Vol 5(1), March 1, 2005
mi40005000172

Why Provide Music Therapy in the Community for Adults With Mental Health Problems?

By Helen Odell-Miller **|Author bio & contact info|**

Editors note: This article was originally published in British Journal of Music Therapy, vol. 9 (1), 1995, and is republished here with the kind permission.

This paper describes music therapy within a community mental health setting for adults using a care programme approach in England. It describes the setting, and emphasises the importance of multidisciplinary teamwork in order to enable music therapy to be effective. It provides some statistics and descriptive clinical information which demonstrate the efficacy of music therapy for adults with long-term mental health problems, and argues that music therapy should be a priority for this client group. To support these points of view, the article includes a case study showing a psychoanalytically informed approach in music therapy. This paper was given as a keynote address at the 1994 Australian Conference of Music Therapy.

In Maranto's recent book Music Therapy International Perspectives (1993), Erdonmez, Bright and Allison write that "the definition [of music therapy] has needed to reflect a changing attitude" in health care to that of preventative care and meeting the needs of those who have transitory difficulties' ... "with de-institutionalisation there is no time for work whilst the patient is in hospital." Reading this and discussing mental health systems with colleagues in psychiatric rehabilitation who have recently visited Australia, I feel that there are many parallels between the two countries, particularly in connection with the devolution of services for people with mental health problems from hospitals into the community.

As I am going to concentrate on the field of mental health (psychiatry) in this paper, a quick summary is needed of current provision in the UK in order to put this work into context. In the UK, there is now a distinct "market-led economy" in health provision with a purchaser/provider "split." Purchasers (old Health Authorities) decide on policies and buy services on behalf of local populations. Providers are those who provide the service. Services for the mentally ill are provided by three major agencies: the Health, Social and independent (voluntary) sectors. Most music therapy services, like ours in Cambridge, are based in the health sector, but there is an increase in the employment of music therapists in the voluntary and private sectors.

One aspect of our psychiatric services is the development of Community Mental Health teams. These are usually divided into teams for people over 65, and teams for younger adults under 65. This paper will concentrate on the under-65 group. Locally we have excellent community facilities, and developing community teams that are increasingly resourced jointly by the Health Service, Social Services and the Voluntary Sector. We have tried to ensure that sessional music therapy is available for people looked after in the community by these teams. Music therapists throughout the UK are organised differently depending upon local patterns of care. However, as an overview, I include some statistics (see Figure 1).

Figure I. Music therapists in Great Britain (1993 figures quoted by APMT)

Association of Professional Music Therapists

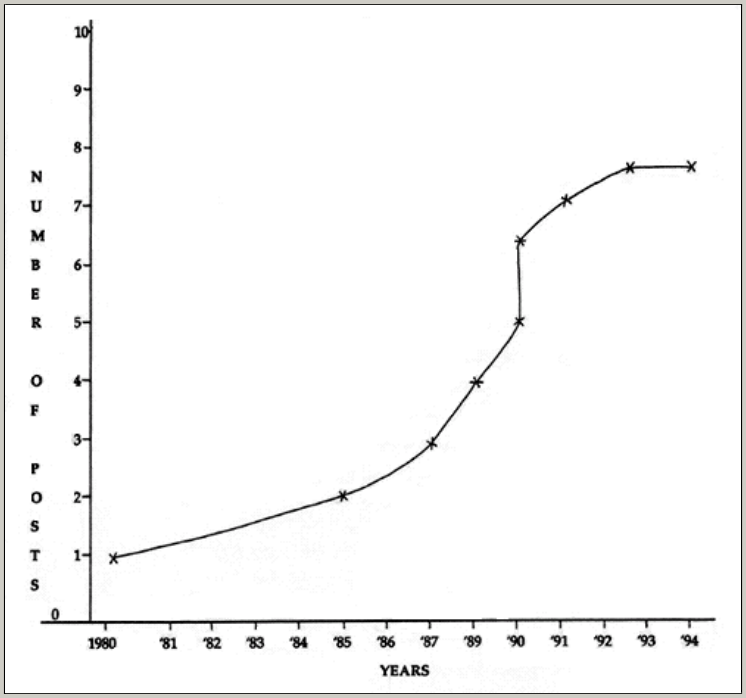
260	Current members
175	Registered members
84	NHS
91	More than one organistation*
22	Charitable organisations

Developmental disabilities	60%
Mental Health	15%
Other	25%

eg sexually abused, HIV and AIDS, epilesy, stressed business people

*Some therapists work in more than one organisation or with more than one client group.)

Figure II. The development of the music therapy service in Cambridge



I should clarify that in this paper I am concentrating on an approach to music therapy in psychiatry in our local service, but that this service is similar to others in Britain. This is in order to address exactly the phenomenon highlighted by Erdonmez, Bright and Allison mentioned earlier. My music therapy model is based on one described in Case Studies in Music Therapy (Bruscia, 1991). A summary is necessary here of my approach, based on the work in the relevant chapter:

My Music Therapy group model is not based on one theoretical framework, but has grown from years of clinical practice and supervision. Freud and Bion have been influences, in addition to Yalom, and the social psychiatry model practised in the setting where I work. The approach involves practical music-making, using improvisation as the focus. My rationale is that the way clients improvise may reflect their current states, and can lead to an understanding of internal and external, interpersonal and intrapersonal changes which may be desirable. A variety of instruments are used including tuned and untuned percussion, violin and piano.

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

An intense experience of hereand-now is provided by a Music Therapy group. Interactions are played out often within improvisations, and it is fundamental to this way of working that the therapist gets hold of this and does not avoid issues she perceives or hears, if clients are ready to look at this. It is also important to recognise when music-making might be encouraging

defences. In this method, free improvisation provides an experience for transference and countertransference relationships to be dealt with between group members as well as with the therapist. In addition, feelings of members about the way others play, and their degree of skill, provide material which can be used by the Music Therapist to understand more about the group and its members. The Music Therapist is a trained musician in this way of working, but the clients need not have any previous musical skills.

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

When individual work is practised, the basic principles outlined above are relevant, using interpretation and analytic concepts, but then naturally the emphasis is upon the individual and not the group.

People are referred with a view to long-term rehabilitative music therapy which can continue whether they are in hospital for a short episode, or living out in sheltered accommodation - all with the same music therapist. The music therapy model offers a long-term, stable "containing" therapeutic space, with the therapist encouraging insight-orientated work in a supportive way in which both music and words are possible. Our experience has shown that people with long-term chronic mental health problems, such as schizophrenia and manic depression, have been able to remain outside the hospital/ward environment whilst engaged in music therapy, and did have fewer "episodes of breakdown" than before music therapy started. As described later, this is also a result of team members working very closely together, and we are not attributing these positive changes to music therapy in isolation. More research is necessary in this field, but our small survey showed that 90% of long-term chronically ill people engaged in music therapy for periods of two to four years, once or twice a week, individually and in groups, had a regular pattern of breakdown and admission to hospital before embarking on therapy, and a decrease (and often cessation), after embarking on a period of music therapy.

Reasons for Referral

So why should purchasers buy music therapy for the mentally ill in this market-led economy, where there is competition for resources for even the most basic services?

We, as health care professionals, will immediately have at our fingertips many reasons why, usually based on clinical material and examples of how individuals have benefited. In the following table (see Figure III), I have listed the most common reasons for referral to music therapy in our service that have been given on referral forms by other health care professionals for people who are living in the community, or who are moving out into the community. Alongside this I have also listed the therapists' and teams' view of the benefits of treatment, or the current aims and goals if the treatment is still in progress.

Figure III.

Age Diagnosis Sex	Length of treatment	Reason for referral	Aims, benefits and outcomes as described by therapist and other clinicians
53 years Depression, personality disorder Female	3 years	To provide long-term support and a place to deal with suicidal and lonely feelings through a medium other than (but including) words.	Took on the role of a `core' member and felt needed by others. No self harm whilst attending the group and has since been discharged from the group and clinic. Long-term regular contact enabled full rehabilitation.
39 years Manic depressive Female	2 years	To look at reasons for manic depressive episodes - to look also at her feelings about her role as a wife and mother.	Able to acknowledge her feelings more, and see that intellectualising often masked a true understanding of her emotional states. Returned home - able to resume role as

			mother and return to teaching which gave her confidence and self-respect.
41 years Manic depressive Male	4 years	To contain and reduce feelings of anxiety he usually experiences with groups of people. To encourage expression of aggressive feelings. To provide a secure place for him to understand some of his depressive feelings, and hopefully prevent the recurrent pattern of admissions to hospital.	Has helped in areas of reducing anxiety; the ability to make close relationships, and to understand aggressive and angry feelings. He has been in therapy for 4 years, in a group, and had no admission to hospital for 3 years. He feels the group has helped him get better.
41 years Schizophrenic Male	2.5 years	Spends all his time on his own. Hardly communicates in groups at all. Has never expressed an interest in another group.	Made relationships. Gained insights into how he affects others - this seems to be linked with having a place to deal with strong angry "negative" emotions. More settled in life.
34 years Manic depressive Female	2 years	To help her sense of low esteem. To look at major life change - divorce - and losses throughout her life.	Able to release some emotions through the medium of music. Has learnt to trust others - has lived independently in sheltered housing for 2.5 years with only one admission.
41 years Schizophrenic Female	3 years	To reduce her sense of isolation and increase ability to relate to others. The possibility of making a relationship through a creative medium should help her.	Has felt confident and secure enough to leave hospital and live in sheltered accommodation 4 years later, much more independent, seems happier and more integrated. No admissions since (to hospital).
31 years Schizo-affective disorder Male	5 months	"Coming to terms with my problems" (filled in by patient).	Able to deal with feelings of aggression and anger, and deep hurt through music and talking. Using containing regular relationship with therapist as a `nurturing' place, when everything else seems against him.
51 years Manic depressive Male	6 months	"To extend horizons" (filled in by patient).	Exploring life issues, developing confidence, self-esteem and insight since his discharge. Sessions are an important supportive and stabilising factor in keeping him out of hospital.
51 years Manic depressive Male	2 weeks	"M has been attending the Day Centre sporadically for about one year. During this time he has had several relapses. Both M and I [OT] feel there is a need for some form of therapy to reflect on his past and understand its effects on his current situation".	Settled in to one session in the group. The aim is to help him gain insight into illness and himself, in order to maintain life in community.

41 years Depressive disorder Male	2 weeks	"N attended music therapy on an acute ward and found it very beneficial/therapeutic in coming to terms with his feelings - particularly of anger and disappointment".	In two sessions, he has been able to work through music and integrate some thoughts and feelings. Aim is to rehabilitate himself into a more normal lifestyle.

Recently, when I met with the Director of the Purchasing team for our local Mental Health services, I began fervently to explain in detail about music therapy and the processes involved. After a very short time he stopped me and said, "I am very aware of the processes involved in music therapy and of its value in general - of that I do not need convincing." He then went on to say that he did not even need to know the specific details of how much occupational therapy, arts therapies etc. were purchased for people with mental health problems as long as we were supporting community mental health teams (CMHTs). Most important of all, he said that he would particularly expect our service to be helping people such as those with long-term problems related to chronic schizophrenia and manic depression who "might other wise have slipped through the net". I make this point because his priorities and ours as therapists, whilst at first seemingly based at opposite ends of the spectrum of health care priorities, are closer than we might first have thought.

Let us look back at Figure III. As you can see many of the reasons for referral include a longterm perspective, and for patients referred whilst in hospital who are expected to move towards living in the community, treatment is being planned on a long-term basis. This obviously takes into account both those focal points mentioned by the purchaser, and at the same time fits in with the therapist's philosophy which is usually that if there is to be any fundamental change for people with long-term/chronic mental health problems it may not be possible unless a long period of time is allowed and a stable relationship is established. So how can any of this be achieved?

A key element to the efficacy of music therapy is the assessment. This may seem obvious, but we have found within this rehabilitation model that having a clear picture of the future aims of the patient and those case-managing him/her (usually within the CMHT) is essential at the outset, and enables realistic future planning of therapy.

The assessment will involve talking to all the key players. The assessment itself may take one meeting or more, depending upon the nature of the information gained, and the pace of the session. It may or may not involve music depending on the patient's readiness to communicate verbally, and the therapist's approach or need to ascertain how the patient might use music before the actual therapy begins. The areas for important consideration in an assessment to examine whether music therapy would be useful in our service for people with long term mental health problems are shown below (see Figure IV).

Figure IV.

Nature of interactions/content of discussions:
Level of commitment (expectations):
Degree of insight:
Responses to medium:
Potential for change:
Therapist's recommendations:
Reasons for taking on patient/aims:

Prior to this a referral form will have been received. We have a joint central referral system together with other arts therapies, and Figure V shows excerpts from our joint brochure which help referring agents to understand the service.

Figure V.

• We work with the principle that central to the person's well being is their need to relate to, and have meaningful contact with others. Disturbances in relationships and in the capacity to relate, therefore, are major con tributing factors in psychological distress.
• We believe that an essential need for patients in our service is to have the chance to com municate about themselves, in a setting which is structured, and which takes into account that relating through verbal language may not be the best place to start.
• Patients are encouraged to enter the therapeutic relationship in whatever way they choose or are able. They are helped to express themselves and to understand how and why they relate as they do. Through this insight and their experience of the therapeutic relationship some

considerable relief from distress can be gained. Change then becomes an option. The capacity to find more meaning and satisfaction in life and relationships is free to develop.

- In music therapy the non-verbal improvisa tion on percussion instruments allows individuals the opportunity to express their emotional state and to enter into an interactive dialogue with the therapist. Here, old patterns of relating can be reflected on, explored and reorganised.

Referral

- Difficulties in dealing with depression
- Problems in relating positively to others
- Difficulties with communication
- Problems with understanding the meaning of their behaviour
- Difficulty with managing feelings Problems of self-confidence
- Difficulty with making sense of the past
- Difficulty in overcoming traumatic experiences
- Problems relating to loss and grief

John et al (1993)

The following case presentation highlights points made earlier in the paper.

Case summary

Name: Len Started: March 1990

No. of sessions: 144 Age: 48

Diagnosis: Manic depressive

Referred by: Acute Ward Music Therapist, Psychiatrist and Psychologist to a group (the approach was described earlier) in a Psychiatric Day Clinic in the centre of Cambridge, away from the hospital.

It was felt that music therapy would be useful for containing the anxiety Len felt with others in a group, and his expression of aggressive feelings. Ongoing therapy would provide a "secure" place for him to be understood, and to understand his depressive feelings. Hopefully, together with a whole discharge package, therapy would help to prevent a recurrent pattern of admissions.

Description of the therapy

Before admission to the Acute Ward, and subsequently a Secure Unit (December 1990), Len attended 20 music therapy sessions, and said he felt he could relax by "throwing himself into improvising". He often talked about a "workout", and seemed to find the group increasingly useful. His previous history indicated that he had at least one manic episode per year, resulting in admission, and sometimes a need for more secure provision (e.g. Secure Unit).

After his long admission to the Acute Ward and the Secure Unit (six months), Len returned to the group. It is significant that during his absence he corresponded twice from the Secure Unit, keeping links with the group, and I made it clear his place was still available. It is also significant that before October 1990 his attendance was spasmodic whilst settling into the group, but following his return was much more regular.

Len has now had over three years with no admissions to hospital, for the first time since before 1980. He has developed a capacity to use the group to gain insight into his problems, and has found ways of integrating this into his life. He has had excellent all-round "case management," with regular reviews held with the Community Psychiatric Nurse (CPN), Clinic staff and me. He discusses his worries and anxieties about becoming manic, and has trusted the group with starting to make links with his authoritarian parenting (particularly his father), his childhood, and his own experiences of being a parent (precipitated by my pregnancy). He has been able to acknowledge competitive feelings with other men in the group. This is reflected in his interactions musically and verbally. He has become "identified"' musically with the Gato drum, which he uses to give a firm "lead," moving from there to less controlled outbursts on drums and cymbals.

The improvising seems to have helped him to integrate his different internal `parts', and he has discussed this. For example, he has expressed worries of becoming "high" and "anxious," saying that music enables him to relax but also to give vent to angry feelings. He has understood some of his wild fantasies about women as a result of my constant working through the transference and countertransference with the group. For example, I was able one day to make an interpretation about how he was singing a love song in the group, improvising in a seductive and almost violent manner (this was reflected in the words of the song). He needed to know that I would not respond to this, and that I was strong enough to tolerate his often loud, strong music and sexual innuendo. These interpretations needed to be reflected to him slowly but clearly, and following this developing understanding, Len's relationship with his long-standing female friend seemed to blossom. It was important to let his CPN or case-manager know if he became disinhibited, as this was often a sign of the beginning of a manic episode.

Len developed more insight into his own state, and began to want to remain well. In one review meeting he stated that for four months he had been at his most depressed, and had tried to curb this by withdrawing from some very demanding daytime activities. He found music therapy was the main thing that enticed him out of bed in the week, apart from CPN visits. He later became more stable and energetic, and also benefited from a house move. He began to look ahead to try to work - to get things published, and to make a role for himself within the mental health self-help system e.g. in meetings about philosophy, mental health issues etc. He became a powerful group member, often acting as a catalyst for others - asking questions and taking an interest in their lives, which was a new development. Musically, he often brought ballads to sing in sessions; and I usually found the words significant for him and for what was happening in the group at the time. His improvising became much freer, and he trusted himself to "let go" and not rely on structure, whilst at the same time being able to tolerate the "group"s music'.

Len has now been in a stable relationship for some years. Prior to attending the group, and at times during the first two years, he would have small involvements with other (often younger) women. Through exploring these issues in the group, and at times uncovering who it was that I, and other members, represented for him, he seemed able to control his sometimes aggressive impulses towards women. He went on holiday with his friend, and he began writing again. He became of great support to others with similar problems, and able to help them.

After four years, Len began talking and thinking about leaving the group, and subsequently did so. During four years of music therapy, he had changed a great deal, and most striking was his rehabilitation back into the community. Previous discussions about discharge from the therapy led to Len feeling he needed the group for ongoing support, although he seemed to have reached a peak of "change." Maintenance is a very important part of music therapy in the community with those with diagnoses of chronic mental health problems. Nevertheless, Len now attends many other activities which previously he did not have the inner strength to do, such as sheltered work and a guitar education group.

In summary of his case, I quote some of Len's comments about his music therapy:

> (Len): "It's taken me a long time to realise it because quite frankly I was bored, well not bored just quiet, and I was feeling depressed with a lot on my plate really ... sometimes raucous and cacophonous - grating and getting on my nerves, but I really like the Gato drum. I like banging that drum there and tinkling around on the xylophone - I even like playing the piano - I remember it when I first came to the group."
> (Me): "You've found a way it can help you?"
> (Len): "That's right yes - it's a good way of sorting out one's problems - a form of meditation through music - co-operating and not cooperating, performing and not performing." Len also wrote a letter after leaving the group acknowledging how the therapy had helped, and that it seemed time to" move on.

Conclusion

Murray Cox, a well-known psychiatrist and psychotherapist, recently said in a lecture that what is important for those with forensic histories is to be surprised. They need, he said, something which stops them in their tracks and enables them to adapt to something new, to move away from old patterns of relating. I believe a long-term relationship, concerned with understanding both conscious and unconscious processes in a music therapy context, is a unique way of meeting needs. This is equally true for many long-term chronically ill people suffering from mental health or psychiatric problems. Purchasers should continue to buy music therapy - it

provides an excellent long-term form of therapy for those with chronic mental health problems.

References

Bion, Wilfred R. (1961). *Experiences in Groups*. London: Tavistock Publications.

Bruscia, Kenneth E. (1991). *Case Studies in Music Therapy*. Phoenixville, PA: Barcelona Publishers.

Erdonmez, Denise, Bright, Ruth, Allison, Davies (1993). Music Therapy in Australia. In Maranto, Cheryl D. *Music Therapy: International Perspectives*. Pipesville, PA: Jeffrey Books.

John, D., Appolinari, C., Odell-Miller, H., Storey, D., O'Conner, C., Karpas, M., Davies, A. (1993). *Arts Therapies in the Mental Health Services*. Cambridge: Addenbrookes NHS Publications.

Maranto, Cheryl D.(Ed.) (1993). Music Therapy in the United Kingdom. In *Music Therapy: International Perspectives*. Pipesville, PA: Jeffrey Books.

Odell-Miller, Helen (1991). Group Improvisation Therapy: The Experience of One Man with Schizophrenia. In Bruscia, Kenneth E. (Ed.). *Case Studies in Music Therapy*. (pp 417 - 431). Phoenixville, PA: Barcelona Publishers.

Yalom, Irvin D. (1970). *Theory and Practice of Group Psychotherapy*. New York: Basic Books.

To cite this page:
Helen Odell-Miller (2005). Why Provide Music Therapy in the Community for Adults With Mental Health Problems?. *Voices: A World Forum for Music Therapy*. Retrieved from http://www.voices.no/mainissues/mi40005000172.html

Moderated discussion

Add your comments and responses to this essay in our Moderated Discussions. Contributions should be e-mailed to either ***Barabara Wheeler*** *or* ***Thomas Wosch*** **Guidelines for discussions**

View contributions on this essay:

- December 04, 2006: **Response to "Why Provide Music Therapy in the Community for Adults With Mental Health Problems?"**, by Brian Johnson