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One Size Fits All, or What is Music Therapy Theory For?[1]

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> Discourse cheers us to companionable reflection. Such reflection neither parades polemical opinions nor does it tolerate complaisant agreement. The sail of thinking keeps trimmed hard to the wind of the matter (Heidegger, 1971, The Thinker as Poet, p. 6.).

Abstract

In this writing I explore theory in music therapy opinion, discourse, research and practice. To this end, I define theory and examine factors impinging on music therapy theory and the exchange of information within and beyond music therapy. I contend that we all have theories and that these ideologies-including beliefs, goals and ways of knowing music, music therapy and ourselves-must be shared. I question whether a grand, general theory for music therapy is possible. And I conclude that rather than striving for one grand theory of music therapy, music therapy theo*ries* must enable us to remain open to ambiguity and the multiplicity of meanings inherent in music and life.

Introduction

The impetus for this writing began with a colleague who does not understand the importance of theory for music therapy practice; it gained momentum in conjunction with ruminations about theory, research and practice.

To begin, I locate myself as someone who stands barely 4 feet and 11 inches tall on this good Earth. I suffer the one-size-fits-all syndrome daily through encounters with all manners of things, including (but not limited to) chairs, bank counters, cars, and kitchen cabinets. I assert that one size should not, can not, must not and does not fit all. What follows is discussion about why and how this pertains to theory and its role within music therapy research and practice.

In Theory

What is theory? The definition of theory, derived from the Greek, *theoria*-the act of viewing, contemplation, consideration-includes "a belief, policy, or procedure proposed or followed as the basis of action; a principle or plan of action; generalizations, abstract knowledge, judgments, conceptions, conjecture and speculation" (*Webster's Third International Unabridged Dictionary On-line,* 1993). Theory, then, is the means by which music therapists view, contemplate and consider beliefs about ourselves, music, ourselves as musicians, and ourselves as music therapist clinicians with our clients.

Theory is both produced by and guides practice; it is both chicken and egg. David Hunt (1987; 1992) claims all theories begin with us and that we can be our own best theorists. We all operate with theories, whether we are aware of them or not. For example, when I walk across

the room I turn left to go down the hallway because I have a presumption that if I keep going straight I will walk into the wall. This, too, is theory.

Theories are diverse. There is, for example, empirical-analytic, hermeneutic and critical theory (Miedema, 1987), general, or grand, worldview theory (Parse, 1997; Strauss, 1995) and everyday, garden variety procedural theory or models.

Music therapy theories are dependent on definitions of music. Definitions of music can be informed by numerous sources, including:

- modernist philosophy and aesthetics (e.g., Adorno, 2003; Dahlhaus, 1989)
- postmodernist and critical philosophies (e.g., Kramer, 2002; McClary, 1991)
- anthropology (e.g., Berliner, 1978; Blacking, 1987; Seeger, 1987)
- sociology (e.g., DeNora, 2000; Keil & Feld, 1994; Small, 1998)
- psychology (e.g., Stern, 2000; Trehub, 2000; Trevarthen, 2002; Trevarthen & Malloch, 2000; Winnicott, 1971)
- physiology (e.g., Damasio, 1999; Gallese, 2001; Rizzolatti, 2001)
- psychoanalysis (e.g., Kohut, 1955, 1957; Stern, 2004; Winnicott, 1971).

Jane Sutton (2004) remarked that "one is left with the impression that there are as many approaches to defining music as there are authors willing to undertake the task" (p. 2). This bears directly on music therapy because music is, after all, the stock of our trade. Indeed, the musicology one subscribes to and the music definitions upon which it is founded informs the music therapy one practices and researches (Ruud, 1998).

In Music Therapy

When asked about music therapy over twenty-five years ago, Carolyn Kenny (1982) reflected:

> "My God, here it is again. What am I going to say this time?" Every time it is a challenge, a task, an invitation to increase my own understanding by assigning words to something which is indescribable by nature and has the additional aspect of being something different every time it happens (p. 1).

Music therapy in those years was informed and constrained by the powerful domination of behaviourism, which was the prevailing "flavour" of psychology research and practice (Ruud, 1978). Behaviourism is an empirical methodology characterized by 1) the study of only what can be observed, and 2) an essentialist philosophy claiming that intrinsic properties exist and that science can find and represent absolute truth. Alternatives to behaviourism and its agenda of prediction and control were humanistic and third force psychology and the qualitative-constructivist research paradigm.

Music therapy in the United States, where Kenny was educated, was established following World War II when music was being used as a milieu therapy in hospitals with veterans. Music therapy learned to explain itself using medical and psychological language and concepts. Tired of explaining herself in others' terms that were ill-fitting, Kenny subsequently pioneered the way towards music therapy theory borne of her own practice and in her own language (Kenny, 1989). She broke trail and those that followed created the qualitative music therapy research milieu we know today (Aigen, 1991; Amir, 1992; Forinash & Gonzalez, 1989; Langenberg, Aigen, & Frommer, 1996; Ruud, 1998; Smeijsters, 1997; Smeijsters & Kenny, 1998; Stige, 2002). No longer constrained to study only what can be directly observed, qualitative research in music therapy has enabled exploration of the deeper meanings that exist. This has contributed to a broader understanding of music therapy practice.

Hospital and school administrations, however, are not interested in deep, meaningful understandings of music therapy practice. They want simple answers about outcomes and cost effectiveness that only quantitative research methods can provide. Both methodologies, then, are necessary to answer these different kinds of process and product questions.[2]

Theory plays out in music therapy in interesting and exciting ways. It is important to be knowledgeable about theory created from within music therapy (Kenny, 1989; Lee, 2003; Ruud, 1998; Smeijsters & Kenny, 1998; Stige, 2002) as well as other theories outside music therapy that are relevant to practice. Recent scholarly writings in this *Voices* forum from the feminist (Hadley & Edwards, 2004) and linguistic (Rolvsjord, 2004) lenses expand the perspectives that inform our work. Furthermore, theories from psychology, sociology, anthropology, physiology

and psychoanalysis that are familiar to the other professionals with whom we work can serve as bridges with which they may enter into our territory.

We, in turn, are beginning to have an impact on some theorists beyond ourselves. In the revised edition of *The Interpersonal World of the Infant,* Daniel Stern (2000) writes:

> One consequence of the book's application of a narrative perspective to the nonverbal has been the discovery of a language useful to many psychotherapies that rely on the nonverbal. I am thinking particularly of dance, music, body, and movement therapies, as well as existential psychotherapies. This observation came as a pleasant surprise to me since I did not originally have such therapies in mind; my thinking has been enriched by coming to know them better (p. xv).

Kenny (1998a) and Smeijsters (1998) delineate some complexities for general music therapy theory. Kenny (1998a) says that "though the specifics of our experiences are varied, we have the common ground of 'music therapy experience' upon which to build" (p. 195). I question this assumption when approaches within my own practice of 25 years-spanning infants and their teen parents, cancer patients, neurologically impaired children and adults, and music psychotherapy-vary so widely. How common is our ground? How universal is our practice?

Perhaps we should think of the practice of music therap*ies*, similar to how ethnomusicologists refer to music as musics. This would recognize the diversity that exists among us. Recognizing and accepting our differences may enable us to listen to each other more openly.

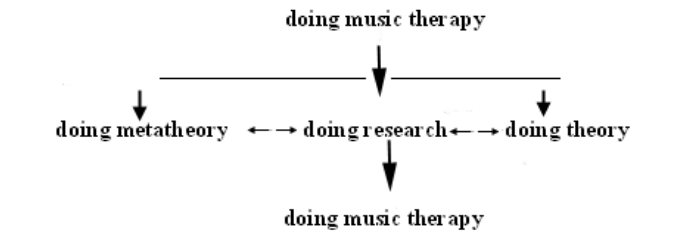
Ruud (1995) points out that "people interpret reality differently, that our lifeworlds inform our interpretation of music in a way that makes all concerns for universality in music problematic" (p. 19). Our lifeworlds are culturally based and may be elusive. "Culture hides much more than it reveals, and strangely enough what it hides, it hides most effectively from its own participants" (Hall, 1959, p. 30). One general theory of music therapy is a laudable ideal towards which we may strive. But is it possible, do-able? Is it desirable? Should it be?

Stige (1999) thinks not. He states that "any general theory on the meaning of music in music therapy will be in trouble. (p. 64)" The meaning of music is, indeed, the foundation upon which all else rests. But yea or nay, any general theory of music therapy will be a long time in the making because we are so passionately attached to our various competing beliefs about music and knowledge.

In Music Therapy Theory, Research and Practice

Metatheory, theory, research, and practice are inter-related (Stige, 2002). Metatheory may be seen as ideology, not in the critical theory sense, but as an interpretive scheme used by a social group to make the world more intelligible to themselves (Talcott Parsons in Bell, 1988). This is conceptualized here for music therapy as:

Figure 1, adapted from Kirby & McKenna, 1989, p. 165.



Carolyn Kenny (1998) stated that any general theory (Strauss, 1995) of music therapy should be inclusive, striving for "both-and," not "either/or." In this postmodern world of multiple truths and embodied, local, intersubjective knowledge all musicologies can co-exist: The big "T" truth is that there are multiple "truths." This is not the problem. The problem occurs when the epistemology that frames the musicology is not readily apparent, either out of awareness or not articulated by the music therapist.

In their book, *Methods from the Margins,* Kirby and McKenna (1989) talk about the importance of the researcher "writing their conceptual baggage":

> Conceptual baggage is a record of your thoughts and ideas about the research

> question at the beginning and throughout the research process. It is a process by which you can state your personal assumptions about the topic and the research process (p. 32).

> Writing your conceptual baggage allows you to identify, at a later point in the research, whether any pre-established goals, assumptions or responsibilities may be overly influencing how your research is developing (p. 51).

Writing conceptual baggage is good practice for all music therapists, not just researchers. It is also the means by which we may come to understand ourselves and communicate this understanding with one another, as Even Ruud (1995) states:

> In order to maintain a rational dialogue within the field of music therapy we have to make explicit our concepts about music and man which lie at the bottom of our theories about the therapeutic application of music. (p. 19).

Carolyn Kenny (1998b) uses the image of a tree to describe research: roots (philosophy) ? tree trunk (theory) ? branches (method) ? leaves (data). Writing conceptual baggage may be seen as tilling the soil and planting the seeds. It is in the confrontation with our conceptual baggage that we face our dragons (Kenny, 2003), clarify and communicate our ideologies and understandings.

Research *should* result in a repackaging of our theoretical bags. This may be standard practice for some, and unsettling or totally unacceptable for others. Can any single, general theory of music therapy accommodate this phenomenon and all our various reactions to it?

Can one size fit all? Not in my experience. Rather, it is the very ambiguity in music that makes our practice so unique. I believe we must work to remain open to this ambiguity and multiplicity of meanings. This is what theory is for.

In Conclusion

Theory is crucial to practice. Those who do not understand this are operating within theoretical assumptions of which they are unaware. It is only through reflexive practice-the packing and repacking of our theories-that awareness grows.

I posit that the notion of one-size-fits-all is a social construction (Berger & Luckmann, 1966) that belongs to the same rubric of myth as magic buttons and perfect pills. One-size-fits-all is fast, easy and convenient. But because our practice hinges on music, which is intangible, ineffable and diffuse, music therapy theory construction is, by necessity, a slow, hard and messy business. As Heidegger advises, we must keep our thinking sails "trimmed hard to the wind" when it comes to music therapy theory and anything else that matters.

I conclude with a whimsical wish for the construction of music therapy theory: Let's write down our conceptual baggage, feed it to the dragons and receive it back transformed by their fiery breath. When the smoke clears, cogent theories of music therapy will be heard singing out from the ashes in glorious counterpoint. . . . *Ah-h-h!*

Notes

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[2] Interestingly, the domination by behaviourism of yesterday is similar to the domination by "evidence-based medicine" experienced today. Evidence-based medicine has garnered considerable criticism (Feinstein & Horwitz, 1997; Miles, Grey, Polychronis, Price, & Melchiorri, 2004; Tonelli, 1998) and an alternative to the Cochrane Colloquium has emerged in the Campbell Collaboration (**www.campbellcollaboration.org**). Hopefully standards developed for evidence-based practice and non-randomized controlled clinical trials will enable acceptance for the use of convenience samples, which is crucial for clinical outcome research.

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