Music Therapy
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Edited by
Lisa Summer, MCAT, RMT-BC, GIM Fellow
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This decade has brought a growing sophistication of the recording industry, electronic instruments, and computerized music technology. Music of every genre is now available to the general public (even music which was previously known solely by musicologists). At the same time, the public’s growing interest in alternative therapies and self-help materials (books, tapes, and workshops) has spawned an increase in popularized, quick musical cures. Acoustical phenomena and music therapy theories have become popularized, and confused; bringing about a proliferation of sound/music healing techniques which are accomplished without the presence of a professional. In addition, “music healers” who prescribe these impersonal, simplistic methods claim extraordinary, unsubstantiated results: specially composed music cures cancer; music with subliminal messages ameliorates AIDS, musical intervals balance your brain, and extra low sonic frequencies are guaranteed to bring spiritual enlightenment.

As music therapists, we understand the depth and the complexity of the triadic relationship between the client, therapist, and the musical experience; and the development of the music therapy process over time. Transformational work with sound and music cannot be quick, simple, nor prescriptive — not when it is truly centered upon our clients and on the therapeutic, aesthetic qualities of music.

This volume of the *Music Therapy International Report* is a testimony to the music-centered, client-centered practice of music therapy across the globe today. Although previous volumes have focused upon each country’s music therapy clinical practice and education, emphasizing its unique culture; Volume Ten makes no attempt to identify a particular country’s music therapy. Rather, each author in this issue represents an innovative application in a particular specialty within the music therapy field. (For example, although Connie Tomaino is an American, she does not represent American music therapy. Her article is included as an example of innovative, state-of-the-art music therapy clinical practice with the elderly.) The twenty-one articles on research, clinical practice, methods, and related topics form a volume which attests to the
innovative applications of music as a therapeutic modality across the globe. I hope that you will enjoy the creative approach of each author in his/her article, and that you will be inspired by the breadth and depth of the work taking place in our field today.

For many of the authors who have contributed to this volume English is a second language. The editors have worked to maintain the integrity and individuality of each author’s voice.

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SECTION 1: New Directions in Music Therapy Research
Music Therapy As A Science: A Narrative Perspective

Even Ruud
Norway

During the last decades we have seen a general shift in the conception of science: from measurement to interpretation, from quantitative to qualitative, from mechanistic and organismic thinking towards a more narrative and discursive practice. What does this mean for our conception of music therapy as a science?

Traditionally, music therapy as a scientific discipline, has sought its recognition through models taken from natural science, hermeneutical traditions (as, for instance, in analytical therapy), or a more phenomenological approach as sometimes seen within the humanistic tradition. The natural science model, as it has been adapted by the behavioral music therapists, seeks to establish truth through measurements of the effects of music in therapy. This pragmatic mode of thinking is contrasted with the hermeneutical tradition, which has sought to focus its efforts upon meaning, trying to reveal some of the hidden layers of meaning behind the behavior of the client as s/he is involved in the symbolic interaction with music. In the phenomenological approach, truth is sought in revealing the essence of what music "really is," i.e., to define the core or "nature" of music or musical behavior as observed in the clinical situation.

These three main approaches may all have their strengths and weaknesses when scrutinized from the field of philosophy of science. The natural science approach, when it is closely attached to the positivist system of values, has been criticized because of its beliefs in objective, "pure" data, as if it were possible to describe something without involving values and ideas. The behavioral music therapist following this positivist model is, of course, making selections and interpretations regarding what is important to focus upon, disregarding phenomena which would be important when seen from another theoretical perspective. The phenomenological researcher may also be criticized for making naive assumptions about the possibility of defining essences, of seeing things "as they really are," as if it were possible to define the world without a language. The character of language, as it has been transformed and infused by ideologies and cultural values throughout history, may hamper any effort to define the essence of something – instead, yielding nothing more than a good representation, a good story. This problem may be met by establishing a broader interpretive approach, as with some hermeneutical traditions, where truth is sought not in a possible correspondence between reality and the phenomenon observed, but in the correspondence between the phenomenon and a broader interpretive context. But
often, hermeneutical interpretation has been exercised too subjectively, as if the researcher had some kind of superperspective upon reality (or the client/music situation), an ability to speak for us all, regardless of cultural position.

I am not claiming the illegitimacy of any of these three positions. In a postmodern climate there has been room for a variety of values and approaches. Music therapy certainly will need the pragmatic evaluation of the effects of music in therapy, efforts at making good essential descriptions of musical behavior, as well as a broader, contextual interpretation of our symbolic interaction with music. There is no easy answer out to a world seen as a single reality, where truth is reached through better measurements, more exact definitions, or deeper interpretations. Instead, what I plead here is that the music therapist accept the discursive and narrative aspects of their scientific activity. What does this mean? First of all, if we accept the idea that we live in different subjective realities, differently informed by language, values and cultural realities, there can be no general objective theories in music therapy. It is, therefore, impossible to make statements about Music Therapy or Music which can be generalized to all patient populations or methodological approaches. Truth is local, and the best we can do is to give good interpretations and descriptions of what happened then and there. Secondly, our interpretations and descriptions are always communicated through language. This means a choice of metaphors and a narrative structure which is enforced upon our descriptions of reality. If music is seen either as “communication,” “interaction,” “reinforcement,” “expressing,” or whatever, our choice of metaphor is sought from other fields of language, other theoretical models. Of course, sometimes our choice of metaphors, or our ways of enacting the music therapy situation may prove rhetorically efficient especially when our choice of narrative comes from a well respected neighboring discipline. Thirdly, we should be aware that our ways of describing, interpreting or “proving the effects of” music therapy are a kind of discourse which has the effect of creating the reality we believe in, and which we want other people to believe in. This discourse must be felt by the clinician to be “true,” otherwise we would meet with both serious ethical and practical problems in dealing with the clients. Fourth, there must be a high degree of reflection in regard to our unique perspective when conducting scientific activity. This aspect may create a conflict between the music therapist as a researcher and as a clinician. As researchers, we always have to deal with the underlying values of our activity, our ways of conceptualizing and narrating our perceptions. This, in the end, will reveal the arbitrary nature of our choice of communicative form, of our ways to telling others the story of our work.

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Towards The Development Of A Research Culture In Music Therapy

David Aldridge
Germany

Over the past ten years Germany has seen an emerging demand for music therapy research. A number of individual researchers based in different countries have attempted to promote music therapy research. Music therapy, like nursing, psychotherapy, and various other forms of helping professions, is also being challenged to produce research results. That challenge is coming simultaneously from within the profession, itself, and from the outside. From within the profession, a new generation of music therapists is demanding academic credibility, and this call is linked to the establishment of postgraduate music therapy courses leading to masters or doctoral qualifications. Music therapists, too, are demanding, within their own career paths, the possibility of deepening their understanding of their own work and gaining academic credentials by further study. With this internal necessity, we are seeing a demand for outcome research related to varying therapeutic initiatives, both from third-party funders and from employing health institutions. With government cut-backs in health and education, enhanced scrutiny in university spending, and fiscal demands for efficiency and productivity, music therapy departments are having to either justify their existence by producing material evidence of their efficacy or produce research papers to improve their academic points rating. This means that a relatively new profession is being forced to develop research results without having had the chance to establish research training, without a satisfactory background of research material, and without the opportunity to negotiate an acceptable way of doing research that is related to therapeutic outcome.

In addition, we are faced with a relative lack of research expertise. Some of us have a research career with experience in undertaking various forms of research projects. However, few of our colleagues have had the opportunity to do post-graduate research and are being expected to teach research methods and supervise research projects. While this situation may be unavoidable at the present time, I suggest that, in some cases, we will find that music therapists are being prepared for an over-idealized world of academic research which does not reflect music therapy clinical practice so much as it reveals the current lack of research experience within the profession. Furthermore, in the present situation, newly qualified postgraduate colleagues without any research experience other than their own study, are attempting to supervise other researchers and teach research methods. However, being able to carry out
research and being able to teach research are two separate activities, as are being able to do music therapy and being able to teach others how to do music therapy.

It is vital that we begin to develop a solid base of research-oriented clinical practitioners. Several initiatives have been underway during the last ten years to provide a research infrastructure within individual countries, and which hopefully will meet the challenge of cooperation on an international level. For example, some of us are attempting to provide research support that suits music therapists, themselves, while also serving their needs to reach out to an external community.

At the heart of much of this debate is the difference between process research and outcome research. Many music therapists will be interested in what happens when they do music therapy. They ask the question, "How does the music unfold and what has this to do with the changing status of the person with whom I am working?" This changing status may be musical, aesthetic, psychological, clinical, or social. Those outside the profession, however, may be more concerned with comparing the differences in a person before and after music therapy treatment. This question is not so much concerned with how the process of music therapy is carried out; rather, it is concerned with the actual clinical outcome itself – and sometimes the costs incurred related to that outcome. Within the whole field of health-care delivery in the Western world, such questions are being placed in the foreground of research initiatives.

Furthermore, one must consider that there are different purposes of research. At the moment, with our "junior" profession, there are researchers preparing masters material and doctoral studies. These studies are often of a different nature than post-graduate research studies and research contracted by outside agencies. Doctoral studies are focused on the development of the doctoral candidate. They are there for the sole process of developing an individual who will later be able to carry out research, and the work will often be of an intensely deep and inward nature. The research that is carried out by experienced researchers, often at the request of an external agency wanting to see some material benefit from their investment, will be more outward looking. Therefore, the purposes and the methods used will differ. I am arguing the need for both of these forms of research; to foster only inward-looking research will restrict the nature of music therapy research; and, thereby, practice in the future.

The kind of research we do and the methods we use will be influenced by the philosophy of science that we have. My main proposal is that science is a process – an activity – not a set of commandments set in stone for all time as the basis for a dogma. In a post-modern world, where all of the major themes are challenged and deconstructed, it is our responsibility to construct themes that are appropriate to the knowledge that we need. Science is an activity of creating knowledge; perhaps it is this creativity that may appeal to many of us,
while others feel lost in the scientific activity. Knowledge is something that can be done; it is a creative activity – a process – not a fixed product. Indeed, the word knowledge in English is distantly derived from a root that means “I can” (Middle English le can, German kÜnnen and kennen), and is perhaps best described as the statement “I can know.” Once we take the position that knowledge can be actively acquired, then we can speculate upon the various arts of doing science. This is a move away from the Cartesian position that separates mind and body as reflected in “cogito ergo sum” – “I think therefore I am.” What I am proposing here is “ago ergo sum” – “I perform therefore I am.”

How do we create knowledge, then? This is a question of methodology, and it lies at the center of many modern scientific debates. One of the criticisms of modern science is that the scientific argument rarely concentrates upon the subject matter of the inquiry and infrequently leads to a new creative discovery. What appears to be more prevalent in the activity of science is the pressure for us to conform our knowledge to a set of prescriptions that are applied to a given body of knowledge; that is, methodolatry, not methodology. It is the struggle with an appropriate methodology that we find in the current creative arts therapy literature. This has been hotly debated during the last decade within other fields of applied therapeutic practice.

We see the struggle with methodology breaking out in the debate over quantitative or qualitative research, where one is proposed as the only form of research inquiry. Research in music therapy has often been polarized into two opposing camps: qualitative research versus quantitative research. The grounds for this polarization appear to be historically based in the establishment of a political professional identity. What some of us have been trying to do is to avoid such polarization and to foster a climate of tolerance that allows us to develop music therapy research that suits music therapists and their various purposes. All too often, this debate has been at the foreground of research initiatives, and has masked the underlying political debate about which group should hold political sway within the profession. We could just as easily translate this debate into the intolerance of varying music therapy schools for one another. Such arguments are superfluous at a time when the profession is ripe to develop; and, in its maturity, it should be ready to extend the tolerance necessary for knowing together.

If science is a creative act - an aesthetics of research - then the act which can create knowledge about being human can be sung, played, danced, or acted. Underlying this approach is a philosophy of the world that moves away from a solely materialistic perspective and towards a perspective that sees the world as a living organism improvised in the moment in which we are all taking part. Taking such a position, music therapy research begins to make sense as a creative act. Knowledge is performed in the world. Some of us may choose a
style of knowing that is qualitative; others may choose a style that is quantitative. For example, the manner in which we present this work in the future may demand a more flexible approach than solely written texts; as new electronic media, with its ability to incorporate text, sounds, graphics and movies, appear to point to a potential format capable of demonstrating the richness of research as it is performed.

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New Directions in Qualitative Research in Music Therapy: Personal Report

Since April, 1995, I have been head of the Music Therapy Department at the University of the Arts in Berlin where I direct a postgraduate music therapy program (Diplomstudiengang, M.A.). Teaching, training and supervising is based upon clinical experience in various fields of treatment, with a focus on analytically oriented psychotherapy with psychosomatic patients.

A qualitative research section for music therapy as a part of the Music Therapy Department (with its development of methods appropriate to the situation) provides a close connection between practice, research and teaching. The exchange of ideas between clinical practice, teaching and research is a central issue of our work.

In the young field of music therapy research we are dealing with a therapy form that presents new ways of experiencing relationships and mental fine-tuning processes within an artistic medium; and music therapy is on its way to becoming an established profession within the health care system. But it remains to be discovered what exactly brings about a process of change in the interaction between patient and therapist, and how to describe this process. The personal encounter in the therapy process requires research methods which must be able to examine different qualities of the work. In the case of musical improvisation, these are qualities of the musical improvisation which include the exchange of thoughts, feelings and fantasies accompanying this encounter, as well as the qualities of the relationship formed by the personalities of both the patient and the therapist. The differentiated interaction with the holistic character of this therapy has its own structures and meanings that have to correspond with a differentiated approach to the case study research.

Historical Development

From 1981 to 1995 I worked as an analytically oriented music therapy clinician in a psychosomatic hospital. In this position, my main goal was to integrate this form of psychotherapy into the treatment plan for specific patients. I wanted to be able to evaluate the processes in music therapy so that they could be compared with standards from psychotherapy. Musical works produced during music therapy sessions have rarely been treated as objects of research. Certainly, one reason for this in Germany is that music therapy has
not yet been well established as an academic discipline within the framework of professional psychotherapy. As a result, most music therapists with university or professional school degrees are relegated to secondary positions and are limited to auxiliary functioning within the healing professions. In such a context it is difficult to initiate research activities in music therapy, or even to include music therapy in the research projects of an institution with a previously established research focus.

However, interdisciplinary cooperation is necessary in order to utilize strategies which have already been developed in research on psychotherapeutic processes. At the Department of Psychosomatic Medicine and Psychotherapy of the Heinrich-Heine-University in Düsseldorf, we were able to find this kind of cooperation between a music psychotherapist, a psychiatrist and psychoanalyst. This collaboration was accomplished in our clinical work with patients who suffered from a broad range of disorders such as psychosomatic disorders, neuroses and severe personality disorders. In these patients there is often a lack of self-awareness, sensitivity, differentiation of affects and feelings; and there is only tenuous contact with the inner and outer world. For each patient, we attempted to integrate different treatment forms into an individually tailored model (especially in our inpatient and day hospital treatments). Our project utilized a qualitative research approach which we developed directly from our clinical practice. As a pioneer project and because of my position as a psychotherapist with academic training in music therapy, we used music psychotherapy as the main therapy for select patients. The concept of “resonator function” (Langenberg, 1988) which was used in the clinical treatment and research, was the basis of our music therapy project. This qualitative approach to evaluation met with interest at the university, as well. The cooperation with Jörg Frommer, of the Research Section for Qualitative Methods in our Department, started in 1991 (Langenberg, Frommer, Tress 1993, 1995).

Report of Current Practice

The treatment follows the principles of psychoanalytic music therapy (Priestley 1975, 1983; Eschen, 1980; Langenberg, 1988), where the encounter and relationship between patient and therapist takes form in the musical improvisation. Hence, the patient can explore his or her own unconscious issues and memories, experience and recognize feelings and emotions, and integrate realizations in the interplay of music and speech. The instructions beginning the improvisations are: “Let us play whatever comes to mind, letting ourselves be guided by whatever needs to be expressed!” The concept of the “resonator function,” utilizes a perceptive approach with a personal instrument which is used to relate musically to another person. This concept includes the significance of the musical instrument, as well as the capability to resonate and
be audible and tangible in the encounter. Additional qualities of the transference relationship become, therefore, more obvious in music therapy. In the music therapy encounter, the therapist is continuously tangible and we take advantage of this perceptive approach in order to explore the situation. The concrete research design uses a triangulation of perspectives.

Independent describers, the patient, and the therapist obey the instruction: "Describe frankly the associations that arise in you upon hearing the music! You can report feelings, thoughts, images, mental pictures, stories - even if they seem chaotic." In addition, a musical analysis of the improvisation is carried out using, in this case, an individual system of signs from the notation of particular modern music. These results are then analyzed in relation to the clinical data from the patient’s case history (Langenberg, Frommer 1993, 1995, published in English).

International Cooperation in Qualitative Research

International cooperation began in 1994 at the “First International Symposium for Qualitative Research in Music Therapy” which took place at the Clinical Institute and Clinic for Psychosomatic Medicine and Psychotherapy of the Heinrich-Heine-University in Düsseldorf. Throughout the conference and the dialogue process afterwards, the attempt was made to develop a culture of research while meeting high standards and guidelines of research in the field of psychotherapy. In this phase of orientation, the high standard of music psychotherapy research is obvious in its methodological awareness of specific research problems. The change of paradigm to single case studies and process research, as well as the use of qualitative methods (in order to examine the interaction within the treatment situation and the context of interpretations), uncovers the personal constructs of the researchers.

The book Qualitative Research in Music Therapy - Beginning Dialogues edited by Mechtild Langenberg (Berlin), Kenneth Aigen (New York) and Jörg Frommer (Düsseldorf) will be published in 1996, two years after the inspiring symposium. The conference, itself, and the subsequent process of editing this book (compiling the different papers and staying in contact with numerous participants over thousands of miles have revealed similarities, shared problems, and differences between the researchers involved. We feel that both similarities and tensions between different views have enriched our understanding of qualitative research in music therapy. We feel encouraged to continue this kind of approach by a growing community of qualitative music therapy researchers who form a vital multicultural group with their different backgrounds as clinicians, artists and researchers. In July, 1996, the “Second International Symposium” will be in Berlin as a preconference of the “World Congress for Music Therapy” in Hamburg, where the symposium group will present results of their discussions.
In addition to these international contacts, a group of students, postgraduate candidates and interested colleagues is proliferating, developing projects under the supervision of Mechtild Langenberg and Jörg Frommer associated with the University of the Arts in Berlin.

References


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Evolution Of A Research Experiment: A Personal Account

Suzanne B. Hanser
U.S.A.

I was in labor. The confused nurses and panic-stricken obstetrician let me know that there was no fetal heartbeat. There was nothing they could do. Labor would proceed as indicated. I had brought my music cassettes. Being a music therapist, it was natural that music would have to accompany the most important day of my life. Little did I know it would be the only element that could provide comfort, familiarity and stability on the most traumatic day of my life. Fourteen hours later I would give birth to a stillborn daughter. The music, playing continuously during labor and delivery, distracted me, riveted my attention to something more powerful, directed me to breathe in rhythm, and provided a world of images to transport me to a less frightening place.

At that time I understood that it was the music that carried me through this traumatic experience; but, what of dealing with it in my life? How could I work through such a significant trauma? As it happens, this event became a critical experience that precipitated an entire line of research. The impact of music on my coping with the shock of this personal tragedy raised questions in my mind which led to a lengthy series of research investigations. This process, in turn, had a profoundly positive effect upon me and the many others who participated in the research. But, in addition to being a therapeutic outlet for my own recovery, the research process was an account of how research is inspired and evolves over time. This article describes the various methodologies which culminated in a highly controlled experimental design to support the effects that I observed so personally and deeply.

The process began on the day of the birth and death of my daughter. If music could be so powerful in helping me cope with the hundreds of contractions, perhaps it could help other women in their labors. Using a phenomenological perspective (Forinash, 1995), I began to analyze my experience of listening to the music. At first, I needed something to distract me from the psychological jolt I experienced when no heartbeat could be detected. "How incompetent is this medical staff!" I thought, allowing denial and the distraction of music to take me away from reality. The music I selected was the most familiar and comforting of the cassettes I had brought to the hospital. Mozart sonatas that I had played as a child and the Debussy string quartet that I loved were played over and over as I concentrated on every single note. As labor progressed, the rhythm of the music guided my breathing and paced the next several hours. The stability of an ongoing beat in Vivaldi's chamber music and Bach's keyboard works kept me
breathing regularly and getting through contraction after contraction, measure by measure. During a very long and difficult transition stage of labor, Prokofiev's chaotic and dissonant piano concerto matched my torment and somehow, curiously, I felt empathy with the music.

Phenomenology allowed me to interpret the meaning of the experience and the effects of the music. Later, I reviewed the critical elements to articulate a model for selecting the most appropriate music to accompany labor. The most significant factors included rhythm and meter, familiarity and previous associations with the music, imagery generated by the music, and relaxation responses which were previously conditioned to the music.

Descriptive research led me to pilot case studies which applied the model to other women in labor. I personally coached and interviewed several women to refine the model and develop the protocol. I engaged two graduate students to do independent observations and assist in the research process. To my delight, the women we worked with, as well as their coaches and medical teams, embraced the model and enthusiastically cheered us on to continue. Their fortunately uncomplicated birth experiences demonstrated the replicability of the model and added a celebratory component with the birth of the baby. These multifaceted endeavors encompassed various forms of qualitative research leading to new theories, hypotheses and approaches to test. Meanwhile, I was witnessing personally a supremely positive outcome to birthing to conclude my own traumatic experience.

Before honing in on a specific hypothesis to test, there were several detours to traverse along this path of exploration. A friend with cancer was enduring the hideous side effects of chemotherapy. I gathered up a collection of cassettes to accompany her next treatment. Although she reported some distraction and positive mood changes during the next two sessions, she began to experience nausea when she played these musical selections at home. Horrified, I recognized the role of music in conditioning this distressing response. I needed to study the behavioral conditioning literature, and consult with fellow clinicians and researchers. My historical review of the development of classical and respondent conditioning paradigms enlightened me on these unplanned results. Subsequently, I took care to emphasize conditioning positive effects of music prior to experiencing pain or trauma and to incorporate multiple tests of the influence of music in each client or patient.

Back on course, I embarked on an experimental design to test the effects of music listening on women in labor. Using each patient as her own control, my collaborators and I observed pain responses during ten contractions while music was playing and compared them with their responses during five contractions without music. The observation continued throughout labor with extremely positive results. Every woman we observed had fewer pain responses during the music listening condition (Hanser, Larson & O’Connell, 1983).
I began to investigate other applications of the model, including dental patients and surgical outpatients. Soon, I was encouraged to examine the application of an adapted model to others undergoing stress and anxiety. Using the collected research evidence to support music therapy, I was honored with a National Research Service Award from the National Institute on Aging to develop and test this model with depressed and anxious older adults and caregivers of cognitively-impaired individuals.

Finally, I published a highly controlled research experiment using a control group and follow-up observations nine months after the completion of the experiment. I found statistically significant differences between music therapy and control groups at the end of treatment, observed clinically significant changes by the end of treatment, and demonstrated maintenance of these gains at the follow-up measurement. These objective group comparisons documented the kinds of positive outcomes which I had observed subjectively in a very different setting several years earlier (Hanser & Thompson, 1995).

The evolution of this research experiment led me to a positive working through of personal trauma while contributing to the body of music therapy research. The greatest compliment to the work is that the model continues to give birth to new theories and applications while other investigators adapt the model to innovative research of their own (Shiraishi, 1994). I encourage my colleagues to collaborate, replicate, question and become part of the life of this music therapy approach as they add their own perspective and expertise to it. This process is the greatest gift that I can offer my fellow music therapists who are committed to the research process for examining our life’s work.

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SECTION 2: New Directions in Music Therapy Clinical Practice
Aspects Of Improvisational Music Therapy
For People With HIV And AIDS

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Historical Development and Clinical Principles

Improvisational music therapy (Aldridge & Neugebauer 1990; Ansdell, 1995; Lee, 1995, 1996) and Guided Imagery and Music (GIM) (Bruscia 1991, 1992, 1995a, 1995b) have developed as the two main clinical tools for people with HIV and AIDS. Improvisation, used as a creative dialogue between client and therapist, provides an opening for the client’s representations and the therapist’s mirroring and reflection. It is vital as a tool in the therapeutic relationship as it enables a mutually responsive expression of the issues facing the client. The relationship set up through a primarily non-verbal means of communication can be crucial in expressing emotions that are too difficult or painful to verbally articulate.

The following principles have developed through my work:

• that music therapy provides a space for growth when potentially all around is shrinking;
• that music therapy works, not only with issues of death and dying, but with health and life;
• that music therapy can facilitate an in-depth relationship between therapist and client built non-verbally. During the dying process, this relationship can generate an intensity of understanding that is profound and unique;
• that music therapy asks no questions and makes no demands; it simply enables the person to be. For people living with a terminal illness this can be important (Lee, 1996, p. 25).

In a recent piece of writing, I attempted to explore the imperceptibility of musical expression in the face of loss and death:

When working with dying people I am always acutely aware of trying to offer that experience of escaping from the world of external reality into the more intangible breadth of music. It is my belief that the inner world of music has no element of illness and so, at its most essential level, offers a release that is both liberating and spiritual (Lee, 1996, p. 25).

Offering communication through music for people with HIV and AIDS can be a deeply empowering and incorporeal experience. One client described his experiences thus:
I have been on a long journey during the past eight years and now it is my chosen task to find a form of creative expression in which I may find the inside of me. Music therapy for me is about a common language of understanding that will lead to the heart, leaving the intellect free to do only the work it was designed to do, as a servant of the heart. Music therapy allows me the access to a self-remembering of the past data held in my mind. It is this data that has a form and symmetry to it. A path of random symmetry that means for just a very brief moment you can almost see the essence coming from me (Lee, 1996, p. 24).

Contemporary writings on improvisation (Lee, 1996) and GIM (Bruscia, 1995b) have initiated the incorporation of the therapist’s feelings alongside the client’s as integral to evaluation and assessment. Bruscia proposes four levels of experience for the therapist: spontaneous, affective, reflective, and intuitive, concluding that “we as therapists must be prepared to move our consciousness—with courage, humility, and respect—into uncharted regions of the client’s world, our own world as a person, and our world together as a client and therapist” (1995b, p. 197). Acknowledging the therapist’s personal response to the therapeutic process is now becoming crucial to the documentation and development of clinical practice.

Case Study: Charles – Proclaiming the Creative Soul

This short case study describes the initial stages of music therapy with a young man with HIV. Charles and I experienced many moments of musical union. His improvisations were always free and often wild; they epitomized the absolute searing freedom of creative expression, as well as the most controlled and beautiful. For him music reflected both anger and beauty, energy and stillness; his music was never perfunctory and was always deeply personal.

Charles referred himself for music therapy. When he came to see me for an initial discussion, he was depressed and ill. He had been diagnosed HIV positive for nearly a year, had recently been made redundant from his managerial position in a large corporate company, and was now facing the possibility of having his property repossessed. The assessment session revolved around the potential he had for creative expression. He had learned the piano during his childhood and subsequently had not played for nearly twenty years. Charles stressed that he was not concerned with extending his life through music therapy; but rather, he wanted to make each moment richer. We agreed upon a series of ten sessions. Soon after our work began he also started art therapy and drama classes.

Charles found improvising natural. The first five sessions were musically concerned with exploring the sounds of the percussion instruments, including piano. Verbally, we discussed the possible boundaries for translating the musical
experience into words. Words were important for Charles, and he could talk at
great length about issues both personal and political. The problem we foresaw
was that it might be easy for the sessions to become too broad; and therefore, we
agreed that verbal discussions would be directly related to the musical experience.
By session ten, it had become apparent that music therapy was becoming an
important part of his life. We agreed that our work would be ongoing and that our
future aims would be as follows:

- to refine the improvisations that mirrored his personal states;
- to further explore the balance between words and music;
- to consider with greater relevance those periods of cathartic release, and how they affected him outside of the sessions;
- to allow him the availability of hearing the taped sessions during the ensuing week; and thus, extend the potential benefits of the therapeutic process.

At this time Charles articulated his feeling about music therapy in the form of a short report:

A few words to try and express my thanks to you for music therapy which has become such an important part of my ability to maintain my health. In the beginning I did not know what to expect, nor realize how music therapy could help someone not only get better from their illnesses, but explore deep feelings from inside. After a few sessions, however, once the trust between us had been established, I started to understand the importance of searching within ourselves for the key to some of the answers of life. Having the facility to express through music, without the constraints of technical or learned ability, enabled me to express my feelings in a totally new way. Listening to the tapes we made allowed me to explore what was produced musically which gave me insight into the way I was feeling and how I interacted with people, depending on the environment I was exposed to during the week. This facility for monitoring one's feelings has helped to establish a balance, with the result that I am more able to tackle any diseases and emotional difficulties which come my way.

After session ten, the therapeutic relationship became more and more insightful. Through wild improvisations, Charles was able to explore issues of anger and exultation. Alongside these extrovert expressions, he found great strength in utilizing what became a finely tuned ability to express both tranquility and pain through the minimum of notes. As the sessions evolved, his use of musical idioms became precise. Improvisations would fall naturally into a mode or scale that seemed to act as a form of emotional transcendence. His use of
instruments became more individual: from session eleven, the piano became the main vehicle for expression; the percussion being used only as a means to fathom those times when he felt specifically indignant or aggressive. Through the availability of audio recordings, he was able to use music therapy as an anchor for situations outside the sessions. As our work developed, so his health began to improve, and his general physical disposition became more level. This was a time of great wonderment for Charles. He attributed the success not only to music therapy, but the complete flowering of his creative potential through art and poetry, as well.

Charles and I continued working together for another eighteen months. We experienced more expansions of his creative potential as well as the eventual highs and lows of his physical deterioration. Due to a change in my work situation, we concluded our sessions approximately one year before his death. We kept in contact, however, and he continued with art therapy throughout. Creative expression for Charles became fundamental in his journey with HIV and AIDS; it allowed a profound totality of being that was never indifferent and always unique:

Music therapy for me is about extension and growth. In the fact of my life and potential death it has provided a time that is about energy as well as fatigue. Music is an important part of my life and so it seemed only natural that music therapy would be important too. Our work reflects for me not only music itself and our relationship, but who I am, Charles the creative soul the artistic man.

Conclusion

Music therapy for people with HIV and AIDS is a rapidly growing area of clinical practice. In terms of research and assessment, this area of work can provide clear evaluations of the client. The therapist’s interpretations of and reactions to the musical relationship further adds to the growing literature that enables a more complete picture of the processes of music therapy. These two fundamental assumptions provide only the tip of new and innovative approaches to the work in palliative care. Further explorations will hopefully search new areas of clinical practice that are not only applicable to HIV and AIDS, but all areas of music therapy.
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"The Pause That Follows":
Some Thoughts About Clinical Practice

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The Knot
When a note is played
The pause that follows
Is no longer silence

"The pause that follows," the central line from the above poem, describes for me both what is intangible or mysterious about working with music as therapy, as well as a quality that enables us to be involved in this process. In experiencing and thinking about our roles as therapists we often find ourselves at the place that follows the pause.

My clinical work has been influenced by many varied experiences, environments and opportunities. As colleagues, we might find common threads in each others’ work, but I also have my own particular understanding of what we call music therapy. It is important to place my current practice within this perspective, and to include a brief narrative outlining my experiences of music therapy.

When I began practicing in 1982 I brought to my work a mixture of developmental and analytical models (Winnicott 1971; Stern, 1977), an awareness of music and musical behavior (Nordoff & Robbins, 1977), with a post-training enthusiasm and openness to explore. I was fortunate to work with many other therapists, receiving support, supervision and the opportunity to come into direct contact with a wide range of clients.

After five years I moved to Belfast, six months after the Enniskillen bomb and six years before the word "ceasefire" was first discussed. Although at that time I felt isolated because there were no practicing music therapists living in N. Ireland, I relished the space to find my own way; and within two years, I was joined by the first two therapists of the current team of five.

From my beginnings in developmental work, balanced with a central musical focus, I explored further my analytical skills through contact with new colleagues from music, art, dramatherapy and psychotherapy backgrounds, as well as from my reading, clinical supervision and personal therapeutic work. Observations in my different work settings allowed me to step onto research pathways where I met people with Parkinson's Disease, girls with Rett Syndrome, speech and language impaired children and those who have experienced psychological trauma. I would like to focus on my work with these four groups.
**Parkinson's Disease (PD)**

During short contract work over the first eighteen months in Belfast I came into contact with over thirty people with PD. Their music therapy focused on the emotional effect of PD, and particularly the sense of loss related to living with a body that, later in life, had become less and less reliable and more and more difficult to coordinate. I became interested in the moments during sessions when my clients’ musical–emotional experience of themselves became so intensely focused that there was a visible integrating effect on their physical–emotional being. At these times tremors might disappear, walking became steady, the voice reclaimed its strength, and movements were fluid. Clients talked of discovering “extra self–confidence,” being able to “overcome rigidity” as movements “came almost naturally,” and of “depression lifting” and feeling “more active” (Sutton, 1988). There were dramatic moments, such as when one client quickly and gracefully removed her jacket – able to do this for the first time in many years.

These observations are not unusual in this work, but they were new to me. I hypothesized that music was connecting with and activating areas of the brain which the PD had obstructed, or perhaps accessed the brain in a way that, because of the PD, had otherwise become an unreliable pathway. Erdonmez has discussed this issue, applying the hypothesis of music as a “mega vitamin for the brain” (Erdonmez, 1993, p. 112–125). Further experience with those with neurological conditions has not convinced me otherwise.

Further collaboration with a neurologist (Sutton & Swallow, 1993), and later conversations with psychologists and neurologists have also suggested that, because brain function is varied in different situations, music may well provide opportunities for global rather than local stimulation of the brain. Our knowledge of where and how music impacts within the brain itself is still limited; and it is possible that, rather than to think about the “right brain–left brain” debate, it would be more useful to consider music’s effect within both surface and deep brain function. The brain also processes information differently for different tasks and experiences. My familiar, unanswered question, “How does music relate this?” has intrigued clinicians and researchers from many disciplines, and any explanations inevitably must arise through such many–stranded enquiry.

**Rett Syndrome (RS)**

Over the past nine years I have met nearly twenty girls with Rett Syndrome and have observed again and again their physical response to musical experience in a similar way to that which I have just described with PD. These girls also have acute difficulty in coordinating their bodies; and it is likely that, in addition, most aspects of cognitive life are affected (Hagberg, 1989; Lindberg, 1991). This syndrome influences every aspect of their development and can leave them in extreme isolation.

I believe that there are fundamental differences between PD and RS in the music
therapy setting. I also feel that three significant areas are central to music therapy and RS.

1. The girl with RS responds to music at a primarily sensory level, feeling and sensing the music pre-cognitively, as if feeding herself musically. In one sense, her music is her, perhaps connecting with the early part of life when we do not differentiate between ourselves and others, and where we merely perceive feelings and are as yet unaware of boundaries between ourselves and the external world. I have noticed that the girls can appear to take the music into themselves, responding strongly and immediately. Music holds their interest and can be a source of some delight.

2. At other times in music therapy sessions with these girls I have felt that there was a musical, physical and emotional link between our different musics. In common with many colleagues, it is my belief that by improvising music together we can access the subtleties of timing and the changing nuances of expression within interaction between self and other that characterize the first infant relationship. This seems to enable the RS girl to access again this part of her development.

3. Furthermore, in my current work with one young woman there are signs that she has developed the kind of "musical thinking" that Andsell has described as contributing with "musical feeling" to constitute a quality of "musicality" (Andsell, 1995, p. 210-4). Andsell defined "musical thinking" as "an ability to control musical intentions: to give form and meaning to sound: to create something coherent in the world of music" (p. 210). He also made distinctions between "real" and "musical" thought, with one basic assumption that the basis of "musical" thought was in the action of music-making itself, connecting with the music at a fundamental level.

For my client, in experiencing and discovering her musical vocabulary, she has been able also to make the leap towards using this vocabulary, choosing specific pitches and patterns of pitches and forming these into larger musical structures. At times her responses to our piano duets revealed a grasp of how music works; where she is able to select groups of intervals in such a way that they mark harmonic structural points (such as dominant, tonic, subdominant) which, in turn, relate to the blues chord progressions I played. Recently, she seemed to be trying to add her own note clusters to her melodies in much the same way as I had provided harmonic underpinning. The RS dramatically affects the gross and fine motor control of her hands and can influence her ability to manipulate her hands. It was an intuition of mine to offer black-note chords played with the palm of the hand or the forearm. Within moments she had adopted this technique, changing the music from slow blues to a Messiaen-like texture. This, to me, was a clear example of "musical knowledge" grounded in the "musical thought" outlined by Andsell.
Speech and Language Impairment (SLI)

In 1990 a funding opportunity arose that enabled me to work in a specialist school offering educational and speech and language therapeutic support for children with complex SLI. During the two years that I was employed two days each week at the school, I worked with individual children and small groups.

Not surprisingly, few children used their voices at all during the first sessions with me. Their voices had become the focus of their unsuccessful attempts at trying to understand or make themselves understood in the verbal world. Many children had begun mainstream education but were transferred to the specialist school, heightening the sense of failure. Many were hungry for the spontaneous, communicative experience of clinically improvised music-making.

Apart from the emotional content of their music, I noticed that many children were demonstrating difficulty in focusing their attention on any one way of making music. While initially chaotic, as they expressed their feelings onto the instruments, their music seemed to shift in and out of steady tempi, and they became confused with more complex rhythmic material. I discussed this with colleagues at the school and discovered that the majority of children had underlying auditory processing (AP) problems. These were often subtle and identified by an unusual (although not clinically significant) EEG trace, or sequencing difficulties highlighted during psychological or speech and language therapy testing. Whatever the reason, if AP problems affected the perception of speech sounds, then I felt this must also be true for musical sounds. I developed an experimental theory that considered a musical sound event as comparable with the phoneme level of speech. I concentrated on rhythm, and analyzed short audio recordings from sessions where tempo shifts were apparent. Reviewing the analyses I found that I could identify the optimum processing time for hearing, assimilating, processing and coordinating drumming with an underlying musical pulse (for example, after 9 crotchet beats at 80 beats per minute, the child’s drumming lost its regularity for 2–3 beats, resuming regularity after this point for a further 7–10 beats).

In the case of one seven year-old boy, there was a strong link between his developing speech and language and an analysis of the rhythmic and structural components of his music: first musical phrases coincided with first simple sentences, and the ability to sustain short rhythm patterns preceded the emergence of syntactic features in speech (Sutton 1993). These links corresponded to the concrete language level, with the boy’s therapy then moving into spontaneous story which, in turn, explored the more abstract language–conceptual levels such as those of time and aging. There were underlying themes of loss underpinning our work together, centering initially on the death of the family dog many years earlier, first with feeling (music), and then with words (story with improvised music).

I took the rhythm-processing a stage further in research, looking at how short rhythm patterns were copied by both mainstream and language impaired children (4–7 years) (Sutton 1995b). I hypothesized that a natural ability to hear and group
single sounds into short pattern units was either not present or unreliable for SLI children. I also expected that the mainstream children would find regular, predictable rhythms easier to process than irregular, unpredictable patterns, and that the SLI child would find both types of rhythm equally difficult to process. In addition, each rhythm pattern was more complex than its predecessor, in order to test the findings of Canadian researchers who had suggested it was the complexity, rather than the length of sound strings that was difficult for those with AP problems (Tallal 1976, 1980; Trehub et al, 1977, 1990). While there were difficulties standardizing the rhythm patterns, my results showed a strong trend supporting the hypotheses. There were also implications for diagnosis.

While I would not wish to lose sight of the therapeutic process seen through the musical-emotional elements of the SLI child’s music and the developing child-therapist relationship, I feel that these explorations into music processing inform our work with this client group.

Psychological Trauma

My experiences with one SLI child whose father was in the army in N. Ireland prompted me to embark on another pathway. This seven year-old boy was referred because his behavior (believed to be linked to the stress of his speech and language impairment) was challenging to those around him. As the therapy unfolded, it became clear that his emotional explosions related to the traumatic events occurring in Belfast. His fears about his own and his father’s safety combined with the silence within home and community, where – in order to cope – the very real threat of violence had to be ignored.

“When abnormality becomes normality” was a cliché often used to describe this dilemma. Researchers based in N. Ireland have identified the kind of coping mechanisms necessary to survive psychologically in an environment where complex, changing social and cultural factors have influenced a twenty-five year conflict (Dunn, 1995). In the young boy’s case, he was silenced both by his SLI and by his community, where he could not or dare not talk. He was also vocally silent during the first part of his therapy, although his use of the percussion instruments spoke volumes. As our relationship developed, he discovered that the music therapy sessions offered him a space where he could begin to explore some of these frightening aspects of life. Fittingly, this was done through his improvised story and music, where he created scenes and conflicts, assumed many different characters, and finally – with great courage – faced some of his fears and moved towards resolving them. It was difficult work for both of us, which also made me aware of some of my own anxieties and eventually face how I, too, had become traumatized by terrorism. I have become familiar with this pattern of learning with and from the client, where one finds oneself working with particular types or groups of clients with whom one resonates deeply at the unconscious level.
An Update

At the time of this writing I have just received word that the Peace and Reconciliation Fund for N. Ireland has awarded a two–year grant to enable music therapy to be accessible to those in N. Ireland who are experiencing the effects of psychological trauma. This will allow me to set up a research project and coordinate a team of therapists in the greater Belfast area, where we will offer support, a clinical space and also look at how the therapy process unfolds. I am expecting that music therapy will be of particular use to those who have developed post–traumatic symptoms. The flashbacks, nightmares, excessive anxiety related to not feeling safe in one’s environment, and the inability to trust others are some of the characteristics connected with the problems of coming to terms with events at the very extremes of human experience. The memory or impact of the traumatic incident can remain unprocessed at the unconscious level for many years and it is here that music may effect both a fundamental connection as well as a mechanism where processing can begin.

Finally, I return to the title of my paper, which I felt reflected a view of how unpredictable, intriguing and intangible our work can be. Perhaps the more we listen to and think about the note and the pause that follows, the more we will find.

1"The Knot," from a collection of poems entitled “Another Nation,” by Michael O’Loughlin
2The Enniskillen bomb killed and injured several people attending an open–air Remembrance Day service in 1987. The IRA had intended the bomb to explode when members of the security forces marched past, but it detonated early, while members of the general public were gathering to watch the parade.
3The story of my process of research during this work was also recorded (Sutton, 1995a).

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Music Therapy In A General Hospital Setting

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In the late 1960's a group of medical doctors founded the Hospital in Herdecke, working towards a better, and holistic, approach in medicine. They wanted to inaugurate new methods in medical care and social cooperation within the existing health system in Germany. Their work, which was based upon the ideas of Rudolph Steiner and Husemann, utilized and developed an approach to medicine that is founded on the philosophy of anthroposophy. Steiner understood anthroposophy as a "consequent development of occidental philosophies, especially the antique philosophies of Plato and Aristotle, as well as ‘German Idealism’" (Kienle, 1989). Anthroposophical medicine does not consider itself an alternative medical approach; but, rather, it is an extension of traditional medical understanding (supported by natural and medical science) which incorporates the idea of the individual as a physical, emotional, and spiritual being. The focus of the therapeutic endeavor is, therefore, the individual need for healing that leads to new ways of diagnosis and treatment for both acute and chronic conditions.

The hospital developed into a clinic which now has approximately five hundred beds. Departments include gynecology, midwifery, internal medicine, urology, pediatrics, radiology, anaesthesiology, neurology and psychiatry (divided into children, adolescents, and adult psychiatric wards, as well as a closed ward), surgery, neurosurgery, and an intensive care unit. It also offers a polyclinic for out-patient treatment.

The basic idea of an individual, who creates his or her individual health in correspondence with natural laws, lead to the incorporation of various creative arts therapy approaches in the hospital setting right from its inception. Thus, today we find art and sculpturing therapists as well as eurythmists, language and drama therapists, and music therapists in the hospital; either forming their own sub-departments or incorporated into various therapeutic teams. In addition, the hospital offers sound proof therapy rooms and offices for the music therapists.

In the 1980's, the University Witten/Herdecke was developed from the hospital and now offers courses of study in economics, dentistry, medicine, natural sciences, nursing science, and music therapy. The training in music therapy is closely linked to the hospital department. Music therapy staff from the university work in the hospital as therapists, and hospital music therapists teach the university coursework. There are nine music therapists offering music therapy in individual and group contexts within the hospital, as well as six
students per year, who are supervised by them. This means that each student has a training tailored to his or her needs and preferences.

The underlying idea for incorporating music therapy in the work of a general hospital is that health and illness are not understood as static conditions. They are dynamic processes emerging and developing in time. They are not only conditions that happen to us, but in their individual form of occurrence, they are "created." While it may be accepted that psychic processes lead to change, promote stability or offer protection, it is also possible that physical conditions offer these potentials, too. If we regard health as something that we create, it follows that we can apply creative approaches to support treatment; we can even find unique access to creating individual states of health (Aldridge, 1989).

It is from this idea of health being a dynamic and creative process, that music therapy has developed in the Hospital at Herdecke. This development has always been linked closely to the cooperation of music therapists and medical staff with their individual interests and insights in both directions, musically and medically. The point of view of an artist, with his or her individual artistic perception, is considered by the hospital doctors to be as valuable as the information from a diagnostic procedure or a laboratory examination. Therefore, the structure of work is basically cooperative, non–hierarchic and focuses on patient needs. The arts are highly respected as a treatment modality and a diagnostic tool.

The development of music therapy in Herdecke and at the university can be traced back to the pioneering work of Nordoff and Robbins (Nordoff & Robbins, 1977) which was applied to the treatment of handicapped children. The neurologist, Konrad Schily, initiated the application of this knowledge within the field of adult psychiatry and neurology, which further promoted the development of music therapy for a wide range of adult patients within the hospital. Music therapy work has been developed in all departments of the hospital by my colleagues, which has, in turn, contributed to the growth of music therapy in Herdecke and at the university. Today my colleagues are working with individuals who suffer from psychosomatic diseases, psychiatric diseases, cancer, HIV and AIDS, spinal injuries, chronic pain, and asthma. The work with children includes those who suffer from cancer, and those who need intensive care treatment. Each individual music therapist affiliates him or herself with certain wards, according to the needs of the hospital and his or her individual interests, preferences, and capabilities. In cooperation with nurses, doctors, and other complementary therapists, they form a therapeutic conference which perceives the patient from varying perspectives. Each therapist is accepted for their personal capabilities and individual contributions. In this cooperative atmosphere, the therapeutic teams attempt to find what is best for the patient, regarding therapies and treatment. In clinical meetings, which occur at least once each week, the chosen approach to treatment is
The atmosphere of acceptance and cooperation makes the hospital an ideal place for music therapy to develop its own very special strength. Freedom from the struggle for acceptance and the questions about professional identity has allowed us to look at our work in a scientific way. The department of the hospital and the institute for music therapy at the University have developed academic work within the department as a whole, and published a number of articles concerning clinical practice and research methodology. New areas of clinical practice have emerged from the expertise of music therapy colleagues and other fields of practice.

We, at the hospital and university in Herdecke, are aware that these working conditions are not representative of the overall situation of music therapists in Germany. We have a unique and privileged situation. The hospital is an important example of the contribution that art therapies can bring to medical care; in fact, there is interest from the medical world, especially when medicine comes to its borders in ethical or scientific respects. The music therapy students are closely tied to this atmosphere, in which clinical practice and research activities are understood as interweaving processes (Aldridge, 1996); and these students have developed their own work in other clinics, based upon the model of clinical practice in Herdecke. The general approach is now found in specialized clinical institutions, such as hospitals for rehabilitation, psychiatry, and neurology, or in homes for the elderly. What we hope is that we can foster the development of music therapy, as we cooperate with music therapy colleagues, inform health authorities and medical professionals, and convince others that our therapeutic work in these extraordinary conditions is enabled by conditions such as those that exist at our workplace.

1In this article, I refer only to the music therapy aspects of the cooperation, which may also be seen as representative for the other arts therapy approaches.

2Some of these articles are listed in the reference section; however, I have only given references that are easily accessible to the reader. For more information or literature requests, please contact me directly.

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Music Therapy With Hospitalized Children

Sara Shoshani
Israel

On the Children’s Unit of Shaare Zedek Hospital in Jerusalem, Israel, between sixty and eighty children are hospitalized at any given time. They are heterogeneous, comprised of Jews, Moslems, and Christians, secular and religious, Israelis, Palestinians, new immigrants, from urban and rural backgrounds, representing different cultural and socioeconomic groups, and presenting language barriers with some of the children.

This article will focus on my work with children hospitalized for lengthy periods, as in oncology, for burns, Cystic Fibrosis, Crohn’s disease, juvenile diabetes, and other chronic illnesses. I work in the special education school on the Children’s Unit, staffed by special education teachers and therapists of various disciplines. The cooperation between the medical, nursing, and educational-therapeutic staffs of the Unit contributes to the children’s well-being.

The hospital is an alien place to the newly-admitted child, who is suddenly cut off from home, family, friends, school, and daily routine, like being in a foreign land where everything is different: food, daily routines, language, rules, clothes, smells, sounds. The child is totally dependent upon the authority of strangers; (s)he takes medications, fasts, accepts orders, and limits regarding activity. His/her privacy is invaded and various body parts are handled. There are feelings of humiliation, pain, fear, anxiety, and helplessness, and an inability to express the ever-increasing stress that overwhelms the child (Kadishai & Lehrman, 1980). The parents, normally perceived by the child as all-powerful, are suddenly helpless and unable to ease the pain.

Today, modern medicine tends to shorten hospitalization to the extent possible via heightened aggressiveness of treatment which disturbs and traumatizes the child and his entire family. Thus, support for the parents becomes increasingly important; especially when (because of the often-severe bodily reactions) the child focuses more and more on the treatments and the pain, and less on the disease.

The child’s emotional and social states in the hospital depend on several factors: heredity, prenatal conditions, influences during the child’s life; and quite importantly, the child’s experiences with adults. The quality of the child’s relationships with adults prior to hospitalization determines the degree to which a child may trust adults and also determines his/her reactions to adults in the hospital. Further, personality factors and personal outlook play an important role in establishing the basis from which a child copes with what awaits him/her.
in the hospital.

Obviously, the disease itself cannot be ignored, nor its factors, its severity, its duration, and the treatments required to combat it. These factors determine the child’s reactions to the disease and to the hospitalization. There are also environmental factors within the hospital itself which affect the child, from admission through discharge. Final factors affecting the child are relations between the various staff members, and between staff members and the child.

The approach of the Children’s Unit at Shaare Zedek Hospital is based on the holistic model. Watson and Drori’s description of the primary elements of the holistic model in medicine include the idea that health is considered a natural, positive state that takes into account the whole person, and as such, the treatment is not just physical but also emotional and spiritual. The disease is seen as an opportunity for personal growth and self-discovery (1990, p. 26).

There is a need to extend the child’s realm beyond those relating to the medical treatment to activities that focus the child on other areas and re-connect him to his healthy world, via learning games, computers, music, singing, art, reading, watching TV, etc.

In therapeutic musical work with hospitalized children, physical, psychological, social, and cognitive aspects are dealt with. Emphasis is placed upon contacting the strong, healthy parts of the child which normally regress during hospitalization. The focus is on the “music child” (Nordoff & Robbins, 1977, p. 1).

Physical Aspects:

- Involving the child in active pursuits, reducing passivity and apathy
- Stimulating various bodily systems in accord with needs and medical limitations
- Relaxation of the body and of the surrounding atmosphere
- Pain control and reduction

Psychological Aspects:

- Preparing the child for painful medical procedures
- Reducing anxiety, fears, tension, stress
- Inducing the feeling of control, choice, and self-esteem
- Accepting feelings and needs and expressing them
- Providing fun and enjoyment
- Establishing trust between child and therapist
- Dealing with side effects, pain, and loss
- Providing support, a feeling of partnership, encouragement, a feeling that the child is not alone
- Developing positive self-esteem and self-confidence
Social Aspects:
- Reducing the child’s feeling of isolation
- Encouraging friendships between patients
- Maintaining contact with friends from the outside (i.e., school, the neighborhood, etc.)
- Helping the child to utilize his time effectively

Cognitive Aspects:
- Providing intellectual stimulation
- Understanding the disease and the treatment regimen
- Adapting to the new situation — that of hospitalization
- Developing a therapeutic and supportive environment

Two additional elements deemed critical in this work:
- Personal contact with the hospitalized child’s family
- Guidance of parents, siblings, and “significant others”

Aldridge (1993) cites research dealing with the effects of music on various physical parameters, such as pulse, blood pressure, electromyography, skin temperature, and muscular reactions, on mood and other emotional reactions, as well as on cognitive responses mixed with imagination and associations.

The techniques used in music therapy are as follows:

Playing
Although teaching a child to play an instrument is normally not part of a music therapist’s work, many hospitalized children want to learn to play, in their attempt at connecting with life outside the hospital. Learning to play an instrument also fills many otherwise idle hours during hospitalization, distracts the child’s attention from more unpleasant aspects of his stay and increases self-esteem and pride. The children play music, improvise, create harmonies and melodies, record themselves, change octaves and keys, write words, and create interesting pieces. During particularly difficult times, children often ask to listen to their creations. Sometimes, it is possible to talk with the child while listening to the piece.

Listening
Each child has a cassette player along with cassettes of their favorite music, familiar music, and also blank cassettes. The child and the family are instructed in their use, as in background music, or special music during painful times. Using this music, the child feels less alone, enjoying familiar music.

Singing
Singing is an important way for a child to process what he experiences, involving proper breathing (resulting in relaxation). The child chooses a song, discusses its relevance with the therapist, and then sings and records it.
Children enjoy listening to these songs during their most painful, difficult times. The children take their cassettes home upon discharge.

**Writing Songs**
Writing songs is one of the most important and effective techniques in music therapy. Through it the child’s attention is diverted and he expresses experiences, thoughts, and feelings. The process includes choosing a subject, writing the song, recording it, re-recording adding instruments, elaborating on the song’s relevance to the child, and talking about it.

Some children ask to play the cassette for the doctors, nurses, family members, and guests, thus allowing further therapeutic processing and enjoyment, pride, improved self-esteem and contact with the hospital environment, as well as improved dealing with pain and loss.

**Improvisation**
Improvisation is common in most models of music therapy and is quite effective. Improvisation is used in singing and playing, allowing the child to lead, thus encouraging his/her expression of frequently changing feelings, moods, anxieties, and needs.

**Guided Imagery**
In this technique, the child is led via images given by the therapist, elicited verbally and/or musically. These images also elicit heightened and/or reduced bodily activity. The imagination can be used in each sense separately and in all senses together with the therapeutic goals of pain management, self-control, anxiety reduction, relaxation, and attention diversion. Music, in guided imagery, aids in achieving relaxation by entering the imagination more quickly and easily. Associations and memories are readily activated, while background distractors are masked by the music. Music furthers and deepens both the therapeutic process and the results.

**Attention Diversion**
Here, the child’s attention is diverted from attending to the pain and fear, via other stimuli, including music, providing intellectual interest and enjoyment. Thus, playing an instrument or listening to music during a painful medical procedure improves the child’s ability to cope.

**Relaxation**
Pain causes anxiety, and anxiety increases bodily tension, thus increasing the sensation of pain. In other words, mental stress is translated into physical tension and vice versa (Feldenkrais, 1949, Chapter 10). Relaxation is a technique in which the child can be active; (s)he can take control, rather than passively, helplessly, enduring the pain. Relaxation focuses the child in an active process requiring concentration and attending, thus diverting the child’s attention from the pain. Music aids the child in relaxing the body, in creating the appropriate mood, and in following the child through the entire process,
thus increasing the child’s confidence that (s)he is in control.

Conclusion

Music therapy can be an integral part of medical treatment given in the hospital. It increases the possibility that the patient will be treated with respect. The hospitalized child’s healthy energies are brought out in music therapy and can help him/her cope with the problems, difficulties, and complications related to lengthy hospitalization and medical treatments.

The music therapist is not perceived by the child as related to the pain of the disease and/or medical treatments. This allows the child to participate willingly, knowing that the experience includes no pain or discomfort. Thus, the child benefits from the therapeutic aspects of the music therapy; and in addition, the trust that the child develops in the therapist can then influence the child when (s)he is receiving other, less pleasant, treatments.

Music therapy is perceived at Shaare Zedek Hospital as an adjunctive therapy to medical procedures. Through music therapy, it is possible to delve deeply into the hospitalized child’s emotional life, enabling him/her to express fears, difficulties, and anxieties, and to learn to cope with them more effectively. In this way, the child endures the hospitalization more easily, as stated by Daniel Whitehead Hicky (1902): “No friend like music when the heart is broken, to mend its wings and give it flight again.”

References


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The House of the Seven Muses — A Research Project
Music Therapists In Collaboration
With Other Creative Arts Therapists

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Background
After several years of preparatory work to gain the financial and practical support of the Swedish state, in 1992 the research project called “Enkoste” was born with the support of a handful of dedicated politicians. Enkoste [“Enheten för konstnärligt skapande terapiformer; the Department for Artistic and Creative Therapy Approaches (author’s translation)] was established as a collaboration among the creative arts therapy disciplines. The project was based upon an object–relations theoretical framework along with theories underlying the arts in therapy which are formulated around the creative process and the paradigm of arts as an aesthetic healer (Hillman, 1989; Kenny, 1989; Knill, Barba, & Fuchs, 1995; Levine, 1992; Levine, 1995; McNiff, 1981; Robbins, 1994; Summer, 1992) and its main goal was to gain more information about the effects of the creative arts therapies, including music therapy, in adult psychiatry. Enkoste was established at a time when the practice of music therapy in adult psychiatry in Sweden was entering a stage of growth and development; it ended in the spring of 1995.

Enkoste: Description and Results
Two complementary goals were formulated: the first, to offer music, art, dance and expressive art therapies to enrich treatment options within the state funded psychiatric health care system; the second goal, to study the effects of these therapeutic approaches. A secondary aim of the project was to develop avenues for collaboration among the different creative arts therapy disciplines and, hopefully, to contribute to a deeper theoretical understanding of how these disciplines function together. The setting of Enkoste was a separate house on the grounds of Löwenströmska Psychiatric Clinic just outside Stockholm. The clinic gave some administrative and financial support to the project which otherwise was considered a separate department with its own research money and treatment responsibilities. The treatment team consisted of one director and six part–time therapists. There were two music therapists, two dance therapists, one art therapist, and one expressive arts therapist. The role of the therapists was to give treatment, either individually or in groups and to record the therapeutic process carefully through notes and, in some instances, through
video recordings. The therapists received weekly supervision for their work. A number of other professionals were involved on a contractual basis and three recognized, creative arts consultants were brought in from abroad on a regular basis to work with the whole team, and to provide individual supervision. In the area of research, testing personnel were involved along with independent researchers who assisted in analyzing and comparing the data with other clients groups. At this point in time three research reports with preliminary results have been issued by the project director (Bylund, 1992, 1993, 1994) and a final research report is due to be published this fall (1996).

The Enkoste patients were carefully screened and tested (through projective testing and videotaped interviews) before treatment started. Forty-four patients were enrolled in the project [at the time of the second report (Bylund, 1993)]. Over eighty percent of these patients were diagnosed with severe personality disorder. Many had a history of prior treatment, but for the duration of the project this was the only therapy they received. According to a self-rated measure, patients reported suffering from their symptoms an average of sixteen years before coming to the project. Each patient was discussed thoroughly in the team before treatment started and a decision was made regarding which creative arts modality would be most appropriate. Another battery of tests was conducted after one and a half years of treatment and again, after treatment had ended. Tests measuring intrapsychic changes were used along with self-rating scales which measured "quality of life." Preliminary results after 14-15 months of treatment showed that the methods used were effective. Patients seemed motivated, remaining in treatment at a significantly higher rate than comparable patient groups involved in traditional verbal psychotherapy. Another result was that the use of psychotropic drugs was considerably lower for those patients who had used medication before the project. In addition, hospitalizations were reduced to a minimum. According to the test results (using SCL-90, levels of symptoms; Lubarsky's Health and Sickness Rating Scale measuring comprehensive functional level; and Kajandi, measurement of qualities of life) symptoms were reduced to a level which was under the mean level for comparable out-patient groups. Despite the fact that the general functioning level of the Enkoste patients at the beginning of treatment was, on the average lower than a group of patients in verbal psychotherapy, the general functioning level was found to have increased significantly at the second battery of testing. The experience of quality of life was improved to a level just above or just below the average non-patient depending which quality was measured. Examples of qualities of life are the living situation; work; relationship to friends, to parents, to children; experiences of freedom, self acceptance; ability for emotional experiences; and feelings of wholeness. An interesting result of our study is that, for the Enkoste patients, the last two qualities mentioned were improved from a low measure to a level far above the
experiences of average non-patients.

These preliminary results relate to all patients regardless of which treatment modality was used. The final report on the project will include the analysis of data from a Rorschach Test measuring whether structural changes within the personality have taken place. The final results of our tests will give us a clearer idea about the effectiveness of each modality.

Music Therapy at Enkoste

As one of the music therapists on the Enkoste team I will highlight the music therapy part of the project. Music therapy was conducted in three ways. One approach in individual music therapy was through improvisational models as described by Bruscia (1987), Katsh and Fischman (1985), and Nolan (1994). Another individual approach was The Bonny Method of Guided Imagery and Music (GIM) as presented by Bonny (1978), Goldberg (1992, 1994), and Summer (1988) in combination with expressive music therapy. The third approach was an expressive arts group where music was used in guided fantasy journeys, in group improvisations, and as means for intermodal transfer. [Intermodal transfer term refers to changing from one modality to another as a way to deepen the therapeutic process and to enhance the aesthetic experience (Knill, Barba, & Fuchs, 1995).] Although I am not yet able to give a final report upon the therapeutic results using these approaches in music therapy, I am able to describe how music functioned as an aesthetic healer in the Enkoste project.

Case Studies

Susanna, a 45-year old mother of three, entered music therapy with a desire to heal her crippled body and to work on painful memories. She had suffered from abuse and significant losses as a child, presented multiple somatic problems, and showed difficulties in areas of attachment, separation, and differentiation. She had been unemployed for eight years and was attempting to go back to work full time. During her two and a half years of treatment she worked primarily in GIM, along with an occasional expressive music therapy session where she would put significant images into a musical form. One early GIM experience presented the image of an evil queen who wanted to destroy her. In subsequent sessions this theme, which related to her negative self-image and her biological mother, was explored further. Susanna had difficulty tolerating strong affect, yet in her sessions her affect was able to be expressed and held safely, contained within the images themselves. One breakthrough occurred about one year into treatment as the music evoked the image of a depressed mother who was unable to care for her newborn infant. Susanna was stuck, and experienced a sense of numbness. I suggested a musical improvisation. After some warm-up music she moved into a realm which I call the “arena of authentic music.” This is a space of timelessness and profound
creativity wherein the music which comes forth is an expression of the Self (Wärja, 1994). The sound has its own form and, like a fetus traveling through the birth canal it demands to be born. The self seeks expression, its sound demands to be shaped into an audible form. Susanna moved between small bells, drums, and larger gongs. As she played tears were streaming down her face; the music was created by caressing the instruments, hitting them, shouting at them, holding them close, and thrusting them away. In the months that followed Susanna could connect with her feelings more fully and began to differentiate between a larger range of feeling states. She faced images holding intense affect such as hate, rage, terror, shame, and longing. In her daily life she was able to keep her job without somatizing. At the conclusion of her treatment Susanna’s somatic symptoms of severe rheumatism and allergy had decreased significantly.

Thomas, a 33-year old single male with no prior psychotherapeutic experience, was referred to the expressive arts group which I co-led with the expressive arts therapist. Thomas was a gifted musician suffering from performance anxiety, panic attacks, and insomnia. The freedom to make music without “performing” seemed deeply liberating for Thomas, and he entered the creative field with awe and a child’s curiosity. The interpersonal learning that took place and the experience of not being alone with his problems in this group of three male and three female clients clearly had a strong effect on Thomas’s well-being. One sequence of events started with a drawing in which he expressed his feelings in the moment. In the drawing there were a few angular shapes in different primary colors. As the drawing was explored in a drama, he had a strong insight into his family of origin and the controlling subliminal communication that existed under the surface between family members. Some months later Thomas conducted a musical psychodrama (Moreno, 1980) in which he understood more fully how restricted and controlled he felt as a child, how he was forbidden to make mistakes. He realized that he now lived with an inner meticulous and sadistic tyrant. This understanding tore apart his view of himself as a happy-go-lucky Bohemian musician. But, most importantly, he was able to connect and stay with the feelings of despair, and fear of abandonment that the music had shown him. This authentic contact with his true self made it possible for him to begin to perform publicly again. At the conclusion of treatment, Thomas’s panic attacks had decreased, his sleeping had significantly improved, and he was enjoying success as a performing artist.

Conclusion
The collaborative work in Enkoste was a rich and rewarding experience. There is still much that can be discerned from the testing data, process notes, and video recordings to bring forth new perspectives on treatment. I believe that working together as creative arts therapists will give us a stronger impact, more
momentum, and will also enhance and deepen our theoretical understanding. A united path brings a holistic view addressing the whole range of senses which is desperately needed in the field of psychiatry where treatment tends to be compartmentalized and pathologized. Most importantly, the arts focus upon the aesthetic, on beauty, and that part of each individual that has a will to live despite deep suffering. The arts cannot cure us, nor save us, but the arts can bring riches and meaning to our lives.

References


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Music Therapy Practice With Autistic Children And Children With Autistic Tendencies

Karin Schumacher
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Context of Practical Music Therapy Work
I work in a day school for autistic children and children with autistic tendencies, ages five through thirteen years old. The children are taught and cared for each day by specialist teachers and therapists. I work with each child individually for up to forty-five minutes, once a week. Work with the parents and other members of the treatment team is also integrated in my work.

Basic Theories
Every human being needs another person to help develop his predisposition accordingly. When one’s ability to make contact with another human being is disturbed, one suffers not only from developmental disturbances, but also from isolation. The main problem is that through this lack of contact and isolation the motivation for further development is lost. The ability to build a relationship with oneself, as well as with other people and objects, is based upon the ability to coordinate sensory perceptions and to process them meaningfully. If this ability is missing there develops a fundamental contact and relationship disturbance which results in stereotypic behavior, lack of eye contact, and play and speech disturbances. These symptoms lead to the diagnoses: early infantile autism, psychoses, or autistic tendencies. In earlier decades, the Anglo-American literature utilized the labels “autistic” and “psychotic” children synonymously (Rutter, 1977). The basic contact, relationship, and developmental disturbances that begin before the third year are diagnosed as “early infantile autism.” This diagnosis is first described by Leo Kanner (1943) and by Hans Asperger (1944) as “autistic psychopathy.” The cause is probably a disturbance of the senses of perception and coordination, which could be of a genetic, physical and/or psychic nature.

In my music therapy practice I work with autistic children with various degrees of mental retardation. I also work with children who show autistic tendencies for different reasons (such as early brain damage, emotional deprivation through repeated broken relationships, or through sexual abuse with psychotic symptoms and mutism).
Basic Qualities of the Therapist/Concepts of Training

A requirement for the therapist in this work is the acceptance of autistic behavior; an expectation of communication; good capabilities for perception, resonance, and emotional attunement. The musical requirements include the ability to perform a "musical" assessment of the child, to make emotions audible and to find musical forms of game-playing, and to take one's cues from the child and develop them musically. The ability to balance closeness and distance both in the musical dialogue and physically is essential in order to develop and keep contact. These skills are practiced and developed through self observation and in methods seminars.

Techniques/Approach/Aims

First of all the child's movements, which indicate his psychological state, are brought into a musical concept. An attempt to establish contact is made through proprioceptive (caring, rocking), visual (simultaneous imitation), and auditory stimulation. Auditory stimulation is accomplished through instrumental and/or vocal accompaniment according to the child's physical/psychological condition.

The child is given an awareness of his often quiet and rudimentary vocal and instrumental expression through simultaneous imitation, and other forms of imitation, as well as variation and accompaniment by the therapist.

The therapist finds a form of musical game-playing that develops from the child's own expression. This form becomes embedded in the experience, becomes meaningful, and provides the room within which interpersonal relationships can develop. The child's recognition of his own expressions helps to develop self-awareness. A lively repetition of the recently found forms of game-playing create an area for developing interpersonal relationships.

Elementary music/movement/word games are excellent ways of forming and establishing the relationship. These include: clapping games; finger games; nursery rhymes; tactile fairy tales; body, movement, and dance songs; activity songs; nonsense rhymes and nonsense songs.

Only through the shared emotions ("interaffectivity"; Stern, 1985) with the therapist during the musical-physical games, is the motivation to vocally and instrumentally express himself on his own awakened in an autistic child.

Through music therapy it is possible to attain an improvement in body and self awareness. This constitutes a departure from emotional isolation and the establishment of an internal motivation for emotional, cognitive, vocal-speech, and play abilities.

The results of my own research through the analysis of videotaped long term treatment prove that music therapy is effective with autistic children and children with autistic tendencies in developing an ability to make contact and form relationships (Schumacher, 1995).
References

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The music therapist is a specialized listener; not a listener specialized in beautiful music but, more precisely, a listener of human expression in sounds and musics. This specialized listening is at the same time acoustical, musical, emotional and symbolical, psychological, and sometimes, psychoanalytical.

My Interest in Autism

As a consequence of this theoretical viewpoint, I have decided to care specially for the sonorous spontaneous productions of patients without access to speech. I consider that, in these cases, something specifically human is to be heard through these productions (cries, sounds, hummings etc.) even if this kind of primary emotional level of expression and archaic symbolization is difficult for us. The issue in this work is to stimulate the general interest in their special sonorous productions (if any), to find interpretations, and to learn how to react therapeutically.

This clinical stance led me to carry out research on a particular, common, sonorous expression: humming. I consider humming as a manifestation of musical thought (through a process of free association of musical ideas, a process comparable to the verbal free association of ideas). Although I cannot set forth this research in this short article, one part of my study is dedicated to the particularity of many autistic patients using humming in the absence of any verbal expression. This example offers, through its pathology, the observation of the humming as dissociated, isolated from the verbal process. In this regard, autistic patients can help us to understand our own psychic functioning (because their musical and verbal expressions, such as intonation, can be seen separately; whereas normally they would be closely associated.)

The sonorous or musical behaviors of autistic patients can be viewed through the following three models of autism:

- The Genetic and Neurobiological Model is an etiological model which hypothesizes that functional difficulties in dopamine or serotonin, left or right hemisphere lesions, or both are the causes of the autistic person's behaviors.
- The Psychological, Neuropsychological, Cognitive Model is a descriptive model which proposes that autistic behavior can be seen as a deficiency:
1) in the processing of sensory information (the absence of filtering, excessive filtering, or distortion of incoming signals);
2) in the process of symbolization;
3) in the social cognition; and
4) in the theory of mind.

• The Psychoanalytic, Psychodynamic Model is an interpretive model which posits that autistic behavior is an active defense against anxiety which can be manifested:
  1) in a "sonorous wall" (Bettelheim);
  2) in a process of dissociation and isolation of the sonorous experience (Meltzer);
  3) in the creation of an autistic sonorous object (Tustin);
  4) in a deficiency of the sonorous envelope (Anzieu); and
  5) in "adhesive identification," (as in "sticking" on the mother's skin) (Bick).

Although I am presenting separate models (corresponding with different "schools" of psychopathology), aspects of these models can be combined (for instance, the first model with the third, or with the second; or even the three models together).

To summarize the questions about the relation that autistic persons have with sounds and musics, I point out several observations: 1) a relation to deafness (perhaps as sensory withdrawal), 2) a sensitivity to sounds, noises (perhaps, hyposensitivity or hypersensitivity), and 3) a sensitivity to music and to musicality (for example, listening repetitively to music and humming).

These different possibilities can be related to the three models mentioned above. A lesion of the left hemisphere, for example, could be at the origin of the autistic person's specific sensitivity to sounds (neurobiological model); a defect in the processing of sensory information might also be the cause of this aural sensitivity (neuropsychological model), (perhaps a retardation of the evoked response in auditory stimuli, especially); or the idea of an active defense against anxiety is developed in the psychoanalytical model. Whatever model one uses to explain how an autistic person relates to sounds (my own is psychoanalytic) the evidence is that the sonorous response is an important factor in autism. This has been observed by many music therapists and clinicians and, in fact, is why I am especially interested in it.

**My Clinical Experience**

In my clinical practice through the years as a psychotherapist and music therapist I have encountered several cases which stimulated my special interest in the autistic person's relationship to sound.
Mireille (Lecourt, 1980) who was 43 years old repeated, in a stereotypic style, "il était un..." ("there was a"), which is the beginning of a children's song: "Il était un petit navire" ("there was a little boat"). Mireille had two or three more such automatic children's songs; however, she always began with this particular song fragment. I wondered, "What was the value of this repetition?" "Why this song particular song?" "What significance did this have inside for her?"

These questions about stereotypical behaviors were central in the treatment of a young male, David (Lecourt, 1987, 1990, 1991), who was four years old when we began music therapy together. It took me a long time to record and analyze his stereotypical behavior. Finally, at a point when David was becoming more active in developing a relationship with me, he tried to "show" me something which was deeply meaningful. The complexity of the behavior which he showed me could have been overlooked had it been taken superficially, as pure repetition. This was, for me, a crucial lesson in listening to autistic persons. This inspired me to help my students at the university to undertake research which would address these stereotypical behaviors by autistic and psychotic patients (Pelletier, 1996).

I have also noted interesting observations about humming in autistic persons. For instance, Claudine (Lecourt, 1987), 13 years old, made vocalizations of pleasure during music therapy sessions, and I could sometimes hear a pure humming. However, she would stop humming when she felt the presence of a person. At the end of our work together she sometimes developed her humming but only allowed herself to do so by hiding behind my back. (This relation to the back, and to an anal component of sound production was also present in David's experience.)

Damien (Lecourt, 1986) was a six year old boy whom I observed during supervision. His echolalia was associated with a vocal "play back," which appeared as an internal humming, being on the edge of externalizing expression (but with the voice still inside). This kind of "play back" was also observed in other autistic patients in individual music therapy. None of these patients could speak at the beginning of treatment when I met them; however, Mireille, David, and Damien developed this capacity through music therapy.

Clinical Research

We are in the process of recording the spontaneous free sonorous/musical expressions of such autistic patients in order to analyze their expressions and to relate their expression to their personal history. But furthermore, we are interested in developing a better analysis of the different levels of psychic functioning which these patients present, and the relationship of their sonorous/musical expressions to their pathology (as a differential factor in diagnosis, for example).
The first recordings were made by K. Nasra in Algeria of nine young people who were abandoned at birth and placed in an institution. Two of them represent significantly different musical expressions. The first, Fatima, a girl of 23 years presents (in her daily life) a variety of emotional expressions which contain onomatopeias and echolalia. Her hummings are sometimes associated with weeping (without explanation); although she has no speech, she has some adaptive behaviors. On the recording Fatima’s rhythmical repetition progressively transforms into singing, which vibrates with pleasure. This musicality seems to be in tune with her general level of development. The other patient, Karim, is quite the opposite of Fatima. Karim is a 16 year old male with a motor cerebral disability associated with epilepsy. He is very dependent (in his daily living skills), passive and gentle. He does not answer to his name, nor does he speak. In contrast to his daily behavior, one can hear on our recordings a wealth of sonorous activity. Karim expresses a wide variety of sounds and rhythms, and what we may call “sonorous peculiarities.” We are using these recordings to develop an understanding of these patient’s musicality and their different sensitivity to sounds. These issues seem to me to be very important for our clinical work.

The sonorous experience takes an important place in the autistic world, whether in a positive or negative sense. The capacity of humming and its qualities can teach us about thought processes, perhaps there exists a special musical intelligence (Gardner) present in some of these patients. This may make it possible to differentiate between severely retarded patients and autistic patients.

The spontaneous, free sonorous and musical productions of these patients bring us the means to explore our own functioning in sounds, the relation between conscious and unconscious levels of experience, between affect and thought (from emotion to symbolization), between withdrawal and communication, a way to listen to our own emotional world through sound. Exploring these relationships within ourselves will ultimately improve our listening; the listening which is so necessary to work with our patients in our day to day clinical work.

References


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New Directions In Music Therapy Practice With Abused Clients

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United Kingdom

In recent years, acceptance of the occurrence of childhood sexual abuse in public and professional domains has been paralleled by an increase in knowledge of the consequences of abuse. These have been described extensively and include an assortment of psychological impairment, distress, including enhancement of learning difficulties (Sinason, 1992) and complex psychiatric problems. Two thirds of female psychiatric patients are reported to have histories of childhood physical and/or sexual abuse (Bryer, Nelson, Miller & Kroll, 1987). Such research findings clearly have considerable relevance to music therapists working within mental health.

There are few publications about music therapy with abused clients, although music therapists are increasingly involved with the identification and treatment of survivors of childhood sexual abuse. While few music therapists are working in clinical teams dedicated to the abused child or adult survivor, many music therapists have the experience of working with an abused client. The literature that is available describes various models of music therapy in use with abused clients. Rogers (1992, 1993, 1994, 1995) and Barth-Scheiby et al. (1993) report the use of psychoanalytically-informed music therapy. Bruscia beautifully documents the use of Guided Imagery and Music (GIM) with an abused client (1991). The use of Guided Imagery and Music is also described by Sonnon (1993). Clendenon-Wallen (1991) discusses the use of music therapy to influence self-esteem and self-confidence in a group of sexually abused adolescents, using more structured approaches including song or “rap” writing, song discussion, improvisation and music and movement activities. Henderson (1991) describes therapy with an abused thirteen year old in South Africa, in which improvised song stories are used, modeled on Barbara Grinell’s “Developmental Therapeutic Process” [reported in Improvisational Models of Music Therapy by Kenneth Bruscia (Ed.), Springfield, IL: Charles C. Thomas, 1987].

As awareness of abuse increases, one would expect more music therapists to specialize in this field. Music Therapy practice with abused clients includes many salient features (Rogers, 1992, 1993, 1994, 1995). However, two elements in particular, the legal and supervisory aspects need consideration, and distinguish this work from the practice of music therapy with other client groups. In considering new directions in music therapy practice with abused clients, these two features demand attention. Both have implications for the
future direction of music therapy practice with abused clients and for the training of music therapists.

Legal Dilemmas

Music therapy is typically framed within a context of client confidentiality. If a client discloses that they are being abused, the music therapist is faced with the dilemma of either colluding with the power of the secret, and the abuser, if they maintain the client’s confidentiality (Rogers, 1994); or conversely, in breaking that confidence and possibly the therapeutic alliance, by forwarding information to the statutory authorities of the Police and Social Services. While breaking the secret of abuse can break the power of the abuser it also leaves the child exposed to the trauma of an investigation and all possible repercussions. Although as yet no music therapist has been challenged through the courts for withholding information regarding a disclosure of abuse, this is certainly a possibility. It is necessary to recognize that therapy can become anti-therapeutic and potentially damaging. This is a danger where therapy is conducted without adequate child protection action being instigated. Therapy alone cannot protect children; because of the addictive and secretive nature of child sexual abuse; the child who makes a disclosure of abuse is well aware of the consequences of that disclosure.

An awareness of the legal context that surrounds work with abused clients is vital for music therapists. For the music therapist working in the UK, (and pertinent for other countries with similar legal systems), there are legal implications if, during therapy, a child reveals that they have been abused. In the UK, the only bodies that have a statutory duty (one determined by a Statute or Act of Parliament) to act upon alleged or suspected child abuse are the local Social Services and the Police. Other professionals whose work brings them into contact with children, such as doctors, health professionals, therapists and teachers do not have a statutory duty to report child abuse. While professional codes of ethics and/or the policies of some employing authorities may govern the way in which many professional groups are expected to deal with allegations or suspicions of abuse, such constraints may not bind others. The Association of Professional Music Therapists (UK) does not prescribe what action a therapist should take within its code of ethics. Thus, for the music therapist, the decision about what to do in regard a disclosure or any suspicions of either abuse or abusive behavior may be left to the therapist’s personal judgement.¹

Where a child or adult does disclose that they are being abused, an investigation may follow. Once the therapist has “spoken out,” others will determine the child’s fate and take control; the therapist’s subsequent experience of powerlessness as others determine the pace of any investigation may mirror that of the child after disclosure. This parallel experience may
contribute to the finding that many professionals show considerable reluctance or denial in believing that a child has been sexually abused. The therapist’s desire to believe that behavior is based in fantasy rather than fact may deter them from pursuing a suspicion that what the child produces through sexualized play may suggest a re-enactment of an experience of sexual abuse. An actual ability to “hear” that a child has been abused (or equally, that the child is being abusive) is therefore very important. Equally significant is the recognition that informing statutory authorities may bring traumatic consequences not only for the child, but also the therapist, as the therapist may feel—and be—powerless to protect the client during ensuing proceedings.

Where a child is interviewed as part of an investigation, music therapists may find themselves involved in a Child Protection Case Conference as the chief instigator of a statutory instrument known, in the UK, as an emergency protection order (EPO) or observing the decision making processes regarding whether criminal proceedings will occur against an alleged abuser. An EPO is a statutory power through which a child may be removed from their family home to a place of safety.

In the UK, only a very small number of reported sexual offenses against children result in the criminal prosecution and conviction of an abuser due to the degree of evidence required to secure a criminal conviction being “beyond all reasonable doubt.” Often, the therapist will see criminal proceedings being dropped, or witness additional stress to the abuse victim as the delays and continuances that characterize criminal prosecutions occur. In criminal proceedings, the victim is only a witness for the prosecution by the state. Many cases result in civil cases such as care proceedings. It is the protection of the child and the child’s welfare that is the court’s paramount consideration during care proceedings, rather than the prosecution of the criminal—the abuser. The evidence here needs to be only “balance of probability,” and the child is central to the proceedings. In either instance the therapist may be called upon to give evidence in court and the necessity for clear and concise records of the whole therapeutic process is clear.

There is continued debate about whether involvement in any judicial proceedings causes additional harm to abused children. Some researchers maintain that testifying may be cathartic or contribute to recovery by restoring power and control. Others recognize that the process of investigation causes its own additional traumas.

A final dilemma posed through the legal context is the question of whether therapy should be suspended while investigations or court proceedings take place. The debate over such issues is complex. A common strategy in this regard is to cite “false memory syndrome,” claiming that the therapist has “implanted the memory.” This criticism obviously applies to therapy prior to proceedings and can be rebutted. It is harder to disprove the allegation that
continued therapy (particularly with the same therapist, who may also be a witness) is prejudicial to a proper defense. However, for the client, the experience of presenting evidence in court, the development of the skills to be an effective witness, and the possibility of being removed from their family can be traumatic and daunting. This is often where the support found in therapy is most needed. Each of the above will also affect the therapist and have implications for clinical practice, training and supervision.

The Necessity for Adequate Clinical Supervision

Supervision is clearly vital in such cases (Rogers, 1992). The emotional impact of work with abused clients is increasingly acknowledged (Morrison, 1990). Personal awareness by therapists of the impact of their own gender and sexuality are germane in work with abused clients. Therapists may experience personal revulsion at the abuse a client has experienced and, with a young abuser, committed. Countertransference issues that arise in therapy with this client group are of particular significance (Rogers, 1995; Barth-Scheiby et al., 1993) especially where a client may literally have no words. A therapist’s own motivations for working in this field need careful exploration; it is not simply by chance that one third of the professionals working with abused clients have a personal history of abuse (Furniss, 1992); the adage, “When your client group all has the same problem, is it their problem or your own?” requires sensitive consideration.

In conclusion, the above issues regarding abused clients illustrate the need for the further training of music therapists before engaging in clinical work with these clients. Consideration of the emotional and legal contexts of work with abused clients should be included in the basic training of music therapists, but specialization in this area demands advanced training and sensitive supervision.

1 Editor’s Note: As a contrast to the United Kingdom, in the U.S.A., state law mandates that therapists report the suspicion of abuse even if it has not been confirmed. In addition, this suspicion may be grounds for breaking confidentiality. (Limits of confidentiality should be addressed at the onset of therapy.)

References


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A Pilot Experience
Using Music Therapy With Homeless Children

Lia Rejane Mendes Barcellos
Brazil

A characteristic of modern urban societies is the increase in violence, suicide, theft, homicide, and the neglect of minors and adolescents. Although the problem of homeless children is a world problem, it has risen to extreme proportions in Latin America; and especially in Brazil, as official records have pointed to this country as having half the homeless children in Latin America. This is due to the fact that a homeless child is defined as a minor who wanders the streets without an adult’s supervision. These children are in search of activities which would create income for their own survival and to contribute to the maintenance of their families. The variety of activities they use to survive are limited only by the imagination. Those who manage to survive the various diseases on the streets develop strategies to confront the everyday dangers of “street society” (Rizzini, 1993) – gangs, people in transit, and drug pushers. In their wanderings, it is inevitable that they are exposed to drugs, exploitation by adults, violence and death.

In 1993, eleven homeless children were murdered in front of the Candelaria Church in downtown Rio de Janeiro. This incident led me to reflect upon how I could participate in helping homeless children. The decision wasn’t difficult; the best way would be to work with music therapy. Paradoxically, it was very difficult to become engaged in an existing project, even as a volunteer. It was a challenge to find an avenue to use music therapy with the homeless children in Rio de Janeiro because there had never been any music therapy work done with homeless children in Brazil. I decided to develop the work with a colleague, and I invited a music therapist, Lenita Vieira Moraes to work with me. Contacts from her participation in the so-called “Solidarity Project” (a project coordinated by Psychologist/Pastor of Christ Church in Ipanema, Edson Fernando de Almeida) enabled us to be accepted as volunteer music therapists in the project, “Homeless Children, the Future is Now.”

The Project

The homeless children project began in 1990 when a group created the Social Department of the Association of Tourist Hotels, and soon after, associated itself with the “Crusade of Minors,” an organization established in 1920 to attend to tuberculosis patients. The objective of this project for homeless children, like so many other projects in Rio de Janeiro developed by non-governmental organizations, is to offer homeless children “the right to
construct their conditions as free citizens, growing as individuals able to integrate in collective structures” (without date).

The project had five phases: approach, day-house, home-house, school-workshop and “hostel.” In the first phase (approach), teachers went out into the streets to “create a link of communication” with minors, taking them food, medical assistance, and attempting to reintegrate the children into families. The second phase introduced meals in the “day-house,” while the minors continued to live in the streets. The third phase established the minors living in the (home) house. The fourth phase (school workshop) marked the beginning of professional activities; and finally, in the last phase (hostel), the minors were responsible for maintaining the house in which they resided in groups.

**Music Therapy**

We decided to introduce music therapy into the third phase (house-home) of the program because it was the phase in which the minors were removed from street life. Our music therapy group was comprised of seven black adolescents, ages 11–19 years old, six males and one female. (A one-year-old girl who was born in the house also attended meetings.) Some facts discovered about the seven minors were astonishing: all were using many types of drugs (the most common being “crack”); all had been victims of family or police violence; many were victims of sexual violence by the police; and a majority of the group had lost all contact with their families – having lived in the streets for 1-7 years.

Our first session began routinely enough as we interviewed the group to assess their music preferences. Among their preferences were “RAP” (Rhythm and Poetry), “Pagode” (a Brazilian rhythm), Funk, Charm, and “slow music.” However, our session took an unexpected turn when the group brought out their own “house” percussion instruments, and proceeded to play, sing, and dance their favorite rhythms with amazing nimbleness. Needless to say, their relationship with this music was highly developed; and although we joined them, they danced these rhythms better than we possibly could. This first contact made us realize what a creative challenge it would be to work with these children. From that point on, our goal was to develop our work from their interests; and believing in the capacity and possibilities inherent in these children in spite of all adversity, we determined that we would utilize a humanistic theoretical approach. One interesting note from this first session: although the group members had not included the “Samba” among their preferences, it was this characteristic rhythm of Rio de Janeiro which appeared first in their playing.

In the sessions that followed, we dealt with the important issue of rules. We learned that all of the rules which were posted in the house (rules regarding cleaning, care of house possessions, timetables, attending classes, abstinence from drugs and firearms, stealing, etc) had been created by the residents of the
house themselves. Violation of the house rules led to a warning, suspension and expulsion from the house. Realizing that our group members not only accepted limits, but that they were able to create their own rules (which, in our opinion, were sufficiently rigid), we began to establish limits that would certainly be necessary for their adaptation to social life.

In one of our sessions, the participants chose a name for the music therapy group, “Dream/Hope,” and, once more, created rules for behavior regarding issues such as attendance and use of the instruments – even including a signed agreement for their use. For our part, we transformed ourselves from therapists into “students”; so for some time, in an attempt to be accepted, we submitted ourselves to “the lessons,” and we all enjoyed dancing to Funk. This was very pleasurable for us, and probably “clumsy” in their eyes. We noted that this group who behaved so loosely, danced with rigidly marked choreographies, sang the long phrases of RAP with exactitude from beginning to end, and marked their rhythms with precision. We began to wonder how we could transform these activities which they carried out with such astounding ability, but in an almost “mechanical” way, into a form that could provide the possibility for expressing their problems, ideas and feelings; and finally, to reveal all that needed to be revealed. We needed a form in which we could be present to “hold” those expressions and to share those moments.

Paradoxically, it was our inability to follow their dance that broke the rigidity of our activities and, functioning as “involuntary interventions,” opened the way for a change. During one of the sessions, a group member spoke a phrase referring to himself within the group, and we asked how it might be transformed into music. The reactions were immediate: “We don’t know how to do that!” This was a turning point in the session, and the group began to create its first musical phrase to express what had been said. In our opinion, musical composition seemed to be the best technique to help our group “show themselves.” Bruscia (1991) relates that composing in music therapy is to be used with patients who need to “organize their decision-making, learn selectivity and commitment, develop economy of means, identify and develop themes, document inner thoughts and feelings, or have tangible evidence of personal achievements.” At the same time, we worried that our group might feel that we were basically strangers to them because we were not familiar with their “reality.” Despite our apprehensions that we were still at an early stage of our work, we found that the way was open! We proceeded with the development of the composition process – the words, the music, the recording, and singing and playing along with the recording. This composition process, without doubt, permitted the group to express their conflicts, desires, thoughts, and even their opinions about present day Brazil. One of their compositions, shown below, expresses the manner in which the country treats social questions.
Dream 1

Today I had a dream, A different dream, (Repeat)
I dreamt, That everybody was human.

We are the dream,
I dreamt that violence was going to end,
Homeless kids thrown to the ground, to the ground

How can this country continue then,
Happily live,
Live the happiness (Repeat)
Brazil can’t live without you.

The RAP and Funk are forms of expression which are played often on the radio, and are used mostly by organized gangs to portray and to protest against the social situation in Brazil. However, in this composition mixed with the RAP form, the cultural roots of Brazil appear once again with the Samba. Since it is not possible for you to listen to the music, it must suffice to say that this composition is in a Major key, in a 2/4 beat with strong rhythm. Melodically, rising sixths are used with the words “we are the dream;” ascending sevenths and fifths are used when they refer to themselves as “thrown to the ground.” In spite of the tragic words in this particular passage, the Samba rhythm gives it a happiness that confirms what Lusk and Mason say, citing Felsman: “in fact, what is dignifying to note despite the shadowy and inexorable atmosphere contained in the literature about homeless is that, in absolute poverty and urban violence, they are surprisingly happy.”

The songs created by this music therapy group are charged with happiness while simultaneously giving voice to their protests. It includes protestations about the way that they are treated, the manner in which the country handles the problem of homeless children, as well as their worries about the future. They are infused with cultural elements at the same time that they express the problems of the culture.

This work must be considered a pilot project because of the small number of participants and the brief period of therapy. Unfortunately, the project was interrupted for two reasons: first, most of the minors were admitted to work in a Brazilian company on an experimental basis; and second (which brings a taste of the reality of our country), the children’s shelter was invaded by armed drug-traffickers who assaulted the house. This precipitous end to our project does not interfere with the belief that we have gained from our work – that music therapy
can contribute to the amelioration of the present situation with homeless children in Brazil.

References


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Music Therapy For The Elderly
In Long Term Skilled Nursing Care
And Short Term Rehabilitation

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When I began my clinical work eighteen years ago in a small nursing home, I found myself struggling between my concept of what music therapy should be and the music activity work that was required by the facility where I worked. Music has power to effect many changes, neurologically, psychologically, spiritually, and physically, yet the therapeutic music activities I was asked to do were only touching the surface. When I began to work at Beth Abraham Hospital sixteen years ago, I had the opportunity to work with residents who had severe dementia. It was with this population that I began to learn how integral music is to our lives, and the role it can play in retrieving "lost" function. Three years ago, I was able to establish a music therapy department at this facility as part of their medical services, and all patients are referred for treatment based on medical need. The scope of music therapy practice with the elderly in the U.S.A., has expanded in the past ten years to include areas such as preventive care and family therapy. My work has focused mainly on music and neurologic function, especially in the following areas.

Music and Memory

Current research in neuroscience indicates that there is a strong connection between the auditory system and the limbic system. This biological link makes it possible for sound to be processed almost immediately by the areas of the brain that are associated with long term memory and the emotions. This link is also mediated at a subcortical level, making it possible for processing of information despite higher cortical damage. This is evidenced clinically by the strong emotional responses to familiar music that we observe in persons with memory deficits, such as multi-infarct dementia or Alzheimer's disease. Familiar songs become a tool for connecting to seemingly lost parts of the personality by providing a necessary link to the "self." We have memories, not only for the particulars of a song, such as the melody or lyrics, but the rich associations that keep the melodies alive for us throughout our life. Memories are not actually lost with dementia; rather, the ability to retrieve and gain access to them is damaged. Music, then, can provide access not only to specific moods and memories, but to entire thought–structure and personality of the past. The ability of music to provide these connections makes it an essential tool for any
therapy with persons with memory deficits.

Music and Rehabilitation

As we possess memories for factual information, we also possess memories for physical movements. Many elderly are institutionalized following a stroke which leaves them with a weakness or paralysis on one side. Even persons with dementia may lose the ability to initiate movements. Music, and in particular rhythm, can play an essential role in treatment by providing the necessary cues to reintegrate the sense of movement. Research in the neurosciences has shown that in many adults, the loss of neurologic function triggers the activation of compensatory mechanisms which have been lying dormant within the brain to partially or completely “take over” the absent function. This phenomenon is known as “neural plasticity.” There are many alternate nerve pathways and connections that can be used to re-establish behaviors. In persons with severe dementia, music which has a strong rhythmic base can allow for spontaneous movement, thus keeping limbs and joints free from possible atrophy and contractures. In persons with hemi–pareisis (a weakening of one side of the body) it may be possible to stimulate alternate motor pathways with the “right” music/rhythm. For example, walking and dancing, though both physical movements, use a different postural schema. By stimulating a similar, but different, physical activity through music therapy, we have the ability to help a person reintegrate the sense of movement that they have lost.

For persons with language disorders secondary to stroke, we have also seen improvements through music therapy. Those with expressive aphasia (difficulty in word retrieval but good comprehension) can often sing familiar musical phrases without problem. When singing stimulates the language centers of the brain, it can aid in non–musical word retrieval making it eventually possible for purposeful speech. Likewise, persons with dysarthria, a motor speech problem that makes verbal communication difficult, can also be helped through music therapy. Many dysarthric patients, though able to learn intelligibility techniques, have problems in carry over and thus are not able to employ these techniques consistently. Through the underlying tempi, melodies, and enhancement of phrasing, music therapy can provide the internalization of correct breathing and phrasing needed for these patients to produce coherent speech.

The Institute for Music and Neurologic Function

Most recently, Beth Abraham Health Services has established an institute to provide support for research into the effects of music on neurologic function. We are able to work with a team of neuroscientists who are investigating some of the basic questions of how music is processed. We are also engaged in clinical research in the areas discussed above to gain a better understanding of
how music can be used to effect specific changes in physical, cognitive, and psychological functioning. We have just completed an eighteen month study on the effects of music on memory in persons with dementia, funded by the New York State Department of Health, as well as a funded research project on a joint speech therapy/music therapy program for persons with dysarthria. We will be publishing our findings from these two projects shortly. Anyone interested in clinical music therapy training and research at this facility should contact me at the number below.

CONNIE TOMAINO, ACMT-BC, is a past-president of the American Association for Music Therapy. She is on the advisory boards of the Institute for Music and Neurologic Function at Beth Abraham Health Services (Bronx, N.Y.) and the Research Center in Alternative and Complementary Medicine in Rehabilitation at the Kessler Institute for Rehabilitation (West Orange, New Jersey). ADDRESS: Beth Abraham Health Services; 612 Allerton Avenue; Bronx, New York 10467; U.S.A.; PHONE: 1–718–920–6020; FAX: 1–718–405–1206.
Fritz Perls once said that Gestalt therapy is too precious to be reserved only for patients. I join him in this sentiment regarding music therapy and, in this regard, point out the need to develop a broader concept of therapy than we utilize at the present time. In music therapy we have vigorously concentrated upon the treatment of clinical disturbances and diseases that can be classified by the ICD 10 or DSM IV, but we will have to become more aware of collective, cultural disturbances and problematic developments such as the increasing phenomena of alienation from our being. Anthropological diseases are a cultural effect from collective ideologies and our value systems that imposes upon our way of life.

Anthropologically disturbed developments make it necessary to help people before they fall ill. Normal persons do not (yet) need clinical treatment, but there is just a slight distinction between the normal person and a client or a patient. Traditional Chinese medicine always took care of healthy people. Doctors did not wait until a person fell ill before they helped. They were paid for their competence to keep people healthy, but they did not get paid for the treatment of ill people. Music therapy, with its long tradition of encouraging the normal person's creativity, has an important function for prevention and prophylaxis in the service of public health. During the last few years music therapy in Germany has been very concerned with its identification as a clinical psychotherapy, and music therapists who worked in the field of prevention were often disqualified as therapists. I hope this will change in future.

I believe in music therapy as a form of therapy that can be used in various ways, because it is a form of clinical and anthropological therapy that specializes in relations: like members of a group or a society, musical tones change their characters and colors according to their different relationships. It is not the individual tones that are meaningful, but the intervals and harmonies in between the tones (Zuckerkandl, 1963). Music therapy is a field where clients and patients can create and experience relations and relationships and learn what it means to take interest in each other (Latin: inter-esse: to be in between). Music therapy provides us with the living experience of how it is to be part of an intersubjective world that is shared with others – how it feels not to be isolated from others. Improvising with others gives shared emotional experience. This is an important step in building up a rich identity as an individual and a social person.
In Germany different forms of music therapy have been developed. Integrative Music Therapy is a form developed and taught by me and my colleagues at the Fritz Perls Institute of Integrative Therapy, Gestalt Therapy and Promotion of Creativity. Integrative Music Therapy (IMT) is a method of Integrative Therapy (founded by Hilarion Petzold in the late sixties based upon Fritz Perls Gestalt Therapy, but developed much further), and the clinical and anthropological concepts of IMT are based upon the metatheories of Integrative Therapy.

The four dimensions of healing below (Vier Wege der Heilung; Petzold, 1988, Frohne-Hagemann, 1990) show how IMT utilizes the above mentioned therapeutic perspectives. The first two dimensions focus more on clinically oriented (music) therapy, whereas dimensions three and four concentrate on anthropological goals. These four dimensions of therapy should be understood as different views on the therapeutic proceedings that can easily change within each single therapy process.

The Four Dimensions of Therapy

1. (Music) therapy is seen as a way to find meaning in our life – to understand why and how we have become what and who we are. This dimension mainly corresponds to psychotherapy with neurotic patients.

2. (Music) therapy is seen as a means to nurse and re-parent a person – a way to provide him/her with new experiences of relationships; because s/he could never have the experience of a healthy development, nor an adequate conception and construction of reality. Compared to the first dimension, this one corresponds more to psychotherapy with early disturbed patients.

3. (Music) therapy is seen as a means to help people to develop their creative potential and to enfold the richness of their personality. We want to help to start the creative spiral which is a lifelong rhythmic process that organizes our capacity for perception, memory, and expression in hierarchic spirals (Frohne, 1981, Petzold, 1993). Healthy persons are creative persons that are in accord with their inner and outer world.

4. (Music) therapy is seen as a means to understand the metaperspectives of the cultural system in which one was raised. Music therapy is a means to help people understand themselves as parts of their ecological and social system, helping to motivate them to take responsibility for this system. Music therapy here (more than in dimensions one to three) has a political dimension and the function of cultural hygiene.
Since the reunion of East and West Germany, this fourth dimension has achieved special significance for music therapy because deep sociological and psychological problems have surfaced that cannot be handled in therapy merely as an individual psychological problem of the patient or client. A music therapist must be aware of the different cultural backgrounds, ideologies, and experiences, and should never neglect the social psychological perspective when he or she analyzes symptoms like depression and communication problems.

An Example of IMT

A technique I call the musical life-panorama\(^2\) can be utilized with normal persons. Several clients in a group are invited by the music therapist to share their experiences with music during their lives: what kind of music their parents listened to, what kind of music was taught in school, what kind of music has had importance to them - when, how and why? Briefly said: what kind of significance throughout their personal and social biography has music had, and how did music influence their identity? With this topic-oriented approach, the group members very quickly develop a very intimate contact with each other. The music they talk about and have listened to always has a precious personal meaning (especially during sensitive periods in life like puberty or during restricted political conditions like we had in the former GDR), and this music often functions like a code that shows where we belong and who we can trust. Personal disclosures such as musical taste, emotional connections of music with certain events, values, ideologies, and persons are made. This provides possibilities for us to relate, to communicate, to determine whether other persons will take us seriously, and perhaps to appreciate what and who we are, and how we behave. This kind of sharing of different social worlds may help to stabilize a permeable identity. In this example, one can understand how music can be used and misused for political, economical, social and individual purposes (dimension four).

The work with the musical life-panorama also includes an active part (dimension three) in which a group member uses the other group members in order to musically create a certain life-event or the atmosphere of a certain period in his/her life, etc. It is a procedure where the protagonist gives exact directions regarding how the chosen instruments should be played (s/he demonstrates this). S/he reconstructs the atmosphere of the past and some of the important feelings connected with the past in the "here and now." By listening to this orchestra, and experimenting with further musical activities and interventions, s/he has the chance to transform difficult experiences into experiences that can be handled. The creative person of today will be enabled
to construct new realities.

Music therapy with normal persons is necessary. However, a prerequisite to music therapy with normal persons is the consensus and acceptance that we are all potential patients. A healthy person is a person who is his or her own creative therapist and is reasonably aware of his or her "psychohygiene." I hope that the concept of creativity will turn out to be one of the most effective possibilities for health care; and I hope that music therapy, apart from being a clinical method, will be inaugurated as one of the promising prevention therapies.

1Western ideology, for example, is based on the freedom of the individual, self development and so on, values which have their advantages, but also their shadow sides. Individuality often does not correspond to its social roots, and self actualization and experience often become distorted into values which are disconnected from the social context. On the other hand, we find in Eastern ideology an exaggeration of the "we," and thus a suppression of individuality which has a shadow side, as well.

2This therapeutic approach was the topic of some very interesting research I did with East-Germans and West-Germans.

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Music Therapy In Practice
In Palliative/Hospice Care

Deborah Salmon
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Introduction
Palliative/hospice care philosophy embraces the concept of whole person care, recognizing the vital importance of all aspects of personhood, and understanding that suffering may occur in physical, psychological, social and spiritual realms. The multidimensional nature of music and its vast impact on human experience seem to resonate with the complex needs of the terminally ill, making music therapy particularly well-suited to this population.

It follows that tremendous flexibility and a broad range of music and music therapy interventions are employed in this work. Techniques range from vocal (singing, song choice, songwriting), to instrumental (playing instruments, improvising) to listening (GIM, various music/relaxation interventions, active listening) often in combination with other modalities (massage, other arts, verbal processing).

Clinical Practice

Physical
Some of the physical symptoms associated with terminal illness are pain, nausea, shortness of breath, and insomnia. Anxiety may be one result and the further cause of such symptoms. Here, music therapy has much to offer in the way of music/relaxation techniques, helping to break the symptom–anxiety–symptom cycle, and teaching the patient skills which, in turn, provide a greater sense of control. Relaxing music, appropriately chosen for a particular patient, combined with one or more of the following – breathing techniques, imagery, massage, autogenic or progressive relaxation – is often effective, and can help potentiate medications.

Psychological
Music therapy facilitates the experience and expression of deep emotion; patients readily laugh, cry, reflect on their lives, and reminisce in sessions. Whether the expression be symbolic (e.g.; through improvisation, imagery or song choice) or concrete (through the sharing of memories), the important tasks of reviewing life, grieving losses, and finding personal meaning are often taking place. Sometimes this process finds creative expression in songwriting or in the making of an audio or video tape which incorporates the dying person’s songs,
stories and/or words of wisdom. These become precious gifts to the patient’s loved ones.

Palliative/hospice care is an area where knowledge of verbal “active listening” techniques and psychotherapeutic processes are invaluable. For many patients and families this is a time of great emotional vulnerability. Habitual defenses may be weakened and the music readily touches upon a host of feelings: regrets, or echoes of earlier losses; and unresolved grief, fear, anger and feelings of impotence exist alongside hope, faith, love, and a deep appreciation of life itself. The music therapist must be skilled in helping patients experience and process these feelings, verbally and nonverbally, as well as be keenly aware of his/her own emotional responses.

Social

Although most work with the dying is done on an individual basis, group work does occur, often with patients and their families. Here, music therapy can ease strained relationships and reinforce positive ones through shared musical experience and reminiscence. I have observed that family members often move close to the patient and make greater physical contact during music therapy sessions.

Where patients originate from another culture, playing their music can provide comfort and reassurance, bridging their past, present and cultural identity.

In a lighter vein, music can bring patients and families together in pleasurable activity. In our palliative care unit, volunteer–run concerts, musical teas, and a piano–bar style “Happy Hour” all serve to lift spirits, provide beauty, and help pass the time.

Spiritual

Music carries a capacity to transcend daily realities; it may enable us to experience hope, faith, love, beauty and meaning in the face of loss and deterioration. Music therapy interventions with the terminally ill may incorporate silence, profound verbal, musical or other nonverbal communication, deep religious and spiritual expression, sounds and images of nature, and great works of music which have immortalized their composers.

Regardless of the intervention employed, music therapy with this population demands from the therapist a certain presence, an intense awareness of and capacity to be with others, in suffering, levity, boredom, fear or joy. The therapist, together with the music, provides a holding environment for the depth and complexity of the patient’s experience. I have felt this quality of presence poignantly when playing or improvising for comatose patients. Here the music making is guided by the rhythm of the patient’s ebbing breath, the tonality of any vocal sounds, and one’s own intuition. It demands deep, focused attention.
Current Practice

The benefits of music therapy in the care of the dying seem to be widely acknowledged; however, budget constraints and, perhaps, the lack of an established professional status in medical realms have prevented music therapy from flourishing in palliative/hospice care. In my view we need to continue to publish and present our work widely, as well as conduct research and train students through internships with music therapists experienced in palliative/hospice care.

Several important contributions to this field have been made in the past few years. In 1993, the Journal of Palliative Care (Volume 9, No. 4) published a group of five articles written by music therapists. Susan Porchet-Munro wrote a chapter on music therapy in the Oxford Textbook of Palliative Medicine (Doyle, 1993). The second International Conference on Music Therapy in Palliative Care took place in Oxford, England in 1994, and its proceedings were compiled into a book called Lonely Waters (Lee, 1995). Mary Rykov and I are currently preparing a bibliography of music therapy in palliative care (available in September, 1996).

We are not numerous, but I suspect our numbers are growing. In the United States, the American Association for Music Therapy’s 1996 membership directory reports eighteen music therapists working either in hospice or with the terminally ill. (Nineteen members reported working with AIDS, and nineteen with cancer patients – not necessarily in the terminal phases of disease). In addition, the National Association for Music Therapy’s 1995 member sourcebook, lists fifty-eight music therapists working in hospice. In Volume Seven of the Music Therapy International Report (1990–1991), the following countries reported music therapists working with the terminally ill: Argentina, Australia, Canada, Germany, Great Britain, Israel, Japan, the Netherlands, New Zealand, Poland, South Africa, Spain, Sweden, Switzerland, and the United States.

Internationally, we share problems of an aging population, increasing incidence of cancer, and the ongoing devastation of AIDS. We grapple with questions of euthanasia, physician-assisted suicide and quality of life. Music therapists have a unique role to play in enhancing the quality of life of terminally ill people – by helping to ease suffering, bring beauty, and elicit meaning. Our challenge remains in establishing a strong professional identity in palliative care through excellent work, research, publication and training.
References


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SECTION 3:
New Directions in Music Therapy Methods
Current Developments
In Nordoff–Robbins Music Therapy

Kenneth Aigen and Clive Robbins
U.S.A.

International Background

It is fitting for a report on current developments in Nordoff–Robbins Music Therapy (NRMT) to be presented in this International Report for a variety of reasons, some of which are historical. The approach itself began in 1959 with an international orientation: the team of Paul Nordoff (USA) and Clive Robbins (United Kingdom) worked closely with their principal advisor, Herbert Geuter (originally from Germany) in determining the fundamental paradigm of their music therapy process. From the beginning, the perception and application of music was also inspired by a broad ethnology, in addition to more conventional classical and popular forms of expression, the palette from which Nordoff and Robbins drew their musical resources included idioms from ancient Asia, and many national folk styles.

For the following fourteen years, Nordoff and Robbins worked continuously at the development and dissemination of their treatment approach and clinical research in the UK, Scandinavia, continental Europe, and the USA. The first accredited training course in Nordoff–Robbins music therapy was established in 1974 in London. The same year they undertook a lecture tour of Australia and New Zealand. Following Paul Nordoff’s death in 1977, the ongoing development and dissemination of the work was carried by Carol Robbins and Clive Robbins, and increasingly by therapists trained in London, and subsequently in other Centers.

The Main Centers

Since 1974, four centers dedicated to the practice of Nordoff–Robbins Music Therapy have been established in America, Australia, Germany, and Great Britain. These have come about largely as a result of the enthusiasm of educational and medical specialists, music therapists, parents, and committed fund-raising groups mostly belonging to the music industry. Each Center makes its individual contribution to the continuing growth of music therapy. All offer training in the Nordoff–Robbins approach. An organization for the study of the approach has been formed in Japan. Recently, in order to meet the extent of international interest, to define standards of training and practice, and to safeguard and authorize the use of the name, the International Trust For Nordoff–Robbins Music Therapy was formed.
Great Britain
The Nordoff–Robbins Music Therapy Centre, in London, first became active in 1974 and was established as a charitable trust in 1980. The Centre occupies a custom built music therapy building and provides on-site music therapy services for over 150 children, adolescents, and adults variously diagnosed as having developmental delay, severe to profound learning disabilities, physical disabilities, autism, emotional disturbance and behavioral problems. An outreach program serves HIV/AIDS clients at the London Lighthouse.

The Centre:
• offers the one-year City University Post Graduate Diploma Course in Nordoff–Robbins Music Therapy, and a two-year program leading to a Masters degree in Nordoff–Robbins Music Therapy.
• supports research, houses archive materials, and acts as a place of meeting and sharing for the British Society for Music Therapy and the Association of Professional Music Therapists in Great Britain.
• operates several outreach programs in schools and hospitals in the London area. These are conducted by Nordoff–Robbins trained therapists who also provide post diploma supervision for newly qualified therapists.
• promotes new Nordoff–Robbins units or departments in the United Kingdom and overseas. Departments in Scotland and the Republic of Ireland are supported professionally by the Centre’s Board of Governors. Currently, developments are in process evaluating the possibility of establishing a Center in South Africa.

Germany
Nordoff–Robbins training in Germany was first established in 1978 at the Music Conservatory, Aachen, in cooperation with the Community Hospital, Herdecke. Music therapy practice began at the Hospital the same year with developmentally disabled and multiply handicapped children, and in the child, adolescent and adult psychiatric wards.

Music therapists in Herdecke have progressively extended the Nordoff–Robbins approach to the treatment of patients of all ages with acute and chronic medical conditions in such fields as pediatrics, geriatrics, spinal injuries, neurology, psychosomatic illnesses, internal medicine, and intensive care.

In 1985, the post-graduate training course gained full government approval and was established at the Institute for Music Therapy, Faculty of Medicine, University of Witten/Herdecke.
The Institute:
- offers a two-year graduate training course leading to a Diploma in Music Therapy. Post-diploma study and research is also available leading to the degree Doctor Rerum Medicinalium (Doctor of Medical Matters).
- maintains a research program which studies the widening of clinical practice, and the relationships between music therapy and the field of medicine. Its publications have appeared in numerous professional journals.
- has disseminated its work to many psychiatric and medical clinics and special education centers in the region. An important extension is the program at Clinic Holthausen, a center for neurosurgery, in which music therapy provides treatment for patients in post operative coma and accompanies them through the stages of personal and social rehabilitation.

United States of America
Drs. Carol and Clive Robbins first lectured at New York University in 1976. Subsequently, they gave a series of summer courses as Adjunct Faculty, maintained an active connection with NYU and, in 1990, opened the Nordoff–Robbins Center for Music Therapy on the University campus.

The Center:
- operates as part of the Music Therapy Program at NYU and provides outpatient treatment services for over 100 children, adolescents and young adults with special needs in the New York City area. An outreach program for HIV/AIDS clients has been recently established at the Gay Men’s Health Crisis in Manhattan. More outreach programs are being planned.
- offers, in collaboration with the New York University Graduate Music Therapy Program, a two semester internship leading to a Masters degree; an additional semester of supervised clinical practice is required for the Certificate in Nordoff–Robbins Music Therapy. The Center also provides field work experience and internships to students in NYU’s Music Therapy Program. NYU also offers music therapists a doctoral program leading to a Doctor of Arts.
- conducts research in two main areas of study: 1) selected current clinical work and 2) the identity of Nordoff–Robbins Music Therapy, which is being defined through a historical investigation into the evolution of Paul Nordoff’s and Clive Robbins’ clinical approach.
• is active in the dissemination of information on music therapy; at the professional level through published articles, monographs, and chapters in specialist texts, and through workshops, demonstrations, and lectures; at the public level, through television programs and articles in the popular and non-technical press.

Australia

Nordoff–Robbins Music Therapy Australia began in 1978; its Center was established in 1984.

The Organization:
• concentrates its clinical program in a residential school and adult activity center for variously disabled children, adolescents and adults in a northwestern suburb of Sydney. It conducts outreach programs in the Metropolitan Sydney area and the Blue Mountains.
• offers a one-year post-graduate “Diploma Course in Music Therapy (Nordoff–Robbins).”

Japan

The connection between Japanese professionals and Nordoff–Robbins began in 1974 with the publication of a translation by Professor Hitoshi Sakurabayashi of Therapy In Music For Handicapped Children by Nordoff and Robbins. The connection was strengthened in 1984 by a lecture tour by Carol and Clive Robbins that included Tokyo, Kofu, Kyoto, Osaka, and Hiroshima. Several Japanese students have studied the Nordoff–Robbins approach, three in London, one in Germany, and two in New York.

In 1993, mainly through connections with the New York Center, interested music therapists, music professors, fund-raisers and administrators formed the Nordoff–Robbins Ongaku Ryoho Kenkyukai—Organization for Studying Nordoff–Robbins Music Therapy (O.S.N.R.M.T.). With the cooperation of many dedicated volunteer members, the organization successfully raised funds and arranged for Carol and Clive Robbins to give introductory and advanced seminars in Tokyo in the summer of 1993. The purpose of the organization is to take the necessary steps toward the dissemination of the Nordoff–Robbins work in Japan, and toward the possible development of a treatment and training Center.

Development, Diversity, and Questions of Identity

The practice of Nordoff–Robbins Music Therapy is in a period of transition and development because of the number and variety of cultures and clinical contexts into which the work has been introduced. Further, over two hundred
individuals have now been trained in this approach and these individuals are practicing in the full range of health facilities with a wide range of client populations, including adult psychiatry, geriatric care, individuals with medical problems, self-referred adults, and emotionally disturbed children.

These widely varied spheres of application have stimulated much discussion over issues of identity within the Nordoff-Robbins movement, and examinations as to which elements of Paul Nordoff's and Clive & Carol Robbins' original practice is of general application and which, if any, are population specific. For example, some practitioners no longer work in teams where this is clinically unwarranted; some rely more heavily on improvisation, and others employ precomposed music in their work; some do very little work in groups; some include verbalization in their sessions, some use a wide variety of world music and others stay more to classical and western forms and supplement the traditional instrumentation and repertoire with electric instruments and current popular idioms. It is no longer possible to characterize Nordoff-Robbins work as including (or not including) any of these elements.

Many of the variations among NR practitioners can be understood in terms of where one stands on the question of the relationship between NRMT and music psychotherapy; paralleling this issue is the examination of the relative functions of music and words in music therapy. There is a full range of opinion here, constellating around three primary positions: those therapists who comfortably complement their Nordoff-Robbins practice with externally derived psychotherapeutic constructs, theories and practices; others who feel that Nordoff-Robbins practice, as constituted, functions as a psychotherapy, not requiring the application of extrinsic theory; and a third stance which consists of the belief that the nature of music psychotherapy is antithetical to the music-centeredness at the heart of NR practice.

There are a number of specific areas in which these different positions are being expressed. Some practitioners believe that the relationship dynamics between therapist and client are potent forces in the therapy, and bear examination in supervisory contexts, for example. Others feel that the primacy of music in the approach mitigates against the need for this. The role of verbalization is also being discussed in terms of whether the therapist should incorporate this into sessions when clinically warranted — and practice clinical work in this medium — or if one should avoid diluting the musical experience in this way. One additional area of discussion involves the degree of directiveness that a therapist should employ. The approach's originators were often quite directive with their clients, feeling the responsibility to intervene in an otherwise helpless (and often hopeless) pathological condition. Some contemporary therapists have chosen a different path, taking a less directive stance.
These and other issues are being discussed in a variety of forums, such as conferences, symposia, and published works. A new generation of Nordoff–Robbins practitioners is considering conceptions of the work in a variety of treatment contexts, as well as issues in the creative use of improvised music in general. Gary Ansdell, who represents those who believe Nordoff–Robbins practice is most definitely not a form of music psychotherapy, has authored *Music for Life: Aspects of Creative Music Therapy with Adult Clients* (1995, Jessica Kingsley Publications); the book is comprised of case studies (illustrated by clinical recordings on CD) woven around theoretical discussions. Colin Lee has a forthcoming book entitled *Music at the Edge: The Music Therapy Experiences of a Musician with AIDS* (1996, Routledge), which is also accompanied by a CD. Jacqueline Robarts has been applying the work of theorists in infancy research and object relations, such as Daniel Stern, to clinical processes in creative music therapy with a range conditions, from autism to eating disorders. David Aldridge has just written *Music Therapy Research and Practice: From Out of the Silence* (1996, Routledge) which examines the variety of medical applications of Nordoff–Robbins work. Kenneth Aigen has written two in press research monographs, *Being in Music and Here We are in Music*, the first of which examines the values and concepts underlying Paul Nordoff’s and Clive Robbins’ training of their approach and the second which is a one year naturalistic research study of an adolescent music therapy group. Last, a forum for these discussions is the Newsletter of the International Association of Nordoff–Robbins Music Therapists, available through the Center at New York University. Titles from a recent issue include: “Creative Music Therapy and Psychotherapy in Music” by Clive Robbins; “Thoughts on NRMT, Music Psychotherapy and Psychotherapy” by Kenneth Aigen; and “NRMT and Psychodynamic Thought” by Jacqueline Robarts.

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New Directions in The Bonny Method of Guided Imagery and Music (GIM)

Frances Smith Goldberg and Helen L. Bonny
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The use of imagery as a process has gained acceptance in psychological and medical practices in the last two decades. Within these practices imagery as a healing mode is structured with specific suggestions toward agreed upon goals. When music serves as the generating stimulus to evoke imagery, a new paradigm emerges. The image/symbol which is static in real time assumes a life of its own as the elements of dynamic movement, changing rhythms, multi-dimensional colors play upon the attentive ear of the listener. What we call the aesthetic qualities within great music demand a spontaneous response. Predictability is less measurable; the images move and change with the musical dynamics, the musically evoked feeling states intensify providing the tension/release mechanisms that make music such a defining revealer of our true selves.

Since guided imagery and music was introduced in 1973 there have been a number of important developments in its practice. The first is a name change. With the proliferation of imagery techniques, with and without music, the name was altered to differentiate GIM from other techniques. We now refer to it as the Bonny Method of Guided Imagery and Music.

The Bonny Method of GIM

The Bonny Method of GIM, as defined by the Association for Music and Imagery (AMI), is a music-centered transformational therapy which uses specifically programmed classical music to stimulate and sustain a dynamic unfolding of inner experiences, in support of physical, psychological, and spiritual wholeness. It is a depth-oriented psychotherapy where the client listens to a specially programmed series of musical selections while in a relaxed state. The client tells the therapist of his/her experiences of mental imagery, bodily sensations, feelings and memories as they are experienced. The therapist offers verbal support and encouragement throughout the music listening. While the primary application of the Bonny Method is in individual work, group approaches have also been developed.

The Association for Music and Imagery was founded in 1986 by GIM practitioners to develop and maintain training standards through certification for trainers and training programs. At present there are twelve authorized training programs in the United States, Australia, New Zealand, the United Kingdom, and Europe. In addition to those countries, training programs have
been held in Canada, Sweden, Norway, Germany, Austria, Switzerland, Denmark, England, Scotland, Mexico, and Spain. Those who have completed the stringent training are known as Fellows. There are now Fellows in the USA, Canada, Sweden, Australia, New Zealand, Denmark, England, Scotland, and Indonesia. In addition, students from South America, Asia and the Middle East have enrolled in the training. After many years of steady growth, the Bonny Method is now enjoying a period of rapid expansion throughout the world.

The applications of this method are also experiencing rapid growth. In addition to its original use with generally healthy individuals seeking help with depression, life transitions, and personal growth, the method is now employed in a wide range of settings and clinical populations. While most GIM practitioners work in a private practice, many also work in psychiatric hospitals, hospice programs, substance abuse agencies, and gerontology programs. The method is being integrated into programs for eating disorders, dissociative disorders, anxiety disorders, autistic adults, post-traumatic stress disorders, and other victims of abuse, violent crimes, and other trauma. Very interesting work is being reported with couples and families, as well as children and adolescents, and in group therapy as well as individual work. In addition, the Bonny Method is being combined with other approaches such as psychodrama, bioenergetics, biofeedback, and Eastern contemplative approaches. A major growth area is its use in the medical arena such as with closed head injuries, cancer, AIDS, rheumatoid arthritis, and other psychoneuroimmunological disorders. The Bonny Method practitioners subscribe to a number of theoretical orientations, such as psychoanalytic, Jungian, humanistic, and transpersonal. All, however, view their work within the framework of the transformational power of music.

An exciting new application of the transformational aspects of the Bonny Method is in the social arena, toward the healing of racial and ethnic animosity and wounding. It is being applied to ease racial tensions in the USA and also to effect healing of American first and second generation Jewish holocaust survivors and Germans.

The training for GIM has traditionally been in three levels with authorization to practice under appropriate supervision after the second level. That has been recently changed, however, to reflect the growing awareness of the depth and complexity of GIM. Any medium with the power to facilitate depth-oriented growth and healing also has the power to do harm when used improperly. Therefore, the Association for Music and Imagery now requires the full three-level training to practice the Bonny Method. All Bonny Method training programs offer a five-day Level I Introductory training. For most programs, the advanced training module requires three years to complete.

Those who study the Bonny Method are music therapists, psychotherapists, or health professionals, with a strong background and interest in music. All applicants must be either trained therapists or complete therapy studies.
concurrent with the Bonny Method training. In order to become a Fellow an applicant must complete an authorized Bonny Method of GIM training program and demonstrate training, skills and knowledge in counseling and psychotherapy, and music.

The literature base for the Bonny Method is expanding. The Association publishes the annual Journal of the Association for Music and Imagery. It is a refereed journal of both clinical and research articles. In addition to three books and three monographs, articles and book chapters on the Bonny Method have appeared in several professional journals and manuals.

Research has been slower to develop. Bishop (1993), in a retrospective study of fifty hospitalized abused women who received GIM sessions, found that those with healing imagery within the course of 3–8 sessions showed significant improvement on independent ratings on the Global Assessment Scale. Wrangsjö and Körlin (1994) researched fourteen outpatients of the seven-therapist advanced GIM training group in Sweden. In this pre- posttest study, psychiatric symptoms and interpersonal relationship as measured on the Hopkins Symptom Checklist and the Inventory of Interpersonal Problems, showed significant decreases in most symptoms and in interpersonal problems. A significant increase, in the experience of life as more meaningful and manageable, was measured by the Sense of Coherence Scale.

In controlled studies, McDonald (1990) demonstrated that GIM significantly decreased hypertension; McKinney et al (1994) demonstrated that GIM positively affected mood and cortisol in healthy adults, and McKinney et al (1995) found that experimental subjects receiving a series of six GIM sessions were significantly less depressed.

These studies tend to support clinical reports in the literature; however, conclusions must be cautious due to the limited number of studies and the small number of subjects in these studies. Carefully controlled quantitative and qualitative studies are necessary to document the full range of effects of the Bonny Method of GIM in both group and individual therapy.

The explosion in the growth of the Bonny Method, with the infusion of therapists from a variety of backgrounds and with different interests guarantees the continued expansion of clinical applications. Each new application requires some adaptation of the method. And each new adaptation yields new understanding of the method and its potentials. As these adaptations are shared through conferences and publications, new ideas are generated. There is increasing interest in research, and as the various adaptations are studied, we are confident that the research base will grow and document the clinical effects of the Bonny Method and establish more clearly the indications and contraindications for its clinical use. Current research and practice of the Bonny Method of GIM will also bring new understanding of the influence of music on the person. The music which is utilized in the method is carefully
chosen from the classical literature. It is the central generating medium which modifies, directs, and contains the evoked imagery. Research into understanding the influence of music in consciousness and how it manifests transformational change will bring insights into the workings of the mind and the healing of the person.

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SECTION 4: RELATED TOPICS
MusicMedicine 1996:
Music In Prevention, Therapy And Rehabilitation
– Medical, Social And Economic Aspects

Ralph Spintge
Germany

Introduction and Definitions

Substantial and steady progress both in research and the clinical application of Music in Medicine has occurred during the last twenty years (Maranto, 1991; Pratt & Spintge, 1996; Spintge & Droh, 1987, 1993; Spintge, 1992). Added to the fifty years of research and application of Music Therapy we now have solid evidence that music has reproducible effects and valuable preventive, therapeutic and rehabilitative properties. We propose to define the therapeutic use of Music in Medicine as MusicMedicine (one word with capital “M”s): MusicMedicine means the scientific evaluation, as well as the practical application of musical stimuli in prevention, therapy, and rehabilitation, in order to prevent disability or illness, to complement usual medical treatment, or to facilitate rehabilitation, always considering the particular disability or illness, medication and procedures involved in each individual.

This approach is much broader than Music Therapy which, especially in central Europe, is mainly understood as part of psychiatric care or psychotherapy (Aldridge, 1993; Mosby’s Dictionary, 1994). Actually, considering only this kind of Music Therapy means to neglect the by far larger part of the health care market, including prevention, rehabilitation, and even palliative care. In the United States there is a broader approach and the combined strength of MusicMedicine and Music Therapy working cooperatively with the music merchants industry can substantially promote our common goal (NAMM Report, 1996).

Applications and Research

We use music for: 1) Prevention (education against low–back– pain, workplace on–site exercise programs against over–use– syndromes, and fatigue in the use of muscles and tendons); 2) Therapy (chronic pain syndromes, acute stress and pain in surgery/anesthesia/intensive care, during labor, sportstherapy, after cardiac stroke); and 3) Rehabilitation (physical therapy after trauma and surgery or stroke, workplace reintegration).

So far most scientific research has focused upon music complementing medical procedures. In general, conducting MusicMedicine studies, the standards of research in clinical applied studies need to be fulfilled, i.e., state–of–the–art clinically controlled research designs with a solid statistical evaluation must be
secured. This can be achieved, at best, through multidisciplinary research groups.

Results

Our experiences and results can be summarized in two major points: medical and economical findings.

Results and practical experiences with about 95,000 patients demonstrate an improvement in patient care and treatment outcome in ninety-five percent of all cases. Stress hormone levels in blood, pain perception, electrical brain activity as measured through EEG and drug demand for anesthesia and pain relief, all show a significantly better outcome for music patients as compared to non-music patients. It is important to note that we find identical effects in different cultural spheres such as Europe, North America, and Japan. However, the selection of music and musical instruments needs to be adjusted to socioethnic characteristics.

Besides the medical advantages there are, of course, economic benefits. Some hard data taken from recent studies are as follows:

- Sedatives used to prepare patients for medical treatment (such as anesthesia and surgery) were reduced to 50% of the usual dosage. Our hospital in Germany saves about 6,000 US dollars per year (i.e., one US dollar per patient) which would mean many times that in the United States.
- Shortening the length of stay in an Intensive Care Unit for premature infants saves about $30,000 per baby.
- Earlier discharge of elderly patients after eye-surgery (a surgical treatment of steadily growing importance) saves the cost for a full day of hospital care.

General Socioeconomic Aspects

The latest OECD report (1995) as well as several recent national health care surveys provide strong evidence as to the economic importance of the findings listed above (NAMM, 1993; NIH, 1995; Hoffman & Hoffman, 1995; Thelen, 1995):

- Costs for hospital care in percentage of overall health care costs:
  USA: 41.8%   GER: 34.8%   GB: 43.6%   FR: 45.3%
- Costs for hospital care in percentage of GNP:
  USA: 4.6%    GER: 3.0%    GB: 3.1%    FR: 3.9%
- Costs for one day of hospital care (average):
  USA: $8,000.00   GER: $4,285.00

(N.B.: Germany has three million hospital patients with an average duration of hospital stay of ten days)
There is a new, but substantial, potential for MusicMedicine/Music Therapy in the demographic development in societies all over the world. We are getting older:

- In North America and Europe there will be twice as many elderly people within the next thirty years, i.e., 35% of the population will be older than sixty years old.
- In Germany 4.5 million people will be over eighty years old at that time.
- Every third surgical procedure is carried out with patients over seventy years old.
- At the same time, the number of people with mental or physical disabilities will probably double.
- Already today twenty percent of the American, as well as of the European population, need increasing health support, most of it dealing with prevention of disability and rehabilitation of disability.

We recognize that today’s curative medicine has reached its limits:

- Therapeutically, medical science has had to realize that the availability of high-tech equipment is not congruent with better patient care in general.
- Economically, all health care systems in the world are running high financial deficits; and
- As a consequence there is a fundamental paradigm shift from a high-tech, biomedical approach towards a holistic, or better, a humane view of the patient.

There are two major implications regarding these facts: firstly, “quality of life” is reestablished as new/old central measure for health care. Secondly, the Art of Medicine is making a comeback (see for instance, Graham–Pole, 1994).

Another fundamental paradigm shift has occurred in our medical agenda: goals are redefined. Practicing therapy with illness/disability is no longer the first priority; prevention and rehabilitation are the main goals in today’s health care politics. We have to learn that increased health and increased wellness for more people can be achieved and afforded only through improved prevention and improved rehabilitation. The medical and scientific communities all over the world are now ready to accept complementary therapies (see for instance NIH Office for Alternative Medicine).

**Predictions**

The observations outlined above lead to certain predictions with regard to the relationship between MusicMedicine/Music Therapy and health care in general:

1. In health care, research efforts will be directed at developing health support methods which are holistic and affordable. MusicMedicine is one of these methods.
2. In the music industry, the development of new products will be significantly affected by demographic changes and by research in education and health care within the next two decades.

3. This gives the "art of music" a chance to underline substantially its importance in human life, not only as a part of leisure activities or pure aesthetic experience, but to preserve humanity, itself, where it is endangered: in illness, disability and aging.

References
Evolving in the 1970’s, the term, “Music and the Brain” was used in conference themes, books and articles, to enable discussion of the mechanisms by which the brain processes musical information. There is no field or discipline of “music and the brain”; rather, the term has historical significance, reflecting a period of time when neurologists, psychologists, musicians and music therapists came together to discuss music response and brain processes. Research in the 1970’s focused on differentiating left and right hemisphere functions, differences between musicians and non-musicians in processing music information, and differentiating brain mechanisms according to whether a task was “holistic” or analytical. There seemed to be a trend towards wanting to isolate or regionalize areas of the brain responsible for specific music processing tasks – music memory, rhythm, perception, etc.

One of the key conferences of the time on “the neurology of music” was held in Vienna in 1972. The Proceedings of that conference were published in a book edited by MacDonald Critchley and R. A. Henson, entitled Music and the Brain: Studies in the Neurology of Music. This book is still cited in contemporary literature, which suggests that either the material of the book is still current, or that another major text has not yet matched the range of papers offered in Music and the Brain. Two chapters describe the unusual condition known as musicogenic epilepsy. One recent article has appeared in the music therapy literature on musicogenic epilepsy (Smeijsters & van den Berk, 1995), and this area of research needs further attention. Another unusual condition described by Critchley and Henson is that of Amusia, a condition describing neurological impairments in musicians. This term does not appear in primary texts of music therapy, the assumption being that music therapists do not identify the different levels of musical skill in clients they treat.

Other chapters of Critchley and Henson examined physiological measurement of music response through EEG, heart rate, and respiration rate. These conventional measurements of music behavior have been eclipsed by the emergence of more sophisticated equipment. In the 1980’s studies revealed new evidence of the differentiation in hemispheric processes by mapping cortical activity within the brain. Brain scanning, through Positron Emission Tomography (PET), traces the metabolism of glucose in the brain in the area of the brain being activated. One study, conducted by Mazziotta at the University of California in Los Angeles (cited in Restak, 1984), confirmed that areas in the left hemisphere were activated when the task was analytical, and that the
temporal lobe of the right hemisphere was activated when the stimuli comprised chords or tones. Many of the topics covered in this early publication, *Music and the Brain*, have been absorbed into other fields, such as music psychology and music medicine.

In the music therapy literature, Scartelli (1989) has contributed substantially to our understanding of the effects of music in stress reduction through relaxation and biofeedback. Studies on pain control and the wider area of psychoimmunology have grown out of this earlier research.

Some understanding of brain function is essential in the practice of music therapy. Music therapists need to know about the relationship between different brain processing systems in order to understand clients with neurological conditions following either brain trauma or cerebral vascular accidents (CVAs), those who have Alzheimer’s disease and other forms of dementia, those in a comatose state, and those who are in advanced stages of diseases where deterioration of neural processing occurs over time.

Music response can be clearly observed in those who have extensive areas of brain impairment and damage caused by CVAs. Despite damage to the language centers of the brain which causes difficulties in verbalizing, these clients will often sing in tune, mouthing the lyrics of a song, sometimes even enunciating the words. Michael Thaut (1992) has made a significant contribution to our understanding of rehabilitation following stroke and other neurological trauma, particularly in illustrating the importance of rhythm in developing motor control and in the rehabilitation of gait.

Coma arousal is an area of music therapy practice where knowledge of the hierarchical nature of response is relevant. Interestingly, there is very little research about coma arousal; perhaps, because of the great difficulty in defining a procedure or method of practice. A sensory stimulation protocol has been developed by Mary Boyle (1995) which may prompt wider research into music therapy procedures related to the various stages of arousal.

There is now a large body of literature on music therapy and dementia: reducing agitated behavior (Brotons & Pickett-Cooper, 1996) and retrieving losses (Hanser & Clair, 1995) are two recent studies. While these studies discuss methods which are effective in working with dementia, rarely is music response discussed in relation to the neurological impairments of those with Alzheimer’s and other forms of dementia. In working with people who have dementia, we need to know about the connections between music memory and emotions aroused through activation of associations with music. Memory for songs learned in youth is remarkably well preserved in long term memory storage. Short term memory though, is severely impaired in people with dementia; hence, they cannot remember the song that has just been sung. They may ask to sing the same song over and over again.

According to Restak (1984), emotions related to past memories are more
difficult to access than the images of those past events. Thus, it is easier for patients to describe the event, and more difficult for them to describe how they felt at the time. Memories that are associated with positive feelings are best remembered, whereas negative feelings tend to be more difficult to access (Restak, 1984). Thus, times of crisis and conflict are difficult to recall and describe. The ramifications for music therapy are obvious. Frequently, music therapists use songs to evoke reminiscence for our clients. Since describing an event is an easier task than describing the feelings associated with the event, our questions to prompt discussion may need to be modified accordingly.

A further area of clinical interest involving music, images, and emotion is that of Guided Imagery and Music (GIM). This method brings together the auditory perception of music in a deeply relaxed state with the experience of sensory imagery and emotions associated with the music and/or the imagery. Sometimes the emotion can be felt without imagery occurring, and other times imagery can be experienced without felt emotion (Goldberg, 1995). The interplay between these modes of experience offers fascinating research potential.

Many neurological diseases involve a deterioration of brain functions over time. Some music therapists relate their clinical procedures to the stages of the disease; and furthermore, link deterioration with neurological signs (Magee, 1995). The well respected work of Connie Tomaino stands out here. (See her article on Music Therapy for the Elderly in the “Music Therapy Clinical Practice” section of this Report.) Her approach to music therapy always incorporates a basic understanding of the neurological condition. We can learn much from her approach and her interdisciplinary work with Oliver Sacks.

Another example of interdisciplinary writing can be found in Rogers and Smejatsky (1995). Their study of schizophrenia places the research within a neuropsychological context, thereby increasing our knowledge and understanding of music response in people with significant neuropsychological limitations.

**Conclusion**

A knowledge of neuropsychology principles seems essential in the education of music therapists at the basic level of training. Music therapists need to realize that all responses to music are activated through brain systems. In particular, an understanding of the client’s background in music is essential.

Future research needs to call on interdisciplinary efforts with neurologists and psychologists to explore the variability of music responses in people with brain impairments, and to increase our understanding of the relationship of music, memory, and emotion.
References

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Sound And Psyche:  
The 1996 International  
Music Therapy Congress In Hamburg  

Lisa Summer, Editor  
U.S.A.

A 100 page, three language program heralds the upcoming international congress: Sound And Psyche, the 8th Congress of Music Therapy/2nd International Congress of the World Federation of Music Therapy, with greetings from its organizers: Cheryl D. Maranto, President of the World Federation of Music Therapy (WFMT); Hans-Helmut Decker-Voigt, Coordinator; and Henk Smeijsters, Chair of the International Scientific Committee of the World Federation of Music Therapy.  

Sound and Psyche, takes place on July 14-20, 1996 at the Congress Centrum Hamburg, located in a park in the center of the city. The official Congress languages are German, English and Spanish; simultaneous interpretation is provided. This International Congress offers 240 events. Presentations are divided into three topic areas: Music Therapy in Practice (111 presentations), Music Therapy in Research (35 presentations), and Music Therapy in its Socio-Cultural Environment (14 presentations). Supporting events such as concerts, performances, art exhibitions, and commercial and non-commercial exhibitions are scheduled, and there is a special “Students’ Coffee Bar.”

An International Congress is an unparalleled event in our field. This year, the number of presentations — from Canada, U.S.A., Cuba, Venezuela, Brazil, Argentina, Chile, South-Africa, Australia, China, Japan, Israel, Cyprus, Greece, Slovenija, Hungary, Italy, Spain, France, Belgium, The Netherlands, the United Kingdom, Northern Ireland, Denmark, Norway, Sweden, Finland, Estonia, Poland, and Russia — is evidence of the expanding practice of music therapy across the globe. As well as offering a wealth and variety of experiences, Sound And Psyche provides a unique opportunity for professional exchange to take place on an international level.

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