detail. The time boundary was particularly significant on this occasion as his playing took place in the last moments of the group, allowing no space for discussion or musical response. His music was heard and accepted. It is difficult to see how he could have such feelings accepted and understood through words alone; at this stage nearly all his expressions were through music.

Reflections on duration

There are important questions about length of treatment. Steve's previous individual treatment had been very long term, but one might question how effective it had been, particularly in view of his history of maternal deprivation. Could he have developed an addiction to therapy? Whilst I am sure that the length of time in the group was

right for Steve, I had to consider these issues. Although he never revealed all the details of his relationship with his family, and with his mother in particular, it appeared that some of his difficulties with attachment arose from these experiences. He described his mother as over-critical and disapproving. He was deeply entrenched in some of these ideas, and so I thought it necessary for him to take his time in the group, whilst recognizing the possible difficulties of over-dependency. The group was taking place within a well-established culture of long-term therapy.

The second year

At this point Steve revealed that he had often 'dreaded' the group because it raised painful feelings, physical and emotional, not only when improvising, but also just before starting to play music. He said he now felt more excited about the group and looked forward to it, which surprised him. I noticed that he started to relate more directly to others in the group and to express thoughts and feelings to them about himself, and about what they were experiencing. He said that this group was the only place where he could feel accepted and close to others, and that he felt this particularly in the music. He thought this was partly due to a release of tension followed by exhilaration. I made several comments about this over the weeks in terms of what he seemed to be voicing for the group. In summary, the destructive, painful, 'real' feeling world that the group found hard to address seemed to be the central issue here, represented musically by loud cacophonous playing. Steve also seemed to be voicing the ambivalence in the group about making close relationships, and to be actually trusting that the group might be a safe place for all kinds of issues to be expressed and explored. In the middle of this stage Steve went through a period of feeling 'unwell'. He started to miss sessions and we looked at what he might be avoiding in terms of the pain and fear of possible rejection or abandonment. Here the internal and external representations of the group, both musically and otherwise, were important and it was essential to draw him into the process. The fact that the group functioned when he was absent and, indeed, that others thought about him and played music for him in his absence, was significant throughout the long period of time.

Towards the end of this year he became more vociferous and was really beginning to work in the group. He worried about how he could integrate his emotions, often saying that he could be at one extreme or another – placid or angry – but never integrated. I shared with the group my sense that he represented to and for the group the split off, emotional world that perhaps had never been fully nurtured earlier on for him and others. Could the group repair any of this? Allowing that would mean coming to terms with conflicts in the group and differences between members. At this stage Steve often acted as a catalyst for acknowledging conflict, but the group was perhaps not ready to be able to work at this level. The group acknowledged that expressing feelings through music might be safer than articulating them verbally. Steve was able to discuss his fear of affection, and behind this his fear of his own destructiveness. At this point perhaps some of the work Steve might have done in the group was curtailed by people joining or leaving (which we were able to look at later as connected with the group itself, rather than just as 'accidental'). Steve often became paired with a new young female member of the group with whom he made endless very tribal sounding music, but with whom he was never able to speak other than in polite pleasantries. Membership changes in the group raised his anxieties and he retreated into himself. He was able to express his sadness after the female member left the group, but not in the period up to her departure. In terms of the internal and

external use of space, this was markedly different to the final year in which at last he became able to address issues musically and verbally with members of the group in their presence.

The third year

Steve seemed to go through a period of 'resistance', and acknowledgement of this led to a powerful working through of some of his destructive tendencies in relationships. He played these out in the group by improvising extremely loud music, particularly on the piano, often drowning out others' music and sounding omnipotent and angry. He would later feel ambivalent about this and was able, with help from the group, to look at what it represented for him in relation to his life both in the group and outside it. He wanted to have the final say and often seemed unable to take others into account, whereas previously he had been prepared to help others at the expense of mentioning his own needs. This is where the time elements of the musical improvisations were most crucial. There were musical 'battles' between group members over how to end the pieces and over who was leading or setting the pace for the cadence points. Steve needed to know that the group could survive his destructive loud piano playing, and eventually others were able to risk sharing this role at a point when the group reached its most potent level of tolerating open conflict rather than hiding from it. Particularly important in this were exchanges between Steve and another male member who was sharing his childhood memories of abuse, and close interactions with an older long-standing female member of the group, which at times felt like an established 'marriage'. Steve seemed to move forward both inside and outside the group. He began to work again in his field and joined a specialist Eastern music group. He felt sustained and encouraged by knowing the therapy group was there as his support.

The fourth year

Starting work raised enormous anxieties for Steve. He worked full time for a few months, building attendance at the group into his timetable. Precipitated by difficulties with work colleagues, Steve explored openly and in depth his real difficulties with trusting in relationships. Later, prompted by the powerfully annihilating music, I suggested he was also afraid of the 'murderous' things he might want to do to people who might hurt or abandon him, an indication of the enormously painful anger which he felt towards his parents. These feelings were towards his mother in particular, whom he felt had abandoned and rejected him and for whom he was never 'good enough'. Musically he started to take risks and to explore chordal progressions on the piano. He said he felt it was a relief to have some of these things understood and admitted that he usually compromised himself in relationships to avoid confrontation and then ended up feeling resentful. He related his dominant music to allowing himself to 'misbehave'; not playing nicely and supportively in the group allowed him to be anarchic whilst still maintaining some social responsibility as he became able to start to think about the effect of this on others. So at this point he allowed himself to be in touch with his most primitive destructive feelings, which was frightening, yet brought him some relief. This was a turning point: disagreement and conflict, as well as challenge to the therapist and her role, became possible.

This exploration brought some very difficult periods for Steve which later led to him moving on and coming to terms with his difficulties. At the time, however, it

was a painful process. He developed colitis and was unable to go to work. He managed to attend the group regularly, nonetheless, and brought with him an 'oppressive' presence. He acknowledged that the child part of him always wanted desperately to be helped, but owing to his abusive earlier experiences, he often felt in the role of victim and could not believe help would be forthcoming. He was striving to be an adult, which he understood as being able to recognize others on an equal footing. He was very reflective at this stage and at the end of the period he also started to address the issue of leaving the group. He was terrified at the thought, but knew he would have to face it at some point. He was silent throughout the whole of one session at this time and needed the group to accept him as he was, even when he felt at his most vulnerable. Here the boundaries between the internal and external space of the group were particularly important because Steve was allowing different aspects of himself to emerge within the safety of the group. This enabled him to feel held outside the group and to accept aspects of himself even if his work environment, for example, was difficult.

The fifth year

During this period Steve really began to work on his painful difficulties. He showed musically how he 'cut off' from people if they came too close; after improvisations he spoke of the fears underlying this. I felt most of all that the group offered the safe, containing, nurturing space that he desperately needed. He spoke of the conflicts he felt within relationships because of his destructive feelings, manifested sometimes in stabbing, discordant music. There was a sense that his music was 'breaking down' and that he was afraid of 'breaking down' himself.

In one sense he did 'break down', but owing to the support of his care co-ordinator, the music therapy group, his GP and one particular set of friends, he managed not to be hospitalized, although he was extremely depressed. He felt a failure owing to losing his job (which he eventually managed to go back to the following year). Dependency and trust became big topics for Steve and the group, together with the establishment of the group as a caring family rather than the frightening one which it had represented during the previous year. Gradually he returned to work.

Steve discussed how he could hide behind his music and how at the same time it had been the very vehicle that allowed him to come to terms with his destructiveness. He worried about whether he was too dependent on the group and so started to think once more about the prospect of leaving, this time working on it more and feeling more ready. He showed his ambivalence about being assertive in relationships and taking risks, but admitted that he had never thought he would have to make an ending. He thought that one day I (the therapist) would leave and that would be the end. He would not have to face up to doing the leaving. We acknowledged that leaving was going to be one of the most significant times in the therapy for him and the group as a whole. He gradually became more able to integrate his good and bad feelings.

The sixth year

Steve spent much of the final weeks exploring his relationship with the group, and in particular exploring his feelings about me. Had he become too dependent? What were

the group and I feeling about him in terms of approval or disapproval? He now felt he wanted to go off and 'be an adult'. He discussed how affected he was by different people in the group and how he had taken risks in expressing competitive feelings towards some members, caring ones to others and confrontational ones at other times. He had survived all this, which seemed both a relief and a surprise to him. He had resumed his job and began to speak of starting to live his life. I reflected to him that following such a long therapy this was now going to be the best outcome: to live his life without therapy. He grappled with how he had always avoided endings or had them 'done to him' and wondered whether he had continued so long in the group owing to habit, fear of change, or fear of making an ending. In the past he had felt that in making an ending destructive parts of his personality had always taken over his whole life and not just the part of his life he was leaving (he feared 'breaking down' during this leaving process). He was extremely insightful at the very end of the group and the last few weeks were very poignant. He said he had bought a self-help CBT book. We discussed how this could be a way of helping to manage the ending and to give him a sense of a continuity. Perhaps he was now 'becoming his own therapist'; on the other hand, perhaps in order to end properly he had to undermine (or destroy) this form of music therapy by suggesting another, as an aspect of his destructive tendency. As a result he was able to voice some extremely sad emotions surrounding the ending and expressed these musically and verbally.

In the penultimate group there was a very intense atmosphere and he was healthily grappling with some angry feelings and struggling to keep the balance between his capacity for integration and his tendency to split off parts of himself. He discussed his contempt for some members and his feelings of envy and omnipotence. A very important earlier stage had been concerned with helping him recognize that the group would go on and survive without him. He admitted that leaving was like leaving a family. After so much work and preparation, in the final group he managed the whole session and made an appropriate, almost celebratory ending with all the members. He later followed this up with a letter indicating how important the group had been, although very hard work, and that after one week 'so far so good'. He was given the chance for a six-month, follow-up appointment which in fact took place after a year (at the time of preparing to write this chapter), as he had not initiated it previously.

Conclusion: the significance of time

Ending in this music therapy group came at the right time for Steve. As his time to leave approached I took a more proactive role. At the beginning he had seemed isolated, disabled and unable to make relationships. By the end he had a network of friends, work and other activities outside the group (including musically related ones, the latter being an important 'by-product' of the group). At the beginning he had suffered acute anxiety about going out and putting himself in the external arena. Physical difficulties had also seemed very disabling; by the end these were no longer significant 'symptoms'.

Another way of looking at the length of treatment involves taking account of the fact that a music therapy group necessarily involves the act of making music and that this way of relating through improvisation is unique to each patient's life. It is not the usual way of conversing or relating to others, but in this group it was a means that Steve found beneficial.

Thinking about discharge from the group involved stopping the action and the idea of relating through music in a way which was understood and accepted, whatever the external sounds produced. This unconditional aspect of the relationship sometimes accounts for the length of treatment. Attachment theory is central to an understanding of this process. Major aspects of the group, such as the consistency of membership and reliability of the therapist, needed time to reveal themselves, especially as Steve's experience of relationships had been that they were not consistent enough and that his family did not have his best interests at heart. The fact that he needed this long time to be convinced of this and for it to become a reality might call into question the benefits of his years of individual therapy. Perhaps something very different was happening in this group for him to allow himself to become involved in another long attachment and the risk of eventual separation that it involved. Other people were present who represented different elements for him in his life, to whom he became very committed and with whom he could relate on a musical, non-verbal and verbal level. This in turn enabled him to express strong emotions in a way that was not acceptable or possible in the external world. This process needed time to unfold and develop meaning.

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3.3 Discussion of Chapter 3

The publication included in this chapter is relevant to the main research question of the thesis because it is puts forward a particular long term model for patients with diagnoses that are perceived to be chronic and inhibiting to everyday life. For example the patient needs rehabilitation and recovery which includes symptom control. In treatment these needs are addressed through focussing upon using the music therapy group, and literally the music itself, as a microcosm of the external world that the patient lives in. Concepts of internal and external space are explored using musical improvisation as a container, and acting as a boundary and a vehicle through which important clinical aims can be explored, such as holding down a job, forming and maintaining relationships.

As the main research question is asking how music therapists describe their work in relationship to diagnosis, this chapter acts as a case study demonstrating one model of long term work where music therapy is specifically indicated for a person with depression, and who is verbally articulate. This is important because this patient group are not always seen as a priority for music therapy.

Musical improvisations as a metaphor of what is happening in the dynamics of the group are central to the description of improvisational music therapy. Also the importance of using music as a vehicle for the expression of anger (which is often repressed in stages of depression) is demonstrated. Techniques of endings, both musical and non-musical are discussed, and detailed descriptions of the assessment and referral process.

Attachment and the issues surrounding difficulties with this are addressed, stressing the long term nature of treatment necessary to work through some of these issues. Less focus on theory is intentional in this chapter which primarily attempts to describe in detail musical processes using words, showing how verbal interpretations about the music can relate to the members lives and help gain new insights. The particular benefits of allowing music to express repressed emotion such as anger and rage, is discussed in detail. When the patient is depressed, improvisation can reveal ways of communicating that are unavailable to the patient through words.

This is particularly pertinent in leading up to the next published work by Odell-Miller (2003). Whilst the first two publications put forward points of view that show how psychoanalytic technique and theory support and influence the music therapist's work and aided the development of a new approach, defined as 'psychoanalytically informed', the next publication offers arguments from the converse perspective that music therapy can and does influence psychoanalysis.

It does this by using examples from the first two publications and shows how musical processes as described in these chapters above, can influence psychoanalytic thinking and technique by adding to the knowledge and experience of the non-verbal and pre-verbal alliance.

CHAPTER 4

ARE WORDS ENOUGH? MUSIC THERAPY AS AN INFLUENCE IN PSYCHOANALYTIC PSYCHOTHERAPY

4.1 Introduction to Chapter 4

The question of the relationship between psychoanalysis and music therapy is the primary focus in this chapter. Music therapists in recent years have drawn extensively upon psychoanalytic theory, particularly concepts of transference, counter-transference, object relations and attachment theory in order to inform their work. In doing this music therapists have used these theories and linked them to music therapy in a detailed way. The theories have particularly helped understand much of the non-musical phenomena, such as the relationship between patient and therapist, together with an understanding how early deprivation can effect relationships in late life through attachment theory. Examples of music therapy authors who have discussed this are given in the text.

The new thinking in this chapter addresses the fact that it is now time to redress the balance. An argument is put forward that there are numerous insights and practices from music therapy that can influence and enrich psychoanalytic practice, particularly in the areas of spontaneity, the non-verbal relationship and work with regressed states. The concepts developed here form part of current theory building research that not only defines specific theory within music therapy, but also explains where that theory and its application in clinical practice impact on pre-existing theoretical paradigms and clinical practice. As such it again relates to the main research question in the thesis whilst not necessarily providing definitive answers. For example similar case material from Chapters 2 & 3 is discussed but focus upon the musical processes and how these are unique and how in general they might be useful to verbal psychotherapists.

4.2 Are Words Enough? –Music Therapy as an Influence in Psychoanalytic Psychotherapy

Helen Odell-Miller

Introduction

Music therapy is marked by its unique emphasis on live improvised music and by a level of activity that contrasts markedly with that of the psychoanalytic psychotherapist. In the past twenty years music therapists have drawn on psychoanalytic theory, particularly on concepts of transference, counter-transference, object relations and attachment theory to help understand the relationship between patient and music therapist. There are however numerous insights and practices from music therapy[3] that might in turn enrich psychoanalytic psychotherapy, particularly in the areas of spontaneity, the non-verbal relationship and work with regressed states.

Music therapy and psychoanalytic thinking

Arts therapies owe much to psychoanalysis, but I am conscious that over the last two decades, the art forms within the arts therapies have sometimes been in danger of disappearing under a sea of theoretical knowledge. This knowledge enabled the disciplines to grow[4], (for example by enhancing the understanding of transference and counter-transference), but the unique possibilities of the art forms have sometimes been overlooked.

It is essential to remember that music therapy is derived from music itself. Music provides a structure within which the therapist and patient can literally play

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[3] As a music therapist I discuss this question in the light of music therapy, but the arguments might well apply to other arts therapies, which also focus on Jungian Psychology, for example.   See 'Where Analysis Meets the Arts (Searle & Streng 2001, Schaverien 2001).

[4] This growth is reflected practically in the development of training courses and international organisations, intellectually in the establishment of specialist journals and a wide literature, and politically in the State Registration of Art, Music and Dramatherapists.'

improvisations or pieces of music which represent a particular feeling in the room, or an aspect of the relationship that might be difficult to express in words. It also presents an aesthetic, creative possibility for form and structure at a particular moment in time:

'*Music uses a mode of symbolism which is adapted to the presentation of 'unspeakable' things*. (Hobson p.91 1985).

Looking at the history of the discipline it is clear that music therapy owes everything to the particular art form at its heart. In the early music therapy approaches (Nordoff & Robbins 1977; Alvin 1975), the musical impact upon the patients was considered of prime importance, rather than concern for understanding the relationship between therapist, patient and music. Alvin, a cellist who studied with Cassals, and Paul Nordoff and Clive Robbins (the latter a composer), both held the music as central. Alvin's approach was more focussed around free improvisation, and Nordoff and Robbin's around a more structured composition-based improvisation model. During the last twenty years the actual function of music therapy has developed in two separate directions. The first has gradually incorporated the psychoanalytic concepts of transference, counter-transference and projective identification into the music therapist's therapeutic vocabulary as a means of elucidating the musical relationship between patient and therapist. The second has tried to maintain an entirely musical understanding of the relationship. (Ansdell 1995). It might be suggested that in the first approach music therapy could be in danger of becoming a mere adjunct to psychoanalysis, whilst in the second the therapy might be too dependent on musical analysis and ignore the wider clinical picture.

Music therapy and psychoanalytic psychotherapy are both concerned with encouraging the spontaneous expression of the person. In music therapy this is rooted in musical improvisation whilst in psychoanalytic psychotherapy this may be seen in free association or in a more general encouragement towards expressiveness in the relationship with the therapist. Within psychoanalysis there has been long-running debate about whether interpretation and analytic technique

are the key to healing, or whether they might be stifling and prevent a real aspect of the therapeutic relationship developing. As Peter Lomas describes elsewhere in this volume, the fact that Freud was frequently active, spontaneous and emotional in his relationships with patients, has been obscured by Freud's own emphasis on technique and interpretation in his theoretical writings. In contrast writers from Ferenczi onwards have emphasised empathy, interaction, responsiveness and an authentic and emotionally transformative relationship as essential to good therapy.[5] Music and other arts therapies capture this essence through their activity in the consulting room. Musical form and structure offer access to things which are difficult for the patient to articulate verbally, without descending into 'acting out' and without transgressing the boundaries of the therapeutic relationship.

In exploring how music therapy might influence psychoanalytic psychotherapy it is important to consider musical improvisation in its own right, succumbing neither to a purely musicological view nor to the hegemony of psychoanalysis. It is essential to understand the strengths of musical improvisation in active participation, finely attuned listening and responding and the development of an attitude which enables patients to explore their emotions within a real musical relationship. Psychoanalytic and other theoretical knowledge has to inform rather than drive the work.

Hobson (1985) captures the importance of this non-verbal interaction in the following comment about a clinical session:

'But perhaps it was the fine details that mattered most, how I grunted, when I spoke and when I kept my mouth shut------' p220.

This suggests that the musical training and skills that music therapists have in a non-verbal medium might be essential in enhancing the understanding of these moments, especially in being able to tap into affect and mood. This can acknowledge or show to a patient that the essence of their particular state has been understood and heard. In music therapy there are often moments where patients ask to play, and the result of

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[5] This strand in psychotherapeutic thinking is discussed and developed in Lomas (1987) and Hobson (1985).

this is a revelation of something hidden or repressed. It can also be a way of expressing an un-named emotion where the patient allows herself to experience that emotion within a relationship possibly akin at that moment to an early interaction with a mother or significant care-giver.

A central problem for psychoanalysis may be that its conceptual structure has overwhelmed the simplicity of its origins in unstructured free association leading to losses and lack of development in precisely those areas where music therapy is strong. Music therapy could help restore this balance but it too can become overburdened by explanation (whether in terms of psychoanalysis, neuro-psychology or musicology). In my view therefore the question music therapists have to consider is how to keep improvised music-making central, whilst at the same time maintaining clinical rigour.

The following brief example from a teaching situation illustrates both the difference between talking and improvisation and the capacity of musical improvisation to offer something unique to a group relationship. The group were psychotherapists and doctors working in the NHS who had come together for a music therapy experiential group. The consensus amongst them was that if members had to talk to each other 'it would be so much more difficult'. Their musical interactions involved singing, chanting and instrumental improvisation. In learning from the experience, members discussed the power of the interaction in terms of accessing a part of themselves that was 'beyond words'. The agreement was that the access to the group affect, and a physiological sense of almost being transported to 'another place' allowed relaxation and interaction at a deeper level than if the members had been struggling with words. This experience is not an isolated incident, but one encountered time and time again when music therapists and other arts therapists explore non-verbal communication. Later we will look at a clinical example to support the claim that music can get at a pre-conscious or unconscious level within the therapeutic relationship, but for now it is interesting to look at music therapists attempts to explain this phenomenon by using psychoanalytic theory.

Priestley (1994), a British music therapist, was the first to articulate some of the connections between psychoanalysis and music therapy in the early 1970s, and interestingly at that time her ideas were taken up in Germany rather in Britain. I suggest that this is because music therapy in Britain was founded by musicians, and upon musical and developmental theories and that therapists were not ready for this viewpoint. One example of Priestley's use of music as an extension to psychoanalytic theory is found in her ideas about musical structure and its ability to take the place of a superego function when working with repressed emotion. This has been taken up by others such as Nygaard-Pederson (in Eschen 2002); and Eschen himself who trained with Priestley:

'Priestley has been using what she calls the structure of thought (a given scale, a given rhythmical pattern, and so on), only for the purpose of a superego function, and thus letting the scale or mode almost take the place of a repression of the emotions not approved by the superego. It is as if the superego approves of a set task, such as playing in a certain scale of mode, and when this is done a repression is slightly lifted in the patient's mind during the improvisation, with or without it being expressed in the music (when working with repressed emotions).' (Eschen 2002 P.76)

This points to the fact that involvement in music could articulate and move the process on for the patient who might not be able to reach this state of understanding through words. However it is an extremely literal example which is difficult to describe without hearing the musical example, pointing to another difficulty of the relationship between words and music, and how words can describe music. Musicologists have been grappling with this for some time, and the modern philosopher Scruton (1997) succinctly puts a view of music which supports music therapists' claims that music is more than an aesthetic experience, and one which is fundamental to life itself.

'---the experience of rhythm is something more than an experience of metrical structure. -------Beats do not follow one another; they bring each other into being, respond to one another, and breathe with a common life.---------------But they become rhythm and stress when our own life speaks to us through sound. What we hear then becomes something more than sound for us, something more urgent, something more

immediate, and more intimately connected to processes that we know in ourselves. It is then that beat accent and grouping emerge. This is particularly obvious when we consider silent rhythm: rhythm that is not heard but sensed in some other way, as when we dance without music or when we see another dancing but do not hear the sound. Here we are observing a particular display of life, and the regularity that we see in the movements is minutely qualified by the style and phrasing that lead us to move in sympathy' (Scruton 1997 p.35)

Despite these unique qualities, music therapy has sometimes been thought of as a form of modified psychotherapy which uses a mode of non-verbal communication to facilitate the relationship and rapport between patient and therapist, suggesting that some have missed the very essence of its therapeutic value, as if the music is an adjunct. Existing literature also reflects more of a 'middle ground' in a *psychoanalytically informed* approach where the detail of how music therapists *integrate* psychoanalytic theory into the practice of music therapy in varying ways is explored. (Odell-Miller 2001). Examples are numerous, but there has been debate about the balance of music and psychoanalytic thinking, and the danger of the loss of music if psychoanalytic theory 'takes over'. There is also debate about the richness and clinical rigour that psychoanalytic thinking can bring to the music therapy relationship, and whether it is possible to define musical transference and counter-transference.[6] Clearly in music therapy the musical rapport is central, but a balance must be maintained and I would stress that the relationship with the therapist is of equal value to that of the musical form. In my view, a music therapist will focus on the person as a whole primarily through music, but also paying attention to the aspects of the person shown not just through the art form, but also through talking and thinking. It is about balance. It might follow that talking therapists should consider what the arts therapies might have to offer both in the understanding of non-verbal relationships and in the role of spontaneity and responsiveness.

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[6] Some examples of texts which together summarise the development of how music therapy draws upon psychoanalytic theory are. Priestley 1994, Woodcock 1987, Towse 1991, John 1992, Brown 2000, Streeter, 2000, Odell-Miller 1999, 2001, Davies and Richards 2002.

The music therapy process: improvisation and activity

In order to explore these possibilities it is important to understand how musical improvisation works. During the session, patients are offered the opportunity to improvise on instruments and with voice with the therapist. A variety of instruments is used including tuned and un-tuned percussion, violin and piano. No musical ability is required by the patients: people who benefit range from those who are accomplished musicians to those who have no previous musical skill. The structure of music including rhythm, pitch, duration and timbre, and its emotional and interactive nature provide focus and expression for the patient's current state. This is particularly helpful for people who find words difficult, or who are in an emotional state where words fail them or feel inaccessible. The time element and rhythmic dimensions in particular offer an immediate and intense experience of the 'here-and-now'. Complex interactions can be played out within an improvisation and it is fundamental to this way of working that the therapist responds to this. The patient's expression through music and the therapist's *attunement*, through their training as a musician and therapist, facilitates the development of other therapeutic processes which may be desirable. It is also important to recognise when music-making might be encouraging defences, such as becoming lost in steady repetitive duple time phrases, instead of expressing feelings of distress and chaos in a more irregular rhythmic pattern.

The role of the music therapist is crucial in facilitating the patient's expression, particularly when the latter seems stuck or tentative. This is sometimes understood in symbolic terms as a parental role. For example, in some cases, my harmonic input from the piano can inhibit patients from being able to work through their own problems. In other cases the opposite is true and the basis for someone exploring a problem is that I take a supportive role in the musical dialogue. The music therapist does not pre-plan the path of the musical intervention, even if pre-composed music is introduced. Here a familiar phrase or a tune might be offered as part of a response to the patient. It will then be adapted, changed and extemporised around in order to meet and follow the patients needs. The strengths of improvisation lie in the therapist's

active participation, her finely attuned listening and responding and her capacity to help patients explore their emotions within a real musical relationship.

Therapy is often concerned with trying to re-create a sense of life for those who have lost it. When people are ill, physically or mentally, they often atrophy, feeling unconnected within themselves and with their surroundings. This is supported by research findings, such as Condon & Ogston (1966) who found that people with learning disabilities, schizophrenia, autism and other related disabilities lacked synchronicity within themselves, and in relation to interactions with others, in comparison with the general population. As I will later illustrate, the possibilities for exploring connection are particularly potent within musical improvisation. If this is true, there is also an indication here that music therapy can offer something essential to the relationship between patient and therapist, where there is less radical impairment, but where words and thinking are temporarily unavailable.

Musical improvisation is thus a way of creating a structure which is creative, meaningful for the person concerned, and enables them to connect with others. The musical relationship is highlighted in this approach, where music therapy involves the use of live interactive improvisation, where the therapist finds a way of building a musical relationship with the patient, and a shared musical experience takes place. The emphasis here is that the basis of music therapy is action-orientated, rather than passively orientated. This is particularly significant as the music therapist is commonly involved in the musical improvisation, whereas in some other arts therapies, for example art therapy, the therapist is more likely to observe and interpret rather than participate.

Early relationships and regression

Music Therapists have particularly contributed to an understanding of early interaction, and I will now look at some ideas from music therapy that might be useful to the psychoanalytic psychotherapist working with regressed or less-verbal patients.

The music therapist, similarly to a mother in early mother- baby interactions can respond to the tiniest nuances to show listening, understanding and meaning, without words. As Davies and Richards (2002) write in their book about analytically informed group music therapy:

If that gaze is withheld or unavailable, the infant is at a loss and left with the terrifying sense that there may be no recognition or containment of her intense feelings. The same can be said of sounds. An existence in which a carer relates to her child in silence, or what the child perceives as silence, is equally traumatic. When the carer cannot listen to or be moved by the baby's voice, she and her baby together cannot develop the idiosyncratic shared vocabulary of sounds that needs to be at the heart of their interactions. At the early stage the overwhelming needs is for communication, recognition, response and sharing of feeling, long before there are words available to make statements or explain ideas.

(Davies and Richards 2002 p.17-18).

Stern (1985) uses musical metaphor to describe processes that have always been in the music therapist's vocabulary such as 'affect at*tune*ment' and therefore already we see that much can be gained by paying attention to the forms of interaction music offers. Vitality affects, defined by Stern (ibid) to describe mother infant interactions, relate closely to concepts from musical terminology such as rhythm, pitch and timbre, and Trevarthon's research supports these findings (Trevarthon and Marwick 1986). Music Therapy can address early relationship in particular. Improvisation in music therapy; involving spontaneous almost reflexive communicative interactions; is similar to what Trevarthon calls proto-conversation in his research with young babies. He suggests that the emotions constitute a time-space field of intrinsic brain states of mental and behavioural vitality that are signalled for communication to other people, and that are open to immediate influence from the signal of these others. There are resonances here with the process of free improvisation. Trevarthon, who has carried out research with music therapist Pavlicevic, uses the analogy of a musical duet to describe this mechanism of proto-conversation. (Pavlicevic & Trevarthen 1989). Motives for communication and indeed a principle form of human dyadic communication is shown by a musical duet where two performers seek harmony and

counterpoint which is synchronised (improvised). They create together a piece of music that becomes a coherent and satisfying narrative of feelings in a time structure that they share in a whole piece. Of course, such satisfying narrative and synchronicity is not always the aim of psychoanalytic psychotherapy, where working through conflict or getting hold of the negative transference may be central. However, where there is not enough ego strength present for this complete 'working through' of the process, something else, of a more vital spontaneous nature in the moment, is needed in order to contain the process, and to offer an intuitive sense about the essence of the patient's world. Music therapy has much to offer in this respect.

It is in this spontaneous area of the music therapy relationship that improvisation seems most powerful. It can produce and develop interaction and synchronicity where they may have failed as a result of disability or illness. My own research looking at improvisation in music therapy with those suffering from dementia, led me to become interested in the ways in which developmental systems become reversed, the more advanced the dementia becomes. Emerging clinical evidence and research findings suggest that music therapy might be as effective as other treatments, particularly in some fields such as dementia and autism (Wigram, Bonde, Nygaard-Pederson 2002 p.221-267), so this suggests that there is more to be gained from multi-disciplinary exchange. It may be time to move on and challenge the notion that there is a hierarchy of treatments, with psychoanalysis as the primary influence in psychological treatments.

Davies and Richards (2002) also draw attention to inventiveness, another pre-linguistiuc phenomenon often lost in adulthood, and of the directness that music encompasses along with its capacity for embracing emotional complexity and contrast. They draw attention to a discussion about music by Langer (1942) where she celebrates the ambivalence of music, and as a result, its capacity to be true to life because music cannot be directly translated into words. These, and many writings of music therapists during the last 50 years support the idea that music therapy has always had something fundamental to offer other disciplines; to the field of therapeutic practice generally; and that now it is time to recognise this phenomenon.

Many patients seeking therapy have been deprived of relationship, and musical interaction can often give the direct experience of recognising and showing that this deprivation has been heard, processed and given meaning. This can happen in a way that words might not be able to address owing to their inherent lack of 'affect' in some cases, or total absence, in others. To illustrate this process further I will consider a case vignette of a 35 year old man with manic depression, whom I saw individually for music therapy over a period of 4 years.[7] Early sessions consisted of music which seemed symbiotic in nature, where I seemed drawn into the counter-transference as a nurturing maternal figure. One example of change taking place literally musically; but helped by my understanding of the counter-transference in that I knew a shift would be necessary for him to move on; is from session (9). In this, the patient reveals a very destructive aspect of himself, expressing loud violent-sounding cymbal playing for four minutes. During this, I play the drum, trying to provide some rhythmic structure and stability, whilst at the same time supporting him in his need to express himself and release tension. This was a turning point in the therapy - as the therapist, I provide rhythmic language through improvised drum beats in order to help the client find order within chaos, at the same time as validating his emotional state by showing this in my playing reflecting the powerful 'affect' in the room. If you could hear the taped example you would hear intense cymbal playing, sounding loud and uncontrolled. I use gradually more regular drum beating and also some irregular in order to support the patient in this form of expression. There is also a 'rallentando' at the end, precipitated by a gradual subtle slowing down of my drum beats in order to encourage the music to end, as a boundary was necessary. The qualities of music which enable 'real' time to be experienced through musical interaction are vital here. He had been using the cymbal in this way for 4 minutes. It was important for the destructive side of his life to be expressed with me in the session in, for me to survive this and to return the following week. At this point verbal interpretation was not appropriate, but in following weeks the experience provided the material for the possibility of helpful interpretation as described in the full case discussion. (Odell-Miller 2001). It is difficult to see how this crucial experience of playing the cymbal, or something like it, could have taken place without the musical context, unless some destruction to objects or people had taken place.

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[7] The case is written up in detail in the book 'Where Psychoanalysis Meets the Arts' (Searle & Streng 2001).

The second musical example, of an interaction from the last few months of his therapy, shows a supportive role taken by the therapist from the piano, using predictable harmonic progressions to follow, support and interact with the patient's playing on a metallophone. There is a sense of integration here, and acknowledgement of an interaction - a consideration by the patient of this relationship both musically and socially. At the start of therapy he had no way of showing consideration for others, was suicidal and depressed, had been violent towards his ex-wife, was estranged from his three sons, and he found it difficult to relate to me. In our sessions we moved between music and words, re-creating some patterns of relating (which seemed to represent early relationships), which were very significant owing to the fact that his mother suffered from schizophrenia and had been unable to look after him. He became able to respond to my music and there was a sense of two people able to 'give and take': neither merged nor 'cut off'. This musical experience led to further understanding of his feelings and behaviours, and provided the basis for interpretation and understanding. For example a lullaby quality was prevalent in many early sessions. Whilst the patient's music was often still somewhat rigid, by the end of the therapy, there were points of fluidity. After 4 years of individual weekly music therapy he managed to stop his destructive, violent behaviour in relationships, and said he was helped by the improvisations we had together. We see here the importance of the active relationship with the therapist, whilst maintaining the therapeutic boundaries of the sessions. The understanding of the patient's life events was possible with improvisation being a vehicle for expression and integration of previously un-integrated states

Working with very damaged people places enormous demands on the therapist. In work with disturbed people in a long-term setting change may be little and infrequent. Indeed there may be no motivation for change for people who may have resigned themselves to never again being part of community life. Depression may be enormous, and this coupled with the confused or psychotic expression of some patients requires staying power by the therapist. This can be helped not only by understanding unconscious processes and transference and counter-transference phenomena, but also through understanding the musical processes which often make it possible to access people in a way that traditional psychoanalysis fails to do

Harold Searles (1961) points to something which music therapists recognise, concerning the importance of non-verbal, pre-verbal interactions, when he describes the work of Spitz (1959). In his work on the early development of the ego, Spitz repeatedly emphasises that emotion plays a leading role in the formation of 'organisers of the psyche' during the first 18 months of life. He points out that the pathway to the integration of isolated functions is constructed by the infant's object relations and reminds us that experiences of an affective nature, which he calls affective behaviour, clearly precede development in all other sectors of the personality by several months. This is important because music therapy concentrates on an expressive 'affect' as well as on talking and thinking. If the latter are absent, because the patient is too regressed, not ready, unable to speak or think, then the language of music is important. This can be equally relevant when working with people with dementia, if the client has regressed and reverted to pre-verbal early infant-like speech and behaviour.

In reversing the usual debate about the influence of psychoanalysis upon music therapy, I have suggested that music therapy as a profession has also emerged with its own theoretical discipline. It offers the possibility of literally 'playing', and it offers possibilities to explore social functioning in group-work, whilst at the same time offering interpretation and therefore meaning. Music therapy, and other arts therapies could therefore be seen to challenge psychoanalytic orthodoxy, whilst also developing through its influence. Particularly where there are non-verbal or regressed states encountered, musical or non-verbal relationship might enhance and perhaps challenge some established aspects of psychoanalysis

In her lecture '*Levels of Meaning in Psychoanalytic Work: Areas of Overlap with Music Therapy*' given at the tenth World Congress of Music Therapy, the psychoanalyst Anne Alvarez (Alvarez 2002) described vividly how orthodox analytic training was inhibiting and holding up the process of the real relationship necessary for any sort of meaningful contact with a young person with autism. She vividly described how instead of using interpretations she needed to act authentically, by becoming more interactive, and for example saying 'please. ' My response to this

during her lecture was on the one hand to feel exuberance and to admire her work with this young person. On the other hand I asked myself the question 'why have music therapists not been more able to share their knowledge about these aspects of real relating and influence psychoanalytic psychotherapy more widely?' Perhaps the time has arrived, I thought, as Alvarez entered into a dialogue of exchange with the music therapy respondents.

A further look at clinical improvisation helps to develop this notion further. Pavlicevic (1997) writes:

'Clients who are not normally musicians are involved in what may be complex musical acts not ' knowing' what they are doing.

By this I think Pavlicevic was assuming the client may not have skills as a musician, which of course many do. However, her comment also points towards the unknown, which could also be understood in terms of the unconscious, a phenomenon which music therapists are intensely interested in. There are moments in clinical improvisation where music seems to act literally as a bridge between the unconscious and conscious. Improvisation allows the patient to become spontaneously involved in an interaction which can take on its own shape and form, with the therapist's in-put guiding this. It can take on a dream-like quality. Patients are often surprised at the manner or mood of their expressions, pointing towards a similar process to the unconscious, at work. Articulating this in words has always been a problem for music therapists and whilst psychoanalytic theory has supplied some mechanisms for doing this, the very nature of music makes this complex. Some would argue that it is by describing musical interaction that we understand what is happening in music therapy. Pavlicevic (1997) describes these complex skills as part of music therapy improvisation:

'If we dissect first moments of improvising with a client, we see that as music therapists we listen first of all to the spontaneous sounds --------As we listen, we organise these sounds in our minds using natural brain perceptual mechanisms so that these sounds become ordered and grouped into patterns. By creating patterns in our minds we begin to discern sequential groupings and at the same time we assign these sounds with musical meaning –ie we do not hear a string of sounds but rather we hear music.' (Pavlicevic 1997 p55)

This helpful description of the process is mindful of the psychoanalytic concept of listening to the patient and engaging in the analytic process through thinking and talking in order to interpret or ascribe meaning to what the patient has said within the therapeutic relationship. It is striking having explored the mechanisms of improvisation here, that there are elements of this process that have already added to psychoanalytic theory and practice particularly in the area of working with those whose thinking and talking processes are damaged or halted in some way.

Where music therapy is concerned, it is almost as if music therapists thought that linking music therapy to psychoanalysis would make it more clinically acceptable. An example of this phenomenon is the following definition of musical counter-transference:

'Musical counter-transference takes place in a shared clinical improvisation. As the therapist you realise that you are playing in a certain way in response to the patient, which previously you had been unaware or unconscious of. You are then subsequently able to make use of this musical experience. This would be by consciously altering your musical style; which could be called a musical interpretation; and/or after the music has finished, making a verbal interpretation during discussion arising from the musical interaction. This interpretation helps the patient understand how they may have influenced your response.' (adapted from 0dell-Miller 2001)

However, in describing it like this there is already an indication of what music therapy might offer to psychoanalysis. It lies at the heart of what musical interactions can articulate in terms of atmosphere, and implication: those things which cannot be easily spoken.

Conclusions

To conclude, it seems clear that people for whom music therapy rather than another treatment is helpful, are likely to be those who find independent listening and thinking difficult and need a transitional space, (the therapy session), and some assistance with which to do this (the music therapist). I would suggest, for example that a live musical interaction through improvisation is like an active communication that requires some effort, but at the same time taps into the spontaneous flexibility of the brain to adapt

and even manipulate its surroundings. It is well known that mood can change following a musical experience. Many can make these connections alone, and understand meaning within those moments, but for some, a live interactive experience through music therapy might be the only way of thinking and feeling and developing an identity. The value of improvisational music therapy rather than listening therapy is in the fact that it encourages thinking and feeling, and helps relate to others, for people who may need some assistance with this. Theoretical insights from music therapy literature may certainly be helpful to psychoanalytic psychotherapists working with patients in such states. More importantly, actual experience of music therapy in an experiential workshop could help psychoanalytic psychotherapists in the area of attuning to non-verbal responses, and listening with an acute awareness to what lies behind the words.

Music therapy's contribution goes beyond this however to a confirmation of the trend within psychoanalytic psychotherapy which emphasises spontaneity, creativity and authentic relationship. Psychoanalytic psychotherapists are often fearful that a normal, human reaction may turn out to be 'acting out' and place a check on their warmth and responsiveness in case it is transgressive. Music therapy offers a model of therapy in which direct responsiveness is valued as highly as interpretation. Again some experience of music therapy during training may help psychoanalytic psychotherapists develop confidence in this aspect of their work.

To summarise, I have illustrated that music therapy can contribute to the future of psychoanalytic psychotherapy particularly in the area of active participation, listening, authentic relationship, and in getting hold of and enabling patients to explore affect and emotions within this relationship. It can also be a way of allowing a shared understanding of the essence of what is really trying to be expressed by the patient in the room, when words or interpretation might be redundant. Good psychoanalytic practice naturally strives for these things, but where fragile interaction, and an intense awareness of rhythms, timbres and tempo are necessary, music therapy provides a framework which includes listening, attending, attuning, responding and interpreting, within an attitude that can be reflective, vital and thoughtful all at once.

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4.3 Discussion of Chapter 4

This publication included in this chapter describes the development of both a political and a clinical argument. It takes music therapy away from looking up to its patriarchal figure of psychotherapy into considering in what ways it could be described to have become an influence to psychotherapy. In doing this it links to the main research question of the thesis by describing a theoretical argument for music therapy in psychiatry, drawing upon case examples mainly from this field. It puts music therapy in the frame as an essential discipline particularly for those who do not find verbal therapy alone a helpful medium for participating in therapy. Furthermore it goes over the theoretical links between the way people develop and behave, and musical processes. This discussion indirectly links to, or forms the beginning of thinking towards the research sub-question how do music therapists define what they do, with whom and why?

These first three publications define some areas of thinking and clinical foundations of Odell-Miller, and also focus upon the formation of psychoanalytically informed music therapy in the UK which holds both psychoanalytic principles and live music as central to its theory and technique.

The next chapter was written earlier and includes foundational thinking about these matters, but particularly addresses issues concerned with research and how to research non-verbal and verbal components of music therapy. It draws on similar case work but goes into detail about the systematic collection of data, and starts the process of thinking about a specific research project in music therapy which culminated in a large project discussed in the sixth chapter, including all four arts therapies in a Randomised Controlled Trial (RCT), that included mixed methods in one project. The publication included in this next chapter is significant to the research question because it formulates some important questions underpinning why music therapists do what they do, and describes a pilot project that was an antecedent to the publication described in Chapter 6, in which patients were asked what they thought was significant about music therapy and why and how they benefited.

CHAPTER 5: INVESTIGATING THE VALUE OF MUSIC THERAPY IN PSYCHIATRY: DEVELOPING RESEARCH TOOLS ARISING FROM CLINICAL PERSPECTIVES

Published in: Clinical Applications of Music Therapy in Psychiatry
Eds Wigram, T & de Backer, J. (1999)

5.1 Introduction to Chapter 5

This chapter arose from the author's search to find effective methodologies for evaluating music therapy with adults. It discusses the difficulties of finding suitable evaluation tools and research designs, and proposes a design at the end, which is later taken up in the author's research. This design includes both qualitative and quantitative methodology. In line with other chapters in this edited volume, it starts by describing the author's approach to music therapy. Specifically at this time, the author wanted to stress the importance of a music improvisation based approach, but which pays equal attention to the relationship between therapist and patient, and other 'extra' musical factors. At this time in the history of music therapy particularly in the UK there was frequent polarisation between approaches, and in particular there were debates about whether music is therapy itself, or whether music is a tool which helps the therapeutic process. The author repeats aspects of descriptions of her approach from previous publications and which also appear in later publications to be considered in this thesis. The reason for the repetition is that the author is describing a specific way of thinking and working where approaches previously thought of as separate, are integrated. For example the author describes a method she developed which integrates theoretical models which appear more musically based, for example influenced by Alvin (1975) and Nordoff – Robbins (1977), together with a more psychoanalytically based method, influenced by Priestley (1994). So, what is described is an approach where what the therapist *does* in the room is very interactive and musically structured within a free improvisation culture. This is directly balanced and integrated within a psychoanalytically informed way of thinking, with the music remaining central rather than theory governing practice. This subtle distinction between approaches underpins the authors' work and is a thread running through all the published works. At the time of writing this is quite common in the UK, but at the

time of publication, was a new way of thinking. Prior to this, authors had usually rooted themselves firmly in one place or another, rather than integrating these different aspects. The hypothesis is that all facets of different aspects of the approach are integrated –there is a balance between structured music, improvisation, the relationship, clinical extra musical considerations, and theory. This is then expanded in the next chapter in this thesis published two years later in 2001.

5.2 Investigating the value of music therapy in psychiatry: developing research tools arising from clinical perspectives

The original published article is printed on the following pages, with the original page numbering.

5.3 Discussion of Chapter 5

The publication included in this chapter describes the beginnings of a research project in the field music therapy in psychiatry, particularly focussing on thinking about designing outcome measures to look at both changes in life quality and quality of the music therapy experience, in terms of the benefits and the specific reasons why patients find music therapy helpful as opposed to another treatment. The work described here has now developed into a larger outcome arts therapies research project

The main thrust of the chapter is about research and evaluation. The author stresses the importance of looking at outcomes in terms of the life of the patient rather than only in isolation, or only focussing upon the musical aspects. This runs through the chapter in that this is the angle the author is seeking in order to design effective music therapy evaluation and larger more far reaching research projects.

There is a review of earlier relevant music therapy research, where research is divided between work where only musical parameters are measured (Gilroy and Lee 1994) and work where both musical material and outcome from this such as non-musical behaviour and life phenomena are considered.

The author discusses three examples:

The first is a musically-centred analysis of a group improvisation using words to describe the music but using musical terminology

The second is a transcription of an evaluation session of group music therapy asking specific questions, as a topic guide

The third is a transcription of a verbal exchange between therapist and patient who are themselves discussing the music therapy treatment and its meaning to the patient after four years of therapy.

The main points made by including these different types of material emphasise the importance and complexities of evaluating both musical and non-musical material arising in sessions, and arising as outcomes from sessions. The author stresses that whilst some researchers only look at one aspect, this might mean that whole parts of the process are missing, for example what a patient thinks and says about the improvisations, and what else is going on in the patients' life. Likewise only looking at non-musical material might miss musical subtleties, such as those the author tried to capture in vignette1.

5.4 Conclusion to Chapter 5

All this leads up to the author seeking to design a research methodology that has both qualitative and quantitative parts of the study, and which examines aspects of the musical material (particularly what patients say about the experience) and also non-musical aspects such as general relevant outcomes for the patient. The author is responding to the political health culture of the time, and urging music therapists to consider the wider implications of music therapy treatment rather than take an inward looking narrow focus. The author suggests a need to set up a controlled trial looking at all the arts therapies together, and also suggests that the following questions are crucial to any experimental action-based research: 'What are the benefits and outcomes?' and 'How are these the same as or different to, other related forms of treatment in a particular service?'

By H.Odell-Miller, P Hughes, Dr Mark Westacott

6.1 Introduction to Chapter 6

This investigation was initiated and led by the author, supported by a professional advisor (clinical psychologist Dr Mark Westacott), and three research assistants. The results of this study were presented at Aalborg University in November 2001, at the European Music Therapy Conference in Italy, 2001, and at the Society for Psychotherapy Research Annual Conference in Weimar in 2003. The original publication for the submission of this thesis was an in- house publication, (Odell-Miller et al., 2001) but since then the research has been published in an internationally peer reviewed journal *Psychotherapy Research*, so it is this publication which is submitted.

The initiative for the study was based on current practice, where arts therapies treatments offer patients therapy through non-verbal means i.e. art forms such as music, art, drama, or dance movement. They are suggested to be particularly effective where normal communication is absent or has broken down. This study was undertaken as a randomised control design with four separate questionnaires to measure the effectiveness of the arts therapies and the quality of their intervention for people with severe mental health problems. The numerical results were not conclusive, owing to high variability and small sample size, but the qualitative data revealed interesting factors, for example that the therapist and patients perceptions of the treatment coincided in all treatment cases. The author has been interested in looking at the relationship between music therapy and the other Arts Therapies, and this study takes this work forward, developing themes of diagnostic links between music therapy and the other arts therapies and what the trends for referral and outcome might be in the future.

6.2 An investigation into the effectiveness of the arts therapies for adults with continuing mental health problems

The published article follows, with the original page numbering.

6.3 Discussion of Chapter 6 and conclusion to Part I of the Thesis.

This publication demonstrates the need for looking at each Arts Therapies modality separately, and for articulating more detailed information about each discipline. It also highlights certain trends in the pattern of referrals and in the articulated benefits of the Arts Therapies. For example, the highest number of referrals in the study in the above publication were of people with schizophrenia. This reflects national trends in music therapy as demonstrated by the survey in Part II, where trends are shown to be towards prioritising people with schizophrenia in music therapy centres in Europe included in the survey in Part II. Furthermore, the qualitative data in the publication in section 6.2 only came from two detailed music therapy cases, and this influenced the decision that further discipline-specific research is needed in the field of adult psychiatry which looks at the particular links between diagnosis and approaches and techniques of practice. The limitations of the Arts Therapies outcome study also had influence on the development of other single diagnostic, and single Arts Therapies modality research studies. For example since then, two major studies, one in music therapy and one in art therapy have been designed to look further at these therapies uses with people with schizophrenia (Maratos 2004) which is cited in the Cochrane Review about schizophrenia, and a Nationally funded multi-centre RCT trial in Art Therapy and Schizophrenia to be started in September 2006 in the UK.

The above publication demonstrated the importance of the therapist's and client's co-agreement about the benefits (or lack of) of the therapy, combined with the fact that results point towards the particular unique benefit of the non-verbal media and how these can help provide meaning for patients. In terms of music therapy there is a small indication from the detailed case studies provided, that a combination of moving between words and music with a psychoanalytically informed way of thinking from the therapist, but which insures that practice is firmly rooted in active music making within an interactive relationship, is a useful model for the diagnostic groups of schizophrenia. However this is speculative with such a small sample and with a multi-media and multi-diagnostically based study.

The research project described excited this researcher to find out more diagnostic and music therapy specific information, but also led to a firm conclusion that no RCT-

designed clinical trial would bring forth significant results unless is was multi-centred, included over 100 participants as a minimum at the outset, and had national funding and resources attached to it. For this reason, the research study in Part II was designed to provide as much background information as possible on how music therapists define and carry out their work, and whether or not this is related to diagnostic work, as a preparation for any future large diagnostic specific clinical trial. It was also designed to specifically draw out detailed information from therapists, not actively asked for in the above publication apart from in the two cases about music therapy. Even then, the therapists are describing clinical benefits and processes, but not describing their theoretical framework or rationale for the work. For example Client E26 with a schizoaffective disorder, refers to the therapist playing jazz to her, but it is not clear whether this is as part of receptive listening or as part of an improvisational approach which the client perceived as 'being played to', but which might have been an interactive piece of music.

The above publication includes detailed discussion about the limitations and findings of the research project, and will not be repeated here apart from concluding that further music therapy specific work was definitely a priority. The work in Part II arose from this study and was this researcher's next project. As a final comment leading into Part II, it is also clear that whilst much patient data was gathered and analysed in the above publication, there is a constant challenge to music therapists to articulate what they do and why, and therefore whilst the patient view should always be part of any clinical research, Part II focuses upon the therapist's view in order to examine whether there are assumptions and trends that have not been researched and published which would help towards clarifying the application of music therapy in adult psychiatry.

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PART II

THE PRACTICE OF MUSIC THERAPY FOR ADULTS WITH MENTAL HEALTH PROBLEMS: THE RELATIONSHIP BETWEEN DIAGNOSIS AND CLINICAL METHOD

Investigating the Value of Music Therapy in Psychiatry
Developing Research Tools Arising from Clinical Perspectives

Helen Odell-Miller

Introduction, method and approach to music therapy

This chapter will focus on the evaluation of music therapy with people with mental health problems. Clinical examples will illustrate the importance of finding a suitable research design and the chapter concludes with a suggested model for looking at outcome, using qualitative and quantitative methodology.

The orientation in my music therapy approach has grown from years of clinical practice, first, in the field of learning disabilities and, for the last 18 years, in the field of psychiatry. The particular emphasis is that live music is improvised to follow the therapeutic process as it unfolds for each patient. Whilst I would describe my approach as psychoanalytically informed (Odell-Miller 1995b, 1996), it is not based on one theoretical framework but has grown from years of clinical practice and supervision. As demonstrated by Priestley (1994) and Streeter (1995), a fundamental aspect of this approach in music therapy is a belief that unconscious processes are an important force in the work.

As I reported in a case study (Odell-Miller 1995), the relationship with the therapist is of equal value to that of the art form – music. The music therapist will focus on the person as a whole, primarily through the music but also paying attention to aspects of the person shown not just through the

music – for example, talking and thinking. In this approach the context in which the music therapy takes place is also of vital importance.

The work of Sigmund Freud and Bion (1961) have been influences, in addition to Yalom (1975) and the social psychiatry model practised in the setting where I work. Music psychology and musicological developments have also been influential, particularly the recent developments in findings concerning the practice of improvisation in general and in the field of therapy and education as described by Clarke (1992). For example, it is my hypothesis that music offers something very particular, which is inherent and inextricably bound up in the music therapy process, in addressing issues of old age, the onset of confusion related to dementia and for those with learning difficulties. That is to say, it has something specific to offer those who find verbal communication difficult, as well as those who may be very articulate, and need a different method to enable the exploration of affect or feelings. My approach, described in detail elsewhere (Odell 1988; Odell-Miller 1991, 1995b, 1996, 1997), involves practical music making, using improvisation as the focus. My rationale is that the way clients improvise may reflect their current states and can lead to an understanding of internal and external, interpersonal and intrapersonal changes which may be desirable. A variety of instruments are used, including tuned and untuned percussion, violin and piano.

I believe that an important element in this way of working is to help clients understand more about themselves and gain insight through the process of improvisation and talking. This process can often take time and inner changes may not at first be apparent to client or therapist.

An intense experience of 'here and now' is provided by a music therapy. Interactions are played out, often within improvisations, and it is fundamental to this way of working that the therapist responds to and does not avoid issues she perceives or hears if clients are ready to look at them. It is also important to recognize when music making might be encouraging defences. In this method free improvisation provides an experience for transference and countertransference relationships to be dealt with between group members as well as with the therapist in a group, and between therapist and patient in individual work. The music therapist is a trained musician in this way of working but the clients need not have any previous musical skills.

Central to the method is an understanding of musical counter-transference, referred to also by Streeter (1995) and also in this book. My working definition is:

> This would take place in a shared clinical improvisation. As the therapist you realise that you are playing in a certain way in response to the patient, which previously you had been unaware (or unconscious) of. You then are able subsequently to make use of this musical experience. This would be by consciously altering your musical style; and/or after the music has finished, making a verbal interpretation during discussion. This interpretation helps the patient understand how they may have influenced your response. (Odell-Miller 1996)

The developmental and neurological aspects of understanding music therapy are important because it is now well known and well researched that when brain damage occurs, musical functioning often remains intact and can be the last faculty to deteriorate (Alajouanine 1948; Basso and Capitani 1985; Gordon and Bogen 1974).

There are many unanswered questions as to why music is therapeutic. However, one important underlying factor is that the four main elements of sound – pitch, volume, duration and timbre – are all found in the human voice. A collection of sounds made up of these elements leads to the formation of music.

The most important stages in voice development of the child are discussed by Moog (1976). He illustrates how important the human voice is in musical terms. This is pertinent to the older person because a more spontaneous uninhibited form of relating often emerges as part of the dementia process or in a music therapy session for someone with schizophrenia. Moog shows that from being inside the womb onwards, children have spontaneous responses to music which are not taught – for example, smiling, movement of the body when music is played.

For the elderly, loss of memory and the onset of dementia may seem to make a psychoanalytic approach redundant. Likewise, with depressed adults or those with schizophrenia, a music therapy approach which pays attention to unconscious processes might seem redundant. My experience is that this is not so. Working with very damaged people places enormous demands on the therapist such that she needs to understand unconscious processes which may be going on. This is in order to work with disturbed people in a long-term setting where change may be small and slow. Indeed, there may be no motivation for change for continuing care residents who may have resigned themselves to never being discharged to community life. Depression may be enormous and this, coupled with the confused or psychotic expression of some patients, requires tenacity by the therapist. This

can be helped by understanding the transference and countertransference phenomenon, and supervision is essential. Cohen (1952), when talking about long-term psychoanalysis, writes in a way which is relevant for the music therapist in a long-term residential setting with clinically ill people:

> …it seems that the patient applies great pressure to the analyst in a variety of non-verbal ways to behave like the significant adults in the patient's earlier life. It is not merely a matter of the patient's seeing the analyst as like his father, but of actually manipulating the relationship in such a way as to elicit the same kind of behaviour from the analyst. (p.233)

Searles (1961), possibly without intention, confirms the importance of music therapy with the long-term institutionalized client. He points to something which we, as music therapists, all know concerning the importance of non-verbal/pre-verbal interactions when he describes the work of Spitz (1959). Spitz, in his work concerning the early development of the ego, repeatedly emphasizes that emotion plays a leading role in the formation of 'organisers of the psyche' during the first 18 months of life. For example: '…the road which leads to this integration of isolated functions, is built by the infant's object relations, by experiences of an affective nature … it is an affective behaviour which clearly precedes development in all other sectors of the personality by several months' (p.84).

This is important because music therapy concentrates on an expressive 'affect' as well as talking and thinking, and if the latter are absent (because the patient is too regressed/not ready/unable to speak/think), the language of music is important.

In the history of music therapy in the United Kingdom there were two main theoretical influences emerging during the 1960s and 1970s. Examples of these are found in the writings of Alvin (1975) and Nordoff and Robbins (1971, 1977). Both emphasize the use of improvisation. I wish to emphasize that my approach adheres to what I think is reflected in these approaches: that music therapy did not develop by adding music to other clinical or theoretical practices. Improvisation and live music helps to determine how the therapy evolves within the therapeutic context.

Whereas Alvin and Nordoff and Robbins emphasize the importance of improvisation, they differ in the manner in which the music is applied and interpreted. Nordoff and Robbins developed specific guidelines for harmonic progressions and assessment scales, emphasizing that therapy takes place in the music and is healing in itself. In contrast, the Alvin

approach regards music as a tool which facilitates change rather than being healing in itself. The most striking development during the last two decades has been the increase of influences in clinical practice from other disciplines. Psychoanalytically informed work centres on understanding the meaning behind the music, symbolic links arising from musical improvisations and unconscious processes.

I would describe my approach as 'psychoanalytically informed' and not 'music psychotherapy'. In my approach the theories have grown out of years of reading, discussion, supervision and thinking, but with ideas from psychoanalysis informing the work, rather than building the music therapy upon other theories. Hence it is important to say that I unashamedly borrow concepts which seem to fit into, and explain further, music therapy processes (Odell-Miller 1991). A clinical example from work with older people with dementia further illustrates my method (Odell-Miller 1995a) and, whilst the approach with less confused people would differ, the fundamental music therapy principles remain the same.

Vignette

Connie, an elderly lady with dementia, always seemed excited on arrival at the sessions and recognized everyone as if saying hello through her disjointed vocalizing. These group sessions lasted for 45 minutes and the instruments used were tuned and untuned percussion, including gongs, drums, tambours, cymbal, maracas, metallophone, kalimba, bass xylophone, recorder, guitar and voice.

It is important in my group process to allow space for each person to acknowledge their presence. Connie used this space as a chance to express her individuality by using an instrument (usually metallophone or maracas – her choice) whilst vocalizing. I would improvise with her and gradually a rapport built up through this interaction. Over the time we were working, Connie developed a way of following me around the group and greeting others in the group.

Improvisations in dyads and triads allowed more in-depth feelings to be shared verbally and musically and expression could be more intense. Connie would sometimes hum or beat in a particular way which, with facilitation, could lead to others joining in.

Connie developed a preference for the bass metallophone and would share this with another member, Mary. They developed an interest in making music together, using the 'white note' scale, giving them a feeling of

interaction and dialogue. I would support from the piano or with the recorder, taking a containing role. Sometimes, I would play firm harmonic rhythmic chords in the bass whilst another member improvised in a free way, perhaps aggressively drumming at irregular intervals.

Connie needed to express herself loudly at times and that this would often be followed by a quieter period of reflection, when she would sometimes be tearful. It was important for me to show support and understanding to her during these cathartic experiences by reflecting to her musically or verbally how she might be feeling.

Ending therapy sessions is a critical process, of which Connie became more aware over time. Occasionally, song material was improvised around a theme of ending and goodbye, perhaps putting Connie and others in contact with their own experiences of endings, grief and death. Connie often seemed to want to express profound emotion, sometimes demonstrated by hugging, kissing and clinging onto Mary, her neighbour, or a helper in the group. She would then be able to settle again and leave peacefully, as if the group had 'contained' these feelings. I would be aware of a need to slow down or speed up the musical and rhythmic pulse according to the mood of the group.

Connie related with others in an excited exuberant way, valuing the consistent relationships in the group. I could understand, perhaps, something of what she was experiencing and often felt she was 'clinging' to a familiar nurturing relationship reminiscent of other relationships she may have experienced. My countertransference response was to be a nurturing figure but I needed to allow her freedom to break away from a symbiotic relationship. The multidisciplinary team supported the therapy but it was noticeable that they would often respond to her as a child and I felt, at times, that in the music I may have been tempted to do this too. However, the group provided a stable space within which she could be herself and deal with these last years of her life.

Evaluating music therapy

The adult mental health service has an integrated arts therapies service consisting of art therapy, music therapy, drama therapy and dance movement therapy. Research has to be service led in order to obtain funding and, owing to this, factors other than just music therapy need to be taken into account, such as moving from clinically based practice and process-orientated research to a relevant research methodology which will look at arts therapies outcomes in general rather than music therapy in particular.

Existing relevant research

The relevant research pertinent to music therapy in this field of psychiatry falls into two main categories. The first is concerned primarily with using musical parameters to determine outcome (Aldridge 1996) and focusing on musical material to draw conclusions for outcome (Lee 1995). The second category is of research carried out by music therapists who consider both musical material and outcome from this (i.e. non-musical behaviours and phenomena) as essential in evaluating outcome (Bunt, Pike and Wren 1987; Hoskyns 1995; Pavlicevic and Trevarthern 1989; Rogers 1995). Aldridge (1996) looks at both categories and discusses the importance of recognizing the force of the art form for people who communicate non-verbally whilst maintaining rigorous research methodology. Aldridge and Verney (1988) discuss a proposed design for research with people with anorexia nervosa and other psychosomatic disorders which is similar, in respect of asking general questions, to this proposed study. Tang, Yao and Zheng (1994), in their study with people with schizophrenia, show that music therapy cut down negative symptoms, increased the ability to converse with others and that an increase in outside events was shown as a result of a randomized trial over a period of one month. This is significant, although both passive listening and active singing of songs is described in the method of music therapy rather than extensive use of improvisation.

Pavlicevic and Trevarthern (1989) showed musical similarities to other behaviours found in other studies with people with schizophrenia (see Fraser *et al.* 1986; Lindsay 1980). However, whilst this confirms the use of music therapy as a possible diagnostic tool, it looks in detail at what happens in music therapy rather than at outcome related to the life of the patient in general outside of the therapy session.

Bunt, Pike and Wren (1987) used a questionnaire evaluation method on a residential psychiatric ward, looking at outcome. The methods of evaluation were mainly related to the actual sessions themselves, although one more general question was connected with asking the patients what effects the treatment had on them, if any.

In practice, we might find that a meaningful outcome for a person with schizophrenia or manic depression is quite practical and could be included in quality of life measures as defined by Ford (1995) – see Table 7.1. Whilst we might need to adapt these to include an emotional or psychological component, important questions for this population regarding outcome of music therapy might be: Does it help me feel better about myself? Does it

help me relate better to friends and family? Does it help me get a job? Does it keep me out of hospital? These questions often form the basis of less formal ongoing evaluation, as we will see from the clinical examples.

Other major sources of research to be considered in addition to music therapy and other arts therapies research is that concerning psychological or action-orientated therapy treatments/interventions with this client group.

Table 7.1

general life satisfaction	finances
religious beliefs	legal and safety issues
health	mental health services
social functioning	living situation
daily activities	work

Shepherd, Murray and Muijen (1994) and Shepherd, Hardy and Hill (1996), in two different publications, show how important client involvement is in evaluating treatments and services.

In studying the existing literature the music therapist is faced with a dilemma: whether to look at the outcome of the process itself, and study or analyse sessions in detail, or whether to look at the reflection of change in general areas for the patient. My hypothesis is that both are important, and this is crucial to any study.

In terms of the complexity of adults with mental health problems where general life changes are crucial to well-being, it is important to measure generalities in addition to musical parameters and to use client-centred techniques, such as questionnaires which clients and their carers answer themselves. Musical parameters reflect change but, in isolation, do not necessarily verify that other changes have happened – for example, quality of life changes, as shown in the clinical example. Consideration of length of music therapy treatment and other psychotherapeutic interventions with people with chronic mental health problems is crucial. These long illnesses rarely disappear completely. Symptoms and ways of dealing with them can

only change over a long period of time because, often, patterns of relating and coping with the illness have become habitual, or cyclic, and it takes time to break into that cycle. This is shown in a previous article on this subject (Odell-Miller 1995b).

Anecdotal outcome related to reasons for referral show reductions in hospital admission. A small survey showed that 90 per cent of long-term chronically ill people engaged in music therapy for periods of two to four years had a regular pattern of breakdown and admission to hospital before embarking on therapy and a decrease and, often, cessation altogether of these admissions after starting long-term music therapy.

The main results of outcome research in the field of psychotherapy with people with schizophrenia, reviewed by Roth and Fonagy (1996), show the efficacy of family intervention programmes aimed at modification of the support network of the schizophrenic person and cognitive behavioural treatment of acute symptoms. Perhaps music therapy and other arts therapies would be mentioned here if increased systematic research in the field was implemented.

Developing a clinically appropriate methodology

In this section process and theoretical issues will be considered in passing but not looked at in detail. I am concerned here with outcome, how to define it and how to measure it, looking primarily at music therapy and mentioning other related therapies.

Outcome is defined as the effect or result of an event or of circumstances. Therefore, we must assume that in discussing outcome in music therapy we are relating the particular outcome to the events or results of music therapy. How is this possible with a diverse population of people suffering from severe mental health problems? How do we define meaningful outcome for this population and how then do we measure this outcome? I will consider some clinical examples in order to put these questions into context.

Clinical examples

These examples were not part of a clinical research trial but part of ongoing clinical work. They show three different ways of describing outcome but they do not attempt to measure outcome in a scientific way. However, in my view they all show evidence that music therapy is effective in some way, but they do not set up a generalized formula typically generated from scientific

research. Ultimately, the chapter will conclude with a model for doing this, which will be carried out over the next two to three years. The examples will give a direction for designing a research methodology to look at outcome in a more rigorous scientific way and will help to focus on the issues and dilemmas facing the music therapy researcher in this field.

The three examples are short 'clinical vignettes', each relating to a different clinical episode of music therapy. All reflect outcome related to reasons for referral but in three different ways. Vignettes 1 and 2 are from the same music therapy group but on different occasions. The first is a clinical analysis of a three-minute video excerpt from the group and the second is a written transcript of a recorded discussion by the same group about the value of the same ongoing music therapy group. The third vignette is an excerpt from an individual music therapy session showing verbal dialogue.

EXAMPLE 1

This example is connected with a music therapy group run in a psychiatric day centre. The group has a membership of four people but only two are playing in this extract.

Simon, playing the metallophone, is a 40-year-old man suffering from chronic anxiety and depression who has been attending the group for nearly three years. He was referred because he found another music therapy group on an acute admission ward useful during his last and only hospital admission to a psychiatric unit four years ago. Rosalind, playing the glockenspiel, is a 56-year-old lady with chronic depression and anxiety who has been attending the group for three years. The other two members of the group not playing on this occasion are Melissa, a 30-year-old lady with chronic schizophrenia, and David, a 40-year-old man with anxiety and depression.

This improvisation arose out of silence and was initiated by Rosalind who began to play quiet a-rhythmic phrases on the glockenspiel. The therapist moves to the piano to respond and support this musically whilst Simon plays answering phrases on the metallophone. The quality of these opening phrases is like a recitative, with accompaniment from the piano and metallophone, as, at first, the therapist and Simon seem to be following and responding to the whole group improvisation whereas Rosalind appears to be in her own world. Simon then moves to expressive fast quavers, which eventually penetrate the whole improvisation, and these seem to reflect his obsessional personality. This fits in with a common pattern both in the group

Table 7.2 Analysis of significant moments of clinical vignette 1		
Therapist **Piano**	**Simon** **Metallophone**	**Rosalind** **Glockenspiel**
		Quiet phrases.
Accompaniment – Single notes/Chordal. Long notes. Listening.	Answering phrases to R.	Crochet and quaver beat.
Finding S's pulse, with a slow, containing accompaniment, to relate also to R's music.	Expressive fast semiquavers.	Experimenting with quaver/and crochets. Not with S's pulse at first.
Octaves in bass.		
Chordal passage.	Listening and absorbed.	Crochet figure (own metre).
Descending chordal sequence.		R picking up piano figuration.
Chromatic notes introduced in relation to S's playing.	Fast patterns – interacting with therapist.	Crochet figure (own metre).
Double speed.	Expressive playing.	Fast glissandi patterns.
Glissandi.		Glissandi patterns in response to others.
Responding to underlying expression with dotted rhythm.		
Expressive interactive section between all three		

and outside it for both Simon and Rosalind. More detail is given in Table 7.2, where you can follow the development of the interactions of the clients.

So, what can we tell from this example? On the one hand, I expect that if I were to play the music without the written description, a group of music therapists would be able to hear a great deal of what I have analysed as clinically significant in the summarized description – for example, points of interaction, points of rhythmic synchronicity, points of pitch reference. It could be analysed using musical parameters (Aldridge 1996).

However, this analysis of musical material does not tell us what the history or diagnosis of the patients is, why they first came to music therapy, why they still come two years later and what their quality of life is.

Simon has acquired a full-time job during the last six months, joined a Gamelan group during the last two years and has been treasurer of it during the last year. As we will see from the next example, his thinking about the benefits of the music therapy group is sophisticated. Whilst the musical analysis gives us a great deal of information, it is necessary to include other aspects of a non-musical nature in order to evaluate progress or efficacy of treatment.

EXAMPLE 2

This second vignette is a verbal transcription of an evaluation session of the same music therapy group with all four members present. This may help us towards defining meaningful outcome after a sustained period of music therapy. Anecdotally described outcomes have covered areas such as self-confidence, self-esteem and 'letting off steam', therefore leading to cutting down stress, self-expression where words are not necessary and a general feeling of well-being, trust and a belief in oneself.

The boxed text below shows the transcribed answers to various questions which were discussed with the therapist, not as part of a formal research project but as part of an ongoing clinical evaluation process. They serve to indicate what would need to be part of a topic guide in any future research plan.

What are the benefits to you of this therapy? – In your life in general?

Others: Letting off steam.

Frustrations – getting them out.

Talking about problems outside the family.

It's safe here – you can say things which won't be spread around outside, but which connect up with the outside world.

Simon: Feeling understood.

Are there any changes you have experienced which you could attribute to this therapy?

Simon: If I'm fed up I could go through the day not knowing how I feel – I could be vaguely aware of something which is a problem. Music therapy makes you more aware – it makes you focus on how you feel and then deal with it or not. After therapy I often go away and have material to think about for days.

What is different about this group music therapy in what it offers you to other treatments/forms of help?

Simon: Gives you access to parts of yourself that you never get through words.

Playing music gets you in touch with feelings.

It's difficult to articulate in words – I know what it is until someone asks me. It's impossible to explain in words – I know its value for myself but I can't express it.

Others: Fitness–stamina. You have to think, feel and play music, which is a physical act, in music therapy.

Something to look forward to during the week, joining others with their music, then 'letting go'. I did not have anything to look forward to before.

Simon: It's enormously important that it is not just verbal therapy because I've done a lot of that, and it's not a good way of accessing parts that you might otherwise hide. Areas can be hidden in psychotherapy, and/or defended against, but you can't do that in music, you sneak up on part of yourself in music therapy just when you're not expecting it. Much harder to control than words.

People assume that playing music is to break the ice – then you have therapy, i.e. through talking, then you go back to music. It's not like that – it's a continuum. One other important thing – being in a group I find it hard to talk to people. In a music therapy context even if you can't talk, you do come together to play music and have a shared experience.

What makes the group play music, and stop talking?

Others: Sometimes I find it hard to get going into it.

Letting go is a need. If you don't play at all it's still 'in you'. I think it seems to help calm me down a bit.

I find that when I want to start, and it's a little later than when I expected, and the music does not start, I get very nervous. I want the whole group to play, not talk all the time.

Simon: There are no formal expectations – when I am drawing, I am too intent on using my expert skills (he is a graphic designer) and my anxiety gets worse not better. I am filled with fears of expectation – it's impossible to start with a blank page. Music gives immediate access to what I'M feeling. That's what makes me want to start to play.

From this vignette we can start to group the issues under more headings and develop a topic guide which will be part of the main research to be carried out, as you will see later. For example, topics could be: relationships, non-verbal interaction, self-expression and access to feelings. The point here

is that whilst it is clear that music and the musical relationship is the vehicle for change and development, and also for what is meaningful outcome to the patients/clients, I would argue that we could not have deduced all this from purely listening to the music. In highlighting Simon's issues in more detail we begin to see the way in which the music and the whole person are inextricably bound up and that we cannot separate one from the other.

It is also important for fundholders, managers and other colleagues to be able to generalize and articulate expected outcome. Of course, we cannot do this from only this discussion between four people, but when the research takes place we will ask similar questions of a much larger number of people, as shown in the proposal in the final section of this chapter.

EXAMPLE 3

The third vignette illustrates how subtle some of the research measures need to be to really capture meaningful outcome for a person who has been involved in long-term in-depth therapy. This man suffers from manic depression (Odell-Miller 1996). He has now finished a period of four-and-a-half years of individual music therapy and filled in his own referral form at the start of treatment. Here, if we look at outcome in relation to reason for referral, we find a very interesting phenomenon, which is that four years later, towards the end of the therapy, the patient is talking about one of the issues he mentioned on the referral form. He wrote: 'Coming to terms with my personal problems.' He also wrote: 'Some problem expressing myself, I would rather leave a situation than deal with it.' His key worker, and Malcolm himself, also had a notion that music therapy would help because of a constant underlying affect of rage towards everyone coming into contact with him. This excerpt happened as part of a normal session, but again it shows us a way forward in how to ask the right questions when we are designing our research tools. For example, we can see from here that he is able to use the therapy to explore the very issues he mentioned at the start of therapy and, as the therapist, I would also be able to say how much Malcolm's anger towards others has subsided. Other team members think that there is a direct link between this change and his involvement in music therapy. They report that Malcolm seems easier to get on with and less angry. There are also other major changes which have taken place over the period of therapy. For example, he has improved his access and relationship to his children. Now, we cannot attribute these changes to music therapy, without Malcolm being part of the research, but we can learn from this that we need to design

questionnaires relating to expectations of patients and to design questions which should be asked of the therapist and patients. Rogers (1995) writes about this major concern for the music therapy researcher – that it is essential to pay attention to the client/therapist relationship. She points out that client and therapist may have radically different ideas about whether the relationship or the music therapy process as a whole is making the most impact on the client. In view of this she points out that unless the client is involved in evaluation, the research could be entirely based upon the subjective views and aims of the therapist.

Again, the verbal excerpt in the boxed text illustrates this point, where you can see a long-term relationship has been established, where the patient has been able to feed back to the therapist something of what he has been noticing about the therapist and the relationship. At the same time, this reveals to the therapist a significant change since the beginning of the therapy, as the dialogue shows that Malcolm can now reflect, think and gain insights for himself through the musical relationship.

M   The problem I've got – I have got a slight problem – I'm quick tempered – so I've got – or – I just walk out of the situation – or – say it's my wife – I leave it until it gets out of hand then…

Th   You've never walked out of here.

M   If I'm working and I was under a lot of pressure – and I'd talked it over with my wife and she says 'no, I don't want to hear about it' – that's putting a lot of pressure on me and she isn't listening to what I'm saying…

Th   So, in here you feel listened to.

M   Yes, but the thing is – yes – er – yes – well – but if I was in a job, I might have got cross at you – not all the time, just now and then – if I didn't think it was right.

Th   Well – you've been cross with me sometimes.

M   Yes, yes, but I wasn't really cross – I didn't really go POW! (Makes hand gestures of hitting out.)

Th   There was one time when you played the drum and – (M Yes.)
     – cymbal very, very loudly – (M Yes.) – for about 4 minutes,
     and I thought that you were angry with me…

M   Yes – you see – but the thing is…

Th   I was just saying, it was to do with you thinking about some
     difficult upsetting things in the session.

M   Yes.

Th   Do you remember?

M   Yes – (Thinking) but I normally hit something when I'm angry
     – see what I mean, but I leave it until I get home – but the
     thing is – if I was on my own I wouldn't do that – because
     when I'm with someone I take the frustration out on them, see
     what I mean? – which isn't really their fault, not all the time,
     but they can build it up as well – see what I mean?

Th   Well – somebody else being there, and maybe saying things,
     or responding in a way you're not sure about – (M Yes.) – or
     you don't like.

M   Yes – or I don't like more like, yes.

Th   On the one hand you're better on your own, and on the other
     hand if you can have a relationship where there isn't that
     pressure – or you feel there isn't that pressure, then…

M   That will be easier.

Th   You have your competitive side and also a sadder side, when
     you've been upset. This is a part…

M   Hmm hmm – you've got a slight fault – (Th Yes.) – I don't feel
     you tell me everything. You sit back and listen, and keep a bit
     to yourself.

Th   And you're a bit critical of that?

M   Yes, I'm a bit critical of that.

Th   It's probably a bit unnerving.

M   Yes, I don't know what you're thinking.

Th   And that leaves you with having to think your own thoughts and feelings – (M Yes) – it's not a battle.

M   No – but I don't know what you're thinking, I can only imagine what you're thinking or what you're trying to think, but I could be wrong – see what I mean? I know I could be wrong – but I can't prove it either way because you don't tell me.

Th   I only say things about you – about what is going on in here.

M   No, but you keep it to yourself, because you can see it on your forehead, how you are thinking about everything, like that, I can see it all in your head – how you're thinking – you – you move your forehead, and I can see how you're thinking – I'm very observant. (Laughs!)

Summary of clinical examples in relation to evaluation

In this discussion we have highlighted the wealth of material involved in music therapy sessions with this population and the importance of looking not just at the musical material but at the whole picture for a person if we really want to determine the outcome and benefits of this type of music therapy. In example 1 it is clear that we are hampered by not being able to hear the whole excerpt, at least on audiotape but also on videotape, if we want to gain a full understanding of the musical group relationship. Conversely, example 2 reveals explicit verbal material with some very complex thinking about the whole process which has come from the musical interactions but which would be impossible to know from only listening to the music. Example 3 incorporates the whole process as the patient and therapist discuss directly a musical improvisation episode and this is related to both this relationship and those outside the music therapy setting. In addition, attention is drawn to a developing process over time where the quality of relating has changed between the therapist and patient. This can be heard in the musical examples also, but unless there is discussion the music

therapist cannot be sure that the patient has consciously become aware of the meaning and integrated the whole process. This is particularly essential for verbally articulate patients.

Proposal for music therapy research design

A single case study design looking at all arts therapies referrals to a psychiatric service over a given period of time, with both a qualitative and a quantitative part to the research, has been planned in consultation with aforementioned organizations and researchers (Onyett 1998). First, a qualitative pilot study will be carried out with the next ten referrals to the arts therapies service after a given date, in order to design tools of measurement of arts therapies outcome for this client/patient group. This would be done by basically asking 'What are your expectations of the therapy?' and, later, after a predetermined period, asking whether these expectations seem to be met. Where a patient is unable to answer questions, carers or advocates will be included. A topic guide will be used to prompt answers, gathered from material we have looked at in this presentation. The interviews will be depth interviews and carried out by a research assistant. They will be tape recorded and transcribed, out of which common themes will be phrased into questions and a rating scale devised for the questionnaire to be used in the larger study – for example, 'Do you think music therapy helps with making relationships?'

Following the pilot study, at the end of which the tools for measurement will have been designed, expected and actual outcome will be measured by using interview and questionnaire techniques relating to the original reason for referral to arts therapies and related to expected outcomes. Referring agents and/or significant others, such as relatives and carers, will also be interviewed. A controlled study will be necessary, looking specifically at groups who are not referred for arts therapies.

Measures to be included, in addition to questionnaires and interviews, will be numbers of admissions to hospital before, during and after treatment, and quality of life measures (Ford 1995). Second, the quantitative phase would use these tools to measure outcome for at least 100 cases referred to the arts therapies service, applying them as expected outcome measures.

Conclusion

The major question to be answered when formulating this research is not 'Does music therapy work?' in the field of psychiatry. In 1998 there is no doubt about that, as previous music therapy research has demonstrated (Bunt 1994; Bunt and Hoskyns 1987; Odell-Miller 1995, 1997; Wigram, Saperston and West 1995). The more important questions asked by all fund holders, service providers, managers, chief executives and fellow clinicians are 'What are the benefits and outcomes?' and 'How are these the same as, or different to, other related forms of treatment in a particular service?' For this reason it will be important to look at all the arts therapies, rather than only at music therapy. We can and must continue to evaluate music therapy specifically, and, indeed, the process of music therapy still needs to be understood. Alongside this work, music therapy must be looked at in a wider context. It is also notoriously hard to say that a particular treatment was the one which made the difference and the larger the sample the more effective results will be. This is not only important in terms of service delivery but also in terms of funding. Arts therapies have in common a non-verbal focus and a psychological basis. As such, there is an argument for grouping the interventions together as related, but different, forms of psychotherapeutic intervention.

I am grateful to all who helped towards this chapter – particularly to my patients, whose names and identity have been changed to protect confidentiality.

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Glossary

Containing accompaniment: the absorption of the patient's musical material into the therapist's musical (in this case pianistic) accompaniment in order to support the patient and his or her musical improvisations rather than take it forward or 'interpret' at this stage.

Musical countertransference: the therapist's unconscious reactions to the patient (both musical and otherwise), especially to the patient's own transference. A fuller definition is found in the actual text.

Music psychotherapy: a method where psychotherapeutic concepts and theories literally govern the music therapy process, rather than an approach where there is a mutual integration.

Psychoanalytically informed music therapy: a method where psychoanalytic theory and practice aids understanding and thinking about the music therapy process, rather than governing its process. The music therapy process is the focus but important elements of psychoanalytic theory, such as transference, countertransference and unconscious processes, inform the work.

An investigation into the effectiveness of the arts therapies for adults with continuing mental health problems

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Abstract
Arts therapies treatments offer patients therapy through primarily nonverbal means (i.e., art forms such as music, art, drama, and dance movement). They are particularly effective when normal communication is absent or has broken down. This study used a randomized control design and involved a treatment ($n = 10$) and a control ($n = 15$) group. Treatment was one of four arts therapies delivered in group or individual format. The authors used four separate questionnaires, administered over a 6-month period, to measure effectiveness. There was also a qualitative interview at the end of that period for the treatment group patients. The numerical results were not conclusive owing to high variability and small sample size, but the qualitative data reveal interesting facets of the process (e.g., that the therapists' and patients' perceptions of the treatment coincided in all treatment cases).

This article aims to investigate the arts therapies as a treatment for adults with continuing mental health problems. The authors' background is in the United Kingdom, where the arts therapies are now offered in all four modalities (music, art, drama, and dance movement) in some hospitals. Music, art, and drama therapists (although not dance movement therapists as yet) have now achieved state registration, so that their professional titles are protected.

The arts therapies are used in a variety of settings but are particularly useful for people who find meaningful verbal communication difficult or impossible. The mechanism by which each therapy operates varies according to the setting, structure, and particular orientation of the therapist. Briefly, arts therapies provide a psychotherapeutic intervention that enables patients to effect change and growth using art materials to gain insight and promote the resolution of difficulties. Dance movement therapists focus on the use of body movement and dance, and the connections among mind, body, and emotion, in working toward changes in perception of their body and their difficulties. Dramatherapists also encourage patients to experience their physicality, to develop an ability to express the whole range of their emotions, particularly using drama, storytelling, and role-play. This, in turn, can increase their insight and knowledge of themselves and others. Music therapists facilitate interaction and development of insight into patients' behavior and emotional difficulties through music making, often using live, improvised music working with rhythm, pitch, tonality, and mood. Previous literature on their effectiveness in psychiatry in the United Kingdom was often based on case studies (Davies, 1995; John, 1992, Odell-Miller, 1991, 1995b; Payne, 1993). Although some scientific outcome studies have been carried out (Odell-Miller, 1995a; Wilkinson, Srikumer, Shaw, & Orell, 1998), these have been mainly concerned with people older than 65 years with dementia and related diagnoses. There is a need for outcome-based research with a younger population. In response to that need and to the clinical governance agenda in the National Health Service (NHS) and within local mental health services, this project aimed to investigate the effectiveness of arts therapies through numerical measures and through qualitative interviews. The need for an outcome study for this client group is further highlighted by the variable recognition of arts therapies as a treatment of choice in the NHS.

Developing the methodology: Literature review

A specialized literature review was carried out in the field of arts therapies and this population. Also relevant psychotherapy literature was examined concerning rapport and alliance, because these

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were areas thought to be particularly crucial in any arts therapies treatment with this population. One such study (of 143 patients with schizophrenia) influenced the design of the current study (Frank & Gunderson, 1990). This study showed no distinct difference in active engagement between supportive and insight-oriented treatments, but in both groups the facilitation of a good rapport, or alliance with the therapist, made for a good outcome. There is also evidence that patients who formed good alliances with their therapists in the first six months of their treatment were significantly more likely to remain in psychotherapy, comply with their medication regimens, and achieve better outcomes after two years, with medication, than patients who did not. This points to the importance of a good alliance, which anecdotally before the study, arts therapists reported as something patients seemed to achieve often more readily through art forms than talking in some cases. It also supports the 6-month measuring period, which was in the design of this arts therapies study but which could have been thought of as quite short.

Many people have addressed the problem of how arts therapists carry out research in both specific and general terms. The dilemma for the therapist is always whether to look at process or outcome. Can meaningful outcome be measured without looking at the art medium? Aldridge (1996) examined both categories and discussed the importance of recognizing the force of the art form for people who communicate nonverbally while maintaining rigorous research methodology. Brotons (2000) had completed the Cochrane Review of Music Therapy and Dementia, which, although providing evidence for a possible beneficial effect on various symptoms of dementia, also highlighted the need for further well-designed randomized controlled trials (RCTs) in this field. However, this is with a different patient population than that studied here and thus is not discussed in detail.

Tang, Yao, and Zheng (1994), in their study of patients with schizophrenia, show that music therapy decreased negative symptoms and increased the ability to converse with others. In addition, an increase in outside events was shown as a result of a randomized trial over a 1-month period. This is significant, although both passive listening and active singing of songs are described in the method of music therapy rather than extensive use of improvisation.

Pavlicevic and Trevarthern (1989) show musical similarities to other behaviors found in other studies involving people with schizophrenia (Fraser, King, Thomas, & Kendell, 1986; Lindsay, 1980). However, although this confirms the use of music therapy as a possible diagnostic tool, it looks in detail at what happens in music therapy rather than at outcome related to the life of the patient in general outside of the therapy session. Bunt, Pike, and Wren (1987) used a questionnaire evaluation method on a residential psychiatric ward to assess outcome. The methods of evaluation were mainly related to the actual sessions themselves, although the patients were also asked about any effects the treatment had on them.

Design issues

Background

It was important to set up this research in a scientific way without interfering adversely with the therapeutic process. The choice of qualitative or quantitative design was considered, and it was agreed initially that the study should include both aspects. Much thought was given to the design process, and a pilot project, partly funded by Anglia Polytechnic University, was done (Odell-Miller, 1999). This involved asking systematic questions about arts therapies and their value to patients as part of an ongoing evaluation process, and asking similar questions of UK arts therapists working in this field. Finally, in response to service needs, it was decided to study all arts therapies together, using an RCT design.

The Arts Therapies Department of the Cambridge Mental Health Services operates an integrated referrals system for the four treatment modalities and was a pioneer for this model in the United Kingdom. A single-treatment modality study (evaluating music therapy only) was planned (Odell-Miller, 1999) initially, but it was felt that the whole service should be evaluated. The RCT design was favored by medical colleagues and was also a condition for one of the grants. It was also considered important to include a qualitative aspect to the study in the form of interviews with patients who had undergone therapy. At all stages the project was submitted for approval by the NHS Trust Ethics Committee.

A meaningful outcome during and after arts therapies treatments for a person with schizophrenia or manic depression may be quite practical and could follow the quality of life measures defined by Ford (1995). These life measure questionnaires rate aspects of the following areas: general life satisfaction, finances, religious beliefs, legal and safety issues, health, social functioning, attitude to mental health services, living situation, daily activities, and work.

Although we might need to adapt these to include an emotional or psychological component, outcome measures for this population might be items such as "Does it help me feel better about myself?," "Does it help me relate better to friends and family?," "Does

it help me get a job?," and "Does it keep me out of hospital?"

With these considerations in mind, we deliberately adopted a range of questionnaires, three of which measured social functioning and mental health: Clinical Outcomes in Routine Evaluation (CORE), Life Skills Profile (LSP), and Hospital Anxiety and Depression Scale (HAD). The fourth questionnaire—Personal Questionnaire Rapid Scaling Technique (PQRST)—addressed issues that the patient considered important. The qualitative interview allowed further opportunity for patients to tell us what aspects of the outcome were important to them and to give some information on issues related to the process and the use of the arts medium.

Process or outcome?

In studying the existing literature, the arts therapist is faced with a dilemma: whether to look at (a) the outcome of the process itself and study or analyze sessions in detail or (b) the reflection of change in general areas for the patient. We hypothesize that both are important, and this is crucial to any study. In terms of the complexity of adults with mental health problems for whom general life changes are crucial to well-being, it is important to measure generalities in addition to arts media-based parameters and to use client-centered techniques such as questionnaires that patients and their caregivers answer themselves. Arts-based parameters reflect change but in isolation do not always verify that other changes have happened (e.g., quality of life changes), as shown in the clinical examples in Odell-Miller (1999). The study is also not diagnostically specific. It is recognized that this presents many variables. However, at this stage, the arts therapies service did not operate diagnosis-specific treatments. It was, therefore, thought to be important to look generally at the mental health service population referred to arts therapies together but to maintain information about diagnosis so that diagnostic groups could be assessed retrospectively. It was also hoped that the study might lead to some significant diagnosis-specific outcomes or indications for further research, because arts therapies are often not mentioned as effective therapies in the literature owing to the lack of outcome studies. One example of this is found in a review of effective psychotherapy treatments for patients with schizophrenia (Roth & Fonagy, 1996). Family intervention programs aimed at modification of the support network of the schizophrenic person and cognitive–behavioral treatment of acute symptoms are mentioned as effective treatments, but not arts therapies. However, arts therapies are mentioned as

treatments of choice for patients in a Department of Health survey "Treatment Choice in Psychological Therapies and Counselling" (Department of Health, 2000). All this leads to the recognition of the need for outcome studies in the arts therapies.

Anecdotal single-case study evidence

Anecdotal evidence from single-case studies is often seen by therapists as convincing in terms of the efficacy of the treatment, and the following example illustrates the positive and negative aspects of this in terms of research design. Some cases were examined retrospectively as part of the pilot project, looking at outcome in relation to reason for referral. A very interesting phenomenon is illustrated in the final vignette in Odell-Miller (1999, p. 133). Four years after the beginning of his therapy, toward the end of treatment, the patient is talking about one of the issues he mentioned on the original referral form. He filled in his own referral form and wrote as reasons for wanting therapy "coming to terms with my personal problems" and "some problem expressing myself; I would rather leave a situation than deal with it." His key therapist, as well as the patient himself, also had a notion that music therapy would help because of a constant underlying affect of rage toward everyone with whom the patient came into contact. The clinical excerpt described in Odell-Miller (1999) shows that the patient has developed insight into these problems, which were originally articulated by him. The vignette described is part of a normal session and was examined as part of the pilot study for this research. It shows a way forward in how to ask the right questions when designing the research tools. For example, we can see that the patient is able to use the therapy to explore the very issues he mentioned at the start of therapy and that the therapist believes that the patient's anger toward others has subsided. Other team members believe that there is a direct link between this change and the patient's involvement in music therapy. They report that he seems easier to get along with and less angry. There are also other major changes that have taken place over the period of therapy (e.g., he has improved his access and relationship to his children). These changes cannot be attributed to music therapy without the patient being part of the research, but from this we can learn that we need to design questionnaires relating to expectations of patients and to design questions that should be asked of the therapist and patients. The PQRST questionnaire described later is ideal in this respect.

The therapist–patient relationship is often reported by arts therapists as a crucial tool in bringing about an effective treatment outcome. According to Rogers (1995), it is essential to pay attention to the patient–therapist relationship. She points out that patient and therapist may have radically different ideas about whether the relationship or the arts therapy process (music therapy in this case) as a whole is making the most impact on the patient. In view of this, she points out that, unless the patient is involved in evaluation, the research could be entirely based on the subjective views and aims of the therapist. This again influenced the design. We were particularly keen to use the PQRST measure because it allows people to think of their own goals and also is more suitable for severe mental health problems than, for example, the CORE measure, which was not designed for people with psychotic symptoms. The qualitative interview design was, therefore, developed in order to gather data from both patients and therapists about the process.

Further qualitative considerations

Owing to the reasons stated previously, it was decided this project would be concerned with outcome, how to define it and how to measure it. Outcome is defined as the effect or result of an event or of circumstances. Therefore, we must assume that, in discussing outcome in arts therapies, we are relating the particular outcome to the events or results of music therapy. The questions used in the pilot project (Odell-Miller, 1999), which later formed the basis for the qualitative interview in the main project, is summarized as follows: What are the benefits to you of this therapy? In your life in general? Are there any changes you have experienced that you could attribute to this therapy? What is different about this group music therapy (or other arts therapy) in what it offers you compared with other treatments or forms of help? What makes the group play music (or use another arts medium) and stop talking?

Based on data from the pilot study, these issues were grouped under headings, and a topic guide was developed that formed part of the main qualitative interview. Topics were relationships, nonverbal interaction, self-expression, and access to feelings. Although it is clear that music, art, dance, or drama and the arts relationship is a major vehicle for change and development, this cannot be deduced from purely listening to the music or examining the art form. In highlighting issues in more detail, we begin to see that the art form and the whole person are inextricably bound up and that we cannot separate one from the other. It is also important for fund holders, managers, and other colleagues to be able to generalize and articulate expected outcome.

Method

Participants

The sample population included patients referred from adult psychiatric services to arts therapies services. All participants had continuing complex mental health problems (e.g., schizophrenia or a mood disorder such as depression or bipolar affective disorder) and were receiving a normal episode of psychiatric treatment. Their illnesses were generally quite severe (see Table I for the distribution of their psychiatric diagnoses); all were on prescribed medication, and all had been admitted to the hospital at different times. Some of the patients remained in the hospital during the study, whereas others were able to live in the community; none was well enough to be employed full time. Of the original sample of 45 participants, 25 (15 women and 10 men) completed all the questionnaires. The mean age was 36.8 years (11.9 *SD,* range = 20–60). The mean length of psychiatric history for all the recruits was 11.3 years (8.9 *SD,* range = 1 month to 33 years). These figures did not differ significantly for the subset of patients who actually finished the study.

Referral

A referral for arts therapies treatments was made by the participant's key worker (community psychiatric nurse, ward nurse, or occupational therapist) in consultation with the psychiatrist. The most common reasons were the patient's own request and an interest in the medium. Patients presented with a variety of problems (Table II); most had problems in more than one category. Several of the more common problems (withdrawal, difficulties with relationships, difficult to engage) are difficulties in communicating; the benefit of arts therapies is seen as offering an alternative, nonverbal mode of communication. Patients were randomized to either the treatment group or the control group and completed the questionnaires for six months.

Table I. Distribution of diagnoses

Diagnosis	Frequency
Schizophrenia (F20)	9
Bipolar affective disorder (F31)	6
Depression (F33)	3
Recurrent depressive disorder (F32)	3
Schizoaffective disorder (F25)	2
Dementia (F02)	1
Eating disorder (F50)	1

Table II. Currently presenting problems

Current problem	Frequency
Difficulties with relationships	16
Withdrawal	14
Anger	13
Difficulty coping with life events	13
Affect variation	12
Difficult to engage	12
Overanxiety	10
Suicidal ideation	10
Substance abuse	9
Delusions	6
Difficulty coping with trauma	5
Self-harming	5
Inappropriate referral	4
Bereavement	3
Hallucinations	3
Somatic symptoms	3
Incoherent speech	2
Depression	1

Referral criteria are discussed by Odell-Miller (1999), but the following were the most common criteria at the time: difficulties in dealing with depression, problems relating positively to others, difficulties with communication, problems with understanding the meaning of their behavior, difficulty managing feelings, problems of self-confidence, difficulty making sense of the past, difficulty overcoming traumatic experiences, and problems relating to loss and grief. The usual referral procedure is that a member of the multidisciplinary team or key worker for a particular patient would fill in a detailed referral form in discussion with the patient's consultant psychiatrist and the patient. The form is then sent to the arts therapies clinical manager, and normally an assessment is carried out. The patients in the treatment group had arts therapies input over the six months (and this would typically continue after the study period), whereas the control group was eligible for treatment after their participation. Patients in the study also received their normal psychiatric treatment, which would typically entail medication, and contacts with their key worker and psychiatrist.

Randomization process

To achieve sufficient statistical power in order to obtain 95% confidence levels, we planned to recruit at least 20 patients each for the control group and the treatment group. The total number of patients recruited was also limited by the length of time we could run the project, which, in turn, was dictated by funding.

All potential participants for the study were screened by arts therapists to assess their suitability for an arts therapies treatment. Any patients regarded as unsuitable for arts therapies treatment were not approached further by the research team. After agreement was reached that the referrals were appropriate, the patients were invited at that stage to take part in the research. The first interview with a patient was semistructured and had the aim of developing a set of five statements to be used in the PQRST, obtaining informed, witnessed consent to participate, and obtaining the first set of measures (including identifying a significant other to complete the LSP).

At the next stage participants were randomly allocated to the treatment group or control group: Two successive patients would go to the treatment group, then two to the control group, and so on. This clearly should lead to an equal number of patients in the treatment and control groups; however, in practice this was also affected by different numbers of people dropping out of the research. The randomness of this process depends on the random arrival over time of patients to the service; this was felt to be a valid assumption. Thus, the randomization process was after the intervention (arts therapy) was assigned.

Patients in the treatment group received a routine arts therapies assessment, which determined the therapy medium, and moved on to the appropriate therapeutic program (Table III shows how many patients undertook therapy in each medium and which format [group or individual]). As indicated in Table III, the experimental group was dominated by art and music therapy; only one patient received dance–movement therapy, and no one received dramatherapy. Although we might have preferred a more even spread, this reflected both the availability of spaces for the different modalities at that time and the suitability of particular patients, as determined in the assessment. The rationale for obtaining the first set of scores before assessment was that the assessment itself can often be a therapeutic experience and forms a part of the intervention. During the research, all participants concurrently received a standard episode of psychiatric support.

Table III. Numbers of patients using each arts medium

Patient no.	Therapy input (medium/format)
1	Art individual
2	Art individual
3	Music individual
4	DMT individual
5	Art individual
6	Art group
7	Music individual
8	Art group
9	Art individual/group
10	Music group

Note. DMT = dance–movement therapy.

The randomization process was implemented as follows: The manager of arts therapies assessed patients for suitability for arts therapies, and the researcher allocated the patients to either the treatment or the control group. The research assistant met the patients to enroll them in the study and later to administer the questionnaires.

The interviewer was initially unaware of the outcome of randomization. In practice, this anonymity could not always be sustained because patients would sometimes inadvertently reveal this information in discussion.

Measures

The four questionnaires gave a good overall mix of information based on personal issues (PQRST), the overall level of distress or severity of symptoms (HAD and CORE), and an objective measure of the patient's presentation by a third party (LSP). The interview also gave qualitative data, which could be cross-referenced with the quantitative scores. The questionnaires were administered three times (at zero, three, and six months), except for the PQRST, which was administered monthly (i.e., seven times). The PQRST questionnaire was administered more often because it was felt that this measure particularly captured the benefits of therapy and might show changes more immediately.

PQRST (Mullhall, 1978). This questionnaire is based on five issues that the patient identifies as important. The issues were framed in a quantifiable way (e.g., "My level of confidence is . . . ," taking account of whether an increase was desirable or undesirable. From a series of comparisons (e.g., "little" vs. "considerable"), a score was arrived at for the patient's satisfaction with that issue, and the five scores were totaled. This measure reflects issues directly relevant to the patient and hence fits well with the aims of therapy.

Hypothesis 1: Realistic personal goals that the patient identifies as important are more likely to be reached after arts therapy input.

HAD (Zigmond & Snaith, 1983). This measure is well used and has been shown to have validity and reliability in measuring the symptoms of anxiety and depression The HAD measure was chosen because many of the patients in the referral population do suffer from anxiety or depression or both.

Hypothesis 2: Patients referred to arts therapies commonly exhibit symptoms of anxiety and depression (even if this is not their primary diag-

nosis). Symptoms of anxiety and depression are ameliorated by arts therapy input.

CORE. This patient-completed questionnaire provides an indicator of global distress from the total score. Four subcategories indicate the level of symptom severity, social and life functioning, general well-being, and risk to self or others. The average score, between 0 and 4, was calculated for each subcategory and for the whole questionnaire; a high score represents a high level of distress. If any risk questions were answered positively, the relevant health professionals were informed.

Hypothesis 3: Symptoms of psychological distress as measured by CORE are ameliorated by arts therapy input.

LSP. This was the only questionnaire not completed by the patient. It is designed for people with chronic mental illness and is completed by a third party (in this case key worker) who knows the patient well. Functioning is assessed in categories of self-care, communication, nonturbulence, responsibility, and social contact.

Hypothesis 4: Functioning in a patient's daily life is improved by arts therapy input.

Six-month interview. Complementing the quantitative aspect of the study, the patients who were in therapy were interviewed at the end of their 6-month participation. A set of questions arising from the pilot study was used. They typically became more of a checklist for the interviewer, in an informal topic-guided interview, focusing on the usefulness of the therapy in general and the importance and use of the arts medium in particular. At the same time, the therapists were asked to produce a report, using the same list of issues as prompts. It was hoped that the two perspectives would reveal something of the arts therapy process and where it might be distinguished from purely talking therapies.

Hypothesis 5: Information on the process of arts therapies may be gleaned directly from patients, and this will coincide with the views of the therapists as demonstrated through clinical reports.

Statistical methods

Because the PQRST data cannot be assumed to have a metric scale, a nonparametric test, the chi-square statistic, was used. For the other three measures (HAD, CORE, and LSP) the analysis of variance (ANOVA) parametric test was used. The interview

data were analyzed using qualitative methods: Quotations from the patients were grouped into themes and compared with the comments from the therapists' reports. When possible, the qualitative data were cross-referenced with the quantitative scores.

Results

Participant Flow and Recruitment

The flow of participants through the stages of the study is shown in Figure 1; 45 patients enrolled in the study, although some left before completing all the questionnaires. Of the 25 who did complete all the questionnaires, ten were in the treatment group and 15 in the control group. Only the results from these 25 patients are included in the analysis; the missing results for patients who dropped out were always in the latter half of the 6-month period, so extrapolation would have been difficult. The interviews were carried out between November 1998 and May 2001; a research assistant was employed between September 1998 and September 2001, thus including time for setting up and compiling results.

Numerical results

The numerical data comprised the results of the four questionnaires. For each patient there were seven PQRST questionnaires and three each of the HAD, CORE, and LSP questionnaires. By comparing the numerical scores of the two groups and using
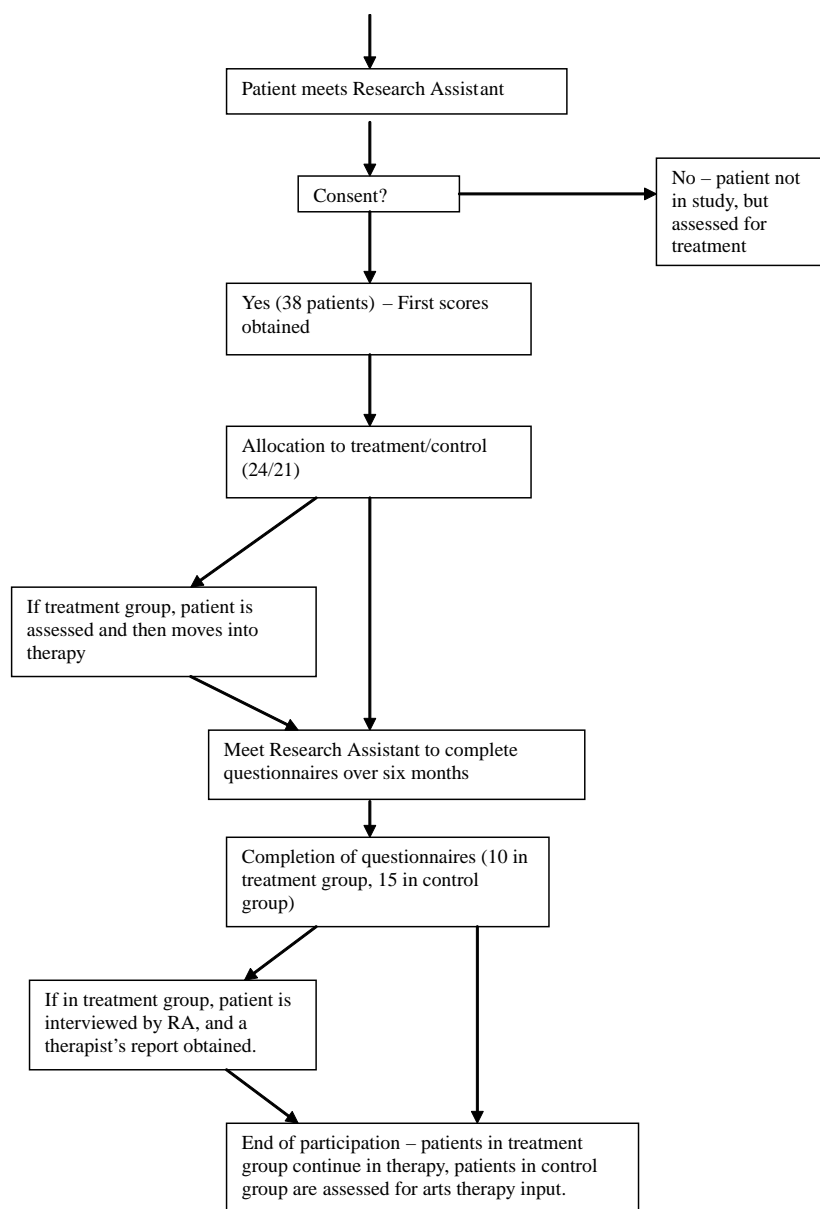
Figure 1. Flow chart to show progress of participants through the study.

standard statistical tests, we hoped to investigate whether arts therapies input made a statistically significant difference to patients' well-being.

PQRST analysis. Because the PQRST data cannot be assumed to have a metric scale, a nonparametric test, the chi-square statistic, was used. For a 7×2 table, $n = 6$ and the critical value is 12.592; the actual value of the statistic was calculated to be 1.952, so no significant effect of time or treatment could be shown.

PQRST: Ancillary analysis. The prior calculation was done using the totals for all five problems. However, we felt that in some cases (perhaps to make up the number to five) patients had selected problems that might not usually be associated with the outcomes of arts therapy (e.g., "My level of fitness is . . .," "My belief that I will ever get better is . . ."). With this in mind, the problems were ordered according to the initial score, and the chi-square analysis was recalculated using only the problem with the worst initial score, then with the two worst initial scores, and so on. The resulting chi-square statistics (7.714, 5.325, 7.321, 4.005, 1.952) are all still under the critical value but are noticeably higher when only the most pressing problems were considered. The approach of ordering by the initial scores was felt to be more objective than the alternative of attempting to filter out problems by their relevance to the aims of therapy. In any case, concentrating on only the single worst initial score eliminated the examples cited previously.

ANOVA. For the other three measures (HAD, CORE, and LSP), the ANOVA parametric test was used. The results are shown in Tables IV, V and VI: The p value represents the chance of the particular result purely because of random variation; the conventional cutoff is .05. For the CORE measure the score for each question ranged from 0 to 4, and the average was taken for all the questions. For the LSP measure a high score indicates a level of functioning, whereas for HAD and CORE a high

Table IV. Hospital anxiety and depression scale scores (maximum $= 42$)

Time	Control group		Treatment group		
	M	SD	M	SD	p
1	19.5	11.2	17.9	11.8	.729
2	17.3	11.3	16.9	8.8	.920
3	15.1	10.3	16.6	10.1	.716

Note. For reference, the maximum scores for Life Skills Profile is 156.

Table V. Clinical outcomes in routine evaluation scores (maximum $= 4$)

Time	Control group		Treatment group		
	M	SD	M	SD	p
1	1.72	1.10	1.24	0.95	.277
2	1.37	0.86	1.17	0.79	.574
3	1.30	0.95	1.32	0.78	.948

Note. For reference, the maximum scores for Hospital Anxiety and Depression Scale and Life Skills Profile are 42 and 156, respectively.

score indicates a high level of distress. In none of the tests is $p < .05$, so no significant effect of time or treatment was shown (within or between group). Significance tests were also carried out for the subscores but showed no significant results.

ANOVA: ancillary analysis. Additional analyses were carried out with the data grouped according to diagnosis (schizophrenia was separated from the mood disorders). No significant results were obtained because the sample size was too small.

Qualitative results

Several approaches to qualitative analysis of interviews exist, some of which are rigorous but rather mechanistic, involving counting the occurrences of significant words. We felt that in a small sample people would express concepts differently from each other and that this approach would not add anything to the professional insights of the researchers. Instead, we chose a more interpretative approach based on the concept of grounded theory (see, e.g., Glaser, 1978; Glaser & Strauss, 1967). All the patient's significant quotations from the interview were selected and then arranged in related blocks (e.g., all the comments about the medium). To a certain extent this coding stage was influenced in advance as a result of the pilot study. Therefore, a focus of the interview was the difference for the patient between the arts therapies and other (e.g., talking) therapies. Comments about the arts medium were bound to form a theme in the analysis;

Table VI. Life skills profile scores (maximum $= 156$)

Time	Control group		Treatment group		
	M	SD	M	SD	p
1	127.9	13.7	133.1	11.3	.326
2	131.3	12.5	131.7	13.9	.936
3	136.3	9.6	129.5	12.5	.139

Note. For reference, the maximum scores for Hospital Anxiety and Depression Scale is 42.

however, apart from this constraint, the coding stage was approached without prejudice. No analysis of the number of times a theme was mentioned within an interview, or between interviewees, was attempted; in a small sample this would have had limited use.

Once the patient interview was coded into themes, the therapist's report was compared with these themes, and representative quotations from each block were tabulated with corresponding quotations from the therapist's report. The themes might be different for each patient, although we will see that common themes did emerge.

For each patient, the demographic data and the scores from the questionnaires were also summarized to give a picture of the patient and relate the subjective impressions to the numerical results. Thus, a case study was constructed for each patient, and overall reflections were given to highlight the agreement between the therapist and patient and to try to understand the possible reasons for discrepancies. Two sample case studies are given in Appendix I. This whole process was carried out by the research assistant, who had also performed the interviews. Five themes appeared many times for different patients and are discussed next. We will see in these examples, and in the case studies in Appendix I, that a remarkable degree of agreement was found between the therapist's and the patients' view of their encounters. In the following examples, the relative imbalance of the different modalities in the experimental group (see Table III) is reflected, with art and music therapy dominating. In summary, points of agreement were found in almost all the interviews, especially in describing the quality of the rapport, even when both agreed the therapy was not particularly successful.

Rapport with the therapist

This area is obviously very important in any form of therapy. In most cases, the patient felt the therapist was personally important to them (e.g., in the context of a group, expressing a wish for more attention from the therapist). In one or two cases, either there was quite a fragile rapport or the patient decided to terminate therapy altogether, but even here there was a large measure of agreement between the two parties.

Linked to the rapport is the level of involvement of the therapist in active participation. Some arts therapists limit their own participation, instead commenting on and supporting the patient's endeavors, adhering to a more psychoanalytic model. These issues are explored further later. In some cases, the patients appear to have drawn great support from the therapist's involvement.

> Patient J33: I think it puts thoughts into my head, like I did a drawing of myself at home with my door closed and I put lonely on it, and [the therapist] did a neighboring house with a pathway going up to my door.

> Patient E26: And she played jazz for me. And I played jazz on the xylophone, and it was terrific. The piano and the xylophone together. It was really nice ... I loved to hear the sound of rhythms getting together.

> Patient F02: The thing is that you are confiding in someone who is leaving it confidential and you can talk about anything whether it's art therapy or whatever. I find the lady's got a lot of wisdom and she helps me in the feedback. I try to cope with everything on my own if I can, but I must admit the art therapy is doing me a lot of good, it's not a waste of time.

> (Patient F02 was a man suffering from schizophrenia. His LSP, CORE, and HAD scores remained stable; the PQRST scores fluctuated over the seven meetings but ended a little higher, from 35 to 41.)

Patient E26, who has a diagnosis of schizoaffective disorder, also expresses her appreciation of her therapist:

> She's very nice ... It [the relationship] was as important as doing the music, yes.

Use of the medium

Clearly, the use of the medium was a focus of the interview, and the patients gave a variety of answers, showing the value of the art forms for them in terms of self-esteem and the alternative way of expressing their problems.

> Patient E26 (on music therapy): You're actually taking part in something. And achieving something.

Her therapist agreed that "she readily engages in playing the instruments and it is obviously an enjoyable medium for her."

> Patient M31 commented on a particular use of the nonverbal medium. Her art therapist wrote that "the group has tended to use the shared picture

space as a 'graffiti' sort of wall in which to write what cannot be said."

Sometimes it was difficult to communicate verbally amongst the group, it was easier to express yourself up on a wall you know, and to actually draw or write words or communicate through that way.

Patient J33, previously quoted, had a diagnosis of schizoaffective disorder. Here she describes using the image of a cabbage to represent her depressed state:

Putting things down so that you can see them. Sometimes images, you know, I put down a cabbage once. I described myself as a cabbage and [the therapist] drew a cabbage and . . . it keeps a record of things better than when you're just talking.

Her art therapist mentioned her being "in a deadly 'cabbage-like' state, very depressed," also "a way of working with the medium which I think was crucial to her way of relating to me in the room." Linking this qualitative analysis with the PQRST measure, we recall this involved the patient choosing five problems that were important issues for her. Patient J33's five problems were as follows: "My level of self-esteem is . . .," "The amount of time I feel I have someone to turn to is . . .," "The amount of time nonachievement of goals troubles me is . . .," "The amount of time I gain pleasure from my day is . . .," and "The amount of time I feel at a loss what to do is . . ."

We can see that these problems were all being addressed in the therapy. The PQRST scores did show an improvement from 8 to 24 between the first and sixth scores; however, at the final meeting, J33 commented that she had had a bad week, and her PQRST score relapsed to 11.

The effect of prior experiences of the medium

This was one area in which the therapists' reports were usually silent, because they naturally focused on the actual therapy process; however, in several cases, the patients mentioned their prior experiences, good and bad, and these may well have impacted on their initial perceptions of the therapy.

Patient M45 is diagnosed with schizophrenia and was attending a music therapy group. For him, music was clearly a valuable part of his life outside the group:

I like the experience of music as well, I'm not a great player myself, but it's what I've always listened to in my heart, to keep going.

On the other hand, Patient E12 describes a negative experience of music as a child:

My mother . . . started to teach me to play the piano, and I hated it and I never learnt. So I have a past history of not liking music.

Her music therapist realized she "may feel herself to be 'unskilled' in relation to the other members of the group." This aspect of her history was at times a barrier in terms of being able to participate fully in sessions; however, it also enabled her to both address some difficult issues from the past and move on by feeling the support of the group when she did manage to participate. This led to feeling a sense of achievement.

Somebody else said why don't you do this . . . I started banging away, and it eventually turned, they said it fitted in with what they were playing, but I don't know about that– the rhythm was the same as theirs, I think.

Benefits in terms of personal issues

A number of patients cited particular issues that they felt had been explored and helped by the therapy. In some cases, these were issues that were in the PQRST problems but, interestingly, not in every case.

Patient E26 appears to have addressed one of her PQRST problems: "The amount of time I've been able to get a good night's sleep is . . .":

I was getting up through the night, smoking and having a drink . . . But that's improved, considerably.

Patient J33 mentions the benefits she has found in terms of her relationships:

We were talking about my sister and I think . . . since I've been doing art therapy I've put more into the relationship. . .it's more of a two-way relationship, because [the therapist] was saying . . . I depend on people and . . . if I want relationships . . . I've got to put something into them, and I find that difficult. I'm quite absorbed with my problems, and I'm working on that."

Patient L29 had a diagnosis of bipolar affective disorder; she talks about the motivational benefits

of arts therapies. One of her PQRST goals was "The amount of time I feel things are a chore is …"

> People who are depressed … I mean it's happening to me still now, you get very lethargic, and you close within yourself … day-to-day is just getting up, doing what I've got to do, going to bed, there's no joy in it … doing things like art therapy and dance therapy requires a degree of activeness.

Patient M31 also appears to have found benefits in terms of personal issues:

> I have found it beneficial, yes. It's been interesting to talk about my life generally, you know as a child, which has made quite an impact on my adult life. I don't know whether that's good or bad, but it has affected my adult life, what's happened to me in my childhood, in a lot of ways.

> I think the art therapy has given me quite a lot really … it's filled sort of a space that my father hasn't been there.

Group issues

As in the rapport with the therapist in individual therapy, we find issues that also come up in a talking therapy. For example, Patient M45 found benefit in the commonality of others' experiences:

> 'Cuz other people have the same problems as you, you can share it together, what you've been through.

Patient M45's music therapist felt "he interacted with others well through talking and music making and started to relax in the group."

Patient E12 was quoted earlier; some of the issues mentioned previously are brought out in group issues:

> Because we know each other so well, if someone was trying to persuade you to go and do something, which I normally wouldn't take any notice of, but, we've become friends now, so I get up!

Her music therapist mentions that "when she is 'enjoying' a rather vigorous teasing game with another group member, she often responds to humor in this way apparently…despite herself." One of her PQRST problems was "My self-confidence is …"

One of Patient M31's PQRST problems was "The amount of time I feel accepted by others is …"

I only really got to know B … most of all in the group … a bit of a criss-cross mismatch … I can understand her sort of feelings for it's affected her and … me in similar ways…I'm beginning to realize…how much other people are affected as well.

It is noticeable that several of these comments correspond with some of Yalom's (1995) therapeutic factors. For instance, the comments from Patient J33 show instillation of hope in operation, and the quotes on personal issues relate to Yalom's existential factors. Finally, the discussion of group issues shows the benefits of universality (the recognition that other patients may have similar problems) and the development of socializing techniques.

Discussion

Measures

By definition, a measure of a patient's subjective state of mind is never perfect, and the questionnaires were designed to focus on different aspects of their presentation, giving different advantages and disadvantages.

PQRST. The PQRST measure was chosen because it should identify the issues that are directly relevant to the patient, and the focus on the patient as an individual accords well with the aims of therapy: to explore personal issues. A possible disadvantage has already been mentioned in that people sometimes chose problems that might not be realistic goals to work toward in therapy. Another possible disadvantage is the increased complexity (and hence cognitive demands) of the questionnaire compared with the more standard format of the other three. In some cases, patients found the subtle linguistic distinctions difficult.

HAD. The HAD measure was chosen because many of the patients in the referral population do suffer from anxiety or depression. However, it is also true that for some patients these symptoms are not particularly apparent; for instance, a person with schizophrenia might not show overt depressive symptoms because these are often masked by severe psychotic symptoms.

LSP. The advantage of the LSP questionnaire is that the key worker's responses give an objective measure of how the patient appears to and copes with the outside world. The disadvantage is that the measure can be removed from issues that matter in the patient's internal world (i.e., the ones that are primarily addressed in therapy). One hopes that there is an indirect effect: If these issues are resolved

in therapy, a patient becomes more ready to engage with others, and there should be outward signs of this. We hope for the communication score to increase, but also, more indirectly, the other categories such as self-care might improve. Another disadvantage in the application of the LSP in this project has been that key workers can change relatively frequently. It seems likely that extra variability was introduced when this happened.

Clearly, these observations had an impact on the possibility of finding a clear difference between the treatment and control group. The more general reasons for the lack of significant results are discussed next.

Reasons for the lack of significant results

The most obvious reason for the inconclusive nature of the numerical results is the difficulty in recruiting and retaining enough participants in each sample. Patients and their key workers were often understandably unhappy about the possibility of having to wait 6 months for treatment. Once in the study, patients were able to exercise their right to leave at any time. Twenty people left the study for a variety of reasons (e.g., physical health, death, moving out of the area), and in some cases no reason was given. In general, the effect of a third party asking the patient questions on quite personal issues is an unavoidable extra factor in the design; in the case of the treatment group, of course, this was at the same time as the exploration of issues in therapy. Some patients may have found this difficult in considering whether to participate or continue participation. It is worth noting that other workers on therapy outcome studies have found dropout rate to be a problem in establishing significant results (e.g., Jones & Asen, 2000). Apart from the small sample size, which in itself made the task of showing a significant difference almost impossible, there were numerous sources of variability, which would obscure any treatment effect, among them (a) age, gender, socioeconomic, cultural background of patient, (b) diagnosis of patient, (c) different therapists, different arts media, individual or group treatment (for the treatment group), (d) different treatment regimens apart from the arts therapy input, (e) different raters for the LSP, and (f) three different researchers.

Some of these sources of variability were unavoidable (the last three). The others were a feature of the design, which sought to achieve ecological validity by testing the effect of the actual service offered by the Arts Therapies Department. This meant taking the population of referrals to that department, rather than a subset (such as people with schizophrenia or depression), and including all the arts media and therapists in the treatments. Considering a subset of referrals by diagnosis, or restricting participation to one arts medium or even one therapist, could have reduced some of the variability, with the cost that any conclusion of a beneficial effect would apply only to those conditions. There is also the obvious drawback that such a restriction would have made the recruitment of sufficient participants even more difficult.

Finally, six months may be too short a time to look for positive change from a therapeutic input, given the severity and long-term nature of the conditions represented in this population. For example, Patient J33 appeared to show an improvement in PQRST scores but said she had a "bad week" when she completed the final questionnaire, which did show a relapse. It is possible that a longer study period would have enabled her improvement to be sustained. This effect might be more important for different diagnostic groups; for instance, one hypothesis for future research might be that people with schizophrenia take longer to engage in therapy than people with affective disorders.

In summary, in hindsight, it was not possible to achieve sufficient statistical power to prove results using the RCT design. Our opinion is that if a similar project were to be undertaken in the future, it would need to be larger in scale and use a longer evaluation period for the questionnaires. To guard against the problems of high dropout rates, the project would need to run for a sufficient time to recruit a large group of patients, and several centers would probably also need to be used to recruit patients. Given the difficulties of funding and then undertaking such a project, future progress in quantitative arts therapies research may tend more toward designs that do not have the rigor of the RCT paradigm yet still show good quantitative evidence, for example, designs in which data can be collected from (a) patients in therapy without affecting therapy and (b) perhaps from their peers in the same unit who are not undergoing therapy. In this kind of design, the randomized element is missing, and the results are complicated by the effect of the referral criteria, but it might still be possible to gain useful information without the impact on therapists and patients.

Qualitative results

Although the different research assistants followed the same guide in the interviews, clearly patients' responses varied enormously. In the context of this project, some additional variables were present, in that all four possible media (art, dance, drama, and music) were used, and there were almost as many different therapists as there were patients in treatment. There were differences in theoretical

orientation within the Arts Therapies Department, although most therapists attach importance to psychoanalytic ideas but may implement these differently. For instance, two music therapy groups, run by different therapists, feature in the study; one was significantly less directive than the other. One therapist might suggest playing music if she thought it appropriate, whereas the other would not do so (the instruments were simply available, and the decision to play was always the patient's). Clearly, the different roles for music in the two groups might lead to a difference in its perceived importance for the patients and different answers in the interviews.

This seems to reflect a difference in the way the psychoanalytic paradigm is applied, when the complicating factor of a second medium is present. In a psychotherapy session only talking is available, and the decision to talk or not is almost always led by the patient. The additional decision, to use the arts medium or not, will be mediated by the patient's relationship to that medium and their experiences of the medium in the past, which may create barriers to using it in the present. This can be seen as another field to explore in the therapy or as something to be overcome to unlock a possibility of alternative expression. Both approaches are valid and represent the individual compromises, which therapists make in finding their own theoretical stance.

Linked to this is the degree to which the therapist was involved directly in the medium. The idea of nondisclosure, crucial to preserving the purity of the transference in the psychoanalytic encounter, may be seen as compromised by the arts therapist's artistic expression, and some arts therapists do limit their own participation rather commenting on and supporting the patient's endeavors. This approach may be more practical, or at least more common, in some media (e.g., art) than others (e.g., music).

There were themes that were more particular to the patient and themes that had some overlap (e.g., four patients mentioned issues of commitment or engagement with the therapeutic process). It is noticeable that some themes were mentioned that are common to therapy in general, the rapport with the therapist being most obvious, but also other issues such as engagement and group dynamics (for those patients in group therapy). On the other hand, the use of the medium is clearly the factor that distinguishes arts therapies from other therapies, and this was a theme for every patient, not least because it was a focus of the questioning.

These examples give a picture of the added level of complexity, which the arts medium gives to therapy, compared with verbal approaches. However, the added value in terms of another mode of expression was shown in many cases, and the agreement between the patients and therapists on the amount and way the medium was used is striking. The following are quotations from four different patients:

> I find it easier to paint and chat rather than just chat and look into someone's eyes I guess.

> Sometimes, I can't believe what I've put down. Like one time I put all space and rockets taking off into the future and stuff . . . So I think it shows how I can be and how I have been . . . I'm not very good with words. I think in terms of symbols and I find pictures easier to express things sometimes than, well, using words.

> Sometimes you don't want to say anything about your problems and sometimes you can say it musically, in that way.

> Sometimes it was difficult to communicate verbally amongst the group, it was easier to express yourself up on a wall you know.

Conclusions

This study set out to investigate the effectiveness of the arts therapies for a population of adults with continuing mental health problems. We were not able to do this quantitatively for the whole group of patients, although individual case studies showed some numerical trends that could be linked to patients' subjective impressions. We conclude that to show the efficacy of the arts therapies using strict quantitative methods would require a large amount of resources, probably focusing on one arts medium and possibly one set of psychiatric diagnoses, and carrying out the study over an extended period of time in order to recruit sufficient participants and show reliable change. However, we also conclude from the qualitative part of the study that patients value and use the different arts therapies well and can articulate the added value compared with talking therapies, and that these impressions tally well with the therapist's viewpoint.

Acknowledgements

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Appendix I – Qualitative Case Studies

In this section two representative case studies are given (one music therapy and one art therapy), to show in more detail how the qualitative research was carried out. The client's words are taken from the interview after six months in the research project (and therefore six months in therapy); the interview was based around certain questions (please refer to sections 3.3, 3.4 and 5.4), but variations on these themes came up in different interviews. We were then able to compare the themes with the therapist's report at the same time. The themes are given in tabular form, with corresponding quotes from the therapist and client set beside each other. They give an illuminating picture from both sides of the therapy process, with in most cases a remarkable degree of agreement. At the beginning of each case study, some information is given on the patient's past psychiatric history, and a summary of the numerical scores. The scores are then correlated with the events described by the patient and therapist, where this seems justified; the points of convergence or divergence in the views of patient and therapist are also summarized.

Client E26 – Qualitative Themes

This woman was 60 years old at the time of her participation. She had a 33-year psychiatric history, and was diagnosed with schizoaffective disorder, for which she was receiving anti-psychotic medication. Her diagnosis had only changed within the last 20 years; she had been admitted to hospital within the last ten years. She was now retired and lived with her partner. The referral was for music therapy, at her own request – she suffered from somatic symptoms, delusions, hallucinations, affect variation and difficulty in coping with life events. Previous support included drug therapy, occupational therapy, GP support and a Day Centre programme.

Over the study period, her anxiety and depression scores both decreased, the total HAD score going from 5 down to 2. The CORE scores also decreased, the overall score decreasing from 0.35 to 0.24 to 0.21. So both the HAD and CORE measures indicate a small improvement. The LSP scores moved from 136 to 134 to 123, so indicating a deterioration; however this could be due to the third questionnaire being completed by a different rater.

The PQRST scores increased (improved) from 25 to 40 during the study period but then decreased again to approximately the same level (28); the decrease would seem to be due to responses to concerns about world events, and about her sleeping patterns. The interviewer for the questionnaires comments on E's lack of insight (she claimed to be completely well and cured of schizophrenia) and felt that this might account for the CORE and HAD figures which indicate a generally low level of distress.

For this person, the therapist's and client's comments did paint a somewhat different picture, at least on the surface. There is little reference by the client to being able to stay with difficult feelings, which the therapist felt was a benefit of the music. However, the therapist comments on the client's tendency to dissociate from her feelings in talking, and to move into delusional or grandiose thoughts. The interview provided several examples of this. This perhaps illustrates a general difficulty in talking with a third party about difficult feelings, but also when the client is not yet ready to put into words the feelings experienced while playing music. Both client and therapist allude to the client's enjoyment of music and playing together; they also imply that there was a positive relationship between them, even if the client's comments are rather idealized.

Theme	Client	Therapist
Use of the medium – Musical interaction	..and she played Jazz for me. And I played Jazz on the xylophone, and it was terrific.. The piano and the xylophone together. It was really nice. I loved to hear the sound of rhythms getting together.	Interaction musically allows her to be a bit more adult and appropriate with another person in a more mutual way through playing music together
Use of the medium – Enjoyment	You're actually taking part in something. And achieving something. I love music. I listen to the radio a lot.	She readily engages in playing the instruments and it is obviously an enjoyable medium for her
Rapport	She's very nice … It was as important as doing the music, yes. And she's a wonderful lady.	Interaction musically allows her to be more adult and appropriate with another person in a more mutual way ..This interactive quality.. also allows E to connect with another person and in so doing express feelings, often of sadness, that in another context, I suspect, she hides.
Issues	Well, it's got things into a sense of proportion. I was getting up through the night, smoking and having a drink.. But that's improved, considerably.	
Delusions	I've achieved the right to play music live on stage if I can. I'm an Arabic Jew.. And that's what I am.	Talking for E often results in delusional thinking and this then becomes a defence against being able to feel in speaking by itself, she tends to split off from feelings and go into grandiose thoughts.
Expression of difficult feelings	Yes, we had discussions, and I found them very helpful. Well she asked me about my childhood, in my young days, if I was a happy child, and I said yes.	..and in so doing express feelings, often of sadness, that in another context, I suspect, she hides. E is often tearful and I think the music helps her stay with the feelings and work.. towards a possible place of thought

Client J33 – Qualitative Themes

This woman was 45 years old at the time of her participation, with an 11-year psychiatric history, currently diagnosed with schizo-affective disorder, treated with anti-depressants and anti-psychotics, though this diagnosis is apparently quite a recent one. Her last admission had been within the past six weeks. She had reached the level of further education.

She had had psychotherapy, clinical psychology and arts therapy input before, as well as drug therapy, and support from a day centre, OT, GP and CPN. Her problems included anger, difficulty in engaging, over-anxiety, affect variation, withdrawal and difficulties with relationships. She was referred at her own request for arts therapies, and was engaged in individual art therapy, followed by group art therapy (with the same therapist).

While the depression scores stayed more or less unchanged (at a very high level), the anxiety score improved and then relapsed (from 7 to 3 and back to 7). Apparently J commented herself at the third

interview that she had been having a bad week. Overall, the CORE scores seem stable; within this, however, the 'functioning' category shows quite a large increase at the second interview, which is sustained to the third interview. This implies a deterioration in functioning; the reasons for this are not clear. The PQRST scores showed an improvement (from 8 at the first meeting, to 24/23 at the 5th/6th interview), but then a relapse to a score of 11 at the final meeting. As already noted, J had said herself at the final meeting that she had been having a bad week. The LSP scores are overall quite stable over the three questionnaires, though the self-care category seems to show deterioration and then a recovery (from 29 to 20 to 26). Note that a different rater completed the second and third questionnaires to the one who completed the first one; so any trends should be in any case be treated with caution.

Several of the scores show a possible improvement, with a relapse at the end of the period of involvement, which might be temporary if, as J says, she was having a bad week. It seems unfortunate in this particular case that the period was not a little longer, to see if the improvement in well-being was recovered. Six months is clearly not very long, in terms of showing an improvement at all, but also in being able to separate a long-term positive trend from short-term variability in mood. Certainly both the therapist and client imply that she has found the therapy valuable, and we can make the hypothesis that some of the improvement in scores could be due to this.

The therapy consisted of individual work, moving towards joining a group, so there are references to both, and to the fact that J feels she has lost some of the attention of the therapist. Both make reference to the feeling of being a 'cabbage', dependent on the hospital system and unable to make the commitment to get to sessions; however, they also agree on the tentative exploration of possibilities for change. The art medium was used to express feelings of isolation, but also of hope for contact with others; the group seemed valuable in showing J the similarities and differences of others' experiences.

Themes	Client	Therapist
Use of the medium – Inertness	".. putting things down so that you can see them. Sometimes images, you know, I put down a cabbage once. I described myself as a cabbage and T drew a cabbage and.. it keeps a record of things better than when you're just talking."	in a deadly "cabbage-like" state, very depressed
Use of the medium – Being alive	"... the space one expressed my hopes, ... that I was picking up and.. I was going to take off and.. become all busy and achieve all my objectives."	Very alive..
Use of the medium – expression, and relating to the therapist.	I try to make it look a bit more like art, but I don't worry too much if it doesn't look very artistic. As long as it expresses what I mean. Sometimes, I can't believe what I've put down. Like one time I put all space and rockets taking off into the future and stuff ... So I think it shows how I can be and how I have been ... I'm not very good with words. I think in terms of symbols and I find pictures easier to express things sometimes than, well, using words. It expresses my dissatisfaction with myself, I think, my art. It's quite self –critical. You know, it pictures the sordid reality of me smoking my life away and, you know, not achieving anything ... And..some of it expresses my hopes. ... I think it puts thoughts into my head, like I did a drawing of myself at home with my door closed and I put lonely on it, and T did a neighbouring house with a pathway going up to my door.	alongside a way of working with the medium which I think was crucial to her way of relating to me in the room.
Art in the group	We only did a little bit of art, but I was the one who said I think we ought to do some art. And I started, but I think that was because we were in a new group getting to know each other. I think we, we probably used it about 50/50. You know when I did it individually, I used quite a lot of art. I would say I used about 60% art to express myself.	she instigates artwork in the group, and T felt the medium was crucial for her in the group as well as the individual work. She and the others can tolerate quite a level of hostility and conflict about difference, starting from.. images, or written messages to one another; she is the most active of the group in this.
Rapport – Being listened to	It's much more helpful than people coming to see me ... I find some of their comments quite ... negative ... you'll always have this low energy. You know, it's something you've got to learn to live with. I mean, I can't accept that.. I sometimes.. find the people that come to see me quite negative, and sometimes they ... describe me as well when I know I'm not.	It seemed important to be telling T herself how she felt, rather than opinions from health professionals

Themes	Client	Therapist
Rapport – Attention from the therapist	Well, I suppose it meant that T could give her undivided attention to me, but you know it's longer the group, it's a bit longer. And I don't feel left out, you know. I don't feel like I want her attention if she's giving it to someone else, not really. No, I find the other people's ideas interesting.	Although with mixed feelings (impatience/ anxiousness) about the start of the group She increasingly said she wanted to meet more often (including Christmas Day!),
Issues – Going back to hospital	You know when I feel that I want to go back to hospital, putting it down on paper helps me to see that that's a dead end.	She has been told she is too well, and T thinks she does actually realise this.
Issues – Relationships outside	We were talking about my sister and I think.. since I've been doing art therapy I've put more into the relationship . . . it's more of a two-way relationship, because T was saying . . . I depend on people and . . . they're all like servicing the cabbage . . . if I want relationships.. I've got to put something into them, and I find that difficult.. I'm quite absorbed with my problems, and I'm working on that. . . .	is aware of sometimes cutting herself off completely from people, . . .
Issues – Lethargy	. . . I've got to work a lot on my activity. I feel very lethargic most of the time . . . I'm very unmotivated and tired. It's lack of energy and lack of self-discipline.. and I can work on the self-discipline.	Yet at the same time lethargic
Goals	I like to get things down on paper . . . I was making a record of.. what I saw as my progress.. and it did help to have a record of that progress. I did a chart and I put my aims.. and how I would rate myself according to my activity levels, and it.. helped to have the goals down on paper as well as.. how I'd progressed from staying in bed all the time. And I think T.. can be quite critical.. You know, I think her criticism is usually constructive.	In individual sessions the artwork became "an almost cognitive behavioural approach", with a diagrammatic style, scoring from 0-10, and labelling how she is and what she would want to be doing in the future.
Ideas for change	I don't know whether I've got the guts to do that or not, but it's something I could explore in art therapy. You know, how to approach people. But it did put the idea into my head.	moving from a deadly inertness in quite a regressed state to having a desire for all sorts of things
Change – moving on from hospital	..I want nurses to look after me, but you know I can't live the rest of my life in a hospital with nurses looking after me. I've got to face the, you know, the hardships of the outside world.	but tells the group how she continues to visit the ward
Group differences/ similarities	other people's similar experiences . . . And I think one of them's got quite a lot in common with me. She's on her own. She hasn't got any children and I think she feels that.. she wishes she had had children and she gets quite lonely. . . . there's another, she's also worried about a course she's doing . . . she's worried that her illness is stopping her . . . . . . some of it I can't relate to, like two of them have got physical problems.. I suppose I'm not a very sympathetic person. I could try to be more understanding really, to learn more.. about how their additional problems are making them feel."	In a shared artwork, she uses words and images, and a real dialogue and exploration of differences and similarities is building up. The value she places on the group also seemed to be shown by her concern for the other group members
Commitment	..it helped me to stick to a commitment,.. I was just told I wouldn't have art therapy if I didn't turn up and I had to come on time. And it helps me to discipline myself to keep to a regular appointment, and..to confront my feelings about things, like going back to hospital.	this did affect her attendance at the individual sessions (10 over six months) . . . Regular attendance gradually developed alongside a way of working with the medium

Zusammenfassung

Eine Untersuchung zur Effektivität von Kunsttherapie für Erwachsene mit lange andauernden psychischen Problemen

Kunsttherapie bietet Patienten Behandlung vor allem auf nonverbale Art (d. h. durch Kunstformen wie Musik, Drama und Tanz). Das ist besonders effektiv, wenn die normale Kommunikation fehlt oder zusammengebrochen ist. Diese Studie benutzte ein randomisiertes Design mit zehn Patienten und 15 Respondenten in der Kontrollgruppe. Die Behandlung bestand aus einer von vier Kunsttherapieen, individuell oder in der Gruppe. Die Autoren benutzen vier Fragebögen, um die Effektivität der Behandlung zu messen, die in einem Zeitraum von sechs Monaten vorgelegt wurden. Für die Patienten in Gruppentherapie gab es auch ein qualitatives Interview gegen Ende dieser Periode. Die quantitativen Ergebnisse waren aufgrund der kleinen Stichprobengröße und der großen Variabilität nicht schlüssig, aber die qualitativen Daten zeigten interessante Facetten des Prozesses, wie z. B. dass die Wahrnehmungen der Behandlung durch die Therapeuten und Patienten in allen Behandlungsfällen übereinstimmten.

Résumé

Une investigation de l'efficacité des thérapies d'art pour des adultes avec des problèmes de santé mentale persistants.

Les thérapies d'art offrent aux patients un traitement par des moyens surtout non-verbaux (p. ex. des formes d'art comme la musique, l'art, le drame et le mouvement de danse). Elles sont particulièrement efficaces lorsque la communication normale est absente ou s'est effondrée. Cette étude a utilisé un design de contrôle randomisé, avec un groupe de traitement (n = 10) et un groupe de contrôle (n = 15). Le traitement était une sur quatre thérapies d'art procurées en groupe ou individuellement. Les auteurs ont utilisé quatre questionnaires d'efficacité administrés pendant une période de 6 mois. Une interview pour les patients du groupe de traitement avait lieu à la fin de cette période. Les résultats quantitatifs n'étaient pas concluants en raison de la haute variabilité et du petit échantillon, mais les données qualitatives révèlent des facettes intéressantes du processus (p.ex. le fait que les perceptions des thérapeutes et des patients sur le traitement coïncidaient pour tous les cas traités).

Resumen

Investigación sobre la efectividad de la arte-terapia para adultos con problemas continuos de salud mental

Los tratamientos de arte-terapia ofrecen terapia a través de medios primariamente no verbales (v.g., formas de arte tales como la música, la pintura, el drama y la danza). Son particularmente efectivos cuando no es possible la comunicación normal o esta se ha quebrado. Este studio utilizó un diseño de control randomizado en el que se realizó un tratamiento ($n=10$) con un grupo de control ($n=15$). El tratamiento consistió en elegir una de las cuatro formas de arte-terapia en grupo o en forma individual. Los autores utilizaron cuatro cuestionarios separados administrados por un período de seis meses a fin de medir la efectividad de aquel. También se llevó a cabo una entrevista cualitativa de los pacientes del grupo al final de tal período. Los resultados numéricos no fueron concluyentes debido a la alta variabilidad y al pequeño tamaño de la muestra, pero los datos cualitativos revelaron interesantes facetas del proceso (v.gr.,en todos los tratamientos las percepciones acerca del mismo, tanto de los terapeutas como de los pacientes coincidieron).

Resumo

Uma investigação em termos da eficiência das terapias de artes para adultos com problemas de saúde mental persistentes

Os tratamentos com terapias de artes oferecem aos pacientes essencialmente terapias mediante meios não verbais (i.e., formas de arte como a música, a arte, o drama e movimentos de dança). Elas são particularmente eficazes quando a comunicação normal está ausente ou foi interrompida. Este estudo usou um desenho de ensaios clínicos aleatório envolvendo um grupo de tratamento (n = 10) e um grupo de controlo (n = 15). O tratamento consistia numa das quatro terapias de arte fornecidas em formato de grupo ou individual. Os autores usaram quatro questionários separados, administrados ao longo de um período de 6 meses, para avaliar a eficiência. Foi ainda realizada uma entrevista qualitativa no final de cada período de tratamento para os pacientes em tratamento de grupo. Os resultados quantitativos foram inconclusivos devido à elevada variabilidade e à reduzida amostra, porém os dados qualitativos revelaram facetas interessantes do processo (e.g., que as percepções dos terapeutas e pacientes coincidiam em todos os casos de tratamento).

Sommario

Efficacia dell'arte-terapia.un'indagine sull'efficacia delle arti- terapie per gli adulti con problemi di salute mentale

I trattamenti di arti-terapie offrono ai pazienti la terapia soprattutto attraverso mezzi non-verbali (cioè, arti quali la musica, il dramma ed il movimento, il ballo). Sono particolarmente efficaci quando la comunicazione normale è assente o interrotta. Questo studio ha usato un disegno randomizzato con scelta casuale di controllo e coinvolto un trattamento (n = 10) e un gruppo di controllo (n = 15). Il trattamento era una delle quattro arti-terapie trasportate nel gruppo o individualmente. Gli autori hanno usato quattro questionari separati, somministrati su un periodo di 6 mesi, per misurare l'efficacia. È stata inoltre effettuata un'intervista qualitativa alla conclusione del periodo di osservazione per i pazienti del gruppo di trattamento. I risultati numerici non erano conclusivi, a causa dell'alta variabilità e della piccola dimensione del campione, ma i dati qualitativi rivelano le interessanti sfaccettature del processo, (per esempio, che le percezioni dei terapeuti e dei pazienti hanno coinciso in tutti i casi di trattamento).

摘要

藝術治療主要以非語言方式 (即藝術形式，如音樂、美術、戲劇和舞蹈動作) 提供個案治療，運用在正常溝通機制欠缺或損壞時特別有效。本研究使用隨機控制設計，包括實驗組 (n=10) 及對照組 (n=15)，分派四種個別或團體的藝術治療形式。作者在 6 個月的期間使用四種分別的問卷來測量成效。同時也在治療尾聲時對實驗組進行質性訪談。因高變異性和小樣本的特性使量化數據未達明確的結論，但質性資料顯示出療程有趣的面向 (如在所有實驗組中，治療者和患者對治療的觀點皆一致)。

CHAPTER 7

INTRODUCTION TO PART II OF THE THESIS:
THE PRACTICE OF MUSIC THERAPY FOR ADULTS WITH MENTAL
HEALTH PROBLEMS: THE RELATIONSHIP BETWEEN DIAGNOSIS AND
CLINICAL METHOD

7.1 Introduction

The main focus of this doctoral study is to provide a critical view of how music therapists define, describe and articulate the practice of music therapy in the field of adult psychiatry, for people between the ages of 18 to 65.

Part II of the thesis reports the results from a survey based research study which set out to answer the question 'How are different approaches and techniques of music therapy defined in adult psychiatry, for people from 18-65 years old, which link diagnosis to treatment?' It was decided to explore current practice as described in the literature, and link this to the results of an in-depth survey from a small sample of five music therapy centres in Europe, in order to find some new knowledge relating to this question. Reasons for this choice were linked to clinical, political and educational perspectives.

This chapter provides an introduction to the new research study and therefore the theoretical framework and the rationale for this, as well as a discussion of the basic concept of the method are prefaced here. Some of the literature cited for this purpose here is inevitably explored again in more detail in chapter 8, and this chapter aims to give an overview of what will be discovered in detail in subsequent chapters.

At the outset, it is important to understand why diagnosis; defined here as the classification of a disorder; is the focus for the study. The author[1] adheres to the view put forward in DSM IV (1994)[2] that it is useful to have 'an official nomenclature'(ibid

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[1] The author of this thesis is referred to as 'the author' and 'the researcher' interchangeably depending on the context and in order to give variety to the reader.
[2] DSM IV is commonly used in psychiatry in Europe and is therefore the chosen point of reference in this thesis.

p.xv), that serves to enable clinicians worldwide to understand each other and the populations whom they serve, across a number of settings. Concurrent with an increasing emphasis upon individual need and recognition that users[3] of mental health services[4] should be involved in decisions which affect the path of their treatment, there is also a focus upon diagnostic categories in the study. This is in order emphasise the importance of finding the right treatment for the problems and symptoms experienced by adults with mental health problems.

This researcher considers that the presence of diagnostic criteria serve to provide an understanding of what someone might need in terms of an intervention, rather than diagnosis existing as a label which might depersonalise the process. This point of view is similar to finding the correct remedy for a physical symptom. For the purposes of this study, the broad idea of diagnosis is used throughout as a short hand for the properties or symptoms that a person might be dealing with. Diagnosis is used as a framework and concept, whilst recognising the many individual people within these categories and respecting at all times their individual personalities and characteristics.

7.2 Rationale and background to the study

The reason for undertaking the research was that at the time of writing there were few comprehensive texts on the subject within the field of music therapy worldwide, and those in existence mainly originated in the USA (Unkefer 1990, Wheeler 1983, 1987). For this reason the study takes a European focus, following on the work of Smeijsters (1996a) which started to look more generally at indication criteria. [5]

In addition, this author, as evidenced in Part I of the thesis, has held a long standing interest driven by clinical and political experience, in defining, describing and researching music therapy in order to clarify theoretical and clinical indications for

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[3] Patients are collectively referred to as 'patients' 'users' or 'clients' depending upon the context of the discussion in order to reflect a variety of cultural differences.
[4] The terms 'Mental Health' and 'Psychiatry' are used interchangeably as collective terms for services which provide treatments for people with diagnoses within the six categories included in the study.
[5] In chapter 8.1 the choice of material presented in the literature review is clarified.

treatment. The arts therapies out-come study (Odell-Miller et al. 2006) (albeit a study about all the arts therapies, not only music therapy); described in Part I, Chapter 6; started to find certain trends in practice. For example the priority for treatment in the arts therapies as a whole was shown as the psychotic disorders, and the particular difficulties of gathering outcome evidence for this population was identified, with outcomes for people with schizophrenia revealing irregular patterns from the applied measures. However this author, (whose job has in the past included managing the provision of an arts therapies service[6] including music therapy), became motivated to find out how knowledge of clinical practice could be increased and clarified.

Music Therapy training courses particularly in the UK would benefit from some clear descriptions and guidance about which approaches and techniques are most suitable for which diagnostic groups in adult mental health, so that future music therapy practitioners can respond flexibly and appropriately to clinical demands and patient need. [7]

The agencies involved in the provision of health services in many countries, for example in the United Kingdom include 'Purchasers' and 'Providers', who often need more detailed information about why certain treatments are effective for certain groups. In addition, the National Institute for Clinical Excellence (NICE)[8] in the UK also evaluates the efficacy and relevance of treatments before recommending their application to the general population. The need for this information is becoming more necessary as other similar treatments are more specific about stating that certain treatments are effective with certain diagnostic groups or problems.

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[6] In the UK Arts Therapies services including Art Therapy, Dramatherapy, Dance Movement Therapy and Music Therapy have become increasingly common since the collaborative government registration of the Arts Therapies under the Health Professions Council. They maintain their trainings and professional identity for each discrete discipline, but are often organised together. (HPC Standards of Education and Training & Standards of Practice. www.hpc-uk.org/aboutregistration/professions/artstherapists

[7] Cassity and Cassity (2006) have published a manual for this purpose since this research was started, but it is derived for USA based trainings and is not necessarily suitable for some of the more psychoanalytically and improvisationally- based European trainings.

[8] NICE guidelines can be found at the following website www.nice.org.uk (type in relevant diagnosis).

One example of this which inspired the study is found in a review of effective psychotherapy treatments for people with schizophrenia (Roth and Fonagy 1996). Family intervention programmes aimed at modification of the support network of the schizophrenic person, and cognitive-behavioural treatment of acute symptoms are mentioned as effective treatments, but not arts therapies.

Arts therapies are mentioned briefly, as treatments of choice for patients in a recent[9] DOH survey 'Treatment Choice in Psychological Therapies and Counselling' (Parry 2000), but there is a lack of information relating to types of interventions related to diagnosis. This gives the impression that music therapy might be out of synchrony with some other treatments such as psychotherapy (Roth and Fonagy ibid), which increasingly link treatments to evidence-based practice. Whilst some have attempted to draw anecdotal evidence and guidelines for practice linked to diagnostic groupings (Unkefer 1990, Wheeler 1983,1987), there is little systematic literature about theory, practice and research in this field, which takes diagnosis into account.

The author feared for the future of funding and provision of music therapy in the mental health field, and aimed to build on existing knowledge by finding out more about how music therapists define what they do, and why, in relation to diagnosis. The discussion which follows relates to the field of adult mental health specifically, although occasional comparisons with other clinical fields are made. In these cases, the particular field will be specified.

In music therapy research and case study literature in adult psychiatry, there is often an omission of diagnostic information relating to the rationale for music therapy approach and technique (Proctor 1997, Odell-Miller 1999, 2001, 2002, 2003) or little emphasis upon diagnosis. Authors who do refer to specific diagnostic groups in more specialised rather than general survey-type articles, often confine their research or explorations to that category, rather than comparative analysis. For example, Pavlicevic, Trevarthen and Duncan (1994) discuss research with people with

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[9] This study began in 2002, and the thinking for it started before that in 2001, so this is why it is described as recent.

schizophrenia and music therapy, with significant outcomes. On the one hand they show a distinct appreciation of the diagnostic considerations, by adapting an approach previously developed for work with children, specifically for adults with schizophrenia. On the other hand, there is no detailed discussion about why improvisation in particular might be beneficial or not for this population as opposed to other interventions, such as using composed songs.[10]

Following an initial literature review, it was concluded (including the chapters by this author in Part I of this thesis), that there is little comparison of techniques and approaches, or discussion of why certain techniques and approaches might be suitable for one population, but not another, in the literature specifically for adults with mental health problems, and particularly in European literature. [11].

In summary, for the purposes of this introductory chapter, the main relevant existing texts are Unkefer (1990, revised 2005), and Wheeler (1987), both from the United States, who have collected information together, and do discuss and compare appropriate approaches related to diagnosis.

Unkefer (1990) and the version of his book which was updated whilst this study was in progress (Unkefer and Thaut 2005) presents a table and states that the table for which techniques to use with which diagnostic groups was gathered by the authors (8.4.Table 8.3). However the explanation of the table does not state how the material in the table was gathered and formulated, or include a discussion of the outcomes and why suggested protocols are proposed. It does state how these techniques were linked with diagnosis in detail ,as discussed in section 8.4. [12]

Important elements to summarise here, relevant to introducing the research study in Part II of the thesis, are that a 'Taxonomy of Programs and Techniques in Music Therapy for Mental Disorders' (Unkefer and Thaut 2005 p.185) divides techniques

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[10] Both this research and other studies are discussed in more detail in Chapter 8.

[11] Since the study has been undertaken The Cochrane review about schizophrenia has highlighted the benefits of music therapy for people with schizophrenia, and there is some discussion about appropriate approaches methods and techniques although these are not discussed in detail. (Gold et al 2005). www.cochrane.org/reviews/en/ab004025

[12] Thereafter, when a section elsewhere in the thesis is referred to, the word 'section' may be omitted in order to maintain the flow of the text, but it will be implied.

into six groups with sub-categories as shown in 8.4.(Table 8.4) of this thesis. The six areas are Music Performing, Music Psychotherapy, Music and Movement, Music Combined with other Expressive Arts, Recreational Music and Music and Relaxation. The sub-categories provide detail such as under Music Performing, whether music is improvised and process orientated, or product orientated and performance orientated. This in itself is confusing to most European schools of thought which would not describe improvisation as performance based. Music Psychotherapy includes 'Supportive Music Therapy, Interactive Music Therapy, and Catalytic Music Therapy. The latter is not a term used in European models and in this study. This in itself is not a problem, but this researcher wondered why music therapy in the adult mental health field has not used the Unkefer (1990) categories, and also wondered if the absence of a theoretical basis in the book, or a psychoanalytic approach, could be one of the reasons. However the information and conclusions drawn for four diagnostic groups; schizophrenic disorders, bi-polar disorder depressed episode, bi-polar disorder manic episode and generalised anxiety disorder (ibid 1990); is detailed, and influenced the design of this study as this chapter will further reveal.

Wheeler's (1987) comprehensive survey is most closely related to this study, and formed an important basis for this study. She suggested three levels of music therapy and appropriate uses of these, arising from a survey of 148 music therapists in the USA. She tested out two hypotheses relating to the three levels of music therapy and found that music therapists were consistent in their categorisation of which levels might be used for which diagnostic groups, in psychiatry. However, there is no evidence in subsequent literature that music therapists actively use and follow these indications of levels when practising, particularly in Europe. There is also little discussion of detailed techniques and situations, with minimal case study information included in the article. A literature review revealed more subtle trends, particularly through anecdotal case studies published by music therapists practising in Europe, some of which contradict Wheeler's findings. One example is given here.

Wheeler's (1987) USA-based survey showed that music therapists considered an activity-based level of music therapy most appropriate for people with schizophrenia, and considered insight orientated music therapy focussing upon unconscious material most inappropriate for people with schizophrenia. Anecdotal evidence in case studies

(Pedersen 1999, Jensen 1999, Odell-Miller, 1991), showed that music therapists do consider this level appropriate over a long period of time, coinciding with some of Wheeler's findings prior to her study. Chapter 8 discusses a small sample of literature which specifically relates to the research question, in more detail and shows how this led to the Method for this research project.

The emergent music therapy literature particularly in Europe reveals a situation where music therapists are perhaps more driven by the philosophy they were taught in their training and by their developed clinical practice, than by following categories, levels or types of interventions consistently and allowing them to inform clinical practice. Freedom of thought and innovative thinking is essential to an emerging profession, but this researcher is concerned with finding out if music therapists can articulate a rationale for the paths they follow in treatment.

There is a need for more articulation about the thinking behind the conclusions in both Unkefer's categorisations (Unkefer 1990, 2005) and Wheeler's (1987) survey, but also to consider why it might be that many music therapists in Europe appear to have largely ignored some basically useful research leading to clear guidelines.

In a local and international climate where health care is constantly evaluated for Evidence Based Practice (EBP), particularly in the UK; and where funding is clearly driven by which treatments seem beneficial for which patient group, more information about the content, efficacy and validity of therapeutic treatment is essential. This researcher set out to investigate the main research question, following many years of pioneering clinical practice teaching and research in the field of adult psychiatry, and with the objective of testing out ideas about approaches which are often un-published and passed on from therapist to therapist informally, often through supervision and team work in music therapy settings, and taught, it appears, inconsistently in basic training.

7.3 Introduction to the research study

The main research question for the complete thesis is 'What research studies, clinical reports and current practice, both published and unpublished, describe guidelines,

approaches and techniques used in the practice of music therapy in adult psychiatry for patients aged between 18-65yrs, which link diagnosis to practice?'

The meaning of the link between diagnosis and treatment here refers to the way in which music therapists are influenced by diagnosis, and also the way in which there may or may not be a possibility for guidelines to be developed advising which types of music therapy approaches and techniques might be appropriate for which clinical populations within the field of psychiatry. To put it another way, if music therapists cannot articulate rationales for treatment and some form of protocol or protocol-type music therapy guidelines linked to diagnosis, purchasers of healthcare services might determine that music therapy treatment is not relevant or indicated for a specific diagnostic category particularly where there are other treatments shown to be beneficial with supportive evidence as shown in the example from Roth and Fonagy (1996) regarding schizophrenia in 7.1 above. This situation is discussed further in Odell-Miller et al (2006), which forms part of this thesis and points to a need for further outcome study research in music therapy. This position verifies that more qualitative information such as has been gathered in this study, is also useful as supporting evidence and in providing clarity for how treatment should be organised.

The main research question of the thesis was investigated in three ways:

1) A presentation and short commentary of the researcher's previous research publications on the subject which forms Part I of the thesis, Chapters 1-6.

2) A literature review including the Cochrane Library and all specialist formal research outcome studies. (Chapter 8 lists the data bases and resource methods used for this search).

3) A survey of existing practice utilising quantitative and descriptive data which forms the basis of Part II of the thesis.

7.4 Further research considerations

Literature which does mention specific diagnostic information, for example Jensen (1999) and Pedersen (1999) who write referring to schizophrenia, is often non-specific about why improvisation is chosen for the approach. An introductory example of the perspective that the author is taking is as follows. Loth (2002) clearly and descriptively presents a case for the use of an improvisational approach in terms of a particular diagnosis (eating disorders), and in the same article mentions the work of other music therapists who use composed song, and other more structured techniques; as being relevant to this diagnosis; but not why they might or might not be used for this specific diagnosis. We might, and often do assume that this is because of the particular training orientation of the music therapists, rather than what might be clinically indicated or desirable. Many authors who are specific about a particular theoretical approach taken, do not necessarily specify which type of music is used, or discuss why a particular approach or method is favoured over another. This lack of clarity is also found in the author's own publications in Part I of this thesis further contributing to the derivation of the research question and the study as a whole.

The unique musical contribution of music therapy within the field is crucial to the decisions made about which patients need which treatment. For example, why should patients be referred for music therapy and not psychotherapy? Music therapy is increasingly documented as effective in the literature, through systematic research studies for this population, (Tang et al 1994, Maratos, 2004). In the recent Cochrane Review, four studies were assessed as providing significant evidence that music therapy is effective for schizophrenia. In a controlled trial, music therapy cut down negative symptoms for patients with schizophrenia, increased ability to converse with others, increased interest in outside events (Tang et al.1994.) All four studies finally included in the Cochrane Review (Tang et al. 1994, Ulrich 2004, Yang et al. 1998,Maratos 2004) compared music therapy added to standard care with standard care alone, and all studies used standardised measures. All studies showed that music therapy and standard care was superior to standard care alone for global state. Continuous measures from one month to three months showed some positive effects for general mental state, on negative symptoms, and on social functioning. Given these outcomes, some discussion is included in Chapter 8 Table 8.3 on the types of

interventions that were found to be useful with this diagnosis, although in all studies there is little detail given about reasons and links with diagnosis for particular approaches and techniques applied. This could lead to the conclusion that approaches and techniques taken followed what was available owing to the experience and training available by therapists in the studies.

Owing to the lack of clarity often found in the literature about which methods of music therapy are used when, and why, other types of qualitative and clinically useful evidence, in addition to the research specific evidence, needs to be gathered systematically to support the more qualitative outcome studies. An example of more anecdotal evidence is found in case study –based literature, which describes how music therapy is recognised as important for its action based non-verbal methods. Davies (1995) and Odell-Miller (1991) for example describe music therapy as helpful when patients are finding difficulty in talking or thinking using words, for example if severely depressed or thought disordered.

This doctoral study therefore aimed at gathering evidence to clarify approaches and techniques, not to demonstrate 'measurable' outcome. It is expected that results will help users, referrers and practitioners gain clarity about which types of diagnostic groups respond best to which types of music therapy treatment. Prior to this study, personal experience of the researcher over many years seemed to show that services in psychiatry for music therapy articulate similar approaches and definitions of perceived effective treatments, but much of this information exists in service-based documents such as annual reports and clinical audit reports, rather than in published articles or books. It has been passed on through word of mouth, teaching and supervision. This makes setting up clear referral systems, training students, planning services and advising government bodies on priorities, very difficult. In the UK this is a particular problem in the field of adult psychiatry. In other fields such as autism there are much more commonly researched and defined procedures, such as the discussion about assessment and evidence in the literature (Wigram 2002).

The main theoretical framework on which the research question is based arose from the presence of some more general tools for assessment and evaluation of clinical intervention, such as the Improvisation Assessment Profiles (IAP), (Bruscia 1987),

which informed the definitions of approaches and techniques devised for the study. Other more descriptive literature about music therapy in adult psychiatry (Wigram and De Backer 1999), where therapists discuss particular approaches to music therapy with adults in psychiatry sometimes with reference to diagnosis, and sometimes without, was also influential in designing the survey and deciding upon categories for the research. In examining the literature is became clear that there is need for clarity about when a particular approach is taken, or technique used.

Smeijsters was one of the first music therapists in Europe to try to articulate indications for treatment in the field of music therapy (Smeijsters 1996a), and more recent literature has emerged which provides some answers to this question (Hadley 2003, De Backer and van Camp 2003). For example, De Backer & van Camp (ibid) provide a discussion about exactly how different levels of musical improvisation are relevant for people with psychosis, and how musical relating replaces the absence or inability of the psychotic person to understand the meaning of words, or to use representational communication. (8.3.3)

7.5 Consideration of the research questions

The main research paradigm was a non-probability survey based study, where purposive sampling using a convenience model was used to recruit a small and relevant sample of established clinical music therapy departments. The results of this survey are presented in Chapters 10 and 11, and were analysed as research case studies. Part I of this thesis has presented the researcher's published works, and mentioned their relevance to the study, and these are further discussed in Chapters 8 and 12.

The main research question for the study is defined as:

> How can different techniques and approaches of music therapy be defined in adult psychiatry, for people from 18-65 years old, which link diagnosis to treatment, by comparing what is described about current practice in the literature, with the results of an in-depth survey from a small sample?

The sub-question focuses on how music therapy practice could change and develop in psychiatry, both in terms of planning services and in terms of effective practice.

Can existing methods and techniques in music therapy clinical practice which are linked to diagnosis, respond to the relevant areas of clinical treatment and if so what are the reasons for this? At the outset there were further sub-questions, but these became beyond the scope and timescale of this study, and the analysis of data did not seek answers to them. An example of a 'rejected' sub-question is

Can implicit *levels* of practice, which link diagnosis to treatment, be clearly documented in the wider context for use by practitioners?

The *levels* of practice were not commented upon by all respondents, and therefore the data relating to this sub-question was not complete, and the question could not be addressed. Reasons for this will be discussed in Chapter 12.

Length of treatments was also a planned focus and it was hoped that an examination of the data from the survey would focus upon protocols for short- term treatment. The rationale for this is that short-term music therapy treatment is often established where treatment packages are set up for six months or shorter, often very effectively, and often as a result of student placements. However the results of the survey did not bring forth the expected information about lengths of treatments and in particular short term work, so this aspect will not be addressed.

In answering the research question, it was expected that existing protocols or guidelines would be examined, and some new ones drawn up from the results of the planned survey, and from examination of existing literature. In practice, the results lead to some important outcomes, and to the beginnings of the formulation of guidelines, but drawing up explicit guidelines was not possible owing to some gaps in the data and the need for further testing out the findings in the wider professional field.

The study explores how specific treatments can be defined, particularly in terms of their application to a single diagnosis. Six diagnostic categories are included and this

is an expansion of the previous work by Unkefer (1990), which only focuses upon four categories. This author wanted to include more recent specialist categories in psychiatry where music therapy is applied Europe, namely eating disorders and personality disorders, in addition to the other four, schizophrenia, bi-polar disorder, anxiety and depression.

Examples of areas of work include discussion about diagnosis, and also about context for example where the patient is seen geographically-in a ward or day unit. The survey was designed to answer the main question of this research, and sub-question. In Chapter 9, within the Method chapter, the questionnaire design, and details about the method of administration and gathering data will be described in detail.

7.6 Summary of the survey

The survey, designed to gain expert opinion about the effective modes of music therapy practice, and what is recommended with which population and for which diagnostic group, had strong validity. A questionnaire was devised to gather in-depth criteria- based data, which was then analysed, from expert practitioners across five European established music therapy centres in adult psychiatry. This included 23 music therapists in total. This means the results will be highly relevant and applicable for future research and can inform good practice. The objective was to target well-established music therapy services where there is a body of knowledge not necessarily formulated into external publications, but which exists in practice or in unpublished reports or documents.

The selected experienced music therapists working in similar departments across Europe, were asked to articulate what methods of music therapy they deploy, and what techniques they find appropriate with which diagnostic groups by filling in a long questionnaire which is include in Appendices 1-V. The material gained was mainly music therapy specific and the researcher had chosen categories of approaches and techniques for the questionnaire, which will also add to knowledge in the field.

The objective was also to find out whether music therapists *can* define and describe what they do in this field, and whether this can be linked to different diagnostic

groups, and situations, in order to provide clarity for users and providers of services. The survey therefore also acted as a way of finding the answers to the main research question, and to the sub-question.

Results were analysed using a mixed design of qualitative and quantitative methods, and the results were considered from two important perspectives, 'Diagnostic', and based upon 'Techniques and Approaches'.

7.7 Summary of Chapters in Part II

In Chapter 8 the literature review is discussed in depth, and a discussion is presented leading up to the rationale for the study. Literature is examined from an international perspective and from the point of view of each of the six diagnostic categories, comparing and analysing different perspectives.

In Chapter 9 the method of the study is described in detail from the original ideas which influenced and motivated the researcher, leading up to the design of the survey. The implementation of the survey across five European established music therapy services in psychiatry which acted as convenience model case studies is described, and the planned analysis of results using both quantitative and qualitative methods is discussed. The properties of each centre are described, and percentages of time spent by the music therapy treatment team with each diagnosis are summarised. Ethical and clinical perspectives which influenced the design of the study are are examined as well as research methodology issues.

In Chapter 10 the results of the analysis of qualitative data are presented for each of the six diagnostic categories and for each of the approaches and techniques included in the questionnaire. The results are presented numerically for each diagnosis in order to give an overview of how many centres use each technique and approach within each diagnostic category in rank order so that patterns of how much or not each approach and technique is used within each diagnostic category, can be seen. For each diagnosis, the qualitative descriptive data given by each centre for all approaches and techniques is discussed and analysed, making some comparisons across centres and

diagnoses. Conclusions are drawn for each approach and technique about how much or little they are used by the centres in the study.

In Chapter 11 the quantitative data is presented across all centres settings and diagnoses in order to see how much or little each approach and technique is used, not specifically linked to diagnosis, but in order to ascertain the extent to which all the approaches and techniques are cumulatively used. Bar charts and numerical data are presented, with a statistical analysis of proportionality so that the data is verified and then linked to qualitative outcomes already discussed in Chapter 10. Comparative and further conclusions together with discussion about the overall patterns and trends are further discussed in Chapter 12.

 In Chapter 12 discussions and conclusions are presented relating to the main research question of the study, and to the themes of the thesis as a whole, linking qualitative and quantitative outcomes across all centres and diagnoses. Conclusions are drawn about whether or not a particular technique or approach is used, and therefore 'indicated' for each diagnostic category, and linked to previous published literature. Limitations of the study and its design, and implications for education, training and clinical practice are explored. Future indications for research are discussed and proposed, and conclusions drawn from the thesis as a whole and the study in particular.

The Appendices include a copy of all the questionnaires (anonymously), examples of ethical procedures, the raw data tables, some extra clinical and research descriptions with examples of particular approaches and techniques.

Chapter 8 now proceeds with a selected literature review presented as a reflection of the background and thinking behind the study.

CHAPTER 8

LITERATURE REVIEW: HISTORY AND BACKGROUND

8.1 Introduction

This chapter reports on some of the literature in music therapy up to the point where the survey was undertaken in 2004, which relates to specific methods and techniques of music therapy linked to diagnosis in the adult psychiatric field[1]. There is also reference to some literature which does not refer to, or link, practice to diagnosis, including some consideration about what can be learned from the current position regarding music therapy in adult psychiatry at this time. Literature which emerged after 2004, adding to what was originally described as a sparse field is not included in the main discussions, unless it is crucial to the overview, and presents relevant new findings.

Two main categories emerge from a study of the selected literature, which are relevant to the project:

- Clinical texts that describe methods, guidelines, protocols and types of intervention in adult psychiatry (for people between the ages of 18-65) which focus on diagnosis

- Research studies which describe method, guidelines, protocols and types of intervention applied in psychiatry which focus on diagnosis

Within these categories, sub-categories were considered which separate out some studies from others according to more specific criteria. In the first category of clinical texts that describe methods, guidelines, protocols and types of intervention in psychiatry, the following subcategories were considered, and are listed as they are laid out in this chapter:

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[1] Adult psychiatry refers to adults with psychiatric diagnoses between the ages of 18-65

a) In 8.2 a general overview is given of the types of literature relevant to the study, clinical and theoretical, which either links method and approach to diagnosis or reveals that there is no such link. Examples are therefore given of the literature which influenced the study in a general way.

b) In 8.3 literature is systematically discussed in the relevant field of adult psychiatry which provides a particular diagnostic focus, relating to music therapy approaches and techniques with psychotic and non-psychotic disorders discussed in detailed sub-sections.

c) In 8.4 literature that attempts to structure and categorise approaches and techniques, in a similar way to this study, relating to diagnosis and adult psychiatry.

In the second category of *research* texts which describe method, guidelines, protocols and types of intervention in psychiatry; two subcategories were considered:

a) In section 8.5, research studies reporting method, guidelines, protocols and types of intervention in psychiatry which discuss adult psychiatry and diagnosis, either linked to a type of music therapy intervention or not.

b) In section 8.6 literature studies which are relevant to the discussion owing to the research methodology content.

The main arguments put forward therefore are informed by the literature available at the time of the study apart from revisions of earlier publications. Furthermore, in order to delimit the potentially enormous amount that could be reported on within the entire diagnostic field of music therapy and adult mental health, including literature relating to psychotic and affective disorders, personality disturbances and many other lesser specialised categories, some limits were applied to the review:

a) The focus of the survey was hospital based music therapy departments whose case load was primarily patients with clinically diagnosed mental health

problems that had led them to in-patient or out-patient treatment within the health system. The review will therefore mainly concentrate on music therapy literature reporting this context

b)   The intention of the survey was to identify methods of intervention relating to diagnosis. The review will therefore focus mainly on literature that refers to this, considering six main medical diagnostic categories as described in DSM IV. (DSM IV 1994). The six diagnostic categories are schizophrenia, bi-polar disorder, depression, anxiety, eating disorders and personality disorders.

c)   In order to add more detail and depth to the review, at the same time as providing an overview of relevant literature, some comprehensive examples will be provided where practitioners and researchers have provided examples and detail regarding intervention methods that can relate to diagnosis.

The main sources of literature were: Relevant Music Therapy Journals, Books, Internet web sites, and search engines focussing upon Music Therapy and Diagnosis in Adult Psychiatry. The following databases were accessed using the Athens gateway, through Anglia Ruskin University library, between 2002 and 2006 (between 2004 and 2006 searches were focussed upon the emerging outcomes of the study, as discussed in Chapter 12):

Allied & Complementary Medicine
ASSIA (CSA)
British Nursing Index
CINAHL (R)
DH-DATA
ERIC
Expanded Academic ASAP Plus
MEDLINE
PsycINFO
PubMed
Musictherapyworld.net
and many other music therapy specific data bases such as <u>music@anglia.ac.uk</u>[2]

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[2] Keywords in the search included the following: music therapy and diagnosis, music therapy and psychiatry, music therapy and adult mental health, music therapy approach, method, technique; music therapy and depression, schizophrenia; bi-polar disorder, manic depression, eating disorders, personality disorders, anxiety, music therapy and psychotherapy, music therapy and GIM, music therapy and psychiatry behavioural, music therapy and psychoanalysis, creative music therapy and

Two major overviews warrant particular mention, one of which was published post 2004 and one in 2004. These are The Cochrane Review on Schizophrenia (Gold et al. 2006), and Wigram et al. (2004), which is an overview of evidence-based music therapy in psychiatry up until 2004. In the latter Wigram, Odell-Miller, Irgens-Moeller and Lund cite a multitude of studies in the following categories, many of which are discussed in this chapter, and which are summarized under the different sections in this chapter. The categories are:

Randomised Controlled trials, Case Controlled Trials, Clinical non-controlled trials, Qualitative Research, Clinical Protocols, Case Studies, Theoretical Papers with Case examples, Theoretical Papers and Expert opinion (ibid. 2004)

The categories identified above at the beginning of this Chapter (8.1), will now be examined in detail. Each section will start with an overview and then move to a more detailed analysis of some studies which particularly illustrate the focus of this research project.

8.2 Theoretical and clinical approaches: interventions in psychiatry

8.2.1 Introduction to theoretical approaches in music therapy in adult psychiatry with or without links to diagnosis

This part of the review reports on some of the music therapy literature which focuses upon theoretical approaches in adult psychiatry and less on musical models and techniques, where there may or may not be specific links to diagnosis. Much of the earlier music therapy literature studies in the adult mental health field discuss case - focussed approaches, often without specific links to diagnosis, although diagnosis is sometimes mentioned in passing (Tyson 1981, 1984),[3] Priestley (1994), Alvin (1975).

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adult mental health/psychiatry. Only literature which focussed upon links between diagnosis, method and approach and diagnosis were analysed in detail apart from summarising some that did not, and using some that did not as examples (eg Stige 1999 8.2.3).

[3] In a later publication Tyson (1987) makes more links in her paper about generalized anxiety disorder and music therapy.

In these studies, the work is more contextual, and general. It does not link particular techniques and method to diagnosis specifically. Other studies where the focus is on theoretical approaches in mental health (Odell-Miller 1995a, 1995b, 2001), often with a case study focus (Darnley-Smith and Patey 2003), mention diagnosis, but with no specific links between approach, method and diagnosis, apart from studies about dementia which are beyond the scope of this research. Instead, points are made according to what has been discovered about theoretical and contextual thinking, in terms of mental health and music therapy in general. Specific case-orientated ways of working are described, but the rationale for thinking in a certain way, or using a certain method is not directly linked to the different diagnoses and pathologies of the cases described. For example, Odell-Miller (1995a, 1999), and Darnley-Smith (2002) find that free improvisational techniques are useful in music therapy groups with people with various mental health problems, particularly whose who have difficulty in discussing and linking problems with their own thoughts and feelings. Odell-Miller (1999) refers to the 'here and now' elements as crucial to this approach, but there are no specific links to diagnostic detail with the adult population. This is in contrast to many other fields of treatment such as Cognitive Analytic Therapy (CAT) where there is a whole body of knowledge related to working with people with personality disorders using a CAT based approach (Ryle et al. 1997). In this and other fields such as Cognitive Behaviour Therapy, (CBT), treatment is linked to diagnosis and research studies exist to substantiate evidence for these as effective treatments for this population. (Grant 2004).

Other music therapists such as John (1992, 1995) and Erkkilä (1997) write about finding the right theoretical concepts which are relevant to the particular pathology or diagnosis of the patient. John develops links between psychoanalytic thinking and music, suggesting a particular emphasis upon the importance of music in working with regressed parts of the person who is psychotic. Erkkilä (1997) although particularly discussing the importance of developing a relevant model in music therapy for children with autism, rather than adults, draws attention to the importance of adapting approaches to suit the diagnosis or needs of the person. He develops a three dimensional model which has three layers of meaning; cognitive, vitality affects and a psychodynamic meaning level and suggests that this is particularly important when cognitive functioning and normal connections are difficult, for example in

autism. His paper is relevant because he emphasises the importance of using the right approach for the right problem or need, which is pertinent to this study.

Similarly, and in contrast to more general literature referred to at the beginning of 8.2.1, Pedersen (1999), Jensen (1999), De Backer and van Kamp (2003) and De Backer (2004) describe a detailed theoretical framework for thinking about schizophrenia and psychosis, and their ideas are discussed in detail below. Different stages and levels of music therapy are described linked to the actual nature of the illness, which relate to clear criteria.

In many studies, there are no references to, conclusions about, or particular relevance given to the appropriateness or significance of a music therapy approach and method for a specific diagnosis, (Ansdell 2002; Procter 1997; Odell-Miller 2001; Darnley-Smith and Patey 2003). Furthermore there is a counter-culture developing within the Community Music Therapy movement that argues for a non-medical approach (Procter 2002; Kenny and Stige 2002). This debate will not be addressed here in detail as it is outside the specific limits of this small literature review but will be addressed in Chapter 12. For now, in order to understand the counter-argument to the one put forward by this research study, the main argument put forward by Kenny and Stige (ibid.), is that prescriptive ways of developing models might be too restricting rather than, in this author's view, providing necessary boundaries and guidance in the patients' interest. Whilst this author understands the rationale for a humanistic community based culture in mental health, the reality is that many patients only access services within the medical psychiatric setting, and therefore is it argued that music therapists need to provide therapy that is rigorously informed and appropriately formulated within that context, whilst maintaining a holistic approach to the person and their needs.

Frequently **not** addressed in the literature, is how the successful process of therapy can be linked or attributed to a specific approach in relation to diagnosis and inherent symptoms.

Some studies will now be considered in more detail, which take the rationale for this study further.

8.2.2 Approaches linked to diagnosis

This section will describe the historical context of the literature considered, and show a range of selected different types of examples in order to illustrate the thinking behind this study. Literature content ranges from early clinical and theoretical (Tyson 1984), more modern clinical technique and the role of the therapist (Camilleri 2001) to a theoretical perspective looking at the multi-disciplinary team in relation to diagnosis and music therapy (Metzner 2003), concluding with one of the few examples of an article which focuses upon diagnosis. In this case music therapy is used as a diagnostic tool (Jahn-Langenberg and Schmidt 2003).

One of the early pioneers of the application of music therapy in acute psychiatry in the United States was Florence Tyson (1984) who worked in one of the first arts therapies centres in the world for people with mental health problems. In her writing, Tyson addresses some diagnostic-specific issues including motivational factors amongst adult psychiatric patients. She points to inner unconscious factors, and their inherent symbolic form. She held the view that these aspects within music are important in helping borderline or schizophrenic people, whose communications she described as primitive and imagistic. Tyson thought that these can only be understood in terms of symbolic meaning. Her writing emphasises affective change, brought about by involvement with music which is full of affect. Tyson also suggests that there is something physiological about music which makes it important for schizophrenia, for example the instinctual drive and activity involved in the music therapy process, which she considers enables new responses. This implies more about physiological processes involved in making music, than the actual component of the vibration of the music itself. She refers to Langer (1942) and Langer's view that music is the least representational art form, and is composed of symbols which unlike words lack conventional fixed associations. Langer's concept of music being non-discursive and therefore an unconsummated symbol and unfixed is interesting to Tyson. She discusses music as 'a tonal analogue of emotive life,' referring to Langer (1953 p.27). Tyson discusses music and the processes of its abstract and non-verbal structures which are helpful to people who find clarity of communication and thinking difficult. Apart from one or two points, the article is not specific about diagnosis, but points to symptoms and types of deficit that might be helped by improvisational

music therapy methods in general ways. Tyson does not specifically comment on use of technique either, but assumes an improvisational technique is taken regardless of diagnosis and context.

Camilleri (2001) touches on a different aspect than discussed so far, which is the specific significance of the therapist's counter-transference. In her paper exploring the therapists's self -awareness, and how that acts as an essential tool in music therapy, Camilleri reports cases related to music therapy and schizophrenia. Some music therapists are previously reported to assume that working with interpretation might not be appropriate with people with schizophrenia (Smeijsters 1996a, Wheeler 1987). This is usually because of a belief that in psychosis, the patient is too out of touch with reality to make use of reflection and interpretation which involve unconscious processes. This view takes the hypothesis that it could be contraindicated to work with unconscious processes which involve phantasy, when the patient has difficulty distinguishing between reality and phantasy, and cannot use symbolic thought. Camilleri's work reflects this viewpoint. However, the therapist uses her own responses to change her approach, which at first was non-structured improvisation, and to therefore help where there was a difficulty of expressing emotions, which she cites as commonly found in schizophrenia. In a music therapy session for females with schizophrenia, the therapist became aware of how her need for safety and control and organisation affected development. Changes in the therapist's leadership style and presence, from a more free style to a more structured approach musically, were able to foster group development through counter-transference. Camilleri's approach of playing more structured music, and leading with rhythmic and melodically directive expressive music, enabled six young females with schizophrenia, in a music therapy group, to musically share using this modelling technique, and subsequently members were able to share personal information in a safe environment.

Similarly, but on a much more developed scale, Metzner (2003) develops a theory around the significance of triadic structures for people with schizophrenia. Both authors point to the significance of the therapist's dynamics and processing outside the session, which then in turn influences the music therapy process. Metzner goes further in reflecting on the team and therapist's processing outside the session, and describes how an understanding of this relates to and reflects the patient's process.

Through a case example of a young schizophrenic patient undergoing psychodynamic therapeutic treatment, Metzner presents a triadic structured model that serves as the basis for theoretically reflecting upon a multilateral transference situation in the multi-disciplinary treatment team on a psychiatric ward. No conclusions are made about musical techniques or music therapy techniques but a strong theory of the significance of triadic structures is put forward in relation to some diagnostic categories. The musical approach is free improvisation but this is described 'in passing' rather than as a focus. It fits within the psychoanalytically informed approach defined (Odell-Miller 2001) and used in the survey for this research, and describes techniques of free improvisation using words, one of the techniques used in the survey. This research survey did not explicitly ask about team dynamics, for example how a psychoanalytic understanding of these might affect treatment, so it will be interesting to see if comments about this emerge from the survey.

Metzner (ibid.) also describes the illness of a female with schizophrenia (p.266) and makes an important statement to support the hypothesis for triadic structures and their importance in this illness. She describes a woman who was adopted and for whom no model of conflict or three way relating existed. Her adoptive parents were both teachers and seemed merged in a way that entirely accommodated the patient in her growing up. She says that if one thinks of an understanding of schizophrenic illness as the result of dyadic disturbance, one would not spontaneously think of triadic disturbance but it is in the musical improvisation that this comes to light. She implies that through the music- making the patient's previously inexpressive dyadic way of relating moved to a more reflective way of playing. "the heartbeat gives support to her and me ….. implies that there is a third entity which could provide support to both, if only it had not dissolved." (ibid. p.266). She had previously described the music as seeming like a heartbeat providing support to patient and therapist but which then 'dissolved'.

This dynamic seemed to be enacted by the multi-disciplinary team who, at the beginning of the music therapy intervention, did not talk to each other and seemed to lack either a motivation or context to relate about the patient. Once the team began to relate, it seemed that the patient could then experience the reality of her situation. She was therefore able to move on, and no longer needed to attend music therapy. Metzner

drew conclusions based on psychoanalytic theory about the general lack of communication and understanding and 'three way' relating in the patient's life which usually equips people with emotional ways of dealing with upset and conflict. She vividly describes the team being caught up in this and suggests that once the team begin to 'triangulate' and link with each other, the patient senses this and feels she can move into the world from a secure base, rather than a two person impotent dyad. "The analysis work in the team which had just started but was quickly increasing in intensity, brought the reality of relations into play, so that the patient was able to use them as a springboard to find her own way. We, who had been used by her as parental figures, were simply left behind together with our relations." (ibid. p.270). On the one hand this does not address the music therapy-specific method and techniques and their importance in work with people with schizophrenia, but on the other hand it does suggest a psychoanalytically based theoretical framework which underpins the work and relates to a particular theory about schizophrenia linked to failure of triadic relating and the place of the parent-child triad in this.

In a later paper (Metzner 2004) given at the European Congress of Music Therapy in Finland, Metzner makes some comments about the limitations of using composed music if the patient is psychotic and might not be able to use the space to symbolise anything from the music. This is very pertinent to the questions in this study, and it is interesting to note whether other centres substantiate this point in the survey results.

From the literature that does refer to diagnosis, there is little discussion about music therapy as a diagnostic tool, and the function of music therapy in relation to diagnosis in adult mental health. Jahn-Langenberg and Schmidt (2003) explores the role of music therapy in diagnosis for patients with psychosomatic disorders, and in a psychoanalytic setting. Here 'diagnosis' refers not only to the psychiatric medical diagnosis, but to a broader understanding of 'diagnosing the problems'. So in this sense the word diagnosis is used in a broader context than in this study, but nevertheless there are interesting findings. In the case study, free improvisation enables regression, desire and playfulness to occur simultaneously, whilst in the verbal work it is harder for the patient to experience this. In addition a particular point seems to be made about the possibilities of the interactive free improvisation relationship sometimes encouraging defences against the underlying depression. This

could be seen as useful or not depending upon the aims and context of the therapy. A discussion will now follow giving examples of how particular approaches and techniques might be contraindicated in music therapy, although the question remains (which was behind the drive for this study), do music therapists' opinions about this stem from their training perspective only, or their knowledge and training in a wide range of techniques and approaches from which they can then choose the one most suitable for the problems presented by the patient?

8.2.3 Approaches not linked to diagnosis

In some studies, importantly, there are speculations and decisions made arising from experience rather than any specific scientific research evidence. Certain author's argue against consideration of a specific approach linked to diagnosis. One example of this will be considered here in order to highlight this phenomenon.
Stige (1999) argues against the use of a psychoanalytically informed approach when he focuses upon the meaning of music from the client's perspective. He gives a detailed account of the case of a man with a personality disorder (emotionally unstable borderline type). In this description, Stige puts forward an argument for holding the meaning of the music for the patient as a focus, rather than making too many assumptions as a therapist. For example he discovers with this particular client, that at certain times the use of improvisation provided a connection to the life history of the patient but at others it provided a disconnection. In contrast, Stige (ibid.) finds that at other times use of composed or more task- orientated music therapy techniques are significant:

> "He would for instance engage himself in different activities, including playing music on the stereo or on the organ" Stige (1999) p. 74

Furthermore Stige starts to speculate upon which technique to use when, and his questions are related to the particular diagnosis of the patient, or to a desirable move away from a more traditional psychotherapeutic music therapy approach. He almost starts to put forward an argument about music therapy technique and personality disorder, but moves, as demonstrated in this example below, to a view that the client's history and the relationship between music, meaning and the understanding of this

between therapist and client, is what should drive the therapy, rather than the diagnosis.

> "In any case, Harold used music as a connection to his life history only a few times. He rarely explored his inner life but he seemed to be successful in his use of music as a disconnection. What importance should then be given to either? This question is related to some clinical considerations that must be explored by any therapist working with a patient with a personality disorder. Is the client ready for explorative therapy or is a more supportive strategy necessary? …… Some of my questions about my own work with Harold were: How much should he be challenged to go in an explorative direction? If he should be challenged, how and when? And how and when could such challenge have a negative function, giving him a feeling of not being accepted and respected in the relationship? Working with Harold made it very clear to me that the clinical aspects of such questions could not be separated from the differences in the value systems of the two partners. Connected to this are differences in ideas on the meaning of music. I felt I needed to know more about Harold's relationship to music."
> (Stige 1999 p.74-75)

As in many studies in music therapy, there is a sense in which the writer points to a need for more specific guidelines about when to do what, and why, but makes no substantial conclusions based upon evidence. The therapist is challenged by the fact that the client has a totally different meaning arising from the improvising together than the therapist, which causes the therapist to wonder about the techniques and frameworks he is using as illustrated at the end of the chapter:

> "Harold's case illustrates, in a very basic way, how the same music might be connected to very different experiences from time to time, while changes in the music do not necessarily create changes in the experience, at least not in the way it is reported verbally. This illuminates the non-fixed between sign (here: music) and meaning, and thus the importance of asking the client for his experience. For

instance, the music of sessions 12 and 13 was not very different. There is no way that any general theory of meaning in music as heard could give rise to much difference in the interpretation of the two improvisations. However as experienced by the client, there was miles of difference between them."

(Stige 1999 p.77)

Here Stige is not thinking about diagnosis any more, although in the chapter there are many allusions to how listening to music and playing more 'predictable' improvisations seemed to reduce the symptoms of anxiety associated with this diagnosis as argued by Procter (1997) discussed later in this chapter. The reader, as in many examples, is more or less left to come to their own conclusions. Nevertheless, Stige does suggest at one point that more rigorous and consistent use of techniques and theory rather than moving around each week and trying out different ways of relating to the patient, might be preferable (Stige 1999, p.79).

This example, illustrated here, together with many other clinical reports and studies in the literature does not articulate specific information regarding the techniques and methods used within interventions relating to diagnosis. The lack of documentation of this area of knowledge has generated the current study. This lack also indicates a potential area of development in training methods for music therapists where there is a need for greater specificity in teaching clinical method.

In the next section examples which do focus upon articulating a specific approach are considered, and their influence upon this study and its direction and focus, is discussed.

8.3 Approaches and techniques in music therapy for specific diagnostic groups

8.3.1 Overview of approaches and techniques linked to diagnoses for psychotic disorders

We now move to consider music therapy literature in psychiatry with a particular diagnostic focus that relates to music therapy models and techniques.

In focussing on the idea of the therapist's process as crucial when working with people with schizophrenia, Pedersen (1997) discusses the music therapist's listening perspectives as a source for information in improvised musical duets with adult psychiatric patients suffering from schizophrenia.

The value of replacing the concepts of transference and counter-transference within the music therapist-client relationship, with the terms 'listening perspectives' and listening attitudes' is put forward by Pedersen. In her view, working with adult schizophrenic people shows that the concepts of transference and counter-transference do not adequately describe affective moments of relatedness. The cases of a female (22yrs) and a male (43yrs) and a male (26yrs) show the therapist's attempts to listen to the underlying emotional affect, to gain information about distance and closeness, of possibilities for musical and verbal interventions, and for timing possibilities. This coincides with Camilleri's opinion (Camilleri 2001), about working with people with schizophrenia and the importance of using a non-music-based tool when listening to the patient, similar to counter-transference, but also using embodiment.

Stephens (1983) in her earlier pioneering work with schizophrenia links the use of improvisation with developing what she calls 'relatedness', often difficult for people with schizophrenia. She writes generally about psychiatry, so her links are not always specific to schizophrenia, or one diagnosis. Similarly to Pedersen, she describes three cases, an individual therapy with a client with schizophrenia, a group with patients preparing for group living in the community, and individual therapy with a neurotic client. Improvisation is shown to be a useful tool for addressing issues of relatedness in an active nonverbal way. However she does not develop a particular detailed theory about approach and technique specifically for different diagnostic groups but starts the thinking that was later developed by others.

In a later study Pedersen (1999) puts a clear theoretical framework forward including some suggestions of music therapy technique and focus, for people with schizophrenia. Her conclusions are based upon years of experience, similarly to Jensen (1999) who puts forward similar frameworks for thinking about stages in music therapy work with people with schizophrenia.

Table 8.1 Summary of Pedersen's approach related to schizophrenia

Recurrent Identified Patterns in the use of music by people with schizophrenia	Therapist's Interventions and Role
Playing a 'wall of sounds with no start or ending-not listening to therapist -Patient wanting to become famous musician-grandiose ideas -Play around on drum kit Patient playing piano in a devaluing way, presenting a negative picture of herself Fragmented sounds on piano rather than listening inwardly to sounds and allowing them to relate to each other -All patient's attention fixed on therapists music to see if he is doing it 'right' Patient not wanting to play in the beginning but allowing the therapist to play for her	-to break down isolation, to create musical frameworks through which the patient can gain in confidence, be listened to and be taken seriously. -to support the capacity for expression and communication and to help prepare the patient to be motivated for further psychotherapeutic treatment -To build a therapeutic alliance. The patient /therapist relationship is the main tool for change. Trust must be built up. - Musical 'Play-forms' are adapted to the needs of the patient and the role of the therapist is in helping the development of the ego, and in being a 'holding' person. -Free improvisation techniques are used, or isolated musical elements. -the use of an ultra-sensitive listening attitude as a function of being a sensitive platform for sound resonance to the patient is crucial in this technique.

Table 8.1 summarises the approach and techniques from Pedersen (1999 p.41), where she compares the patients perspectives on their understanding of using music to the therapist's role and therapeutic interventions. This is a more relevant example of a therapist linking intervention to diagnosis.

Jensen (ibid.) describes four phases in the treatment and gives examples from one patient. In each phase he describes what type of musical intervention the therapist makes as follows:

Table 8.2   Summary of Jensen's approach related to schizophrenia

Phases	Therapists Interventions	Rationale in Relation to the Illness
Omnipotence	Therapist tries to go along with patient-to get into his world. Establishing a musical dialogue in order to match his expression. Plays in same key, same rhythm trying to imitate his melodic and harmonic material synchronically	Psychotic Defence needs to be accepted and understood as it is a necessary protection against much worse chaotic psychotic world
Holding	Support patients identity-submit therapist's music to his music	Musically matching, mirroring, complimenting. Do not challenge his omnipotence but assess which musical aspects could form a dialogue Use structure. Musical ornaments which match his personal style. Using bass guitar to create a grounded tonal bass and structure. The therapist's music should be rhythmic and non- intrusive. A holding harmonic and rhythmic 'base' with sustained chords is important at this point. Counter-transference is particularly essential at this point where the therapist uses her own responses to provide an understanding of what the patient might be experiencing

Phases	Therapists Interventions	Rationale in Relation to the Illness
Potential Space	In this stage the therapist takes a complementary role and makes a contrast to the patient's music.	For example when patient plays the piano, the therapist plays percussion, in one example the therapist described playing a 'Chattering xylophone'-to reflect something different but underlying that seemed to be part of the patient's music. This acts as an interpretation. In the case example the patient responds and the tempo changes. Patient moves away from 'his' phrases as he is ready to be challenged, and can then move back to familiar patterns.
Ending of Therapy (Separation)	Themes of ending and shared musical material	The therapist and patient take more equal roles at this point. The therapist asks the patient to lead, to comment and to take a more equal role. The patient's individual music is reflected upon and sometimes therapist and patient listen back. Interpretation, transference and counter-transference are crucial here.

Both Pedersen and Jensen are specific about the music therapy technique used, in both cases free improvisation, with more or less talking included depending upon the stage of the particular therapy or need of the particular patient. In both cases there is a discussion and rationale about why music is particularly important for people with schizophrenia.

Pedersen (ibid.) describes the main focus of music therapy with people with schizophrenia as breaking the isolation commonly seen in schizophrenia. The therapist aims to work at a basic level of communication, building up a consistent working alliance which involves a sensitive holding attitude of the therapist. Most

referrals to music therapy have been evaluated, and psychotherapy contraindicated. Interestingly Pedersen puts forward the view that music therapy can help the patient decide on future therapy, and prepare for psychotherapy.

Pedersen's work (1999), is extremely relevant to the current study. She refers to earlier work by Smeijsters (1996a) where he suggests four levels of indication criteria for music therapy in psychiatry, and lists diagnoses associated with this. He suggests only the first two in the following list are indicated for schizophrenia: Supportive Music Psychotherapy and Recreational Music Therapy; Music Activity Therapy; Re-educative Music Psychotherapy; and Re-constructive Music Psychotherapy.

> "One of the most significant differences of the four identified modalities is that the importance of the therapists/client relationship grows from one to four and that the aim of the therapy changes from being more supportive and balancing to being more focussed on insight and personality changes." (Pedersen 1999 p.25)

Personal aspects of the interaction between patient and therapist, it is suggested by Smeijster's survey, should stay in the background. Techniques involving structured play-rules and activity-based work which is non-confrontational and less personal, focussing on moods rather than interpersonal conflict, are seen as appropriate for this diagnosis.

As a result of this and of her research work, Pedersen (1999) adds a fifth treatment modality 'Holding and Re-organizing Treatment Modality'. In contrast to Wheeler's findings (1983 and 1987) and Smeijsters (1996a), it indicates very much the therapist/patient relationship as an important tool for schizophrenia. Pedersen's Holding and Reorganising approach focuses upon breaking the schizophrenic person's isolation with his/her surroundings. Music Therapy acts as a modified form of psychotherapy, and links are made with this diagnosis in the approach. In Pedersen's study, five out of seven people benefited from music therapy but had not benefited from psychotherapy in the past. She also emphasises the neurobiological and psychological combined aspect of the approach. The patient's attachment and relating patterns are also analysed. The work is focussed upon the 'here and now'

relationship with the therapist. The therapist must work with this to effect change through the music therapy experience and actions.

Pedersen lists links between schizophrenia and the patient's use of music showing patterns that have emerged in her work and in the work of others. She describes in detail the approach of Holding and why this is appropriate for people with schizophrenia as summarised in Table 8.1. Although the detail focuses more upon the patient's use of music rather than the therapist's interventions, the list is included here because it is interesting to see whether similar material and uses of music are reported in this study.

Both Pedersen (ibid.) and Jensen (ibid.) cite similar musical phases which the patient goes through and in each case are linked to aspects of the diagnosis of schizophrenia. Jensen (ibid.) labels a first phase often encountered as 'Omnipotence' where free improvisation is sometimes also theme based. Both agree that this phase of allowing the patient to experience his/her own omnipotence, which can be achieved through music appropriately, is crucial. This researcher would suggest that this is because similar behaviours in a non-musical context would be seen as bizarre and less acceptable.

What these authors seem to be saying is that the therapist must allow freedom but provide appropriate structure when necessary, a technique which is mentioned by both authors (Tables 8.1 and 8.2). Jensen describes 'cut off' playing in sequences, similarly Pedersen describes a 'wall of sound'. This might not emerge if a very activity orientated or task oriented approach was taken as suggested in other studies as described in Wheeler's USA based research which will be discussed in more depth in section 8.4 (Wheeler 1983 and 1987).

Pedersen (1999) and Jensen (1999) both discuss the fact that the music of people with schizophrenia at the beginning of therapy is often not flexible in interaction. Although the term is not used directly, both therapists describe a psychoanalytically- informed approach, using free improvisation (Odell-Miller 2001), but are also specific about what interventions might be appropriate musically at what stages in the treatment, and they relate these to the symptoms, at different stages of the illness.

Some examples from literature describing music therapy with non-psychotic disorders will now be considered and compared with approaches used with psychosis.

8.3.2 Techniques with non-psychotic disorders compared with schizophrenia

Nolan (2003) in an article about a musician with a dysthymic disorder gives detailed descriptions of the use of free improvisation. He provides a rationale for this, emphasising the strikingly different pathological nature of the musical interchanges within some similar frameworks. For example Nolan talks about the patient's use of repetitive fast figures in the music with no space, but also talks about the moments when the music becomes more interactive and creative in the first phase of therapy. However, Nolan focuses upon what the patient does rather than the therapist's intervention, which therefore does not meet the criteria for this study. Similarly De Backer and van Camp (2003) talk about the repetitive nature of music within a free improvisational model, but for the psychotic patient (and they refer to this being a developing pattern), the repetitive music at first shows no room for play, creativity or interchange with another. Their work will be expanded upon later, in section 8.3.3 and they do focus upon the therapist's intervention, which is the focus of this study.

Nolan (ibid.) is cautious about verbal interpretation in his work, sometimes allowing the musical process to help the relationship develop. His view is that drawing attention to meaning colludes with the patient's psychosomatic ideas, and could further embed them. He prefers to allow the physical and psychological power of music to work on its own, revealing that the process uses words, but not always. Nolan musically describes the use of getting 'in the groove' as important, and as a crucial stage in therapy similarly to Aigen (2005). Aigen puts forward a 'Theory of Music Centred Music Therapy' with musical concepts and frameworks at the heart of understanding the client. Whilst in Nolan's approach musical thinking is linked to diagnosis, Aigen's does not specifically relate his theory to diagnosis, but presents it as a universal approach where musical philosophy and musicology in the general context of 'Musicking' determines the path of the therapeutic relationship.

8.3.3 Example of a detailed analysis of approaches and techniques linked to diagnosis for psychotic disorders

Two central texts (De Backer and van Camp 2003; De Backer 2004) deserve further extensive analysis, because they describe an approach where diagnosis and music therapy approaches and techniques are specifically linked, and rationales for these are described. De Backer and van Camp (2003) write:

> "The world of the psychotic patient is often unknown and inaccessible. Many years of experience with psychotic patients has convinced us that through music we cannot only find a gateway to the amazing world of the psychotic subject, but that we can also develop the means to give a certain shape and termination to the disintegration and timelessness of the psychotic world." (ibid. p. 274)

De Backer and van Camp believe that music provides a gateway to further understanding of the psychotic world and they are specific about how this happens. They write that music "provides a certain shape and termination to the disintegration and timelessness of the psychotic world." (ibid. p.274). Here is yet another important reference to diagnosis in terms of the importance of music, which later De Backer became more specific about, as described below:

> "As psychotic phenomena are traditionally attributed to the failure of the work of repression, psychotherapy should focus on the very conditions that make for the possibility of repression" (ibid p.275).

In their study, music therapists are described by the authors as sometimes resistant to synchronicity in the first stages of music therapy, for example to a mother- infant type of synchronicity. Music can act as a fusional object here, and also has a linear and narrative form. The developmental and sequential nature of music emphasises the connection from one thing to another at many levels, and is ideal for reparation in psychosis. Music can help to create a psychic space for these psychotic patients, who often repeat the same musical pattern; the capacity to make representation is severely affected. The therapist perceives and hears a constant repetition of a specific rhythm

or a small melodic sequence, which becomes an iterative playing, a kind of musical rocking.

In one of two case studies presented in his doctoral study, De Backer (2004) describes stage 1 as repetitive stereotypical music that is not playful, and has no 'life'. The patient appears absent in her play. The psychotic patient at this stage shows no imagination; the only confirmation of life is dead-sounding repetitive sounds. Repetition is emphasised, but although the rhythm is repetitive, it is hypnotic and it is impossible in the counter-transference for the therapist to feel contact with the patient. The therapist feels excluded from playing with the patient in this monotonous rhythmic repetitive playing. De Backer describes the absence of engaging with passion; the patient is lost in the music rather than expressing anything within it.

This is an excellent explanation of the particular function of such free improvisation for people with this diagnosis because it gives a rationale for the 'technique' which is linked to the pathology. De Backer (2004) describes a lack of anticipation, which is defined by an absence of the usual musical expressive components within formed musical improvisation. His description is detailed and vividly shows that when this phenomenon is present, it is impossible for the music therapist to even match the timbre of the patient's play, because there is no possibility for interaction.

During this stage of the patient's process, the musical object can become part of a delusion. The object is made present by having it take place in the form of an auditory hallucination. The healing aspect of delusions and hallucinations, particularly auditory, is referred to as they replace the gap in the patient's inner experience. De Backer and van Camp (2003) comment:

> "This phenomenon is closest to what characterizes the music when we deprive it of its form or its "thought". Music can only exist within this specific modality in which a succession of sounds, intensities, and harmonies "occurs". Hence we say that music cannot be remembered; it can only be repeated." (ibid. p.278)

The delusion possesses the same eventful character. The therapist must therefore break through this delusional character, and the opinion is formed that "it is extremely important that the music therapist can find out how the transition from sensorial impression to musical form can happen." (ibid. p.279).

The music therapy framework is described clearly by De Backer (2004), linked to aspects of the progression of the psychotic process, and linked to musical aspects from the music therapist's experience, the patient's experience, and the music itself. De Backer suggests that the early stage of sensorial play (with no musical form in the improvisation), moves towards musical form, with moments of synchronicity as essential moments within the transition process over a series of sessions. He describes the three types of musical improvisation linked to psychotic aspects of the patient as might be expected in similar patients (the research was with two detailed case studies with music analysed in detail). The technique is active improvisation, and De Backer divides his discussion into psychic aspects, form, musical aspects, aspects of inter-personal /intra-personal experiences from the music therapist's point of view, and aspects of body posture. From this it can be seen that De Backer is clearly relating what happens in music therapy to aspects of the psychotic disorder in question. How this relates to the approach and technique can be seen most clearly in the sections about Form and Musical Aspects as shown in the following excerpt from his diagram.

Form:

1. The play begins with an 'anticipating inner sound or silence'
2. The patient is able to end an improvisation independently with post resonation
3. Silence is an important aspect for structuring the play
4. The patient can incorporate and use musical parameters in a stable way
5. There is a clear musical development in the improvisation
6. There is an inner structure

Musical aspects:

1. Pulse and phrasing are present
2. Rhythmic and melodic themes are present

3. Dynamic variability in the play is present
4. Melody is embedded in a harmonic structure
5. The patient is able to vary and re-introduce musical fragments
6. Single notes and melodic and/or rhythmic fragments are related to each other
7. There is intertwining within the timbre of both players

(De Backer 2004, p.273)

From this we see that, in contrast to Wheeler's (1983 and 1987) findings, De Backer describes what role the therapist can have in a free improvisation-based technique and how this relates to what is important for helping the patient organise him/herself which is a difficulty for a person experiencing psychotic symptoms. He describes the move from no interaction, to interaction, and a development within the improvisation of shared meaning.

De Backer describes the role that the therapist might have in the improvisation, as well as what the patient might be doing in relation to the therapist and why, linked to symptoms and stages of the schizophrenic illness. For example in this later stage of musical form, the patient is able to develop musical images, is no longer isolated, has relevant facial expression and can interact. Musically this means there is more musical spontaneity, with the descant line held by the patient whilst the therapist holds the bass line showing the ability to be independent, and flexibly interactive in the improvisations. This is just one example of a detailed description of musical improvisations linked to psychosis found in De Backer's recent work. It emerged whilst this study was in progress, and in parallel with the design of this survey, which was set up in response to a lack of literature in music therapy, linking technique with diagnosis.

There is also a description in De Backer's work about whether improvisation is likely or not to involve verbal discussion and interpretation, which is also connected to the importance of this for the psychotic patient. It was therefore important for the design of the questionnaire for this research to separate out different types of improvisation as free but with or without verbal interpretation, or theme based and more structured.

Importantly De Backer's work indicates a need for more specific questions to be asked pointing to a need for more research, and for this author's study.

De Backer and van Kamp (1999) in their earlier work had started to describe this approach, and it provides a counter argument to literature (Wheeler 1983 and 1987) that had previously emphasised the need for the therapist to provide clear structures when working with people with psychosis.

A salient feature in De Backer's generic approach for people who are psychotic is that the patient should decide whether the verbal part begins, or the improvisation. After each free improvisation there can be verbal reflection. The patient chooses instruments for her and for the therapist, except in certain situations where by using projective identification the therapist may make a decision to play along on an instrument when patient has not chosen one. The therapist's task is to create a psychic space for play, and he/she does this by variation and movements based on the patient's music - for example adding two note intervals ascending and descending. In one example given at the sensorial play stage still nothing happens. There is still no communication. The therapist then has to stop the patient playing, using words. Then there is silence. The therapist adopts the same posture as the patient and listens in an empathic way. These writers provide a theoretical base for why it is important to help the patient develop creative interactive music. This work is clearly linking method to diagnosis, and to the particular features of the diagnosis, hence the inclusion of lengthy discussion here.

Conclusions drawn by De Backer and van Camp (ibid.), albeit based on a small number of case studies, are that three phases are important and must be adhered to and not avoided by the therapist. In the first phase the therapist must allow musical synchronicity, and in staying with the resistance to making more creative music, the therapist allows the patient to move on towards more creative possibilities which are difficult for people with schizophrenia. "The analysis of the fears of being captured or possessed by the 'Spirit' of the music is the crucial task for the music therapist" (ibid. p.295). In the second phase, at the "moment of the development of musical form" (ibid. p.295), the therapist must recognise the importance of abandoning the repetitive "dead sounding music". The authors have a theory directly related to the infant who is

confronted with the interruption of symbiosis, by motherly deprivation. The music-making patient is forced to break away from the purely repetitive circular character of his musical phrase and at this moment, the therapist is a kind of "Winnicottian good enough mother". (ibid. p.295). The capacity of the therapist to NOT play in the same way as the patient, thus abandoning the ecstasy of the repetition and the analysis of the resistances against it, form , in the authors opinion, the "most essential, although sometimes hardly manageable, tasks of music therapy." (ibid. p.296). The authors also link the importance of hallucination and the relationship between this and music. In the third stage, after variation and development, the patient is able to finish the improvisations musically, and in this case affect and speech are no longer dissociated. The authors state that as a result of following this approach, the schizophrenic patient is now able to speak for himself.

In some European countries apart from in the UK, bi-polar disorder is often not differentiated from schizophrenia, and it was therefore important to separate out these diagnoses for the purposes of the survey in this research. Literature about this disorder and music therapy is extremely sparse, although some authors refer to case studies and to this disorder (Odell-Miller 1995a, 2001, Cohen 1986, de l'Etoile 2002). The latter will be discussed in section 8.5.2, as it describes a research project with a variety of different psychiatric disorders in a hospital setting.

One earlier study (Cohen 1986) reports on a research project which will be discussed later in section 8.5.2 which suggests that structured rhythmic tasks are effective with people in the manic phase of their illness.

Another diagnostic category where there is a small but growing body of literature which links approach and technique to diagnosis is that of eating disorders.

8.3.4 Approaches and techniques linked to diagnosis for eating disorders

Looking at other diagnostic groups, there are links made in the field of eating disorders with technique and theory, more through what is presented rather than a critique of approaches that are not taken and why they might not be indicated. Smeijsters (1996b) and Robarts and Sloboda (1994) indicate a psychoanalytically

informed approach underpinning the theoretical orientation. Trondalen (2003) advocates 'self listening' and bases her approach on mother-infant interaction theory, linking her approach and techniques used to the particular anorexic need for connection with mind and body in music therapy treatment. Trondalen's motivation behind her work also supports the quest for setting up systems within the profession for treatment in clinical practice. She suggests that the growing body of knowledge about musical improvisation and mother-infant interaction has a great deal to offer the profession of music therapy in its quest to establish a systematic body of broadly-informed theory to underpin its clinical practice and to underline its validity within the wider profession. She focuses upon Self Listening, linking this to the problem that people with anorexia have in relation to self image. This type of self- listening helps the process of addressing emotional memories of feelings, "which promotes a sense of belonging in time and space" (Trondalen 2003 p.14). This is in line with the thinking of Procter (1997) discussed later in section who also advocates predictability in music as a useful structure for people with mental health problems, although he does not specifically relate this to diagnostic considerations.

In a case example Trondalen (ibid.) describes significant moments in the music:

> "Julie explored rhythmic syncopation in her drum playing and singing within a predictable musical form and structure, in which repetition was evident in addition to predictability in harmonic and rhythmic elements …. I propose such interpersonal relating through a non-verbal means like music led to a closer connection between soma and psyche, which is an important objective for people suffering from anorexia" (ibid p.15)

Loth (2002) describes the use of free improvisation, and focuses upon the patients use of this, and also upon the difficulty of using the expressive aspects of music to the full when starvation and 'with-holding' are such powerful aspects of the illness. She links an understanding of the ways patients use their music, to aspects of the diagnosis, using metaphor and also a psychoanalytically informed viewpoint. She particularly focuses upon the difficulties of working in a group with this population, and similarly

to Robarts and Sloboda (1994) she agrees that free improvisation invites intimacy and this is one of the most difficult areas for people with anorexia.

Smeijsters (1993,1996b) and Robarts and Sloboda (ibid.) make links between technique in music therapy and the pathological traits of anorexia nervosa, pointing to the use of free improvisation with words, receptive techniques, and improvisation using play rules other media such as story telling, drama and metaphor. These are categories therefore included in the survey in this research, and later results will be looked at to see if similar conclusions are made relating to links with the diagnosis. Robarts and Sloboda link the use of free improvisation to intimacy and the difficulties people with anorexia have in being intimate, demonstrating how improvisation provides an immediate interaction for self experience in relation to the other, in the 'here and now' within what is often a painful situation of close interaction. The less explicit nature of music, but its ability to help emotions be experienced and processed, together with other links with particular problems in anorexia that improvising provides, is emphasised. For example the free imaginative nature of music therapy using free improvisation can give patients the experience of themselves in interactive play. Similarly, Smeijsters discusses the anorexic difficulty with integrating the abilities to be controlled or controlling, and the tendency to only function in a controlling role. He shows how 'Balancing Control' (Smeijsters 1996b p. 10) is more possible through music which includes the need for order and chaos, again indicating a role for free improvisation. He cites a German music therapist's work, Loos (1989).

Loos (1989) has developed a way of playing music which she calls:

> "'Chaos and Order' in which the client experiences both aspects and finds a bridge from on to the other. Order is born by chaos and vice versa. To experiment with freedom and control is possible by fixing some elements of musical improvisation and letting others develop freely, for instance a free melody with fixed dynamics. The playing of a free rhythm in a fixed metre is particularly useful. Because anorexia nervosa clients lack a feeling of rhythm, finding a rhythm is important. ….. For clients who want to perfect themselves by having a slender figure, a musical experience in which 'right ' and 'wrong' do not exist

can be indicated. For them this can introduce an altered state of consciousness in which self expression without rigid standards is possible. Through a play- form such as 'Ghosts in the castle' (Loos 1989), where mysterious sounds are explored, the client can become released from her rigorous struggle for the 'right' behaviour." (Smeijsters 1996b, p.10)

The use of metaphor and other art forms with this population seems to be suggested in some literature and it will be interesting to discuss this in the light of the results of the survey in this study. Parente (1989) emphasises the use of Process Theatre, whilst maintaining music as a main focus, and working with inpatients who have anorexia and need rehabilitation in their move out of hospital. She uses role play and live performance also to give a message to the public about the disorder. This perhaps goes beyond the bounds of music therapy but suggests that this population can work with symbols and imagination in contrast to what seems to be stated in the literature about psychotic disorders.

Justice (1994) supports the notion of using a variety of insight-orientated techniques with people with eating disorders in an in-patient setting, including relaxation techniques, imagery, structured music therapy group techniques and relaxation techniques, although there is not emphasis upon free improvisation or detailed links with the symptoms and components of the disorder itself.

Similarly, Robarts and Sloboda (1994) focus upon improvisation using verbal reflection, play rules and other media such as image and metaphor, which is reflected in the following quotation. There are links to the diagnosis in that self –structure transition and a change in the internal process are key to successful treatment showing that this population can work with symbolic representation. An example is given below following a case study:

"Musical improvisation formed the basis of therapy. However, it will be evident from the case material that, in addition to musical improvisation, Ann Sloboda uses verbal discussions and reflection, plus image and metaphor arising from and/or leading to musical

reflection. Jacqueline Robarts, on the other hand, works more extensively in the dynamic forms of the music-making symbolising and effecting self change in self-structure and inter-personal process from which arise image and metaphor in symbolic play" (ibid. p. 9).

These points where detail about technique is discussed will be re-visited following the results of the survey to analyse whether or not other music therapists in the five European centres use similar techniques for similar or different reasons.

8.3.5 Approaches and techniques linked to diagnosis for personality disorders

There is little specific literature about this diagnosis and music therapy. No specific research has yet evolved, because until recently the diagnostic group was not thought to warrant special attention in the field of psychiatry. This is because there was a lack of evidence that medical (drug) intervention was successful, and only recently has a body of general literature emerged which highlights the importance of psychological interventions with this disorder as mentioned earlier (Ryle et al. 1997).

Some music therapy examples are given here and will be returned to in Chapter 12, as this author has developed but not published some theoretical and practical formulations about music therapy and personality disorder from specialised clinical work and has designed a future research project which will add to the literature relating to the main question in this study.

Hannibal (2003) links the significance of a music therapy approach to a different diagnosis, of personality disorder of the impulsive type. There is less music therapy literature in this field because psychiatry itself has not previously regarded it as a diagnostic category which demands services and focus, until the last decade unless linked to another diagnosis. Hannibal makes several comments about the importance of free improvisation as helpful for one case example in particular, where there is an absent sense of self, common in this disorder. He describes how the phenomenon of musical improvisation, owing to its immediate 'sounding', enables the patient to feel more 'present' through playing music. Hannibal's musical interactions and his way of listening gave the patient a sense of respect she did not seem to have prior to this,

which happened in his view though the concrete act of playing music. She experienced respect for her music and therefore towards her.

Using free improvisation amongst other things enabled her to cut down her judging of herself, which diminished as she experienced Hannibal's acceptance and did not therefore fear rejection. For this person language was a weak way to communicate and establish an alliance. However while free improvisation is described as the preferred method, there is little description of the technique used in detail, linked to diagnosis, or therapeutic strategies.

8.3.6 Approaches and techniques linked to diagnosis for depression and anxiety

There is less music therapy about depression in psychiatric settings, and this reflects the traditional priority given to psychotic disorders in music therapy services. It is therefore interesting to note in this study whether similar priorities are made and why in the analysis of results. Depression is often linked with anxiety, anxiety being regarded as one of the symptoms that can mask depression, but also sometimes in more physiological anxiety–states, as one of the reasons for depression. This phenomenon, and an example of how music therapy works with these symptoms, has been discussed in detail earlier (Odell-Miller 2002 Part I 3.1), demonstrating a long-term psychoanalytically informed approach using free improvisation with talking as the main technique, in group work. The Cochrane study about music therapy and depression is not finished at the time of writing, and interestingly since the study. Smeijsters (2005) has some interesting conclusions about the function and types of improvisation for depressed people particularly regarding a slowing down of pace and therefore musical tempo, which becomes reflected musically. In an earlier research study, Smeijsters et al. (1995) carried out a research study looking at the use of listening to musical excerpts, for people with depression which is relevant to this study and will be discussed in the research section (8.5.3).

Many authors mention depression linked with other diagnoses, for example the major research and case study reports focus upon depression accompanying acute or chronic medical conditions, or other difficulties such as substance abuse, rather than depression as the main diagnosis. For example there is extensive literature about depression, substance abuse and music therapy (Cevasco, 2005, Freed 1987, James

1998, Murphy 1983, Hammer 1996), mainly using receptive techniques and listening, or structured techniques. James (1998) demonstrates the use of song-writing, and Cevasco (2005) the use of movement, rhythm activities and competitive games. As these studies refer to research studies, they will be discussed in the later research section (8.5.3). We have already seen the close link between physiological, psychological and musical components, in the case study (Odell-Miller 2002) where conversely the physical difficulties appeared to arise from chronic depression, rather than the depression arising from an acute medial condition.

Davies (1995) writes about loss and depression, and how a psychoanalytically informed approach in music therapy helped in some cases. She does not make explicit conclusions about approach and technique, but alludes to the importance of free improvisation in both addressing resistance, and in using music as a way of breaking through control mechanisms common for people with depression. She also draws attention to the function of free musical improvisation in being able to move through different self states both "powerful and murderous", also "delicate and vulnerable". (Davies 1995, p. 14).

Tyson (1987), in her individual case study about analytically-oriented music therapy with a male adult musician with the diagnosis of anxiety neurosis who was referred by his psychoanalyst and received 69 weekly sessions, explores the interrelationship between musical problems and unconscious psychological conflicts. There are unspecified links made to the symptoms of anxiety and the perceived roots of the problem, through her description of the separation/individuation process, and creative problem-solving that led to the resolution of the client's future career dilemma.

8.4 Categorising approaches and techniques relating to diagnosis in adult psychiatry

The major literature which attempts to structure and categorise approaches techniques and models in a similar way to this study relating to diagnosis and adult psychiatry

originated in the USA (Wheeler (1983, 1987), Unkefer (1990)[4], Cassity and Cassity (1998)[5]). Smeijsters (1996a), a Dutch researcher, undertook a major investigation in Europe about indications for referral for many different clinical populations. As part of this he attempted to make some links between approach, technique and diagnosis and this work is summarised after discussion of the USA texts. [6]

In her early article, Wheeler (1983) looks at categorisation and describes different levels of music therapy in a psychotherapeutic approach, and these influenced the question in the survey for this research study on levels of work. It is interesting that in the results, centres did not tackle this question. Wheeler lists the levels and types of music therapy approach as *Supportive, Activities-Orientated Music Therapy, Reductive Insight and Process-Orientated Music Therapy, Reconstructive, Analytically and Catharsis-Orientated Music Therapy* (ibid. pp. 146-147).

Wheeler's 1st level of intervention called Supportive is closely allied to a behavioural approach in which clients' impulses are suppressed in favour of more adaptive behaviours. She describes this as useful for re-integration into the community. For example she suggests that poor concentration, inappropriate verbal or motor interaction can be corrected. As examples, she mentions Cook and Freethy (1973) who used contingent piano playing to eliminate 'complaining' behaviour in a woman with schizophrenia, whilst Williams and Dorow (1983) successfully reduced the same behaviour in a chronic depressed male by using a structured approach with music and verbal feedback.

In this 1st level Supportive approach, which is seen as promoting healthy behaviour, insight and processing play only a small part in sessions. Activities are aimed at strengthening defences, and tightening structures. The therapist facilitates supports, clarifies and offers advice.

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[4] Unkefer and Thaut 2005 edition was also consulted later but this was printed after the literature review had finished. There are no changes that affect the discussion here between the two editions.
[5] Cassity and Cassity 2006 2nd edition was also referred to during the writing up phase of the thesis but no change in the discussion was necessary relating to the arguments put forward in this thesis.
[6] This researcher was part of the original working group for this investigation, worked closely with Henk Smeijsters on this, and was involved as a participant in the round table presentation at the 1995 World Congress of Music Therapy in Hamburg where this work was presented and from which the publication discussed here arose. (Smeijsters 1996a).

Importantly Wheeler hints at links to diagnosis, suggesting that people with sound ego structures who have broken down temporarily under stress, acute and chronic patients who are fragmented, regressed, or delusional, who suffer from chronic schizophrenic, affective, or organic symptoms, or who are too phobic or anxious to participate in more demanding levels of therapy, need support, integration and 'sealing over' rather than a verbal investigation of their problems. Reductive and Insight orientated approaches according to Wheeler's study, involve active involvement between therapist and patient, and she refers in the third insight orientated level to a psychoanalytic approach with people who have a stronger ego sense which relates more to the European approaches taken in this study.

It is interesting to note that Unkefer (1990), draws conclusions that are based on early USA approaches in music therapy which do not refer to psychoanalytic concepts, but to 'Music Psychotherapy' (p.155) which includes Supportive, Interactive and Catalytic techniques. Although he does refer to the importance of the unconscious there is little psychoanalytic terminology in his descriptions. He does however include detailed lists of diagnostic criteria and music therapy approaches indicated at each stage of the illness, which seems to have been largely ignored in European literature and practise. The reason for this may be that unlike Wheeler's study later in 1987 where she carried out a survey of 148 music therapists, Unkefer (ibid.) states that his detailed 'recipes' were gathered from experience, and also that there is no discussion of how and why the conclusions were reached. There are no actual examples given from cases but a definite focus upon symptoms and need.

The relevance to this study is therefore crucial, and it will be interesting to compare the conclusions from this study with Unkefer's conclusions. However it is difficult to find meaning for the decisions and owing to this, there is much detail without explanation of why or why not various techniques are or are not used. What emerges is that there is an emphasis upon structured techniques such as Performance, Recreational and Music and Movement based music therapy, for all four diagnostic groups listed: schizophrenia, bi-polar (manic episode), bi-polar (depressive episode), and generalized anxiety disorder (ibid. pp. 150-215). The details of the five categories of technique are outlined in Table 8.3 below. Categories are grouped as: Music

Performing, Music Psychotherapy, Music and Movement, Music combined with other Expressive Arts, and Recreational Music, Music and Relaxation. These broad categories are broken down into different techniques and some examples will be given later. However it must be recognised that the methods are following a mainly medical model and that in the USA at the time of the publication, a behavioural approach to music therapy was prevalent. Davis et al. (1999) state that in the USA the highest percentage of in-put to services by music therapists is within the mental illness category. Davis et al. (ibid p.100) also discuss music therapy as a form of psychological therapy stating that music therapy is useful in re-educating people back to community. Techniques of relaxation help to uplift mood, and the therapist functions as an outside personality who supports, strengthens and guides the patient. Although this is not referring to a psychoanalytical approach it is hinting at some form of containment but with a much more traditionally behavioural tradition than is found in most European countries. It is not diagnostic specific but interesting in the light of this study, as different techniques are referred to some of which are covered in the survey.

Unkefer (1990) states the following which highlights this approach in terms of key elements in his view that are the focus of music therapy rehabilitative treatment for adults with mental health problems.

> "….1) eliciting mood/feeling responses and altering feeling states, 2)aiding interpersonal interaction, 3)improving self-concept 4) promoting cognitive mental organisation, 5) reducing anxiety states, 6) stimulating perceptual or motor activity-are the main focus of every treatment and rehabilitation setting in mental health care. Music works in each area on the psychological and neuro-physiological response levels, and thus constitutes a therapy modality that affects the entire human personality in an objective and measurable manner" (ibid. p.87)

Table 8.3 shows the results of an analysis undertaken by the author on the review made by Unkefer (1990) that identified the number of times Unkefer mentioned the use of a specific intervention method or approach related to a certain diagnosis. This data is based on practice in the USA. Unkefer breaks down all the symptoms and needs for people with schizophrenia and the numbers in Table 8.3 refer to the number

of times under each diagnostic category, a particular 'programme' of techniques is mentioned. Thus the numbers cannot be compared between diagnoses as they relate to the number of symptomatic categories identified for that diagnosis. Anxiety included a shorter list of symptoms for example, and schizophrenia a more complex long list. However, within each category it will be interesting to see the balance between technique groupings and then to compare these with the findings from this study.

Table 8.3: Reported methods of intervention by diagnosis (summarised from Unkefer 1990 pp 174-214))

Category of Groups (Number of Times mentioned)	Schizophrenia	Bi-Polar (Depressed)	Bi-Polar (Manic)	Anxiety	Total number of times a therapeutic intervention is mentioned by intervention
Music Performing	14	9	10	4	37
Music Psychotherapy	9	5	9	1	24
Music and Movement	16	8	8	5	37
Music Combined with other Expressive Arts	1	1	0	0	2
Recreational Music	7	2	7	3	19
Music and Relaxation	2	2	3	3	10
Total number of times different interventions are mentioned within a diagnostic category	49	27	37	16	

The results in Table 8.3 reveal that Music Performing (37) and Music and Movement (37) are mentioned more frequently than other interventions such as music combined with other expressive arts (2) Recreational music (1) and Music and relaxation (10). Music psychotherapy, an approach not widely applied in the USA is nevertheless

identified 24 times in this analysis. Also interesting is the breakdown of applications within diagnostic groups, where there is a greater number of references to intervention methods in schizophrenia than in other diagnostic groups. Music Psychotherapy is reported for use with schizophrenia and bi-polar (manic), but less with depressive and rarely with anxiety, for whom music and movement and music performing seem a more suggested mode of intervention.

At the outset it was identified that Unkefer (1990) does not provide any discussion attached to the tables, hence the need for this study. However some interesting patterns occur such as the prevalence of task orientated approaches, and the small use of improvisation. Even within the definitions of the Music Psychotherapy category, which is not psychoanalytic in its theoretical foundation, there is an emphasis away from free improvisation for all diagnoses. When Music Psychotherapy is used, the main techniques involve pre-composed music and directive listening where the therapist chooses the music for the client. The third level in this category is not used at all for schizophrenia which is mainly Guided Imagery in Music. This mirrors the literature about Guided Imagery in Music at the time, although more recently there have been adaptations of GIM used with people with schizophrenia as described by Moe (2002) and Meadows (2002), discussed in Chapter 12. So in the schizophrenic category there are nine places where Music Psychotherapy is listed, but out of these none are at the third more in depth level. Other interesting phenomena are that Music and Movement features in most categories across all diagnosis and there is little use of the Expressive Arts Therapies combined with music therapy. It should be remembered that this categorisation was done in the USA some years ago, and that trends may have changed since then, another reason for this European study. The detail of the categorisations according to need and specific intervention cannot be discussed here in detail, but what is striking is that there is an emphasis upon detail and technique relating to every symptom of the illnesses and also in relation to need, which is impressive in the light of the drive for this type of protocol at present for psychological treatments, but equally there is no emphasis upon the therapeutic process and the relationship with the therapist, rather most defined interventions describe the music therapist as deciding, choosing, directing the music, even within the psychotherapy categories.

The types of programmes and techniques discussed above are summarised in a table by Unkefer (1990 p. 149), reproduced below.

Table 8.4

'Taxonomy of Programs and Techniques in Music Therapy for Mental Disorders'

1. Music Performing

A Instrumental Group Improvisation (Process Orientated)

B Instrumental performance Ensemble (Product orientated).

C Group Singing Therapy (Process-orientated)

D Vocal Performance Ensemble (Product orientated)

E Individual Instrumental Instruction (product orientated)

F Individual Vocal Instruction (product orientated)

G Individual Music Improvisation/Interaction (process-orientated)

2. Music Psychotherapy

A Supportive Music Group and/or Individual Therapy

B Interactive Music Group and/or Individual Therapy

C Catalytic Music Group and/or Individual Therapy

3. Music and Movement

A Movement awareness

B Movement exploration

C Movement interaction

D Expressive Movement

E Dance (Folk, Square, Social, Contemporary)

F Music and Exercise

4. Music Combined with Expressive Arts

A Music and Fine Arts (Drawing and Sculpting)

B Music and Writing (Poetry and Prose)

5. Recreational Music

A Music Games

B Music Appreciation Awareness

C Recreational Music Performance Groups

D Leisure-Time Skill development

6. Music and Relaxation

A Music with progressive Muscle Relaxation Training

B Music for Surface Relaxation

C Music Imagery

D Music-Centred Relaxation

(Unkefer 1990, p.149)

As can be seen above, there are few improvisation based techniques listed by Unkefer (Unkefer p.149) and the table focuses upon a wide range of other techniques. The detailed definitions of the Music Psychotherapy category also includes mainly structured techniques, and music listening, the third category being the only one to mention free improvisation. This reflects an orientation more commonly found in American clinical practice as reported in the literature, and even in the second edition these categories are unchanged (Unkefer and Thaut 2005).

This study therefore aimed to represent a more European cultural music therapy approach in designing the questionnaire as discussed in Chapter 9. It seemed important to include in this research a high percentage of improvisation based techniques in this research survey. In Unkefer's list there is more emphasis upon Recreation and Performance, but these types of techniques were grouped under one or two headings in the current study survey design (Activity-Based, for example, or Receptive techniques). Another example of the different types of interpretation of technique across different countries, is that under the list above (Unkefer ibid.), one of the few places that improvisation is mentioned is under 1. A 'Instrumental Group Improvisation (Process Orientated)'. This on first reading could sound similar to a free improvisation approach using a psychoanalytically informed theoretical approach. However in the definition of this (p.150) Unkefer talks about the therapist providing "elementary musical forms" and that clients "learn" how to alternate between playing as a group or individually. It must be cautioned that this is one of the problems of describing musical phenomena in words because in another paragraph (ibid. p.150) defining this technique, Unkefer does say that "The clients learn to use

their instruments as an emotional outlet, as a bridge to social participation, and to release feelings of tension and anxiety. Limited attention is given to teaching and rehearsing formal musical skills" which suggests the technique at least in practise might be closer to what is described as structured improvisation in European literature, and in more psychodynamic approaches.

In a later publication Wheeler (1987) describes three levels of music therapy with this population taking a meta level approach:

- Music Therapy as activity therapy
- Insight Music Therapy with re-educative goals
- Insight music therapy with re-constructive goals

In a large survey of 148 USA based music therapists, goals were designated for each level of therapy and respondents were asked to rate the importance of each in their work with psychiatric clients in order to test out her earlier levels. Wheeler concluded that goals for each of the three levels would be consistently used in conjunction with other goals from that level and that client diagnosis could be used to predict the level of therapy. Wheeler (1987, p.39) states that "Classifying music therapy goals into levels may help therapists better understand the goals and course of therapy, and may also assist music therapy students understand when and why certain techniques of music therapy can be best utilized."

Wheeler's study is interesting in relation to this study as it provides more of a goal orientated approach, rather than looking in detail at approach and technique used by music therapists in practise. This influenced the direction of this study and was influential in setting up the survey design and main questions. Wheeler's study (ibid.), does link practise with diagnosis, and it is interesting that despite this work, music therapists in Europe do not appear to have followed these goals or referred to them in the literature. This might be due to the perceived cultural differences between continents, or to a lack of diversity in some European countries for example the UK which has always followed an approach where live music-making through improvised structured and unstructured playing is the main technique. In this case it might be that music therapists concluded perhaps mistakenly that literature presenting a more

diverse set of approaches in music therapy in psychiatry might not be relevant or have the potential to inform and provide meaning to practise.

Wheeler (ibid.) suggests that there are differences in the practice of music therapy at the three defined levels. Activity therapy is not concerned with why behaviours occur, but more with a here and now task orientated non-reflective approach. Wheeler (1983) had already found that this 'first' level of music therapy is likely to be more appropriate for the most seriously ill patients with the most severe personality disorganisation. She lists chronic schizophrenia here but also mentions in general any patients who require long term community treatment. It is interesting to note that two goals a) developing appropriate leisure-time skills and b) improving confidence did not feature at the activity level. It is suggested that perhaps music therapists should more closely align treatment objectives with need, and clearly these might be very relevant goals and therefore perhaps included at this level, to help successful transition into the community.

The second and third levels of music therapy which have insight as a primary goal are considered useful in eliciting emotional and/or cognitive reactions which Wheeler considers are essential for the therapy. She suggests that both these levels are not appropriate with people with severe personality disorganisation, but are more appropriate for people with problems of substance abuse, and those who have affective disorders, neurotic or anxiety disorders, situational disorders, or personality disorders. However, in a review of other music therapy literature she says that these levels can be used for those with illnesses that include symptoms of disorganisation, such as schizophrenia, if used over a period of time. This point relates to the work of Stephens (1983) discussed in section 8.3.1.

Smeijsters (1996a) undertook some research which relates to this study, and which started a discussion about indication criteria in Europe. He took the view that it was important to establish criteria for referral to music therapy in relation to broad categories of patient population and his work started to break these categories down to a few separate diagnoses. This author was part of this research and contributed to it in 1995 as discussed by Smeijsters (2005) later where he discusses the *'round table group'* (ibid 2005 p.16.)

The main focus of Smeijster's (1996a) earlier research was to distinguish how music therapy was helpful then for broad diagnostic categories (mental health, mental handicap) and to differentiate music therapy from other treatments for these categories. For example a questionnaire was sent to leading music therapists asking for statements about if and why music therapy was indicated (ie a suggested beneficial treatment for each category), and as such the design had some broad similarities with this research study.

Smeijster's (ibid) research did not focus in detail upon what type of approach and technique was indicated for each separate diagnosis and why, apart from in some cases such as anorexia and schizophrenia, which were cited as particularly important in the mental illness section. Some of the contributors, (Pedersen 1999, and Odell-Miller 2002), went on to develop these ideas in much more detail, and aspects of the later works are discussed in this thesis. However from the original document some things are important to mention.

In psychiatry certain approaches were defined as useful or not useful and the study was influenced by these and other later works for the general area of psychiatry. It must also be mentioned that this researcher was one of the main respondents to the Smeijsters study, so in some respects this section relates to this researcher's earlier definitions and categories formulated at the time she was involved in the Smeijsters (1996a) study.

The main examples defined by Smeijsters (ibid) from his study as useful in mainstream psychiatry (but not always specifically linked to specific diagnoses) were: recreational music, recreational music therapy, music activity therapy re-educative music psychotherapy and re-constructive music psychotherapy. Later in the Smeijsters (ibid) study there is more specific information which is based upon earlier work by Bruscia (1989) and Wheeler (1983 and 1987) which is also discussed in this literature review and which influenced the eventual design of the questionnaire.

Methods of music psychotherapy and recreational music therapy are linked to categories of how patients are looked after (for example long term, short term, and

crisis intervention) rather than linked to diagnosis specifically. However, schizophrenia is mentioned in particular in respect of supportive music psychotherapy and recreational music therapy. Generic aims for music therapy are mentioned as

> "personal development by using spare time, explore thoughts and feelings, emotional adjustment, reaching emotional balance, strengthening defenses, not focussed on insight and personality change."

> (Smeijsters 1996a p.3)

'Playforms' as part of music activity therapy are also mentioned as useful for people with schizophrenia incorporating musical games and other techniques referred to as recreational music therapy. In addition, the following are listed as problems or diagnoses helped by re-educative music therapy and re-constructive music psychotherapy:

> "mood disturbances, anxiety disturbances, psychosomatic disturbances, addition, relational problems, personality problems which are less severe"

> (Smeijsters 1996a p.4-5).

However many of the approaches list one or two diagnoses, and the survey was not systematically reviewing each diagnosis, but asked an open question about treatments and types of treatments that were indicated for any diagnoses. This was one of the reasons why this research study set out to review each technique and approach separately, linked to five major diagnoses, as mentioned previously in 7.4.

8.5 Research studies reporting method, guidelines, protocols and types of intervention in psychiatry

8.5.1 Introduction to studies in adult psychiatry linked to diagnosis

Outcome studies and RCT trials are predictably sparse in this field owing to the

problems of methodology (Edwards 2002, Odell-Miller et al. 2001, 2006). Diagnosis does not feature as a specific focus in some studies, but in others conclusions are drawn relating to diagnosis, whilst not relating the treatment technique to the particular diagnosis.

Cassity (1976) and Cassity and Casssity (1994) carried out research in general psychiatry, and whilst there is discussion about approach and technique particularly in the overview of USA music therapy studies (Cassity and Cassity 1994), there is no emphasis upon distinguishing between different approaches and techniques in relation to diagnosis. Cassity and Cassity in their study "Psychiatric Music Therapy Assessment and Treatment in Clinical Training Facilities with Adults, Adolescents and Children" designed a questionnaire asking music therapists what techniques are used with these populations. They asked music therapists to rank areas most commonly assessed for children and adults, and used a symptom checklist rather than grouping results into diagnostic categories. One interesting finding relevant to this study was that there was a consensus among the respondents that a key area for music therapy assessment and treatment is in helping with the expression of emotion which their patients were reported to find difficult (p.15). In addition it is reported that:

> "As with adolescents CTD's (Clinical Training Directors), preferred to assess/treat the inability of adults to identify/express feeling by using music listening with discussion. Music listening with discussion was chosen significantly more often than instrumental improvisation, the second most frequent condition" (ibid. p.15)

Whilst these results do not link directly to diagnosis, it will be interesting to see whether overall in this study there are similar outcomes when looking across all diagnostic categories.

8.5.2 Research studies in adult psychiatry relating to psychotic disorders

In the recent Cochrane Review on schizophrenia (Gold, Heldal, Dahl and Wigram 2006), as discussed in chapter 6, thirty four studies were assessed, of which four met

inclusion criteria. These studies were found to provide significant evidence that music therapy is effective for schizophrenia. All four studies (Tang et al. 1994, Ulrich 2004, Yang et al. 1998, Maratos 2004) compared music therapy added to standard care with standard care alone, and all studies used standardised measures. All studies showed that music therapy and standard care was superior to standard care alone for global state. Positive effects were shown for global states in schizophrenia, general mental state, negative symptoms, and for social functioning. Music Therapy with 20 or more sessions always had a significant effect for global states, and in contrast the overall effects of music therapy with less than 20 sessions showed unclear results. The Cochrane reviewers (Gold et al 2006) conclude that:

> "for these low dose interventions, effects on general mental state were non-significant, whereas negative symptoms of schizophrenia showed a significant response." (ibid. pp. 8 and 9)

An important conclusion is made here relevant to this study and links between intervention and diagnosis, relating the positive effect on particular negative symptoms of flattened affect in schizophrenia, to a musical intervention.

> "Negative symptoms are related to affective flattening and bluntness, poor social interaction and a general lack of interest. Music as a medium of therapy may address specifically issues related to emotion and interaction, and therefore it appears plausible that music therapy may be particularly well-suited to the treatment of negative symptoms" (ibid. p.9)

Given these outcomes, a closer look at the specific interventions for this diagnostic group reveals some interesting facts, which point to the need for this study, asking further questions of music therapists about which particular interventions are used, if any, for particular diagnostic groups. This will be discussed later in Chapter 12. Music therapy interventions in the four cited studies are summarised in Table 8.5 below. These four studies are cited by the Cochrane Review as producing evidence of the effectiveness of music therapy interventions for schizophrenia. Interventions are listed and any links with diagnosis made.

Table 8.5 A summary of the four research studies cited in the Cochrane Review (Gold et al. 2006)

Study	Music Therapy Interventions	Comments
Tang 1994	Active and Receptive large group (music listening, singing and playing on instruments, discussion)	In terms of technique, this relates to Using Live and Recorded music which are two categories in this research survey. Approach and theoretical orientation fits within Activity-Based. Definitely not psychoanalytic in approach and not improvisation techniques.
Maratos (2004)	Active individual (improvisation, songs, dialogue)	Psychoanalytically Informed with music improvisation as a focus relates to categories in this research survey: Psychoanalytically Informed Approach and Free improvisation with and without talking in terms of techniques
Ulrich (2004)	Active Group (focussing on musical process and discussion of patients problems)	Activity-Based and Structured Improvisation Based Techniques grounded in Behavioural and Developmental thinking
Yang (1998)	Active and receptive individual and group MT (music listening, improvisation, discussion)	Theoretical approach grounded in a medical model. In terms of techniques, relates to Free Improvisation with Talking and Activity-Based in this research survey.

In summary Table 8.5 shows that active and receptive techniques are used and there is an implication that these are structured, although two studies (Yang 1998 and Maratos 2004) use improvisation. There is little to connect these techniques with the diagnostic aspects of schizophrenia in the studies, and more indication that the techniques used are those which the music therapists in the studies are trained to use. There is also little emphasis upon theoretical orientation and approach, related specifically to the diagnosis, showing a need for this new study to ask questions and encourage music therapists to define these aspects of their work in more detail.

It is interesting to look at generic studies where people with a variety of diagnoses are included and some are discussed below which influenced the thinking for this study. Bunt et al. (1987) carried out a qualitative pilot study with a group of adults with psychiatric diagnoses over eight weeks with a questionnaire method where participants made their own evaluation. Clinical techniques are not described in detail but seem to include free improvisation both structured and theme based and more directed. Positive and negative aspects of the group experience were evaluated. The subjects' diagnoses are not specifically commented upon or linked with outcomes or techniques. One interesting conclusion is that it seemed from the questionnaire evaluation that participants experienced most change during each group in their interactions with others through playing instruments rather than singing or listening. The evidence is quite subjective, as no specific tool was used to measure each technique in detail. In general positive responses from clients outweighed negative ones, but the lack of diagnostic detail points to further exploration of the areas in this research study.

As discussed earlier, Cohen (1986) reports on a research project which suggests that structured rhythmic tasks are effective with people in the manic phase of their illness (bi-polar disorder). The study compared groups of patients in a manic phase of their illness with patients suffering from other psychotic and non-psychotic disorders. The study looked at rhythmicity and subjective tempo, and patients were given three tasks involving maintaining steady beats, reproducing rhythm patterns, and creating rhythm patterns. Analyses of variance showed that the manic inmates were superior to other psychotic inmates and no different from non-psychotic inmates in rhythmicity and

tempo reproduction. The author suggests that these findings show that musical-rhythmic tasks could assist in verifying diagnostic distinctions between manic and other psychotic patients, although, there is not a focus upon actual treatment considerations.

Pavlicevic, Trevarthen and Duncan (1994) carried out one of the first research studies in music therapy which applied a control group design to music therapy improvisational work with people with schizophrenia. The study links method and outcomes both clinically and from a research point of view, to diagnosis. The rehabilitation of people with schizophrenia was explored through the use of improvisation and a comparison made between a treatment group and a control group. Music therapy is defined by Pavlicevic as:

> "the use of improvisation to establish one to one connection………
> The active participation of the person seems particularly appropriate
> for this group whose apathy and lack of motivation and initiative is
> well known ……….. This opens the way for a highly specific mode of
> communication in which, however idiosyncratic a person's utterances
> are, they come to make sense to both players" (Pavlicevic et al 1994 p.
> 87)

So links with the illness and symptoms are made with what music therapy aims to achieve.

In an earlier study (Pavlicevic and Trevarthen 1989) used a musical assessment scale to measure musical engagement. This showed that a group of people with chronic schizophrenia had greater difficulty organising the production of sounds and interacting reciprocally with the therapist, than a group of uni-polar depressed patients or 'normal' controls. Musical expression was frequently disorganised so that the therapist had difficulty supporting and matching. This is explained as the schizophrenic person's incapacity to attend to musical utterances of another player. This therefore led to the later study (Pavlicevic et al. 1994), which explored whether improvisational music therapy as used in assessment may play a significant role in the rehabilitation of people with chronic schizophrenia. Specifically, the study explored

whether the capacity for interaction (a difficult area for many people with schizophrenia), could be significantly improved over ten weeks in individual music therapy sessions.

In this matched study 21 people were allocated to weekly music therapy, and 20 allocated to a control group, the members of which had one session at the beginning of ten weeks and one at the end. There is no mention of why and how the patients were chosen, whether control or treatment, and how the randomisation was organised, for each group.

All 41 subjects took part in the first session which was recorded on audio and video. The session format was described in detail, which is relevant to this study, as few studies describe session format in such detail. A brief interview was given to ascertain each person' s previous musical experience and musical back ground, whether they had played an instrument, if tunes were remembered after one hearing, and if they were generally affected in mood, by music. Subsequently an improvisation took place with the patient playing the bongo drum and a marimba (tuned percussion instrument). Subjects were asked to begin playing in whatever way they liked and were told that the therapist would join and play with them later. For the bongo improvisation, the therapist played the piano concurrently with the subject whereas for the marimba one the therapist and patient took turns to play on the same instrument, as if having a dialogue. All subjects were screened and diagnosed as suffering from chronic schizophrenia, and rigorous standardised measures were applied.

During both improvisations the therapist made alterations of tempo rhythm phrase length for later analysis. Pavlicevic et al. (1994 p.91-2) adapted the Music Improvisation Rating (MIR) scales especially for schizophrenia, with nine levels corresponding to symptoms and features of schizophrenia. This is significant to this study because it suggests thought and consideration to a specific technique in music therapy which is appropriate for people with schizophrenia, focussing upon diagnostic links to technique.

From the first to the tenth session, there was significantly higher change in interaction levels in the treatment group, but not in the control group who only received a music therapy session during the first and the last week.

So what can be learned from the study that is of interest to this study? The treatment group showed a significant increase in their length of interaction by the end of session ten. Control subjects showed a small non-significant improvement for their MIR (S) scores and the difference in the length of their improvisation between their first and final session was negligible. The Analysis of Covariance suggests that those subjects whose initial Brief Psychiatric Rating Scale (BPRS) scores were high (i.e. those who were more severely ill), also had higher final BPRS scores. However the subjects with higher BPRS initially showed a greater drop in their scores and showed a greater degree of improvement in their BPRS scores. (ibid. p.99)

This could suggest that people with chronic schizophrenia who have a more severe illness might benefit more from these techniques in music therapy than those with lower BPRS scores, and could be examined in future studies. It is therefore interesting to note whether the opinions of the music therapists in the survey point to this finding. treatment group subjects clearly improved in their capacity to be responsive to the therapist.

The treatment group gained in capacity to be responsive to the therapist although did not gain in levels 8 or 9 of the MIR scales which include taking the initiative in musical interactions. Patients also responded to the therapist's expressions appropriately in a shared context in the treatment group which points to the technique of Creative Music Therapy as a useful one for this population. A longer period of treatment might have resulted in higher levels of interactions being reached, and scores rising around the eighth session supports this. On the other hand the researchers in the study wondered whether people with chronic schizophrenic can be brought to free levels of co-operation with another person, and suggest further study is required. This influenced the design of the survey, emphasising the importance of including different types of improvisation, and also a Nordoff-Robbins (Creative Music Therapy) approach in the categories.

Much of the literature about schizophrenia concerns live music, and there was little literature available about Guided Imagery in Music for people with psychotic disorders at the start of this research.

However, it is important to mention that Moe (2002) adapted GIM for people with schizophrenia in an inpatient setting, where nine patients diagnosed with schizophrenia or with schizotypical disorders participated in a therapy group during a six month period. The study focuses on 'restitutional' factors in the therapeutic process and the patients' evaluation of their therapy.

Moe describes the experience of four patients, focussing upon their imagery, and developing a theory about the relationship between self-objects, psychological defense mechanisms and restitutional factors. He is therefore linking the approach with facets of the diagnosis, and concludes that music listening and the imagery arising from this acts as a container - providing safety in its structure and a vehicle for the patients' projections. He also found that this approach decreased patients' anxiety. This he describes happened in the following way:

> "According to the empirical material, the patients' image representational system is activated and functional. In my category system areas are highlighted where the image is activated-as well as examples of image transformation. It also appears that the patients are capable of structuring and making emotional connection of certain images, which thereby become self-objects, and also they are capable of connecting images in inner object relation patterns …….. From the empirical results it seems to be the case that, if the ability to symbolise/create images has been established, it is possible to psychotherapeutically process ''stranded'' and fragmented self images and object relations with schizophrenic/schizotypical patients in the setting given." (Moe 2002, p.65)

By this he means that "a contact is created via the music with the experience of the damaged subjective self , which then enters a 'repair' process where exactly stranded objects are identified and picked up." (ibid. p.165). This is important because it

supports the notion that through music a connection can be made which is different to words, but unlike others who focus more on improvisation with people with schizophrenia (Pedersen (1999) and Jensen (1999), he is using listening within an adapted form of GIM.

De l'Etoile (2002) at around the same time as Moe, carried out a study referred to as a pilot study, in order to examine the effectiveness of music therapy in short-term group psychotherapy for adults with chronic mental illness (bi-polar disorder, depressed phase; schizophrenia, undifferentiated type or paranoid type; with and without history of substance abuse). It is included here because the main diagnostic categories in the study appear to include psychosis. The research questions were linked to:

a)   symptoms: as a result of participating in music therapy intervention will patients report a change in psychiatric symptomatology?

b)   attitude: how does attitude change towards seeking professional psychological help as a result of music therapy intervention.

In de l'Etoile's study, eight participants with chronic mental illness, stabilised on medication and living in either group homes with families or independently took part in hour long sessions of music therapy for six weeks. Although the study is not specifically linked to diagnosis, it is linked to interventions and types of interventions and therefore relevant here. The technique includes talking with listening to music, and the musical material is described as follows:

"Musical material was selected from what was considered to be popular music during the young adulthood of most group members, including such artists as Simon and Garfunkel, Bob Dylan. Music experiences were designed to positively modify affect, allow for identification of feelings, and provide opportunities for group members to interact with one another." (de l'Etoile 2002, p.84)

The study is not specifically linked to diagnosis as it describes people with different diagnoses, and is only a pilot study, but the techniques are described in detail and conclusions drawn about symptoms, concluding that the symptoms which appeared to

reduce most as a result of music therapy were related to anxiety. It could be that the high level of structure used in the sessions helped this and the author concludes:

> "perhaps having clear expectations for appropriate participation and being able to anticipate the progression of the session's activities helped to mitigate group members' anxious feelings" (de l'Etoile 2002, p.75)

De l'Etoile (2002 p.65) describes the model as following Thaut's USA approach (Thaut 1989, 1990, and 1999), which involves more receptive and structured techniques as opposed to those more based in live free improvisation described above in much of the European literature. Techniques were music listening, lyric analysis, music in conjunction with other arts media, instrumental improvisation, song writing, group singing, and music for relaxation. Some of these techniques were included in the categorisation for this research study design.

In de l'Etoile's study, there is emphasis upon musical experiences as modifiers of affect and expression of feelings in order to allow members to interact with one another. Verbal reflection in particular relating the musical experiences to what was happening in their lives, was also a technique used. There was high reliability, and measures were taken before the first music therapy session, between the third and fourth sessions and following the sixth session. As such the progress was measured in a similar way to the study by Pavlicevic et al., but in de l'Etoile's study, improvisation was not the main music therapy technique.

Whilst it is not possible to make any firm conclusions from de l'Etoile's pilot study related to diagnosis there are some other interesting outcomes. In addition to the anxiety symptoms that seemed to reduce, three other symptoms, somatisation, depression and psychosis increased steadily throughout the study. However, as all the mean scores tended to be low throughout the study this was not a large increase. De l'Etoile suggests that participants were not experiencing high levels of emotional distress or psychopathology at any point during the study. Not discussed by de l'Etoile is the possibility that these symptoms might become more prevalent when anxiety is reduced. There is a suggestion that group cohesiveness improved over time

which concurs with literature from the field of psychotherapy (Yalom 1995, Evans and Jarvis 1980) and results concur with clients perception that this is important as also discovered by Cassity (1976) which indicated that music therapy increased cohesion over time.

It is important to be cautious about drawing conclusions from a pilot study, and the six week period is not very long for music therapy to take effect with this population. Notwithstanding the fact that there are no specific links to actual diagnosis, there are also things worth noting. Similarly to Odell-Miller et al. (2006) in their arts therapies outcome study with a similar mixed population, the researchers found that there was high variability in the pre and post testing. This was revealed in the participants' responses in discussions and ratings about their perceptions of the music therapy and themselves. In the Odell-Miller et al. study these dramatic swings were found for people with schizophrenia, but there is no way of knowing this detail for de l'Etoile's study, and which particular diagnosis led to this phenomenon.

The final research study to be discussed concerns the use of Song Writing as a technique for a man with schizophrenia (Silverman 2003). Whilst there is a very detailed comprehensive description of Song Writing for a man with schizophrenia who had combative behaviour which reduced in sessions during the research study, there are some omissions in the research design such as how and when the nurse-designed Likert scale was measured. The music therapy technique is activity-based and music itself used in a behavioural way as a reward for completing a given task. There are some links with diagnosis in that the difficulties of rapport, mood, negative interactions and insight are all described as improving after the music therapy, through the song-writing programme (Silverman 2003 p.30-31).

Silverman also makes comments about the diagnosis, and it seems that the setting was quite non-conducive to in-depth therapy as he describes a group of 16 with mixed diagnoses including autism, in the experimental research music therapy group. Silverman cites Unkefer (1990) in his support of song writing, who much earlier recognised that song writing required many behaviours that people with schizophrenia might find difficult, such as talking, insightful thinking, recognising emotion, coherency of language, and writing. Silverman concludes that songwriting can

improve self-esteem and is viewed as a creative way for clients to share thoughts. It will be interesting to revisit this in the light of findings from this survey.

8.5.3 Research studies in adult psychiatry particularly relating to depression and anxiety

As stated earlier, many research studies about depression and music therapy are related to some form of substance abuse, but are worthy of mention here as they focus on more receptive techniques. Some studies link these to the diagnosis although few reasons are given as to why or why not certain techniques are used (Cevasco 2005, Hammer 1996, Chou 2006, Tyson 1987, Williams and Dorow 1983). Radulovic, Cvetkovic, and Pejovic (1997) in a controlled trial, using group analytic techniques of listening to music (described as guided fantasies); compared music therapy and medication, with supportive cognitive methods and medication. There were two matched groups of depressive disordered patients. Conclusions were that both psychotic and non-psychotic patients went through the same phases in the course of the psychotherapeutic process. These were resistance, active sadness, aggression and insight. They concluded that music therapy is equally efficient both for the psychotic and non-psychotic forms of depression, but it is not clear why a listening technique was specifically used with this group of people.

One relevant study, (Smeijsters et al. 1995) looks at the links between sets of values and music excerpt listening for depressed patients. Values are defined as anything important in the person's life, and in this sense, because a sense of value is often lost through depression, the study is specifically making a link between the music therapy technique and the diagnosis.

Depressed patients listened to 16 carefully selected musical excerpts twice, with an intervening period of one to one and a half months. Patients were asked to select from a list of values that they felt were elicited by the music. Statistical analyses revealed that certain musical excerpts evoked certain groups of values. Other variables related to the values evoked by music included: the type of depression, life events, recovery, music education and music listening behaviour. The study suggests that musical excerpts can evoke particular values in depressive patients. What is striking here is

that much of the literature does not seem to focus upon an improvisational interactive approach for depression, so it will be interesting to look at the results of this survey in the light of this. Reasons for this may partly be the prevalence of American based studies within a previously much more behavioural context. This is illustrated by a study carried out by Williams and Dorow (1983) using an ABA single case design to determine the effect of a treatment package (consisting of interrupted music and verbal feedback), on the frequency of the complaints and non-complaints of a chronically depressed psychiatric patient. Results showed a marked decrease in complaints and an increase in non-complaints during the interrupted music phases. Level of complaints remained lower during the final no-music phase, indicating residual effects.

Looking at more active live music therapy techniques, Cevasco (2005) aimed to measure the impact of music therapy interventions on levels of depression, stress, anxiety, and anger of female clients in substance abuse rehabilitation. Although this does not represent the psychiatric settings described and explored in this study, and was written whilst the study was taking place, it is included here in order to provide a more balanced literature review. Ten female outpatients in a drug and alcohol rehabilitation treatment programme received music therapy twice a week for six weeks. The techniques described were movement-to-music and rhythm activities, and competitive games for two weeks, for four sessions per person. After each intervention state-trait anxiety and levels of anger were measured. A repeated-measures ANOVA test indicated no significant differences for the three types of music therapy interventions. This is relevant to this study, particularly as the survey set out to define what music therapists do and why with each diagnostic population. It is also one of the few research studies to report using non-receptive techniques. However treatment was very short term and not much clinical in-depth information is given. Data was collected on daily scores, immediately before and after each session, which indicated that individuals reported a decrease in depression, stress, anxiety, and anger immediately following the music therapy sessions. It could be concluded that these task-based activities are useful with depressed clients also suffering from drug and alcohol-related problems.

Another study about depression and Guided Imagery and Music was carried out by Hammer (1996). Similarly to the Cevasco study, subjects were involved in alcohol and chemical dependency rehabilitation. The experimental group received ten treatment sessions and a control group received no treatment. Stress levels were measured through the State-Trait Anxiety Inventory (STAI) and test results showed that the experimental group experienced a decrease in perceived situational stress that was statistically significant. Verbal reports and observations confirmed this. Results indicate that GIM may benefit people with chronic stress and anxiety.

Having considered the specific literature relating to diagnosis and mental health, and links between approach and technique, a more general final look at the literature which discusses approach and technique is now taken.

8.6 General research relating to approach and method

Skewes and Wigram (2002) discuss a qualitative method of music therapy research using a questionnaire technique and choosing experienced practitioners. In this respect it is very similar to the design taken in this study, but does not specifically relate to music therapy with adults in psychiatry, or to diagnosis. More detail about this is given in Chapter 9, but here the subject-specific aspects are relevant, because Skewes and Wigram's aim was to gather information about approach in groupwork by music therapists.

Skewes and Wigram's study poses no questions about diagnosis, and such information was not asked for from the participants. We could conclude from this omission that the authors consider diagnosis and links to approach and technique not important, or purely that it was not their focus. Conclusions suggest that music is different, and transcends some of the usual ways that people behave or are perceived. However there are comments at the end that therapists who worked with verbal clients tended to assume a non-directive stance and allow adults to find their own direction. Those who worked with interpretation were more likely to desire verbal consolidation than others. This seemed linked to the way people had been trained rather than what might be useful for the patient and their mental state. A comment was also made that

in the analysis, Creative Music Therapists (here meaning Nordoff-Robbins trained therapists) tended to:

> "display a commitment to providing the musical form and structure for the group preferring to play an instrument that could hold the group together when necessary" (Skewes and Wigram 2002, p.54)

Whilst this is not specific to an adult mental health setting, it will be interesting to return to in the light of the results in this study which asks specific questions about Creative Music Therapy and other approaches in adult psychiatry.

Dunbar (2001) and Procter (1997) in their Masters level research both explore, similarly to this study, the question of the music therapist's role and interventions. Dunbar explores the question of what influenced music therapists' choice of pre-composed, semi-improvised or improvised activities. She wanted to know whether it depended upon age, clinical group, or context. Although she does not specifically refer to diagnosis, there are some interesting conclusions which will be returned to following an analysis of the survey results of this study. She found that structure in activities is a fundamental building block of music therapy and concluded that musical structure should be considered at different levels (ibid. p.60-61). Her further findings that the relationship between clinical aims, the type of group, the therapists approach, and the structural development of the session is complex, point to the rationale for this study, although she does not make any specific points in her study about diagnosis for adults between 18-65. She suggests regarding technique, that with the possible exception of dementia (which is not included in this study), that over time all groups examined moved towards more freedom in the activities they were using. She also concluded that the presence of a co-therapist affects the structure by enabling a double focus.

Finally and more relevant to this study, she found that the degree of free improvisation used varied across groups, but was used most in adult mental health settings. Her research was qualitative and there is little example of the actual musical techniques used. However she found that literature on group work with adults with

mental health problems focuses on free improvisation, but includes initial exercises using 'semi' improvised activities.

Procter (1997) in his study about the significance of predictability within the music therapist's input, looks at its significance for adults with mental health problems. Similarly to many other music therapists, and cited by Cassity and Cassity (1994) in their earlier study based on American music therapy techniques and approaches, Procter draws attention to the importance of music providing structure to mental health patients. His argument is that predictability in music is one such structure. He does not link his research to specific diagnoses, although makes some general points about psychosis. He suggests that repetition is important. He makes the point that music therapists should see their task as using structured improvisation to help the client with psychosis become more organised in order to conform to the outside world.

Procter includes a detailed analysis of musical improvisation from notated manuscript, with a person with schizophrenia, and a person with depression. He refers to typical traits linked to diagnosis but no specific link is made between techniques and approaches used, and the different diagnoses specifically. However, it is notable that in the work with a person with schizophrenia, Procter describes constant shifts in the music that seem unrelated to what the therapist is doing. He describes a constant pull to follow, rather than experiencing interactive playing. Predictability in this case enables the therapist and patient come to a comfortable moment: "Together we have found a place where we can be creative within a context of predictable simplicity" (ibid. p.49).

Procter concludes that the predictability which exists in co-improvisation that is meaningful and audible encourages the 'connectedness' that adult mental health patients often find difficult. This correlates with the value attached to structure and predictability in the general mental health literature.

8.7 Summary

It appears that there are very mixed opinions about which music therapy approaches and techniques are indicated for which diagnoses. This literature review reveals different approaches and reported techniques, which are supported, or not, by different authors without consistent clear evidence as to why this is. Some decisions regarding method are related to hard fact and considered clinical opinion from research and experience, while other decisions are made on the basis of the training and expertise available, patient choice, available resources, and orientation of the wider setting. The rationale for these decisions is argued in some cases and not in others. For example for people with schizophrenia arguments are presented supporting the usefulness of working psychoanalytically and encouraging insight, and conversely, of not using this approach. Free improvisation is advocated by some authors, and others stress the validity of more structured music making and receptive techniques. This is sometimes due to preference, as well as the culture within which either the patients or the therapists are grounded.

In conclusion, there is a general lack of clear definitions of approaches and techniques related to diagnosis, particularly in the literature arising from European countries. This may be because of a lack of evidence that one technique or approach is more effective than another, and also because music therapists may perceive that linking treatment to diagnosis will decrease the perception of patients' individuality. It is for this reason that the survey for this research study was designed in order to find some emerging patterns and trends related to each specific diagnosis. This will aim to follow current trends in psychiatry, which often link different treatments to specific diagnoses.

CHAPTER 9
METHOD

9.1 Introduction

The intention of this study was to gather as much information as possible about music therapy approaches and techniques within certain diagnostic categories in adult psychiatry, in order to devise guidelines for music therapy practice in the future. The objective was to target well-established music therapy services where there is a body of knowledge not necessarily formulated into external publications, but which exists in practice, or in unpublished reports or documents.

These services, which acted as 'Case Studies', were chosen because they include practitioners with expert knowledge, who between them would represent a diversity of practice in music therapy in psychiatry across Europe. They represent different types of music therapy training backgrounds, and different cultural aspects of the work between them. This approach, involving both convenience and purposive sampling, is similar to existing models of survey-based research in music therapy and other disciplines. (Grocke 1996, Skewes and Wigram 2002, Hussey and Hussey 1997). The process of taking part in this survey was seen by the centre participants to contribute to knowledge and practice in their own place of work and to the field in general. The rationale was that by asking detailed questions of music therapy clinicians, in five centres in Europe, patterns of information would emerge which answer the main question, and which would fill existing gaps in knowledge.

9.2 Design

9.2.1 Choice of design

The design of the questionnaire was a major part of the project and it involved defining approaches and techniques to be studied, agreeing categories, designing measuring scales, and testing the original tools in a short pilot study. This process took a year and the questionnaire was refined and checked with other researchers internationally within the Aalborg University PhD courses. The questionnaire was

designed by the researcher to answer the specific question: What do Music Therapists do in adult psychiatry, with which populations, and why? Here, 'populations' refers to diagnostic groups, and the main question in the thesis was central to the design.

The hypothesis was that music therapists could articulate previously unreported information in a systematic way about exactly which methods and approaches of music therapy they use with which diagnostic groups, in which contexts, and why. The expected outcomes were that the information gained would inform clinical practice, and would contribute to future knowledge which will be of use to practitioners, users, employers and purchasers. The research questionnaire design was influenced by the researcher's study of the literature, and her involvement in music therapy research nationally and internationally. After carrying out two clinically controlled trials, one randomised and one not randomised (Odell-Miller 1995, Odell et al 2006, discussed and presented in Part I of this thesis), the author concluded that a different and more detailed evidence from practice is needed alongside hard outcome data. The method in this study enabled more detailed practical information about what happens with patients to be obtained.

Major influences for the choice of design arose from the type of data required, which was mainly descriptive, although some quantitative outcomes were also expected. A survey design was therefore indicated, similar to that discussed after the start of this study by Wigram (2005), and as described in a study by Skewes and Wigram (2002). These design issues and a short summary of the thinking behind the design are now explored.

9.2.2 Considerations and influences for the design

The literature which influenced the design was based in the music therapy field and also in the social sciences and business field where demographic and categorical studies about modes of practice are prevalent. In a doctoral music therapy study, Skewes and Wigram (2002) studied the different ways music therapists use improvisation in group work. A purposive sample of music therapy practitioners working in the USA was chosen in order to look at current practice in group music

therapy improvisations, and the ten participants had to meet similar criteria to those in this study:

> "Accessibility, publication or reputation in the area of music therapy of music therapy group improvisations, fluency in English language speaking and willingness and availability to participate in the interviews that would be used for the creation of a current practice review within the thesis" (Skewes andWigram 2002 p.46*).*

Participants were also approached directly by Skewes and Wigram to ensure they met the specific criteria. The design involved gathering rich data from a small number of sources, and is common practice in this type of qualitative study (Hussey & Hussey 1997). Similar types of qualitative studies with some quantitative data were the main influence on the design.

This researcher had used qualitative and quantitative designs in previous research as demonstrated in Part I of this thesis. In designing the questionnaire a topic guide was considered, as used by Odell-Miller et al (2001), Odell-Miller, Westacott and Hughes (2006) ; Skewes and Wigram (2002). In previous studies, after asking questions and developing a topic guide for questions, all interviews were transcribed. A distillation process was used because the data was more detailed and substantial in qualitative terms in comparison with this study.

In this study, factual evidence was required that answered the specific question 'what do you do with which populations and why? The rationale for the study was to see if music therapists could define what they do and why, and it was therefore decided to analyse exactly what music therapists wrote in response to the questions, rather than involve participants in the process, or transcribe detailed interviews. One exception to this was for reasons of geographical location and time constraint. For this centre (centre D), the answers were recorded by the researcher who literally wrote down and transcribed the answers, rather than interpreting or entering into a dialogue. All centres were offered this facility but only one chose to use this means of providing the data. Two other centres were visited in order to clarify procedures. The author held a part-time position in one of the five centres, and contributed by completing part of the

questionnaire which was then incorporated into the team response, co-ordinated by the head of the service.

Other sources considered in designing the methodology included Langenberg et al (1997), an edited text that includes many research orientated studies about music therapy, Gilroy and Lee (1994), and research design sources from outside the music therapy profession (Miles and Hubermann,1994, Strauss and Corbin 1998). Research in the field of business and sociology was also relevant to the survey research design, and O'Brien (1993) for example uses the analogy of a kaleidoscope when discussing theoretical considerations for research such as this. His idea is relevant to this study because the centres and organisations examined in this study are highly complex in nature, and the aim of this study is to elicit clear patterns and trends in a focussed way.

The relevance of research findings to music therapists, their clients and their clinical work was central to the design, as suggested by Aigen (1997p.15) in his self study Combining Clinical and Research Roles. Aigen also stresses that the narrative which music therapists or their patients might have, should be at the heart of any qualitative research. This aim was central to the study, where music therapists would hopefully also learn and gain from describing their work in this way. Aigen's study of four clients could be seen as a parallel design to the one in this study which has similar aims in its qualitative methodology, but which is about five centres and groups of music therapists, rather than about interviewing four clients or patients. This study aimed to gain a narrative which would mean that the work of the centres and the viewpoints of the music therapists in the centres were understood more fully as a result.

Whilst Survey Research is located within Quantitative Methodology, (Wigram 2005), for the purpose of this study, both numerical and descriptive data was expected and so a mixed design was chosen. One aspect of the method was to take five case studies and make comparisons and generalisations by looking at measureable outcomes across these centres. This is congruent with the Survey Approach. However the study also wanted to ask open questions and try to gain an understanding of the music therapist's narrative, the story behind what they do and why. In this way, and because

of the limitation of time for the participants, and size of study, an adaptation of the narrative and case study design was used for the qualitative aspect of the method. This will be discussed further in section 9.6. A survey research approach therefore was used, which is often applied to gain demographic details in social science and anthropological research, following a qualitative descriptive design.

In choosing the research methodology, research based articles were reviewed that discussed either music therapy research methodology in general (Wheeler 1995) or according to their relevance from a methodological point of view (Skewes & Wigram 2002) or according to their focus upon adult psychiatry. (Chapter 8). The details of the latter study have been discussed more extensively in 8.6.

Some other influences were Edwards (2002) who discusses an Evidence Based Medicine approach in hospital-based services. Similarly to Wigram (2002)[1] who presented a hierarchy of 10 types of evidence, she describes four levels of research pertinent to music therapists investigating hospital-based services ranging from a systematic review of controlled trials and randomised controlled trials, to case studies obtained by a case series with pre and post tests.

Edwards suggests that if music therapists do not adhere to all principles of Randomised Controlled Trials (RCT), they should expect criticism. This view is pertinent to this study because this author decided not to carry out another RCT trial unless it could be done under ideal conditions, in terms of being diagnostic specific and using enough subjects to obtain significant results. Therefore as a step towards further such randomised controlled trials which will be necessary in the future, an information gathering research study aimed at categorising the existing knowledge, was favoured.

Interestingly, later in her article Edwards critiques the model of RCT scientific outcome research because she says music therapy is not administered as a protocol, by

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[1] Since this study, a more recent and expanded version of this research involving the whole of music therapy with children and adolescents was published. Wigram, T & Gold C, 2006   Music therapy in the assessment and treatment of autistic spectrum disorder: clinical application and research evidence *Vol. 32 Issue 5 Page 535 September 2006*

the therapist. The interactive relationship so important in music therapy might render the RCT impossible or irrelevant, in her view. Whilst this can be true, there is a drive in the State sector in some countries particularly in the USA and UK to devise at least guidelines and if possible protocols for treatment that relate to diagnosis hence the attempt to discover more in this study.

Edwards (ibid) argues against the placebo effect as in her view it is not always possible in music therapy to isolate the particular effects of music therapy. She says rather than try to deal with the difficulties of the placebo and RCT model, it might be better at the outset to discuss the whole treatment package effect of music therapy. This point is interesting in the light of the fact that music therapy is one of the Allied Health Professions (rather than 'alternative'), and as such makes an 'alliance' with other health inputs that balance out and complement each other . It is implied that music therapists might not necessarily claim the effect of music therapy as an isolated effective treatment, but as part of a whole multidisciplinary intervention. This point was also discussed earlier (Odell-Miller 1995a) during the initial phases of exploring music therapy research with adults under the age of 65 in hospital and community-based services. It was important throughout the survey in this study to ask questions about context and elicit comments therefore about teamwork, although multi-disciplinary work did not emerge as a focus in the study.

It is this researcher's view that music therapy designs that include qualitative and quantitative methodology (Oldfield 2004, Bonde 2005) are suitable in the field of music therapy whether music therapists or their clients are the subjects, to obtain diverse and rich outcomes. The paradigms necessary for conceptualising both the analysis of data and collection of data include both numerical and qualitative data which will be equally important. This is because on the one hand the depth of thinking expected in the participants' responses as to why they do or do not use certain methods and approaches, invites detailed qualitative analysis. On the other hand the yes and no answers and scores cumulated for the many approaches and techniques invite numerical statistical analysis. This way, the context of the data and possibilities for flexibility in making the best use of the data was an essential part of the design, as discussed by Robson (2002) and Wheeler (2005). For example numbers of Yes and No answers expected across all centres for each method and technique could be

amalgamated, and statistical tests carried out. In addition the rich qualitative data could be analysed and discussed alongside the numerical results in order to gain the maximum relevant outcomes from the data. The Survey based design was therefore chosen for the study with a mixed method design.

9.3 Participants

Five music therapy centres in Europe were selected to be included in the study, where there is a long established music therapy tradition in adult psychiatry. The head of each of these services was invited to participate. Before detailing the centres themselves, the selection process, involving a purposeful sample, will be described.

9.3.1 Participant inclusion criteria

The selected music therapy centres were required to meet the following inclusion criteria:

1. The Music Therapy service covers a wide clinical field in psychiatry with the full range of services such as acute, rehabilitation and community services.
2. The Music Therapy service provides for adults between 18 -65
3. The Music Therapy Service is well established.
4. The Music Therapy service is part of mainstream or state provision, with an obligation to serve the whole population, rather than a more elite privately run service.

9.3.2 Participating centres

There were five centres in Europe which agreed to participate in the study.
Of these, two wanted to remain anonymous, so the centres were coded and are discussed without identification during the study.

Centre A is a Music Therapy Service in an adult mental health service with National Health Service (NHS) Trust status in the UK serving a town and rural catchment area. It has a central referral system, with the music therapy service located in a well

established arts therapies service containing all four arts therapies treatment modalities. It has a strong community focus with a medical model predominant, mixed with a range of Recovery, Psychological, and Occupational-based treatments. Facilities include a mix of in patient, out-patient and day facilities, spread across community centres, ward and hospital based facilities.

Centres B & C are large well established city-based adult mental health service with NHS Trust status in the UK, with music therapists and other arts therapists located Trust-wide, having both a central referral system and a location-based service. The Music Therapy service provides in-put to in patients and out-patients and day services.

Centre D is a large well established Adult Mental Health Service in Belgium, with a Psychoanalytically- focussed treatment model across the service. The Music Therapy service provides in-put only to in-patients.

Centre E is a large well established adult mental health service in Denmark with a mainly medical focus, but with some psychological treatments. The Music Therapy Service provides in-put only to in-patients and groups are not generally run by music therapists except in the specialist personality disorders service.

Table 9.1 provides basic demographic information from the five centres. This is placed within the method section, rather than the results section, in order to report details of the sample recruited for this study. The results section will concentrate on reporting the main findings from the survey regarding approaches, methods and techniques.

Further information regarding the range of services within the five centres, their research profile, institutional models and service provision, is provided in Appendix XIII in tables 13.1- (put in appendix the following) : The details provided regarding the centres in Appendix XIII are presented to illustrate the nature of the services involved, and to substantiate their eligibility as participants within this purposive sample.

Table 9.1: Profiles of the services involved taken from the survey

Question	A	B	C	D	E
Years in Service of Music Therapist Head of Service	>10	<10	<10	>10	>10
Number of Music Therapists	5	3	6	4	5
Whole Time Equivalent	2.53	2.6	3.09	2.7	2.5
Type of service	All: hospital-based and community and day services, using a mixture of models as shown in **Table A13.4** (see Appendix XIII)				
Funding	All state/government except D (both state and private)				
Population of area served	20000	20000	216510	20000	Approx 200000

9.3.3 Distribution of diagnoses for the different centres

The centres were also asked about the proportion of resources which were devoted to patients in different diagnostic categories. The charts of these responses are given in Chapter 10, together with the diagnostic qualitative data analysis. Centres were asked to calculate the percentage of time spent with each diagnostic category, by the music therapy team, or the percentage of patients treated in each diagnostic category. This way the results can be looked at in the context of each service and differences and similarities can be seen. In summary the centres all prioritised the psychotic disorders for music therapy, but there are marked differences between centres in how much time music therapists spend providing music therapy to specialist areas such as eating disorders and personality disorders.

9.4 The Questionnaire

The survey design was selected, because rich in-depth data was required, but the questionnaire design also involved some forced choice, ranked questions, in order to collect factual data. It was expected that by categorising the data and analysing it, patterns would emerge and conclusions could be drawn. Therefore the researcher followed a format in the questionnaire which would directly provide answers to the research questions. Owing to this, questions were organised in order to determine:

What do music therapists actually do in the field of mental health?
What populations do they do what with, and why?
What informs their practice?[2]

A small pilot project was undertaken with an experienced music therapist, which mainly resulted in the definitions and categories becoming clarified and some of the categories more fully explained in notes for the respondents. The questionnaire was also tested out with the research team at Aalborg University. This process enabled the design of the questionnaire to be refined. A blank version of the questionnaire is

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[2] These questions are included in the original questionnaire, and are phrased in colloquial language in order to encourage clinicians to relate directly to the questions and apply them in every day work. They are not the main research questions, but arose from the main questions, which were adapted for the questionnaire.

included in Appendix X1 and a summary of the questions is included in Appendix X11

The questionnaire is designed in three sections:

1. Demographic Data to ascertain facts about the setting of the music therapy service

2. Ranking Measures in order to determine patterns of use and non-use of defined specific music therapy techniques

3. Forced choice questions that elicited yes/no using a Likert scale, (Hussey & Hussy 1997 pp. 170 & 171). Open questions that allow participants to write in descriptive detailed information relating to the method of therapeutic intervention were devised. The underlying focus was to elicit information based upon the following questions

a) What do music therapists do? (methodological question).

b) Why do they use a certain treatment method? (diagnostic question divided into theoretical 'approach', and 'technique').

c) When do they use a certain treatment method? (procedural and contextual question).

d) How do they implement a treatment method (technical question).[3]

Respondents were asked for case studies to illustrate their answers to these questions, particularly question d). The full questionnaire is shown in Appendices I-V, together with the guidelines for participants and some Ethics procedure documentation (Appendix VI). A summarised description of the structure will now follow as this formed a major part of the research method.

9.4.1 Summary of the questionnaire and considerations for the design

Sections 1 and 2 of the questionnaire asked for details of the music therapy respondents, including details presented in sections 9.2 & 9.3 above. This was in order to achieve a comprehensive overall impression of the centres. In section 1, many facts were gathered, including statistics of whole time equivalent (WTE) posts, population information and other demographic details. An explanation was given that

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[3] Similarly these questions are summarised here in order to capture information about method, simplifying the research questions for the purposes of the questionnaire.

WTE & FTE (full time equivalent), are terms used in the UK to describe staffing levels as fractions of 1. A five day week was divided into ten units. A person who is employed for one day a week counted as 0.2 and a person who is employed half time (two and a half days) counts as 0.5.

Details of State or Private provision were asked for in terms of cultural and defined populations that they served. For example whether the service was rural, or based in a town or city, and how many people the service should serve. Participants were asked to distinguish between services funded by the government and those free at the point of entry, as opposed to private services which are not free at the point of entry, and for which patients or their insurance companies paid. If it was difficult to define a population served by the particular music therapy service, participants were asked to give more details.

Services were asked for numbers of people entitled to the service (size of catchment area population). This was to give an idea of how many people would be entitled to this service if they had mental health problems. If it was not possible to be specific, participants were asked to give estimates and to describe the type of service and discuss why it was not possible.

Section 3 was designed to find out more detail about the type of facilities included in the organisation and served by the music therapy clinic/service. Guidelines were given to participants owing to the international nature of the study on order to make sure respondents understood the terminology.

The terms used fit in with standard ways of describing facilities in, for example *The World Health Report 2001. Mental Health : New Understanding New Hope* Web ref: http://www.who.int/whr2001/2001/main/en/chapter4/004b.htm

Examples of definitions were given, to help establish parity across different countries, such as:
- Acute Admission Wards are places where patients stay if they are in an acute phase of their illness. They are usually short-term facilities.

- Rehabilitation Services care for people who have long term already identified mental health problems, and can include in-patient day and out-patient services.

- Young People's Services usually care for people between the ages of 16-24 with mental health problems associated with the phenomenon of moving from 'young person' to 'adulthood'.

Also in **Section 3,** diagnostic information was requested as essential to the main research question. It was therefore important to establish parity across the different countries and cultures.[4] DSM IV (1994) generic definitions were used. Participants were not expected to be more specific about different types within a main diagnostic category. A detailed example was given in the guidance notes of what was meant, for one category, schizophrenia, is order to set a precedent, and for other diagnoses, participants were guided to the specific listed pages in DSM IV.

Sections 4 and 5: Were designed to gain information about research, clinical effectiveness and outcomes, and about types of treatment approaches taken by the institutions as a whole.
(The latter were presented above in table 9.3)

Section 5 specifically asked about guidelines and protocols including a request for any written guidelines for assessment and treatment that are specific to music therapy that have been devised.

Section 6 asked about assessment and referral procedures specifically in order to gain knowledge about how clinical assessment decisions are taken.

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[4] It will be apparent from the questionnaire included in Appendix 11 that dementia is included in the list asking participating centres information about their treatment priorities and service provision. Dementia is not included in the study because it is more common for people over 65 and the population studied here is aged 18-65 . However dementia is included here in order to provide an overview of the whole music therapy service and to give details of the specialisms and type of service provision in each centre. The results of this section are not discussed in detail here, but a brief analysis and charts describing percentages is included in Appendix X111

In the guidelines for filling in the questionnaire, a definition of a protocol was given as "a set of rules or documented guidelines for treatment". (Odell-Miller (2004a) PhD Questionnaire Guidelines). (Appendix V1).

Referral and Assessment procedures were also defined as follows:

> "***Referral*** is the procedure by which a patient is passed from one service or professional to another – in some countries, ***reason for referral*** is named ***indication criteria.***

Assessment here is defined as the formal clinical procedure carried out by a therapist with a patient in order to find out about the patients clinical needs, and whether they can be met by music therapy. There may be more than one meeting or this might be carried out once, a decision made and treatment then started." (ibid.) [5]

Section 7 introduced the definitions of the theoretical categories (approaches) that had been refined and discussed with other experts. Table 9.4 below lists the procedure for the Likert scale and also the different categories of approach and origins of the approach. These were not defined in detail (but references were given in some cases), because the objective of the qualitative part of the questionnaire later in section 7.3 of the questionnaire was to elicit data to see what people understood (or not) by these terms. However, brief reference was given to clarify differences, for example between Psychoanalytically Informed and Analytical Music Therapy (as shown below). As most participants completing the questionnaire, were experienced practitioners, shorthand was used in order to point the respondents in the right direction, but not to influence thinking. However, clear guidelines were given in order to differentiate between a 'technique' and an 'approach'. The guidelines and some of the thinking behind the approaches are included here.

Excerpt from guidelines for 7.1:

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[5] Details about assessment were only available from two centres, and therefore owing to size limit of this study, assessment results are not discussed in detail in the results section.

"***Music Therapy Approach/Model*** refers to the theoretical approach or approaches which govern practice in your service i.e. the theoretical orientation, whether this has arisen from a music therapy approach or from another discipline."

These clarifications of terminology are congruent with Bruscia (1998). Bruscia's definition of what is a Method, Variation, Procedure, Technique and Model is relevant here in connection to understanding terminology in theoretical descriptions (Bruscia 1998):

"A method is here defined as a particular type of music experience that the client engages in for therapeutic purposes; a variation is the particular way in which that music experience is designed; a procedure is everything that the therapist has to do to engage the client in that experience; a technique is one step within any procedure that a therapist uses to shape the client's immediate experience; and a model is a systematic and unique approach to method, procedure and technique based on certain principles." (Bruscia 1998 p. 115)

In order to illustrate the above point and to provide the basis for the data collection and categories used for this, an example of the defined Models/Approaches is shown below in table 9.4. [6]

Table 9.4 illustrates a ranking scale already filled in to show more about the design, and a prompt to a well known author of that Approach or Model was included as shown.

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[6] Throughout the research study and thesis the words Approach and Model are used simultaneously when discussing work by others and the literature. This is because there is inconsistency within the literature in the use and meaning of these terms. However the term 'Approach' is used systematically as far as possible when referring to the theoretical orientation or model When 'Approach' is used in the context of this research study, it is always in the context described by Bruscia *'a mode*l *is a systematic and unique approach to method, procedure and technique based on certain principles."* (Bruscia 1998 p. 115).

Table 9.4 Example of an excerpt from questionnaire: 7.1 Music Therapy Approach/Model

Code	Music Therapy Approach/Model	Ranking Order
SP	Supportive Psychotherapeutic	1. 2. **3**. 4.
CC	Client Centred (Rogers)	**1.** 2. 3. 4.
B	Behavioural	1. 2. 3. **4**.
D	Developmental (Alvin, Oldfield)	1. 2. 3. **4**.
PI	Psychoanalytically Informed (Pedersen, Odell-Miller, Heal-Hughes)	**1**. 2. 3. 4.
AMT	Analytical Music Therapy (Priestley	1. 2. **3.** 4.
CMT	Creative Music Therapy (Nordoff-Robbins)	1. 2. 3. **4.**
AB	Activity-Based	1. 2. 3. **4**.
GIM	Guided Imagery in Music (Bonny)	1. **2.** 3. 4.
Other (Specify)	Holding and reorganising model	1. **2.** 3. 4.
Other (Specify)	Alliance based *Non/specific factor model*	**1.** 2. 3. 4.

The decision about which theoretical perspectives to include was based upon the author's knowledge of the literature. Some examples of influences were from Bruscia (1997), and The World Congress Proceedings (World Congress of Music Therapy 1999). A European perspective was taken and categories were tested in the pilot study and through the International PhD course at Aalborg University, gaining opinions from students and teachers from around the world. In defining music therapy technique, the following guideline was included in the notes for participants with the questionnaire.

"The next questions relate to *Music Therapy Technique* and music therapy theoretical orientation i.e. *Music Therapy Approach/Model.* For the purposes of this questionnaire, *Music Therapy Technique (7.2)* is what you DO in music therapy interventions with different populations. This includes techniques that originated from therapeutic techniques in other disciplines such as from psychotherapy (ie musical

or verbal interpretation), or dramatherapy (i.e. musical role play). It includes both musically based and non-musically based techniques, but these are differentiated in the table." (Odell-Miller PhD Survey Guidelines 2004a Appendix V1).

Table 9.5 shows an excerpt from **Section 7.2** of the questionnaire, defining music therapy techniques chosen for the study that represent all techniques commonly used by music therapists, with the code which is used in the thesis as shorthand (particularly in Chapter 10).

Table 9.5 Music Therapy Technique

Code	Music Therapy Technique
FI	Free Improvisation with minimal talking
FT	Free Improvisation and Talking/interpretation
FS	Free Improvisation with structures such as 'turn taking' or 'play rules'.
TBI	Theme based improvisation
AT	Activity based: Tea Dance, Choir, Workshop/Structured Musical Activity
MT	Singing Composed Songs
SW	Song Writing
MP	Musical Role Play/Musical Psychodrama/Art & Psychodynamic Movement
RL	Receptive music using live music eg for reminiscence.
RR	Receptive music using recorded music
IM	Imagery in Music
MR	Music for relaxation as part of MT programme
O	Other (please specify)

(Odell-Miller PhD Survey 2004a)

The second half of **Section 7** formed the basis of the survey, where respondents were asked to indicate, by answering Yes or No, whether they used each technique or approach with each of the six diagnostic groups, and in various different contexts. They were asked to then say why they did or did not use this technique or method.

The first section was about context, with the thinking behind the question relating to whether music therapists moderate what they do according to setting or not. For each technique and approach respondents were asked about the following contexts: Acute Ward, Day Hospital (Acute), Day Care (Rehabilitation), Community Mental Health Team (CMHT), Out-patients/Individuals/Groups in the Music Therapy Department/Specialist Units.

Section 8 was designed to answer the main question of the study. Respondents were asked to answer yes or no to each technique and approach for each of the six diagnostic categories. Respondents were asked to expand upon this by writing about why they use, or do not use, each technique or approach with each different diagnostic category. In section 8.2 respondents were asked to clarify their answers by writing case descriptions. They were asked to write a section on each of the six diagnostic groups and to include the following aspects of their work in their comments: Individual and group work, long and short term therapy, frequency and duration of sessions, models and approaches used, specific methods and techniques they use in addition to the ones described. They were asked to provide a maximum of half to one side of A4 for each diagnostic category.

In **section 9** "Further Questions about Models of Work", respondents were asked to comment further about their approaches and it is noticeable that only Centres A & E were able to do this, and Centre B included many case studies in the previous sections 7 & 8, Centre D referred to published literature by the team members, and Centre C was unable to provide any detailed case studies or discussion material. Respondents were asked to describe any aspects of music therapy that they had adapted or derived into a model of existing practice in another discipline, for example music therapy with a Cognitive Analytic approach, music therapy in a specific short term context. The rationale for this was that the author thought it would be beneficial to music therapy if it could be embedded and understood not only in relation to itself, and to the more traditional models defined and described earlier in the questionnaire, but also in relation to other more emerging treatments.

In **section 10** the aim was to elicit more information from music therapists of a more open nature to find out about their thinking and to compare understanding about terminology and levels of work across the centres as follows:

> **"Levels of Clinical Approach**
>
> Music Therapists sometimes talk about different levels of work depending upon the psychological and developmental stage of the patient. Levels of approach are already defined by others such as Bruscia and Dileo.[7]
>
> Below are some levels of music therapy that have been described in a Music Therapy Service. Could you write one or two sentences about what you think is meant by each one, and whether you think about these in your work.
>
> Community Music Therapy
> Supportive Music Therapy
> Task-based/Activity-based Music Therapy
> Supportive Psychotherapeutic Music Therapy
> Analytical Psychoanalytic Music Therapy[8]
>
> If possible could you give short case summaries to illustrate any of these in treatment or assessment? Please specify each time which level you are using and why." (ibid.)

It can be said at this point that most centres found this section difficult, either because they did not have the information needed to answer the questions, or because they had no time to provide all the detail. The idea was to gain more in–depth material, but only two centres provided enough information here, so in the method and data analysis, it will be given minimal attention. This point will be discussed in Chapter 12 in the light of the aim of the study which was to compare and contrast, and gain knowledge about music therapy practise in relation to diagnosis. As such the method

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[7] Exact references were not given throughout the questionnaire because the aim was to point experienced music therapists towards definitions and existing literature, but to encourage them to make their own descriptions and definitions arising from their own practise. However the author for example was referring to Bruscia 1989 p.83-101.

[8] The questionnaire was designed to elicit participants' perspectives on these levels and perhaps identify potential misunderstandings.

chosen was robust with some open and some closed sections as can be seen from above, but it was also time consuming and demanding for music therapists in busy large institutions with large case loads. For the purposes of this research PhD thesis, sections 1-8 form the main focus of the data collection.

Procedures will now be discussed and more details given about the process of carrying out the survey.

9.5 The procedure

Once the participants agreed to take part they were contacted by telephone and the procedures were explained briefly before formally sending the survey, and prior to the centre making a firm commitment. In addition the ethics procedure was implemented which is discussed in section 9.7. Owing to time restraints and the design of the study, participants will receive feedback once the study is finished and before it is published (other than within the PhD). Participant discussion and feedback was not part of the design for this study. The rationale for this is that the aim of the survey was to test knowledge and understanding at the exact point in time that it was carried out. The research question itself focuses on how music therapists define what they do. Therefore the evidence for this would be in their completed questionnaires, rather than sending it back for revising and refining and thus skewing the data for this purpose. However all centres expressed an interest in the findings which will be disseminated and presented to them in the future after the PhD examination.

Once the centres had been identified, the questionnaires were sent electronically at the same time to each centre, with clear instructions about how to fill in the form, together with a description of the purpose of the survey.

> "This Questionnaire is designed for an established Music Therapy Service. The results will be analysed and used in my PhD and in a forthcoming book. All those who contribute and want to be identified will be acknowledged. The aim is to produce a useful guide for trainees, music therapists and other purchasers and

providers of services, government health departments and other relevant bodies." (Odell-Miller 2004a, p.1)

Participants were told in addition that the research was aimed at helping gain knowledge to help them, the practitioners, and the people they treat.

"The process of filling in the questionnaire is expected to generate debate and discussion within the music therapy departments who agree to be part of the survey, and in itself this is expected to contribute to the service, in return for the involvement in this research." (ibid.)

Furthermore the form explained that the aim was to find out about what the music service provides, and how it does that.

Detailed instructions were given as follows:

"The answers to the questionnaire should therefore be co-ordinated by one senior music therapist on behalf of the whole team. In the specific sections where diagnostic and context details are asked for, it may be that different specialist therapists fill in these sections. In any case these are probably better filled in more individually. If it is therefore impossible to return one form (albeit filled in by different team members), because there are so many diverse approaches in one service, then one general form should still be attempted, but this can be accompanied by up to two other forms filled in by specific individuals or sub-groups of music therapists in your team. The guidance notes accompanying the form are attached to help you fill in the form. As mentioned below, it may be easier to fill in some sections by discussion and I would be happy to come to meet with you to facilitate this." (Odell-Miller 2004a p.2)

All centres had similar explanations given, also verbally and usually by phone. However there were also informal meetings beforehand if requested, to answer questions about the actual procedures. These were requested by Centres A, B &E.

One centre asked the researcher to visit the whole team (Centre C) in preparation for completing the questionnaire.

In completing the questionnaire, only one centre (Centre D) asked the researcher to visit owing to language difficulties, and in this instance the researcher acted as scribe because whilst the team members had good spoken English, it would have been too time consuming at that time to write everything down in English. All the answers were written down in English by the researcher exactly as the participants described them, with no discussion or clarification. This process was therefore identical to that for the four other centres which chose to write all their answers and send them electronically on the original questionnaire form. Following the scribing for Centre D, the researcher sent the completed form in English to the Head of Centre D for verification that the correct sense had been made of the verbal material.

The material was not sent back for checking once analysis of the material had started, as the object of the study was to see how music therapists described and defined their work so the data was not changed in any way for any of the five centres. If gaps were left these were usually explained owing to an absence of a music therapy service in that category or owing to the music therapists being unable to describe something, so this was part of the design, rather than a qualitative design in which data is checked and re-checked (e.g. grounded theory or phenomenology). The participants were informed from the outset exactly what was being researched and why, and an information sheet with guidelines was included about how to fill out the survey (Appendix VI). They were asked whether they wished their service to remain anonymous or be identified, and were asked to sign a consent form (Appendix VI).

As stated in the guidelines quoted above, each Head of Centre was asked to collate and check the final data, prepared by team members, on behalf of the whole team. If that was impossible because there were so many diverse approaches in one service, then the guidelines stated that one general 'return' should still be attempted, but this could be accompanied by up to two other forms filled in by specific individuals or sub-groups of music therapists in the team.

The exact guidance notes, letter to participants, and the full questionnaires are in Appendix I-VI of the thesis as discussed above in section 9.4.

The study gained ethics approval in the United Kingdom, with clearance from the Local Research Ethics Committee for the health district in which the researcher is based (Cambridge). English centres included as participants obtained ethical approval locally to each centre. In the other European countries, Ethics approval was also gained where appropriate, and was the responsibility of the music therapy department and services concerned.

The PhD Team at Aalborg University together with the author selected the five centres which fulfil the criteria shown on the form, and by reputation, as described in detail in section 9.2 & 9.3 above. All five centres agreed to take part and following ethical approval a questionnaire was sent with an offer of a visit from this researcher. A Site Specification Assessment took place in the other two UK based centres following the local ethics approval using the central DOH procedure for ethics approval in the UK.

9.6 Methods of Analysis and Processing Data.

9.6.1. Summary

The method of analysis can be summarised as follows.

1. Demographic Data was presented and analysed using descriptive statistics for a basic content analysis, where tables show figures, numbers and categories. These were then compared across the five centres. This relates to sections 1-6 in the questionnaire described above. Philip Hughes acted as Research Assistant to the project and was involved in early collating, processing and checking of the data, together with the supervisor, Tony Wigram. Christian Gold acted as advisor for one of the data analysis tools, the application of the proportional test of significance. The latter calculations were carried out following his advice, by the researcher.

2. For an analysis of the data which uses ranking to determine how often music therapists use already defined techniques and approaches in music therapy, a content analysis was done and some numerical comparison across the five centres. Owing to the ranking from the Likert scales and the numerical data arising from looking at how much certain Models and Techniques are used, non-parametric tests were also used. A statistical test of proportions using the R statistical package was carried out to determine whether there were significant usage of methods and techniques by diagnosis and treatment context. This relates to sections 7 and 8, but to the factual yes and no or ranking questions and answers, rather than to the more in depth 'why?' questions which were analysed using a qualitative approach.

3. An inductive approach was used for the descriptive data. A simple comparison and discussion about the more statistical aspects of the outcomes was generated, but as this was a small sample, conclusions were expected to be treated with caution, and without generalisation to a wider population. For this part of the analysis a theme-based descriptive qualitative survey analysis was used, as the data was factual and themes could easily emerge. In preparation for the analysis of qualitative data, the research assistant prepared tables under each diagnostic heading, collecting the prose responses together from the diagnostic sections of the questionnaire and also from the Settings and Context sections. These were then organised so that patterns and themes could be easily analysed and examined (Appendix XIX). Patterns of information which emerged, were grouped and categorised, and trends analysed and compared with existing literature in order to answer the main research question, and the secondary ones.

9.6.2 Discussion

The study was based upon a qualitative and quantitative design, namely a Survey Based Design (quantitative methodology), and an adaptation of the qualitative approaches using aspects from Narrative and Case study designs. (Smeijsters and Aasgaard, 2005; Kenny, 2005). (qualitative methodology). The study design used a form of analysis that includes comparative and descriptive narrative, but did not follow the narrative perspective exactly, in that the participants were not involved in the analysis of their narrative. This would be a further stage, and in fact the researcher

wanted to take a 'snapshot' approach owing to the political aspect of the rationale for the study. This is because a service could be asked at any point in time to articulate its approaches and to define why it does what it does with which populations, and it was this knowledge, or possible lack of knowledge within the profession, that was being 'tested' or explored'. For the qualitative data, a simple descriptive approach was taken by grouping all responses about a diagnosis together and making a comparison across groups

The qualitative analysis related to questions 7 and 8 of the questionnaire, where respondents were asked to write why they used certain techniques and approaches, why not and to give case study illustrations. This relates to data described in Chapter 10. Once questionnaires were returned, the researcher, together with a research assistant, looked across diagnostic categories and compared the narratives given and case studies about approaches and techniques, and looked for similar or different patterns. Theme-tracking was the main analytic technique used, and the researchers adapted and simplified the method to suit the project, which was time limited and modest in size.

Tables were constructed (see examples in Appendix VII) of the raw data grouped into diagnoses, and for each diagnosis, five different answers for one technique or approach were read several times and recurrent themes noted and discussed and conclusions then drawn. Similarly lack of agreement between centres and markedly different case studies, with reasons given for using or not using such techniques and approaches, were noted and analysed. All data was checked together with a research assistant and a variety of quantitative and qualitative methods were used.

The Method, using a mixed design with qualitative and quantitative approaches has been described in detail and the next two chapters will present the results. Chapter 10 presents the qualitative data taken from sections 7 and 8 of the questionnaire, with a descriptive analysis of which approaches and techniques are used with which populations and why. Some numerical results are also presented in terms of how many centres use or do not use the approaches and techniques. Chapter 11 then presents the pooled numerical results with statistical analysis of the results in order to show trends of when a particular approach or technique might be indicated, and also

in order to pool results across centres and approach and technique categories to show directions for future guidelines in practise.

CHAPTER 10

QUALITATIVE ANALYSIS

10.1 Introduction: Qualitative data analysed with quantitative summaries by diagnosis

This chapter presents the results of the qualitative data relating to diagnosis, describing approaches and techniques[1] used for each diagnostic group. The six diagnostic groups from the survey are included, with a section on each in the following order: schizophrenia, bi-polar disorder, depression, anxiety, eating disorders and personality disorders.

First, an overview of the distribution of music therapy time given by the centres to each diagnostic category, as stated in the questionnaire, is shown in Figure 10.1. This puts the results into context. Subsequently, for each diagnosis, descriptive statistics of the total reported scores for all centres, showing their use of the different therapeutic approaches for each diagnostic category, are presented in a table. Next, the descriptive statistics for the use of different music therapy techniques with each diagnostic category are presented in a table, differentiating the use of those techniques in group and individual work. Then a descriptive summary is presented, drawing on the qualitative data that was gathered from the centres through the questionnaires (Appendices I-V). The data was collated by the research assistant organised under diagnostic headings which enabled a clear in-depth comparative analysis of responses (Appendix IX). The summary reports relevant comments[2] offered by the centres in relation to their usage of approaches and techniques, and analyses the reasons why centres do or do not use a model or technique, focussing upon similarities and differences. A conclusion is drawn following each section about approaches and techniques. These conclusions focus upon the actual data presented and start to discuss trends and patterns emerging for each specific diagnosis, in relation to the

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[1] For definition of approaches and techniques see section 9.4.1

[2] In this Chapter all direct quotations from the original questionnaires are in italics. Occasionally a slight alteration has been made if the respondent was writing in their second language, and at other times if there are language errors in the quotations, this will be either owing to language variation, or because the respondents were invited to write in 'note form' and therefore not in full sentences for speed.

wider picture for that diagnosis. However, a detailed discussion about how these results relate to existing literature, including a more expansive comparison across diagnostic groups will be discussed in the final discussion and conclusion (Chapter 12) for the whole thesis. The full raw data is included on a CD-ROM (Appendices I-V).

Two aspects should be noted. Firstly, not all centres completed all sections of the questionnaire asking for detailed information, for every question. Secondly, some centres provided very little written information in support of their working practice. For this reason, an analysis and focus about the specific context within which music therapy takes place, and whether this influences what music therapists do and why, was not undertaken as it was deemed to be beyond the limits of the study. However responses to questions about Context which relate to diagnosis, approach and technique are included in the data analysed under the relevant sections, and context and setting is only addressed 'in passing'.

In the questionnaire there was a section entitled 'Other Approaches' for each diagnosis, and in the main part of the thesis where centres ranked how often they used each approach for each diagnosis only some centres used this category.
These responses are not included in the main statistical and qualitative analysis for each diagnosis and centre, but are summarised in a separate section at the end of this chapter. (10.26).

The information presented in this chapter is lengthy, and involves a significant amount of repetition in terms of explaining the results for each diagnosis and each approach and technique. The survey called for extensive information from the participants in these areas, and therefore the results will inevitably be extensive in reporting the data. For a doctoral thesis, it is important to be systematic and comprehensive in reporting the results.

10.1.1 Distribution of diagnoses for the different centres

The centres were also asked about the proportion of resources which were devoted to patients in different diagnostic categories. The charts of these responses are given

below in Figures 10.1 to 10.5. These figures show that some centres are able to break down their work into detailed diagnostic categories and types of groups (Centre A & E), whereas the other centres provide more general information). Centres were asked to calculate the percentage of time spent with each diagnostic category, by the music therapy team, or the percentage of patients treated in each diagnostic category. In summary the centres all prioritised the psychotic disorders for music therapy, but there are marked differences between centres in how much time music therapists spend providing music therapy to specialist areas such as eating disorders and personality disorders.
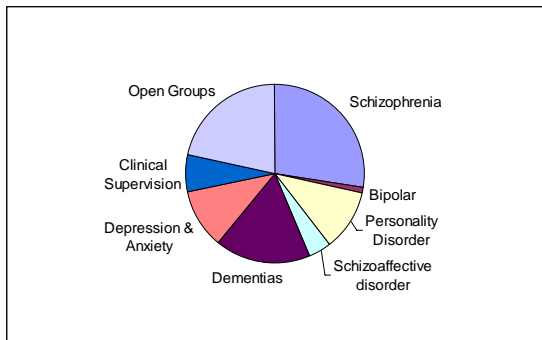
Figure 10.1: Centre A Diagnoses
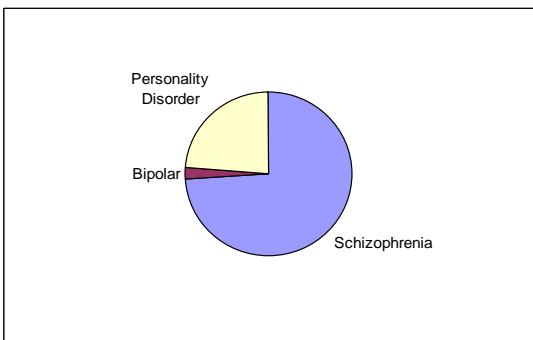
Figure 10.2: Centre B Diagnoses
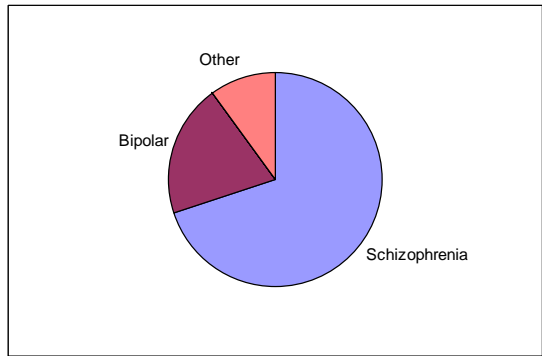
Figure 10.3: Centre C Diagnoses
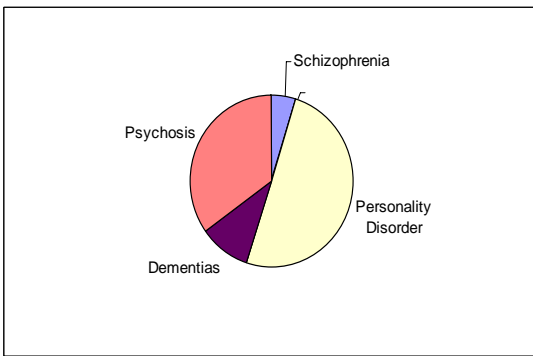
Figure 10.4: Centre D Diagnoses

(Other = Schizoaffective/Drug-Induced Psychosis/Alcohol Abuse)
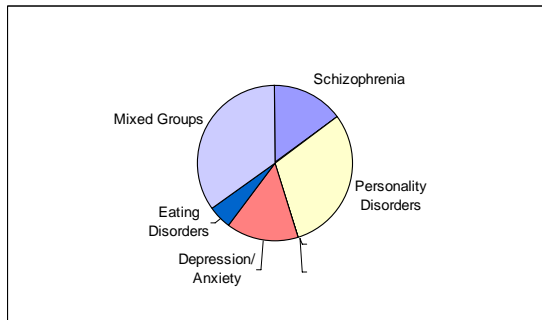
Figure 10.5: Centre E: Diagnoses

10.1.2 Summary of Figures 10.1-10.5

It should be noted that Centre B calculated their answers by percentage of the patient population. The other centres supplied answers based on the percentage of clinical time spent working with each diagnosis, as was the intention of the questionnaire. The answers from Centre B will be similar but not identical to those that would have been calculated, if clinical time had been used.

Overall, the centres clearly show some differences in the amount of time devoted to, or the amount of people seen, with each diagnosis, but some common factors are present. All include a significant proportion of patients with severe mental illness (e.g. schizophrenia and other psychotic illness, for example bi-polar disorder). However the centres do vary markedly in the degree to which they work with people with personality disorders, and other specialities. It is interesting to see that Centre E describes a small population with schizophrenia but a large percentage of treatment is provided for psychosis. The researcher assumed that this category includes some people with a diagnosis of schizophrenia. Centres stated that the calculations were quite approximate and changing, and the above figures represent the percentages recorded nearest to the time of the survey 2003-2004. Each category will now be discussed and conclusions drawn about each category.

10.2 Schizophrenia

10.2.1 Introduction to approaches and techniques with schizophrenia

The centres all reported schizophrenia as a diagnosis that filled a large part of their clinical case load as shown in Figures 10.1-10.5. It appears that given the evident number of referrals to music therapy of patients with schizophrenia, and the much higher level of reporting in the literature of the effects of music therapy with this population (Gold et al 2005), and the number of case studies written, music therapy is an indicated intervention for this diagnosis**.**

Table 10.1 lists the approaches in the left hand column in rank order by the number of respondents who responded that they used each model with patients with

schizophrenia. The middle column reports number of yes scores to the use of each model out of the five centres, with the rank order denoted in the right hand column. This format is used for all similar tables for other diagnoses reported in this chapter.

Table 10.1 Scores for use of approaches with patients with schizophrenia [3]

Approaches	Used by Centres	Rank Order
Supportive Psychotherapy	4/5	1st=
Psychoanalytically Informed	4/5	1st=
Client Centred	3/5	3rd
Behavioural	2/5	4th=
Developmental	2/5	4th=
Analytical Music Therapy	1/5	6th=
Creative Music Therapy	1/5	6th=
Activity-Based	0/5	8th=
GIM	0/5	8th=

Table 10.1 shows a clear polarity in usage of different approaches with patients with schizophrenia, where some approaches are typically used and others are not considered appropriate**.** There is unanimous agreement that Analytical Music Therapy is hardly used, Activity-Based therapy and Guided Imagery and Music (GIM) are not used. Supportive Psychotherapy and Psychoanalytically Informed Music Therapy are used most, although one centre does not use it.

Tables 10.2 and 10.3 list the acronym of the technique followed by the technique written out in the two left hand columns in rank order by the number of respondents who responded they used each technique with patients with schizophrenia. The third column in Table 10.2 reports the number of yes scores to the use of each technique out of the five centres when working with groups, and Table 10.3 reports the same information for working with individuals, with the rank order denoted in the right hand column in both tables. Only four centres reported doing group work, so the

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[3] For all tables the following applies:
a) The figure for ''yes'' comes first, then the figure for the total number of responses
b) In the case of centre D/C, if either therapist uses the approach/technique, that is scored ''yes'' and then reasons given discussed in the qualitative analysis
c) Similarly if a centre said ''yes'' with certain conditions and ''no'' in others, this was scored ''yes'' and then reasons discussed
d) Sometimes there are 'Not Applicable' sections when a centre does not ever treat that population. So some scores do not add up to 5 although 5 centres are included in the study.

scoring shows numbers out of four. [4] The full title of the technique MP is given in Table 10.2, but in subsequent tables it is referred to simply as "Musical Role Play".

Table 10.2 Scores for use of techniques in group work| with patients with schizophrenia

Techniques		Groups	Rank order
MT	Singing Composed Songs	4/4	$1^{st} =$
FI	Free Improvisation with Minimal Talking	4/4	$1^{st} =$
FT	Free Improvisation and Talking/Interpretation	3/4	$3^{rd} =$
FS	Free Improvisation with Structures such as turn taking or play rules	3/4	$3^{rd} =$
TBI	Theme Based Improvisation	2/4	$5^{th} =$
AT	Activity-Based	2/4	$5^{th} =$
SW	Song Writing	1/4	$7^{th} =$
MP	Musical Role Play/Musical Psychodrama/Art & Psychodynamic Movement	1/4	$7^{th} =$
RL	Receptive music using live music	0/4	$9^{th} =$
RR	Receptive music using recorded music	0/4	$9^{th} =$
GIM	Guided Imagery in Music	0/4	$9^{th} =$
MR	Music for Relaxation as part of MT programme	0/4	$9^{th} =$

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[4] This format is also used for all similar tables for other diagnoses reported in this chapter and therefore will be assumed rather than headings written out each time.

Table 10.3 Scores for use of techniques in individual work with patients with schizophrenia

Techniques		Individuals	Rank order
MT	Singing Composed Songs	5/5	1st
FT	Free Improvisation and Talking/Interpretation	4/5	3rd =
FI	Free Improvisation with minimal talking	4/5	3rd =
SW	Song Writing	3/5	5th =
RL	Receptive music using live music	3/5	5th =
FS	Free Improvisation with Structures such as turn taking or play rules	2/5	7th =
TBI	Theme based improvisation	2/5	7th =
MR	Music for Relaxation as part of MT programme	1/5	9th =
MP	Musical Role Play	1/5	9th =
RR	Receptive music using recorded music	1/5	9th =
AT	Activity-Based	0/5	11th =
GIM	Guided Imagery in Music	0/5	11th =

Tables 10.2 and 10.3 show unanimous agreement that Singing Composed Songs is used by all centres for group and individual work. Free Improvisation with Talking is used by all centres for group-work, and by all but one centre for individual work. Free Improvisation with Minimal Talking is used for individual and group work by all centres except one. A major difference in ranking between individual and group techniques with schizophrenia is in the use of Activity-Based techniques. For group work, this is ranked as fifth, equal with Theme-Based Improvisation, but in individual work it is ranked as least used (11th = and not used at all). Song-Writing is used by one centre for group work but by three for individual work There is unanimous agreement that Receptive music using Recorded music (RR) and Guided Imagery in Music (GIM) are least used for group or individual work. Another difference between group and individual work is for Receptive music using Live music (RL). This is used by three centres for individual work and no centres for group work.

10.3 Summary of salient elements from qualitative data for each approach: Schizophrenia

10.3.1 Introduction

All five centres answered for this diagnostic group. The amount of information given in the qualitative data section is the second largest, out of all the diagnostic groups (personality disorders being the largest), confirming that this is a priority group for

music therapy treatment. Centre A defined its own approach, which is referred to in the Supportive Psychotherapy section. Centre A implies that this runs through all the work with this diagnostic group therefore there are sparse answers for other sections. Approaches which are most used emphasise the importance of establishing a strong rapport with patients, focussing upon the musical relationship and using the counter-transference.

10.3.2 Supportive Psychotherapy (SP)

Centre A is very specific about how important supportive work is for patients with schizophrenia, both musically and verbally. Two distinct approaches are defined, as Supportive Psychoanalytically Informed Music Therapy (SPIMT) and Exploratory Psychoanalytically Informed Music Therapy (EPIMT).

SPIMT precludes analysis and interpretation directly to the patient, and works through empathy, but is also 'Psychoanalytically Informed' and therefore fits into both this and the 'Psychoanalytically Informed' section. The relevance here is because it is essentially 'Supportive' rather than strictly 'Analytic'.

Establishing a rapport is crucial for patients with schizophrenia, and respondents are unanimous that the meaning of 'Supportive' is that it is not purely analytic or very interpretive, but empathic. This extends to the way in which music is used in this approach, and Centre A also states that improvisation creative music and songs are common and effective with this diagnostic group, providing a supportive structure. Centre A is of the opinion that patients with schizophrenia are very sensitive to the therapist's counter-transference and will manifest psychotic symptoms if they feel the therapist is having negative reactions to them. Centre D has its own highly developed method of music therapy using sensorial play as a first stage where the therapist stays with, mirrors and listens to the patient rather than acts in an overtly supportive way. The effect is supportive in maintaining the relationship whilst the patient finds his/her own inner space. Centre A distinguishes between SPIMT and EPIMT. EPIMT is less inclined to be actively supportive, and allows a degree of anxiety to be present. So this approach is discussed under 'Psychoanalytically Informed Music Therapy'.

Four out of five centres agree that Supportive Music Therapy is a preferred model for this population, and infer that music plays an essential role in encouraging meaningful interaction which is otherwise difficult for many with this diagnosis. Centre D (respondent b) does not use this model because it uses its own model (De Backer 2004), and Centre E is of the opinion that the approach needed is '*more than supportive*':

'*The music therapist is informed through counter-transference and sensitive listening when and how to intervene, to challenge musically, through playing rules, and verbally.*'

Centre A similarly emphasises that the main work is through the counter-transference and states that the work using this approach is '*less actively supportive*'.

10.3.3 Client-Centred (CC)

Throughout the study, there appears to be a misunderstanding about this approach. In the guidelines it was clear that this approach follows Rogerian Client-Centred principles (Rogers 1959).Three centres C D & E confirmed they use this approach. However Centre C, and therapist a in Centre D appear to be using a loose definition of the approach that follows the clients' needs in general terms, rather than following a specific Rogerian-based theory. Conversely Centre E appears to have therapists trained in the Rogerian approach, and clearly responded that this was a crucial approach with schizophrenia because '*with schizophrenic patients it is very important that the therapist can adapt to the psychotic world view of the patient and still keep grounded*', and '*it is important to work within the logic of the patient's world view.*'..

10.3.4 Behavioural (B)

Two out of five centres said they do not use this approach for patients with schizophrenia. Out of the two centres C & D which said they used this approach, one was from the centre where two therapists gave separate responses throughout the whole questionnaire. (Respondent a in Centre D said yes, while respondent b said no). The reasons given by the centres which said yes were not very conclusive. Centre C

said that boundaries and structures are needed for this population, but did not comment on an actual behavioural approach used. Centre D (respondent a) discussed the fact that music therapy is indirectly linked to a behavioural programme for some patients. A token and reward system is used and all aspects of the programme including music therapy are part of this system. However there was no music therapist employed in the unit described, at the time of the study.

Overall the reasons given that supported using behavioural approaches were not very convincing. Whilst there is an agreement that patients with schizophrenia need structure, the only reason given for a negative response was by Centre D (respondent b)*' I do not believe this is effective-it is more of a structural approach and schizophrenia must be treated more to develop an 'inner space'.* The conclusion from these responses is that a Behavioural approach to music therapy for patients with schizophrenia is not indicated and it is regarded as too directive.

10.3.5 Psychoanalytically Informed Music Therapy (PIMT)

As mentioned above, in distinguishing between SPIMT and EPIMT, Centre A defines SPIMT as less inclined to be actively supportive. With the right training, this can be used with patients with schizophrenia, but the music plays an integral part in facilitating communicative bridges between patient and therapist (which this population find hard in normal relations). Centre A states that music therapy is a unique treatment for this population because both music and talking are essential modes for containing psychotic anxieties. The therapist is attuning to the patients' feelings in the transference, and the counter-transference is therefore the main information gatherer. The approach fits into the PIMT category rather than into Supportive Psychotherapy. It draws on psychoanalytic thinking with the music as an integral part. A *'sensitive therapist who can contain their own psychotic anxieties will be able to feel the difference between the patients' evacuations (beta elements Bion 1962) and their attempted communications (contained looking for a container, Bion 1962). In this model the therapist must be aware of what (in the patient's expressions-both musical and verbal) lends itself to alpha function (Bion 1962) and what is fit only for evacuative processes.'*

Interestingly Centre B responds that PIMT is not used for schizophrenia and other diagnoses, but then defines its own approach (Psycho-analytically Informed Music-Centred Music Therapy (PSMC).This appears to be very similar to the Psychoanalitically Informed Music Therapy (PIMT) approach already described in the literature (Odell-Miller 2001), and in Part I of the thesis. It is not a 'pure' psychoanalytic approach, but an approach placing equal emphasis upon musical phenomena, and the psychoanalytic theoretical thinking used to provide meaning and interpretative understanding. These subtle differences are already clarified in the literature, but Centre B is either unaware of this, or prefers to define its own approach. Centre B defines PSMC as *'a music centred approach where music is used actively as the primary change agent but where psychoanalytic thinking and interpretation also apply. This approach also borrows from Nordoff-Robbins (NR) music therapy the importance of a 'satisfying aesthetic experience' as a way of making meaningful (and memorable) the events that take place between client and therapist, although transferences may evolve within this and are reflected upon (if appropriate for the client).*

This approach is categorised by Centre B under 'Other' approaches, but the researcher has included responses relating to this under the PIMT section. This is because the definition appears to be an accurate description of what is also defined already in the literature as PIMT (Odell-Miller 2001), but with slightly more emphasis upon the aesthetic in the definition and with explicit reference to a Nordoff-Robbins approach. This point is further discussed in 10.26 under the Approaches section, and also in the Discussion and Conclusion Chapter in sections 12.7.3-12.7.5.

In summary, it could be argued that in this section all but one centre agree that PIMT would be the treatment approach of choice.

10.3.6 Developmental (D)

Centres C & E said they used a Developmental approach, while the other centres did not. Reasons for not using this approach were only given by two respondents, both respondents from Centre D, stating that *'it is only possible to work in the 'here and now'*. It is understood that when centres respond, 'yes' or 'no', they consider whether

this approach is central to the work. It can be argued that most therapy has a developmental element, and developmental psychology informs psychoanalytic theory, as evident in the work of Freud (1910). Centres which said they used Developmental approaches implied that aspects of developmental psychology inform their work, rather than drive it. Centre C wrote that it helps to understand what patients are bringing along to the session and informs thinking and reflection in supervision sessions. Centre E gives an example of a Developmental approach as one focussing upon the things the patient is capable of 'at this moment', in a realistic way.

 '*Sometimes I have to work focussed on developing skills in a certain period of the therapy (in psychotic or very fragile phases) even if it is not the main focus of the treatment as a whole – on such skills as concentration because the patients are very restless and cannot listen or play music for more than a few seconds or minutes*'.

This centre also referred to literature such as Pedersen (1999) which describes a specific Holding and Reorganising approach as discussed in 8.3.1.

10.3.7 Analytical Music Therapy (AMT)

This refers to Priestley's theoretical approach (Priestley 1994). Only one centre (C) said they use this with patients with schizophrenia and gave no additional supportive arguments for its use. One respondent in this centre also said no to this approach, so the centre results were not conclusive. Looking at Centre C's overall responses it is unclear if there is an understanding that this refers to Priestley's specific approach, as described in her collective works (Priestley 1994), rather than to any general music therapy approach drawing upon psychoanalytic theory.

Centres which do not use this approach gave two reasons - either the music therapists are untrained in this approach (Centre A), or schizophrenic patients '*mostly cannot work with splitting techniques or use verbal interpretations*'. (Centre E)

10.3.8 Creative Music Therapy (CMT)

This refers to a Nordoff-Robbins approach as described by Nordoff-Robbins (1977), and Ansdell, (1995). Only one centre (B) said they used this approach for schizophrenia. Reasons given for the use of this approach are illustrated in a case summary (Appendix II section 7.3.1 of Centre B's completed questionnaire). The example highlights the potential of this approach particularly in an open group such as in an acute ward, where the music acts as a means of engaging people, and fosters a positive alliance with the institution. It also enlivens people and brings them into contact with others when their symptoms and behaviour might otherwise alienate them from others. Furthermore the potential of a CMT approach is emphasised for otherwise chaotic, inappropriate behaviour, and where symptoms such as delusions and psychotic thoughts can be contained, included and made appropriate within improvisations. This approach provides musical structure and creativity for these behaviours at the same time as providing a creative outlet. It can help both the patient, and also help those around see their behaviour in a different way. The centres which said they did not use this approach referred to not having Nordoff-Robbins trained therapists employed, and to a conflicting view to the above.

Centre D (respondents a & b) said '*A Nordoff-Robbins method is inappropriate with this diagnostic group. Music cannot treat the patient alone, the relationship treats the patient. There is no theory which relates to the psychopathology of this population and this (the pathology) MUST be known before embarking on treatment.*' There is an assumption here that in a CMT approach the pathology would not be explored or known about prior to treatment.

Centre A said that in individual work the challenge is to move patients with schizophrenia away from aesthetic, fixed views about music, often linked to idolisation of themselves as rock/pop stars, adding that too much musical structure prohibits expression. This perspective was made in reference to individual work only, whilst the Centre (B) using a CMT approach gave only group work as an example.

10.3.9 Activity-Based (AT)

All centres say they do not use a strictly 'Activity-Based' music therapy approach with patients with schizophrenia. However Centre B refers the reader to Community Music Therapy and implies that there is a close link with this approach. The definition is summarised by Centre B as '*enabling people to bring their musical experience into the hospital and have it valued.*' Further, although there is no specific reference to this approach for patients with schizophrenia, there is an implied link referring to the types of settings in which people with this diagnosis reside. For example, building a community through this approach in a locked ward, '*encouraging healthier dynamics between staff and patients, instilling hope, de-infantilising the patients, offering opportunities to the staff to be more empathic and less defended against onslaught of disturbing projections from patients.*

This Community Music Therapy approach described by Centre B, would be improvisational, but might include some structure such as '*Songs From Home*' where staff and patients bring songs from their homeland. This fits into the category of an Activity-Based approach. Centre E implies that while an AT approach might be useful for patients with schizophrenia; in fact music teachers provide this type of input. Centre D disagrees directly with Centre B and says that the approach is not suitable for newly diagnosed people with schizophrenia, but might be more useful with people with chronic illness and also implies that the CMT approach lies within the Activity-Based approach. This is interesting because Centre B, which **does** use CMT, is also the only centre that talks about using AT (under the definition of Community Music Therapy).

10.3.10 Guided Imagery in Music   (GIM)

All Centres said they did not use this approach with patients with schizophrenia in group work or individual work, either because they are not trained in the approach, or because they think it is not suitable. Centre E reports that although it does not think GIM is suitable with schizophrenia, therapists there are aware that is has been modified for this population by Moe (2002).

10.4 Summary of salient elements from qualitative data for each technique: Schizophrenia

10.4.1 Introduction

All five centres answered for this diagnosis, although only four centres appear for groups, as Centre A does not run groups with this population. Both therapists in centre D agreed for this category. The amount of information given in the qualitative data section is the second largest, out of all the diagnostic groups (personality disorders being the largest), confirming that this is a priority group for music therapy treatment. Centre A defined its own approach, which it also refers to here as an explanation for a particular technique, placing it under either Suppotive Pyschotherapy or Psychoanalytically Informed music therapy in the approaches section. Centre A filled in the yes and no responses but provided little other qualitative detailed comments for many of the questions. This is because the centre defined two approaches and treated this as a summary of techniques as well, without differentiating between different detailed techniques. Centre C did not provide any qualitative data.

10.4.2 Free Improvisation with Minimal Talking (FI)

Centre E does not work with groups at all. Centre C ticked yes and no boxes throughout the questionnaire but only gave comments in one diagnostic section (eating disorders). Centres B, C and D said they use this technique in group work and Centre A does not, with no reason given. All centres except Centre A said they use this technique in individual work. Reasons given for the use of this technique were most clearly given by Centre B. '*Schizophrenic patients are more likely to be compromised verbally – e.g. thought disorder, pressure of speech etc and also are less likely to be able to think reflectively, therefore free improvisation aims to meet them where they are, extend their range of emotion, give them a sense of being connected as well as improved self-organisation.*
To extend range of emotion
To increase sense of self and self-boundaries
To break the isolation
To improve self-organisation'

A clear example is given by Centre B emphasising the importance of music replacing talking and acting as a way of understanding social interaction.

Case example Centre B:

'Sometimes patients can't or don't want to talk. e.g. a group for 4 schizophrenic patients, all male, came just to play together and hardly talked for over a year. Their music-making became more exploratory and they were increasingly able to listen to one-another as well as challenge each other. Roles changed within the group so that the 'loud' people became more integrated and less overwhelming, while the more withdrawn members began to play more confidently.'

Centre D says that free improvisation is like free association in verbal therapy. Centre D explains that playing music, for a psychotic person is on the same level as their pathology which is often lacking in spontaneous connection and affect. It is implied that musical free improvisation provides something in the 'inner space' which is often part of the pathology for patients with schizophrenia.

'Only in the beginning of the building up alliance phase does the therapist have to be careful with empathy and use of transference/counter-transference. In this phase the therapy is more supportive.'

Centre E emphasises that the therapist's role is to provide meaning for patients with schizophrenia, who have a great need to be listened to, adding that they can seldom concentrate on playing, or even be engaged in their playing, for longer than 5-15 minutes.

In conclusion, there is some agreement that FI is useful for patients with schizophrenia, although Centre B has a more psychodynamic and social way of thinking about it, and Centre D a more psychoanalytic way of thinking about it, referring to de Backer's sensorial -play ideas. Centre E equates FI with a supportive way of being and says that playing music without much talking is only useful at the beginning of therapy whilst establishing a rapport with the patient.

10.4.3 Free Improvisation with Talking/Interpretation (FT)

All four centres use FT in group work with patients with schizophrenia, and four out of five centres report its use in individual work. So this is a strongly indicated technique for schizophrenia. Centre A says FT is the most likely approach with schizophrenia, and reasons given refer to the previous approaches section where EPIMT and SPIMT have been described. (10.3.2).

The statements also clarify why FI was not used, in that the potential for talking and thinking is seen as important with this group in conjunction with improvisation taking the role of helping to establish a supportive rapport. Centre B agrees with this notion of words and processing being important with this client group, although Centre B also reported that free improvisation with minimal talking is used.

Two clinical examples are given showing the importance of verbal processing, and these are supported by Centre E in the following quote:
'Most schizophrenics talk more than play. We have had a few though who in the beginning played repeatedly without beginning and ending and who could not verbalise on their playing'

One can see here (as in the example from Centre B) that attention is also drawn to the importance of improvisation without talking as important:

Examples from Centre B: *'Participants often start off with improvisation but may feel the need to process their experiences verbally. This is often done on the acute ward through 'upward interpretations' - .e.g. one patient used to talk about how cold it was every time we came to the end of our session, and once actually hallucinated snow outside the window. I suggested that maybe it felt a bit cold as we were sad to be finishing the session?' e.g. Patient T's music tended to be disorganised, continuous and emotional. In one session, she started talking about how her life has been 'messy' and was able to make links with her music.'*

Centre D, in a comment about working in Day Centres, cautions that patients need to be mentally healthy for interpretation to be useful, therefore it might not always be

appropriate to interpret with this population. Similarly, Centre E is cautions about interpretation. *'It is very important that the interpretation is not corrective or given from an expert perspective (I know better than you!). The interpretation has to be logical within the patient's reference of thinking and experiencing.'* Musical Role Play is referred to here as useful in contrast to not having playing rules available *'The playing rules can transform the patients understanding of his own life-world.*

In conclusion this is a strongly indicated technique because it allows the strong components of music to help the person with schizophrenia connect, and includes thinking and verbal processing which can then become a possibility as a result of improvisation.

10.4.4 Free Improvisation with Structures such as turn taking or 'play rules' (FS)

Less importance is attached to this technique, although it is more prevalent in group work. Three out of four centres use this in group work and only two out of five in individual work. Centres A & B concur in that they both use FS in groups but not with individuals. Centre C does not use it at all, giving no reason, and Centres D & E both use it with individuals.

Centres B and E agree that FS provides necessary structure to help the patient organise themselves through turn taking showing the patient is fitting in or adapting to the therapist's music by imitation, or as a way of providing aid to organisation which schizophrenic patients are too disturbed or ill to manage themselves.

Centre B writes:
' Some patients in group sessions (especially those on locked wards) are too disturbed/ill to organise their music. FS offers a safer container than a completely unstructured session, and can be a form of dynamic administration which enables the therapist to manage several acutely unwell people trying to make satisfying music together.'

Centre D writes:

'If the patient is playing 'sensorially', he cannot understand verbal interpretation-it is as if the sounds they are making do not belong to them. When music and interpretation comes, it comes. Techniques change when processes change. For psychotic people, use minimal interpretation'.

Centre E gives an example highlighting the use of 'play rules' through a case example given in the section reporting on its use in the acute ward:

' A schizophrenic patient talked about the God and the devil. He was always connected to God against the devil. One day he came with a piece of paper where he had written a (for him), very important insight. He wrote: Now I realise that both God and devil exist – also inside me'. We created together a playing rule called: "To play both the good and the bad sides coming together in me." The music did not really mirror the topic, but for the first time this patient played fluently melodies and relaxed in his playing. He reflected afterwards that for the first time he was not always concerned about if he played the right music compared to the therapist's music (if he was GOOD enough – the GOD) – now he did not care because he also had bad sides (the DEVIL) and he could better relax and relate fluently to the music and to the improvisation at a whole.'

In conclusion there seems to be agreement that structures such as turn taking, and 'play rules' act as a necessary action-based technique, successful with this population when they are in a phase of not being able to work with interpretation and abstract concepts.

10.4.5 Theme Based Improvisation (TBI)

Only two centres use this technique. Centre A (in group work only) gives no reason, and Centre E states that it is very important, giving two detailed examples of its use in an Acute Ward setting with individuals.

'For these patients sometimes the theme is more important than the music. Often the theme is important to make them play music and often they forget about the theme during playing so the theme really is a motivational factor. For example, a

schizophrenic patient told stories about her family and we played: "How I see myself in the family?" The patient was very keen on the topic and played for a very long time – very monotonous and without variation. Afterwards she told a long story about what had happened during playing. The story was very dramatic, but it was not expressed in the music. The music served to keep her concentrated on the story (she did act during her imagination – her hands were occupied and she was followed by someone).

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A 'schizotypic' patient told about problems of authorities and how she felt like not existing when being with authorities. We played: "I am allowed to stay on my feet when being with authorities." The patient was suddenly much more significant in the music and I could play more loudly and independent. After the music she told me that she for the first time had felt a kind of inner strength when playing music and that the topic had really been important to her to let herself be that audible as she was here. It was a new experience for her. Also it was a new experience that she did not feel that I disturbed her even if I played that loudly what she normally could not stand.'

Centre B gives a reason for not using TBI owing to a lack of training and also lack of a need to apply this technique. Centre D implies that the technique is not used because it involves understanding symbolic meaning and that this is too unfocussed for people with schizophrenia*'You never know where you are going'* which seems to mean that the patient cannot control what is happening.

10.4.6 Activity-Based: Tea dance, choir, workshop/structured musical activity (AT)

Only two centres use AT with patients with schizophrenia, and both report its use only with groups. However interestingly no qualitative comments are included and the sections are mainly blank apart from for Centre E which makes a general statement *'We do not offer this in our service'* with no reason given.

10.4.7 Singing Composed Songs (MT)

All centres are unanimous in their answer that yes, Singing Composed Songs is used for people with schizophrenia for group and individual work. All centres suggest in their answers that this technique is safe for the psychotic patient when they might sometimes feel 'invaded. ' Centre E states: *'Sometimes in critical phases where the schizophrenic patient can feel fear of being invaded this singing is a more safe way of being involved in the music.'*

Centre B gives a similar reason and then an example, concurring with Centre E: *'Some patients feel too exposed to start improvisation immediately and often choose to sing/play pre-composed songs. Later this is often extended to free improvisation. Patient U was seen individually and began by bringing Beatles songs to sessions – 'Don't Let Me Down' formed the basis of a discussion around the risks of our work together. Gradually the songs became more flexible and U began improvising his own solos in the gaps between verses. The verbal processing of the song material also enabled the therapy to become more exploratory, both in terms of free improvisation and also in terms of verbal exploration*.'

Centre D states that the structure of singing composed songs allows the psychotic person to relax and furthermore that it allows all individuals in a group *'the possibility to participate at the same level.…… The group decide how to play but at the same time there is the possibility of cohesion'*. The idea seems to imply that it is a way of sharing that might not otherwise be possible for patients with schizophrenia in a group. The group members accompany the music therapist, implying that this 'expert' leadership provides stability. Furthermore Centre D is enthusiastic about the voice encouraging expression of affect (implied-which might not be possible through free improvisation and without the familiarity of composed songs). *'Voice is very important as it helps provide a level of affect. People can move with a meta voice-can hear one's own voice, as an inner movement. It's the best. Sitting round the piano can be like an antidepressant'*.

In summary there is unanimous agreement that this social and musically derived idea of Singing Composed Songs in groups is very appropriate and helpful for patients

with schizophrenia allowing safety and creating a coherence which might not otherwise be possible particularly in a group.

10.4.8 Song-Writing (SW)

Only Centre A uses SW in group work with clients with schizophrenia. No reason is given. Three out of five centres said they use SW in individual work, but only two centres state reasons. Centre D, one of the two centres that said no to SW, states that words do not have meaning for people with schizophrenia, so this technique is not useful. Centre B characteristically gives a case example of why SW is used for patients with schizophrenia in group-work. *'Patient A requested MT with the sole aim of putting music to his lyrics……..* The therapist *'suggested to patient (who wrote a lot of poems) to improvise melodies and turn them into songs.'*

10.4.9 Musical role play/musical psychodrama/art & psychodynamic movement (MP)

Only one centre said they use MP with patients with schizophrenia in each section of group and individual work. Centre A uses MP with groups, (no reason given), but not in individual work. Centre E which does not run groups, uses MP in individual work and gives reasons **'***Schizophrenic patients like often to make drawings during music listening………'I often let patients listen to improvisation and offer them the possibilities to paint a picture through listening. With the schizophrenic patients the drawings often are not connected to elements as dynamic, timbre, drive or movements in the music. It is as if they use the music as back ground to help them to concentrate on making a drawing from within their life view.'……They often like to draw while listening because it helps them keep invasive thoughts away.'*

Centre E provides a good example of a 'body-related' music therapy technique: *'using a very simple rhythm which we clap or vocalise together or play on congas, we repeat and repeat. I ask the patient to close her eyes and try to let this rhythm come into the body. … schizophrenic patients who had no or poor connection with their body can gradually keep this rhythm with the help of feeling it somewhere in the body*

which can stabilise their lack of pulse and help them feel better connected to the body.'

Two other centres (B & D) gave reasons for not using MP as not having training, and that is too difficult for people with psychosis who are 'not interested in others.' This implies that group techniques are referred to in giving this view.

In conclusion MP is not often used, but Centre E provides a convincing rationale as to why other media might be important or working through the body. Drawing for example whilst listening to improvisation might keep positive symptoms away and help patients with schizophrenia to concentrate; connecting rhythms to the body can stabilise a lack of pulse providing a better connection to the body.

10.4.10 Receptive music using live music e.g for reminiscence (RL)

No Centres use this with patients with schizophrenia in group work, but three out of five centres use it in individual work, Centres A C & E. The only reason given for using RL was from Centre E. *'Sometimes the schizophrenic patient asks me as the therapist to play some centering music at the beginning if he feels very disorganised or fragile'*.

Centres B & D give reasons for not using RL. Centre D is very strong in negative comments, seeing this approach as encouraging resistance and a defence against anxieties which Centre D considers not useful for this patient group. *'You would not ask a client in psychoanalysis to bring a book and read it during the session, so why ask patients to bring CDs with them and listen to music in the group session?'* This suggests a more passive understanding of the use of live receptive music, or perhaps reveals a misunderstanding; were these comments intended for the next section RR (Receptive music –using recorded music)? Either way, the point made is that the idea of listening and then talking about the music is not useful for patients with schizophrenia, because the music chosen may have nothing to do with the patients, or they will not be able to identify with it. Furthermore Centre D gives the opinion that clients with this diagnosis in particular need an inter-subjective experience, and the use of RL would be a way of avoiding it, or would be too

complex, especially in groups. The respondents also see RL as as too much like verbal therapy, because the only thing resulting from listening to the music is 'talking' about the music.

Centre B says that RL is not the role of the music therapist, but of the community musician. Occasionally in the context of an improvisation patients might ask for something to be played by the therapist. The underlying dynamic often connected with idealisation of the therapist or dependency, would usually be explored anyway as part of the therapeutic process. Centre B states that 'just' playing to people has not seemed useful for patients with schizophrenia in music therapy.

10.4.11 Receptive Music Using Recorded Music (RR)

Only one Centre (A) reported using this in individual work. The reason given was that it is often used for patients with schizophrenia as they do not dare to listen to their own improvisations, and therefore bring their own music at the beginning stages of the therapy particularly. One centre, Centre B, gave one reason for not using RR as *'this tends to be done by the OT's and nurses.'*

10.4.12 Guided Imagery in Music (GIM)

No centres use this for patients with schizophrenia. Reasons given are only by Centre B which states that no one is trained in this method, and Centre E which states that people with schizophrenia cannot listen in a lying down position and *'cannot contain a longer piece of music or challenging music.'*

10.4.13 Music for Relaxation (MR)

Only Centre E said they use this model in individual work **'***very often at the end of a session'*. This suggests that RR is only used for a small part of the session, and not as a specific technique in itself for a whole session.

10.5. Summary: Approaches and techniques; schizophrenia

From the data and the comments there is agreement that this population need a loosely supportive model. Opinion is divided equally between those who think that a Supportive Psychotherapy approach to music therapy is best, and those who think such an approach is not adequate, and that a more interpretative Psychoanalytically Informed approach should be followed. It is emphasised that this approach requires the right level of skill (by relevant training) available in the music therapy team. Those who think that a more psychoanalytic approach would not be suitable are of the opinion that patients with schizophrenia would not be able to work with interpretation.

Those who think that with the right training, a Psychoanalytically Informed approach can be used with patients with schizophrenia, maintain that the music plays an integral part in facilitating communicative bridges between patient and therapist, which this population find hard in normal relations.

Another important theme arising from the data is that music therapy is a unique treatment for this population as both music and talking are essential modes for containing psychotic anxieties. The therapist is attuning to the patients feelings in the transference, and the counter-transference is therefore the main information gatherer. It is implied generally that music plays an essential role in encouraging meaningful interaction, which is otherwise difficult for many with this diagnosis.

A Behavioural approach to music therapy with schizophrenia is not indicated as it is considered too directive. Although one centre reported using it, reasons given were unclear. There is almost unanimous agreement that Analytical Music Therapy, Activity-Based and Guided Imagery (GIM) approaches are not used, and some agreement about reasons. Reasons for not using GIM are not specified apart from lack of training and also that it would not be useful. Reasons for not using an Activity-Based approach are not given but one centre describes a Community Music Therapy approach which could be improvisational, but might include some structure such as '*Songs From Home*' where staff and patients bring songs from their homeland. This

fits in with the researcher's definition of Activity-Based, a point which will be returned to in 12.7.3.

In considering the reported use of different techniques, there is agreement that Free Improvisation with minimal talking (FI) is useful. The Centres comment that their use of Free Improvisation with talking/interpretation (FT), is also strongly indicated, which to an extent ties in with the underlying preferred approaches discussed above. Some centres have a more psychodynamic and social way of thinking about FI and others a more psychoanalytic way of thinking about it, referring to ideas regarding 'sensorial play' (De Backer 2005), for example, which reflects similar divisions for the approaches as expected, for this population. A supportive way of being is indicated for this population throughout, some saying that playing music without much talking is only useful at the beginning of therapy whilst establishing a rapport with the patient.

Free Improvisation and Talking/Interpretation is a strongly used technique by the Centres in the study, because it allows the strong components of music to help the person with schizophrenia connect, and includes thinking and verbal processing which can then become a possibility as a result of improvisation.

Singing Composed Songs is also used strongly in both group work and individual work, and there is unanimous agreement that this social and musically-derived idea of singing composed songs in groups is very appropriate and helpful for patients with schizophrenia. It allows safety and creates a coherence which might not otherwise be possible particularly in a group.

This view is supported by Tang et al (1994) where mainly composed live music was used. The Tang study, discussed in Chapter 8, showed results in four weeks and this is also very important when considering the benefits or not of short term work in acute or later stages of their illness.

Strikingly, whilst there is much comment upon the fact that music offers something unique for this diagnostic category, few comments make links with exactly what it is about the music and the way it is used in detail, linking diagnosis to technique and

approach. A summary of what the researcher has understood from the general comments is listed here:

-Rhythm can help poor 'connections with the body' and stabilise movement
-Singing Composed Songs provides structure and safety, with some affect possible using the voice, but without pressure on self expression.
-The use of music to help remember events and to provide an aesthetic component in the midst of chaos.
-Social components are important such as singing round the piano and sitting round the therapist who acts as provider of stability, in a group. It can act 'like an anti-depressant.'
Free improvisation allows for natural structures within music to provide a containing function.
-Music can provide emotional 'contact' for people who find this hard at the same time as helping to maintain boundaries owing to its structure.

What we see here are quite general statements which focus more upon the social and psychological aspects of music rather than on its musicological and technical structure in detail in relation to people with schizophrenia.

Finally, a major difference in ranking between individual and group techniques with schizophrenia is for Activity-Based techniques. For group work, this is ranked fifth equal, but for individual work it is reported as being not used at all. There is unanimous agreement that Receptive Music using recorded music and GIM are not used in group or individual work.

The analysis of the qualitative data, together with the findings of the quantitative analysis from Chapter 11 will be considered and elaborated in an extended discussion in Chapter 12 where examples of the findings supporting current and previous literature are reviewed.

10.6 Bi –Polar Disorders

10.6.1 Introduction to approaches and techniques with bi polar disorders

There are four centres included for each section, because Centre E has entered 'not applicable', making the statement that there is no separate diagnostic section for bi-polar disorders. In Centre E all people with psychotic disorders come under one category of schizophrenia. Centre D (Therapist b) states that his answers would be the same as for the section on schizophrenia where only his particular approach is used, but therapist a in Centre D has scored, and written comments for this centre. For techniques this is the same. Therefore the qualitative comments below are from those Centres which regard bi-polar disorder as a separate treatment group and who have defined more detail. These centres are B, D, A and C. The latter gives yes and no responses but characteristically for this centre, no comments.

Table 10.4 reports the scores given by the centres for the use of approaches with bi-polar disorder, and their rank order.

Table 10.4 Scores for use of approaches with bi-polar disorder

Approaches	Used by Centres	Rank Order
Supportive Psychotherapy	4/4	1st
Psychoanalytically Informed	3/4	2nd
Client Centred	2/4	$3^{rd}=$
Analytical Music Therapy	2/4	$3^{rd}=$
Creative Music Therapy	2/4	$3^{rd}=$
Activity-Based	2/4	$3^{rd}=$
Developmental	1/4	$7^{th}=$
Behavioural	1/4	$7^{th}=$
GIM	0/4	$9^{th}=$

Table 10.4 shows a clear polarity in usage of different approaches with people with bi-polar disorder where some approaches are typically used and others are not considered appropriate. There is unanimous agreement that Supportive Psychotherapy is used, and all but one centre uses a Psychoanalytically Informed approach. Analytical, Creative, Activity-Based and Client Centred are the third most used approaches, but only used by two centres. One centre uses Behavioural and

Developmental approaches, and all centres are unanimous that Guided Imagery in Music is not used for bi-polar disorders.

Tables 10.5 and 10.6 reports the scores given by the centres for the use of techniques in group and individual work respectively with clients with bi-polar disorder in the format described above.

Table 10.5 Scores for use of techniques in group work| with clients with bi-polar disorder

Techniques		Groups	Rank order
MT	Singing Composed Songs	4/4	$1^{st}=$
FI	Free Improvisation with minimal talking	4/4	$1^{st=}$
FT	Free Improvisation and Talking/Interpretation	4/4	$1^{st=}$
FS	Free Improvisation with Structures such as turn taking or play rules	3/4	$4^{th}=$
TBI	Theme Based Improvisation	2/4	$5^{th=}$
RL	Receptive music using live music	2/4	$5^{th}=$
SW	Song Writing	1/4	$7^{th}=$
MP	Musical Role Play	1/4	$7^{th}=$
AT	Activity-Based	1/4	$7^{th}=$
RR	Receptive music using recorded music	1/4	$7^{th}=$
GIM	Guided Imagery in Music	0/4	$11^{th}=$
MR	Music for Relaxation as part of MT programme	0/4	$11^{th}=$

Table 10.6 Scores for use of techniques in individual work with clients with bi-polar disorder

Techniques		Individuals	Rank order
MT	Singing Composed Songs	4/4	$1^{st}=$
FI	Free Improvisation with minimal talking	4/4	$1^{st}=$
FT	Free Improvisation and Talking/Interpretation	4/4	$1^{st}=$
FS	Free Improvisation with Structures such as turn taking or play rules	3/4	$4^{th}=$
SW	Song Writing	3/4	$4^{th}=$
TBI	Theme Based Improvisation	2/4	$6^{th}=$
RL	Receptive music using live music	2/4	$6^{th}=$
MP	Musical Role Play	1/4	8th
AT	Activity-Based	0/4	$9^{th}=$
RR	Receptive music using recorded music	0/4	$9^{th}=$
GIM	Guided Imagery in Music	0/4	$9^{th}=$
MR	Music for Relaxation as part of MT programme	0/4	$9^{th}=$

Tables 10.5 & 10.6 show FT, FI and MT are used by all centres for group and individual work with patients with bi-polar disorder. Song Writing (SW) is used by three out of four centres for individuals (and only by one centre for groups), and Free Improvisation with Structures (FS) is used by three centres for groups and individuals. Theme Based Improvisation and Receptive Music (live - RL) is only used by two centres, and recorded music listening (RR) & Activity-Based (AT) by one centre (groups) and none for individuals. There is unanimous agreement that no centres use GIM or Music for Relaxation.

10.7 Summary of salient elements from qualitative data for each approach: bi-polar disorders

10.7.1 Introduction

Four centres answered for this diagnostic group, and the amount of information is less than for schizophrenia and personality disorders. In this section it is implied for some centres that information already given for schizophrenia also applied to other psychotic disorders such as bi-polar disorders, so it is difficult to get a true sense of approaches. Centre B describes its own approach, which is used particularly in this category. Centre E does not see this group as separate from other psychotic disorders so gives no information and Centre C does not expand on yes and no answers.

10.7.2 Supportive Psychotherapy (SP)

All four centres agree that SP is used with people with bi-polar disorders, and two centres A and D state similar reasons for its usefulness. This is confirmed by Centre A's focus that a supportive non- interpretative approach is useful at certain stages in the illness. Whereas normally Centre A would use a psychoanalytically informed approach in general, with people with bi-polar disorders, a Supportive approach is preferred *'people in acute phases of mania or severe depression cannot cope with anything other than a 'holding' type of music therapy.'* Centre D agrees *'a supportive attitude is always necessary with this population.'*

In conclusion, there is agreement that Supportive Psychotherapy is useful in acute stages of the illness when support rather than interpretation is needed.

10.7.3 Client –Centred (CC)

It is unclear whether the two centres that state they use this with bi-polar disorders are referring to a true approach Client –Centred therapy, as no reasons are given. However Centre A which states CC is not used with this population, shows a full understanding of the approach, and states that it is impossible to apply this model in the true 'Rogerian'sense (Rogers 1959), as there will be many team members looking after patients with differing approaches. Furthermore, the culture in a National Health Service setting does not allow for this. Centre A also makes a strong statement that in any case this model should not be used because '*patients in this category need firm structures and a firm position taken by the therapist, rather than responding to every mood swing and different phase of their illness'*.

10.7.4 Behavioural (B)

Only Centre C uses a Behavioural model with people with bi-polar disorder, and states '*setting boundaries'* as the only reason. As no other details are given it is difficult to see whether Centre C uses a full Behavioural approach, or whether the centre considers that aspects of a Behavioural approach in music therapy with this population (such as boundary- setting) are important. Centre A merely states '*not useful'* with no other details given either, and Centre D states reasons for not using it as '*Because it would be opposed to supportive ways-we do not want to demand anything of these people.'*

So in conclusion a Behavioural approach is not indicated as useful with this population.

10.7.5 Psychoanalytically Informed (PI)

Centres A C & D all agree that a Psychoanalytically Informed (PI) approach is used with people with bi-polar disorder. Centre A uses PI as the main treatment approach

for this population (stated already under SP in 10.7.2), and gives a reference to a much fuller theoretical case discussion in the case of 'Malcolm' in Odell-Miller (2001) in the chapter 'Music Therapy and its Relationship to Psychoanalysis' in Searle and Streng '*Where Analysis Meets the Arts*'.[5] In this approach the music is as important as the interpretation and use of words, but both are interconnected. The therapist moves between the two and is concerned with unconscious processes and in understanding the meaning of the musical process as either a defence against talking, or as an encouragement to the use of words. Similarly to the diagnosis of schizophrenia, Centre B responds 'No' to PI for bi-polar disorders, and says a very specific music-centred approach is needed, implying that PI might not be music-focussed. In defining its own approach (Psycho-analytically informed music-centred music therapy (PSMC), Centre B appears to be using what the literature defines as PI (Odell-Miller 2001), as opposed to a 'pure' psychoanalytic approach. This approach and the definition has already been discussed in 10.3.2 & 10.3.5 in the the previous section about schizophrenia and will be further discussed in 12.7.2.

Centre B illustrates its defined approach (PSMC) with the following case example:
 '*People who are in a manic phase of their illness tend to come to open music therapy groups while on the ward. They often begin by playing in a very 'high' way, loudly or provocatively and with little concern for any one else. This is seen as a manic defence in this approach and the aim is largely to get behind this to a depressive position where the client has more reflective capacity and openness to relating. This often happens musically and people who begin by being very high might leave the session tearful. However, there is scope in this place for them to feel connected with the group and might talk about their experiences – usually a distressing or humiliating series of events leading to hospitalisation.*'

Finally there is agreement also from Centre D (Therapist a), which responds that PI is used with bi-polar disorders, stating that minimal interpretations give insights depending upon the psychotic-neurotic structure of the person. '*If the person's illness has a more psychotic structure, we work more with music than interpretation. Neurotic structure of the illness means the approach is more interpretative.*'

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[5] See Part I of this Doctoral thesis.

In conclusion there is almost unanimous agreement apart from Centre B where no reasons are given, that a Psychoanalytically Informed approach is the approach of choice for this population.

10.7.6 Developmental (D)

Similarly to a Behavioural approach, only Centre C uses a Developmental approach with Bi- Polar Disorders, but no reason is given. Centres A and D give almost identical reasons for not using this model with patients with bi-polar disorder. They suggest that elements of Developmental thinking might help the approach but would never be the driving force. They both use the word 'drive' in the sense that Developmental thinking would not drive the therapy approach, but might inform the process.

10.7.7. Analytical (AMT)

Two centres use this approach (Centres D & C). No reasons are given for using it and it is not clear if a true Priestley approach is considered or just that approaches are analytical in general. From the Centres which agree is it not used, Centre B comments that no one is trained in this approach and Centre A that '*it is too prescriptive and not flexible enough.*'

10.7.8 Creative Music Therapy (CMT)

Centre A gives clear reasons for not using this approach '*Not trained in this method and also these patients need links to be made between musical and verbal meaning and between conscious and unconscious processes. Creative Music Therapy does not address the whole person in this respect only the music part.*' Conversely   two centres B & C use this approach and Centre B comments in detail upon why it is important, giving a case example whereas Centre C does not.

Case example '*H had previously attended a counselling group and left in frustration at the lack of "doing". In her earliest sessions she played drums very physically,*

using her whole body and always speeding up. It was exciting but ultimately monotonous playing. She only attended sessions when manic. As trust developed, she accepted invitations to try other instruments. This change of instruments, coupled with my musical role, enabled her to try different ways of playing until ultimately her repertoire included not only the manic, energetic rhythm-based manner she had presented with but also a more "depressive", phrased, melody-based manner which she had hitherto excluded. She was shocked by her ability to do this and seemed over time to be better able to integrate the various aspects of herself in other aspects of her life, as well as in her playing.'

Whilst there is not direct agreement it can be concluded that music for people with bi-polar disorder, is important because of the ability music has to link with and express 'affect'. Given that extremes of affect and mood are a main focus for problems with people with bi-polar disorder, it is indicated in all responses which give detail that it is this aspect of music that is crucial to success for people in music therapy with this disorder.

10.7.9 Activity-Based therapy (AB)

Centres A & C agree that this is used with bi-polar disorders, although Centre A states that this would not be the main focus usually unless there was a perceived need. It is not clear what that 'need' would be for this population, but types of work might include '*elements of performance or.....gigs as part of a music therapy programme*' Centre C gives no reasons as usual, but Centre D says that this would not be used as it would '*go over the boarders'*. It is assumed that this means it would break a boundary because in this approach the therapist might also be a performer and not strictly in therapist role. Centre D further states that an Activity-Based approach is '*not a priority as psychotherapy approaches are favoured here with this group.'*

10.7.10 Guided Imagery in Music (GIM)

All Centres are in agreement that GIM is not used for people with bi-polar disorders. Two centres A & B state that there is no one trained in this approach. Furthermore Centre A gives reasons as follows: '…… *it would rarely be possible or desirable.*

This is because the GIM approach requires people to listen to music in what is similar to an altered state of consciousness and this would have contra-indications for people who are already struggling between reality and phantasy, and are struggling to cope with the difference between their inner and outer worlds.'

10.8 Summary of salient elements from qualitative data for each technique: Bi-polar disorders

10.8.1 Introduction

Four centres responded to this for bi-polar disorders for group and individual work, showing less difference between group and individual work than for schizophrenia. All centres agree that three techniques, Free Improvisation and Talking/Interpretation, Free improvisation with minimal talking and Singing Composed Songs are used for group and individual work, and there is unanimous agreement that GIM and Music for Relaxation are not used for people with bi-polar disorders in these centres. Reasons for answers are again patchy, with Centre C giving little or no information to support yes and no answers, and other centres including more detail.

10.8.2 Free Improvisation with Minimal Talking (FI)

All Centres agree FI is used with bi-polar disorders. Reasons given from Centre A are as follows:
'In individual and group-work it is more likely that talking will accompany FI, but sometimes sessions may include no talking at certain stages of the process. However talking would be an end goal for most people, using the FI to access thoughts and feelings.(see Odell-Miller (2001) In Searle & Streng, for detailed approach)

In conclusion FI is indicated as a significantly useful technique with people with bi-polar disorders.

10.8.3 Free Improvisation with talking/interpretation (FT)

This is used by all centres and some specific reasons why it is important for this population are given by Centre A.

'In individual and group-work it is most likely that usually this would be the most common technique, although some sessions may include no talking but this would be part of a process and talking at some stage in between improvising would always be a desired focus. Added to this, interpretation would be used if appropriate to the patient, (ie if the patient has enough ego strength, capacity to think and to learn from it)-otherwise talking between therapist and patient would be used to understand meaning in the person's life arising from the music and to see how a person can move forward.'

In conclusion FT is indicated as a significantly useful technique for people with Bi Polar Disorders

10.8.4 Free Improvisation with Structures such as turn taking or play rules (FS)

Only Centre B indicates that FS is not used for individuals with Bi-Polar-Disorder, but is used for groups although no reasons are given for this decision. Centre A gives a detailed answer emphasising that structures might be very important in improvisation in order to help with manic and other chaotic symptoms and in actually structuring the socialisation process for patients with bi-polar disorders, and for controlling mood.

' Structures are particularly important in some group and possibly individual sessions with this population who are particularly manic, and who need a high level of structure in order to engage and hold them. Where there is a need for learning about socialisation and relationship through music, people with this diagnosis might particularly benefit from a structured approach as a non-structured approach could lead to further the mood swings and chaotic thinking often very present. Music is ideal for controlling or eliciting mood and therefore the therapist needs to take control lead/provide structure accordingly.'

10.8.5 Theme-Based Improvisation (TBI)

Opinion is divided here equally with Centres A & C using TBI with bi-polar disorders, and Centres B & D not using it. Again only Centre A gives a reason for using TBI with groups and individuals, which is only if the ideas come from the patients. '*It would relate to material raised in the session rather than arbitrary choosing of themes which would not be appropriate*'.

It is difficult to conclude anything here as opinion is equally divided and there are no specific reasons indicated by most centres.

10.8.6 Activity-Based: Tea dance, choir, workshop/structured activity (AT)

Only Centre B states that this is used for people with bi-polar disorder, with groups but not for individuals. All the other centres do not use AT with this diagnostic group. Only Centre A indicates reasons:

'*Group and Individual-This would rarely be used in individual work-if more structured music lessons for example are needed it would be more likely for other professionals to do this or seek this in the community or use artists in residence.*'

The conclusion here is that AT is not significantly used with this population.

10.8.7 Singing Composed Songs (MT)

All Centres indicate that Singing Composed Songs is definitely a technique used for people with people with bi-polar disorders. Centre A reported that in group and individual work Singing Composed Songs ' *might be part of the way that an interaction happens if desired by the patient, particularly at the beginning of the therapy. However it would not be a goal or focus unless it seemed as if this was the only way to start a relationship.*'

It is difficult to conclude why there is such unanimous use of MT with this population. However, because two centres state that their answers are the same as for

people with schizophrenia, it can be assumed that reasons, which are often extensive, given for people with schizophrenia, also stand for people with bi-polar disorder. (See 10. 4.7).

In summary from the schizophrenia section it seems that the presence of structure is important and that the social and musically derived idea of Singing Composed Songs in groups is very appropriate and helpful for patients, allowing safety and creating a coherence which might not otherwise be possible particularly in a group.

10.8.8 Song Writing (SW)

Results of the use of Song Writing with people with bi-polar disorder are mixed, but indicated more strongly in favour of use in individual work rather than in groups. Centre A B & D say it is used, but Centres B & D state only in individual work. Centre A agrees with this giving reasons that in groups there *'might not be enough ability for concentration and the atmosphere might be too stimulating if trying this (SW) in groups.'*

Centre A also states that only occasional use is expected *' if the individual patient seems to be able to use voice and song-writing as a therapeutic part of the relationship. It would not form a focus on its own, or act as the main technique of working, as instrumental improvisation would also be used.'*

In conclusion SW does not seem significantly indicated for people in groups with bi-polar disorders, but there is some indication it is used for people in individual sessions.

10.8.9 Musical role play/musical psychodrama/art & psychodynamic movement (MP)

Only Centre A states that this is used with people with bi-polar disorders, the other centres say it is not used with no reasons given. Centre A indicates that MP is most likely to be used in individual sessions rather than group work, for the same reasons as stated for Song Writing, and also because working symbolically in groups is likely

to be very hard for this population. '*Very occasionally if patients are able to work symbolically,…… musical role play might be appropriate to act out or rehearse a particular situation. However careful attention would be paid to whether the person was enough in touch with reality for this technique to be appropriate or make sense to the patient.*

In conclusion, MP is not strongly indicated for bi-polar disorder, but the reasons given by Centre A are strong and thought through in terms of the diagnosis.

10.8.10 Receptive music using live music eg for reminiscence (RL)

Opinion is equally divided with Centres A & C saying RL is used with bi-polar disorder, and Centres B & D saying it is not used. No reasons are given as to why not, but Centre A states that it is used in individual & group-work 'very occasionally'- '*if patients want to hear something live and if this is part of the therapeutic relationship/goals for the overall therapy.*'

It can be concluded therefore that RL is not a significantly used technique for bi-polar disorder.

10.8.11 Receptive music using recorded music (RR)

All Centres say that RR is not used with bi-polar disorder apart from Centre A which says it is used only in groups. However the emphasis is that it might take place but may not usually be necessary as follows:
' *MIGHT take place in group work but not usually necessary as part of individual interactive music therapy – the exception might be if a patient brought some material to listen to and it was thought that listening to it together with the therapist (ie giving it meaning) was crucial to the overall therapeutic goals*'.

It can be concluded therefore that this is not a significantly used technique for bi-polar disorder.

10.8.12 Guided Imagery in Music (GIM)

All Centres agree that GIM is not used with bi-polar disorder. Centre A states one reason, that there is no training in the team in this technique. However it also suggests GIM might be inappropriate for people with serious mental illness, particularly psychotic disorders.

10.8.13 Music for Relaxation as part of MT programme (MR)

All centres agree this is not used with bi-polar disorder. Centre A, the only centre to give a reason for not using it however does not say that it would not be useful for this population, but that it is not the music therapists role to use MR ' *Is not usually seen as part of music therapists role-possibly OT/Nurse might organise this.'*

In conclusion MR is not used significantly with bi-polar disorder.

10.9 Summary: Approaches and techniques; bi-polar disorder

From the data it is clear that techniques which include improvisation with some structure are most used. This is similar to results for people with schizophrenia. There is unanimous agreement that Supportive Psychotherapy is used, and all but one centre uses a Psychoanalytically Informed approach. There is agreement that a non-interpretative holding approach is needed particularly in the acute phases of the illness, and an agreement that music can be very useful in helping with manic phases.

Analytical, Creative, Activity-Based and Client Centred are the third most used approaches, but only used by two centres, one centre uses Behavioural and Developmental approaches, and all centres are unanimous that Guided Imagery in Music is not used for bi-polar disorders although reasons given are quite vague. Lack of training, and a statement that GIM would not be useful for people with bi-polar disorders are reasons given. Apart from in one case where a considered reason is given, this leads the researcher to think that these music therapists are not well informed about GIM. However the reason given for not using GIM points out that going into an altered state of consciousness might have contra-indications for people

already struggling between reality and phantasy, and with the difference between their inner and outer worlds. Section 12.4.6, 12.4.7, 12.5.1 & 12.6.4 will discuss this point further.

Whilst there is not direct agreement it can be concluded that music for people with bi-polar disorder, is important because of the ability music has to link with and express 'affect'. Given that extremes of affect and mood are a main focus for problems with people with bi-polar disorder, it is indicated in all responses which give detail that it is this aspect of music that is crucial to success for people in music therapy with this disorder.

The analysis of the qualitative data, together with the findings of the quantitative analysis from Chapter 11 will be considered and elaborated in an extended discussion in Chapter 12 where examples of the findings supporting current and previous literature are reviewed.

10.10 Depression

10.10.1 Introduction to approaches and techniques: Depression

Only two Centres A & E gave consistent and full answers on the questionnaire with a full set of detailed qualitative and quantitative results for Depression. Centre B did not give detailed yes and no answers, but stated that people with this illness tend to be seen in out-patient settings only, and as no one is referred to the music therapy service directly by General Practitioners (Family Doctors), the only patients seen with depression tend to have personality disorders. Centre B wrote 'not applicable' apart from that one case study was given for CMT with depression in the settings section. Similarly Centre D stated that patients in their service were not referred with depression as the main presenting diagnosis. Patients with depression as the main presenting diagnosis are seen in the medical service not in the psychiatric service and treated with medication or psychotherapy but not music therapy. Therefore Centre D (a&b) scored as not applicable. It seems to be common practice that people with more severe depression who music therapists *do* treat, are seen as part of a personality

disorder service. Table 10.7 lists the approaches as in the other sections. The middle column has only three centres as other centres did not work with this population.

Table 10.7: Scores for use of approaches with depression

Approaches	Used by Centres	Rank Order
Psychoanalytically Informed	3/3	1st
Supportive Psychotherapy	2/3	2nd=
Client Centred	2/3	2nd=
Analytical Music Therapy	2/3	2nd=
Creative Music Therapy	1/3	5th=
Activity-Based	1/3	5th=
Developmental	1/3	5th=
GIM	1/3	5th=
Behavioural	0/3	9th=

Table 10.7 shows a clear polarity in usage of different approaches with patients with depression, where some approaches are typically used and one (Behavioural) is not considered appropriate. There is unanimous agreement that a Psychoanalytically Informed approach is the main approach, with all three centres using it, closely followed by Supportive Psychotherapy, Client Centred and Analytical Music Therapy. Creative Music Therapy, Activity-Based and Developmental approaches are only used by one centre in each case.

Tables 10.8 and 10.9 report the scores given by the centres for the use of techniques in group and individual work respectively with clients with depression in the format described above.There are less centres reporting group work as Centre E does not run groups in the general music therapy service.

Table 10.8 Scores for use of techniques in group work| with patients with depression

Techniques		Groups	Rank order
MT	Singing Composed Songs	2/2	1st=
TBI	Theme based improvisation	2/2	1st=
FI	Free Improvisation with minimal talking	2/2	1$^{st=}$
FT	Free Improvisation and Talking/interpretation	2/2	1st=
FS	Free Improvisation with structures such as turn taking or play rules	1/2	5th=
SW	Song Writing	1/2	5th=
MP	Musical Role Play	1/2	5th=
AT	Activity-Based	1/2	5th=
RR	Receptive music using recorded music	0/2	9th=
GIM	Imagery in music	0/2	9th=
MR	Music for Relaxation as part of MT programme	0/2	9th=
RL	Receptive Music Using Live Music	0/2	9th=

Table 10.9 Scores for use of techniques in individual work with clients with depression

Techniques		Individuals	Rank order
FI	Free Improvisation with minimal talking	3/3	1st=
TBI	Theme Based Improvisation	3/3	1st=
MP	Musical Role Play	2/3	3rd=
FT	Free Improvisation and Talking/interpretation	2/3	3rd=
FS	Free Improvisation with Structures such as turn taking or play rules	2/3	3rd=
MT	Singing Composed Songs	2/3	3rd=
SW	Song Writing	1/3	7th=
MR	Music for Relaxation as part of MT programme		7th=
RL	Receptive music using live music	1/3	7th=
RR	Receptive music using recorded music	1/3	7th=
GIM	Guided Imagery in Music	1/3	7th=
AT	Activity-Based	0/2	12th

Table 10.8 & 10.9 show slightly different results for individual and group work. For group work there is unanimous agreement from the two centres that Singing Composed Songs (MT) Theme Based Improvisation (TBI) Free Improvisation with Minimal Talking (FI) and Free Improvisation and Talking/interpretation (FT) are used most. For individual work, FI and TBI are used most with close second ranking of Musical Role Play (MP) and FT. The other main difference between the two, although marginal owing to the small numbers, is that for groups the following are not used:

Receptive music using recorded music (RR), GIM, Music for Relaxation as part of MT programme (MR), and Receptive Music using live music (RL). For individuals one centre uses each of the following, SW, MR, RL RR and GIM.

10.11 Summary of salient elements from qualitative data for each approach: depression

10.11.1 Introduction

Only three Centres A C & E gave answers for this, and all centres gave much less information for this category than for the previous two. This is reflected in the percentage of time spent in each centre treating people with depression, and also by the literature discussed in Chapter 8. There is also little difference therefore owing to the small number of centres and also four approaches are ranked in fifth position meaning only one centre uses Creative Music Therapy, Activity-Based, Developmental and Guided Imagery approaches. None use a Behavioural approach.

10.11.2 Supportive Psychotherapy (SP)

Centres A & C use SP with patients with depression. Centre A states:
'*At a profound stage where thinking is distorted, challenges are unmanageable and there is high suicide risk. This* (SP)……*can be used to maintain relationship in the hope of further work.*'

Conversely Centre E says that Supportive Psychotherapy is not used for patients with depression because 'empathic challenges' are needed and people with depression are very used to manipulating their surroundings to be supportive. Therefore this model does not bring them forward but encourages stuck patterns.

No reason is given by Centre C for using the approach so there is no real conclusive outcome here.

10.11.3 Client –Centred (CC)

Only Centres C and E use this and Centre E is very specific about why this approach is important. If the approach is not client centred the person with depression will feel not respected or understood. Centre E emphasises that sometimes the therapist might impose her own structures upon the patient through being unable to be client centred and follow the patient. It might be that the therapist introduces structures to contain her own anxieties instead of following the patient. Centre A merely states that CC is not used as there is no training in the centre in CC approaches.

10.11.4 Behavioural (B)

No centres use B with depression, so this is a unanimous outcome. Reasons given are by A that it is inappropriate because in depression deep feelings require processing. Centre E states that the required music therapy approach with depression should not be directive or combined with rewards and punishments**.**

10.11.5 Psychoanalytically Informed (PI)

All three centres A C & E use this, which is a conclusive unanimous response indicating that PI is used more with depression than other approaches. Reasons given by Centre A, are that the underlying issues related to depression are historical, and also that personal theoretical preference influences which approach is chosen. This implies that choice is influenced both by training preference and by diagnostic phenomena. Centre E focuses on the therapist's counter-transference and suggests that there could be a tendency to avoid the depression by resorting to less psychoanalytic approaches *'The transference and counter transference issues inform my work. It is important to be able to share and contain the heavy atmosphere and not to try to escape by suggesting some other activities to really respect and strengthen the patient's self esteem.'*

There is a agreement here that underlying issues relating to depression need to be worked through and can be by taking a Psychoanalytically Informed approach.

10.11.6 Developmental (D)

Only Centre C says yes it uses this approach with depression, but no reason is given. Centre A says that a Developmental model does not inform thinking about depression and therefore is not influential in music therapy for people with this disorder. Centre E states that people with depression have lots of skills and that it is their lack of self esteem and destructive self image that prevents them from making use of their skills. (implied-rather than needing help with developing skills).

10.11.7 Analytical (AMT)

Centres C and E say that they use AMT with depression, but only E gives a reason which is that people with depression often have a strong enough ego to take part in splitting techniques and tolerate interpretations.

10.11.8 Creative Music Therapy (CMT)

Although only Centre C (no reason given) uses CMT with depression, and the other centres said it was not applicable for reasons given in the introduction to this section, Centre B elsewhere in the questionnaire gave a detailed case study, stating that this diagnosis is not usually seen separately but as part of the personality disorders service. The case study is included here as there is so little data on this section about depression.

'S was originally referred to psychology but found it very hard to talk about herself. Her psychologist suggested music therapy as an alternative means of expression. In her initial session, she meekly followed my instructions but there was little sense of life in her playing, and no eye contact between us. Towards the end of the session, I waited a long time for her to choose an instrument for herself. Eventually she chose the recorder, on which she seemed to remember a few notes from school days. However, her playing was based on blowing and over-blowing, and the effect was a startlingly expressive improvisation in which I had the role of listening acutely through my piano playing. I had to show her I could match her strength and intensity, and yet in no way overpower her. At the end of that improvisation she cried, and we

agreed to continue meeting. Over the next few weeks, she played various instruments, but always ended up on the recorder. After playing the recorder she would talk a little about her life and the experiences that had brought her here, to which I responded minimally, wishing to acknowledge this but not detract from the power of the musical experience. After three months, we agreed that she was now ready to go back to verbal therapy. In music therapy she had found a voice: now she was able to go and use it.'

This example suggests that CMT sees itself not as a form of psychotherapy and not as an approach which might include talking and working through. As the approach title suggests, it is adjunctive to psychotherapy and would not act as a 'depth' therapy in its own right as described by Centre B. This is very different to other approaches such as Psychoanlytically Informed music therapy.

10.11.9 Activity-Based therapy (AB)

Only Centre A said AB is used with depression. Reasons are contradictory to Centre E, as in most answers in this section about depression. Centre E which does not use AB with Depression states that '*most depressive patients will experience such activities as childish*.' Centre A conversely states '*Activity/action grounds and enlivens someone who is retarded physically and introverted psychologically. The physical act requires will and motivation'*. However the statement concludes by suggesting that this approach may not require a music therapist.

10.11.10 Guided Imagery in Music (GIM)

Only Centre E states that GIM is used with depression, in '*moderated form.'* Unlike people with schizophrenia where lying down and listening to music was seen by this centre as a problem, people with depression can lie down and listen to music and also engage with imagery. Furthermore this model is indicated particularly for people with depression, as they can be so self critical and therefore not identify with their improvisations. In GIM they have the possibility to allow '*symbols as darkness, deep water or other symbols which can put their experiences into words and pictures.'* No

other centres use GIM with depression and no specific reasons are given apart from Centre A which states '*no training'*.

10.12 Summary of salient elements from qualitative data for each technique: depression

10.12.1 Introduction

Only two centres responded to the group section and three for the individual section for depression. It is noticeable that below there is less information given for this diagnostic category than for the psychotic disorders. There is also more of an emphasis upon the use of techniques which involve working symbolically, than for the psychotic disorders.

10.12.2 Free Improvisation with Minimal Talking (FI)

Similarly to the approaches section, Centre A and E give opposite responses. Centres A & C use this technique, but centre C does not. The opposing reasons are that Centre A states that music can express a livelier creative self, and resist defences against difficult feelings when talking seems to take the patient into a negative spiral. Conversely Centre E states that these patients need '*the getting in and out of the music and talking –not the passive diving into the music'* suggested by no emphasis on talking in this technique.

10.12.3 Free Improvisation with Talking/Interpretation (FT)

All three respondents agree that FT is used with individual patients with depression, and both Centres A & C use FT in groups. There is agreement that interpretation is useful and must be timed so that conscious thoughts can be tolerated and used constructively as a result of the interpretation which can also according to Centre A alleviate confusion and resist 'attacks on the psyche.*'*

10.12.4 Free Improvisation with Structures such as turn taking or play rules (FS)

Centres A & E agree too here that FS is useful with depression, but Centre C does not use it with no reason given. Centre E refers to a case example given in the out-patient section under MP (Musical Role Play/Musical Psychodrama/Art & Psychodynamic movement), which clearly has overlaps with this technique. Centre A agrees with Centre E about this and it is clear that symbolic thinking is regarded as intact for people with depression unlike for those with schizophrenia, and therefore techniques such as FS and MP are very much emphasised as useful. Centre A states that trying out roles other than those usually adopted in free improvisation and encouraging engagement is important.

Centre E example:
Here it is possible to use music to play out important persons in the patient's life and for the therapist to take a role of a person in the patient's life. This can be a very strong experience.
Example: I have a depressive woman who felt totally overwhelmed by her mother: We decided that I should play her mother and she should play herself towards her mother. We both played the congas and I just invaded her from the very beginning. She started to play and stopped very quickly and we talked about what happened inside her. She agreed in trying again and this time she got connected to an inner strength so she could fight with me in the music and felt very energetic and proud afterwards. She really realised how much the dynamic between her and her mother took away her energy and strengthened the depressive tendencies.

Centre E also refers to another case under MP see section 10.12.9, here, suggesting in this section that musical thematic structures such as A, B, A1 are useful with depression as these structures help with their often rigid monotonous or non-dynamic way of playing. The case using A, B, A structures is also referred to in the section on personality disorders. (see section 10.24.9).

10.12.5 Theme-Based Improvisation (TBI)

All three centres agree this is used with depression for individuals, and both Centres A & C use TBI with groups. Centre A states that it is important for group members to initiate the titles. An example is given *'I once improvised on 'guilt' with an individual who found talking cyclical. This led to awareness of anger rather than guilt.'* Centre E makes an interesting point that people with depression do not realise how much strength it takes to keep the depression in place, and therefore identifying with themes which allow for this strength to be recognised in a positive way which can happen musically (implied), is important.

10.12.6 Activity-Based: Tea dance, choir, workshop/structured activity (AT)

Centre A uses this infrequently with individuals and not at all with groups. Structured choral singing, or aspects of performance are the types of things used if at all, but these would be for specific occasions such as a festival or birthday, and very rare. No other centres use AT with this population and so there is agreement about this. The only reason stated is by Centre A which says that a workshop style group may help engagement but would rarely be used with in-patient groups with depression who lack motivation. Centre A also states that this is not the best use of music therapy skills.

10.12.7 Singing Composed Songs (MT)

Centres A & C use this, although no reasons are given by either centre. Centre A states it is used rarely and brackets it with Song Writing, as if they are regarded similarly. Centre A states that these types of techniques were not part of training and are less likely as they might require patient initiation (implying that this might not be helpful or possible with this group). Centre A also states that Singing Composed Songs is less likely to be useful in groups for depression as the members would not share the identification (implying that they would be too depressed to be interested in another member's identification with a song).

So in conclusion this is not seen generally as a useful technique with depression.

10.12.8 Song Writing (SW)

Only Centre A indicates that Song Writing might be useful with depression. Whilst seeing it as possibly useful occasionally, Centre A states a caution *'an individual may use this to avoid contact and spontaneity so I would not encourage it. Depressed people aren't often keen to sing'* This opinion is shared by Centre E but stated in a different way; that people with depression are not usually in the mood for creating, and that it might not be actively encouraged because people with depression would be too self critical of whatever is created. Improvisation is stated as a preferred mode suggesting it prevents the avoidance of facing up to difficulties *'It is easier to make them tolerate deficits in improvising.'*

10.12.9 Musical role play/musical psychodrama/art & psychodynamic movement (MP)

Centres A and E agree this is very useful and Centre E includes the following case example in the 'Context' part of the questionnaire for MP.
Often these patients make drawings while listening to our improvisation and they can relate their drawings very much to the mood and structure of the music.
Example: I made the A,B,A1 form with a personality disturbed patient with anxiety and depressive tendencies. We played very piano and harmonic in the first part, very dynamically and disharmonic in the second part and very much together in the third part. She made a drawing with a pastel coloured flower at the left side of the paper (almost invisible). In the B part (in the middle of the paper) she drew herself bowing over on her knees on the floor with lots of heavy stones on her bag as if being weighed down by burdens, in the third part she draw green and red lines waffled about each other and she said: It is you and me and we are together and this is new for me." She was aware that she needed the disharmony to become more present in her body and in the relationship but she was afraid of it and hated it. She could allow it in the music because it was symbolic and she herself could decide when to go back to A1.

Centre C gives no reason for not using MP with depression. In summary Centre A suggests that MP is useful, particularly the use of role play, although this requires motivation which might be lacking for some people with depression. Centre E says

that often patients with depression like drawing during listening- '*in the drawings they can express the darkness and heaviness without burdening others (such as in sound expressions).*'

Again this reveals a general agreement between the two centres that people with depression can work symbolically and that other media can be a useful addition to music when music might be too direct or active.

10.12.10 Receptive music using live music eg for reminiscence (RL)

Only Centre A uses this with individuals. However Centre E whilst indicating RL is not used, implies that it might be advantageous, but that it is very hard for people with depression to think of themselves as being worthy of a therapist playing to them. '*.....if they can overcome this barrier it is very touching*'. This concurs with Centre A's reasons for using RL, which point to the emotional release that could be present if a patient with depression is played to by the therapist. Centre A implies that most often it is important to engage patients actively, but that the RL technique would be useful if a patient were catatonic '*I may play to them and have done so and found this released emotion.*'

10.12.11 Receptive music using recorded music (RR)

Only Centre E uses RR for depression. Centres A and E disagree about this. Centre A does not use RR saying it is restrictive and the meaning for the client cannot be known. Also stated is '*Client unlikely to initiate this*'. Conversely Centre E suggests that listening to receptive music could be crucial to contacting someone who is in the depths of depression '*Even if they feel like being in a deep dark cave not being able to get out-the listening to music can enter this cave.*'

10.12.12 Guided Imagery in Music (GIM)

Only Centre E uses this and probably is the only centre which responded to this section on depression which employs music therapists who are trained in GIM. Centre A states the reason for not using GIM as not knowing how to use it rather than

suggesting it would not be appropriate. Centre E emphasises the importance of symbolism and says that symbols can carry some of the darkness and heaviness for people with depression.

10.12.13 Music for Relaxation as part of MT programme (MR)

All centres say MR is not used with depression except for Centre E where it is clearly not used as a whole programme, but for part of the session '……..*Mostly at the end of sessions.*'
Centre A merely states that a relaxation programme is not used and that relaxation may not be needed by this group.

10.13 Summary: Approaches and techniques; Depression

The qualitative data is comparatively small for depression compared with the psychotic disorders, which reflects referral patterns. Tables 10.7, 10.8 & 10.9 show the proportions and numerical data and summary. Although in group work there is unanimous agreement from the two centres that Singing Composed Songs (MT) Theme Based Improvisation (TBI), Free Improvisation with Minimal Talking (FI) and Free Improvisation and talking/interpretation (FT) are used; most reasons are not conclusive or particularly comprehensive. However, techniques such as those using role play and themes (TBI and MP) are used more with depression and ranked high, indicating the use of music and symbolic or metaphorical thinking which is possible for this group. For individual work, FI and TBI are used most with close second ranking of MP and FT. In groups, (RR), (GIM) (MR) and (RL) are not used, and for individuals one centre uses each of the following, SW, MR, RL RR and GIM. The analysis of the qualitative data, together with the findings of the quantitative analysis from Chapter 11 will be considered and elaborated in an extended discussion in Chapter 12, where examples of the findings supporting current and previous literature are reviewed.

10.14 Anxiety

10.14.1 Introduction to approaches and techniques with anxiety

Similarly to depression, only three Centres A, C and E responded to this section. Centre C again gave no comments but answered the yes and no sections. Centre B said anxiety is treated as a secondary diagnosis to personality disorder and therefore patients are not seen separately presenting with this as a main diagnosis, consequently music therapy is not practiced in a specialist way for people with anxiety. Centre D made the same point, stating that people with anxiety are treated similarly to those with depression and therefore scored as *'not applicable'* on the questionnaire. Anxiety in this case would be regarded as *'a positive evolution'*. This researcher's understanding of this point is that anxiety, like depression is often regarded as a symptom of personality disorder. If these symptoms are already diagnosed, it is a step forward for the patient, but it means in Centre D that the patients would not be treated in the main psychiatric service and therefore not treated by the music therapists. *'Anxiety and depression symptoms often uncover a personality disorder so often people with depression are referred to the Personality Disorder Service.'*

Similarly to depression only comments from Centres A and E are recorded and analysed. Table 10.10 shows scores for approaches with anxiety. The centre column shows 3 centres as similarly to depression, with the rank order in the right column, and only 3 centres answered this section.

Table 10.10 Scores for use of approaches with anxiety

Approaches	Used by Centres	Rank Order
Psychoanalytically Informed	3/3	1st=
Supportive Psychotherapy	3/3	1st=
Client Centred	2/3	3rd=
Analytical Music Therapy	2/3	3rd =
Creative Music Therapy	1/3	5th=
Behavioural	1/3	5th=
Developmental	1/3	5th=
GIM	1/3	5th=
Activity-Based	0/3	9th=

Tables 10.11 and 10.12 report the scores given by the centres for the use of techniques in group and individual work respectively with clients with anxiety in the format described above.

Table 10.11 Scores for use of techniques in group work|with patients with anxiety

Techniques		Groups	Rank order
MT	Singing Composed Songs	2/2	$1^{st}=$
TBI	Theme Based Improvisation	2/2	$1^{st}=$
FI	Free Improvisation with minimal talking	2/2	$1^{st=}$
FT	Free Improvisation and Talking/interpretation	2/2	$1^{st}=$
FS	Free Improvisation with Structures such as turn taking or play rules	2/2	$1^{st}=$
SW	Song Writing	1/2	$6^{th=}$
MP	Musical Role Play	1/2	$6^{th}=$
RL	Receptive music using live music	1/2	$6^{th}=$
RR	Receptive music using recorded music	0/2	$9^{th}=$
GIM	Guided Imagery in Music	0/2	$9^{th}=$
MR	Music for Relaxation as part of MT programme	0/2	$9^{th}=$
AT	Activity-Based	0/2	$9^{th}=$

Table 10.12 Scores for use of techniques in individual work with clients with anxiety

Techniques		Individuals	Rank order
FI	Free Improvisation with minimal talking	3/3	$1^{st}=$
TBI	Theme Based Improvisation	3/3	$1^{st}=$
RL	Receptive music using live music	3/3	$1^{st}=$
FS	Free Improvisation with Structures such as turn taking or play rules	3/3	$1^{st}=$
MP	Musical Role Play	2/3	5th=
FT	Free Improvisation and Talking/interpretation	2/3	5th=
MT	Singing Composed Songs	2/3	5th=
SW	Song Writing	1/3	8th=
MR	Music for Relaxation as part of MT programme	1/3	$8^{th}=$
RR	Receptive music using recorded music	1/3	$10^{th}=$
GIM	Guided Imagery in Music	0/3	11th=
AT	Activity-Based	0/3	$11^{th}=$

Table 10.11 & 10.12 show results for techniques in individual and group work. For group work there is unanimous agreement from the two centres that Singing Composed Songs (MT) Theme Based Improvisation (TBI) Free Improvisation with

Minimal Talking (FI) and Free Improvisation and talking/interpretation (FT) are used most. For individual work, FI and TBI are used most with close second ranking of Musical Role Play (MP) and FT. The other main difference between the two, although marginal owing to the small numbers, is that for groups the following are not used: Receptive music using recorded music (RR), Guided Imagery in Music (GIM), Music for Relaxation as part of MT programme (MR), and Receptive music using live music (RL). For individuals one centre uses each of the following, Song Writing (SW), MR, RL RR and GIM.

10.15 Summary of salient elements from qualitative data for each approach: Anxiety

10.15.1 Introduction

Only three centres answered for approaches for anxiety. Psychoanalytically Informed and Supportive Psychotherapy are the most used, and Activity-Based is not used at all. However in the data that is provided there are some comments which show music therapists are linking their approach with features of the illness. Section 10.16.1 makes some general points that refer to the fact that some centres regard anxiety and depression as linked, and reasons given also relate to this section.

10.15.2 Supportive Psychotherapy (SP)

All three centres said that SP is used with anxiety. Both centres which gave reasons for the use of SP, agree that SP is useful because it does not require exploration, as it might be overwhelming. Especially in the initial stages of the illness, patients with anxiety need to feel there is safety and support given in a non intrusive way. The similarity of the two centres' comments and reasoning suggests evidence for the use of SP being specifically linked to the diagnosis as shown in the quotes here:

Centre A: *'This approach may be used for a short period if anxiety is transient, possibly related to external events, and exploratory work would be overwhelming'.*

Centre E: '*For some very anxious patients it can be important in some critical phases to work more with diversions and not to empathize too much in the mood of the patient. The patient needs to feel someone is out there safe and not interfering,- a stable centre.*'

Centre E illustrates the specific detail further in a case example: '*A patient which is chaotic and anxious in his playing do not need that the music therapist is following the mood but more needs that the therapist is stabilising the situation by playing either one tone or one repeated melody sequence or a repeated rhythm.*'

In conclusion the three centres all agree that SP is useful with anxiety.

10.15.3 Client –Centred (CC)

Centre C says CC is used with anxiety, but does not give a reason. As previously stated it is not clear that a pure Rogerian approach (1959) is what is being thought about here, or whether Centre C defines CC as 'anything which puts the clients needs at the centre.' Centre A says CC is not used with A because no one is trained in this approach and Centre E whilst saying that it is used, is ambivalent. '*Basically yes but sometimes the patient can need a more directive style in critical phases.*'

So the conclusion is that CC is not strongly indicated for anxiety disorders either because music therapists are not trained in CC or because patients with anxiety need a more directive rather than totally patient-led approach.

10.15.4 Behavioural (B)

Only Centre E says that B is used with anxiety, but reasons suggest ambivalence and that it would not be the focal model for this population. Centre A states that anxiety is not seen as a behaviour in the centre, and therefore B is not applicable because as a music therapist would want to work with underlying issues rather than only the behaviour. Centre E starts by saying that a basic behavioural model is not used, but then says that it might sometimes be used because '*the very anxious patient needs concrete tasks and firm demands to be able to fight against the uncontrollable*

anxiety. These demands can be to '*choose another instrument (not to hang on to the only safe one), and to imagine the frightening situation (bus driving or other situations) during musical improvisations*'

In conclusion, a Behavioural approach is not a primary model for people with anxiety, although some of the more structured concrete task-orientated aspects of the theory might be useful sometimes.

10.15.5 Psychoanalytically Informed (PI)

All three centres A C & E say that a Psychoanalytically Informed approach is used with anxiety. Centre A states that PI is important as it helps to gain insight into causes of anxiety. PI also '*encourages tolerance of thinking which anxiety defends against*'. Centre E more specifically states that '*the therapist has to be aware of and recognise when it is possible to empathize and to work in the field of transference and counter transference and when it is not. The aim is that it can become possible to make the patient more cognitive about his/her symptoms on an emotional connected base. Not just as explanation.*'

In conclusion, there is agreement that PI helps the patient by encouraging thinking and understanding (implied through interpretation) .

10.15.6 Developmental (D)

Only Centre C states that D is used with patients with anxiety, but typically for this Centre, gives no reasons why. Centre A does really give a reason for not using except that it is '*not a theory I use to understand anxiety*'. Centre E gives a more definitive reason '*The patients anxiety is the prohibition for development so the aim is to overcome the anxiety not to train skills.*'

In conclusion, a Developmental approach is not significantly used for patients with anxiety, and there is no real sense that the respondents link this with music therapy approaches for this population.

10.15.7 Analytical Music Therapy (AMT)

Centres C & E state that AMT is used with people with anxiety. However there are not clear reasons for any responses given. Centre A states that music therapists in the team have no training in AMT but there are no clinical links made with the decision not to use it. Centre E states that the AMT approach can replace the Supportive Psychotherapy approach.

Whilst two centres state that AMT is used with anxiety, there is inconclusive reasoning to suggest that AMT is a preferred approach for this population.

10.15.8 Creative Music Therapy (CMT)

Only Centre A states that CMT is used with anxiety. because *'Creativity develops problem -solving ability and can relieve the state of anxiety or hold it so client doesn't break into other states.'* Centre E emphasises, in rejecting this approach that for this population, it is not improving at playing music that is important. Neither is becoming more conscious of musical elements which might be associated with CMT, a crucial factor in this approach.

There is a lack of reasoning for this approach which prevents any definitive conclusion to be reached.

10.15.9 Activity-Based therapy (AB)

All Centres agree that AB is not used with anxiety. Centre A states that *'Activities may help alleviate mild anxiety, but referrals are unlikely for mild anxiety and this may not require a qualified therapist.'* Centre E implies that patients suffering from anxiety may search for something that is safe, but implies that this is not what is needed for people with anxiety: *'It is not a part of the treatment in our service.'*

10.15.10 Guided Imagery in Music (GIM)

All centres suggest that GIM is not used for anxiety although Centre E suggests ambivalence about whether GIM is useful for people with anxiety as revealed in the following statement:.

Centre E states '*In the phase of panic anxiety it is not possible to make these patients calm down to listen and to let the music influence their imageries. Later this model can be very useful as it can help the patient to better contain the anxiety (use the music as a co-therapist and a third person which helps them get through the dangerous areas and transform them)*'

Centre A states that GIM is not used owing to no one being trained in this.

In conclusion GIM is seen as potentially useful in controlling symptoms of anxiety but it is not strongly identified as a significant approach for people with anxiety.

10.16 Summary of salient elements from qualitative data for each technique: Anxiety

10.16.1 Introduction

Centres A, C and E responded to the section on anxiety in the questionnaire. Centre C gave no comments but answered the yes and no sections. There is less information in the results of the survey about anxiety than for any other diagnostic group, suggesting that music therapy is not a priority treatment for anxiety disorders in these centres.[6]

Centre B said anxiety is treated as a secondary diagnosis to personality disorder and therefore patients are not seen separately presenting with this as a main diagnosis, and music therapy is not practiced in a specialist way for people with anxiety. Centre D made the same point, stating that people with anxiety are treated as for those with depression and therefore scored as '*not applicable*' on the questionnaire. It is not seen as applicable because anxiety is not treated as a separate diagnosis in this service and

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[6] This introduction repeats material from the introduction about approaches, owing to the overlap of a small amount of information for this section.

would be seen as part of other diagnoses, for example personality disorder. Anxiety in this case would be regarded as *'a positive evolution'*. This means that anxiety, like depression is often regarded as a symptom of personality disorder. If these symptoms are already diagnosed, this is a step forward for the patient, but it means in Centre D that the patients would not be treated in the main psychiatric service and therefore not treated by the music therapists. Furthermore Centre D says that people with anxiety are commonly treated with psychotherapy and medication. Centre D also points out that anxiety and depression symptoms often uncover a personality disorder so often people with these diagnoses are usually referred to the personality disorder service. Therefore similarly to depression only comments from Centres A and E are recorded and analysed.

10.16.2 Free Improvisation with minimal talking (FI)

Centres A and C use Free Improvisation with Minimal Talking with anxiety, but Centre E does not. Again no reason for using it is given by Centre C, but Centre A states that *'playing can relieve anxiety, although it could be used to avoid experiencing anxiety'* This latter comment showing a reason also for not using FI is echoed by Centre E although the reason differs *'they need to talk and to be in control.'*

In conclusion is seems that FI is useful but that not talking might encourage avoidance or increase symptoms of anxiety such as being out of control. It does not appear the preferred technique.

10.16.3 Free Improvisation with Talking/Interpretation(FT)

All Centres use FT with anxiety, although Centre E states that it is more useful later in therapy, making the point that in the beginning phases of music therapy treatment FT might be too free as patients need to be in control. Centre E suggests that if FT is used at the start of treatment with anxiety, improvisations are usually pianissimo and only in a few keys. Centre A focuses upon the inclusion of talking rather than upon the nature of free improvisation *'Talking can help to gain a sense of control over emotional experience & this can alleviate anxiety.'*

In conclusion it seems this is a preferred technique with anxiety because talking can help take control and alleviate anxiety. It is also agreed that music alone in free improvisation style may be problematic and increase symptoms of anxiety owing to lack of structure and unpredictability.

10.16.4 Free Improvisation with Structures such as turn taking or play rules (FS)

All Centres use FS with anxiety and agree that structures in the music help relieve the symptoms commonly found for anxiety.

Centre A '*Structure can relieve the anxiety produced by freedom. This gives opportunity to try out different roles.*'

Centre E '*These structures can be good in the beginning especially the turn taking on the black keys.*

Both responses are included here so that the similar responses can be seen, as both focus upon the possibilities for meaningful interaction; turn-taking for Centre E, and role play for Centre A.

10.16.5 Theme-based improvisation (TBI)

All centres agree that Theme Based Improvisation (TBI) is useful with anxiety. Centre A makes the general statement that TBI may further exploration of issues when anxiety presents understanding. Centre E focuses on the advantage of TBI as it is possible to provide a concrete 'as if' theme that is personally related to their problem, making the point that people with anxiety cannot easily be motivated through more abstract uses of themes. Centre E states '*....they need something rather concrete*' for example to '*play how you feel in your stomach right now*' or '*play a certain situation*'.

In conclusion TBI can help thinking and meaning when anxiety might prevent this. The structure of a theme can enhance music-making.

10.16.6 Activity-Based: Tea dance, choir, workshop/structured activity (AT)

All Centres agree that AT is not useful for anxiety. The only reason given is by Centre A which is slightly ambivalent as the response suggests that AT might be useful but it would not be the role of the music therapist to provide this.

'Activity may distract from mild anxiety, but anxiety so easily alleviated wouldn't require the specialist services of a music therapy'.

In conclusion AT is not an indicated music therapy technique for anxiety from the responses by these centres.

10.16.7. **Singing Composed Songs (MT)**

There are opposing views and reasons here from Centres A & E. Centres A & C both use Singing Composed Songs (MT), and Centre E does not. Centre C typically gives no reason.

Centre A states:
'*A known song may feel more manageable and provide security,'*going on to state that it is not the preferred way of working without saying why. Centre E conversely states simply that they (people with anxiety*) 'often do not like singing-it is too frightening.'*

No real concensus is found here, and no conclusion can be drawn as one centre suggests MT is too frightening and the other that MT might provide security.

10.16.8 Song Writing (SW)

Only Centre A uses SW with people with anxiety, saying that a '*focus may avoid feelings of being overwhelmed by anxiety. Adding structure to self expression may be helpful.'* No reasons are given by Centres C or E for not using it.

10.16.9 Musical Role Play/Musical Psychodrama/Art & Psychodynamic Movement (MP)

Centres A & E use MP with anxiety, and Centre C does not, but gives no reason. Centre A suggests that occasional use of role play would provide a perspective on a situation, and Centre E states that painting during listening to music is popular with people with anxiety as '*it is the only way they can express diffuse anxiety*'

In conclusion it is suggested that other media or role play might provide helpful additions to music therapy with anxiety by providing a new perspective or helping to explore feelings of anxiety.

10.16.10 Receptive music using live music eg for reminiscence (RL)

All Centres use RL with anxiety. Centres A & E agree that this is useful and for very similar reasons. Both refer to the lullaby quality that might be helpful for people with anxiety.

Centre A : '*May use with an individual who is too anxious to manage anything else. Used with anxious mothers to calm her and her baby*'
Centre E : '……*they like the therapist to play something like a lullaby to calm down*'.

In conclusion, it seems that RL is useful for people with anxiety, and that calming music might be most commonly used.

10.16.11 Receptive music using recorded music (RR)

Only Centre E uses Recorded Music (RR). Centre A states that this is not the centres theoretical orientation and also that if it was seen as helpful, the patient would be referred to a music group (not music therapy). Centre E conversely states that RR is very popular '*they often prepare pop/rock music something they can move their body to.*'

10.16.12 Guided Imagery in Music (GIM)

All Centres say GIM is not used specifically with anxiety. Centre A suggests therapists in the centre are not trained in GIM, but no other reasons are given for not using it. Centre E states that GIM is '*often too challenging*' because people with anxiety do not dare to let go and lose control with the music. However there is a suggestion that GIM might be useful '*If they come to a phase where this is possible it is a success.*'

10.16.13 Music for Relaxation as part of MT programme (MR)

Only Centre E uses MR with anxiety and the only information given is '*Often at the end of session*' suggesting that it is not a major technique but used as part of a session. Centre A does not 'work within a programme' of relaxation with no reason given.

In conclusion there is no indication that MR is a priority technique for anxiety or commonly used by the centres in the study.

10.17 Summary: Approaches and techniques used with patients with anxiety

Free Improvisation with minimal talking, Theme Based Improvisation, Receptive music using live music and Free Improvisation with Structures such as turn taking or play rules are the most used techniques for patients with anxiety. All centres that reported working with anxiety use them although information about why is much less substantial than for the psychotic disorders. This is partly because only three centres in the study treat people with music therapy who suffer from anxiety as a separate diagnostic group, whereas all centres provide a specific service for people with psychotic disorders. Only two centres who responded to this section do group work for this population. Receptive music using live music (RL) is used more for people with anxiety, than for other diagnoses in the study. For example calming music is used with anxious mothers unable otherwise to calm their babies. This is supported by two centres, one of which suggests that the therapist might play something like a lullaby to help an adult with anxiety to calm down.

Free improvisation with talking is useful, because not talking might encourage avoidance or increase anxiety about loss of control, and therefore Free Improvisation with Talking and Interpretation is a preferred technique.

Song Writing is indicated by only one centre as useful, suggesting that focussing upon it may avoid overwhleming feelings of anxiety and structures added to help self expression might be useful.

Interestingly the three techniques involving recorded music are used very little, Guided Imagery being the least used. One opinion that was offered from one centre regarding the use of GIM with severe anxiety states with hospitalised patients is that the loss of control is too challenging for a person with anxiety. Patient involvement is seen as important and therefore live music planned and improvised together with the patient is considered more successful for this diagnosis by centres in the study.

The analysis of the qualitative data, together with the findings of the quantitative analysis from Chapter 11 will be considered and elaborated in an extended discussion in Chapter 12, where examples of the findings supporting current and previous literature are reviewed

10.18 Eating Disorders

10.18.1 Introduction to approaches and techniques with eating disorders

Only three Centres responded in full to this section for approaches, Centres A C and E. For techniques, only Centre C responded to working with groups, and three centres, A, C and E responded to working with individuals. Centre E typically does not run groups, and Centre A at the time of responding did not run groups specifically with eating disorders.

Centre B said they had not treated any people with this disorder over the last year. However one case study was provided in the Day Hospital section by Centre B, in order to describe an example of the particular Psychoanalytically Informed Music-Centred Music Therapy (PSMC) defined by this centre, so this is included below

under 'Other Approaches' (10.26). It is a very similar if not identical approach to a Psychoanalytically Informed approach.

Centre D left the section on eating disorders blank and said these patients are looked after in a separate unit and music therapists are not employed there. From this it could be deduced that music therapy is not seen as a priority treatment in either centre for music therapy. So mainly there are three main respondents to each section, Centres A, C & E.

Table 10.13 shows scores for approaches with eating disorders. The right hand column shows three centres. Similarly to categories of depression and anxiety, only three Centres answered this section.

Table 10.13 Scores for use of approaches with eating disorders

Approaches	Used by Centres	Rank Order
Psychoanalytically Informed	3/3	$1^{st=}$
Supportive Psychotherapy	3/3	1st=
Client Centred	1/3	$3^{rd}=$
Analytical Music Therapy	1/3	$3^{rd}=$
Creative Music Therapy	1/3	3rd=
GIM	1/3	$3^{rd}=$
Behavioural	0/3	7th
Developmental	0/3	7th
Activity-Based	0/3	7th=

Tables 10.14 & 10.15 report the scores given by the centres for the use of techniques in group and individual work respectively with clients with eating disorders in the format described above.

Table 10.14 Scores for use of techniques in group work with patients with eating disorders

Techniques		Groups	Rank order
TBI	Theme Based Improvisation	1/1	1st=
FI	Free Improvisation with minimal talking	1/1	1$^{st=}$
FT	Free Improvisation and Talking/Interpretation	1/1	1st=
FS	Free Improvisation with Structures such as turn taking or play rules	1/1	1st=
SW	Song Writing	1/1	1st=
MP	Musical Role Play	1/1	1st=
MT	Singing Composed Songs	0/1	7th=
RL	Receptive music using live music	0/1	7th =
RR	Receptive music using recorded music	0/1	7th =
GIM	Guided Imagery in Music	0/1	7th =
MR	Music for Relaxation as part of MT programme	0/1	7th =
AT	Activity-Based	0/1	7th =

Table 10.15 Scores for use of techniques in individual work with clients with eating disorders

Techniques		Individuals	Rank order
FI	Free Improvisation with minimal talking	3/3	1st=
TBI	Theme Based Improvisation	3/3	1st=
MP	Musical Role Play	3/3	1st=
FT	Free Improvisation and Talking/interpretation	2/3	4th=
FS	Free Improvisation with Structures such as turn taking or play rules	2/3	4th=
SW	Song Writing	2/3	4th=
RR	Receptive music using recorded music	2/3	4th=
MT	Singing Composed Songs	1/3	5th=
MR	Music for Relaxation as part of MT programme	1/3	5th=
RL	Receptive music using live music	1/3	5th=
GIM	Guided Imagery in Music	1/3	5th=
AT	Activity-Based	0/3	12th

Tables 10.14 & 10.15 show results for individual and group work. Three centres answered for individual work, Centres A, C & E, and one for group work because Centre A and E were not running groups with patients with eating disorders at the time of the survey. Whilst there is a clear polarity of responses to techniques used, all centres agree unanimously that TBI, FT and FI are used with patients with eating disorders. For individual work all centres agree that TBI is used, and this is ranked

higher than for most other diagnostic groups. MT, RL, RR, GIM, and MR are not used at all for group work and AT is not used in either group or individual work.

10.19 Summary of salient elements from qualitative data for each approach: Eating disorders

10.19.1 Introduction

Only three Services responded in full to this section for approaches, Centres A C and E. Similarly to anxiety, the approaches most used are Psychoanalytically Informed and Supportive Psychotherapy. One centre uses GIM, and no centres use Behavioural, Developmental and Activity-Based approaches. Centre C responds in detail to this section and this is in contrast to the other diagnoses. There is an inclination in the responses here to link approaches with the particular special problems associated with eating disorders.

10.19.2 Supportive Psychotherapy (SP)

All three centres said SP is used with eating disorders. Furthermore there is agreement between all Centres that SP is particularly useful for encouraging a sense of self which is often one of the major things lacking for people with eating disorders. Centre E and C suggest that this support should be more or less firm at different stages in the therapeutic relationship. Centre C is most specific and states that less support is needed as the relationship develops with the therapist.

Centre C links the model with the actual symptoms of eating disorders in some detail. Both Centres A & C discuss support that is necessary whilst body weight is low with a risk of death. Centre E draws attention to the idea of support being provided at a distance because often people with eating disorders cannot tolerate empathy or intimate relationships.

Centre E sums up what the other two centres point to, but they do not give so much detail as Centre E..
Centre E:

'This is the model used in the unit…….by all therapists. The role of the music therapy in the programme is to look at underlying issues relevant to the development and maintenance of the eating disorder. This includes such things as working on connecting feelings to the body, looking at behaviour generally through /music. Relationships, ways of communicating, sibling rivalry and other key psychological and social factors are a focus. In the earlier stages of the illness more support is needed. Patients are less able to have insight and work dynamically when very low in weight and suffering effects of starvation on brain function. As they become more robust, the work is more direct and analytic,, using more interpretation.
Centre E states that the various levels of defence mechanisms must be taken into account when deciding how much interpretation is possible.

In conclusion, Supportive Psychotherapy is seen as useful with eating disorders by the centres in the study; all centres agree it can specifically help to build the self which has often disintegrated. How much or little support should be given varies, for example less support is needed as the relationship develops with the therapist.

10.19.3 Client Centred (CC)

Only Centre E uses this, the other two stating that music therapists are not trained in this approach. Centre E says that these patients also some times need to be firmly and repeatedly faced with the view of themselves and their body from the surroundings (meaning in this case the therapist), in an understanding way.

It is unclear exactly how a Client Centred model is integrated within music therapy and little information is given, suggesting it is not a priority for eating disorders.

10.19.4 Behavioural (B)

All Centres say this is not useful or appropriate and that they do not have training in Behavioural approaches. Only Centre E elaborates but there is no rationale given linked to eating disorders, as to why it is not useful. Centre E states that in music therapy reward and punishment principles are not used, but sometimes patients are told by other staff that they are not able to attend music therapy before they have put

on weight, but this approach is not initiated or followed by the music therapists in the centres.

In conclusion a Behavioural approach is not indicated as useful for people with eating disorders by the centres in this study.

10.19.5 Psychoanalytically Informed (PI)

All three centres agree this is used. However there is a caution about how much interpretative work people with eating disorders in very fragile stages can cope with. Centre E and Centre A both draw attention to this and Centre E suggests this is greater in non-critical phases where the therapist can play and verbalise counter- transference feelings which are often very strong.

Centre C states that a Psychoanalytically Informed approach underpins the work but also shows caution, stressing it is crucial to make sure the person with eating disorders is ready to take in an interpretation. Centre C states about a Psychoanalytically Informed approach:

'This is my training. I use this in my thinking and understanding of the work. However, would not necessarily communicate this directly to the patients. ..... It (PI) informs how I act, and I how I interpret for myself, and how I might describe things to staff, but comes through in a more digestible form for patients. It is important to consider what these patients can take in and digest, without evoking automatic defence structures.'

Centre A draws attention to the useful aspect of gaining insight into symbolic aspects of the disorder as a defence, and issues related to the self.

In conclusion a Psychoanalytically Informed approach is seen as very useful by the centres in the study, for people with eating disorders, with a careful balance between interpretation when patients are ready, and music.

10.19.6 Developmental (D)

All centres agree this is not useful. Centre A does not give a reason other than it is not the theoretical leaning of the centre. Centre E gives a reason linked to the approach as to why it is not used '*These patients are so self-critical so it is not a question of developing skills but of tolerating oneself to be less critical.* So here is an assumption that a Developmental approach would mean developing skills which in child developmental theory is the case. Centre C says D is not appropriate with eating disorders but gives no reason.

In conclusion D is not indicated as useful with people with eating disorders by centres in the study.

10.19.7 Analytical Music Therapy (AMT)

Only Centre A uses this model with eating disorders, stating that it is only possible to use this model when the patient has become much better and can take part in an exploration about their life situation as a basis to the work, rather than a purely concrete or black and white view.

In conclusion Analytical Music Therapy is not strongly indicated for eating disorders by the centres in the study, and when indicated, is only recommended in later stages of the illness, when the patient is nearer recovery.

10.19.8 Creative Music Therapy (CMT)

Only Centre A uses CMT with people with eating disorders, and has definite reasons for doing so, stating that the ' *act of creativity builds the self, counters destructive acts, provides an alternative symbol for internal experience, and helps develop body awareness*.' The centres which do not use CMT do not state why, apart from Centre C which says that music therapists are not trained in this method.

10.19.9 Activity–Based (AT)

All Centres agree that an Activity-Based approach is not useful for people with eating disorders. Centre A is the only centre to give a specific reason, and states that a more intense treatment is needed because inpatients with eating disorders are too ill for the approach. The other two centres state that AT is not appropriate without elaborating.

In conclusion AT is not indicated as useful for people with eating disorders by centres in the study.

10.19.10 Guided Imagery in Music (GIM)

Centre E says GIM is useful in modified form in the later stages of music therapy, for eating disorders, and the other two centres do not indicate whether or not it would be useful, but state that no one is trained in GIM in the centres.

10.20 Summary of salient elements from qualitative data for each technique: Eating disorders

10.20.1 Introduction

As described for Tables 10.14 & 10.15 three centres answered for individual work, Centres A, C & E, and one for group work as Centre A and E were not running groups with patients with eating disorders at the time of the survey. All centres agree unanimously that Theme based Improvisation (TBI), Free Improvisation with and without the use of words are used with patients with eating disorders in groups. For individual work all centres agree that TBI is used, and this is ranked higher than for most other diagnostic groups which is discussed further in 12.5.3.

10.20.2 Free Improvisation with minimal talking (FI)

Two centres use Free Improvisation with minimal talking (FI) with people with eating disorders, and Centre E does not, saying '*it is a fight to make them play'*. Centre C implies that it is hard for people to play with minimal talking unless there is

continuity and they can function well as a group (which is rare), and states this would be easier in individual work which is not used on the unit. So although it is used, Centre C agrees with Centre E that it might be hard for people to play with minimal talking. Centre A is more positive about FI saying that it is is an alternative means of self-expression, and encourages freedom & flexibility. The point is made that FI discourage intellectualisation and develops integration of emotional experience, the same point made for FS.

In conclusion, opinion is divided about whether FI is useful by the centres in the study.

10.20.3 Free Improvisation and Talking/Interpretation (FT)

All centres agree FT is used with eating disorders, particularly to encourage freedom and flexibility, discourage intellectualisation and develop integration of emotional experience. (Centre A). All centres stress the importance of free improvisation and talking and Centre C states that people with eating disorders find it very hard to work only musically in free improvisation, as they have such need for structure and control, but for this reason it is useful as their difficulties can be explored.

Centre E states that interpretation is not often used especially in critical phases and Centre C agrees with this, saying that those with eating disorders are often concrete and find thinking metaphorically difficult. '*They need much help with linking, becoming aware of cut-off feelings…..'*

In conclusion, there is significant agreement between the centres in the study that FT is used with eating disorders especially to help with self expression and integration of thoughts and emotions.

10.20.4 Free Improvisation with Structures such as 'turn-taking' or 'play rules' (FS)

Two centres use FS with eating disorders (E & A), and Centre C does not; stating that this population would find FS patronising. Conversely Centres A & E agree that because give and take ('taking in') is a problem, FS is useful because it can help do this in other ways. Centre E states **'***It is a problem to give and take(in) so turn-taking can be a tolerable way of being challenged.'*

In conclusion, similarly to RR, all centres agree on the function that FS might have, but two centres see this as useful and one centre does not.

10.20.5 Theme Based Improvisation (TBI)

All centres agree TBI is used with eating disorders. Agreement is that the theme must generate from patients material (Centres E & C) and that themes might arise from the preceding improvisations and that more structured ways of working with material is needed in order to prevent dissociation. All agree this type of exploration musically and verbally combined, can move an issue forward. Centre E states that the theme might become more important than the music. Centre C says it is the main way of working with eating disorders.

In conclusion, TBI is used significantly by the centres in the study to provide structure arising from patients material musically and through talking intertwined.

10.20.6 Activity-Based (AT)

All Centres agree this is not used for people with eating disorders. Centres E & A do not give a specific clinical reason, but Centre E states it is not offered, and Centre A says it is not the most useful intervention or the best use of the music therapist's skills. Centre C states a reason why this is not used, which is that it provides too much structure which this population need to get away from. . '*The aim with this client group is to get beyond structure and activity, which they readily use to defend against anxieties and feelings.'*

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10.20.7 Singing Composed Songs (MT)

Only Centre A uses MT with eating disorders but '*only if this was all an individual could tolerate and the song communicated something. In a group, it would be unlikely to meet everyone's needs.* Centres C & E do not think it would be useful, Centre E commenting that '*they mostly do not think of themselves as being that important as to let the voice be heard in singing.*'

10.20.8 Song Writing (SW)

Centres A & E agree SW is useful, and Centre C says it is not useful with no reason given. Centre A makes the point that it would be useful '*to express something*' but the respondent adds she has no training in this technique. Interestingly Centre E implies training is useful, but for the patients; stating that SW is only useful if patients are familiar with SW beforehand.

In conclusion SW is seen as mildly useful for people with eating disorders by centres in the study.

10.20.9 Musical Role Play/Musical Psychodrama/Art & Psychodynamic Movement (MP)

All Centres agree this is used, and all stress the importance of role play with music. Centre A specifies that role play can aid exploring the safety of different positions, for example levels of control or vulnerability. Centre E states that drawing and painting whilst listening to music is used, and Centres E & C stress that this would be on an individual basis (Centre E does not run a group programme).

In conclusion, all centres agree that role play is particularly significant for people with eating disorders, as it helps explore issues, with music.

10.20.10 Receptive music using live music eg for reminiscence (RL)

Only Centre A uses RL with eating disorders, only when an individual is too ill to be active. *'may use music to reflect to them, or to relax or stimulate'*. Centre E links the reason for not using RL with a major problem for eating disorders-that of taking things in, stating that people with eating disorders cannot 'take in' music played for them. Centre C gives no reason for not using RL.

10.20.11 Receptive music using recorded music (RR)

Two centres, E & C use this sometimes, and Centre A does not. However, all centres comment on the quality of listening passively and whether this is useful or not. Centre A says that active involvement would be needed to evoke change, as responsibility is crucial for people with eating disorders, implying that the technique is too passive. Centre E suggests similarly that listening is passive *'not so demanding to listen to'* but gives this as a reason why it might be useful *'It is more neutral – the music is not composed for them so it is not so demanding to listen to.'* Centre C agrees also *'Clients sometimes ask for this – which I feel is as a defence against having to actively participate themselves, and thus remain in control and not inadvertently let anything out.*

In conclusion for RR there is agreement that listening can be a defence against change and looking at the self. For this reason opinion is divided as to whether it is part of the process leading to change, or not useful.

10.20.12 Guided Imagery in Music (GIM)

Only Centre E uses GIM *'in modified form.'* for people with eating disorders. Centres A & C do not use it and give the same reason which is that no one is trained to use GIM, so there is no detailed information about GIM and its positive or negative links to the illness and how even a modified form would be used.

10.20.13 Music for Relaxation as part of MT programme (MR)

Only Centre E uses MR, and only at the end of the session with eating disorders. Centre C states strongly that people with eating disorders '….*cannot bear to relax.*' Centre A does not give a reason apart from that it does not use MR.

In conclusion MR is not often used with eating disorders by centres in the study, and when used is only part of music therapy, not a complete technique in it's own right.

10.21 Summary: Approaches and techniques used with patients with eating disorders

The data showed a general emphasis upon working with the internal state of the patient and an expectation that understanding meaning, whilst difficult, should be central to the approaches and techniques used for people with eating disorders. Centre C again produced no qualitative data as if there is no opinion about why responses are 'yes' or 'no'. This was partly owing to time constraints, and partly owing to some members of the team not wanting to discuss their work in terms of diagnosis. Surprisingly therefore the responses from Centre C for eating disorders reflects a high level of knowledge, expertise and considered rationale for why responses are yes or no. It appears that one team member has particular expertise working with this diagnostic group.

Supportive Psychotherapy is used with for patients with eating disorders, by all centres and there is agreement that it can specifically help to build the self which has often disintegrated. How much or little support should be given varies, for example less support is needed as the relationship develops with the therapist. There is little connection here with the particular musical aspects of this treatment and how it links with the problems for people with an eating disorder. However some points made *are* related to the unique musical elements in music therapy which will be discussed in chapter 12.5.3

Two centres use Free Improvisation with minimal talking (FI), and one (Centre E), does not. There is agreement that it is hard for people with this diagnosis to play with

minimal talking unless there is continuity and they can function well as a group (which is rare). One centre states that this would be easier in individual work. Conversely one Centre (A) is more positive about FI saying that it is an alternative means of self-expression, and encourages freedom & flexibility. FI discourages intellectualisation and develops integration of emotional experience. This may reflect differences in theoretical orientation and training because it reflects the differences between whether difficulties can be analysed and challenged or not.

The analysis of the qualitative data, together with the findings of the quantitative analysis from Chapter 11 will be considered and elaborated in an extended discussion in Chapter 12 where examples of the findings supporting current and previous literature are reviewed

10.22 Personality Disorders (PD)

10.22.1 Introduction to approaches and techniques with personality disorders

This diagnostic group produced the largest amount of information, and interestingly the rank order of approaches is exactly the same as for the eating disorders group. This is not surprising as some services referred to the fact that they did not see people with eating disorders as a separate group of people, but within the personality disorders categories. Four centres, A B D & E gave qualitative answers, and all five centres amounting to six answers (therapist a & b for Centre D) gave yes and no answers. Only three centres gave detailed answers about the use of techniques in this section, (Centres A D & E), for patients with personality disorders, but in the settings section some case examples and comments about people with personality disorders were given by Centre B, which are included here. The numerical scores in tables 10.17 & 10.18 therefore show five responses for individual work and four for group work. Centre D gave two separate answers, as there was little agreement, and this is reflected in the qualitative data, but in the table only the numbers of centres have been counted for this section, following the rule that if one respondent scores yes in a centre with two returns, the score is yes because it *is* used.

Table 10.16 shows scores for approaches with personality disorders. All five centres answered for this diagnosis.

Table 10.16 Scores for use of approaches with personality disorders

Approaches	Used by Centres	Rank Order
Psychoanalytically Informed	4/5	1st=
Supportive Psychotherapy	3/5	$2^{nd}=$
Client-Centred	3/5	$2^{nd}=$
Analytical Music Therapy	3/5	$2^{nd}=$
Guided Imagery	2/5	$5^{th}=$
Activity-Based	1/5	$6^{th}=$
Behavioural	1/5	$6^{th}=$
Developmental	1/5	6th =
Creative Music Therapy	1/5	$6^{th}=$

Table 10.16 shows a clear polarity in usage of different approaches with patients with personality disorders, where some approaches are typically used and others are only used by one centre.

Tables 10.17 & 10.18 report the scores given by the centres for the use of techniques in group and individual work respectively with clients with personality disorders in the format described above.

Table 10.17 Scores for use of techniques in group work with patients with personality disorders

Techniques		Groups	Rank order
FT	Free Improvisation and Talking/interpretation	4/4	$1^{st}=$
FI	Free Improvisation with minimal talking	4/4	$1^{st=}$
FS	Free Improvisation with Structures such as turn taking or play rules	3/4	$3^{rd}=$
TBI	Theme Based Improvisation	3/4	$3^{rd}=$
MT	Singing Composed Songs	3/4	$3^{rd}=$
AT	Activity-Based	2/4	$6^{th}=$
RL	Receptive music using live music	2/4	$6^{th}=$
RR	Receptive music using recorded music	2/4	$6^{th}=$
SW	Song Writing	1/4	$9^{th}=$
MP	Musical Role Play	1/4	$9^{th}=$
GIM	Guided Imagery in Music	0/4	$11^{th}=$
MR	Music for Relaxation as part of MT programme	0/4	$11^{th}=$

Table 10.18 Scores for use of techniques in individual work with clients with personality disorders

Techniques		Individuals	Rank order
FI	Free Improvisation with minimal talking	5/5	1st=
FT	Free Improvisation and Talking/interpretation	4/5	2nd =
TBI	Theme Based Improvisation	3/5	3rd =
MP	Musical Role Play	2/5	4th=
RL	Receptive music using live music	2/5	4th=
SW	Song Writing	2/5	4th=
RR	Receptive music using recorded music	2/5	4th=
MT	Singing Composed Songs	2/5	4th=
MR	Music for Relaxation as part of MT programme	1/5	9th=
FS	Free Improvisation with Structures such as turn taking or play rules	1/5	9th=
GIM	Guided Imagery in Music	1/5	9th=
AT	Activity-Based	0/5	12th

Table 10.11 & 10.12 show results for individual and group work.

Free Improvisation with minimal talking is used by all centres and free improvisation with talking and interpretation is second in the ranking order, used by four out of five centres.

10.23 Summary of salient elements from qualitative data for each approach: Personality disorders

10.23.1 Introduction

Five centres, gave answers for this section, and four out of five centres agree that a Psychoanalytically Informed approach is used. Approaches using Supportive, Client-Centred and Analytical approaches rank joint second with three out of five centres agreeing these are used. Interestingly there are no approaches which are not used at all, although Activity-Based, Behavioural, Developmental and Creative Music Therapy ranking last, are all used by one centre only.

10.23.2 Supportive Psychotherapy (SP)

Two centres said they do not use SP with personality disorders, and gave very similar reasons : Centre D (Therapist b) : *'Don't need it because are open and inter-subjectivity is there for borderline patients. They need confrontation not support.'* and Centre E simply said *'They need more challenge'*

Centre C did not answer this question at all and did not mention this diagnosis in any section. This Centre has a specialist service for people with personality disorders with no music therapy in-put to that service.

Centre D (therapist a) said this is the main approach used, and that this group need help with getting in touch with feelings. This approach can help people *'stay in their own space for a long time'* and therefore bring feelings to the fore such as sadness in a way that other non-musical approaches do not.

A five stage approach was described by Centre D (therapist a) showing a theoretical framework involving mentalisation (see Appendix VIII). In these five stages the different levels of improvisation are linked with the stages, ranging from stage one where there is resistance to using music at all, to stages four and five where there is felixbility within musical improvisations and layers of meaning emerge where patients gain insights through discussion and reflection. In the first stage the purpose if improvisation is often questioned, with no empathy, and aesthetics are sometimes used as a defence, whereas by the last stages, more experimentation with sounds arising from their own feelings is common. *'Mentalisation is an important part of this process 'how they are.' Psychoanalytic process in groups with people with PD is important –patients often seem present but with no active engagement.'*

Centre A said that SP is used very closely combined with a Psychoanalytically Informed approach once interpretation is possible. SP is therefore more useful at the early stage and with the most seriously ill people who seriously self harm and cannot cope with anything other than a 'holding' approach.

In conclusion there is agreement that Supportive Psychotherapy is useful, with Centres A & D providing the most detailed information, and a consensus amongst those that use it that the holding non-interpretative nature of improvisation is useful in the early stages of the illness in particular.

10.23.3 Client-Centred (CC)

Two centres C & E use a Client Centred approach although it is not apparent why for Centre C. It is possible, as for other diagnoses, that this centre is using the term loosely to mean anything which puts the clients needs at the centre rather than a specific Rogerian approach (Rogers 1959). Conversely Centre E is more specific and says '*This is the most important basic model as they have most often felt like being wrong in their relationship with other people. They need to be followed and guided and challenged to find the new ways from inside – being seen and heard in all phases of this travel. The life view of the patient informs the therapist's intervention.*'

Of the three centres which do not use A, B &D, with people with personality disorders, Centre A says that in a State hospital setting, even with community orientated psychiatry, it is not possible to work in this way because '*People with this diagnosis commonly have so many team members looking after them, and the culture does not really allow for a true Rogerian approach nor would it in my view be suitable as patients in this category need firm structures and a firm position taken by the therapist, rather then responding to every mood swing and different phase of their illness.*' This seems to directly contradict Centre E's position. No other specific reasons are given.

In conclusion there is a very mixed picture here and no agreement, plus reasons given for not using this approach are similar to those given for using it by another centre.

10.23.4 Behavioural (B)

Only Centre C uses a Behavioural approach to working with people with personality disorders, with no reason given for this. Centre E says this approach is not used as it is too '*directive*'. As stated above in the section on CC, this population need an

approach where they can find new ways of being *'from inside'*. Centre A says that *'true behavioural approaches would be too restrictive and not analytic or psychologically-minded enough'*.

In conclusion, a Behavioural approach is not indicated by the centres in the study and is seen as too directive because this population need to be helped to reflect and find new ways of being from inside, not imposed upon them.

10.23.5 Psychoanalytically-Informed (PI)

This is the most indicated approach for people with personality disorders, (along with an Analytical model) although three centres use it and two do not. Centre A refers to a long description of technique in discussion, which points to the need for a music focussed Psychoanalytically Informed model where music might put people in touch with painful memories and this needs to be both analysed, but also supported and connected with. In addition a modified form of a Psychoanalytically-Informed approach is used, which provides structure and reciprocity between patient and therapist at the same time as being interpretative and analytic. This modern model, Cognitive Analytic Therapy underpins all the work on this particular centre and will be discussed in more detail in 12.5.5 & 12.5.6. Centres A & B agree that any Psychoanalytically Informed approach with this group must be music- focussed, and centres D and E emphasise the use of psychoanalytic theory, Centre D singling out projective identification *'Working with projection with this group is essential in the re building of the damaged self and restoring safety,'* and Centre E emphasising working with transference issues *'Together with a client-centred approach, this is the most important basic model, as the therapist is informed through transference issues.'* In addition, Centre D, when discussing work in Day Centres with people with personality disorders, states that a Psychoanalytically Informed approach is more important than when working with people with schizophrenia.

In conclusion, there is agreement that a Psychoanalytically Informed model with music-making through improvisation, and interpretation is indicated with people with personality disorders, who need to address meaning and understand psychological frameworks for their mental state in order to progress.

10.23.6 Developmental (D)

Only one Centre, C uses this but characteristically does not give a reason. Centre A says that a Developmental model might inform the thinking a little but would never be the driving approach, but does not elaborate on this point. Centre E equates a developmental model with too much emphasis upon developing and achieving which is often inherent in the problem to start with '*They are often very talented but deficits in self esteem or identity prohibit them in success. The aim is to uncover and integrate and heal deficits in relation to themselves, others and the world.*'

There is agreement that this is not indicated as an approach for treatment for people with personality disorders.

10.23.7 Analytical Music Therapy (AMT)

This is the most indicated and used approach for people with personality disorders, alongside a Psychoanalytically Informed Model. It is also interestingly indicated by more centres for people with personality disorders, than in other diagnostic categories. From the two centres, A & B which do not use the approach with people with personality disorders, Centre A says the approach is too prescriptive and not flexible enough, and Centre B simply says no one is trained in this approach. The only reason given for this approach is by Centre E and it echoes the point made throughout this section which is that this group of people are often able to work with unconscious processes and to work with interpretation. '*Many patients in this population have the capacity to struggle with splitting techniques and to tolerate also provocative interpretations*'

In conclusion this is used widely because this population can tolerate an analytic approach working with unconscious material through music and talking.

10.23.8 Creative Music Therapy (CMT)

Only Centre B uses this with people with personality disorders. There is a long case study also discussed in 12.7.3 which is found in Appendix II section 8.1.1 e) &7.3.1 of the questionnaire, which indicates details of the approach. Here musical improvisation is the focus but it appears that the therapist uses psychoanalytic ideas and interpretation which she does not necessarily share with the patient, but focuses upon musical process. However it is apparent that the approach is informed by psychoanalysis further discussion will evolve in 12. The point emphasised by Centre B is that the spoken dialogue can be used as a defence, especially by very articulate people and the Creative Music Therapy model enables people to make music in improvisations which are not consistently interpreted, but occasionally one interpretation might be offered which will lead to further music. At the beginning of the therapy the patient's music was very 'obedient' and later the therapist suggests that in this approach the patient knows that it is the music making that is powerful, although this is not elaborated upon. Centres that do not use the approach give mixed reasons-that they do not have training in what is implied as a Nordoff-Robbins approach, and also that these patients need to reach insights through connections between conscious and unconscious processes being linked. Centres A and E give similar examples and also imply a critique to the model although focussing upon different elements:

Centre A: '*Not trained in this method, and also these patients needs links to be made between musical and verbal meaning and between conscious and unconscious processes and Creative Music Therapy does not address the whole person in this respect.*'

Centre E '*They need insight and also to feel they come to "peak experiences" by their own force – if they come – not by the seduction from the therapist.*'

In conclusion, CMT is not indicated for this population strongly and Centres that do not use it have strong reasons for not doing so.

10.23.9 Activity-Based (AB)

Only one out of five centres, Centre A, uses Activity-Based music therapy with people with personality disorders. However, this Centre states that this is not the main approach, but that Activity orientated aspects of the work are involved but it is not the main focus. '*Aspects of the work might include elements of performance of songs and of an education approach when necessary-indeed 'gigs' as part of a music therapy programme particularly in group work, might be appropriate in some cases. However an Activity-Based approach would not be a main focus-but occasionally if this is felt to be needed then it would not be ruled out.*'

Two main reasons are given by centres that do not used an Activity-Based model with this population as to why it might not be used. Centre B says it is not appropriate because patients may feel '*deskilled*'. Centre D suggests that this approach may prevent the necessary working through of transference, and *fill a gap* that people with personality disorders can do themselves. Furthermore that projections from patients should be analysed, and '*there is a danger using too much activity focussed approaches would prevent change and working through.*'

In conclusion, an Activity-Based model is not indicated because it might prevent people working through things in a more Psychoanalytically Informed way, which this group are able to do.

10.23.10 Guided Imagery in Music (GIM)

Only one centre (E) uses this, and states that '*in modified form (shortened) this model can be very useful with these patients as they can really use the connection with the music as a partner to gradually transform their identity*'. Centre D acknowledges that there are music therapists (Moe 2002) who indicate this is useful for people with personality disorders, and Centre B says that no one is trained in this approach but does not indicate if it would be useful if available. Centre A gives the most substantial reason for not using GIM, in addition to the fact that no one is trained in this approach '*it would rarely be possible or desirable as in its true definition it requires people to listen to music in what is similar to an altered state of consciousness. This would have*

contra-indications for people who are already struggling between reality and fantasy and are struggling to cope with the difference between their inner and outer worlds, or for whom going into such a state re-activates memories of trauma. Whilst the latter (remembering traumatic events) might be part of a desirable part of therapy, it would be better as part of an interactive more defined experience rather than arising during intense music when the patient is not in a state to take control or understand meaning.'

In conclusion, GIM is not strongly indicated for this population, and reasons are given as to why it should be modified if used, which might involve working with a partner. This concurs with the view stated by one centre that GIM in its 'pure' form might not allow the patient enough control. However it is apparent while trained GIM therapists ARE employed in Centre E, some of the reasons given about its use are from respondents who are untrained in this approach.

10.24 Summary of salient elements from qualitative data for each technique : Personality disorders

10.24.1 Introduction

Five Centres responded for individual work and four centres for group work. Free improvisation with and without talking are the most used (unanimously) for group work and free improvisation with minimal talking is used by all centres for individual work. In individual work theme based techniques are used by three out of five centres, and three out of four centres use Free improvisation with structures, which shows a trend towards more symbolic work.

10.24.2 Free Improvisation with minimal talking (FI)

Five out of six respondents use this with people with personality disorders, Centre E not using it, implying that more talking might be needed '*It can be a fight to make them play at the beginning.*' Centres A & D state specific reasons for using FI. Centre A emphases that talking will always accompany improvisation although at times there will be no talking '*In individual & Group work it is more likely that talking will*

always accompany FI, as a central focus. However sometimes sessions may include no talking at certain stages of the process. However talking would be an end goal for most people, using the FI to access thoughts and feelings.'

Centre D Therapist a states that improvisation gives opportunity to work with empathy, particularly in a group *'Use improvisation in the group because they meet themselves-it is "confronting" in the way they meet in the group.'* Further Therapist a implies that if others have difficulty coping with another's playing, improvisation can help ' *see/hear it or sense 'atmosphere'.*

Therapist b Centre D links the importance of music-making to pathology in that music is affect-based like the illness *'Music helps at the level of affect. Pathology is affect-based-there is more of a mentalisation problem. Person cannot digest; they project it to the therapist. The therapist is often 'affected' at a physical level (projective identification).Patients often who have been abused cannot understand at first what improvisation is for.'* This implies that the music therapist's task is to help the person understand the meaning of the affect.

10.24.3 Free Improvisation and Talking/interpretation (FT)

There is unanimous agreement that FT is used for people with personality disorders, and Centre A gives a very comprehensive response, and also refers to a case summary and further work which will be discussed in Chapter 12. Centre D also gives comprehensive reasons from both therapist a & b, and Centre E states that FT is more and more important in later phases of the work when people start to transform some of the rigid patterns. Throughout these answers (quoted below), there is a direct link made between music and interpretation, and the importance of this also refers to 'freeing people' which links to Centre E's comments.

Centre A: *'This is the main way of working with this population. The very central aim of the work is to use music to help integrate thoughts and feelings and to allow access to some emotional expression which is either kept hidden or often expressed inappropriately. For example many with PD experience aggressive out-bursts towards others and moving between words and music might help understand some of*

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the emotional structure and strategies needed for more integrated or appropriate expression. Similarly, talking about self-harm in relation to pain and feelings experienced when playing strong or intimate music with others, might be useful. Therefore in group and individual work this method will be the focus. Added to this interpretation would be used if appropriate to the patient, (ie if the patient has enough ego strength, capacity to think and learn from it)-otherwise talking between therapist and patient would be used to understand meaning in the person's life arising from the music and to see how a person can move forward.'

Centre D: Therapist a**: '***When people are more confused and difficult to reach they will not talk so much except to give direction and structure. Reflection is very usual after improvisation. Talking is used to avoid misunderstanding and to decrease tension. It is not a major task to give interpretation in the group . The music is* **talked** *about –most people are having psychoanalysis individually on this unit anyway and have to confront things there. In the group the therapist will help to give a word or 'carry' something, but not go deeper.'*

Centre D Therapist b**: '***This is important as through this the patient can start to integrate traumas in a symbolised way. Borderline patients need less structure than psychotic people. Can be left to be more free to project, as they are stronger and do not need to be held so much. Can cope with less structure. Therapist can be more in the background and let people do their own work'*.

Centre B includes a case study in an acute day hospital setting, which shows this technique as useful with a person with narcissistic borderline personality disorder. Talking and improvising is linked to her relationships with her family and parallels are drawn showing musical development from 'defensive' one beat music to more spontaneous risk-taking musically. These changes correspond with a lessening of her narcissistic traits.

In conclusion FT is strongly indicated for people with personality disorders owing to the mixture of affect-based free improvisation which can move between necessary structured and unstructured frames and which needs interpretation and talking to help break rigid patterns, also providing meaning. This helps people move from destructive

or other behaviours that need to change in order to lessen symptoms and enable people to function better in their lives.

10.24.4 Free Improvisation with Structures such as turn taking or play rules (FS)

One centre uses this with individuals and three centres with groups of people with personality disorders. Reasons given either way are sparse in comparison with FT and FI apart from Centre A which gives a substantial reason in some detail. '*Structures are particularly important in some settings where there might not be a containing enough environment for less structured work to take place, or where emphasis is on socialisation and learning about relationship through music. For this population who find it traumatic to let go and who are often good at hiding or re-directing feelings (into self harm) and who often feel shame and lack of self –worth, some structured approaches build up a sense of achievement and help manage difficult feelings particularly in a group.*' Centre D agrees with this (therapist a) that if people are really stuck then structures can help. Centre E does not use this and says that people with personality disorders need to connect the music to pictures, emotions or thoughts and this is substantiated in the next section (TBI).

10.24.5 Theme-based Improvisation (TBI)

There is a mixed view about using Theme Based Improvisation with people with personality disorders. Centres A, C & D (Therapist a) use it with individuals and Centres A, C & E with groups. There is unanimous agreement that this is useful only if the themes come from the members, and that it is this very aspect of creative control linked to relevant themes of character, emotions or life events that make it so useful. Centre E refers to a whole case study published in Hadley (2003) and Wigram, Pedersen & Bonde, (2000)

Centre A refers to a case where a member used a loud gong whilst thinking about the death of her Mother which was her chosen theme. '*This is particularly useful for this population ……………. would come from the patient. It would relate to material raised in the session rather than arbitrary choosing of themes which would not be appropriate, but this group are often able to work symbolically.*'

Centre D Therapist a '*Yes if THEY propose it. Theme based is used if it is stuck in the group. For example the therapist might suggest placing the cymbal in the centre of the group –all say a theme out loud and let it sound –then changes when a person changes by hitting cymbal. With people with PD is difficult to change mood-or with borderline patients. They have no difficulty being in a mood or expressing it but have trouble responding to other people's demands or moods.*'

In conclusion, there is agreement that because people with personality disorders can work symbolically this is a very useful model, but there are also three centres that do not use this with no reasons given for lack of use.

10.24.6 Activity-Based (AT)

Only Centres A and B use this (B only in groups). Only one reason for not using it is given by Centre D, which assumes that the therapist would have to be involved playing music and therefore this would affect their role '*Would not be able to be objective in the transference if the therapist got involved musically in activity based music*'

Centre A gives a detailed explanation as follows '*This might be an important part and there might be an emphasis upon achievement at some stages in the therapy where a group would work on respect and trust of others by a shared activity for example. If more structured music lessons for example are needed it would be more likely for other professionals to do this or seek this in the community or use artists in residence, but talking about this and organising it, and feeding back to the therapy group about own achievements would be useful. Also sometimes the group might develop more aesthetic desire, as more self worth develops and this aspect must be kept in mind with this group, therefore activity based work performing or improvising more composed material as part of a choir or ensemble, within the therapy must not be ruled out.*'

In conclusion, Activity-Based work is not indicated as a main focus treatment as more in depth exploration of meaning is needed for this group. However there is a strong case put forward that it could be useful in specific circumstances in order to help self

worth and develop confidence and a sense of achievement. This would be for people for whom this emphasis upon achievement is not already seen as an unhealthy aspect for the person.

10.24.7 Singing Composed Songs (MT)

Three Centres (A B & C) use this with groups and two (A & C) with individuals for people with personality disorders. Centres D & E agree this is not useful because this population need free improvisation rather than more structured music in order to explore inner tensions. Although put slightly differently these respondents imply that composed music could act as a defence by having a holding function which might prevent working on their own issues.

Centres A and B however give quite substantial reasons linked to this population for why this might be useful. In the Acute Day Hospital settings section Centre B includes material about songs that have been composed by group members.

Centre B: '*People often bring songs they have written, and the therapists' role includes composing an accompaniment. eg. a patient who had been violently sexually assaulted never talked about it but began to bring songs describing this horror in a metaphorical way. This seemed to have been a safe way for her to begin to tackle this. Processing it musically and creating a satisfying aesthetic seemed to enable her to take some power back from the abuser, and begin to mourn. She went on to psychotherapy after 2.5 years of MT.*'

Centre A '*Group & Individual-This might be part of the way that an interaction happens if desired by the patient, particularly at the beginning of the therapy. It MIGHT also be a goal or focus if it seemed as if this was the only way to start a relationship or if it seemed to help with overall therapeutic goals. Performance helps some overcome or explore feelings of shame, and builds up feelings of self- worth if handled in the right way with a music therapist*'.

10.24.8 Song-Writing (SW)

Only centres A & B use this with individuals. Centre B's response overlaps with this category, describing songs which are composed outside the session, and then the therapist accompanies (see 10.24.7 above). Centre D also refers to the same response given in section 10.24.7, for the use of Composed Songs, saying it is not useful.

Centre A states that SW is not used as a focus for the whole session, but that it might sometimes be usedin Individual & Group work. '…… *Used very occasionally if material arises and if the patient seems to be able to use voice and song-writing as a therapeutic part of the relationship. It would not form a focus or the main way of working, as instrumental improvisation would also be used.'*

In conclusion, in general it seems that opinion is divided about whether the use of Song Writing is useful because it provides a holding structure particularly at the beginning of therapy, or whether this in itself might prevent patients moving on further into more in depth personal meaningful exploration. In conclusion Song Writing is not strongly indicated by the centres in the study for use with people with personality disorders.

10.24.9 Musical Role Play/Musical Psychodrama/Art & Psychodynamic Movement (MP)

Two Centres A & E use this with individuals and only Centre A uses this with groups. Centre D therapist B's reasons for not using this are the same again as for SW & MT. This is that improvisation is necessary to go into the patient's inner world. Centre D (therapist A) adds, as a reason for NOT using it that people with personality disorders find looking at other people's experiences difficult. However this seems to be a reason *for* using it as implied by Centres A & E.

Centres A & E agree in general about reasons for the use of MP; Centre A provides a summary, and Centre E gives a detailed description in the 'Outpatient/group Settings' section of the survey.

Centre A: '*Individual perhaps but group-work more likely if patients are able to work symbolically and particularly musical role play might be appropriate to act out or rehearse a particular situation*'.

Centre E '*Here it is possible to use music to play out important persons in the patients life and for the therapist to take a role of a person in the patients life. This can a very strong experience. …… Often these patients make drawings while listening to our improvisation and they can relate their drawings very much to the mood and structure of the music.*

Centre E describes a detailed case example already discussed in 10.12.9 because the patient suffers from depression, and has a personality disorder. The function of MP here is to allow a symbolic way of working, drawing the patient in to depth work, where structures both musical and using other media, allow her to be in control. Centre E gives a further example as follows:

'*I also often use a perspective from psychodynamic movement where I ask the patient to stand up with closed eyes together with me and to imagine a personal and a social space around her. She is now asked to fill out her own space with the voice and be aware how it is to be there – how big it is etc. I as the therapist is filling out my own space so we are improvising in a so-called (parallel play- structure). The next step is to move together into the social space where we influence each other and build up sounds and music together. The focus is here for the patient to stay in contact with her private space also when being in the social space.* Pedersen (2002)

Centre E also refers to the same material in the depression section 10.12.4, when discussing free improvisation using structures. It is apparent that the concept of musical role play and use of other media which allow for integration between thought and feelings is demonstrated clearly by these examples.

10.24.10 Receptive music using live music (RL)

Centres A & C are the only centres which use this. Centre E implies that this would be too passive '*they want to be part of the game*' but interestingly Centre A assumes

that the receptive part might be only for some, as the patients themselves might be providing the live music for others to listen to

 '*This group often bring songs to sing to each other, and are sometimes accomplished and want to help each other by performing to each other and adding meaning to the process. Individual-Very occasionally if patient wants to hear something live and this is part of the therapeutic relationship/goals for the overall therapy'*.

Centre D cites cultural reasons why this is not used.*' People do not have this experience with each other any more culturally-in modern civilisation people do not sing with each other so much any more, do not go to church etc. So not so much part of the culture. When people with PD work with live music, they want to perform in a 'perfectionist' way-many good musicians come to therapy-they know we work with improvisation so do not come with composed live music.*

Never listen –improvisation is better.'

In conclusion, there appear to be strong views about the advantages and disadvantages of RL for reasons which relate to cultural and theoretical difference across centres in the study.

10.24.11 Receptive music using recorded music (RR)

There is a mixed picture here with Centre D (Therapist a) using RR for groups and individuals, and Centre A using it for groups and not individuals, Centre E using it for groups. Centre E states that it is a major technique for this population, often followed by painting or descriptions of imageries. Centre A states that it would be part of the work:

Centre A '*Individual-this would be more likely in group work but not usually necessary as part of individual interactive music therapy –the exception might be if the patient brought some material to listen to and it was thought that listening to it together with the therapist (ie giving it meaning) was crucial to the overall therapeutic goals. In group-work patients often bring CD's as a form of life story process or way of telling others things about themselves 'through another' which lessens the pain and discomfort. So this might be part of a process but never the whole technique which would always include improvisation for reasons given above under FT'*.

Centre D (therapist a) gives a full response, and conversely therapist b (Centre D) writes '*never listen improvisation is better*'

Centre D : 'has different meanings for different people, some do not dare-you will see how they feel and they are afraid to show themselves-some think listening is safe. Why did you bring this now? Why is it different outside? Meaning to the group and the meaning to you. If give lots to recorded music, avoids interaction so it can be a resistance. Might loose confrontation-have to be careful. Patients are 'touched'-gave a good feeling but it can be an 'entrance' when there is tension or people are resistant to improvisation. However with this patient group, time should always be made for improvisation-it must be in the culture. Recorded music avoids interaction but it can tell others how patients are feeling from what a person says or which music they choose. This is only half the process-you have to then find out the meaning and why? Listening to recorded music avoids spontaneity and the uncontrolled and unexpected, which is difficult but necessary for this patient group in therapy.

Similarly to RR it appears that there are cultural and theoretical issues that are linked to thoughts about the diagnosis, but which also arise from the psychoanalytic approach favoured in Centre D in particular.

10.24.12 Guided Imagery in Music (GIM)

Only Centre E uses GIM for people with personality disorders, but in modified form 'they cannot listen to a total programme' Centre D Therapist b gives a reason for not using it the same as for RR **'***never listen improvisation is better*'.

Centre A gives a detailed reason for not using it, which are the same as those used for the response to approaches for this category in 10.23.10 above. Further discussion about GIM and its lack of use by centres in the study is found in 12.5.1, 12.5.2 & 12.6.4.

10.24.13 Music for Relaxation as part of MT programme (MR)

Only one centre responded that this is used in group work, Centre E. The only reason given was '*mostly at the end of sessions*'. This seems to imply at the end of sessions there might be a relaxation section in a session. Otherwise this is not used with patients with personality disorders by the study centres. Reasons given for not using it from centres A & E are firstly that this might be part of the OT or Nursing role, on a workshop basis. Secondly that if patients ask for this type of activity, it would be seen as a defence, because it would be '*easier*' (presumably than working on personal material), and this technique is not part of the music therapy 'culture' in Centre D.

10.25 Summary: Approaches and techniques with personality disorders

There is a high level of information which links a robust understanding of the problems facing patients with personality disorder. Active engagement in music therapy is seen as crucial with a psychoanalytic process involving mentalisation because patients often seem 'present' but with no active engagement. Music is therefore ideal in encouraging an interaction between thinking and emotions.

The five stages of improvisation suggested by Centre D (Appendix VIII) are supported by Centre A which gives detailed information also about the importance of links between cognition, emotions and insights into the personality. These have already been discussed in 10.23.2. Aesthetic value, and the importance of this or not, emerges as a theme here, and this will be discussed in more depth in 12.5.5 & 12.5.6, and in 12.10.3 where this idea links to new clinical research possibilities for people wth personality disorders.

An approach to Supportive Psychotherapy is useful, with Centres A & D providing the most detailed information, and a consensus amongst those that use it that the holding non-interpretative nature of improvisation is useful in the early stages of the illness particularly.

However a Psychoanalytically-Informed approach is the most indicated approach.

The point emphasised by Centre B, that the spoken dialogue can be used as a defence, especially by very articulate people indicates that a Creative Music Therapy approach, (CMT) enables people to make music in improvisations which are not consistently interpreted, but occasionally one interpretation might be offered which will lead to further music. So CMT is not indicated for this population strongly by these centres unless combined with interpretation. Solely Activity-Based work is not indicated as a main focus treatment, however there is some disagreement about improvisation and its role in accessing the patient's inner world. There are also reasons given contra-indicating its use because people with personality disorders find looking at other people's experiences difficult. Recorded music avoids interaction and spontaneity, but it can tell others how patients are feeling from what a person says or which music they choose.

In summary, Developmental, Behavioural and more passive approaches such as using recorded music for listening and relaxation are not indicated and would be too directive as this population need to be helped to reflect and find new ways of being from inside, not imposed upon them.

GIM is not used by the majority of centres for this population, and one centre offered substantial reasons for why it should be modified if used, and this involves working with a partner, which concurs with the view that GIM in its 'pure' form might not allow the patient enough control.

In conclusion, there is an equal emphasis upon the specific role of music and more non-musical considerations than for other categories. A longer description about the indications and contra-indications of music, and why it might or might not influence the approach chosen, will be included in Chapter 12.

10.26 Other approaches

The 'Other' approaches are summarised here and further referred to in 12.7.3-12.7.5. Owing to the lack of diagnostic specific data for these 'other' approaches and the obvious imbalance for each centre (because only the centre defining the approach actually uses it), the data is not included for each diagnosis. It would also be difficult

to do justice to the approaches which are extensive and the detail is beyond the direct question of the study concerning links with diagnosis. For some centres the data reveals the most in-depth thinking because in every case the 'Other' defining categories have been invented (and are sometimes published in the literature), by the respondents themselves.

Centre A's definitions of Exploratory Psychoanalytically Informed Music Therapy and Supportive Psychoanlytically Informed Music Therapy have already been discussed under section 10.3.2 in detail, and are not re visited here because Centre A decided to put these into the Psychoanalytically Informed and Supportive Music Therapy sections of the questionnaire, rather than defining them as 'Other',

Centre B puts forward a Psychoanalytically Informed Music –Centred approach, and gives a case study which is included here as an example. It has already been discussed in 10.3.5 because the researcher made the decision to include the approach in the Psychoanalytically Informed section although making the point that the respondent regards this as a significantly different approach. This debate will be further developed in 12.7.3-12.7.5.

'Patient Q was a 31yr old musician who had a long history of childhood sexual abuse resulting in severe anorexia and self-harm. We worked together for 3 years. For the first year the music was 'nice' but affectless; the therapist would emerge from sessions feeling uneasy about feeling like a wonderful therapist. On beginning to listen back and index sessions one year in, it emerged clearly that Q was highly adept at making it seem as though she was taking the initiative but that in reality she was picking up miniscule cues from the therapist and playing what the therapist expected. This led to the T holding back much more, and a much sparser music began to emerge, with Q often sticking resolutely to a single beat for much of the session. This was understood in terms of a variety of models - 'ontological deficits' (Pedersen) & a malignant envy. It seems that Q had fragile internal self structures and would rely on others to assist in defining her identity. Q began getting angry with me in the music and deliberately trying to wrong-foot me harmonically. I responded by going atonal and we began to be able to play together with much more emotional commitment, though it was a struggle. We were able to discuss these phenomena however, and in a

turning-point session, she stated she didn't have any friends because she couldn't bear them having so much more than her. I hoped the musical experience of my not colluding with the role she had ascribed to me helped her to build up her sense of self and by the end of our work she was taking her own decisions and began to bring songs she had written which opened a door onto her childhood experiences. I referred her to verbal psychotherapy to continue this work after we finished.'

This case appears to this researcher to be describing what is understood as Pyschoanalytically Informed Music Therapy because there is an emphasis upon interpretation arising from the musical interactions and analysis, both musically and verbally, with a balance determined by what is needed for the patient.

Centre D describes a specific approach defined by De Backer (2004) as Psychoanalytic Music Therapy, and although this appears similar to what might be understood by either a Psychoanalytically Informed approach, or Analytical Music Therapy, it is put in the 'Other' section by the respondent, because it is an approach seen as different to that already described in the literature under the other two similar categories. This approach is extensively described in the literature and has been discussed in detail in Chapter 8. Whilst it is unique, similarly the researcher sometimes (and the centre concerned) refers to this approach in the Psychoanalytically Informed section.

Centre E uses a Holding and Reorganising approach (Pedersen 1998) and also a Body and Voice (Pedersen 2002) related approach stating the latter should be applied carefully and often it is not possible before the rigid destructive picture of the body is modified. Centre E also suggests that a cognitive approach combined with music therapy is useful as destructive patterns need to be understood without repetition. This can involve 'homework' and keeping a diary in a similar way used for Cognitive Analytic and Cognitive Behaviour Therapies in the field of psychotherapy. Centre E appears to be placing the particular Body Orientated technique in the 'Musical Role Play and use of other media' technique category, which seems appropriate. The extensive description of Holding and Reorganising which is described in Chapter 8 (Pedersen 1998) and has been adapted from Analytical Music Therapy is also unique,

but sometimes is included in the Analytical section and sometimes separately by Centre E.

Centre B describes a Community Music Therapy approach and refers to Ansdell (2003) and this researcher decided to include this in the Activity-Based approach (AT) because when analysing the data, it seemed to be defined as an aspect of what is understood by this approach to music therapy. This is discussed above in 10.3.9, and the anomalies and difficulties of categorisation of approaches will be taken up in Chapter 12, particularly in 12.7.3-12.7.5.

10.27 Conclusion

The analysis of qualitative data reveals some patterns of agreement (for example for schizophrenia) where is is possible to draw specific broad conclusions about the function of music in music therapy for this diagnosis, as described in 10.4. For other diagnoses, for example anxiety and depression, whilst there is some agreement between centres, there is less data, owing to lower clinical priority given to music therapy intervention with these diagnoses by the centres in the study. The percentage of time given to each diagnosis within each centre is, in itself, a possible reflection of the way that music therapy is regarded by these centres, and reflects a wider picture as discussed in Chapter 8. Some interesting comparisons emerge. For example there is more emphasis upon techniques that allow symbolic thought, or at least make a connection between action and thought, for the eating disorder and personality disorder groups, than for psychotic disorders. These points and a more in depth comparison and conclusion will be discussed in Chapter 12. Prior to this, Chapter 11 now presents the statistical analysis of data relating to approaches and techniques, examining accumulated data across all centres.

CHAPTER 11
QUANTITATIVE ANALYSIS

11.1 Introduction: Approaches and techniques for all centres

The responses from all five centres to the sections of the questionnaire relating to the use of approaches, methods and techniques with different diagnoses and in different settings, have been analysed. Due to the small size of the sample with only five centres, results could not be expected to reach a level of statistical significance when analysing the application of approaches, methods and techniques on each specific diagnosis and setting. Therefore the scores were cumulated for diagnoses and settings, and a statistical test of proportions applied to determine the degree to which specific therapeutic approaches, methods and techniques were applied by the centres. The data here has been normalised by converting the yes and no responses to percentages, due to varying numbers of respondents.[1] In these numerical calculations, the two therapists, a and b from Centre D , reporting separately their responses, have been counted separately, in order to determine whether such differences within a centre allow a more detailed use of numerical data. For each approach of therapy, and subsequently for each technique, the results are presented using the following structure and format:

- The first figure is a bar chart illustrating the percentages of Yes and No responses by diagnosis and by setting.

- The first table reports the raw scores of Yes and No responses.

- In this table, the cumulated scores, confidence intervals, sample estimates and p-value for the use of the therapeutic approach (and later the therapeutic method and technique) across all settings, p-value are reported in the first line.

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[1] Normalising the data into percentages, whilst there are small numbers, enabled a comparison to be made between yes and no responses of varying total numbers. These percentages in the case of small numbers should not be over interpreted or generalised.

- Also in this table, the cumulated scores, confidence intervals, sample estimate and p-value for the use of the therapeutic approach (and later the therapeutic method and technique) across all diagnoses, are reported in the second line.

- the cumulated raw scores of yes and no responses across all settings and diagnoses, confidence intervals, sample estimates and p-value and reported in the third line of this table

- The final column of the first table reports the p value calculated from a statistical test of proportional significance of the use of the particular approach and subsequently therapeutic technique.

- An explanation of the results follows the table

- The second table reports the results of a test of proportional significance on the cumulated scores for setting and diagnoses by centre, giving sample estimates, confidence intervals and p-values.

- Some conclusions that can be drawn from the results relating to a specific approach or method, completes each section.

- A statistical test of proportions using the statistical package R was used to calculate significant differences. It is important to acknowledge that there are small n's in many of the chi-square calculations. In some calculations there is a low value of n (the number of results to be tested). This means that the chi-squared approximation used in the statistical test, may not be strictly valid. This applies to any calculations where the total n is equal to or less than 9. However, the results are included for completeness.[2]

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[2] While it might be argued that very small samples cannot be treated statistically, the analyses that were undertaken included the small numbers relating to each centre. Clearly in cases where there are five or less in the total number if responses, the analysis will show a non significant result. This particularly applies to centre D where the Yes No scores were split between one individual therapist in the centre and the rest of the team. As stated above these results were nevertheless included for the sake of completeness, as recommended by the statistical advisor

11.1.2 Data analysis of approaches

The following sections report the results of the analysis of data for approaches across all settings and diagnoses, and the analysis of cumulated scores.

11.2 Supportive Psychotherapy

The percentages of yes and no responses for Supportive Psychotherapy are shown descriptively in bar chart for settings and diagnosis in Fig 11.1
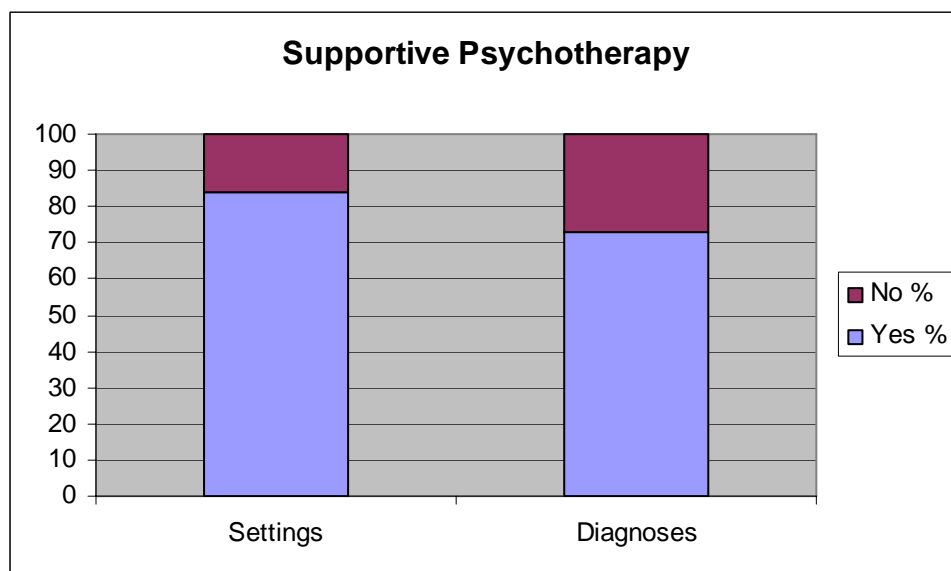
Figure 11.1: Supportive Psychotherapy - bar chart of yes and no percentages

As Figure 11.1 shows, 84**%** yes scores for all settings and 73% yes scores for all diagnoses reveals that Supportive Psychotherapy is indicated as very useful by the centres in the study.

The results of a test of proportional significance are reported in Table 11.1 on the cumulated scores for setting and diagnoses, and then the combined cumulated scores of settings and diagnoses, giving sample estimates, confidence intervals and p-values. This is the format used throughout this section, so this paragraph will not be repeated each time.

Table 11.1: Supportive Psychotherapy - Results for Settings and Diagnoses

Centres	Yes (raw scores)	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	16	3	84%	60%-96%	p = 0.005905
Results for all diagnoses	19	7	73%	52%-88%	p = 0.03098
Results for settings and diagnoses combined	35	10	78%	63%-88%	p = 0.0003466

Table 11.1 shows that the test of proportional significance found that Supportive Psychotherapy is consistently used across all settings and all diagnoses. Looking at the use of a music therapy approach based upon Supportive Psychotherapy, in different settings, Out-Patient/Individuals show the most consistent use of this approach across centres, and Acute Wards also predominately use the approach across centres. Reports on the application of supportive psychotherapy with Bipolar Disorder found the most consistent use of this approach as discussed in section 10.4.

The results of a test of proportional significance are reported in Table 11.2. with the cumulated scores for setting and diagnoses by centre, giving sample estimates, confidence intervals and p-values.

Table 11.2: Supportive Psychotherapy - Results for Centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A	11	0	100%	68%-100%	p = 0.0026
B	4	3	57%	20%-88%	Non-sig
C	9	0	100%	63%-100%	p = 0.0077
D	7	0	100%	56%-100%	p = 0.0233
D (Th b)	0	3	0%	0%-69%	Non-sig
E	4	4	50%	22%-78%	Non-sig

11.2.1 Summary

Looking at the raw data from all centres, three of the centres (A, C & D) use supportive psychotherapy at a significant level. This is irrespective of nationality and training background.

11.2.2 Conclusion

The results here show that a Supportive Psychotherapy approach in music therapy is widely used in the centres in this study. Centres B & E were more ambivalent than the other three centres, which showed a significant use of the approach, particularly in favour of its use with bi-polar diagnoses. Some reasons for this were explained in 10.7.2 and will be further discussed in Chapter 12. In summary, the prevalent use of a Supportive Psychotherapy approach, highlights the music therapists' understanding that a combination of a good therapeutic alliance which is supportive, with a 'not too robust analytic stance', is particularly suitable for people who are severely psychotic or suffering from lack of insight and severe mood swings as in the case of people with bi-polar disorder.

11.3 Client-Centred

This refers to music therapy using a Client Centred approach as its theoretical orientation. The percentages of yes and no responses for a Client-Centred approach are shown descriptively in bar charts for settings and diagnosis in Figure 11.3.1

Figure 11.2: Client-Centred – bar chart of yes and no percentages

As Figure 11.2 shows, 37**%** yes scores for all settings and 52% yes scores for all diagnoses reveals that a Client Centred approach to music therapy is not strongly indicated as very useful by the centres in the study.

Table 11.3: Client-Centred - Results for Settings and Diagnoses

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	7	12	37%	17%-61%	Non-sig.
Results for all diagnoses	14	13	52%	32%-71%	Non-sig.
Results for settings and diagnoses combined	21	25	46%	31%-61%	Non-sig.

Table 11.4: Client-Centred - Results for Centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A	0	11	0%	0%-32%	0.002569
B	0	7	0%	0%-44%	0.02334
C	8	2	80%	44%-96%	Non-sig.
D	5	2	71%	30%-95%	Non-sig.
D (Th B)	0	3	0%	0%-69%	Non-sig.
E	8	0	100%	60%-100%	0.01333

Table 11.4 shows that the test of proportional significance confirms that a Client Centred approach in music therapy is not used significantly across all settings and all diagnoses. Reasons for this related to diagnosis were discussed in the analysis of the qualitative data in Chapter 10.

11.3.1 Summary of significant results

Looking at different settings it is clear that there are no significant uses of a music therapy approach with a client centred theoretical orientation. In terms of diagnosis, there are also no significant patterns emerging in the use of this approach by looking at the numerical results, although some reasons for using or not using it have been discussed in Chapter 10 with no conclusive outcome. Similarly, as shown in Figure 11.3 if we look at all the results, or for all settings or all diagnoses, we find no significant results.

11.3.2 Conclusion

The fact that there are clear differences between the centres, and even within centres, means that there is no overall conclusive use revealed of a music therapy approach using a client centred theoretical orientation. This is also the case when looking at the results in other ways, by diagnosis/setting, or overall, or grouped over all diagnoses and all settings.

From the analysis of qualitative data in Chapter 10 it is clear that centres did not have music therapists trained in a true Client Centred approach, apart from in Centre E, as

defined in the guidelines for the survey. Whilst there is a general view about following the client, data suggests that across the centres in the study there is little evidence to show any links with diagnosis and music therapy using this approach.

11.4 Behavioural

The percentages of yes and no responses for Behavioural music therapy are shown descriptively in bar charts for settings and diagnosis separately in Figure 11.3

Fig 11.3: Behavioural – bar chart of yes and no percentages

As Fig 11.3 shows, **5%** yes scores for all settings and 23% yes scores for all diagnoses reveals that a Behavioural approach to music therapy is not indicated as frequently used by the centres in the study.

Table 11.5: Behavioural - Results for Settings and Diagnoses

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	1	18	5%	0%-28%	0.0002419
Results for all diagnoses	6	20	23%	10%-44%	0.01079
Results for settings and diagnoses combined	7	38	16%	7%-30%	< .00001

Table 11.6: Behavioural - Results for Centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A	0	11	0%	0%-32%	0.002569
B	0	7	0%	0%-44%	0.02334
C	4	6	40%	14%-73%	Non-sig.
D	2	5	29%	5%-70%	Non-sig.
D (Th B)	0	2	0%	0%-80%	Non-sig.
E	1	7	13%	1%-53%	0.0771 (Non-sig.)

Tables 11.5 & 11.6 show that the test of proportional significance confirms that a Behavioural approach of music therapy is not used significantly by settings and diagnoses across all centres in this study.

11.4.1 Summary of significant results

Looking across centres, Centres A, B,D and E all do not use this approach, and Centre C appears divided. Looking across settings, results for Acute Wards reject the approach significantly, while others are not significant. Generally, there appear to be more therapists working in Acute Wards, so it is more possible to get a significant result. In terms of diagnosis, there are no significant results, although for people with bipolar disorder and personality disorder results indicate that the approach is not used often. Reasons for this are discussed in Chapter 10 and in summary relate both to the

therapists' lack of training or orientation in Behavioural approaches, but also to the fact that a true Behavioural approach is not thought helpful as it is too strict and directive. It also does not allow the patient enough control or flexibility to work on less obvious aspects of the symptoms arising from the particular illness/diagnosis. Furthermore looking at all the results put together for all settings or all diagnoses as shown in Fig 11.3 the approach is rejected significantly. This is likely to be for similar reasons.

11.4.2 Conclusion

Looking at all the centres and all the diagnoses and settings, the general picture is that a Behaviourally orientated music therapy approach is not favoured for use by the centres in the study.

11.5 Developmental

The percentages of yes and no responses for developmental music therapy are shown descriptively in bar charts for settings and diagnosis separately in Figure 11.4
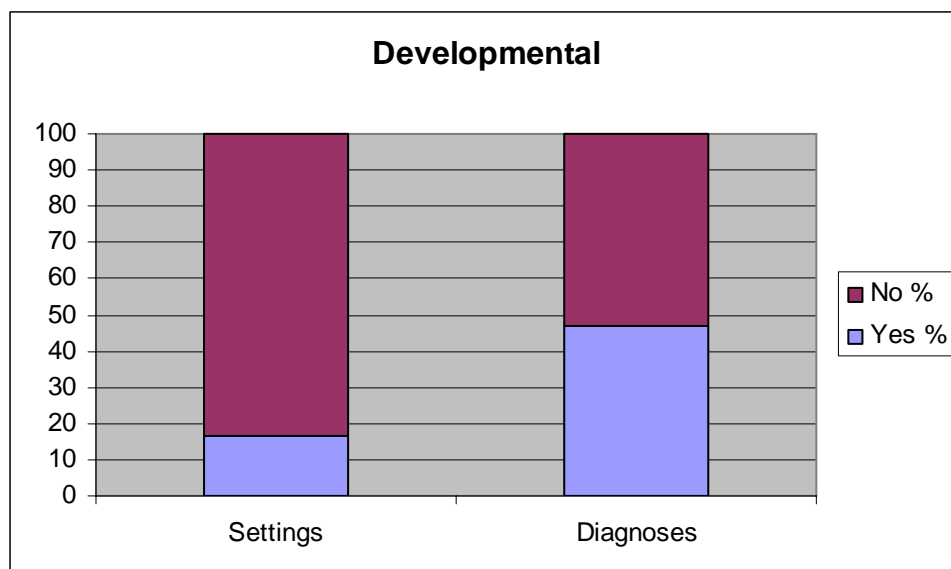
Figure 11.4: Developmental – bar chart of yes and no percentages

As Figure 11.4 shows, 17**%** yes scores for all settings and 27% yes scores for all diagnoses reveals that a Developmental approach to music therapy is not indicated as very useful by the centres in the study.

Table 11.7: Developmental - Results for Settings and Diagnoses

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	3	15	17%	4%-42%	0.009522
Results for all diagnoses	7	19	27%	12%-48%	0.03098
Results for settings and diagnoses combined	10	34	23%	12%-38%	0.0005256

Table 11.8: Developmental - Results for Centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A	0	10	0%	0%-34%	0.004427
B	0	7	0%	0%-44%	0.02334
C	8	2	80%	44%-96%	Non-sig.
D	0	7	0%	0%-44%	0.02334
D (Th B)	0	2	0%	0%-80%	Non-sig.
E	2	6	25%	4%-64%	Non-sig.

Tables 11.7 and 11.8 show that the test of proportional significance found that that a Developmental approach to music therapy is not used consistently across three settings, while accepted significantly by one centre, and there is an indication it is not often used by another centre.

11.5.1 Summary of significant results

Proportional differences reveal that Centres A, B and D do not use the approach, while Centre C does, and Centre E indicates it is not often used. Looking at the results

by settings, the results for Acute Wards suggest that it is not used significantly, while others are not significant. Generally, there appear to be more therapists working in Acute Wards, explaining why a significant result could be found. Looking at diagnoses, there are no significant results, although bipolar disorder and personality Disorder indicate that the approach is not often used. Reasons for this were discussed further in (10.3.6 &10.7.6) Looking at all the results for settings or diagnoses, it appears that this approach is not used significantly by centres in the study.

11.5.2 Conclusion

The overall finding is that the approach is not used, but there is a difference between centres. Centre C uses it, but Centres A, B & D all do not. Reasons discussed in the separate diagnostic sections in the qualitative analysis mainly reveal that music therapists think of a Developmental approach as too linear, and demanding of set patterns of progress and therefore it is seen as inappropriate for music therapy with adults who are at so many different developmental stages psychologically, intellectually, physically and emotionally. Results would probably be different when asking therapists who work with children in mental health, and in summary the rejection of this approach seems to confirm that the centres in this study are focussed upon psychological and psychoanalytic processes rather than expectations that patients will take a step by step Behavioural or Developmental path to recovery or rehabilitation.

11.6 Psychoanalytically Informed

The percentages of yes and no responses for Psychoanalytically Informed music therapy are shown descriptively in bar charts for settings and diagnosis separately in Figure 11.5.
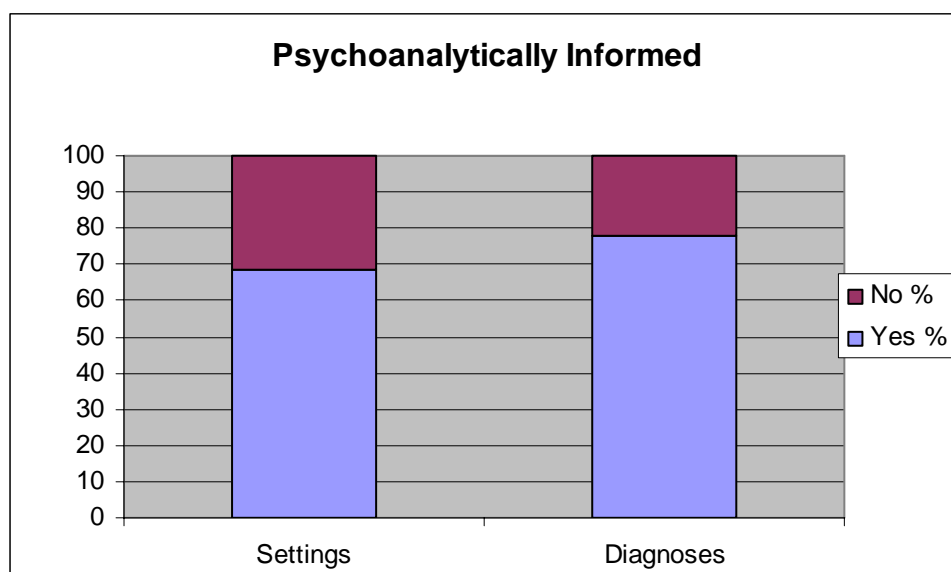
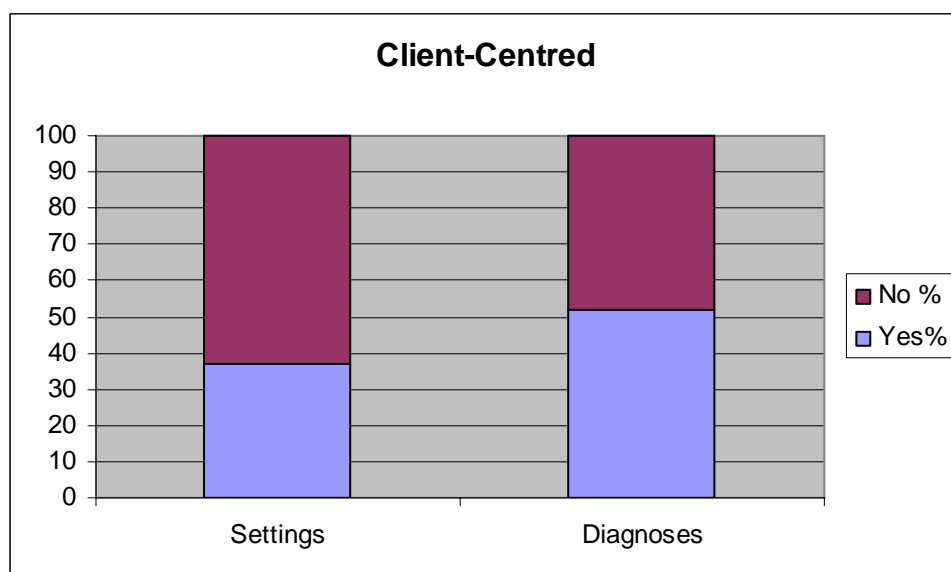**Figure 11.5: Psychoanalytically Informed – bar chart of yes and no percentages**

As Figure 11.5 shows, 68**%** yes scores for all settings and 78% yes scores for all diagnoses reveals that a Psychoanalytically Informed approach to music therapy is indicated as widely used by the centres in the study.

Table 11.9: Psychoanalytically Informed - Results for Settings and Diagnoses

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	13	6	68%	43%-86%	Non-sig.
Results for all diagnoses	21	6	78%	57%-91%	0.007054
Results for settings and diagnoses combined	34	12	74%	59%-85%	0.001960

Table 11.10: Psychoanalytically Informed – Results for Centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes	Confidence intervals of the proportion	p-value
A	11	0	100%	68%-100%	0.0026
B	0	7	0%	0%-44%	0.02334
C	10	0	100%	66%-100%	0.004427
D	5	2	71%	30%-95%	Non-sig.
D (Th B)	0	3	0%	0%-69%	Non-sig.
E	8	0	100%	60%-100%	0.01333

Tables 11.9 & 11.10 show that the test of proportional significance confirms that three centres use the approach significantly, one centre appears polarised and partly indicates use and non-use.

11.6.1 Summary of significant results

Centres A, C and E use the approach significantly, Centre D appears polarised, and Centre B does not use the approach significantly. The data for settings reveal that there are no significant results, although Acute Wards are in the direction of using a Psychoanalytically Informed approach. Looking across diagnoses there are no significant results. However, when analysing by diagnoses, and when cumulating scores for settings and diagnoses, the analysis revealed this approach is used to a significant level.

11.6.2 Conclusion

This again showed a difference between the centres, with Centres A, C & E embracing the approach, Centre D divided in opinion, and Centre B not using the approach. This was discussed in detail in Chapter 10.3.2 & 10.3.5 in respect of the data from the qualitative analysis, because Centre B claims a separate approach which this researcher discusses as very similar to a Psychoanalytically Informed approach. Overall the results show a significant usage of this approach, and when reporting their approach related to the diagnosis, rather than related to the setting, the therapists were a little more likely to say they would use this approach.

11.7 Analytical Music Therapy

The percentages of yes and no responses for an Analytically orientated music therapy approach are shown descriptively in bar charts for settings and diagnosis separately in Fig 11.6.
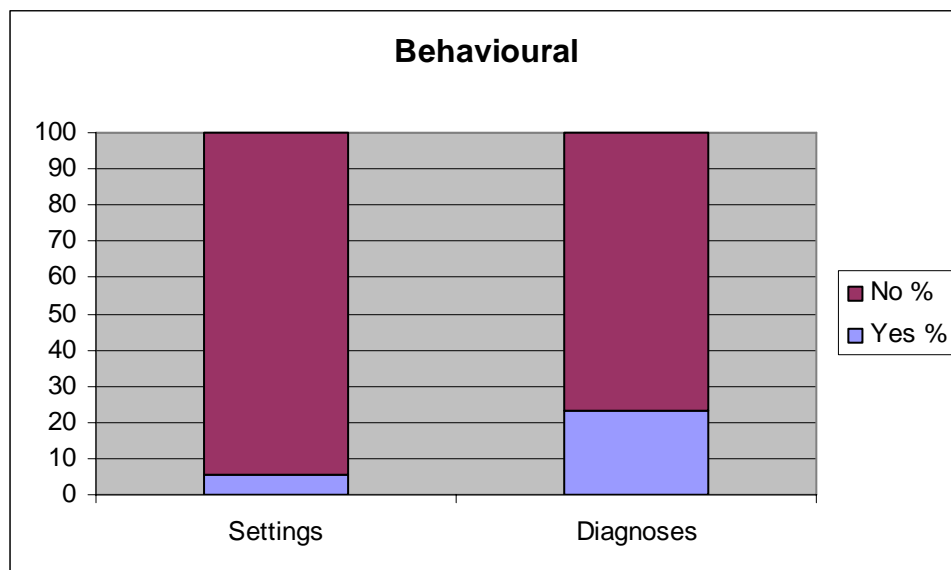

Figure 11.6: Analytical Music Therapy – bar chart of yes and no percentages

As Figure 11.6 shows, 20**%** yes scores for all settings and 42% yes scores for all diagnoses reveals that an Analytical Music Therapy approach to music therapy is not indicated as widely used by the centres in the study.

Table 11.11: Analytical Music Therapy - Results for Settings and Diagnoses

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	4	16	20%	7%-44%	0.0139
Results for all diagnoses	11	15	42%	24%-63%	0.5563
Results for settings and diagnoses combined	15	31	33%	20%-48%	0.02699

Table 11.12: Analytical Music Therapy - Results for Centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A	0	11	0%	0%-32%	0.002569
B	0	7	0%	0%-44%	0.02334
C	6	5	55%	25%-82%	Non-sig.
D	4	3	57%	20%-88%	Non-sig.
D (Th B)	0	2	0%	0%-80%	Non-sig.
E	5	3	63%	26%-90%	Non-sig.

Tables 11.11 & 11.12 show that the test of proportional significance reveals significant rejection of the approach of Analytical Music Therapy across centres, diagnoses, and centres, settings and diagnoses combined.

11.7.1 Summary of significant results

Looking across Centres, Centres A and B reject the approach unanimously, whilst other centres appear more ambivalent. There are no significant results across settings, although Acute Wards indicate that the approach is not used. Looking specifically at diagnoses, there are no significant results, although the use of the approach with schizophrenia is in the direction of being not used. This is supported by the qualitative data analysis in Chapter 10, which is summarised below in the conclusion in more detail. Looking at the results overall, the approach is indicated as not being used significantly. The approach is also not used significantly when looking at the results for all settings, but not when considering diagnoses.

11.7.2. Conclusion

Centres A and B do not use the approach, without any Yes's at all. The other three centres are more ambivalent, with more of a tendency to accept the approach when considering diagnoses, than when considering settings. However, cross referencing with Chapter 10 the centres which do not use this approach gave two reasons - either the music therapists are untrained in this approach (Centre A 10.3.7) or schizophrenic patients '*mostly cannot work with splitting techniques or use verbal interpretations*'.

(Centre E). Considering all the settings together there is a significant majority of No's implying that the specific Priestley approach which was defined as such in the survey guidelines, is not used. There is also a significant result showing that Analytical Music Therapy is not used, when the results from all settings and diagnoses are analysed together.

11.8 Creative Music Therapy

The percentages of yes and no responses for a Creative Music Therapy orientated music therapy approach are shown descriptively in bar charts for settings and diagnosis separately in Figure 11.7.
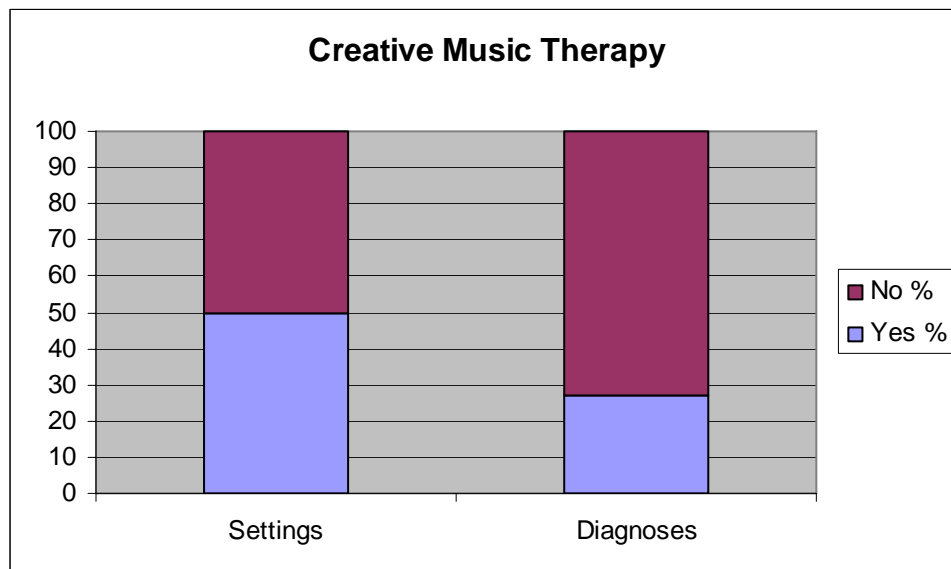
Figure 11.7: Creative Music Therapy – bar chart of yes and no percentages

As Figure 11.7 shows, 50**%** yes scores for all settings and 27% yes scores for all diagnoses reveals that a Creative Music Therapy approach is not indicated as widely used by the centres in the study.

Table 11.13: Creative Music Therapy - Results for Settings and Diagnoses

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	9	9	50%	29%-71%	Non-sig.
Results for all diagnoses	7	19	27%	12%-48%	0.03098
Results for settings and diagnoses combined	16	28	36%	23%-52%	0.09725 (Non-sig.)

Table 11.14: Creative Music Therapy - Results for Centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A	7	3	70%	35%-92%	Non-sig.
B	7	0	100%	56%-100%	0.02334
C	2	8	20%	4%-56%	Non-sig.
D	0	7	0%	0%-44%	0.02334
D (Th B)	0	2	0%	0%-80%	Non-sig.
E	0	8	0%	0%-40%	0.01333

Tables 11.13 & 11.14 show that the test of proportional significance reveals significant rejection of the approach of Creative Music Therapy across centres, diagnoses, and centres, settings and diagnoses combined.

11.8.1 Summary of significant results

Looking across all centres, for settings and diagnoses together, Centre B uses this approach, while Centre C, D and E do not. Centre A does not show a significant result, although there are more Yes's than No's. Looking across all settings, there are no significant results, and similarly for diagnoses there are no significant results.

11.8.2 Conclusion

There is a disparity again between the centres, and overall the therapists seem more likely not to use the approach when thinking about diagnoses, than when thinking about settings. Reasons for non-use were discussed in detail in the qualitative data analysis in Chapter 10, but in summary, the centres that do not use CMT imply that this is because too much emphasis upon aesthetic musical form and structure might detract from the patient having to explore more inner feelings and thoughts. It also might emphasise performance which is thought not useful for most diagnoses because of the implication of 'right' and 'wrong' and that this could be too constraining and also result in self criticism. This could lead to pressures which might add to the problems for example for people with schizophrenia, bi-polar disorder or personality disorder.

The centre that does use CMT appears to be the only centre with music therapists fully trained in this approach.

11.9 Activity-Based

The percentages of yes and no responses for an Activity-Based music therapy orientated approach are shown descriptively in bar charts for settings and diagnosis separately in Figure 11.8.
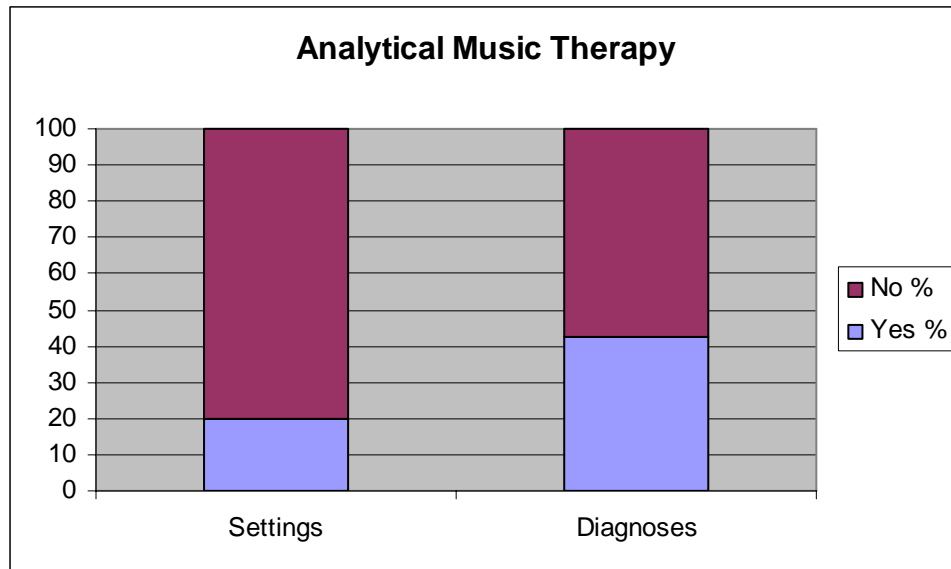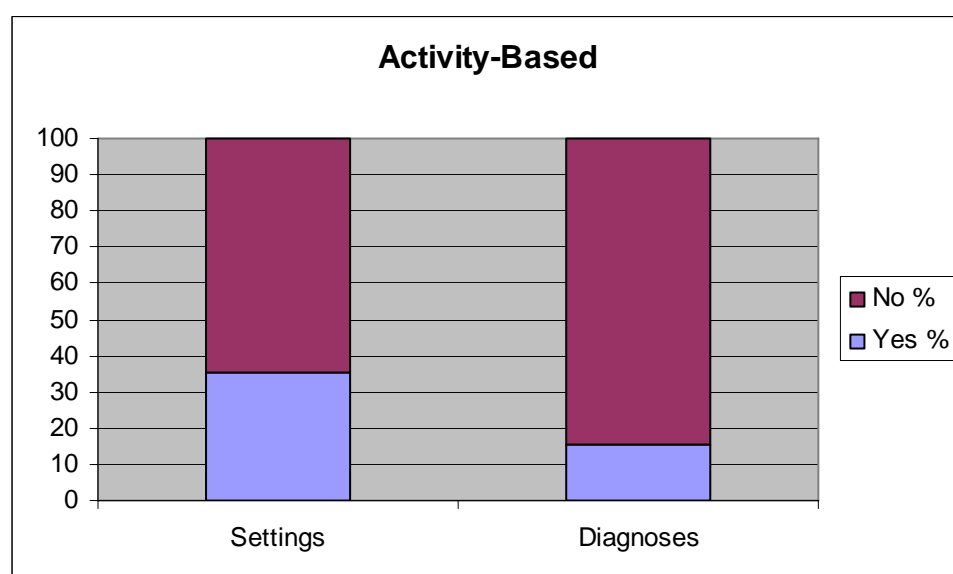

Figure 11.8: Activity-Based – bar chart of yes and no percentages

As Figure 11.8 shows, 35**%** yes scores for all settings and 15% yes scores for all diagnoses, reveals that an Activity -Based approach to music therapy is not widely used by the centres in the study.

Table 11.15: Activity-Based - Results for Settings and Diagnoses

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes	Confidence intervals of the proportion	p-value
Results for all settings	6	11	35%	15%-61%	Non-sig.
Results for all diagnoses	4	22	15%	5%-36%	0.0008561
Results for settings and diagnoses combined	10	33	23%	12%-39%	0.0007937

Table 11.16: Activity-Based - Results for Centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes	Confidence intervals of the proportion	p-value
A	6	5	55%	25%-82%	Non-sig.
B	1	5	17%	1%-64%	Non-sig.
C	2	8	20%	4%-56%	Non-sig.
D	0	6	0%	0%-48%	0.04123
D (Th B)	0	2	0%	0%-80%	Non-sig.
E	1	7	13%	1%-53%	0.0771 (Non-sig.)

Tables 11.15 & 11.16 show that the test of proportional significance reveals a lack of use of the approach of Activity based music therapy across centres, diagnoses, and centres, settings and diagnoses combined.

11.9.1 Summary of significant results

Looking across all centres, Centres D and E do not use an Activity-Based music therapy approach at a significant level. Centre A's yes and no scores are evenly divided.

Across settings there are no significant results. Looking across diagnoses, for schizophrenia there is an indication that an Activity –Based approach is not used and the result is significant. Reasons for this were discussed in detail in 10.3.9 for example. For other diagnoses results are non-significant, although personality disorder is in the direction of non-use. Considering all the results, an Activity based music therapy based approach is indicated significantly as not used.

11.9.2 Conclusion

Overall, this approach is not favoured. The results suggest that music therapists are more likely not to use the approach when considering the diagnosis, than when considering the setting. Reasons given for not using the approach can be summarised as putting the therapist into a leading role within the music which will then affect the ability to work with the transference. This is addressed in chapter 10 when discussing people with personality disorder, and centres suggest that working with transference and counter-transference is crucial for music therapy approaches for people with schizophrenia and personality disorders.

11.10 Guided Imagery in Music (GIM)

The percentages of yes and no responses for a GIM orientated approach are shown descriptively in bar charts for settings and diagnosis separately in Figure 11.9.
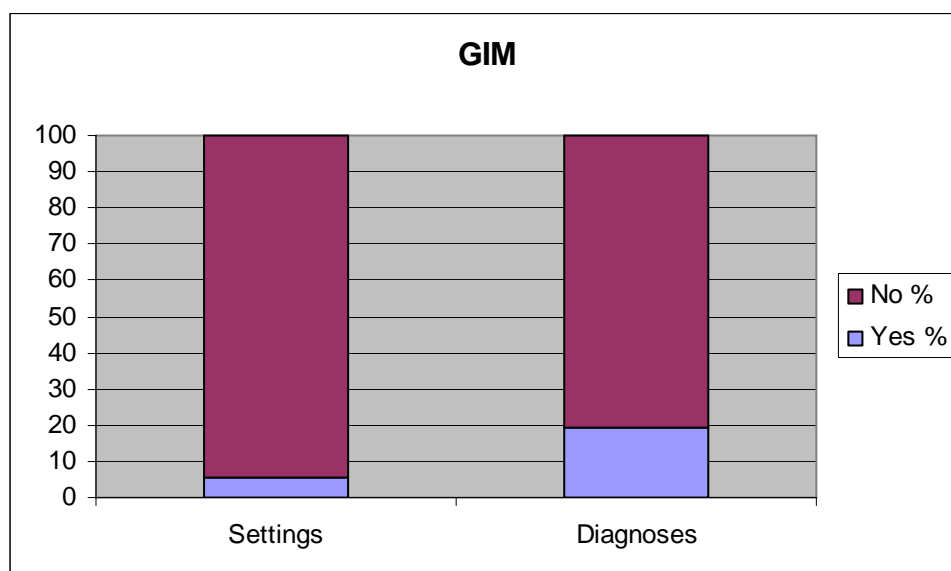
Figure 11.9: GIM – bar chart of yes and no percentages

As Figure 11.9 shows **5%** yes scores for all settings and 19% yes scores for all diagnoses this reveals that a Guided Imagery and Music based approach to music therapy is not indicated as widely used by the centres in the study.

Table 11.17: GIM - Results for Settings and Diagnoses

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes	Confidence intervals of the proportion	p-value
Results for all settings	1	18	5%	0%-28%	0.0002419
Results for all diagnoses	5	21	19%	7%-40%	0.003264
Results for settings and diagnoses combined	6	39	13%	6%-24%	< 0.00001)

Table 11.18: GIM - Results for Centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes	Confidence intervals of the proportion	p-value
A	0	11	0%	0%-32%	0.002569
B	0	7	0%	0%-44%	0.02334
C	0	10	0%	0%-34%	0.004427
D	1	6	14%	1%-58%	Non-sig.
D (Th B)	0	2	0%	0%-80%	Non-sig.
E	5	3	63%	26%-90%	Non-sig.

Tables 11.17 & 11.18 show that the test of proportional significance reveals some significant rejection of the approach of GIM based music therapy across centres, diagnoses, and centres, settings and diagnoses combined.

11.10.1 Summary of significant results

Looking across all centres, Centres A, B, C and D all report not using this approach. Centre E's results are non-significant, but with more use than non-use.

Across settings, the results for Acute Wards do not use the approach significantly, and centres also report not using this approach in other settings. Generally, there appear to be more therapists working in Acute Wards, so it is more possible to get a significant result. Looking across all diagnoses, the results for schizophrenia and bipolar disorder show no usage of this approach by these centres, Looking at the results overall for all settings or all diagnoses, GIM is significantly not used by centres in the study.

11.10.2 Conclusion

The overall picture is that GIM is very little used, Centre E being the partial exception. Reasons for this were discussed in Chapter 10, where it was revealed that there were very few music therapists with knowledge and training in GIM in the centres recruited for the study (10.3.10, 10.23.10). Furthermore, those that did have training and knowledge in GIM were cautious about its use particularly with psychosis, and suggested little use or an adapted use.

11.10.3 Data analysis of techniques

The following sections report the results of the analysis of data for techniques across all settings and diagnoses, and the analysis of cumulated scores. The raw scores tables for each of the techniques are listed in Appendix VII, and will not be referred to again under each technique to avoid repetition. In this section the figures do not include a summary because the percentages are included in the tables and following the style for the approaches section, this will be obvious to the reader now.

11.11 Free Improvisation with Minimal Talking:

The percentages of yes and no responses for this technique are shown descriptively for settings and diagnoses, and also for group and individual work, in the bar chart in Figure 11.10. Raw scores for groups and individuals by settings and diagnoses, together with the percentages, confidence intervals and results from a test of proportions are then reported in Table 11.19 and similar results in a breakdown by centres in Table 11.20.
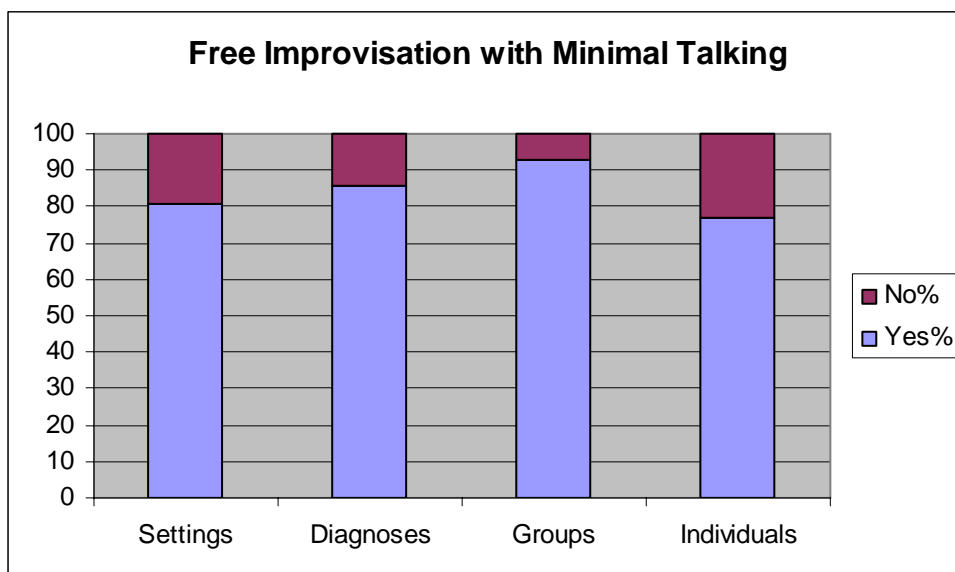
Figure 11.10: Free Improvisation with Minimal Talking – bar chart of yes and no percentages

Table 11.19: Free Improvisation with Minimal Talking – Results for Settings, Diagnoses, Groups and Individual Work

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	21	5	81%	60%-93%	0.003264
Results for all diagnoses	36	6	86%	71%-94%	<0.00001
Results for settings and diagnoses combined	57	11	84%	72%-91%	<0.00001
Results for all Groups	27	2	93%	76%-99%	<0.00001
Results for all Individuals	30	9	77%	60%-88%	0.001362

Table 11.20: Free Improvisation with Minimal Talking – Results for Centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A (group)	9	1	90%	54%-99%	0.02686
B (group)	6	0	100%	52%-100%	0.04123
C (group)	8	0	100%	60%-100%	0.01333
D (group)	4	1	80%	30%-99%	Non-sig.
A (indiv)	8	2	80%	44%-96%	Non-sig.
B (indiv)	6	0	100%	52%-100%	0.04123
C (indiv)	10	0	100%	66%-100%	0.004427
D (indiv)	4	1	80%	30%-99%	Non-sig.
E (indiv)	2	6	25%	4%-64%	Non-sig.

Table 11.19 & 11.20 show that the proportional test of significance reveals that this technique is used very widely and is therefore favoured across all settings, diagnoses, settings and diagnoses combined, group work and individual work. The *p* values all show high levels of significance in Table 11.17.

11.11.1 Summary of significant results

Centres A, B and C all use the technique significantly for both individual and group work, while Centre E does not work with groups. Centres B and C also use the technique significantly for individual work.

11.11.2 Conclusion

Overall, the centres in this study use this technique significantly, with some dissent from Centre E. Reasons for this were discussed in Chapter 10 for each diagnosis, but in summary it appears that opinion differs between putting more emphasis upon working within music for some patients where words would be seen to encourage defence mechanisms, or are not appropriate. Other opinion sees only working in music as secondary, because talking and thinking are a primary focus, helped by musical improvisation. These points are discussed further in more detail in 12.3 & 12.6.2-12.6.4.

11.12 Free Improvisation with Talking/Interpretation:

The percentages of yes and no responses for this technique are shown descriptively for settings and diagnoses, and also for group and individual work, in the bar chart in Figure 11.11. Raw scores for groups and individuals by settings and diagnoses, together with the percentages, confidence intervals and results from a test of proportions are then reported in Table 11.21 and similar results in a breakdown by centres in Table 11.22.

Figure 11.11: Free Improvisation with Talking/Interpretation – bar chart of yes and no percentages

Table 11.21: Free Improvisation with Talking/Interpretation – results for settings, diagnoses, groups and individual work

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	24	2	92%	73%-99%	< .00001
Results for all diagnoses	41	1	98%	86%-100%	< .00001
Results for settings and diagnoses combined	65	3	96%	87%-99%	< .00001
Results for all Groups	28	1	97%	80%-100%	< .00001
Results for all Individuals	37	2	95%	81%-99%	< .00001

Table 11.22: Free Improvisation with Talking/Interpretation – results for centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A (group)	10	0	100%	66%-100%	0.004427
B (group)	6	0	100%	52%-100%	0.04123
C (group)	8	0	100%	60%-100%	0.01333
D (group)	4	1	80%	30%-99%	Non-sig.
A (indiv)	10	0	100%	66%-100%	0.004427
B (indiv)	6	0	100%	52%-100%	0.04123
C (indiv)	10	0	100%	66%-100%	0.004427
D (indiv)	4	1	80%	30%-99%	Non-sig.
E (indiv)	7	1	88%	47%-99%	0.0771 (Non-sig.)

Tables 11.21 & 11.22 shows that the proportional test of significance reveals that this technique is used with a high degree of significance, when considering settings, diagnoses, group-work and individual work.

11.12.1 Summary of significant results

Centres A, B and C all use this technique (unanimously), while the results for Centre D are in the positive direction, but not significant. Centre E does not work with groups. Centres A, B, C and E all use this technique with high levels of significance, while the results for Centre D are in that direction but not significant.

11.12.2 Conclusion

The results show when looking at all settings, all diagnoses, all groups and all individuals, that there is a highly significant use of this technique in each case. Clearly, there is very wide agreement that this is a central technique of music therapy among these five centres. Chapter 10 has described many reasons for this taken from the qualitative data. Whilst one should be cautious about generalising, the flexibility of moving between music allowing less thought and more spontaneity and words, which for some might be an ultimate aim; (although for others used as a defence preventing connection), seems key to the unique qualities of music therapy treatment.

11.13 Free Improvisation with Structures

The percentages of yes and no responses for this technique are shown descriptively for settings and diagnoses, and also for group and individual work, in the bar chart in Figure 11.12. Raw scores for groups and individuals by settings and diagnoses, together with the percentages, confidence intervals and results from a test of proportions are then reported in Table 11.23 and similar results in a breakdown by centres in Table 11.24.

Figure 11.12: Free Improvisation with Structures – bar chart of yes and no percentages

Table 11.23: Free Improvisation with Structures – results for settings, diagnoses, groups and individual work

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	15	11	58%	37%-76%	Non-sig.
Results for all diagnoses	26	16	62%	46%-76%	Non-sig.
Results for settings and diagnoses combined	41	27	60%	48%-72%	Non-sig.
Results for all Groups	20	9	69%	49%-84%	0.06332 (Non-sig.)
Results for all Individuals	21	18	54%	37%-70%	Non-sig.

Table 11.24: Free Improvisation with Structures – results for centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A (group)	10	0	100%	66%-100%	0.004427
B (group)	5	1	83%	36%-99%	Non-sig.
C (group)	1	7	13%	1%-53%	0.0771 (Non-sig.)
D (group)	4	1	80%	30%-99%	Non-sig.
A (indiv)	8	2	80%	44%-96%	Non-sig.
B (indiv)	1	5	17%	1%-64%	Non-sig.
C (indiv)	2	8	20%	4%-56%	Non-sig.
D (indiv)	3	2	60%	17%-93%	Non-sig.
E (indiv)	7	1	88%	47%-99%	0.0771 (Non-sig.)

Tables 11.23 & 11.24 show that the proportional differences indicated no clear significant outcome for this technique across settings and diagnoses for groups and individuals, or across all centres. Although there are more yes scores this is only by a small margin.

11.13.1 Summary of significant results

In group work, Centre A uses the technique significantly, while Centre C is in the direction of not using the technique, outside the significance level. The results for Centres B and D are in the direction of using the technique, but not significantly. When reporting work with individuals, there are no significant results, although Centre E's results are in the direction of using the technique.

11.13.2 Conclusion

There is some variation between and within centres. Clinicians were more definite in accepting the technique for groups, especially at Centre A. Chapter 10 discussed reasons for this in relation to some diagnoses, for example for eating disorders, anxiety and depression, where structure is seen as useful in decreasing anxiety and uncertainty and also structures which involve symbolic thinking are more prevalent than for psychotic disorders. For schizophrenia there is an acknowledgement in the qualitative data that patients who have trouble organising their thoughts might find

structures more difficult. Comments suggest that for these populations, free improvisation, where the therapist might introduce structure as part of the spontaneous improvising rather than imposing a structure at the outset (that would be too confining), is preferable.(10.4.4., 10.16.4., 10.20.4).

11.14 Theme-Based Improvisation

The percentages of yes and no responses for this technique are shown descriptively for settings and diagnoses, and also for group and individual work, in the bar chart in Figure 11.13. Raw scores for groups and individuals by settings and diagnoses, together with the percentages, confidence intervals and results from a test of proportions are then reported in Table 11.25 and similar results in a breakdown by centres in Table 11.26.
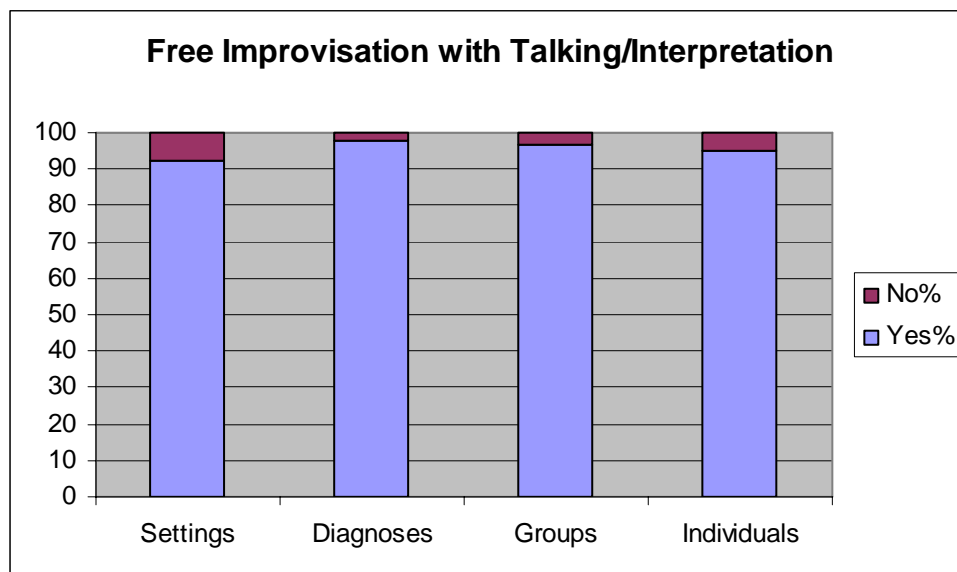

Figure 11.13: Theme-Based Improvisation – bar chart of yes and no percentages

Table 11.25: Theme-Based Improvisation – results for settings, diagnoses, groups and individual work

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	11	15	42%	24%-63%	Non-sig.
Results for all diagnoses	30	12	71%	55%-84%	0.008712
Results for settings and diagnoses combined	41	27	60%	48%-72%	Non-sig.
Results for all Groups	17	12	59%	39%-76%	Non-sig.
Results for all Individuals	24	15	62%	45%-76%	Non-sig.

Table 11.26: Theme-Based Improvisation – results for centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A (group)	8	2	80%	44%-96%	Non-sig.
B (group)	0	6	0%	0%-48%	0.04123
C (group)	7	1	88%	47%-99%	0.0771 (Non-sig.)
D (group)	2	3	40%	7%-83%	Non-sig.
A (indiv)	7	3	70%	35%-92%	Non-sig.
B (indiv)	0	6	0%	0%-48%	0.04123
C (indiv)	7	3	70%	35%-92%	Non-sig.
D (indiv)	2	3	40%	7%-83%	Non-sig.
E (indiv)	8	0	100%	60%-100%	0.01333

Tables 25 & 26 show that the proportional test of significance revealed a highly significant result in favour of theme based improvisation, when considering diagnoses, but not when considering settings, group-work or individual work

11.14.1 Summary of significant results

When working in groups, there is some variation between the centres. The results for Centre A are in the direction of using the technique, while B definitely does not use it. Centre C is in the direction of using the technique, and Centre D appears divided. In individual work, Centres A and C show a non-significant result, although in both cases there are more yes's than no's. Centre D appears not to have an overall verdict. Centre B does not use the technique significantly, but Centre E uses it significantly.

11.14.2 Conclusion

There are differences between the centres, with Centre C indicating it does not use the technique which the others to varying degrees all use. Therapists were more likely to use the technique when thinking about diagnosis than when thinking about setting. This is evident from the responses from Centres A, C and E, where there do seem to be specific settings where the technique would and would not be used. Centre D, for example, does not use the technique for people with schizophrenia (10.3.4), implying that the technique involves understanding symbolic meaning and that this is too unfocussed for schizophrenic patients. Centre E directly contradicts this for people with schizophrenia in an Acute setting, and describes TBI as useful and states that the theme can sometimes be more important than the music, because whilst thinking about the theme, they forget about the music and then join in spontaneously. The music served to keep one person focussed upon the story, and inspired her to 'act' and also benefit from having to follow someone else's music. However, overall the technique is not used significantly.

11.15 Activity-Based

The percentages of yes and no responses for this technique are shown descriptively for settings and diagnoses, and also for group and individual work, in the bar chart in Figure 11.14. Raw scores for groups and individuals by settings and diagnoses, together with the percentages, confidence intervals and results from a test of proportions are then reported in Table 11.27 and similar results in a breakdown by centres in Table 11.28.
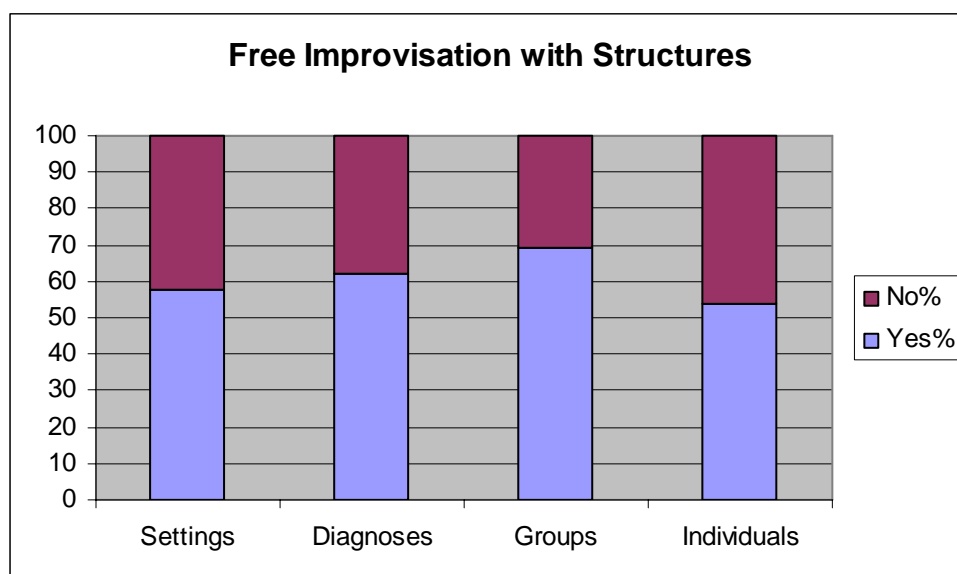
Figure 11.14: Activity-Based – bar chart of yes and no percentages

Table 11.27: Activity-Based – results for settings, diagnoses, groups and individual work

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	8	18	31%	15%-52%	0.07756 (Non-sig.)
Results for all diagnoses	7	35	17%	8%-32%	< .00001
Results for settings and diagnoses combined	15	53	22%	13%-34%	< .00001
Results for all Groups	12	17	41%	24%-61%	Non-sig.
Results for all Individuals	3	36	8%	2%-22%	<.00001

Table 11.28: Activity-Based – results for centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A (group)	7	3	70%	35%-92%	Non-sig.
B (group)	5	1	83%	36%-99%	Non-sig.
C (group)	0	8	0%	0%-40%	0.01333
D (group)	0	5	0%	0%-54%	0.07364 (Non-sig.)
A (indiv)	3	7	30%	8%-65%	Non-sig.
B (indiv)	0	6	0%	0%-48%	0.04123
C (indiv)	0	10	0%	0%-34%	0.004427
D (indiv)	0	5	0%	0%-54%	0.07364 (Non-sig.)
E (indiv)	0	8	0%	0%-40%	0.01333

Tables 11.27 & 11.28 report proportional differences indicating that only some results were significant. In each category the no's were more than the yes's for an Activity-Based technique. It was not used with high levels of significance for individual work, but for group-work it was non-significant. When considering diagnoses, the technique was not used, with high significance, but not when considering settings, although this was only just outside the 5% level.

11.15.1 Summary of significant results

In group work Centres C and D do not use the approach significantly, and the other Centres show non-significant results, while in individual work, Centres B, C, D and E do not use the approach and the result is significant.

11.15.2 Conclusion

Overall the centres in this study report that this technique is mostly not used, although there is some use at Centre A, particularly with groups. Chapter 10 has already addressed reasons for the use of this technique.

11.16 Singing Composed Songs:

The percentages of yes and no responses for this technique are shown descriptively for settings and diagnoses, and also for group and individual work, in the bar chart in

Figure 11.15. Raw scores for groups and individuals by settings and diagnoses, together with the percentages, confidence intervals and results from a test of proportions are then reported in Table 11.29 and similar results in a breakdown by centres in Table 11.30.
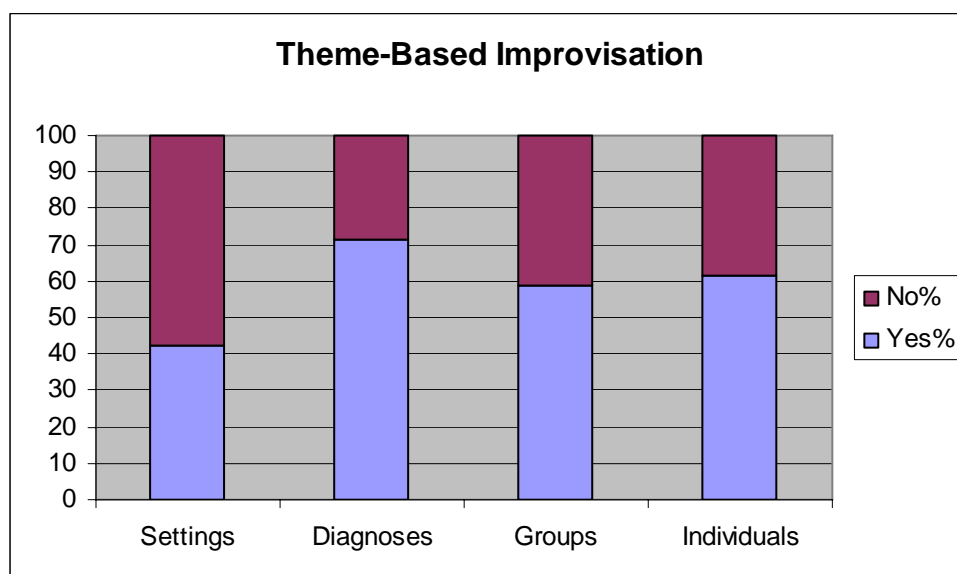

Figure 11.15: Singing Composed Songs – bar chart of yes and no percentages

Table 11.29: Singing Composed Songs – results for settings, diagnoses, groups and individual work

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	19	7	73%	52%-88%	0.03098
Results for all diagnoses	33	9	79%	63%-89%	0.0003867
Results for settings and diagnoses combined	52	16	76%	64%-86%	< .0001
Results for all Groups	24	5	83%	63%-93%	0.0008302
Results for all Individuals	28	11	72%	55%-84%	0.01041

Table 11.30: Singing Composed Songs – results for centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A (group)	9	1	90%	54%-99%	0.02686
B (group)	5	1	83%	36%-99%	Non-sig.
C (group)	7	1	88%	47%-99%	0.0771 (Non-sig.)
D (group)	3	2	60%	17%-93%	Non-sig.
A (indiv)	9	1	90%	54%-99%	0.02686
B (indiv)	5	1	83%	36%-99%	Non-sig.
C (indiv)	8	2	80%	44%-96%	Non-sig.
D (indiv)	3	2	60%	17%-93%	Non-sig.
E (indiv)	3	5	38%	10%-74%	Non-sig.

Tables 11.29 & 11.30 report proportional differences that reveal Singing Composed Songs is used across all diagnoses and settings for groups and individuals.

11.16.1 Summary of significant results

In group work, Centres A and C use the technique significantly, while the scores for other centres are non-significant, while in individual work, Centre A uses the technique to a significant level and Centre C uses the technique although just outside the 5% significance level.

11.16.2 Conclusion

Overall, the technique has a measure of use indicated, although there is more ambivalence at Centres D and E. As discussed in Chapter 10 under each diagnostic section, there are varying degrees of use depending upon diagnosis. The prevailing reason for the use of this technique with people with psychotic disorders is that singing can be a first step towards improvisation, and songs provide the structure needed to help make connections and start engagement, particularly in group work. (10.4.7, 10.8.7). It can provide a safe environment for people who easily feel invaded or 'cut off' from others. Furthermore the personal attributes and 'embodiment' possible through the voice helps people get in touch with 'affect' which is often not easy, but does not demand too much verbal processing and insight. For eating disorders there is less use and a statement that patients often have too low self esteem

to perform or sing. Equally opinion is divided about the used of Composed Songs for anxiety and depression and a reason for not using it in a group is that people cannot take an interest in listening to another's song when they are very depressed, and active improvisation provides a more suitable way of relating. Three centres use this technique for people with personality disorders and these centres gave substantial reasons as already discussed in 10.25. These reasons include working on traumatic past material in a way which seems easier than talking but involves words and music. In group work there is also scope for performance which can be supported by a therapist accompanying, providing nurturing as a starting point for expressing past material.

11.17 Song-Writing

The percentages of yes and no responses for this technique are shown descriptively for settings and diagnoses, and also for group and individual work, in the bar chart in Figure 11.16. Raw scores for groups and individuals by settings and diagnoses, together with the percentages, confidence intervals and results from a test of proportions are then reported in Table 11.31 and similar results in a breakdown by centres in Table 11.32.
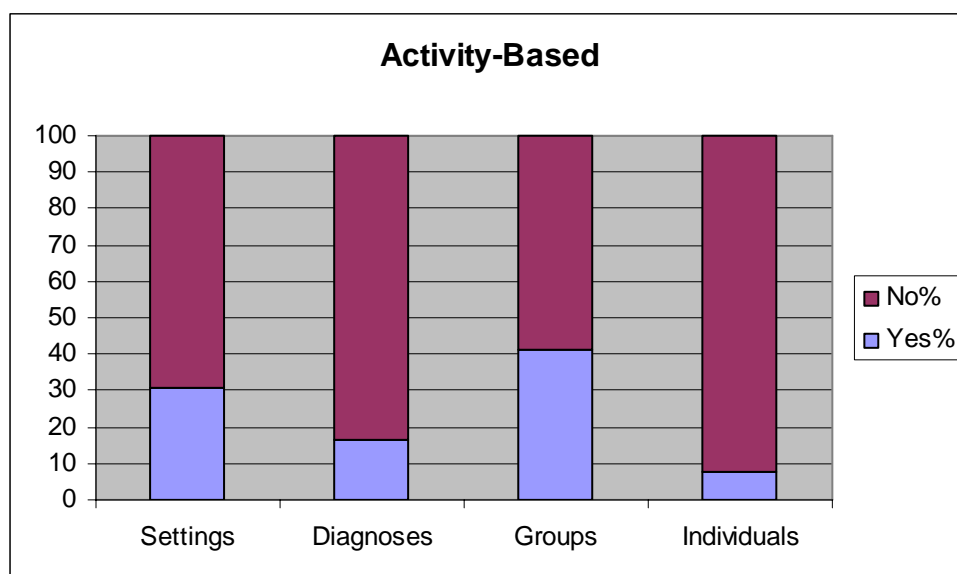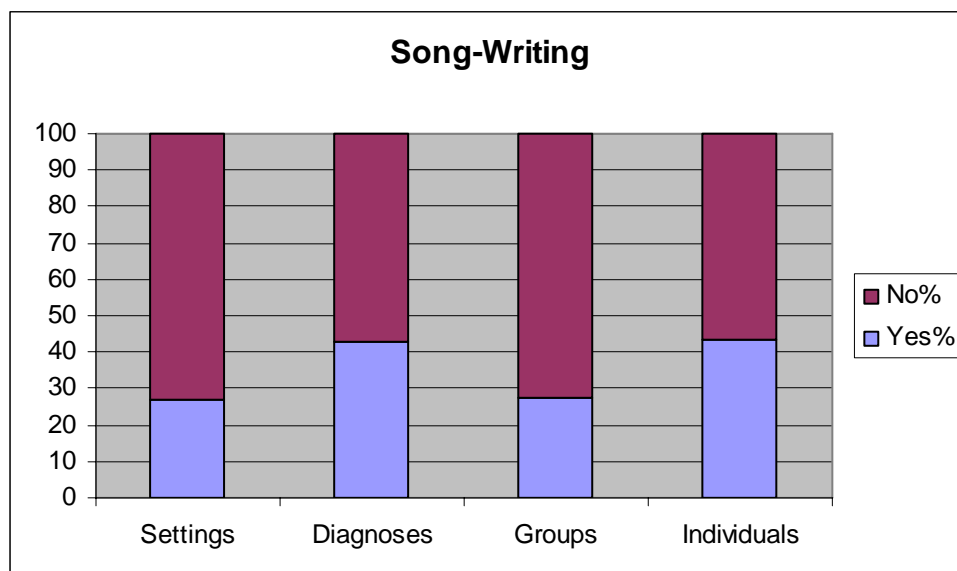

Figure 11.16: Song-Writing – bar chart of yes and no percentages

Table 11.31: Song-Writing – results for settings, diagnoses, groups and individual work

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes	Confidence intervals of the proportion	p-value
Results for all settings	7	19	27%	12%-48%	0.03098
Results for all diagnoses	18	24	43%	28%-59%	Non-sig.
Results for settings and diagnoses combined	25	43	37%	26%-49%	0.03925
Results for all Groups	8	21	28%	13%-47%	0.02586
Results for all Individuals	17	22	44%	28%-60%	Non-sig.

Table 11.32: Song-Writing – results for centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes	Confidence intervals of the proportion	p-value
A (group)	8	2	80%	44%-96%	Non-sig.
B (group)	0	6	0%	0%-48%	0.04123
C (group)	0	8	0%	0%-40%	0.01333
D (group)	0	5	0%	0%-54%	0.07364 (Non-sig.)
A (indiv)	9	1	90%	54%-99%	0.02686
B (indiv)	5	1	83%	36%-99%	Non-sig.
C (indiv)	3	7	30%	8%-65%	Non-sig.
D (indiv)	0	5	0%	0%-54%	0.07364 (Non-sig.)
E (indiv)	0	8	0%	0%-40%	0.01333

Tables 11.31 & 11.32 report proportional differences that reveal that the use of this technique was not sued significantly for settings, and for group-work, and for settings/diagnoses combined, but not for diagnoses and not for individual work. Thus it was clearer that clinicians would not use this technique for groups, but generally would use it in individual work. It was also clearer that the Centres would not use it when considering diagnosis than when considering setting.

11.17.1 Summary of significant results

When reporting group work, Centre A veered towards a use of this technique, while centres, B, C and D all reported not using Song Writing. In individual work, the picture is mixed, with Centre A making a significant use of the technique, while Centre E does not. The other three centres showed a mixture of positive and negative responses.

11.17.2 Conclusion

The results here show that therapists were more likely not to use Song-Writing when reporting usage in settings, and more likely to not to use it in group-work rather than individual work, although there was some variation between the centres on this question. Reasons for use or non-use related to diagnosis have been discussed in Chapter 10, demonstrating a contrasting picture. For example for anxiety, Centre A says this technique helps to avoid overwhelming feelings of anxiety, and the structure of the technique helps self expression. However for a diagnosis of depression, comments suggested that for people who are depressed, emphasis upon creating something might be too open to self criticism and also demand too much activity and pressure. Furthermore it was suggested it might provide a way of avoiding expression of emotion. Only Centre A uses Song Writing for schizophrenia and no reasons are given although Centre D gives a reason for not using it as the fact that this population are not interested in words and therefore it is not useful. (10.4.8., 10.12.8., 10.16.8). So the only tangible conclusion that can be reached from the data is that the centres suggest Song Writing is more used in individual work than in groups.

11.18 Musical Role-play/Musical Psychodrama/Art & Psychodynamic Movement

The percentages of yes and no responses for this technique are shown descriptively for settings and diagnoses, and also for group and individual work, in the bar chart in Figure 11.17. Raw scores for groups and individuals by settings and diagnoses, together with the percentages, confidence intervals and results from a test of proportions are then reported in Table 11.33 and similar results in a breakdown by centres in Table 11.34.
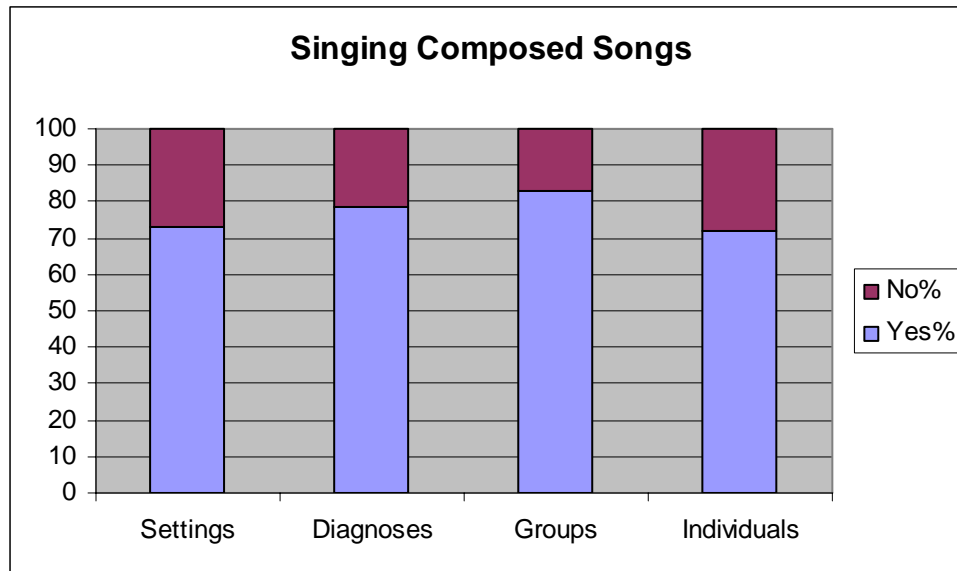
Figure 11.17: Musical Role-Play – bar chart of yes and no percentages

Table 11.33: Musical Role-Play – results for settings, diagnoses, groups and individual work

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	6	20	23%	10%-44%	0.01079
Results for all diagnoses	17	25	40%	26%-57%	Non-sig.
Results for settings and diagnoses combined	23	45	34%	23%-46%	0.01088
Results for all Groups	7	22	24%	11%-44%	0.00933
Results for all Individuals	16	23	41%	26%-58%	Non-sig.

Table 11.34: Musical Role-Play – results for centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A (group)	7	3	70%	35%-92%	Non-sig.
B (group)	0	6	0%	0%-48%	0.04123
C (group)	0	8	0%	0%-40%	0.01333
D (group)	0	5	0%	0%-54%	0.07364 (Non-sig.)
A (indiv)	7	3	70%	35%-92%	Non-sig.
B (indiv)	0	6	0%	0%-48%	0.04123
C (indiv)	1	9	10%	1%-46%	0.02686
D (indiv)	0	5	0%	0%-54%	0.07364 (Non-sig.)
E (indiv)	8	0	100%	60%-100%	0.01333

Tables 11.33 & 11.34 report proportional differences that show there is a lack of use this technique by settings and in group work, and some limited evidence of usage in individual work and by diagnosis.

11.18.1 Summary of significant results

In group work, Centre A tended to use this technique, though not to a significant level. Centres, B, C and D, reported not using this technique. For individual work, there was some discrepancy between the centres. with Centre A tending to use the technique, although not to a significant level, while Centre E reported using it significantly. Centres B, C and D reported not using this technique, although the number for Centre D was too low for it to reach significance.

11.18.2 Conclusion

The technique was used less by settings than by diagnoses, and when considering groups than individuals. The centres showed some variation in their responses. As emerged from the qualitative analysis reported in Chapter 10, only one centre uses this with schizophrenia (Centre E), which emphasises the use of drawing which keeps out invasive thoughts and helps patients listen back to their improvisations, thus adding a layer of meaning more accessible than words. For bi-polar disorders only Centre A uses this and only in individual work, but there is a caution given about

whether role play is helpful if a person is not in touch with reality, even when musical rather than dramatic or verbal techniques are used. For non-psychotic disorders all centres agree that symbolic thought is required for this technique to be helpful for people with eating disorders, while there is division for personality disorders about whether using this is helpful or whether it is too difficult because getting involved in other people's material is too hard. This is actually suggested by Centres A & E as a reason for using it, and similarly for people with depression who can work symbolically and use other media. (10.4.9., 10.12.9., 10.30.9., 10.24.9).

11.19 Receptive Music (live)

The percentages of yes and no responses for this technique are shown descriptively for settings and diagnoses, and also for group and individual work, in the bar chart in Figure 11.18. Raw scores for groups and individuals by settings and diagnoses, together with the percentages, confidence intervals and results from a test of proportions are then reported in Table 11.35 and similar results in a breakdown by centres in Table 11.36.

Figure 11.18: Receptive (Live) – bar chart of yes and no percentages

Table 11.35: Receptive (Live) – results for settings, diagnoses, groups and individual work

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	5	21	19%	7%-40%	0.003264
Results for all diagnoses	19	23	45%	30%-61%	Non-sig.
Results for settings and diagnoses combined	24	44	35%	24%-48%	0.02122
Results for all Groups	7	22	24%	11%-44%	0.00933
Results for all Individuals	17	22	44%	28%-60%	Non-sig.

Table 11.36: Receptive (Live) – results for centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A (group)	3	7	30%	8%-65%	Non-sig.
B (group)	0	6	0%	0%-48%	0.04123
C (group)	4	4	50%	22%-78%	Non-sig.
D (group)	0	5	0%	0%-54%	0.07364 (Non-sig.)
A (indiv)	8	2	80%	44%-96%	Non-sig.
B (indiv)	0	6	0%	0%-48%	0.04123
C (indiv)	5	5	50%	24%-76%	Non-sig.
D (indiv)	1	4	20%	1%-70%	Non-sig.
E (indiv)	3	5	38%	10%-74%	Non-sig.

Tables 11.35 & 11.36 report proportional differences suggesting that this technique is not widely used.

11.19.1 Summary of significant results

When reporting group work. the only significant result was that Centre B does not use the technique, and for Centres A and D the trend was in the same direction. Centre C

showed an even division. Responses regarding individual work found Centre B not using the technique. Results from the other centres are not significant, although Centre A seems to use the technique to some extent.

11.19.2 Conclusion

Live Receptive techniques are clearly not used when considering settings and group-work more than diagnosis and individual work. Three out of five centres use this technique with individuals with schizophrenia for example, but no centres for group work as reported in Chapter 10. The main reason given for this is that when working with people with schizophrenia in a group, this technique might further distance these clients, who might choose music to listen to that is not related to them, whereas improvisation draws them in, when making this type of connection is often hard. Opinion is divided for depression, and Centre E gives a specific reason for not using this with eating disorders because of the difficulty patients often have of 'taking things in'. There was some variation between the centres, with Centre A using the technique to some extent for individual work. The qualitative data supports this from Chapter 10 in the specific comments related to each diagnosis. Themes which emerge are related to whether or not it is the music therapist's role to undertake this type of intervention, and whether or not it is a passive intervention. For example, for people with personality disorders, Centre E says it would not be useful because this group need to feel part of things. Yet, Centre A implies that this technique would involve patients as performers themselves and therefore it is not just a passive technique and could be useful for adding meaning and developing confidence. The mainly interesting finding is that both Centres which answered for anxiety agree it is useful because it can be applied as a soothing 'lullaby' type intervention. (10.16.10).

11.20 Receptive (Recorded)

The percentages of yes and no responses for this technique are shown descriptively for settings and diagnoses, and also for group and individual work, in the bar chart in Figure 11.19. Raw scores for groups and individuals by settings and diagnoses, together with the percentages, confidence intervals and results from a test of

proportions are then reported in Table 11.37 and similar results in a breakdown by centres in Table 11.38.
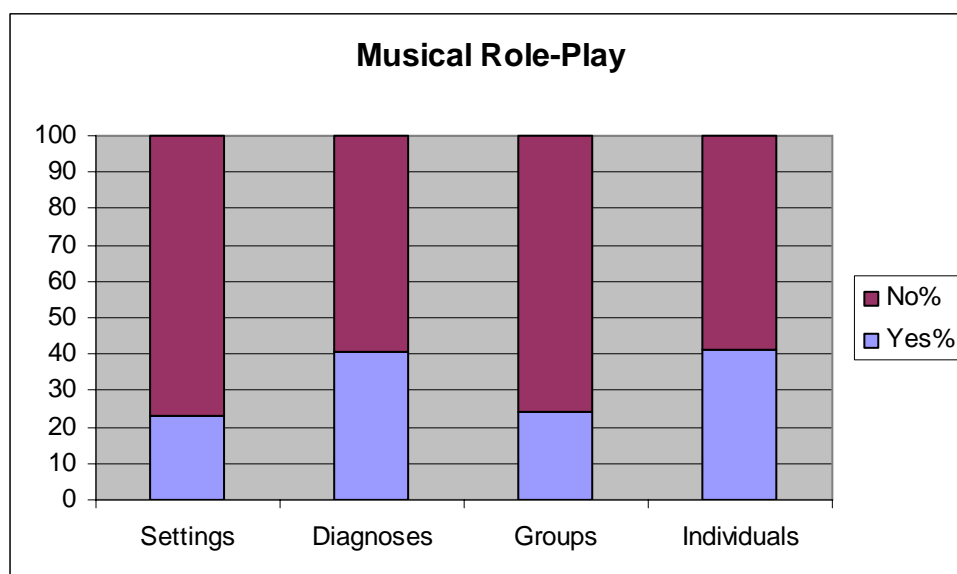

Figure 11.19: Receptive (Recorded) – bar chart of yes and no percentages

Table 11.37: Receptive (Recorded) – results for settings, diagnoses, groups and individual work

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	9	17	35%	18%-56%	Non-sig.
Results for all diagnoses	10	32	24%	13%-40%	0.001194
Results for settings and diagnoses combined	19	49	28%	18%-40%	0.0004368
Results for all Groups	5	24	17%	7%-36%	0.0008302
Results for all Individuals	14	25	36%	22%-53%	Non-sig.

Table 11.38: Receptive (Recorded) – results for centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A (group)	3	7	30%	8%-65%	Non-sig.
B (group)	0	6	0%	0%-48%	0.04123
C (group)	4	4	50%	22%-78%	Non-sig.
D (group)	0	5	0%	0%-54%	0.07364 (Non-sig.)
A (indiv)	1	9	10%	1%-46%	0.02686
B (indiv)	2	4	33%	6%-76%	Non-sig.
C (indiv)	1	9	10%	1%-46%	0.02686
D (indiv)	2	3	40%	7%-83%	Non-sig.
E (indiv)	8	0	100%	60%-100%	0.01333

Tables 11.37 & 11.38 report proportional differences suggesting that this technique is more applied specifically within diagnoses than settings, and for groups more than for individuals.

11.20.1 Summary of significant results

In the report on usage within groups, the only significant result is Centre B non-usage of this technique within different clinical groups. In individual work, Centres A and C do not use this technique, while Centre E reports significant use of recorded music.

11.20.2 Conclusion

The use of recorded music as a receptive technique is not widely used, although there is some differences between the centres, with Centre E using it more for individual work. Qualitative data from Chapter 10 supported this conclusion where, for example, Centre E gave examples of usage with for anxiety, where it is useful in encouraging movement, for personality disorders as part of an aid to exploring their life story, and for depression as it might help 'get out of a dark cave'. Other centres do not use this often, and it is hardly used for people with schizophrenia (only by Centre A in individual work only). It is used by only Centre A with individuals, and with no clear reasons given. Data is very sparse, and one reason given as to why it is not used is that it is more of an OT or Nurse role to carry out such techniques. Other centres state that it is not their theoretical orientation. (10.12.10., 10.16.11., 10.24.11).

11.21 GIM

The percentages of yes and no responses for this technique are shown descriptively for settings and diagnoses, and also for group and individual work, in the bar chart in Figure 11.20. Raw scores for groups and individuals by settings and diagnoses, together with the percentages, confidence intervals and results from a test of proportions are then reported in Table 11.39 and similar results in a breakdown by centres in Table 11.40.
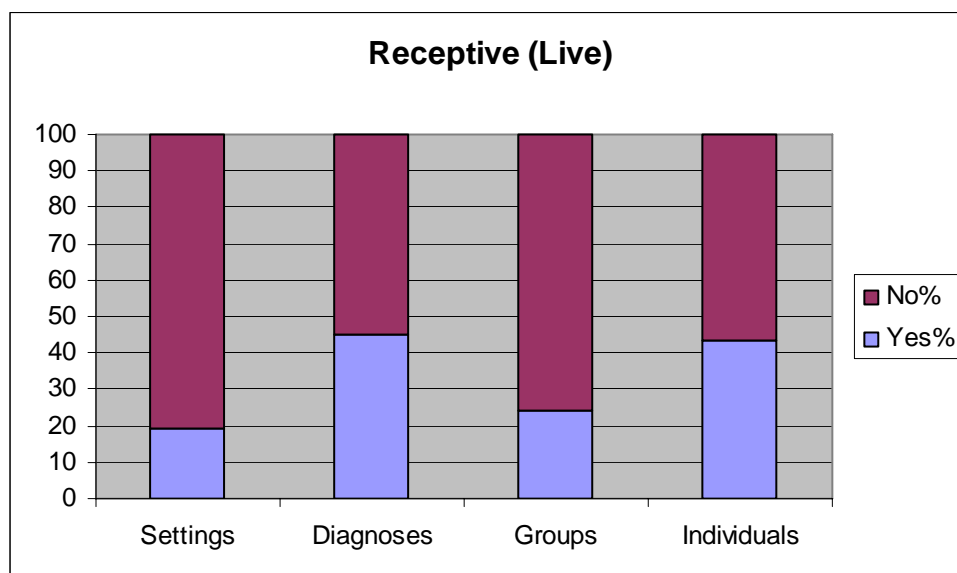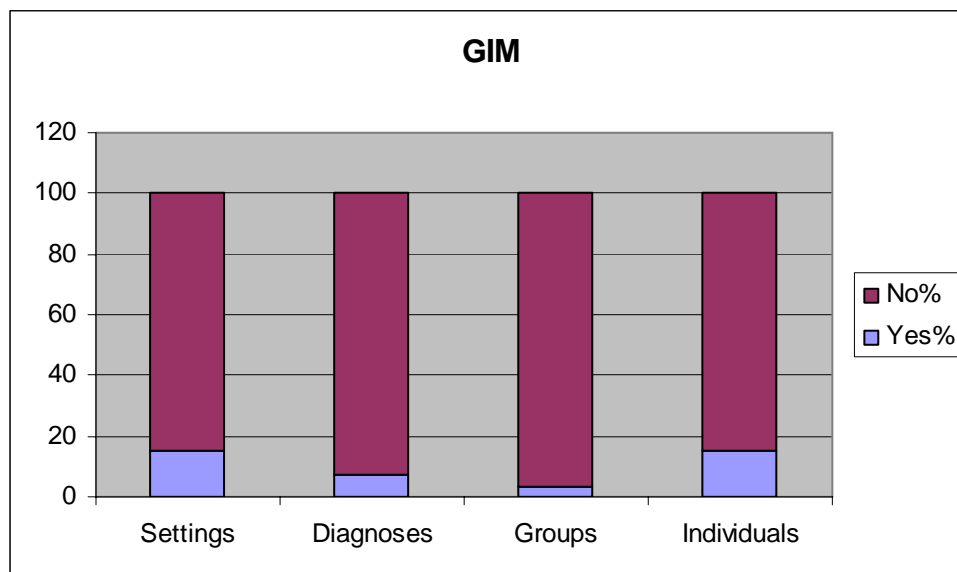

Figure 11.20: GIM – bar chart of yes and no percentages

Table 11.39: GIM – results for settings, diagnoses, groups and individual work

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	4	22	15%	5%-36%	0.0008561
Results for all diagnoses	3	39	7%	2%-21%	<0.00001
Results for settings and diagnoses combined	7	61	10%	5%-21%	<0.00001
Results for all Groups	1	28	3%	0%-20%	<0.00001
Results for all Individuals	6	33	15%	6%-31%	<0.00001

Table 11.40: GIM – results for centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A (group)	0	10	0%	0%-34%	0.004427
B (group)	0	6	0%	0%-48%	0.04123
C (group)	0	8	0%	0%-40%	0.01333
D (group)	2	3	40%	7%-83%	Non-sig.
A (indiv)	0	10	0%	0%-34%	0.004427
B (indiv)	0	6	0%	0%-48%	0.04123
C (indiv)	2	8	20%	4%-56%	Non-sig.
D (indiv)	0	5	0%	0%-54%	0.07364 (Non-sig.)
E (indiv)	4	4	50%	22%-78%	Non-sig.

Tables 11.39 & 11.40 report proportional differences suggesting that this technique is not used within the five centres.

11.21.1 Summary of significant results

There is almost unanimous agreement that this technique is not used in the five centres, with the exception of Centre D being split. Centre E also reported some usage of GIM in specific circumstances.

11.21.2 Conclusion

The overall finding is that the Centres in the study do not use this technique, apart from Centre E, which suggests that the only GIM trained therapist is based there. In relation to diagnosis, the qualitative data in Chapter 10 is unanimous that GIM is not used for bi-polar and schizophrenia mainly owing to lack of understanding and training in the technique, but also Centre E offers an explanation that people with Schizophrenia cannot listen in a lying down position and '*cannot contain a longer piece of music or challenging music.*' (10.4.12., 10.8.12).

There are also statements that people with anxiety would find it hard to listen, and for personality disorders there is more discussion about whether listening, which means losing control, would be helpful or not. There is some evident scepticism (and it is unclear whether this is informed by the literature, as it cannot be informed by experience), as to whether people who are severely ill in any of the diagnostic categories would benefit from such an in depth experience involving imagery. This point is further discussed in Chapter 12.

11.22 Music for Relaxation:

The percentages of yes and no responses for this technique are shown descriptively for settings and diagnoses, and also for group and individual work, in the bar chart in Figure 11.21. Raw scores for groups and individuals by settings and diagnoses, together with the percentages, confidence intervals and results from a test of proportions are then reported in Table 11.41 and similar results in a breakdown by centres in Table 11.42.
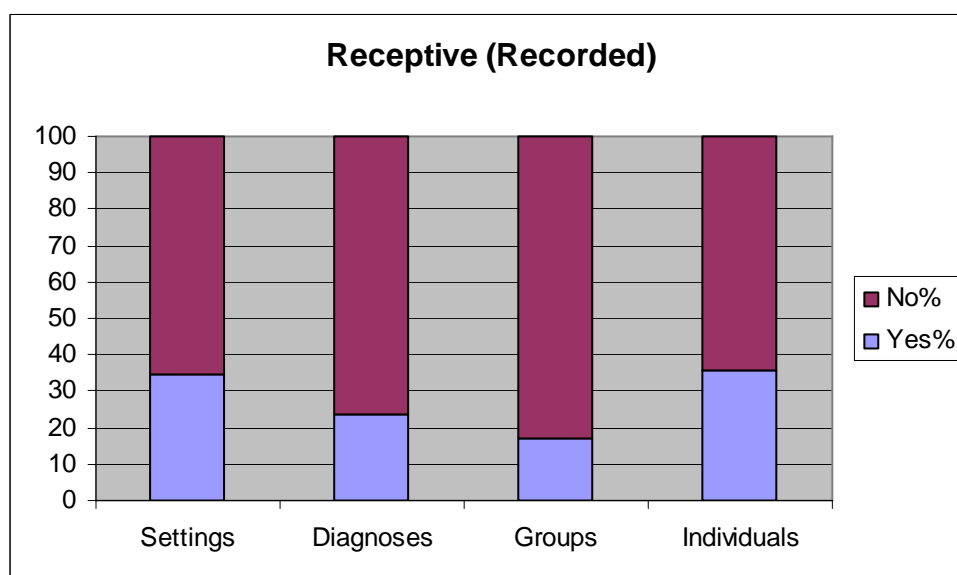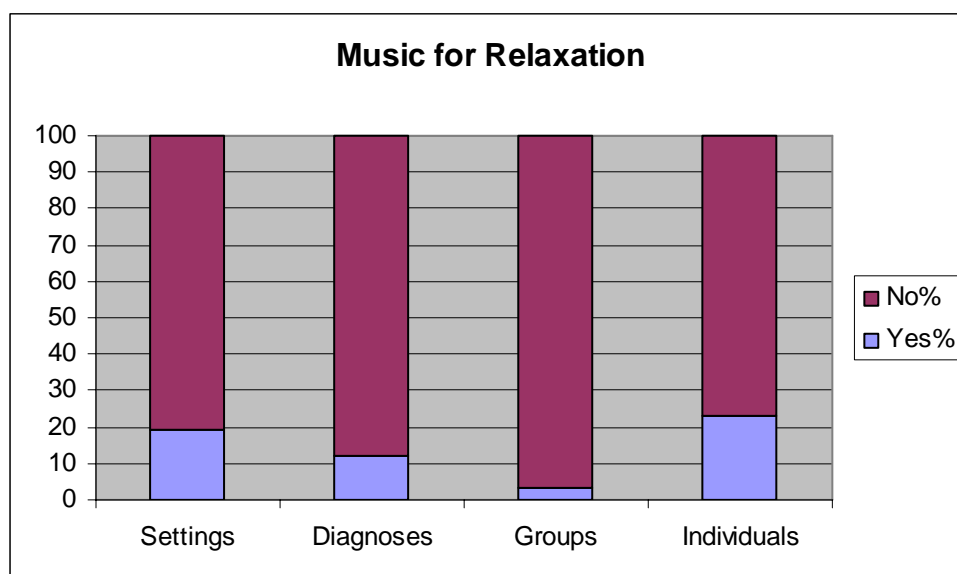
Figure 11.21: Music for Relaxation – bar chart of yes and no percentages

Table 11.41: Music for Relaxation – results for settings, diagnoses, groups and individual work

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
Results for all settings	5	21	19%	7%-40%	0.003264
Results for all diagnoses	5	37	12%	4%-26%	< .00001
Results for settings and diagnoses combined	10	58	15%	7%-26%	< .00001
Results for all Groups	1	28	3%	0%-20%	< .00001
Results for all Individuals	9	30	23%	12%-40%	0.001362

Table 11.42: Music for Relaxation – results for centres

Centres	Yes (raw scores	No (raw scores)	Proportion of Yes scores	Confidence intervals of the proportion	p-value
A (group)	0	10	0%	0%-34%	0.004427
B (group)	0	6	0%	0%-48%	0.04123
C (group)	0	8	0%	0%-40%	0.01333
D (group)	1	4	20%	1%-70%	Non-sig.
A (indiv)	0	10	0%	0%-34%	0.004427
B (indiv)	0	6	0%	0%-48%	0.04123
C (indiv)	0	10	0%	0%-34%	0.004427
D (indiv)	1	4	20%	1%-70%	Non-sig.
E (indiv)	8	0	100%	60%-100%	0.01333

Tables 11.41 & 11.42 report proportional differences suggesting that this technique is not used within the five centres.

11.22.1 Summary of significant results

All centres reported not using this technique; apart from Centre E where it is used a subsidiary technique; either in group or individual work

11.22.2 Conclusion

Chapter 10 has discussed the qualitative data which supports these findings and gives reasons, mainly summarised as follows. Only one centre uses this for schizophrenia (Centre E) but this is not as a main technique, but serves as part of the session at the end, and this is exactly the same outcome for depression and for eating disorders. For the latter, Centre C writes that people with eating disorders '*cannot bear to relax*'. Otherwise no details are given that provide any substantial rationale for using or not using the technique apart from that it is not the role of a music therapist to do this, but a Nursing or OT role.

11.23 Summary

The data examined in this chapter shows the complex nature of looking statistically at the results, and reveals some problems of doing this with such a small sample. One aim in this chapter was to see if there were trends that could be determined across all the respondents from the five centres and categories for approaches and techniques in their own right (not linked to diagnosis). This is why all data were cumulated and statistically analysed, to collect enough data points overall to see if there were some overall characteristics. From this, the following conclusions can be reached in terms of how much centres in the study use, or do not use, the techniques and approaches chosen for this study in adult mental health settings. Three categories emerge as follows:

11.23.1 Approaches and techniques with high levels of agreement about use, across centres

The techniques of Free Improvisation with minimal talking, Free Improvisation with talking/interpretation, and Composed Songs are all highly used with agreement across centres. There are reasons given in the qualitative data in Chapter 10 which support this finding, and it can be concluded that improvisation holds a central focus for adults with mental health problems, with opinion divided about whether talking has a primary focus. Further reasons and conclusions are discussed in Chapter 12.4, 12.5 & 12.6.

The approaches of Supportive Psychotherapy & Psychoanalytically Informed Music Therapy are agreed as highly useful in the accumulated data, and these findings are supported by the qualitative data in different ways, which will be discussed in 12.6.2.

11.23.2 Approaches and techniques with mixed levels of agreement about use across centres

A Theme based - music therapy approach emerges as highly significant in terms of diagnosis, which will be discussed further in 12.4 (for example it is used for non-psychotic disorders), but there are mixed results about usage in general. There is no clear outcome in favour of either using or not using Free improvisation with structure, and Activity based techniques (which also use structures and also fall into this section

of mixed opinion). In general centres either use or do not use this technique, with definite reasons for either, which are discussed more fully in section 12.6.3. Song Writing is not commonly used in group work (11.17), but used more in individual work and this point is discussed further in 12.6.3.

Receptive techniques using live music are neither significantly used or not used, however the results are interesting as they reflect a particular approach to treating people with anxiety. This was the only diagnostic section to fully consider receptive music therapy. Receptive Recorded music techniques are also neither significantly used or not used, and are not used much at all in the diagnostic response sections, a point which will be discussed more fully in 12.6.3.

11.23.3 Approaches and Techniques with high levels of agreement of lack of use

Techniques using GIM and Relaxation are seldom used, a point which is discussed more fully in 12.5.2 and 12.6.3. There appears to be only one centre, Centre E, which employs music therapists trained in GIM.

Approaches such as Activity orientated, Analytical, Creative Music Therapy, Behavioural, Developmental, and Client- Centred are also rarely used, and it is difficult to conclude whether this is because of clinical considerations, or due to a lack of training in these approaches. Further points regarding this phenomenon will be discussed in 12.6.4. The Developmental approach has received little attention throughout the survey, and little information was given by the Centres.(see 11.5).

From the analysis of qualitative data in Chapter 10 it is clear that centres did not have music therapists trained in a true Client -Centred approach, as defined in the guidelines for the survey, apart from in Centre E, a point which will be discussed further in 12.6.4. Similarly a Creative Music Therapy approach is mainly used by Centre B which appears to be the only centre with music therapists trained in this approach. (10.3.8, 10.7.8). This point will be discussed further in 12.6.4 &12.7.3.

There is unanimous agreement among centres that a Behavioural approach is not used owing to respondents mainly referring to the respondents perception of this approach

as rigid, with a lack of consideration of the patient therapist relationship, and a lack of focus on meaning (10.3.4., 10.7.4).

In terms of an Analytical Approach, most centres seem to understand this as the Priestley (1994) approach and there appeared to be little training in this approach by the majority of respondents. The centres clearly reported that for most people with serious mental health problems adapted Analytical approaches using a Supportive Psychotherapy or a Psychoanalytically Informed approach are preferable because there is more flexibility. This will be discussed in further in 12.4 &12.6.4.

11.24 Conclusion

The techniques Free Improvisation with minimal talking, Free Improvisation with talking/interpretation, and Composed Songs, and the approaches of Supportive Psychotherapy & Psychoanalytically Informed Music Therapy are found to be significantly used across all centres, diagnoses and settings. Techniques of GIM and Relaxation are significantly not used, and the approaches Activity orientated, Analytical, Creative Music Therapy, Behavioural, Developmental, and Client-Centred are also significantly not used. Other techniques and approaches show a mixed level of agreement on usage. Reasons for this and further conclusions relating to existing literature and wider music therapy clinical practice will now be discussed in Chapter 12.

CHAPTER 12
DISCUSSION AND CONCLUSION

12.1 Introduction

This chapter will discuss the results of the survey from the point of view of the main research question relating to diagnosis. It will also relate these conclusions to the wider field of music therapy, and to the literature presented in Part I, Chapter 8 and literature published more recently. A shorter discussion and conclusion section will examine what can be learned about technique and approach from the study in general in the field of adult psychiatry. The different approaches and techniques for the diagnoses and comparative summaries which draw on the data from both Chapter 10 and 11 will be discussed.

First, the main findings are summarised, and after each finding there is a section reflecting on the implications. The applicability to clinical work and discussion about the outcomes are incorporated, rather than set out in separate sections, in order to avoid repetition. These aspects will be considered within an overview of the Main Findings (12.3) followed by specific clinical and diagnostic implications (12.4 & 12.5), and a discussion about implications for techniques and approaches for clinical services for adults with mental health problems. (12.6). The latter section will include a discussion about problems of defining music therapy (12.7), followed by a discussion about limitations of the method (12.8), further implications for education and Training (12.9) and Future Research implications (12.10). The final section (12.10.4) summarises what has been learned and how this new knowledge might contribute to the music therapy and health fields in the future.

Wherever relevant and possible, findings from this study are contextualised to previous literature, including any previous research studies, clinical reports or theoretical texts. This is a normal expectation and aspiration of any research study, in order to demonstrate its link in the chain of knowledge that is under a continuous process of development. However it is perhaps important to state at this stage that there is a clear paucity of both previous research and clinical or theoretical documentation that links music therapy approaches or techniques used to specific diagnoses. This has already been noted previously, but could be highlighted here as a

limitation of this study that such connections to previous findings were difficult to establish for some diagnostic categories.

12.2 Main findings

The main findings of the study fall into two categories. Those which relate directly to patterns of techniques and approaches linked to diagnosis, and those which demonstrate knowledge about patterns of service provision, priorities given to different diagnoses in the services, and what this might tell us about general trends.

Whilst it is important to be cautious about drawing any firm conclusions from data collected from a sample of only five centres, it should be emphasised that the total number of music therapists who contributed to the survey was twenty-three. These music therapists, many of whom are leaders of the field in their own countries, have experience spanning thirty years, and backgrounds in at least twelve different music therapy training courses in the world. Therefore the results can be considered seriously, and general patterns and trends in practise identified, which will contribute to knowledge in the field.

12.3 Summary of main findings

12.3.1: Finding 1: There were differences between the centres as to the level of detail they provided to support decisions they made, make linking approaches and techniques to diagnosis.

a) **Music Therapy Centres in the study variably defined what they do and why they do it linked to diagnosis.**

b) **In some cases this was substantiated very thoroughly, with case examples and clear reasoning.**

c) **In other centres this was not substantiated thoroughly, with sparse and limited reasons given for using chosen approaches and techniques.**

Reflections

It is useful here to re state the main question of the study, which is :

'How can different techniques and approaches of music therapy be defined in adult psychiatry, for people from 18-65 years old, which link diagnosis to treatment, by comparing what is described about current practice in the literature, with the results of an in-depth survey from a small sample?'

A straight answer to this would be 'with varying degrees of difficulty'. The motivation for this study was to see how music therapists could define not only their approaches and techniques and relate them to diagnosis, but also to see how they demonstrated understanding of existing approaches and techniques which are used in the literature. This is why each technique and approach was not defined exactly by the researcher, so that it would be possible to see if there are common patterns of understanding for these categories and terms. Those who thought in depth about diagnosis, and related technique and approach to this often defined or invented their own approaches (or referred to existing ones they had already invented). Sometimes these related to diagnosis or patients' needs, and usually to adaptations of existing approaches or theoretical orientation, for example Supportive Psychoanalytically Informed Music Therapy (SPIMT) and Exploratory Psychoanalytically Informed Music Therapy (EPIMT) defined in 10.3.2. & 1.5. These points are discussed in more depth in 12.6 & 12.7.

12.3.2 Finding 2: Music Therapy approaches with a Supportive Psychotherapy approach or a Psychoanalytically Informed approach were used most often, and ranked first or second in every diagnostic category.

Reflection

This appears to relate to both the training and orientation of the respondents, but also to considered reasons as to why psychoanalytic theory is useful, and why a supportive approach is necessary. This was particularly discussed in 10.3.2 where for schizophrenia, it is stressed by more than one centre that working with the therapists' counter-transference is crucial because it allows the therapist to use this to gauge the best way of building a good rapport with the patient. All results show that for severely

mentally ill adults a supportive approach and particularly the building of a rapport with the patient is important.

There is agreement between centres that behavioural approaches are not a priority for any of the diagnostic groups, but that an approach drawing upon psychodynamic ideas and in some cases psychoanalytic processes is essential. Reasons given emphasise the importance of working with the unconscious processes that arise from severe disturbance, and there tends to be an emphasis upon a more supportive approach, which might be expected as all centres work with the most severely ill adults. This finding also reflects the training backgrounds of the music therapists in the centres. Detailed reasons and further considerations are discussed under the diagnostic sections, including the finding that GIM, Receptive techniques (apart from for anxiety), and Activity-Based techniques and approaches are reported as not commonly used (11.15, 11.19 & 11.20). However, there is a mixed picture and the study often reflects polarities where there is disagreement, for example in Song Writing there is very mixed agreement and disagreement about its use. (11.17).

12.3.3 Finding 3: The Techniques Free Improvisation with minimal talking and Free Improvisation with talking/verbal interpretation are ranked highest for all diagnoses, but with some additional differences between psychotic disorders and non-psychotic disorders.

Reflections

It appears that the five centres used improvisation as their main technique in music therapy, and this appeared to be related to previous training as well as sometimes also related to informed decisions about technique linked to diagnosis and patient need. Some centres explained the importance of the use of free improvisation with and without talking (10.4.2) and this related to the importance of the non-verbal qualities of musical improvisation and the potential for encouraging spontaneous interaction, as described in 10.4.2 for people with schizophrenia. At other times justifying the use of improvisation was not included, but taken 'for granted', as described in the next finding there was a difference in use of technique between psychotic and non-psychotic disorders.

12.3.4 Finding 4: For psychotic disorders, using Composed Songs is ranked joint first with either Free Improvisation with Minimal Talking, or Free Improvisation with Talking/Interpretation, for both Schizophrenia and Bi-polar disorders, and there is less emphasis upon using techniques requiring symbolic thinking.

Reflections

This finding is supported by Wheeler (1987) in her research into levels of music therapy, discussed in 7.2 & 8.4, which definitely suggests a more active approach is needed for people with schizophrenia. However in this study there is also equal emphasis upon the importance of working with the therapist and patient relationship through transference and counter-transference as discussed previously (10.3.2). Metzner (2003) makes some comments about the limitations of using composed music if the patient is psychotic and might not be able to use the space to symbolise anything from the music, but this it seems refers to listening to music rather than interacting through Composed Songs. Dunbar (2001) discussed in 8.6, found in her study that free improvisation was most used in adult metal health settings but also with structures and variation (semi-improvised). Composed songs used in an improvisatory context could be described as semi-improvised as some of the case studies show in Chapter 10 (10.4.7) where singing is likened to an 'anti-depressant', and is also described as part of an improvisation.

This was however one of the more surprising findings owing to the improvisation culture that prevailed in all five centres, and will be discussed further in 12.7.3 where it is clear that this is a technique that is part of an Activity or Task orientated approach, and also of a Community Music Therapy approach.

12.3.5 Finding 5: For non-psychotic disorders, techniques that require more symbolic thinking such as Theme based Improvisation, Musical Role Play and use of other media, as well as Free Improvisation using structures such as play rules are ranked jointly first, or near the top of ranking orders for the diagnoses of anxiety, depression, eating disorders, and personality disorders.

Reflections

This finding, although sometimes resulting from small numbers of responses (as in the case of anxiety and depression), confirms an agreed awareness of the characteristics and symptoms likely to be present in some of these disorders, and a recognition of their foundation, also supported in the music therapy literature. Robarts and Sloboda (1994) discuss role play, Smeijsters (1996) describes a range of more symbolic possibilities for people with eating disorders (section 8.3.3) and Smeijsters (1995) in section 8.5.3 also discusses the importance of reflection on past experiences. The roots of some of these disorders arise from early trauma and difficulty, and literature in the psychological therapies supports working through meaning and understanding how to deal with present roles and emotions in the light of reflecting about this through role play, reciprocal roles (Ryle et al 1997), and 'Mentalisation' [1] (Bateman and Fonagy 2004). The latter which was referred to by three centres and there is an emerging interest in this approach in the field of music therapy. European training courses do not appear to recognise that there might be a distinction in desired technique and approach for some diagnoses in particular and this point is taken up further in 12.9.

The next three findings are related and therefore difficult to reflect upon individually, so will be listed and then reflected upon jointly.

12.3.6 Finding 6: Schizophrenia and personality disorder diagnoses are given the highest percentage of music therapy treatment input across all centres.

12.3.7 Finding 7: Personality disorder receives the most attention from music therapy centres in the study, concluded both from the amount of qualitative data collected and the fact that in three out of five centres personality disorders are a major percentage of case load, from 25% ~ 50%.

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[1] 'Mentalization, the capacity to think about mental states as separate from, yet potentially causing actions, is assumed by us to arise as part of an integration of the pretend and psychic equivalent modes of functioning. This happens optimally in the context of a playful parent-child relationship. In such a relationship feelings and thoughts, wishes and beliefs can be experienced by the child as significant and respected on the one hand, but on the other as not being of the same order as physical reality' (Bateman and Fonagy 2004, p.70-71.

12.3.8 Finding 8: Psychotic disorders, incorporating bi-polar disorders and schizophrenia, emerged as a priority group in all centres.

Reflection

This high percentage of service in- put for psychotic disorders is commented upon below in 12.3.9 where the results found that anxiety and depression receive the least attention. The high percentage of treatment input for schizophrenia and personality disorders is reflected in the qualitative data collection, although surprisingly the responses related to personality disorders were the highest in volume, with those for schizophrenia the second highest. This is not representative of the music therapy literature which is sparse in the field of personality disorder and music therapy, but large for schizophrenia (see also discussion below 12.3.9). The fact that people with personality disorders are an emerging priority in many countries accounts for the attention given by the respondents, but not in the literature prior to this study. These points are reflected upon further in sections 12.4 - 12.5.

12.3.9 Finding 9: Anxiety and depression receive the least attention from music therapy centres in the study, concluded both from the amount of qualitative data collected and the fact that in some cases only two out of five centres said they saw people with this diagnosis as their main diagnosis.

Reflections

This is supported in the music therapy literature which concentrates on music therapy treatment with other groups such as schizophrenia. Odell-Miller at al (2006) identified people with schizophrenia as the largest referral group to the arts therapies department in the UK, and the disparity in the amount of literature available for anxiety and depression is also reflected in Chapter 8 by the paucity of music therapy literature for anxiety and depression. Music Therapy treatment for anxiety and depression is discussed in the literature for more medically related diagnoses of anxiety and depression, rather than in its presentation as a long term severe mental illness (Kenny and Faunce 2004, Schmid and Aldridge 2004). Conclusions from this are speculative, but certainly in the UK the priority given to psychotic disorders over anxiety and depression has arisen owing to music therapists intentionally focussing upon areas where other psychological therapies have not been so prevalent. This author does not

interpret the result as an indication that music therapy is less beneficial for people with anxiety and depression, but that firstly psychological therapies are more evidenced in this field, (such as Cognitive Behaviour Therapy), and secondly music therapy has something unique to offer people with psychotic disorders, particularly schizophrenia, in the non-verbal area, because of the qualities of music itself.

12.3.10 Finding 10: Respondents were often unable to link their yes and no answers with specific reasons as to why they did or did not use a particular technique or approach, and this was often related to lack of training in some cases.

Reflections

The positive side to this is that some respondents reported a rigorous training, and frequently stated that they do what they do because that is how they were trained. There is evidence of a robust approach, but also an awareness that one approach might not suit all diagnoses or patient needs. These respondents frequently said that if they did have a different training they considered a particular approach or technique would be useful from their clinical knowledge and sometimes their knowledge of literature. Others sometimes stated that they did not have a training in a particular approach or technique, without discussing whether it might be suitable for that diagnosis, leading the researcher to assume there were no further thoughts to be discussed. Considerations about the implications of the study for education and training are discussed in 12.9.

12.3.11 Finding 11: Music therapists' descriptions of method using case studies as examples (whether or not linked to specific diagnoses), often appeared similar across centres, but were defined and categorised under different approach titles.

Reflections

Case study descriptions given under various different titles such as Psychoanalytically Informed, Psychoanalytically Informed Music –Centred, Exploratory Psychoanalytically Informed and Supportive Psychoanalytically Informed often appeared similar in description and sometimes also in the approach to thinking about the material.

In some cases titles had been defined be centres with much thought and attention to detail. This reflects an emerging profession with experienced pioneers who, rather than being taught an existing profession or 'craft', see themselves as inventing it. The problem with this is that it can have the effect of 'reinventing the wheel', where therapists redefine an approach, with a new title, of something that already exists or is very similar. It also reflects the particular problems of understanding exactly what music therapists do, and which approach is taken, without seeing and hearing it actually happen. There appear to be far more resources available involving videos and audio publications of music therapy with children, than for adults mental health populations. (Oldfield 2004). Adults are far more cautious about consenting to being filmed or recorded. In addition to this is the problem of the availability of music therapy publications, and it appears from the study that many respondents were unaware of some of the literature in their field both in their own country and outside it.

Further considerations will be discussed about approach and technique and the problems of meaning, definition, and nomenclature, in 12.6.3 & 12.7.3.

12.4 Discussion of diagnoses related to approach and technique

12.4.1 Introduction

This study has generated new knowledge regarding music therapy clinical method, through exploring the relationship between approach and technique, and diagnosis. The next section systematically reviews the outcomes from both the qualitative and quantitative analysis within these contexts in relation to what already exists in the literature. It provides a more comparative look at the uses of approaches and techniques and their links (or not) to diagnosis. While the survey provided extensive data, it is not intended to study each defined approach or technique in detail, but rather provide an overview, an encyclopaedic view of the outcomes, in order to stay within the limits of this study.

The discussion will now systematically draw conclusions for each diagnostic group with comparisons across diagnoses where possible, and also reach conclusions about

the use of techniques and approaches. The depth of discussion varies according to the amount of data and literature available, and is informed by the author's clinical specialities in schizophrenia and personality disorders and lengthy experience in the field of adult psychiatry.

Owing to the amount of material and the fact that the study encompasses six diagnostic categories, a full discussion about the findings in relation to the wealth of knowledge and research available in the specialist field of psychiatry and psychotherapy relating to these diagnoses is beyond the scope of the study. However some conclusions about broad contributions to the wider field will be drawn.

12.4.2 Clinical implications: Findings for psychotic disorders

The main conclusions for schizophrenia and bi-polar disorders have been summarised in sections 10.5 & 10.9. Some services stated that schizophrenia and bi-polar disorders are not considered separately, and it is therefore difficult to separate out the distinct approaches and techniques for each diagnosis. The data for schizophrenia is much greater than for bi-polar disorders, but sometimes psychotic disorders are referred to in the same paragraph or sentence as schizophrenia, and so it might be the case that some data for bi-polar disorders is hidden within the responses for schizophrenia.

From the data and the comments there is agreement that people with schizophrenia need a music therapy approach which is 'supportive'. Opinion is divided equally between those who think that a Supportive Psychotherapy approach to music therapy is best, and those who think such an approach is not adequate, and that a more interpretative Psychoanalytically Informed approach should be followed.

A Behavioural approach to music therapy with schizophrenia is not indicated as it is considered too directive and there is almost unanimous agreement that Analytical Music Therapy, Activity-Based and Guided Imagery (GIM) models are not used, and some agreement about reasons. In considering the reported use of different techniques, there is agreement that Free Improvisation with minimal talking (FI) is useful. Free Improvisation and Talking/Interpretation is also a strongly indicated

technique by the Centres in the study, because it allows the strong components of music to help the person with schizophrenia connect, and includes thinking and verbal processing which can then become a possibility as a result of improvisation. The use of Composed Songs is the highest agreed category for this diagnosis, and this is supported by some research evidence in the literature (Silverman 2003), but it is not substantial.

12.4.3 Links to recent research: Schizophrenia

The particular emphasis upon musical importance for this diagnostic group is supported by all the four studies in the recent Cochrane review (Gold et al 2005) and also the importance of the use of song which is particularly emphasised in three out of the four studies that were included in the Cochrane Review (2006) (Tang 1994, Maratos 2004, Ulrich 2004). [2]   Prior to this, Pavlicevic et al (1994) had indicated in their study that patients' ability to be involved in shared musical improvisations improved over time and that a focus on purely musical interactions revealed information about communication and listening.

De Backer (2005) has shown in his research that carefully attuned listening and working with transference and counter-transference phenomenon is imperative in working with people with schizophrenia but that this takes place at a sensorial level, rather than verbal. So the therapist is aware of her counter-transference and using it, but not necessarily making verbal interpretations. This viewpoint is also supported in case work and literature previously described in Chapter 8, such as Jensen, (1999), Pedersen, (1999) and John (1992) all of whom place importance upon the use of listening to the unconscious, or working in the transference or counter-transference allowing the particular qualities of musical improvisation which can contribute something non-verbal, to be activated and to provide meaning.

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[2] Maratos (2004) and Ulrich (2004) studies are not included in the literature review as they were published after the review was completed. However the Cochrane Review is an essential international resource and therefore later publications have been included.

12.4.4 Clinical experience linked to findings: Schizophrenia

One of the outcomes during the preparation for the study was that this researcher compared and contrasted her ideas about approach and technique between two different diagnostic groups in which she has extensive clinical experience, schizophrenia and personality disorders. These ideas are presented below, and will be part of future publications. They were influenced by the setting up of this study and it is interesting to see how these reflections are supported or not by the outcomes in the diagnostic qualitative sections. The assumption here is that if more than one experienced music therapist articulates similar points in terms of approach and outcome relating to diagnosis, then this is important in developing future knowledge and guidelines for work in this field.

Many people with personality disorders, particularly borderline personality disorders have been abused emotionally and/or physically. The researcher has found that the way this population with complex needs use music is very different to the way people with more psychotic-based disorders such as schizophrenia, use music.

The study reveals that the participants do consider what they do differently owing to the needs of these differing diagnostic groups. For example, with psychotic disorders, there is an emphasis upon free improvisation with a supportive approach that considers both the relationship with the therapist and the musical interactions, rather than techniques and approaches that require symbolic thought (10.5 & 10.9).

This supports the researcher's view that in a long term music therapy group for people with schizophrenia, run in a day care setting, patients would regularly use music without question-the instruments would be set up in the room, there would be no particular boundaries sometimes between the start and finish of talking and the start and finishing of improvisations.

In the author's clinical experience, and as taught in post -graduate training Odell-Miller 2004), playing music would not seem 'measured' and would often be at one volume level and intensity, without rhythmic variation, and often a-rhythmic. People would arrive for a therapy session, and be keen to start playing music. Music became

another way of relating, a way of communicating that enabled more of a relationship to be set up, and gave more of a sense of connectedness between members and the therapist. Many people with schizophrenia find that making connections with other people is difficult, particularly in social situations. Beginnings and endings of music were often blurred, and these group phenomena were further described in detail in Part I of the thesis (Odell-Miller 2002) Some of these boundary issues, or lack of awareness of boundaries, would be the focus of the clinical work. The discussion of the internal and external aspects of the music therapy group enabled connections to be made between what happened during an improvisation, and after an improvisation. This sometimes helped to represent or clarify the difference between reality and fantasy. Many people with schizophrenia have problems with orientation in time and space, hence time boundaries of improvisations and moving between music and talking are useful tools.

The study definitely supports this view, as shown in section 10.4.2 where there is agreement by Centre B & D that people with schizophrenia use music as an alternative language and generally prefer to play music than talk and definitely than to verbally reflect. Only Centre E suggests that this population also find playing music hard, but qualifies the statement by saying that particular people who have been unable to use words, have been able to use music instead.

In Chapter 8 Wheeler's research is discussed in terms of the differentiation in the practice of music therapy at three defined levels. Activity therapy is not concerned with why behaviours occur, but more with a here and now task orientated non-reflective approach. This seems to be very much what the process of Composed Song would involve. Wheeler(1983) had already found that this 'first' level of music therapy is likely to be more appropriate for the most seriously ill patients with the most severe personality disorganization. She lists chronic schizophrenia here but also mentions in general any patients who require long term community treatment. Smeijsters (1996) also showed that Activity based therapy is indicated for schizophrenia, and interestingly does not list schizophrenia under his category of Re-constructive music psychotherapy, where symbolic thinking is used, but does list non-psychotic disorders for the latter approach. Therefore, importantly the results in this study confirm his earlier findings as far as is possible to determine because Smeijsters

(1996) study was broader and involved less detailed systematic data gathering from participants.

This researcher's thoughts about the use of musical structures, drawing upon clinical experience in a music therapy group with people with schizophrenia, is further discussed in the light of the findings following the study. The use of improvisation, sometimes with structures suggested by the therapist, is very useful for people with schizophrenia. It is particularly evident that often people with schizophrenia use music to access their emotional world that is frequently inaccessible, but that this is not intentional and happens 'by the way', sometimes leading to insight but often remaining at a here and now level of action and connection. For this reason, role-play, symbolic-based and insight-orientated work is not usually a useful starting point for people with this level of psychotic thought disorder and often strong defence mechanisms when not psychotic. These mechanisms act to defend against frightening psychotic experiences. So free improvisation is useful but must be worked with sensitively and musically by the therapist. The playing 'as if 'phenomena must not be pushed or expected. It seems for this group that the therapy happens by literally improvising in a way with others who seem to accept and understand the music even if it appears inflexible, rigid, 'perseverative' or repetitive.

The stages of musical and personal development might be slow for people with long term problems of schizophrenia (Jensen, 1999, Pedersen 1999). Music forms an alternative to words and can also provide a function of enabling a feeling to be expressed which is difficult to consciously acknowledge. This is different from the often intense levels of sensitivity to feelings experienced by people with personality disorders and non-psychotic disorders, which the person is constantly trying to deal with and put aside more consciously and actively. These intense feelings often arise for people with personality disorders as a result of emotional or physical abuse or other trauma.

12.4.5 Further clinical implications: Schizophrenia

There is a definite outcome for this group which is summarised in 10.5 suggesting that a supportive way of being is indicated for this population, and that playing music

without much talking is only useful at the beginning of therapy whilst establishing a rapport with the patient.

One outcome that is perhaps unsurprising given that all centres employ music therapists trained in a strong improvisation tradition, is that Free Improvisation and Talking/Interpretation is a strongly indicated technique by the Centres in the study, because it allows the strong components of music to help the person with schizophrenia connect, and includes thinking and verbal processing which can then become a possibility as a result of improvisation. (10.5). This supports the notion that the act of playing is literally another mode of communication for this population. The notion is further supported by the fact that running right through the results, respondents agree that a supportive approach is needed for this population and this is evidenced by the fact that a music therapy approach using Supportive Psychotherapy is one of the most used approaches. (see Tables 10.1 & 10.2). In the literature this is supported by Pedersen, (1999) who advocates an adaptation of psychoanalytic approaches implying that this is so that holding and containing can take place which implies an aspect of Support.

The findings also show less use of insight orientated techniques that require symbolic thought when working with people with schizophrenia, such as Musical Role Play and Guided Imagery in Music (see section 10 and Tables 10.1 & 10.2), and conversely for some other diagnoses, particularly eating disorders and personality disorders, more insight orientated techniques and approaches are favoured. (Tables 10.13 10.14 10.15 10.16, 10.17 & 10.18). There is also an emphasis upon verbal processing and talking, and a suggestion that some patients with schizophrenia typically want to talk, and that this must be recognised in music therapy, as described by centres A, B & E in 10.4.3.

This point is also supported by new approaches in schizophrenia and fits in with current mainstream thinking about the Recovery model. The Recovery Model (Pepper and Perkins 2003),is concerned with psycho-social aspects of life for a person with schizophrenia and a non-medical approach to recovery which involves the meaningful day, focussing less upon symptoms and medical aspects (although they are monitored, controlled by medication and noticed), and more upon life and activity. The findings

in this study all support the notion that emphasis is upon meaning and relating to others, although this is a difficult area for many with this diagnosis.

The unanimous agreement that Receptive Music using recorded music and Imagery in Music is not used in group or individual work with people with schizophrenia is an interesting finding because in the literature there is more of a balance between different techniques. This is reflected for example by Moe (2002) and also in Unkefer's tables (Unkefer 1990) which were referred to in Chapter 8. The categories identified as most used for different categories and stages of schizophrenia, by Unkefer (ibid) as Table 8.3 shows, is Music Performance and Music and Movement. Whilst there can be no direct comparison because the data collected by Unkefer is organised differently, and it is not clear how conclusions were drawn and from where, it is interesting to make a comparison with the UK source. Music Psychotherapy is also referred to often in Unkefer's writing, but the main technique described within this is actually listening to music. It is a different form of music psychotherapy than the more psychoanalytic approach described by John (1992) for example for a woman with a psychotic disorder, and this reflects the prevalence of psychoanalytic influence in the UK. What we see are two cultures that are so variable and different, that it is hard to draw any distinct conclusions.

It can be noted that music for relaxation is hardly referred to for schizophrenia, which corresponds to a trend found in this study. Although reasons are not clear in the Unkefer literature, the respondents in this study more than once refer to the difficulty people with schizophrenia might have in relaxing and also that this is not really a goal. Respondents state that this group need to be listened to, understood and engaged with in reality, in the active participation of improvisation or composed songs), rather than through more passive techniques. While a detailed review of the wider treatment research for schizophrenia is beyond the scope of this study, some links with provision of services will be mentioned in 12.10.

12.4.6 Clinical implications: Bi-polar disorder

Whilst there is no consistent agreement between centres, it can be concluded that music for people with bi-polar disorder is important because of the ability music has to link with and express 'affect'. Given that extremes of affect and mood are a main focus for problems with people with bi-polar disorder, it is indicated in all responses which give detail that it is this aspect of music which is crucial for effective treatment for people with bi-polar disorder.

This researcher's comment on this is that the data implies there is a need to use music in a stabilising way at certain times of the illness and in an expressive way at others. Examples of this, and of how music can be used, are found in Odell (2001) in the case of M and also in the same case described differently in Odell-Miller (2003) also included in Part I of this thesis. In this case, the move between the use of strong rhythmic 'symbiotically linked' structures to hold the patient at the beginning of the therapy when he was particularly disturbed and manic, moving to free, very expressive playing when the relationship was more stable and the patient could tolerate this is vividly described in Chapter 2, (2.2) in Part I of the thesis.

The recommended treatment for this population in the recent NICE[3] guidelines is medication, a structured life style which includes work, stimulation, psycho-social elements, and creative and sporting pursuits. The latter are cited not only as being important for physical, but also for psychological reasons. There is little emphasis upon psychotherapy and talking treatments apart from identifying that people with bi-polar disorder need a supportive network which includes people who understand the illness and the person.

Similarly to the data for schizophrenia, Free Improvisation and Talking/Interpretation, Free improvisation with minimal talking and Singing Composed Songs are used by all centres for group and individual work with patients with bi-polar disorder. This researcher has gained the impression that affect and mood are important factors in how music is used and why it is useful for this diagnostic group. Structures of music

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[3] National Institute for Clinical Excellence (NICE) guidelines can be found at the following website www.nice.org.uk (type in relevant diagnosis).

are recognised as important as for the schizophrenia group and it is interesting that music therapy literature is sparse concerning this patient group, again implying that in general many services consider all the psychotic disorders together and do not differentiate.

However for this group a different, more expressive approach, with more emphasis upon interpretation is suggested as important by respondents particularly if the illness has more of a neurotic rather than a psychotic structure, supported by evidence given by respondents (10.7.5). Musical structures both engage and hold this population because of the capacity of music to match and reflect subtle mood changes and more sudden mood swings. Music is ideal for controlling or eliciting mood and the therapist can use these roles actively and to provide structure but also show listening and understanding for patients.

12.5 Clinical implications: Findings for non- psychotic disorders

12.5.1 Depression

With less available data, the conclusions for the non-psychotic disorders cannot carry as much weight as for schizophrenia. However in this qualitative study we are interested in the nature of why and how music therapists link what they do to diagnosis. The following points arise from looking at the data and reflect a mixed picture of agreement and disagreement about indication. Themes such as symbolic work, links between low self esteem and the importance or not of the performance element emerge, and many specific points are made that are different to those for people with psychosis. For example, one centre with specialist training in a Client Centred approach suggests that structures should not be imposed as this will prevent the depressed person from feeling understood. Respondents also suggest that therapists might impose musical structures arising from their own anxieties.

The notion that there should not be imposed structures is also related to the outcome that no centres use a Behavioural approach, and throughout the responses there is a focus upon exploration, looking at the patient's history, and not being too directive.

Musically the rationale for this is that people who are depressed need to feel in control and not faced with too much imposed from outside. This view is supported by Davies (1995) discussed in 8.5.3 in her case work about loss and depression, but it should be recognised that Smeijsters (1995) (8.5.3) found that there is a need for more knowledge about music therapy and depression, a situation which does not appear to have changed for those with severe depression who are cared for by psychiatric services.[4]

It is interesting that in this study there is also a focus upon using more psychoanalytic approaches for people with depression, and a suggestion that not working in the counter-transference and addressing issues could avoid working with the depression itself. This needs to be considered because depression has avoidance as a major component of the illness. This is a reason for the dominance of a psychoanalytically informed approach. However, the current recommended psychological treatment for depression in the UK recommended by NICE[5] is cognitive behaviour therapy (CBT).This is partly because more studies with large numbers have been carried out with CBT, than looking at more psychoanalytic approaches and Depression.

Surprisingly in this diagnostic group there is little comment upon the structure of music and its ability to raise, lower and change mood, in contrast to the bi-polar section. There is however a focus on how making music could either raise or lower self-esteem depending upon the patient's attitude or skills. The point is also made that whilst it is common to find patients who are well-versed at using their skills, this also has meaning and might trigger unwanted emotion, rather than a feeling of success.

The major comment on music and its link to depression is in the Creative Music Therapy technique, showing music- making as an expressive tool. When used musically by a skilled therapist, this type of improvisation can lift some depressive symptoms, which can enable talking about history, triggered by the act of playing music. In the example of a patient using the recorder, as shown in the case example

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[4] Cochrane Review for Depression is not published at the time of the study but might produce interesting findings.
[5] National Institute for Clinical Excellence (NICE) guidelines can be found at the following website www.nice.org.uk (type in relevant diagnosis).

referred to in 10.11.8, the importance of the therapist working along side the patient musically and listening in the improvisation, allows the patient to find her voice.

Throughout this diagnostic group, the active element is emphasised as important. patients with depression need to actively drive the music themselves. This researcher suggests from this that moving in and out of music and words can encourage links with thoughts and feelings and enable resistances to be addressed. A detailed description of such an approach was discussed by Odell-Miller (2002) in Part I, and this case study highlights the powerful emotional, psychological and physical components of free improvisation where links to the patient's inner world, and to their mind and body are a powerful tool for therapeutic change if meaning and analytic interpretation are integrated in the approach.

Opinion is divided about whether people with depression benefit from passive aspects of music (10.12.11).Working symbolically, using role play and 'as if' techniques are all important, and as much use of music to encourage spontaneity as possible is stressed. In addition there are views that free musical improvisation prevents avoidance of difficulties as it is easier to encourage people to tolerate deficits when improvising, than when using composed music. (10.12.8).

Interestingly no centres use GIM in groups with depression, and only one centre for individual work. However, Meadows (2002) in his overview of the use of GIM for people with depression cites four case studies (Bush 1992; Holligan 1992, Walker 1993 and Weiss 1994) and suggests that in general GIM in these cases is used in order to 'lessen defences and help the client enter into unconscious psychic material' (Meadows ibid p. 194). Meadows also draws attention to the different approaches therapists take to focussing upon imagery, either as a way of helping to create images of depression, or to help stabilise symptoms and therefore not focus so much upon using imagery to confront the depression. It is notable that GIM is so little used in the centres in this study which implies that in many European trainings and the UK in particular, GIM training is not prevalent, or non-existent, and therapists also appear unaware of the literature about its use.

Finally there is mention of emotional release as important. This is markedly different to the psychotic diagnoses, which is expected. This may be owing to the fact that encouraging expression is not the most important thing for a psychotic person, they may need to use music to help organise their mind. For the depressed person music can function as an active motivator, and with talking and interpretation it can help change patterns of thinking and feeling over a period of time.

12.5.2 Anxiety

The small amount of data on music therapy for anxiety might indicate that other treatments are more useful, such as Cognitive Behavioural Therapy (CBT) as indicated in the NICE guidelines. One conclusion is that Receptive Music using live music (RL) is most used with this group, and more so than for depression in percentage terms, where only one out of three centres use RL in contrast to three out of three (100%) for Anxiety. Reasons are that music might be used for patients with Anxiety when they are too anxious to manage anything else. For example calming music is used with anxious Mothers unable otherwise to calm their babies. This is supported by two centres, one of which suggests that the therapist might play something like a lullaby to help an adult with anxiety to calm down. (10.16.10)

Whilst music might seem to be ideal for reflecting the mood of the patient, and has the possibility of matching mood and also then working with it in order to help the patient understand how to change mood or consider the meaning of their mood, one centre suggests this might not be useful as it could be intrusive. (10.15.2). It can be important in some critical phases to work more with diversions and not to empathize with the mood of the patient, particularly if the music expressed is a chaotic reflection of anxiety. This is because a stabilising influence is needed, for example musically playing in one tonal centre, or playing repetitious melodies or rhythms. This evidence offers support to the notion that all three centres agree that a Supportive Psychotherapy approach is useful.

Free improvisation with talking is useful, but that not talking might encourage avoidance or increase anxiety about being out of control and therefore Free Improvisation with Talking and Interpretation is a preferred technique The

researcher's comment on this is that music alone in a free improvisatory style may be problematic and increase anxiety owing to lack of structure and unpredictability. Furthermore Theme based Improvisation can help thinking and enhance meaning for the patient, by focussing upon actual thematic material related to the patient, when anxiety might prevent this. The structure of a theme can also enhance music-making, for example focussing the patient upon their physical and emotional state by literally playing the physical sensation of having an anxious feeling in the pit of the stomach. Role play can be similarly useful, but even more structures task/activity based techniques are not indicated. This is perhaps because control would be taken too far away from the patient and external musical form of a pre-composed nature might be too restrictive and produce further anxiety of having to 'play the right thing.'

Song Writing is reported by one centre as useful, suggesting that focussing upon it may avoid overwhelming feelings of anxiety and structures added to self expression might be useful. Interestingly the three techniques involving recorded music are not indicated, with Guided Imagery being the least indicated as no centres use it. Some possible reasons for this linked to lack of training are suggested in section 12.5.1. The possible loss of control is stated by one respondent as being too challenging, but on the other hand the literature reported in 8.5.3 refers to Hammer (1996) whose findings indicate that GIM might be effective for reducing symptoms of anxiety for women with drug and alcohol dependency. As in CBT where the most success seems to be in exploring how patients can gain control of whatever is most causing the anxiety, in music therapy there are similar considerations, and the information given points to the idea that the patient must be involved. This could explain why live music planned and improvised together with the patient is most used for this diagnosis by centres in the study.

In general a conclusion which must be drawn here is that there is a lack of information both in the literature and in the study, leading to caution about drawing clinically applicable conclusions. One might speculate that for this group other treatments serve them well, and therefore music therapy might not be such a priority, whereas for psychotic disorders such as schizophrenia and bi-polar disorders, music therapy is often the only more psychologically based intervention in some centres. This is

because verbally based psychotherapies are traditionally prioritised as more effective for non-psychotic disorders.

12.5.3 Eating Disorders

The data showed a general emphasis upon working with the internal state of the patient and an expectation that understanding meaning, whilst difficult, should be central to the approaches and techniques used for people with eating disorders.

Creative Music Therapy (CMT) is linked to creativity in general by one centre, stating that the act of creativity (making music in this case), provides an alternative symbol (to words, implied), for internal experience, and assists in building the self, countering destructive acts, and helps body awareness. This is very important in a population where the destructive act of self- harm, depriving the body of food needs to be understood and curtailed. The implication here that the aesthetic and physical act of playing music might help cut down this process of self harm is important, although only stated by one centre. This is supported by Robarts and Sloboda,(1994) who state that improvisation and musical interaction should be central to the work.

Similarly, Robarts and Sloboda (1994) focus upon improvisation using verbal reflection, play rules and other media such as image and metaphor which is reflected in the quotation in section 8.3.3 (Robarts and Sloboda 1994 p.9). They make links to the diagnosis in that self –structured transitions, and a change in the internal process are stated as key to successful treatment, suggesting that this population can work with symbolic representation, already discussed in section 8.3.3. This study also found similar outcomes to Robarts and Sloboda, as results show that for people with eating disorders, approaches and techniques which involve symbolic work, for example psychoanalytically informed approaches, role play and theme based techniques using psychodrama, are seen as more useful, and possible, than for patients with psychotic disorders.

In sections 10.20.5 & 10.20.9, the analysis of the data shows how all centres agree that techniques including Theme-based improvisation and Musical Role Play are central to encourage self reflection and help raise self esteem by encouraging patients

to see themselves in different roles. There is also a point made by one centre that there should be a careful balance between musical interaction through improvisation without interpretation, and the use of an analytic approach using interpretation. Implied in the results, and in this author's opinion, careful attention should be paid to timing of interpretations, in order to achieve a careful balance between interpretation and music-making. Therapists have to judge when patients are ready to work interpretatively, and clinical improvisation can help to prepare for this.

The issue of control is important for this population and Theme based techniques are most effective, as a musical structure is provided arising from patients' material, with verbal discussion incorporated. However there is also a comment that the aim with this group is to get beyond structure and activity, (referring to Activity-Based work 10.20.6), implying that too much structure which does not come directly from the patients, (and which they might feel external to), might encourage defences. This might also prevent the spontaneous expression of anxieties, and feelings related to their anxieties. These points also apply also to Receptive Recorded techniques which together with an Activity-Based technique are hardly used by centres in the study.

There is significant agreement that Free Improvisation with talking/interpretation is important as it helps patients with eating disorders in processes of self expression and integration of thoughts and emotions. Singing Composed Songs is linked both positively and negatively to the problem of low self esteem. People with eating disorders do not think they are important enough to hear their own voice singing, therefore implying that this could be both challenging and helpful in overcoming this lack of self worth. Alternatively another centre suggests that therapist-derived musical structures, such as Free Improvisation (FS) with structures might be experienced as patronising. This is a cautious view and in this author's experience, whether the patient experiences musical structures as patronising depends upon the way these are introduced. Clinical experience has shown that patients sometimes ask for structure when lack of structure is experienced as un-containing, and in this situation structures can be nurturing. Centres A & E agree with each other, with a slightly different point of view that because 'give and take ('taking in') is a problem for patients with eating disorders, FS is useful because it can help this happen in other ways.

In conclusion, similarly to the use of Receptive listening, all centres agree on the function that FS might have, but two centres see this as useful and one centre does not. There is agreement that listening can be a defence against change and looking at the self. For this reason opinion is divided as to whether it is part of the process leading to change, or not useful.

There is some understanding shown by the centres of mainstream thinking about eating disorders which is that accessing feelings is very difficult, and intellectualisation and talking can mask thinking and feeling on a more emotional level. This is clearly important for this population. (Loth 2002, Robarts and Sloboda 1994).

It is unclear from the data exactly how a Client Centred model is integrated within music therapy and little information is given, suggesting it is not a priority for patients with eating disorders, and similarly Behavioural and Developmental approaches are reported as not used. This is particularly interesting as there is a trend for eating disorders treatment in general to be quite behaviourally orientated, with close monitoring of reward and punishment mechanism for eating or not eating (Fairburn et al 2003).

There is generally more divided opinion in this section, suggesting caution in trying to reach any firm conclusions. There is also less data than for the major psychotic disorders. However the information is very important because in Unkefer's previous survey (Unkefer 1990) neither eating disorders nor personality disorders were seen as a main stream psychiatric disorder and not included.

12.5.4 Personality Disorders: Approaches and clinical implications

There is a large amount of data from respondents which shows a robust understanding of the problems facing patients with personality disorder by centres in the study. Active engagement in music therapy is seen as crucial with a psychoanalytic process involving 'Mentalisation' (Bateman and Fonagy 2004), because patients often seem 'present' but with no active engagement with other patients in groups, for example. Music is therefore ideal in encouraging an interaction between thinking and emotions. There is evidence that relatively recent mainstream thinking (Bateman and Fonagy

ibid) about specialised psychological therapy approaches needed for this diagnostic group are known about in centres A, D & E. Centre D included a reference to a protocol (Appendix VIII) about a specific approach using the Mentalisation approach linked to music therapy, in 10.25, which describes a five stage music therapy approach.

The fact that a Psychoanalytically Informed approach is most used points to an approach where music might put people in touch with painful memories, and these need to be analysed, but also supported and engaged with during the process of music therapy. In addition a modified form of a Psychoanalytically-Informed approach is used, which provides structure and reciprocity between patient and therapist at the same time as being interpretative and analytic.(10.23.5). This provides links with a modern model, Cognitive Analytic Therapy (CAT) suggested by Ryle et al (1997) to be most useful for people with Personality Disorders.

There is agreement that a Psychoanalytically Informed model with music-making through improvisation, and interpretation is indicated with this group who need to address meaning and understand psychological frameworks for their mental state in order to progress. Alongside Analytical music therapy, there is agreement that this population can tolerate an analytic approach working with unconscious material through music and talking. 10.23.5 & 10.23.7) This is the only diagnosis where an Analytical approach was frequently used.

Similarly an Activity-Based approach is not indicated because it might prevent people working through things in a more psychoanalytically informed way, which this group are able to do. (10.23.9). Only one centre used this and there was general agreement that too much focus upon activity and not enough reflection and thinking might encourage defence mechanisms. This researcher would add that if people are high achieving, a process involving having to demonstrate a skill can further increase pressure. However Centre A says this can be useful in building respect and trust in a group.(10.24.6).

A 'total' Activity-Based approach (as opposed to Activity-Based techniques being occasionally used within a predominantly improvisational approach), is not indicated

as a main focus for treatment. Reasons given are because a more in depth exploration of meaning is needed for this group, but the findings in the study present a mixed picture. There is also a case put forward that it could be useful in specific circumstances in order to help self worth and develop confidence and a sense of achievement. This would be for people for whom an emphasis upon achievement is not already seen as an unhealthy aspect for the person. (10.23.9).

. This has been introduced very recently as a 'Lifeworks' model in a government funded modern project in the Complex Cases service in Cambridge, UK as part of a therapeutic community model, where psychological therapies work alongside real life events so that reflecting upon them and preparing for 'the outside world' with support where meaning can be addressed is crucial to successful outcomes.[6]

12.5.5 Personality Disorders: Clinical implications, techniques

There is unanimous agreement by centres in the study that techniques involving structures such as themes are only useful if the themes come from the patients. (10.24.5). It is the very aspect of creative control linked to relevant themes of character, emotions or life events that make it so useful. There is also agreement that this population can work symbolically as seen in 10.24.5, Centres A & D.

Results from the study, similarly to outcomes for other non-psychotic disorders, also show that composed music could act as a defence by having a holding function which might prevent patients working on their own issues. However, this author has found that if people bring songs they have written, the therapists' role may include providing an accompaniment, and performance can help some patients explore or overcome feelings of shame. This can in turn build up feelings of self- worth if handled in the right way with a music therapist. This viewpoint is also supported by respondents in sections 10.24.7 & 10.24.11, and by some literature specialising in the use of song and composed music (but also sometimes improvised), for people suffering from trauma, neglect and abuse. (Snow-Austin 1998, Montello 1995).

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[6] Denman (2006) Complex Cases Annual Report Cambridge and Peterborough Mental Health Partnership NHS Trust.

In the author's clinical experience, and as taught in post -graduate training (Odell-Miller 2004b), it can frequently be a 'fight' to encourage patients with personality disorders to play music, when they are embarking on music therapy, and talking might be preferred. However, techniques and approaches which include both talking and music, with the possibility of moving between the two, encourage the integration and access to thoughts and emotions once trust is established. Improvisation in groups provides opportunities to work with empathy, because often patients have difficulty coping with another's playing, and improvisation can help through seeing, hearing or sensing an atmosphere.

Furthermore the initial experience of patients in a music therapy group is often of a fear and dread of playing music. This is particularly the case for people who have been sexually abused, which is a very common feature in borderline personality disorder. Fear and dread may be present because of the heightened emotions that come to the fore through music. In Western culture particularly, the room and instruments can bring vivid early memories of school or nursery to mind. Patients might even experience fear and dread of impulsive self harming or harming of others in the presence of many objects that can be seen as potential weapons. In addition to this is the relationship with the therapist and other group members, all of whom suggest potential for intimacy and contact, which for a group of abused clients can often bring back painful memories of abusive (physical, sexual or emotional) relationships, and can be immediately uncomfortable. This view is supported by Hannibal (2005).

The results from this survey support the use of structured improvisation, as three out of five centres suggest this is useful for similar reasons, particularly if a person is feeling stuck. (10.24.4). Furthermore Centres D, E and A suggest recorded music is used with personality disorders (10.24.11), although Centre D cautions that the use of recorded music might encourage defences and avoidance of interaction. However it is clear that it is not used as a technique on its own but in conjunction with other more interactive techniques both by the study results and in this researcher's clinical experience. This researcher would argue that the main focus of work with this population is in making links between emotion and more cognitive processes. This

can happen in many different ways, but often involves patients wanting to use composed music which has meaning for them, as well as using improvisation.

In considering the clinical implications of the findings of this study for this diagnostic group and for the group with schizophrenia, this researcher has been able to draw upon extensive clinical experience, and as mentioned in 12.4.5, in preparation for this study, a comparative description of how the different diagnostic groups use music therapy was made but is unpublished. (Odell-Miller 2004 b). Further detail about clinical applications of technique linked to the diagnosis and symptoms is described below, with comments about how this links to findings from the study.

12.5.6 Group music therapy: Personality disorders

The description below of some clinical work (ibid), illustrating how this population use improvisation, and its meaning in relation to the problems they experience, was written up after two years of observation and systematic analysis of audio-taped musical material. This was undertaken in preparation for a research project which will be referred to later in 12.10. (Appendix X). The results of the clinical process illustrating the use of musical structures such as Composed Song, in addition to Free Improvisation using talking and interpretation, can be related to responses and comments from Centres A & B (10.24.6 &10.24.7), while Centre D suggests that very free structures are possible. (10.24.3).

In this project, a long term music therapy group run for two years and a referral system was established for people with severe personality disorders.(Cluster B type mainly), some of whom have an additional diagnosis such as depression, and often more than one type of personality disorder. The group was therefore complex, as is usual for such a unit (Bateman and Fonagy 2004, Gunderson 2005). Members of the music therapy group had different types of personality disorders including narcissism, obsessive compulsive disorder, antisocial, and depressive paranoid. Often there was a high risk of self harm, including regular severe cutting, or over-dosing, and a difficulty in dealing with high levels of emotion often so intensely felt that strong cognitive processes or physical rituals or self harm had developed to counter the feelings, or to express deep hurt in another way.

In the music therapy group there were clear boundaries between the beginnings and endings of music, manifest in often very controlled playing, and an avoidance of 'letting go'. There was a conscious avoidance of playing loud music, or playing freely with no structure. The therapist therefore had to use musical structures to provide a containing function and to lessen the re-experience of trauma. This is in contrast to the use of improvisation that can be experienced by people with schizophrenia, where a salient feature is a lack of clear boundaries between the beginning and end of an improvisation as described previously in 12.4.5.

As suggested by the results of this study, Free improvisation is often possible with structures leading up to it and away from it. Clinical experience (ibid) also supports this notion and a short case example[7] is given here. A 25 year old personality disordered lady used the large orchestral tam-tam (gong) to 'bash' (her words) as part of an improvisation after her mother died. She had experienced her mother as un-loving and as un-protecting (she had not protected her against a male member of the family who sexually abused her). She had just begun to form a more loving and different type of relationship with her mother, when her mother's death occurred. The overwhelming, angry and raging feelings were expressed once in the group and the patient often refers back to that single 'gong bashing' as the most therapeutic moment for her. She however also acknowledges that making such music puts her in touch with such painful feelings that she does not want to 'go there' again although she has also acknowledged that if she could, this type of playing may act as an alternative to her severe cutting and therefore ultimately help her function more in the outside world. So for this person, structured music improvised by her with other members of the group is important in keeping her in touch with the potential emotions she knows she needs to deal with that are often extreme (the destructor, the destructed, the abuser, the abused). This lady has brought songs with hopeful and depressing suicidal themes to listen to with others in the group in order to help her link her thinking and feeling and to try to find strategies to manage these in her life.

In summary the importance of music-making links to the pathology of personality disorders because music, like the illness, is affect-based. This implies that the music

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[7] This case example is based on several similar instances from a variety of cases, and in order to preserve confidentiality, these have been accumulated to give an example which illustrates the point.

therapist's task for people with personality disorders is to help the person understand the meaning of the affect. This was suggested in Hannibal's case study (Hannibal 2003) discussed also in 8.3.4, and is supported by Pedersen (2003).

As a clinician and researcher the author would recognise from the findings of this study that Free Improvisation with talking/interpretation is used as a main technique. This technique provides a relevant mixture of affect-based, free improvisation, and possibilities for insight. It allows movement between the necessary structured and unstructured frames where interpretation and talking help to break rigid patterns, leading to understanding meaning. This helps people move from destructive or other behaviours that need to change in order to lessen symptoms and enable better life-function. This point is supported both by Hannibal (2005), who works in a specialised service for people with personality disorders also run according to Bateman and Fonagy's theories, as well as by psychological thinking and literature now available about this population (Bateman and Fonagy 1997, Gundersen 2005)

In summary, the results of this study confirm that people with personality disorders can work psychoanalytically, as approaches favoured by centres support this view. However the study and literature suggest that the approach might need to be adapted, for example focussing on reciprocal roles, a major feature of cognitive analytic therapy. (Ryle et al 1997). This author's clinical and research experience substantiates this view that music can be both challenging for people who have been abused as well as helpful in linking thoughts and feelings. The need for allowing a balance between structure and space for a person to feel they can 'be themselves', supported and valued, before then moving to more challenging insight-orientated work, is indicated strongly in the results.

Generally this population need less structure as therapy progresses, and in comparison with the majority of seriously ill people suffering from psychotic illness, this group can tolerate interpretation and musical improvisation that moves between thinking and feeling, in order to understand meaning. The results of the study suggest that Activity-Based work could increase rigidity instead of providing freedom, and could act as something for people to hide behind. Conversely Activity-Based work can also be useful to build self esteem and encourage listening, trust and co-operation with others if applied in a considered way. Free improvisation is very useful in allowing people

to be in touch with their difficult emotions and can provide links to meaning and words that might not otherwise have been available as evidenced above through the study findings, clinical experience and the support of a very small body of music therapy literature.

12.6 Clinical applications: Cumulated results on approaches and techniques

12.6.1 Introduction

The data examined in Chapter 11 shows the complex nature of looking statistically at the results, and reveals some problems of doing this with such a small sample. One aim in this chapter was to see if there were trends that could be determined across all the respondents and categories for approaches and techniques in their own right (not linked to diagnosis). This is why all answers were cumulated and statistically analysed, as they provided a larger amount of data. From this, the following conclusions can be reached in terms of how much centres in the study do or do not use the techniques and approaches identified at the beginning of this study, in adult mental health settings. Three categories emerge as shown in 12.6.2-12.6.4: those with predominantly high levels of agreement of use, those with predominantly mixed levels of agreement, and those with high levels of agreement of non-use. This section looks at all the responses for settings and diagnoses, so is not diagnostic-specific but draws some general conclusions about approaches and techniques in the centres.

12.6.2 Approaches and techniques with high levels of agreement of use

The techniques Free Improvisation with minimal talking, Free Improvisation with talking/interpretation, and Composed Songs are all highly used with agreement across centres and settings. Reasons for this are given in the qualitative data, and it can be concluded that improvisation is a central focus for adults with mental health problems in the centres in this study. Opinion is divided about whether talking has a primary focus owing to its necessary function for adults with mental health problems, or whether free improvisation with minimal talking is preferred because talking might encourage defence mechanisms and prevent therapeutic outcome.

The approaches Supportive Psychotherapy and Psychoanalytically Informed Music Therapy are agreed as highly useful in the analysis of cumulated data, and these findings are supported by the qualitative data in different ways. Mainly it is agreed that attention to the transference and counter-transference phenomenon is the most prevalent reason for using a Psychoanalytically Informed approach, and that it is not appropriate to use a full analytical approach with many severely mentally ill adults, particularly in music therapy where the unique focus is on the interaction through music.

There is also a theme concerning training, where music therapists are using the approach first and foremost in which they are trained, and not always attributing this to clinical priorities. However it is interesting, given this finding, that Composed Songs are also widely used, particularly as this technique has not been covered as a central technique in many European training courses. In the UK at the outset of music therapy treatment in psychiatry in the early 1960's and 1970's, Priestley (1975) advocated its use in a psychiatric in-patient setting. More recently there is an emphasis on the use of Composed Song in the Community Music Therapy approach as described by Maratos (2004).

12.6.3 Approaches and techniques with mixed agreement regarding usage

It is obviously difficult to draw any conclusions from a mixed picture of use, apart from that there are variations in practice that seem more linked to training backgrounds than to clinically appropriate decision-making. There was often not enough information given by respondents to fully understand these decisions other than those points already made in relation to specific diagnoses in 12.4.

A theme-based music therapy approach emerges as highly significant in terms of diagnosis, as already discussed in 12.4 (for example it is used for non-psychotic disorders), but there are mixed results about usage in general. There is no clear outcome in favour either of using or not using Free improvisation with structure, but when reasons <u>are</u> given for using it they are clear and related to specific diagnoses or problems for patients. This is shown in 12.5.6 by discussing the use of this technique for people with personality disorders, to help them become 'unstuck', or to help

people with schizophrenia organise their music which they often find hard themselves (10.4.4).

Other examples given were to help push someone with depression towards finding her inner self (10.12.4) where the therapist provides possibilities for role play, or in the use of musical form (ABA structures) for a woman with depression. This is referred to under the Theme based section but also under Musical Role Play (10.12.9), which is another technique in this mixed section where opinion is divided about usage. In general it can be concluded that structured work is most often used for group work across the diagnostic groups and settings as found through the analysis in 11.13.1.

Activity-Based techniques also fall into this section of mixed opinion, and in general centres either use or do not use this technique, with definite reasons for either, which are discussed more fully in section 12.6.3. There is also a problem of defining and what is meant by Activity-Based which is also discussed in 12.7.3, but there is a clear overlap between this technique, and the use of Composed Songs, and Free Improvisation using Structures.

Song Writing is not commonly used in group work (11.17), but used more in individual work. This is interesting and leads the researcher to draw the conclusion that for populations of adults with mental health problems, the personal individual tailoring of a song might have the most therapeutic effect, and that Song Writing would involve very complex dynamics in group work (Baker and Wigram 2005). It will be interesting to see whether this new literature in the field influences future trends in music therapy practice with this population.

Receptive techniques using live music are neither significantly used or not used, however the results are interesting as they reflect a particular approach to treating people with anxiety. This was the only diagnostic section to fully consider receptive music therapy techniques such as using music to calm and sooth, as reported in the results in Chapter 10 (10.16.10, 10.16.11, 10.16.13), and discussed above (12.5.2.). Receptive Recorded music techniques are also neither significantly used or not used. (11.20), which seems to further reinforce a general agreement among these centres that music therapy for adults with mental health problems typically deploys live

music, while recorded music techniques can be carried out by others (not including GIM) and are not always desirable for reasons of passivity. Section 10.4.10 shows a good example of the prevailing attitude to more passive techniques in general by the centres. Centre D writes *'You would not ask a client in psychoanalysis to bring a book and read it during the session, so why ask patients to bring CDs with them and listen to music in the group sessions ?.'* Later Centre B describes the use of live music as a receptive technique as the role of the Community Musician, and subsequently in 10.4.11 describes the use of receptive recorded music as the role of Occupational Therapists and Nurses. This attitude is a particular one found in the UK, and in some other European centres where music therapists have a psychoanalytically based or music centred music therapy training background. It could be seen as a focussed way of practising, or as a narrow focus, depending upon the thinking behind what the music therapist does, and the aims of the therapy.

There are many USA based approaches described and tabled by Unkefer (1990, 1995) as discussed in Tables 8.3 & 8.4, which include receptive techniques, and the lack of use of these in the study could either suggest that training and clinical practice should be broader in some European countries, or that the diverse disciplines within music therapy should be recognised as explicitly different. This point will be developed in 12.9.

12.6.4 Approaches and techniques with high levels of agreement of lack of use

Techniques using GIM and Relaxation are not used significantly as concluded in 11.21 & 11.22. In relation to diagnosis, the qualitative data in Chapter 10 is unanimous that GIM is not used for bi-polar and schizophrenia, mainly owing to lack of understanding and training in the technique (10.4.12, 10.8.12). However Centre E also offers an explanation that people with schizophrenia cannot listen in a lying down position and *'cannot contain a longer piece of music or challenging music.'*(10.4.12).

There appears to be only one centre, Centre E which employs music therapists trained in GIM, and it is questionable whether the other centres that give reasons for its non-use do so from an informed perspective, or as a result of no training in the approach.

There is a lack of awareness of the literature supporting the use of GIM in psychiatry, and some degree of bias, such as demonstrated by Centre A (10.8.12), which suggests GIM might be inappropriate for bi-polar disorder for people with serious mental illness, particularly psychotic disorders. Centre E appears unique in discussing techniques using GIM (10.3.6 & 10.4.9) and this appears to relate to specialist training in that centre.

It is clear that the adapted forms of Guided Imagery in Music discussed by Meadows (2002) for in- patients with mental illness are not known about by the respondents in the study, or the approaches discussed by Bruscia (2002) in his examination of a psychodynamic orientation to the Bonny method of GIM. In this literature Bruscia discusses in depth the concept of resistance in GIM and transference, where the music can act as a vehicle for transference for example, and resistance to involvement with the GIM experience is analysed and used in providing meaning for the client. Meadows in an overview of many music therapists' work, discusses four approaches where GIM is adapted for use with mentally ill people, although specific diagnoses are not analysed. Shortening the length of sections of the session, such as the relaxation part, and an avoidance of exploring too much in depth material, are crucial to the approach which uses GIM for people with serious mental illness. Meadows (2002) writes, of one particular adapted approach:

> "This approach was discussed by nearly all therapists with a wide variety of clients, including those with PTSD, depression, schizophrenia, and mania. When sessions were adapted, considerable variation was made to the length of the relaxation induction, music, and/or goals of therapy. Rather than focussing on goals that uncovered deep psychic material, therapists focussed much more on "here and now" issues such as helping the client a) gain control over her imagery and her mind, (Goldberg 1994), b) connect with feelings (Blake [8] 1994), c) reduce social isolation (Goldberg, Hoss and Chesna (1998), and d) address current life stressors (Goldberg 1994; Goldberg, Hoss and Chesna, (1998); Summer (1998)."
>
> (Meadows 2002 p.196)

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[8] The reference here appears to refer to Blake and Bishop (1994) but in the original quotation Blake (1994) is given as the reference.

This is interesting because the adaptations fit in with the similar adaptations of psychoanalytic approaches discussed in 10.3, relating to working with people with schizophrenia, advocating similarly working in the here and now, avoiding exploration of deep psychic material and cutting down stress and isolation.

Approaches such as Activity orientated, Analytical, Creative Music Therapy, Behavioural, Developmental, Client Centred and GIM are not used significantly and it is difficult to conclude why this is, whether it is clinically significant or whether the reasons are mainly connected with lack of training. The Developmental approach has received little attention throughout the survey, and little information was given by the Centres.(see 11.5).

From the analysis of qualitative data in Chapter 10 it is clear that centres did not have music therapists trained in a true Client -Centred approach, as defined in the guidelines for the survey, apart from in Centre E. Whilst there is a general view from the centres that following the client is a preferred therapeutic strategy, data suggests that across the centres in the study there is little evidence to show any links with diagnosis and music therapy using a true Client-Centred approach. Similarly a Creative Music Therapy approach is mainly used by Centre B (10.3.8) which appears to be the only centre with music therapists trained in this approach. Centre A refers to CMT as not useful (10.7.8) for clinical reasons, but it is clear that this centre is not aware that CMT has been adapted for use with this population as described in 10.3.8 and evidenced in the literature by Pavlicevic at al (1994). However Centre B articulates the potential of a CMT approach, emphasising that for otherwise chaotic, inappropriate behaviour; and where symptoms such as delusions and psychotic thoughts can be contained, included and made appropriate; within improvisations, CMT is useful.

There is unanimous agreement that a Behavioural approach is not used owing to respondents mainly referring to its rigidity and lack of appreciation for the patient therapist relationship and focus on meaning (10.3.4, 10.7.4). Whilst there is an agreement that patients with schizophrenia need structure, the only reason given for a negative response was by Centre D, implying that a Behavioural approach is too structured for people with schizophrenia who need to develop an 'inner space'. The

conclusion from the responses from these five centres is that a Behavioural approach to music therapy for patients with schizophrenia is not indicated and it is regarded as too directive. In 10.7.4 Centre D describes the approach for people with bi-polar disorder as too demanding.

In terms of an Analytical approach, most centres seem to understand this as the Priestley (1994) approach and therefore lack of training is an issue. Also the point is made clearly, and has been discussed in 12.4, that for most people with serious mental health problems adapted Analytical approaches using a Supportive Psychotherapy or a Psychoanalytically Informed approach are preferable, because there is more flexibility. This author believes that most people in these diagnostic categories do not have sufficient ego strength and capacity for staying with painful difficult emotions and doing their own inner work on meaning, to make its use possible or appropriate.

12.7 Problems of definition and specialist categories

12.7.1 Introduction

As described in 12.3.1, those who thought in depth about diagnosis, and related technique and approach to this, often defined or 'invented' their own approaches (or referred to existing ones they had already invented), sometimes related to diagnosis or patients' needs, and usually adaptations of existing approaches or theoretical orientation. For example, Supportive Psychoanalytically Informed Music Therapy (SPIMT) and Exploratory Psychoanalytically Informed Music Therapy (EPIMT) which are defined in 10.3.2. Chapter 10 has already introduced these 'Other Approaches (10.26) and these points are now discussed in more depth. Differences are not so apparent in the case examples given, but more so in the descriptions given from a theoretical point of view.

12.7.2 Psychoanalysis and music therapy

This author has already referred to two published works on this subject (Odell-Miller 2001 & 2003) which looked at defining different and similar approaches in music therapy and tried to discuss some of the historical influences and clinical implications

of the psychoanalytic field. What follows are some examples of the problems of definitions, labels and the relationship between theory and practice arising from the study. Implied in this discussion is that music therapy, which draws upon psychoanalytic theory, particularly focuses upon the unconscious, interpretation, transference and counter-transference, and in some cases attachment theory, object relations theory and other derivative theories from Freud's original works. (Freud 1910, Odell-Miller 2001, 2003, De Backer 2004).

For example Centres A and B, in their responses relating to the various psychoanalytic approaches, both placed emphasis upon the musical relationship and active involvement of therapist and patient. Added to this in both cases is an informed interpretative approach that functions in order to enable the patient to engage more in the therapy and to develop in musical interaction as well as in psychological awareness.

Whilst there are many similarities looking in detail at casework described by Centres A and B, it appears to be tradition, experience and training that influences the way that these things are defined and framed. For example Centre B as referred to in 10.3.5, (and the case described under 10.26), states that the centre's approach is different to a Psychoanalytically Informed Music Therapy approach and defines a new approach adding the words 'Music-centred', resulting in 'Psychoanalytically Informed Music Centred Music Therapy '. The centre however stresses that verbal interpretation is important throughout in terms of commenting upon the musical interactions in order to help the patient get in touch with their 'good object'. If asked to define this work (Centre B provided extensive examples similar to the one described in detail in 10.26), it would fit into the Psychoanalytically Informed Approach already described in the literature (Odell-Miller 2001) and in Part I of this thesis. However the respondent says that the Psychoanalytically Informed Music-Centred Music Therapy approach is different. This perspective may be influenced by the fact that the music therapy literature discusses theory in a way which suggests that the sessions are not music focussed, when in fact they are. (Odell-Miller 2001). The more typical style in music therapy literature in this field is not to notate actual musical examples, but to reference musical events with some musical description and musical parameters, and interpret them.

In terms of describing Centre B's Psychoanalytically Informed Music-Centred Music Therapy approach (PSMC), it is best understood from the case study in 10.26 which is introduced in 10.3.5. However when reading the case material from Centres A & B in particular it appears that the focus is on music and talking/interpretation, using the therapist's skill and focus in knowing when to use which, always keeping the music focus in mind. This is what is unique about music therapy, and makes it different to other therapies, and therefore beneficial in 'unsticking' patterns. A Psychoanalytically Informed Music Therapy approach also helps to understand the meaning of behaviour and feelings, through the expression of affect, and the process of linking thoughts and feelings, in order to enable patients to move forward. In all settings there is agreement that this happens in stages and through musical changes which are worked with, and consciously developed. Decisions about whether to use more or less verbal intervention as the therapist, or more or less structured music, songs and performance elements are a matter of clinical judgement.

Centre A similarly describes the two approaches reported in 10.3.2, as Exploratory Psychoanalytically Informed Music Therapy (EPIMT), and Supportive Psychoanalytically Informed Music Therapy (SPIMT), and this has been discussed at the beginning of this section (12.7.2). What transpires in the case material is that the approaches described, decisions made about what to say and how to interpret, coupled with a very sensitive approach to setting and consideration of the stage the patient has reached and how things should move forward, seem very similar to Centre B's generic description of PSMC. The theoretical approaches arise from people who are experienced and innovative and want to describe the subtleties of their work in order to avoid misunderstandings of labels. Looking back at the literature, it is easy to see why this can happen given the large amount of terminology and the difficulty in ascribing meaning to words. For example the term 'music psychotherapy' is used as a term to describe any form of therapy which, on the one hand, involves psychological thinking and is not Behavioural, (Unkefer 1990) or can be understood as a term implying a more traditional psychoanalytic approach (John 1992), or as a collective term for music therapy approaches drawing on varying amounts of psychoanalytic theory (Bruscia 1998). Yet the outcome is a tendency, as in the broad field of psychotherapy, to formulate discrete labels of approaches that have far more

similarities than differences, for the purpose of establishing a unique identity and distancing from another.

12.7.3 Activity, Task-based and Community Music Therapy

Centre B describes a Community Music Therapy approach and refers to Ansdell (2002) in the questionnaire. (10.3.9). This researcher decided to include this approach in the Activity-Based music therapy section, because when analysing the data, it seemed to be defined in a way that is understood by an Activity orientated approach to music therapy. This is discussed in 10.3.9 and the anomalies and issues are relevant for further discussion here.

In summary the Community Music Therapy approach described by Centre B, would be improvisational, but might include some structure such as '*Songs From Home*' where staff and patients bring songs from their homeland, as reported by Centre B in their Survey Response (See Appendix II, Questionnaire B 7.3.1.) However, it is interesting to note that this description also fits into the category of Activity-Based work, which has also been termed 'task-based'. There is an issue here about the naming of approaches in order to delineate uniqueness about a certain approach such as Community Music Therapy, which has been defined in the literature (Ansdell 2002), but which also seems to be regarded by some centres as an already defined approach within the context of music therapy for this population, under a different name.

For example early music therapy work (Priestley 1975) in developing performance related work for adults with mental health problems, and a Music Therapy approach to the Tea Dance (Odell-Miller 1997) have been established in the literature as part of music therapy tradition for some decades, and also fit into some of the modern categorisation of Community Music Therapy as described by Pavlicevic and Ansdell (2004). Centre A mentions the use of 'gigs' for community based music therapy in accompanying evidence not tabled in the main body of the questionnaire, which includes performance similar to that described under Community Music Therapy in Centre B's description.

An example is reported by Centre A in their survey response and is categorised by Centre A as an Activity-Based technique. Owing to its place in this section, it is assumed by this researcher to be relating to people with schizophrenia as it refers to long term rehabilitation in a day centre, and it conforms to what is described as Community Music Therapy by Centre B, but is described differently. ' *The contextualising of music making in a recognisable social form may be part of a more formal "therapy" in this setting or the culmination or point of the work. It may be useful in promoting new staff views of patients in the treatment setting.*' (See Appendix I, 7.3.2.) A similar point was made by Centre B concerning the function of music therapy in this approach, (and in a Creative Music Therapy approach), as helpful in involving staff and patients interact and understand one another, within the immediate community. (Appendix II 7.3.1 a)

Centre E implies that while an Activity-Based (AT) approach might be useful for patients with schizophrenia, music teachers can provide this type of input. Centre D disagrees directly with Centre B and says that the approach is not suitable for newly diagnosed people with schizophrenia, but might be more useful with people with chronic illness and also implies that the Creative Music Therapy (CMT) approach lies within the Activity-Based approach. However there is a further complication in that some examples from Centre B concerning CMT are also informed by psychoanalysis (10.23.8, illustrated by case example in (Appendix 11 section 8.1.1 e). This is interesting because Centre B, which **does** use CMT, is also the only centre that talks about using AT (under the definition of Community Music Therapy). This ambiguity may seem very confusing to people seeking music therapy.

What seems to emerge is that music therapy is difficult to define in a precise and generic way, and continues to develop a multi- theoretical basis. Within this broad church, it would be useful to try to achieve some clarity of description between some of the many approaches, such as exists for example in the distinctions between Cognitive Analytic Therapy and Cognitive Behavioural Therapy (Gabbard, Beck and Holmes, 2005, Grant, Young and DeRubeis 2005, Parry, Roth and Kerr 2005).

12.7.4 Holding and Reorganising Therapy

Finally in this section about approach and technique defined by participants, there is an emphasis from one centre upon their unique approach of Holding and Reorganising (Centre E). This is described in the literature (Pedersen 1999). In short, various things emerge from looking at the data. In other centres, apart from Centre E, there is little emphasis upon this actual Holding technique, although it is documented, in the music therapy literature. However the term 'containment' is used throughout when centres are describing a psychoanalytic process for patients, and it can have a similar meaning. (10.3.5., 10.4.4 & 10.24.4).

12.7.5 Body and Voice

Section 10.26 introduces this approach, and only Centre E refers to its use for people with personality disorders. In considering these more specialised approaches music therapists might need to be flexible and gain training in dealing with more aspects of the person than only at a musical level, particularly when working with people who have been abused and whose problems are embodied. This might be one of the few ways (in addition to musical improvisation using instruments) where affect and thought can be connected and an unlocking of past trauma and pain can take place. (Pedersen 2002).

One of the more pertinent conclusions that this study might offer to future music therapy services for adults with mental health problems is that to the external employer, or prospective patient this multitude of approaches might be very confusing, particularly if not linked to the likely problems or diagnoses for which they can help, and some clarity in the potential for 'prescribing' is necessary.

12.8 The limitations of the study

First it is interesting to remark upon the fact that the study was planned as a small study in order to accompany the author's already researched publications in Part I. It was also planned that these should form the basic theory leading up to the small study. In this respect, although the study is not small, the author's quest for learning from

clinical experience, searching for frameworks and clear systems for determining what approaches and techniques work for whom, and looking at how music therapy for mentally ill adults can be explained to other professions, has been achieved to some extent.

There are some clear findings emerging from the rich data, but the study has focussed upon answering the question about how music therapists define their work linked to diagnosis. The survey included all six main diagnostic categories found in mainstream psychiatry, but this strength is also a limitation because the centres included in the study do not specialise in all these diagnostic fields, individually or collectively. However it emerged that the clinical areas in which the researcher had previous expertise (psychotic disorders and personality disorders) transpired to be the main priorities in all the centres, eliciting the most data. Consequently there is still incomplete data and knowledge regarding the other three diagnoses, anxiety, depression and eating disorders. It is interesting that similarly a limitation in Odell-Miller et al (2006) in Part I of the thesis was that it tried to look at too many therapies and also too many diagnoses. To an extent this 'mistake' has been repeated, perhaps stemming from the researcher's experience as a manager and service policy maker in UK, which required an inclusive rather than an exclusive approach. In terms of inclusion, the study design could be challenged for not including patients' views, but the study set out to address current political and professional agendas where clear articulation by professionals is crucial. This does not lessen the equitable value of the patient voice which can be addressed at a later stage.

The study set out to provide guidelines, and therefore it might be expected that in the conclusion, definitions of approaches and techniques linked to diagnosis would be included. Owing to the inconsistency of the data, this has not been possible. Without detailed musical examples as found for some of the categories in Wigram's book '*Improvisation*', published after the study started (Wigram 2004) it is difficult to provide such detail. Wigram's research provides detail about different techniques and diagnosis, but these are not linked in detail to diagnoses, not is that the focus of his book, although it provides a reference point for future articulation of the musical components of the approaches and techniques discussed in this study.

The second limitation is the small size of the sample. The study could have recruited a larger number of centres from different countries, or a larger number of individual therapists. By choosing a purposive sample, the centres were known to the researcher and in fact one included the researcher's workplace. On the one hand this assures that the data is well understood and the researcher has an in-depth knowledge of the subjects but on the other, it could be said that these centres are too alike. Centres in the USA, Canada or other countries in Europe such as the Netherlands where training is at an undergraduate level and differently configured, would have brought forward more varied data. The fact that the centres were alike, however, and that they largely included music therapists who have undertaken a postgraduate training based on improvisational music therapy, means that there are some patterns in responses that serve to strengthen the outcomes as well as present limitations.

The reliability of the study has to be in question because the responses to the questionnaire were not consistent in that not all questions were fully addressed by all centres, and some centres wrote responses of variable length and content. In terms of construct and criterion validity, the responses demonstrated that the questionnaire served to elicit a comprehensive and highly relevant response to the main research question.

Considering the questionnaire design has been a major part of method, and whilst there was careful consultation at an International level through the conference network (Finland European Congress, 2004), four years of attending the Aalborg University PhD programme, and extensive knowledge of literature in the field, the questionnaire was long and at times too demanding. As a result only one centre provided detailed case material in each category, and only one really answered the questions about levels of work (Chapter 9). As a result, data from only one centre could hardly be considered as representative, and could not be included.

The questionnaire started with questions about context instead of diagnosis which might have ultimately affected the amount of data participants thought to include specifically about diagnosis. Although the analysis of data sifted out diagnostic specific information from the 'Context' questions in section 7 of the questionnaire,

many centres did not include all the contexts in their services. For example, not all centres included Day centres and Out-patient services at the time of the study.

Another limitation, common in many surveys and questionnaires, was that participants were busy professionals with full case-loads, and this could have affected the amount and type of data produced for some centres. The timing of the questionnaire coincided with a total reorganisation of services in the UK and of healthcare in general through the Agenda for Change[9] in the UK and this was an enormously pressured time period for the centres. In addition the choosing of centres with established clinicians and researchers meant that these music therapists were involved in their own research and publication activities. So while the supplied information is of high quality, time pressures may have limited the potential extent to which data was comprehensively given for each part of the lengthy questionnaire.

The statistical analysis undertaken used a measure of proportions to determine to what degree an approach or technique was reported as used within a context or for a diagnosis. The limitation for this analysis was the very small sample, and significant results need to be treated with a degree of caution. As stated in chapter 11, in some calculations there is a low value of n (the number of results to be tested). This means that the chi-squared approximation used in the statistical test, may not be strictly valid. This applies to any calculations where the total n is equal to or less than 9. However, the results are included for completeness.

The results for context and diagnosis were also combined to allow a more robust calculation. The limitation with this is that Context and Diagnosis are two rather different variables, and combining them only serves to give a general indication as to the usage of approaches or techniques. Separating out the data in these two categories would equally limit the viability of any significant usage being found from an analysis of proportional differences. The most useful result from these analyses was a good indication of general usage overall.

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[9]

http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingPay/AgendaFor Change/fs/en

12.9 Implications for music therapy education

One emerging theme that is very clear is that participants in this study, who are also involved in music therapy training courses, appear quite focussed on one theoretical approach or method. Many times in the study music therapists stated that they did not use a particular technique or approach because they were not trained in it (10.7.7 in relation to Analytical Therapy, and 10.7.10, 10.8.12, 10.11.10, 10.12.12, 10.15.10 GIM). This feature was not just confined to more specialised approaches and techniques such as Guided Imagery in Music, which requires a long and specific training; but also to aspects which might be seen as part of the core music therapy techniques acquired by most music therapists, such as receptive techniques (Grocke and Wigram 2007) [10] or Activity-Based techniques. However it is often difficult to ascertain a reason for non use, or whether Centres would have used a technique if they had training in it. For example Centre A, in their response to the question regarding the use of Receptive Music Therapy (RR), mentioned that this is not the centre's orientation, but they did not explain why. (10.16.11).

There was also one centre in particular, (C) which gave a 'yes' or 'no' answer to most questions, but did not give any reasons for why a particular approach or technique was or was not used, apart from the exception in the eating disorders category, where the music therapist particularly oriented to this clinical field. Other centres acted similarly for some sections of the questionnaire and it appeared that respondents were hesitant to make any generalisations about reasons for links with diagnosis. From discussions with centres in preparation for the study, the researcher concludes that this is either because they did not feel qualified or experienced enough to do so, or because they were against making links on ideological grounds, with a concern that this would de-personalise treatment.

Some respondents were so extremely grounded in their own theoretical training and approach that they declined, or found it very hard to think about possibilities of adapting, moderating or intensifying a particular approach or technique as a result of diagnosis rather than the perceived personal needs of patients. Linked to this, some

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[10] As will be evidenced by Grocke & Wigram (2007) in their book about Receptive Techniques in press.

respondents were very informal in their answers, with a chatty style which was refreshing, but also led the researcher to wonder whether music therapists are always professionally prepared for having to articulate clearly what they do and why. Casual and rather off-the cuff comments such as 'this is not my scene' or 'not my bag', or 'this is my way' were included in responses from some centres. This phenomenon certainly confirmed the researcher's motivation for undertaking the study, which was partly driven by an impression that music therapists might need to articulate more sharply their practice particularly in countries where there is a market-led, evidence-based culture. The aim of this study was that some of the findings would contribute to this process.

Certainly the emergent evidence is that in these five centres, the main training backgrounds were grounded in a Psychoanalytically Informed approach, and different permutations of this, as discussed in 12.7, and also from a predominantly music improvisation-focussed training background. Only one centre included substantial input from someone trained in a Creative Music Therapy approach, Centre B, and only Centre E included training in GIM as far as can be definitely determined.

Most centres included experienced practitioners who are also music therapy educators and leaders in their particular speciality in psychiatry (Centres A, B, D & E). Centre C appeared reticent about giving information about training or substantial information but included a specialist in the field of eating disorders. As a result of this it could be said that knowing limitations and stating that an approach is not used owing to lack of training is clinically desirable.

In terms of music therapy education, and the use of approaches and techniques linked to diagnosis that could be taught on training courses, the researcher found little evidence of this regarding the field of Mental Health and suggests that there is still a need for guidance and in depth thinking to clarify systematic and consistent approaches and techniques for these populations. This would add to the existing USA-based literature (Unkefer 1990, Cassity and Cassity 2006), which does not reflect European approaches and techniques.

The NICE guidelines in the UK would benefit from additional input from music therapists in relation to diagnosis, and if these were evidence-based they would carry more weight. The findings here could contribute some initial marker- points for this purpose, and in the UK would fit with new National Service Framework agendas and add to the existing HPC requirements for Education and Training referred to in 7.2 [11]

The drawing up of definitive guidelines originally planned will be a further piece of work for the future, as the data was not complete in all cases. In addition, while the study looked at six diagnoses, only two centres responded to the section on depression, which means that for this diagnosis, and some others, future studies might replicate this survey across a larger number of centres for single diagnoses. Furthermore, the findings related to the diagnostic categories would benefit from dissemination in the wider psychiatric field which is planned for 2007. Following this some guidelines for the training of music therapists would be proposed.

The results of this study and further up-dating will be important to related professionals to improve working relationships and ultimately treatment for patients. This researcher has been asked to draw up guidelines for the leading group in this field, Psychiatrists, by the Royal College of Psychiatrists in the UK. The modules will be part of their on line modular post training Continuous Professional Development (CPD) programme. The modules will serve to inform rather than to train, this group of colleagues, regarding which patients can benefit from which type of approach, as well as offering better criteria to assist referral, and inform their clinical teams. Information will be drawn from the findings in this study, and from studying other music therapy training manuals in the world. This will include the seven UK based trainings which now have extensive formal curriculum documents under the HPC following recent validation events. In order to do this clearly, the findings of this study first need to be published and discussed amongst the music therapy professions as suggested above.

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[11] In the UK Arts Therapies services including Art Therapy, Dramatherapy, Dance Movement Therapy and Music Therapy have become increasingly common since the collaborative government registration of the Arts Therapies under the Health Professions Council. They maintain their trainings and professional identity for each discrete discipline, but are often organised together. (HPC Standards of Education and Training & Standards of Practice. www.hpc-uk.org/aboutregistration/professions/artstherapists

The first stage would be to target the training courses and centres linked to the study in order to publicise and test out some of the main findings and some of the more clinically detailed outcomes from the conclusions sections in Chapter 10 for each diagnosis and from Chapter 12 .4 & 12.5.

In conclusion, the dilemma for the profession to address is whether it is desirable to expand techniques and approaches taught in all trainings which would respond to changing trends, (and this should include advances in music technology, notably absent from the study), or to develop the trend for specialised trainings where music therapists are trained to be focussed in what they do within certain boundaries, and for particular populations. One very new example of the latter is the planned Community Music Therapy (Nordoff-Robbins)[12] training in Manchester, UK.

12.10 Future research directions and further clinical implications

12.10.1 Introduction

This study aimed at giving an overview of the main diagnoses in adult psychiatry. There is further work to be done for each diagnostic category, as well as for the different approaches and techniques. However a priority in this researcher's view is to carry out further clinical outcome studies and controlled trials where different approaches and techniques are researched. It must also be appreciated that one aspect mentioned in the limitations of this study (12.8) is the absence of descriptions by the patients of their experience of the process.

Many music therapists do not want to articulate specific details about a range of techniques and approaches other than Free Improvisation, if they are grounded in a psychoanalytic tradition where free association and working with the relationship as it develops is key to the process. However it has been found for other psychotherapies that a firm and clear approach based upon evidence is essential for inclusion in modern treatment programmes. (Roth and Fonagy 1996).

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[12] http://www.nordoff-robbins.org.uk/training/community/ accessed 24th November, 2006.

There is a need indicated from the study for further research for each specialised diagnostic category, and this would allow more depth and detail to be explored regarding the influence of music therapy for the different diagnostic sub-categories within each main diagnostic group. In future research there is a need for outcome studies with larger samples, within the framework of Randomised Controlled Trials and Clinically Controlled trials. Music therapy could then be considered as an indicated treatment. This is specifically relevant in the UK in order to meet NICE guidelines, otherwise funding will not be secured for treatments.

Personality disorders and schizophrenia were the two diagnostic categories that reaped the largest amount of data in this study. The study also shows that these two diagnostic groups are seen as a priority by the centres because music therapy has something unique to offer in the form of non-verbal and musical processes which are necessary for these groups as already discussed throughout the thesis.

12.10.2 Future research in schizophrenia

From the perspective of further research for schizophrenia the Cochrane review on schizophrenia and schizophrenia-like illnesses (Gold et al 2005), has highlighted such a need for further outcome studies, and the findings showed that music therapy is a beneficial treatment for this population over and above standard care. In Europe, there is a developing system of only funding treatments that show enough clinical evidence from outcome studies as required specified by The National Institute for Clinical Excellence (NICE). Interestingly there is no emphasis in the NICE guidelines on the value of supportive psycho-social treatments for the individual patient alone, or interactive work in groups for people living with schizophrenia. The guidelines for treatments for schizophrenia are currently limited to Family Therapy, Cognitive Behaviour Therapy and Medication, and do not mention Arts Therapies.

At the time of this study, and just published at the time of writing, a randomised controlled trial was carried out on a sample of 81 patients with schizophrenia, which concluded that further large studies with more than 200 participants are needed, in order to demonstrate at a significant level the benefits of music therapy with this population. (Talwar et al 2006). Clinical implications of their study were that music

therapy provides a means of engaging people with schizophrenia in active treatment during an inpatient admission and may improve symptoms of schizophrenia and aid recovery. Strikingly, the music therapy approach described appears synchronous with the approach favoured in this study, which found that a Supportive Psychotherapy and Psychoanalytically Informed approach as the most common theoretical orientation, and Free Improvisation with and without talking and Composed Songs are the most favoured techniques for intervention. The description of the music therapy approach used in the Talwar et al study (ibid 2006), seems to encompass all these aspects, including co-improvisation, to make a supportive interpretative musical and verbal intervention as shown in the following statement. At the end of this statement the writers refer to Pavlicevic et al (1994) and Bruscia (1998) to clarify the approach taken here which focuses upon improvisation.

'The focus of the therapy was on co-creating improvised music with talking used to guide, interpret or enhance the musical experience. Initially the therapist listens carefully to the patient's music and accompanies them closely, seeking to meet their emotional state in musical terms. Subsequently they offer interventions in the form of opportunities to extend or vary the nature of the musical interaction.' (ibid p.405).

Whilst this randomised controlled trial could not report significant results in the improvement of symptoms, the trend of the findings was in a positive direction. It is important to note that in the survey for this study, twenty-three therapists concluded that these ingredients of music therapy for clinical intervention are used to a significant degree for this population.

12.10.3 Research in personality disorders

The other major diagnostic group in this study is personality disorders, as discussed in 12.5.6, and reasons emerged for the use of free improvisation and also structured music techniques. These were often linked by respondents to common difficulties associated to this diagnosis, particularly borderline personality disorder. For example many people who self harm and have suffered abuse are found to have very low self esteem.

At the beginning of this study the author had already initiated a pilot research project, together with a consultant psychiatrist and research assistant, which aimed to look at some of these issues further in a way that had not previously been undertaken. (Odell-Miller et al 2005 Appendix X). This study supports the need for such a project, which is in the proposal stage for submission for national funding. The small amount of music therapy in this field also confirms the need for more research.

Hannibal (2003) refers to a patient developing respect for music and therefore herself, through music therapy, which appeared to reduce the degree of negative self-concept. This is interesting because the pilot project aimed at evaluating what musical changes might occur in the playing of members of the weekly music therapy group for people with personality disorders, and at exploring a link between musical aesthetic development and improved self image. (ibid).

The main question under investigation is how participants' music changes over time in a weekly music therapy group, and how this relates to changes in symptoms or in the way participants feel about themselves. The hypothesis for this new study is that changes will occur which could be associated with more interaction between the members, and more expressive playing. This in turn might relate to increased self esteem and a wish to create something 'whole' or aesthetically satisfying, which is particularly crucial for this population who often self-harm. An example might be where a member of a group changed his/her playing from an overwhelming volume showing no regard for the other members of the group, to listening and playing music that shows regard for others and forms part of a whole creative act. If a clear progression emerges in terms of musical expression, and musical interaction with peers and the therapist, it is hoped that patients would be able to transfer these increased skills of positive expression and interaction, to their experiences in the outside world. The planned research will investigate this further, and the musical analysis, together with the psychological questionnaires measuring the patients' emotional state will be correlated within each subject.

The results of the pilot study (Appendix X) following detailed musical analysis showed that the musical improvisations developed, in terms of emotional expression and aesthetic quality, over a ten month period, although progress was not linear. It is

interesting to note that often the first impression of the researcher carrying out the musical analysis was of an expressive group piece, and then the listener had to separate the individual contributions of the players. It was concluded that the increased level of group expression gave all members new possibilities, regardless of who may have initiated playing in that way. These findings indicate that there is a need for the new research study to be carried out in the future, and it is pertinent to this study because it looks at links between components of the diagnosis, and the amelioration of symptoms, for example the decrease of self harm and increase of self-value in patients, through their use of music.

12.10.4 Final conclusion

In relation to this study, and further similar encyclopaedic research in order to clarify which approaches and techniques are most useful with which diagnoses, there are some interesting future directions. The main findings here show that there are some definite indicators that certain approaches and techniques are used more or less for different diagnosis, for example there are differences between psychotic and non-psychotic groupings. (12.3.1-12.3.9).

Whilst this thesis did not directly collect patient data as part of the survey, it reported studies and clinical reports that did. The information gained from music therapists in a systematic way through the questionnaire/survey, could be tested further, by setting up a study involving patient participants and the multi-disciplinary team. The findings from the current study will be presented to the centres involved, and to the wider music therapy population in adult psychiatry in order to then produce guidelines for music therapy practice that would inform both music therapy clinicians, and the statutory bodies responsible for funding and employing music therapists. The other main area for further research is that of training, and this study indicated a need for a systematic examination of how music therapists are trained and equipped to work in the field of adult psychiatry.

It is clear that every music therapist will bring his or her own style into the therapy room and this is what will determine the essence of the therapy, in addition to training and experience. The focus upon labels in this study for both diagnoses and approaches

and techniques is for the purpose of categorising, to provide a working framework for understanding the process of music therapy and this will be addressed in publications arising from this study. A suggestion for further developing the ideas presented in thesis is to convene an international group of experienced music therapists to further clarify the use of approaches and techniques with different diagnoses. While this does not in the author's view, detract from the fact that each patient and therapist bring their own individuality to the therapy room, it will insure more consistency of approach.

The findings from this study will offer new knowledge in the field of music therapy worldwide. For example, in the UK the findings will contribute to the Department of Health's working groups on developing NICE guidelines, and whilst the evidence is not gathered from clinical trials, it provides evidence about the work.

Returning to the original motivation for the study, involvement has been extensive in establishing the profession of music therapy in the public domain for which definition and articulation are crucial. Two of the author's articles in Part I were concerned with an exploration of the relationship between music therapy and psychoanalysis. One major development during this research period which contributed to the literature review and wider participation with other professionals was the author's involvement with a publication for inclusion in the new Oxford Textbook of Psychotherapy (Schaverien and Odell-Miller 2005). The chapter 'The Arts Therapies' is listed in the first section of the book, under the heading 'Major Modalities', together with all the major psychotherapies. This is confirmation of the position of the professional standing of music therapy in the wider field, but the study shows there is more to be achieved.

It is difficult to provide a unified picture to the external world whilst there are so many experienced music therapists who are developing their own subtle approaches which they unfortunately feel the need to define differentially, but which with closer examination, and for the purposes of marketing and referral criteria, might effectively be put under one umbrella.

Until now music therapists have been focussing upon setting up a profession, and establishing standards, and this has now been achieved in some European countries. This has meant that music therapists have not come into a culture of an existing established methodology (with one or two exceptions), and so neo-pioneers have been keen to invent and develop their own methods.

The need for more systematic documentation of approaches and techniques linked to diagnosis, and research which supports anecdotal findings is essential in order to secure the future of music therapy in adult psychiatry, so that there is clarity for users and purchasers of music therapy services. This study provides definitive information to add to existing literature for this precise purpose.

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Danske resumé af Helen Odell-Millers ph.d.-afhandling:

The Practice of music therapy with adults with mental health problems: the relationship between diagnosis and clinical method.

Klinisk musikterapi med voksne med psykiatriske problemstillinger: forholdet mellem diagnose og klinisk metode.

1.1 Introduktion:

Denne ph.d.-afhandling falder i to dele. Første del indeholder fem af forfatteren publicerede forsknings artikler, som udgør halvdelen af afhandlingen og ligeledes er udgangspunkt, historisk baggrund og referenceramme for anden del (Odell-Miller 1999, 2001, 2002, 2003 og Odell-Miller et al 2006). Forfatteren er en erfaren kliniker og forsker, og desuden cand. mag. i filosofi, 1989. Artiklerne og bogkapitlerne, der er inkluderet i første del var alle publikationer, som blev indleveret til fagtidsskrifter med peer review eller redigerede bøger, og de har derfor gennemgået en systematisk evaulering som led i publikationsprocessen. Første og anden del er forbundet på den måde, at forskningsprojektet i anden del opstod ud af hovedspørgsmålene og temaerne i disse publikationer, primært temaer inden for voksenpsykiatrien, herunder forholdet mellem musikterapi og psykoanalyse.

Hovedtemaerne relaterer til forfatterens ønske om at definere, hvordan musikterapi er indplaceret i voksenpsykiatrien, både klinisk og teoretisk, og hvordan den definerer sig selv i forhold til psykoanalytisk teori såvel inden for eget fagområde som i forhold til andre fagområder indenfor sundhedssektoren. Ligeledes efterlyser to publikationer (Odell-Miller 1999, Odell-Miller et al 2006) en forskningsmetode, der er anvendelig til besvarelse af spørgsmålene om hvor gavnlig og virksom musikterapi er i psykiatrien, og til hvilke diagnosegrupper.

Efter en præsentation af publikationerne og en kort diskussion af deres relevans for forfatterens spørgsmål, følger anden del af afhandlingen med en spørgeskemaundersøgelse tilrettelagt med henblik på at besvare hovedspørgsmålet: "Hvordan defineres forskellige behandlingstilgange og –metoder der relaterer diagnose til behandling? i voksenpsykiatrien, med 18-65 årige patienter,"

Forskningsdesignet er både kvantitativt og kvalitativt og inddrager statistiske og kvalitative analyser, som opstår ud fra den målrettede undersøgelse. Det undersøges, hvad der er beskrevet i litteraturen om nuværende eksisterende praksis, og dette knyttes til resultaterne af en dybtgående spørgeskemaundersøgelse af en lille gruppe på fem musikterapeutiske klinikker i Europa, med det formål at finde ny viden relateret til førnævnte spørgsmål. Begrundelsen for dette valg forbindes med kliniske, politiske og uddannelsesmæssige perspektiver.

Anden del: Spørgeskemaundersøgelsen

I kapitel 7 etableres der et bindeled mellem første og anden del af afhandlingen, og forskningsprojektets rationale opsummeres. Baggrunden forklares og knyttes til et bredere professionelt musikterapeutisk fagområde samt til psykiatrien i Europa, ligesom det knyttes til forfatterens kliniske erfaring og erfaring med forskning. Der gives eksempler fra den gennemgåede litteratur og en introduktion til undersøgelsen, dens design og proces.

I kapitel 8 diskuteres litteraturen om musikterapi indenfor psykiatri, hvilket fører frem til forskningsprojektets rationale og behovet for ny viden inden for området, der knytter diagnose og valg af behandlingstilgang og -metode indenfor musikterapien i psykiatrien sammen. Litteraturen undersøges både i et internationalt perspektiv og i forhold til diagnosegrupper, og i gennemgangen sammenholdes og analyseres forskellige perspektiver.

I kapitel 9 beskrives metoden for forskningsprojektet i detaljer, fra den oprindelige ide, der motiverede og inspirerede forskeren, frem til spørgeskemaundersøgelsens design. Udførelsen af undersøgelsen af de fem etablerede europæiske musikterapiklinikker indenfor psykiatri, der blev udvalgt som en egnet gruppe til casestudier, beskrives, og den planlagte analyse af resultaterne, med inddragelse af både kvantitative og kvalitative metoder, diskuteres. Rammerne for hver enkelt klinik beskrives, og det musikterapeutiske teams tidsforbrug i forhold til hver enkelt diagnose opsummeres. Etiske og kliniske perspektiver, der har haft indflydelse på designet af forskningsprojektet, undersøges grundigt, og det samme gælder aspekter af de forskningsmetoden.

I kapitel 10 fremlægges og analyseres resultaterne fra de kvalitative data for hver af de 6 diagnosegrupper, og for hver af behandlingstilgangene og –metoderne, som er inkluderet i

spørgeskemaet. Resultaterne præsenteres for hver diagnose for sig, med henblik på at give et overblik over hvor mange klinikker, der anvender hver enkelt metode og behandlingstilgang indenfor hver diagnosegruppe, opstillet på en sådan måde, at mønstre synliggøres i forhold til i hvilken grad hver behandlingstilgang og metode er anvendt eller ikke anvendt inden for hver diagnosegruppe. For hver diagnose diskuteres og analyseres de kvalitative beskrivende data fremlagt af hver klinik i forhold til alle behandlingstilgange og metoder, og disse sammenholdes på tværs af klinikker og diagnoser. Der drages konklusioner for hver behandlingstilgang og metode i forhold til, hvor meget eller hvor lidt disse anvendes af klinikkerne inkluderet i forskningsprojektet.

I kapitel 11 præsenteres de kvantitative data på tværs af klinikkernes settings og diagnoser, med henblik på at se i hvilken grad hver enkel behandlingstilgang og metode bliver anvendt, her ikke specielt knyttet til diagnose, men derimod til graden af anvendelse. Data præsenteres ved hjælp af søjlediagrammer og deskriptiv statistik med statistisk analyse af den proportionelle anvendelse, som derefter relateres til det kvalitative resultat, der blev diskuteret i kapitel 10. Komparative og flere yderlige konklusioner samt diskussioner vedrørende de overordnede strukturer og tendenser fortsættes i kapitel 12.

I kapitel 12 præsenteres diskussioner og konklusioner relateret til forskningsprojektets hovedspørgsmål, og til studiets temaer som helhed, og på tværs af klinikker og diagnoser knyttes de kvalitative og kvantitative resultater. Der drages konklusioner vedrørende anvendelsen af specielle metoder eller behandlingstilgange, om hvorvidt disse er "rettet mod" en bestemt diagnosegruppe, og hvilke relationer, der påpeges i forhold til litteraturen. Forskningsprojektets og dets designs begrænsninger undersøges, samt implikationerne i forhold til uddannelse, træning og klinisk praksis. Fremtidige indikationer for forskning diskuteres og anbefales, og der drages konklusioner ud fra afhandlingen som helhed og især ud fra forskningsprojektet.

Undersøgelsens rationale og baggrund

Begrundelsen for at udføre dette forskningsprojekt var på det tidspunkt, hvor projektet påbegyndtes, at der var sparsomt med fyldestgørende tekster om emnet indenfor det musikterapeutiske fagområde internationalt, og de der eksisterede kom fra USA (Unkefer 1990; Wheeler 1983, 1987). Med udgangspunkt i dette vælges et europæisk fokus i undersøgelsen. De organisationer, som er involveret i mange landes sundhedsvæsen, for

eksempel i Storbrittanien, inkluderer "købere" og "sælgere" (*"Purchasers" and*
"Providers"), der ofte har brug for detaljerede informationer om, hvorvidt bestemte
behandlinger er effektive for bestemte målgrupper. Det kan tilføjes, at National Institute for
Clinical Excellence (NICE)[1] i Storbritanien også evaluerer effekten og relevansen af en
behandling, før den anbefales indført generelt i befolkningen. Behovet for denne information
er stigende og mere og mere nødvendig, i takt med at behandlingsformer, der ligger tæt på
musikterapi, er mere specifikke i deres påstande om at bestemte behandlinger er effektive i
forhold til bestemte diagnosegrupper eller problemstillinger.

Et eksempel på dette, som inspirerede til dette forskningsprojekt, kan findes i en gennemgang
af effektiv psykoterapeutisk behandling af skizofrene (Roth &Fonagy 1996).
Familieterapeutiske programmer, der har til formål at modificere det støttende teamarbejde til
den skizofrene, samt kognitiv adfærdsterapi til akutte symptomer nævnes som effektive
behandlinger, men kreative terapier nævnes slet ikke.

Kreative terapier nævnes kort som et muligt frivilligt behandlingstilbud til patienter i en nylig
DOH-undersøgelse "Behandlingstilbud inden for psykologiske terapier og rådgivning" (Parry
2000)[2], men der mangler information om interventionernes karakter, knyttet til diagnosen.
Dette giver indtryk af, at musikterapi måske er ude af takt med andre behandlingstilbud
såsom psykoterapi (Ruth & Fonagy ibid), der mere og mere definerer behandlingsformerne
inden for rammerne af evidensbaseret praksis. Mens nogle forfattere har forsøgt at inddrage
ikke-systematisk dokumentation i opstillingen af retningslinier for praksis knyttet til
diagnosegrupper (Unkefer 1990; Wheeler 1983,1987), er det sparsomt med systematisk
litteratur om teori, praksis og forskning inden for musikterapi, der inddrager diagnose i
overvejelsen.

Ligesom der er et klinisk behov for denne undersøgelse, ville den musikterapeutiske
uddannelse, specielt i Storbrittanien, kunne få glæde af nogle klare beskrivelser og
vejledninger i forhold til spørgsmålet om, hvilke behandlingstilgange og -metoder der er mest
anvendelige til hvilke diagnosegrupper i voksenpsykiatrien, sådan at fremtidig praktiserende

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[1] Retninglinerne for NICE kan ses på: www.nice.org.uk (indskriv derpå den relevante diagnose).

[2] Denne undersøgelse begyndte i 2002, mens overvejelserne til den startede allerede i 2001, så dette er årsagen
til at den beskrives som nylig.

musikterapeuter kan reagere fleksibelt og relevant i forhold til kliniske krav og patient behov.
3

I musikterapeutisk forskning og casestudie-litteraturen er der ofte generelt en udeladelse af diagnostisk information relateret til en logisk begrundelse for en musikterapeutisk behandlingstilgang og metode (Proctor 1997; Odell-Miller 1999, 2001, 2002, 2003) eller der lægges ringe vægt lagt på diagnose-aspektet. Forfattere, som refererer til specifikke diagnosegrupper i mere specialiseret end generelle undersøgelsestyper r, afgrænser ofte deres forskning eller undersøgelse til den specifikke kategori, i stedet for at foretage en komparativ analyse. For eksempel diskuterer Pavlicevic & Trevarthen (1994) forskning i musikterapi med mennesker, der lider af skizofreni, som viser signifikante resultater. På den ene side viser de en tydelig værdsættelse af diagnostiske overvejelser, nemlig ved at tilpasse en behandlingstilgang udviklet i arbejdet med børn, specielt til voksne med skizofreni. Dog rummer undersøgelsen ikke en detaljeret diskussion af, hvorfor improvisation i særdeleshed kan være gavnlig eller ikke i forhold til patientgruppen - sammenlignet med andre interventioner såsom at anvende komponerede sange.

Det konkluderes (også ud fra kapitlerne i første del af denne afhandling), at der i litteraturen vedrørende voksne med psykiatriske problemstillinger, og specielt i den Europæiske litteratur, er meget få generiske, dvs. ikke-specifikke sammenligninger af metoder og behandlingstilgange, ligesom der kun er få diskussioner af hvorfor bestemte metoder og behandlingstilgange kan være egnet til en gruppe, men ikke til en anden.[4] Opsummerende kan man derfor sige, at de mest relevante eksisterende tekster er Unkefer (1990, revideret i 2005) og Wheeler (1987), begge fra USA, der har indsamlet information og som diskuterer og sammenholder relevante behandlingstilgange relateret til diagnose.

Introduktion til spørgeskemaundersøgelsen

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[3] Cassity & Cassity (2006) har siden denne undersøgelse tog sin begyndelse publiseret et manual til dette formål, men den er rettet mod basis træning/uddannelse i USA og ikke nødvendigvis anvendelig for mere psykoanalytisk- og improvisationsbaseret Europæiske træning.

[4] Siden denne undersøgelse tog sin begyndelse har tidsskriftet Cochrane gennemgået skizofreni og dermed fremhævet fordelene ved musikterapi til skizofrene, og egnede behandlingstilgange og metoder er diskuteret, skønt disse ikke er behandlet detaljeret. (Gold et al 2005) www.cochrane.org/reviews/en/ab004025

Det vigtigste forskningsparadigme var en ikke-sandsynlighedsbaseret spørgeskemaundersøgelse, hvor formålsrettet sampling blev anvendt til at rekruttere en lille, relevant gruppe af etablerede musikterapiklinikker. Der var seks kliniske hovedkategorier (skizofreni, bipolare lidelser, depression, angst, spiseforstyrrelser og personlighedsforstyrrelser), ni musikterapeutiske behandlingstilgange og tolv behandlingsmetoder, som fremgår af nedenstående liste.

Metoder/teknikker	Behandlingstilgange
At synge komponerede sange	Støttende psykoterapi
Fri Improvisation med begrænset verbalisering	Psykoanalytisk baseret
Fri Improvisation og verbalisering/verbal refleksion	Klientorienteret
Fri Improvisation med struktur som f.eks. tur-tagning eller spilleregler	Adfærdsorienteret
Temabaseret improvisation	Udviklingsbaseret
Aktivitetsbaserede interventioner	Analytisk musikterapi
Sangskrivning	Kreativ musikterapi (Nordoff/Robbins
Musikalsk rollespil	Aktivitetsbaseret
Receptiv musik, der anvender *live* musik	Billeddannelse til musik (incl. GIM)
Receptiv musik der anvender *indspillet* musik	
Billeddannelse til musik	
Musik til afspænding som en del af et afspændingsprogram	

Et spørgeskema blev udviklet til at indsamle dybtgående kriterie-baserede data, som derefter blev analyseret. De fem klinikker/centre havde i alt 23 musikterapeuter ansat. Formålet var at finde veletablerede musikterapiklinikker, hvor der var en velfunderet viden og erfaring,

ikke nødvendigvis beskrevet i officielle publikationer, men en viden som eksisterer i praksis eller i upublicerede rapporter eller artikler.

Opsummering af de vigtigste resultater og konklusioner

Resultat 1: Der var forskelle mellem klinikkerne i forhold til hvor detaljeret de leverede informationer, der støttede beslutningerne de traf i forhold til behandlingstilgange og metoder knyttet til diagnose.

- Musikterapiklinikkerne i undersøgelsen definerede med varierende grad af detaljering, hvad de gjorde og hvorfor de gjorde det i tilknytning til given diagnose.
- I nogle tilfælde var dette dokumenteret meget grundigt med case-eksempler og klare ræsonnementer.
- I andre klinikker manglede grundig dokumentation, idet der kun blev givet få og begrænsede begrundelser for valg af metoder og teknikker.

Resultat 2: Musikterapeutiske tilgange med en Støttende psykoterapeutisk tilgang eller Psykoanalytisk funderet tilgang var de mest anvendte og rangerede øverst eller næstøverst i alle diagnosegrupper.

Resultat 3: Teknikker som Fri Improvisation med begrænset verbalisering, og Fri Improvisation med verbalisering/verbal reflektering rangerede højest indenfor alle diagnoser, men med visse forskelle mellem psykotiske forstyrrelser og ikke-psykotiske forstyrrelser.

Resultat 4: For psykotiske forstyrrelser rangerede anvendelsen af komponerede sange øverst sammen med Fri Improvisation med begrænset verbalisering og Fri Improvisation med verbalisering for både skizofreni og bipolare lidelser, og der lægges mindre vægt på at anvende metoder, der kræver symbolisering.

Resultat 5: For ikke-psykotiske forstyrrelser rangerede metoder, der kræver symbolisering – så som temabaserede improvisationer, musikalsk rollespil og anvendelse af andre medier, og Fri Improvisation, der anvender strukturerede spilleregler – øverst, eller næstøverst i forhold til diagnoserne angst, depression, spiseforstyrrelser og personlighedsforstyrrelser.

Resultat 6: Skizofreni og personlighedsforstyrrelser er de diagnoser, der modtager den største procentdel af musikterapeutisk behandling i alle musikterapiklinikker.

Resultat 7: Personlighedsforstyrrelser fik den største opmærksomhed i de deltagende musikterapiklinikker, konkluderet både ud fra mængden af indsamlede kvalitative data og ud fra det faktum, at patienter med personlighedsforstyrrelser i tre ud af fem klinikker udgør den største del af klientellet, fra 25 – 50 %.

Resultat 8: Psykotiske forstyrrelser, inklusiv bipolare lidelser og skizofreni, var en højt prioriteret gruppe i alle klinikker.

Resultat 9: Angst og depression fik mindst opmærksomhed af musikterapiklinikkerne i undersøgelsen, konkluderet både ud fra mængden af kvalitative indsamlede data og det faktum, at der i nogle tilfælde kun var to ud af fem klinikker, der fortalte at de behandlede klienter med primære diagnose.

Resultat 10: Respondenterne var ofte ikke i stand til at knytte deres ja eller nej-svar til specifikke begrundelser for hvorfor de anvendte eller ikke anvendte specifikke metoder eller behandlingstilgange. Dette var i nogle tilfælde relateret til manglende træning/uddannelse.

Resultat 11: Hvad musikterapeuten gør i rummet sammen med patienten i settingen (hvad enten dette er knyttet til den specifikke diagnose eller ikke), og hvorfor de gør det de gør, har ofte en del fællestræk i de klinikker, hvor detaljerede case-materiale foreligger. Dog var sammenligneligt case-materiale ofte kategoriseret og defineret efter forskellige, nogle gange specifikt udviklede metode-"overskrifter" eller "-titler".

Retningslinier for fremtidig forskning
Undersøgelsen påviser nogle fællestræk i den aktuelle praksis i klinikkerne, som deltog i undersøgelsen, og undersøgelsen peger ud fra resultaterne på et behov for og mulighederne af at opstille retningslinier for den kliniske og uddannelsesmæssige tilrettelæggelse af arbejdet med specifikke tilgange og metoder i voksenpsykiatrien – og hvorfor de formodes at være særligt anvendelige. Undersøgelsen peger også på et behov for videre forskning inden for diagnostisk orienteret musikterapi.

SUMMARY OF DOCTORAL THESIS: HELEN ODELL-MILLER

THE PRACTICE OF MUSIC THERAPY FOR ADULTS WITH MENTAL HEALTH PROBLEMS: THE RELATIONSHIP BETWEEN DIAGNOSIS AND CLINICAL METHOD

1.1 Introduction

This Doctoral study is in two parts. Part I includes five published research articles by the author which represent half of the submitted thesis, and also form the starting point, historical background and thinking for Part II. (Odell-Miller 1999, 2001, 2002, 2003 and Odell-Miller et al 2006). The author is an experienced clinician and researcher, completing a Master of Philosophy in 1989. The articles or chapters in books included in Part I were all publications that were submitted to peer reviewed journals or edited books, and have undergone systematic review as a part of that process. Parts I & II are linked in that the research study in Part II arose from main questions and themes emerging from the publications, mainly in the field of adult psychiatry and looking at links between music therapy and psychoanalysis

The main themes relate to the author's quest for defining how music therapy is placed in the field of adult psychiatry, both clinically and theoretically and how it defines itself in relation to psychoanalytic theory within its own community and to the external world of health care services. Two publications (Odell-Miller 1999 & Odell-Miller et al 2006) also address the search for a research methodology that is suitable for answering questions about how beneficial and effective music therapy is in psychiatry, and for which diagnostic populations.

Following the presentation of the publications and a short discussion about their relevance to the author's questions, Part II of the thesis follows with a survey-based research project designed to answer the main question: 'How are different approaches and techniques of music therapy defined in adult psychiatry, for people from 18-65 years old, which link diagnosis to treatment?'

The research design is both quantitative and qualitative and involves some statistical analysis and qualitative analysis arising from a purposeful survey. It was decided to explore what is described about current practice in the literature, and link this to the results of an in-depth survey from a small sample of five music therapy centres in Europe, in order to find some new knowledge relating to this question. Reasons for this choice are linked to clinical, political and educational perspectives.

Part II: The Survey

In Chapter **7** a link between Part I and II of the thesis is made, and the rationale for the research study is summarised. The background is explained linked to the wider professional field of music therapy and mental health in Europe, and linked to the author's clinical and research experience. Examples of the literature review are given and an introduction to the survey, its design and process are also discussed.

In Chapter 8 the music therapy literature in psychiatry is discussed, leading up to the rationale for the study that new knowledge is needed in the field linking diagnosis to approach and technique in music therapy in psychiatry. Literature is examined from an international perspective and from the point of view of diagnostic categories, comparing and analysing different perspectives.

In Chapter 9 the method of the study is described in detail. It arose from the original ideas which influenced and motivated the researcher. These led to the design of the survey. The implementation of the survey of five established European music therapy services in psychiatry which were recruited as a convenience sample to be case studies is described, and the planned analysis of results using both quantitative and qualitative methods is discussed. The properties of each centre are described, and percentages of time spent by the music therapy treatment team with each diagnosis are summarised. Ethical and clinical perspectives which influenced the design of the study are examined as well as research methodology issues.

In Chapter 10, the results of the qualitative data are presented and analysed for

each of the six diagnostic categories and for each of the approaches and techniques that are included in the questionnaire. The results are presented for each diagnosis in order to give an overview of how many centres use each technique and approach within each diagnostic category in rank order so that patterns regarding to what extent each approach and technique is used or not used within each diagnostic category can be seen. For each diagnosis, the qualitative descriptive data given by each centre for all approaches and techniques is discussed and analysed, making some comparisons across centres and diagnoses. Conclusions are drawn for each approach and technique about how much or little they are used by the centres in the study.

In Chapter 11 the quantitative data is presented across all centres settings and diagnoses in order to see to what extent each Approach and Technique is used, not specifically linked to diagnosis, but to ascertain degree of usage. Data is presented through bar charts and descriptive statistics, with some statistical analysis of proportional usage, then linked to the qualitative outcomes already discussed in Chapter 10. Comparative and further conclusions and discussion about the overall patterns and trends is further discussed in Chapter 12.

In Chapter 12, discussions and conclusions are presented relating to the main research question of the study, and to the themes of the thesis as a whole, linking qualitative and quantitative outcomes across all centres and diagnoses. Conclusions are drawn about whether or not a particular technique or approach is used, whether this may be 'indicated' for a particular diagnostic category, and what links can be established to previous published literature. Limitations of the study and its design, implications for education, training and clinical practice are explored. Future indications for research are discussed and proposed, and conclusions drawn from the thesis as a whole and the study in particular.

Rationale and background to the study

The reason for undertaking this research was that at the time of writing there were few comprehensive texts on the subject within the field of music therapy worldwide, and

those in existence originated in the USA (Unkefer 1990, Wheeler 1983, 1987). For this reason the study takes a European focus.

The agencies involved in the provision of health services in many countries, for example in the United Kingdom include 'Purchasers' and 'Providers', who often need more detailed information about why certain treatments are effective for certain groups. In addition, the National Institute for Clinical Excellence (NICE)[1] in the UK also evaluates the efficacy and relevance of treatments before recommending their application to the general population. The need for this information is becoming more necessary as other similar treatments are more specific about stating that certain treatments are effective with certain diagnostic groups or problems.

One example of this which inspired the study is found in a review of effective psychotherapy treatments for with people with schizophrenia (Roth & Fonagy 1996). Family intervention programmes aimed at modification of the support network of the schizophrenic person, and cognitive-behavioural treatment of acute symptoms are mentioned as effective treatments, but not arts therapies.

Arts therapies are mentioned briefly, as treatments of choice for patients in a recent[2] DOH survey 'Treatment Choice in Psychological Therapies and Counselling' (Parry 2000), but there is a lack of information relating to types of interventions related to diagnosis. This gives the impression that music therapy might be out of synchrony with some other treatments such as psychotherapy (Roth & Fonagy ibid), which increasingly define treatments within the framework of evidence-based practice. Whilst some have attempted to draw anecdotal evidence and guidelines for practise linked to diagnostic groupings (Unkefer 1990, Wheeler 1983,1987), there is little systematic literature about theory, practise and research in the field of music therapy, which takes diagnosis into account.

In addition to the clinical need for the study, music therapy training courses, particularly in the UK, would benefit from some clear descriptions and guidance about which approaches and techniques are most suitable for which diagnostic groups

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[1] NICE guidelines can be found at the following website www.nice.org.uk (type in relevant diagnosis).
[2] This study began in 2002, and the thinking for it started before that in 2001, so this is why it is described as recent.

in adult mental health, so that future music therapy practitioners can respond flexibly and appropriately to clinical demands and patient need. [3]

In music therapy general research and case study literature, there is often an omission of diagnostic information relating to the rationale for music therapy approach and technique (Proctor 1997, Odell-Miller 1999, 2001, 2002, 2003) or little emphasis upon diagnosis. Authors who do refer to specific diagnostic groups in more specialised rather than general survey-type articles, often confine their research or explorations to that category, rather than comparative analysis. For example, Pavlicevic & Trevarthon (1994) discuss research with people with schizophrenia and music therapy, with significant outcomes. On the one hand they show a distinct appreciation of the diagnostic considerations, by adapting an approach previously developed for work with children, specifically for adults with schizophrenia. However there is no detailed discussion about why improvisation in particular might be beneficial or not for this population as opposed to others interventions such as using composed song, for example.

It was concluded (including the chapters by this author in Part I of this thesis), that there is little generic comparison of techniques and approaches, or discussion of why certain techniques and approaches might be suitable for one population, but not another, in the literature specifically for adults with mental health problems, and particularly in European literature. [4].

In summary, the main relevant existing texts are Unkefer (1990, revised 2005), and Wheeler (1987), both from the United States, who have collected information together, and do discuss and compare appropriate approaches related to diagnosis.

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[3] Cassity & Cassity (2006) have published a manual for this purpose since this research was started, but it is derived for USA based trainings and is not necessarily suitable for some of the more psychoanalytically and improvisationally- based European trainings.
[4] Since the study has been undertaken The Cochrane review about schizophrenia has highlighted the benefits of music therapy for people with schizophrenia, and there is some discussion about appropriate approaches methods and techniques although these are not discussed in detail. (Gold et al 2005). www.cochrane.org/reviews/en/ab004025

Introduction to the Survey

The main research paradigm was a non-probability survey based study, where purposive sampling using a convenience model was used to recruit a small and relevant sample of established clinical music therapy departments. There were six main categories, schizophrenia, bi polar disorder, depression, anxiety, eating disorders and personality disorders), nine approaches and twelve techniques listed below.

TECHNIQUES	APPROACHES
Singing Composed Songs	Supportive Psychotherapy
Free Improvisation with minimal talking	Psychoanalytically Informed
Free Improvisation and Talking/interpretation	Client Centred
Free Improvisation with structures such as turn taking or play rules	Behavioural
Theme based improvisation	Developmental
Activity-based	Analytical Music Therapy
Song Writing	Creative Music Therapy
Musical Role Play etc	Activity-Based
Receptive music using live music	Guided Imagery in Music
Receptive music using recorded music	
Imagery in music	
Music for Relaxation as part of a relaxation programme	

A questionnaire was devised to gather in-depth criteria- based data, which was then analysed. The five centres included 23 music therapists in total. The objective was to target well-established music therapy services where there is a body of knowledge not necessarily formulated into external publications, but which exists in practice or in unpublished reports or documents.

Summary of Main Findings and Conclusions

Finding 1: There were differences between the centres as to the level of detail they provided to support decisions they made linking approaches and techniques to diagnosis.

a) Music Therapy Centres in the study variably defined what they do and

why they do it linked to diagnosis.

b) In some cases this was substantiated very thoroughly, with case examples and clear reasoning.

c) In other centres this was not substantiated thoroughly, with sparse and limited reasons given for using chosen approaches and techniques.

Finding 2: Music Therapy approaches with a Supportive Psychotherapy approach or a Psychoanalytically Informed approach were used most often, and ranked first or second in every diagnostic category.

Finding 3: The Techniques Free Improvisation with minimal talking and Free Improvisation with talking/verbal interpretation are ranked highest for all diagnoses, but with some additional differences between psychotic disorders and non-psychotic disorders.

Finding 4: For psychotic disorders, using Composed Songs is ranked joint first with either Free Improvisation with Minimal Talking, or Free Improvisation with Talking/Interpretation, for both schizophrenia and bi-polar disorders, and there is less emphasis upon using techniques requiring symbolic thinking.

Finding 5: For non-psychotic disorders, Techniques that require more symbolic thinking such as Theme based Improvisation, Musical Role Play and use of other media, and Free Improvisations using structures such as play rules are ranked jointly first, or near the top of ranking orders for anxiety, depression, eating disorders, personality disorders.

Finding 6: Schizophrenia and personality disorder diagnoses are given the highest percentage of music therapy treatment input across all centres.

Finding 7: Personality disorder receives the most attention from music therapy centres in the study, concluded both from the amount of qualitative data collected and the fact that in three out of five centres personality disorders are a major percentage of case load, from 25% - 50%.

Finding 8: Psychotic disorders, incorporating bi-polar disorders and schizophrenia, emerged as a priority group in all centres.

Finding 9: Anxiety and depression receive the least attention from music therapy centres in the study, concluded both from the amount of qualitative data collected and the fact that in some cases only two out of five centres said they saw people with this diagnosis as their main diagnosis.

Finding 10: Respondents were often unable to link their yes and no answers with specific reasons as to why they did or did not use a particular technique or approach, and this was often related to lack of training in some cases.

Finding 11 What music therapists do in the room with the patient in these settings (whether or not linked to specific diagnoses); and the reasons why they do it; often appear similar across centres where detailed case material was provided. However the similar case material was often categorised and defined under different, sometimes specifically developed approach 'titles'.

Future Directions

The study establishes some commonalities in current practice in the centres included in the survey, and points to the need and possibility for guidelines to be drawn up for clinical and educational purposes from the findings of the study about specific approaches and techniques which are used in adult psychiatry and why they might be particularly useful. It also points to the need for further research studies to be undertaken in music therapy of a diagnostic-specific nature.

Helen Odell-Miller November 2006

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