### C. Music Imagery[3]

*A technique that involves listening to music in a relaxed state to facilitate increased self-awareness, which in turn may facilitate psychological and physical relaxation.* The emphasis of this technique is to encourage the client to reach and explore altered states of consciousness for the purpose of allowing imagery, symbols, and latent feelings to surface from the inner self. Carefully selected music programs allow the client to recall memories, initiate fantasies, and stimulate creative thinking. As part of the music imagery training, the client will learn how to use music as an aid in concentration and relaxation.

The therapist exposes group members to different styles of music and initiates open-ended scenarios that promote imagination and fantasy production. In addition, the therapist facilitates a discussion of material among the clients at the conclusion of the imagery.

### D. Music-Centered Relaxation

*A technique using music as a perceptual focus and stimulus for relaxation training.* The music stimulus diverts the client's attention from states of psychological and physical tension that cannot be dissolved by techniques based on conscious mental and physical efforts, focusing on the particular tension. This relaxation technique utilizes the potential of music as a pleasant stimulus to block out sensations of anxiety, fear, and tension, and divert attention from unpleasant thoughts. Through this positive perceptual experience a reassuring experience of self will occur. The therapist teaches the client initially to focus away from self and then gradually return attention to self in the perceptual process.

The therapist will provide music selections according to the clients' preferences, and will instruct them to follow the music without anticipatory attitude or deliberate intellectual or emotional efforts that would influence the listening experience. Clients are encouraged to follow different elements or events in the music as they attract their immediate attention, without abandoning the attitude of passive concentration. On a second level, once the clients feel comfortable and safe in their listening experience, they are encouraged to let their attention gradually expand to wandering freely back and forth among the music, their bodies, their thoughts, and feelings. Through focusing on the music, the clients will gain a safe, pleasant perceptual experience that may break pathological attachment and anticipation of particular experiences—for example, psychosomatic or anxiety experiences.

Any body position the client finds comfortable, whether sitting or lying down, is acceptable in the beginning. Body positions will usually develop into more relaxed positions during the training process.

[3]This technique is not intended to reach deep intrapsychic material, as would Guided Imagery and Music.

PART 4

# CLINICAL INTERVENTIONS IN ADULT PSYCHIATRIC DISORDERS

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(Authors are listed in alphabetical order; all authors contributed equally.)

The last section of this book is presented in tabular form for quick, ready reference. Patient symptoms and needs, appropriate music therapy interventions, programs, and techniques for specific diagnostic categories are listed.

The tables were developed by the primary authors, whose clinical experiences are lengthy and broad-based in various psychiatric treatment agencies. The diagnostic categories were selected from the *Diagnostic and Statistical Manual of Mental Disorders,* third edition, and later modified with the changes in terminology in the fourth edition, text revised. The illnesses described are those found most frequently in patients in the kinds of units where music therapists are employed. Included are (1) schizophrenic disorders, (2) mood disorders, and (3) generalized anxiety disorders. The bipolar mood disorder is separated into two parts: (a) depressive episode, (b) manic episode. Personality disorders are not included in this volume, nor is there a section for the major depression as separate from the bipolar disorder, depressed episode.

## Use of the Tables

The tables are set under seven headings. The materials under the first heading, "Diagnostic Symptoms," and the second, "Clinical Features," are adapted

need for appropriate leisure-time skills and then on providing suitable musical options. The client is responsible for making decisions and following through with selected activities—with the therapist's assistance.

The therapist sets the occasion for relevant discussion of postdischarge leisure-time needs and guides the client in creating and developing a leisure-time plan. The therapist also assists by sharing information about available community resources (e.g., church choirs, square dance groups, community bands) and by facilitating the client's involvement in such activities when necessary.

## Reference

Piaget, J. (1962). *Play, dreams, and imitation in childhood* (C. Gattengo & F. M. Hodgson, Trans.). New York: W. W. Norton. (Original work published 1945). See chapter IV, "The beginnings of play."

# VI. *Music and Relaxation*

## A. Music with Progressive Muscle Relaxation Training

*A technique using music in conjunction with progressive muscle relaxation training in individual or group settings.* A client will learn to select and use appropriate recorded music found to be effective in eliciting a state of relaxation for that individual. The emphasis of this technique is twofold: to pair relaxation training with appropriate selected music and to condition the client to use music as the overall focus for relaxation.

Appropriately selected music serves as a stimulus to block negative associations and elicit positive mood and feeling responses that facilitate relaxation. The client will learn to discriminate between relaxation and tension responses and substitute acquired relaxation responses for anxiety/stress responses.

The therapist will assist the client in learning the technique of relaxation training and in selecting music that heightens the relaxation response. The therapist may also develop relaxation tapes as well as written materials to be memorized for relaxation training for use pre- and post-discharge.

## B. Music for Surface Relaxation

*A technique using music as a medium for temporary respite from anxiety/stress conditions in individual or group settings.* The individual will learn to use music's potential to facilitate relaxation based on individual preferences regarding style, tempo, volume, and timbre, and locate appropriate resources (e.g., records, tapes, radio). The emphasis of this technique is to provide concrete resources for a client in a short-term setting. Unlike other relaxation techniques, surface relaxation requires no long-term training by the client.

The therapist will provide a variety of musical stimuli for the client to experience as possible resources for relaxation. Additionally, the therapist helps the client understand how the elements of music influence mood, behavior, and physical responses.

# V. Recreational Music

## A. Music Games

*A technique using music games to provide experiences in which human behavior can be acted out in play form, providing participants with an opportunity for emotional and social learning in a safe and predictable environment.* The emphasis of this technique is on the cooperative process necessary for successful group participation and the development of adaptive social skills. The participants will be encouraged to demonstrate attending behaviors, exhibit group responsibility, develop interaction patterns that facilitate the accomplishment of group goals, and work toward mastery of a task. This technique will provide a vehicle for spontaneity and the freedom of play skills.

The therapist serves as facilitator for the development and playing of the music games and ensures the activity is designed to foster successful participation of all group members. Games may fall into four categories of play (Piaget, 1962):

1. Exercise play—sensory-motor repetitive action
2. Symbolic play—a self-expressive language
3. Games with rules—social interaction
4. Games of construction—adaptations or solutions to problems and intelligent creations

Music games such as music bingo, name that tune, lummi sticks, concentration, and music charades provide opportunities for clients to experience competition and enjoyment while encouraging less verbal group members to participate more fully. Games with rules can produce significant changes in peer relationships; winning or losing experiences can provide objective reality testing as well as healthy development of self-confidence leading to a better self-concept.

In clinical settings music games can provide a beginning step to resocialization, promote leisure-time skills, and serve as a prerequisite for more in-depth music group participation.



## B. Music Appreciation Awareness

*A technique using a variety of music stimuli to provide the experience of listening to, and at times creating and performing, music in a group or on a one-to-one basis.* The emphasis of this technique is analogous to the emphasis of music education, where opportunities are provided for an aesthetic experience that is common to all people. The participants will be exposed to many and differing music experiences in an attempt to broaden their music understanding and awareness. The individuals will be encouraged to develop group cooperation and tolerance for varying music styles and to take risks in sharing music preferences.

The therapist provides an environment for sharing and discussing a variety of music selections (e.g., listening to records of various periods and styles, and arranging for live music performances) in a supportive, nonthreatening atmosphere.

In clinical settings music appreciation helps provide confidence in asserting individual opinions while it encourages concentration, on-task behavior, and independent thinking.

## C. Recreational Music Performance Groups

*A technique providing diversional and success-oriented music experiences using instrumental and/or vocal media.* The group setting serves as an initial nonthreatening, enjoyable opportunity for the client to gain orientation to easily acquired music skills. The emphasis is on experimentation and enjoyment rather than a perfected product. The clients are expected to participate in a beginning music group process in order to reinforce self-confidence, risk taking, and discussion of potential leisure-time activities.

The therapist provides a variety of sociorecreational music experiences that will ensure each client's contribution will be fundamental to the group's performance. The following types of music media are associated with this technique: omnichord, ukulele, recorder, Autoharp, guitar, electronic keyboard, pitched and nonpitched percussion, and voice.

The music may or may not be notated, depending on the existing music skills of the participants.

## D. Leisure-Time Skill Development

*A technique to emphasize music's role in a client's discharge planning and community follow-up.* The client is given the opportunity to experience and then focus on appropriate enjoyable musical activities available in the community. Leisure-time planning may be accomplished by either individual or group counseling. The emphasis of this technique is on heightening the client's awareness of the

# IV. *Music Combined with Other Expressive Arts*

## A. Music and Fine Arts (Drawing, Drama, Sculpting)

*A technique focused on combining music and fine arts to provide for expression of feelings and emotions among group participants or on a one-to-one basis.* The emphasis of this technique is on increasing the individual's awareness of self through a nonthreatening multifaceted medium. The individual will be required to integrate both visual and aural stimuli while reflecting emotional content. An individual should demonstrate the ability to reflect changes in feelings and emotions in conjunction with changes in musical stimuli.

The therapist serves as a facilitator to implement the multisensory experiences. Background music is played to set a mood or to heighten the group or individual experience while the secondary medium is used. The music can also provide thematic material for the art experience. The therapist has a choice of providing the group or individual with either a structured (e.g., sculpt a picture of someone important to you in your childhood) or unstructured (e.g., draw feelings) task-oriented activity.

In clinical settings a multisensory approach will provide an additional modality for the individual who is nonverbal or withdrawn to express feelings without words.

## B. Music and Writing (Poetry, Prose)

*A technique focused on combining music and writing to provide experiences for expressions of feelings and cognitive responses among group participants on a one-to-one basis.* The emphasis of this technique is on increasing the individual's awareness of self through a nonthreatening multifaceted medium. The individual will be required to integrate auditory/visual perception and discriminatory thinking while reflecting emotional content. The individual may be asked either to listen and interpret existing written material (i.e., stories, plays, poetry) or write imaginatively and creatively to encourage self-disclosure and expression of feelings.

The therapist serves as a facilitator to implement the multisensory experiences. Music is provided by the therapist as an accompaniment to existing



material (i.e., stories, plays, poetry) to inspire creative expression of feelings and encourage discussion.

In clinical settings this multisensory approach will provide a language modality for the individual who is nonspeaking and/or withdrawn to organize thinking and encourage language expression.

## D. Expressive Movement

*A technique using music and movement activities to assist clients in becoming aware of feelings and emotions that are relevant to their personal functioning and coping abilities in daily life.* Expressive movement activities function as a testing ground to experience and express emotions in an affective, essentially nonverbal modality. Subconscious conflicts, or images and feelings related to significant personal experiences, might be elicited in the client. The clients learn to use music and movement techniques as vehicles for emotional self-expression and to relieve feelings of tension and anxiety.

The therapist designs music and movement exercises in which the clients participate by either moving to music or providing music accompaniment on instruments. Music themes are selected to encourage the experience and expression of feeling concepts such as love, loss and grief, depression, social isolation and withdrawal, interpersonal conflict, hope, and joy. Significant interaction experiences such as help, rejection, and acceptance are also used on this level. Pertinent music and lyrics that express emotional themes can serve as a catalyst for the emotional experience, which is then expressed through movement; the experience may be expanded by original music accompaniment. In addition to being a (1) BACKGROUND ACCOMPANIMENT, (2) TIMING CUE, and/or (3) CATALYTIC STIMULUS, the music also serves to amplify and support the emotional content of the movement experience when the therapist is using the techniques of (4) REPRESENTATIONAL ACCOMPANIMENT and (5) CONTENT ACCOMPANIMENT.

Due to the process nature of expressive movement activities, improvised music is often used on this level. Basic movement characteristics (e.g., slow, deliberate, flowing) are emphasized within the clients' abilities with regard to their potential for expressing feelings. The combination of music and movement, utilizing the auditory and kinesthetic experience, enhances the emotional, social, physical, and aesthetic experience for the clients.

## E. Dance (Folk, Square, Social, Contemporary)

*A technique using established and prestructured danceforms, steps, and styles with music to encourage social interaction, self-confidence, and recreational skills.* Concomitant benefits include improved reality orientation, motor coordination, perceptual processing, memory, attention, and physical exercise. The emphasis is on learning and performing structured dance movements that occur in patterned sequences in rhythm with the music. The focus is on the cognitive and perceptual motor tasks performed in coordination and cooperation with others.

The therapist plans and organizes the dance activity, taking into account the requirements of particular dance forms, such as predetermined gender roles, necessary numbers of participants, technical difficulty in the execution of [illegible]



steps, and appropriate music selections. These decisions are made according to the capabilities and needs of the group participants while considering their interests and cultural backgrounds. Typical dances in this category include folk dance (ethnic and national origins), square dance, social/ballroom dance (waltz, fox trot, polka, and tango), and social contemporary dance (rock, disco, etc.). The (7) DANCE ACCOMPANIMENT provides the rhythmic structure for the dance steps, dictates and/or complements the dance form, and sometimes directly relates to associated cultural rituals.

The therapist may, in conjunction with the group participants, use traditional dance forms or stylized dance steps in a creative manner to construct original structured dances. This approach may serve either as a creative, cooperative task for the client group or as a necessary adaptation of materials to better meet the clients' abilities and needs.

## F. Music and Exercise

*A technique using music to provide the temporal framework for adaptive physical exercise.* The emphasis is on the use of music at selected tempi to encourage physical exercise for individual or group participants to attain, maintain, or regain predetermined physical objectives. Attention is given to adapting music to support or accompany exercises for strength, endurance, muscle tone, flexibility, agility, body control, vital capacity, and cardiovascular efficiency. Music with strong rhythms can activate the motor system, help regulate motor coordination, and increase physical endurance.

The therapist selects participants in consultation with the client's physician and other team members (physical therapy staff) and identifies contraindications or precautions. The choice of exercises is based on predetermined objectives and the client's abilities. Exercises are presented in a progressive manner (regarding the number of repetitions, level of rigor, and endurance required). The function of the therapist on this level is to choose music that is rhythmically compatible with the designated movements in the specific exercise. Variable-speed music reproduction equipment or live performance allows for flexibility in accompaniment. The therapist will demonstrate and lead the exercise program focusing on the beat of the music that fits it. The therapist will document physical gains by objectively assessing various physiological responses such as measurements of strength (i.e., number of repetitions), flexibility, vital capacity, and pulse rate.

It should be noted that appropriate exercise to music can be matched to any age group or any level of movement ability and may vary from limited movement in a prone position to very vigorous exercise. Carefully selected music serves to regulate and encourage exact exercise participation.

The therapist structures music and movement exercises in which the client moves to music or provides music accompaniment on instruments. The therapist may guide the client's movement by demonstrating a movement that the client may model, which makes the activity less inhibiting. Music selections are used at this level as a (1) BACKGROUND ACCOMPANIMENT to the movement. The rhythm and texture as well as other music elements serve to draw participants into feeling less self-conscious and free them to move their bodies with the music. The therapist chooses the movement activity and music selection in an effort to elicit movement responses. Themes for movement should be short, concrete, age-appropriate, and enjoyable, and encourage interaction and self-expression. The function of the therapist on this level is to bring about an elementary awareness of the client's ability to move in a less restricted fashion. Such awareness may in turn help the client develop the ability to express feelings and emotions through movement.

Often in clinical settings clients who have difficulty communicating verbally find that they can learn to express their feelings through bodily movement.

## B. Movement Exploration

*A technique using music stimuli and the elements of movement to explore and improve the client's body image and feelings of competence in moving effectively and comfortably.* The emphasis on this level is to develop a repertoire of body movements that can be used expressively and functionally, and to learn of the client's own movement potential in a state of reality contact and conscious control. Clients may move alone or with partners in activities and exercises where the focus is on their own bodies.

The therapist designs music and movement experiences in which the patients participate by moving to music or providing music accompaniment on instruments. The therapist guides and demonstrates movements to facilitate learning through encouragement and modeling. Movement exercises focus on the exploration of the five basic elements of movement (i.e., locomotion, elevation, rotation, gesture, and position), within the three movement dimensions of time, space, and dynamics. Tasks for exercises on this level include experimentation with concepts such as fast vs. slow motion and sharp vs. smooth motion; moving through space on different levels, directions, and pathways; and moving with different degrees of force/muscle tone.

Movement exercises are designed to aid clients in developing good posture and in moving from position to gesture to locomotion in order to develop awareness and control of body movements. Clients are encouraged to experiment with various movements within a structured music environment. In movement exploration, music can function as a (2) TIMING CUE, (4) REPRESENTATIONAL ACCOMPANIMENT, and/or (6) DESIGNATIVE ACCOMPANIMENT for the movement activity.



The function of the therapist on this level is to assist and support the clients in developing awareness, control, competence, and confidence in their body movements in order to improve their body image, self-esteem, and abilities to use their bodies expressively and functionally.

Basic characteristics of movement (e.g., slow, deliberate, flowing) are emphasized within the clients' abilities. The combination of music and movement, utilizing the auditory and kinesthetic experience, enhances the emotional, social, physical, and aesthetic experience for the clients.

## C. Movement Interaction

*A technique using music and movement activities to provide the opportunity to experience social and emotional concepts in an affective, essentially nonverbal modality.* The emphasis on this level is movement in conjunction with other clients, with the music providing cohesive elements and giving meaning and feedback to the situation. The focus is on self, on self in relation to others, and on the task as expressed or accompanied by the music and or lyrics.

The therapist initiates music and movement experiences in which clients participate by either moving to music or providing music accompaniment on instruments. The therapist selects themes for activities structured so as to provide a secure base for interactive movement leading to meaningful expression and nonverbal interaction. Materials and themes that lend themselves to group interaction are drawn from stories, poems, sketches, dramatic expressions, visual designs, musical sounds, and social concepts. The music serves as a starting point, leading the movement experience, or it serves as an accompaniment, following the movement. In movement interaction, music can function as a (1) BACKGROUND ACCOMPANIMENT, (2) TIMING CUE, (3) CATALYTIC STIMULUS, and/or (4) REPRESENTATIONAL ACCOMPANIMENT for the movement activity.

The function of the therapist on this level is to assess whether the client's movements are reflective of the client's development of social awareness—as indicated by improved levels of cooperation and communication—and self-esteem by evidence of improved self-confidence and appropriate self-assertion. The therapist also serves to identify behavioral cues related to feeling states such as happiness, sadness, fearfulness, boredom, and apathy.

Basic movement characteristics (e.g., slow, deliberate, flowing) are emphasized within the client's abilities, with attention to movement planning and levels of coordination. The combination of music and movement, utilizing the auditory and kinesthetic experience, enhances the emotional, social, physical, and aesthetic experience for the client.

# III. *Music and Movement*

## Movement Accompaniment Techniques

The following seven types of accompaniment are used with musical movement techniques. They appear in capital letters along with the designated number specified for each technique.

1. BACKGROUND ACCOMPANIMENT. Live or recorded music serves as background stimulus to encourage and facilitate movement activities. Music is chosen to express the desired mood and general tempo of the movement activity (e.g., upbeat, energizing, fast vs. solemn, contemplating, slow) and to provide psychological and physiological stimulation to bring about a movement response in the clients. The movement response does not have to be rhythmically synchronized to the music.

2. TIMING CUE. Usually live music serves as an acoustic signal or timing cue to provide temporal structure in movement activities. For example: (a) a staccato chord on the piano introduces a fast motion that turns into a slow motion when a legato chord is sounded; (b) during a certain chord progression clients will gradually move from one still position into another still position; (c) a cymbal sound indicates change in solo movement sections. Music may lead or follow the movement.

3. CATALYTIC STIMULUS. Live or recorded music serves initially for listening experiences that in turn provide a theme for movement interaction and expression. For example: (a) clients listen to a recording of Pictures at an Exhibition (by Moussorgsky) and try to imagine movement activities that express the musical program, with the eventual goal of performing movement along with the music; (b) patients listen to the song "I Am a Rock" (by Simon and Garfunkel) and assume a "human rock" position to express and experience the message of the lyrics. This experience can be followed by a song that focuses on building relationships with others. Clients may be encouraged to change from a withdrawn still position to moving into a group or partner situation. The music experience precedes the movement experience.



4. REPRESENTATIONAL ACCOMPANIMENT. Usually live music serves to reflect the character, style, flow, tempo, and other external characteristics of the movement. For example: (a) music tempo relates to the tempo of the movement; (b) chord texture relates to "light" vs. "heavy" movements (e.g., through change in muscle tone); (c) high or low register relates to space levels of movement; (d) melodic lines vs. block chords relate to change in style of locomotion; (e) sharp vs. sustained attack on the musical instrument relates to sharp vs. sustained motions. Music may lead or follow the movement.

5. CONTENT ACCOMPANIMENT. Live or recorded music serves to enhance the internal aspects of the movement action. The music will only focus on external movement characteristics as part of the internal content of the movement. Music may lead or follow the movement.

6. DESIGNATIVE ACCOMPANIMENT. Usually live music will be used as direct and predetermined translation of movement elements into music elements to guide or accompany movement activities. Each movement component is synchronized to the music events and vice versa. For example: (a) interval leaps relate to jumping and hopping; (b) trills and melodic turns relate to turning, spinning, and rotating; (c) single chords vs. melodic motion relate to still position vs. locomotion; (d) ascending/descending melodic lines relate to upward/downward motion. Music may lead or follow the movement.

7. DANCE ACCOMPANIMENT. Live or recorded music serves to accompany a formalized set of movements, constituting a dance or dance form in tempo, rhythm, and expression. Movements are synchronized to the music in rhythm and tempo. Music leads the movement.

## A. Movement Awareness

*A technique using music and movement activities to encourage clients to interact and express themselves on an introductory level through body movement in a group setting.* The emphasis on this level is to provide a comfortable movement experience in which the group participants can focus on the task at hand and eliminate self-conscious behaviors that inhibit movement and the expression of feelings. The clients may move alone or with partners. The goal of these beginning music and movement activities is to provide a safe and comfortable environment in which to move with music in a less self-conscious manner, with the ultimate aim of developing the ability to explore other types of movement activities. This encourages creativity within music and movement to achieve a better understanding of feelings, thoughts, and emotions through expressive movement individually or in groups.

ensuing verbal interchange provides opportunity to clarify behavior styles and encourages self-evaluation leading to healthy behavior choices.

The therapist structures the music experience, determines procedures for interpersonal interactions, and guides the processing of individual and group reactions, being certain to allow sufficient time for verbal processing. The primary activities used in interactive music group and/or individual therapy are the various forms of guided music listening leading to discussion of lyrics content, mood of the music, and associations with past experiences that have personal relevance to the client's conscious conflicts. The therapist has the prime responsibility in the selection of music, which is governed by goals predetermined by the client's needs or goals emerging through the therapeutic process. Music selections may express and reflect themes and issues that are relevant to the group's process, and thus serve as a focal point for theme-centered interaction. Music can be selected to clarify an individual's interpersonal attitudes. Music can be selected to encourage and reflect states of individual and group development. The function of the therapist on this level is to facilitate the patient's efforts to encounter, express, and resolve conflicts; to adopt new, healthy responses; and to practice the chosen behavior changes.

## C. Catalytic Music Group and/or Individual Therapy[2]

*A technique using music activities as the starting point and catalyst for individual and group therapy processes.* The emphasis at this level is on eliciting awareness of subconscious conflicts and encouraging change by reliving and resolving situations of deepest fear and conflict. The music is used to stimulate images, feelings, and thoughts that are associated with the client's present and past. These musically induced experience states are used to uncover areas of personality development, such as repression, that have come into conflict with reality during the client's life. Music is able to tap deep unconscious levels of emotional processes, which in turn can be used to help challenge and reorganize existing personality structures.

The therapist structures the music experience, determines procedures for interpersonal interactions, and guides the processing of individual and group reactions, being certain to allow sufficient time for verbal processing. The primary activities used in catalytic music group and/or individual therapy are the various forms of guided listening techniques utilized to encourage clients to become more aware of feelings, thoughts, and experiences that previously have been denied or repressed. One such technique, Guided Imagery and Music, utilizes music's

[2]To use this technique, the music therapist must have thorough training and supervision to understand psychopathology, individual and group psychodynamics, and applicable verbal therapy techniques. Often the music therapist functions as a cotherapist with an experienced psychotherapist.



potential to release unconscious material that can be used therapeutically. This specialized approach requires specific training in order to be used most effectively. Individual therapy is often indicated, due to the in-depth psychological material uncovered at this level. The client and therapist decide on musical selections according to predetermined treatment goals in order to trigger intrapsychic processes in the client. The selection process is determined by musical preference and experience, as well as associations and symbolic meanings that are attached to certain music. The function of the therapist on this level is to bring about awareness of unconscious feelings and material and help build new, healthy defenses, better self-understanding, and more mature drives and instincts.

For further reference on Guided Imagery and Music, see the works cited under Bibliography.

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and anxiety. Limited attention is given to teaching and rehearsing formal musical skills.

The therapist provides elementary musical forms in which the client learns to alternate among expressing himself freely, leading or following in a music interaction, initiating or responding in a succession of musical statements (e.g., question-answer forms, contrasting feeling expressions, and musical storytelling). The main music elements are dynamics, timbre, register, texture, rhythm, and melody (e.g., modal scales and modal polyphony). Themes for individual improvisation/interaction can be musical (e.g., different dynamic, rhythmic, or melodic ideas) and nonmusical (e.g., emotions, dramatic scenes, images, poems, pictures). Instruments most frequently used are pitched and nonpitched percussion instruments, keyboard, and guitars.

Often in clinical settings clients who cannot communicate appropriately in the verbal mode interact and express themselves properly on musical instruments.

# II. *Music Psychotherapy*

## A. Supportive Music Group and/or Individual Therapy

*A technique using music activities as a starting point and catalyst for individual and group therapy processes.* The emphasis at this level is on promoting supportive verbal interaction, social participation, and the practice of healthy behavior patterns within an environment that provides a safe, reassuring reality stimulation. For the client, the music stimulus provides an immediate affective experience and serves to evoke associative thoughts and feelings. The music listening experience is designed to trigger verbalizations that are relevant to personal experience. The music also offers an objective focal point, elicits discussion, and leads to exploration of new behaviors or rediscovery of old skills.

The therapist structures the music experience, determines procedures for interpersonal interactions, and guides the processing of individual and group reactions, being certain to allow sufficient time for verbal processing. The primary activities used in supportive music group and/or individual therapy are the various forms of guided music listening leading to discussion of music elements, lyric content, mood of the music, and personal interpretation of the music selection. In some cases the client decides on music selections. In others, the therapist selects music to facilitate predetermined session goals. At this level the therapist's function is to identify and clarify the client's expression of thoughts and feelings, and support appropriate interpersonal behavior.

## B. Interactive Music Group and/or Individual Therapy

*A technique using music and/or music activities as stimuli for initiating individual and group therapy processes.* The emphasis at this level is to focus on conscious conflicts and associated unhealthy defense mechanisms. The process includes the development of insight from observing and discussing the client's behaviors and motivations, followed by identification and consideration of alternative healthy responses. The music stimuli are used to evoke associative thoughts and to heighten awareness of feeling states related to the conflict situation. These thoughts and feelings become the focus of the interpersonal interaction. The

The emphasis of this technique is on the music product resulting from the group's cooperative effort in following directions, accepting group procedures, and learning the music material. The participants learn to accept guidance, leadership, and social feedback; they must subordinate personal needs to group music goals and develop interaction patterns that facilitate accomplishment of group goals. Attention is given to formalized teaching and rehearsing practices to achieve an aesthetically satisfying experience from the music product.

The therapist plans and directs vocal ensembles using a variety of ensemble sizes and voice combinations. The group members function in assigned music roles as required by the music material. Examples of ensembles are secular and/or sacred choirs, small vocal ensembles (trios, quartets), madrigal singers, motet groups, barbershop choruses, jazz choirs, and folk and pop singing ensembles. The music is notated; vocal arrangements vary from melodies sung in unison to multivoice parts. Formalized vocal warm-up exercises at the beginning of regularly scheduled rehearsals are used. Instrumental accompaniment is frequently employed. Performances are planned at times appropriate for all group members, and special consideration is given to the location of the performance, the audience membership, and size.

In clinical settings the vocal/instrumental performance ensemble provides the clients with the opportunity to learn and practice the responsibilities of membership in a formal group organized for a specific purpose to reach a specific goal.

## E. Individual Instrumental Instruction (Product Oriented)

*A technique focused on the acquisition of musical skills by an individual client on any one of a variety of musical instruments.* The client may seek to exercise and improve an existing musical skill or learn and develop a new musical skill. The emphasis of this technique is on the musical product resulting from the individual's effort to learn musical material. The client accepts instruction and evaluative feedback, asks questions, solves problems, and practices the musical tasks assigned by the therapist. The experiences are intended to improve communication in a one-to-one situation, increase frustration tolerance, provide ego support through musical accomplishment, and improve usable musical and interpersonal skills for possible participation in music groups and/or as an outlet for personal expression.

The therapist instructs the client in playing techniques at an appropriate learning level and assigns practice tasks of which the client is capable. The therapist may instruct verbally, model the proper playing skills, and/or accompany the client on another instrument. Common instruments include the following: band and orchestra instruments (woodwinds, brass, percussion, strings), keyboard instruments (piano, organ), folk instruments (acoustic guitar, banjo, Autoharp, dulcimer, mandolin), and pop/rock instruments (trap drum set, electric guitar, harmonica). Notated music is used frequently.



Performances are planned and accomplished when the client can benefit. Special attention must be given to location, type, and size of the audience.

In clinical settings individual instrumental instruction provides an individual with the opportunity to make constructive use of guidance from the therapist on a one-to-one level and experience self-imposed practice.

## F. Individual Vocal Instruction (Product Oriented)

*A technique using the private voice lesson to provide the client with an opportunity to develop and improve singing skills through a series of formalized appointments for instruction and planned periods of individual practice.* The emphasis of this technique is on the music product that results from formal study and practice by the individual learner under the direct guidance of the therapist, who serves as the teacher. The individual learns to accept the responsibility of practice as a self-imposed task and relates his efforts to the accomplishment of an aesthetically satisfying music result.

The experiences are intended to improve communication in a one-to-one situation, increase frustration tolerance, provide ego support through musical accomplishment, and improve usable musical and interpersonal skills for possible participation in music groups and/or as an outlet for personal expression.

The therapist teaches breathing and vocal exercises and provides song materials adapted to the proper development of the client's voice. Attention is given to the teaching of note reading, singing diction, phrase line, and interpretation. Instrumental accompaniment is usually provided by the therapist in the early phases of the experience. Performances are planned and accomplished when the client can best benefit. Special attention must be given to location, type, and size of the audience.

In clinical settings individual vocal instruction provides the client with the opportunity to make constructive use of guidance from the therapist on a one-to-one level and to experience self-imposed practice.

## G. Individual Music Improvisation/Interaction (Process Oriented)

*A technique using musical instruments in individual therapy settings to provide a structured nonverbal mode for communication and expression of thoughts and feelings as well as reality- and sensory-ordered behavior patterns between client and therapist.* The emphasis of this technique is on the creative process of immediate music interaction between therapist and client that is facilitated through the use of elementary musical materials. The client learns to use the instrument as an emotional outlet, a bridge to social interaction, and to release feelings of tension

# I. *Music Performing*

## A. Instrumental Group Improvisation (Process Oriented)

*A technique using musical instruments to provide experiences for socialization, communication, and expression of feelings and emotions among group participants.* The group functions as a laboratory of behavior and interaction patterns using an affective medium to create a structured environment for practice of feeling expression, socially appropriate behavior, sensory- and reality-ordered behavior, and task mastery leading to better self-esteem. The emphasis of this technique is on the creative process of immediate music making, which is facilitated through the use of elementary musical materials. The clients learn to use their instruments as an emotional outlet, as a bridge to social participation, and to release feelings of tension and anxiety. Limited attention is given to teaching and rehearsing formal musical skills.

The therapist provides elementary musical forms in which the group members learn to alternate between playing as a group and playing individually. The main musical elements are volume, tempo, timbre, register, texture, rhythm, and melody. Themes for improvisation can be musical (e.g., different dynamic, rhythmic, or melodic ideas) and nonmusical (e.g., emotions, dramatic scenes, images, poems, pictures). Instruments most frequently used are pitched and nonpitched percussion instruments, keyboard, and guitars.

Often, in clinical settings, clients who cannot communicate appropriately in the verbal mode interact and express themselves properly on musical instruments.

## B. Instrumental Performance Ensemble (Product Oriented)

*A technique using the client's existing musical skills, as well as newly acquired skills, to form teaching and rehearsing performance groups on various musical instruments.* The emphasis of this technique is on the musical product that results from the group's cooperative effort in following directions, adhering to group procedures, and learning the musical material. The clients subordinate individual needs to group musical goals; practice focused attending behaviors; exhibit group responsibility; develop interaction patterns that facilitate accomplishment



of group goals; accept guidance, leadership, and social feedback; work toward task mastery; and have the satisfaction of achieving an aesthetically pleasing experience.

The therapist orchestrates the instrumental ensembles with a variety of instrumental combinations. Group members function in assigned musical roles as required by the musical materials. The following types of musical ensembles are associated with this technique: jazz ensemble, rock combo, Latin American-style ensemble, handbell choir, Orff ensemble, rhythm band, guitar ensemble, folk band, concert band, orchestra, and chamber ensemble. Music is notated. The group meets on a regular schedule to rehearse and develop a music repertoire for performance.

## C. Group Singing Therapy (Process Oriented)

*A technique using singing activities to provide experiences for socialization, communication, and expression of feelings and emotions among group participants.* The group functions as a laboratory of behavior and interaction patterns, using an affective medium to create a structured environment for practice of feeling expression, socially appropriate behavior, sensory- and reality-ordered behavior, and task mastery leading to better self-esteem. The emphasis of this technique is on the process of immediate music making through the use of vocal music materials of common experience. The clients learn to use their singing voices as an emotional outlet and a bridge to social participation as well as to release feelings of tension and anxiety. Limited attention is given to teaching and rehearsing formal musical skills.

The therapist plans various types of structured singing activities ranging from informal singing to creative or improvisatory vocal groups. The group process of informal singing allows for broad participation and reality orientation for clients on all levels of functioning as well as selection of songs according to appropriate states of mood and feeling. Creative and improvisatory vocal groups utilize techniques such as song writing, lyric improvisation on standard musical forms (e.g., blues, scat singing, chanting, choral speaking, sprechgesang). Themes for song writing and improvisation can be musical (e.g., different voice arrangements; textures; and dynamic, rhythmic, or melodic ideas) and nonmusical (e.g., personal experiences, emotions, story lines, images). Often in clinical settings vocal improvisation can be facilitated by the use of props that trigger the use of the singing voice—such as kazoos or microphones.

## D. Vocal Performance Ensemble (Product Oriented)

*A technique using existing and newly acquired vocal music skills to provide experiences in cooperation among group participants through teaching and rehearsing.*

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Chapter 9

# Music Therapy and Psychopharmacology

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Psychiatric treatment is most often provided within a milieu of several types of interventions. These essentially include a supportive and optimally structured environment, a regimen of medication, and an array of psychotherapeutic interventions that includes both verbal- and activity-based therapies. Effective treatment depends on a coordinated effort by the staff members of all these areas; patients may derive primary benefit from any one or a combination.

Psychotropic medications alleviate many of the major symptoms of mental illness that interfere with successful daily life functioning, as well as help relieve the accompanying psychological distress. They also aid the patient in maintaining psychological equilibrium when coping with life stresses after satisfactory functioning has been restored by treatment. This chemical intervention serves to render the patient accessible to psychosocial therapeutic treatment (Gitlin, 1996; Spiegel & Aebi, 1981). The effectively medicated patient is receptive and able to work in the psychotherapeutic situation, since medication provides an avenue to the patient's capacity to change overt behavior and disordered thinking. The term *psychoactive* is sometimes used for this group of medications; however, this term also commonly includes street drugs, in addition to medications legitimately prescribed for psychological treatment.

## Historical Development

Fifty years ago a major breakthrough occurred in the treatment of patients with mental disorders. Henri Laborit, a French anesthesiologist, sought a drug for use in the prevention of surgical shock (Caldwell, 1970). In testing one drug preoperatively, he found an unexpected sedation in patients, an effect he described as a "euphoric quietude." Thinking this might be helpful in treating

systems in the human body (Crowe & Scovel, 1996). Energy systems are proposed to be powerfully affected by our emotions and level of spiritual balance as well as by nutritional and environmental factors (Gerber, 1988). The holistic model embraces vibrational healing as a way to balance such energies that are not in equilibrium.

The trend toward a wide variety of experiential therapies has emerged in the latter half of the twentieth century, their purpose being inner growth and self-actualization. There is a burgeoning directory of practitioners of various healing arts including acupuncture, Ayurvedic medicine, biofeedback, chiropractic, craniosacral therapy, herbal remedies, homeopathy, massage therapy, naturopathy, and meditation.

Holistic therapists view themselves as facilitators. Knowledge is freely shared on the assumption that understanding will enable the client to be active in the healing process. The therapist shares personal experiences, creating a more equal therapist-client relationship. The therapist's techniques not only help the client find information but promote techniques to develop self-responsibility, better nutrition, ample rest, stress management, and proper exercise.

The techniques used in this model encourage the client to look within for his or her own healing. See Taxonomy II, *Music Psychotherapy,* D. "Catalytic Music Group and/or Individual Therapy," for a description of techniques aligned with the holistic philosophy. The emphasis here is to encourage the client to reach and explore altered states of consciousness for the purpose of allowing imagery, symbols, and latent feelings to surface from the inner self. The aim is to help the client develop self-awareness, clarify personal values, release blocked intuitive energy sources, bring about deep relaxation, and foster spirituality and self-empowerment.

Change is evidenced in a client's reduction of stress level and removal of pain or dysfunction, as well as an alteration of affect and a demonstration of more patience, harmony, and peace. The integrated client sees himself as a growing, changing person who is self-empowered.

Terminology used in this model includes *self-care, self-empowerment, inner healing, intuitive abilities, self-responsibility, self-examination, self-healing,* and *awareness training.*

## Conclusion

Many theories have been developed to explain mental illness and guide its treatment. Treatment protocols are designed to help the individual reduce or alleviate psychosomatic dysfunction, address socioemotional difficulties, and/or conquer existential anxieties. In any case, each of the approaches presented above has as its ultimate aim the growth and development of the individual, leading to a more satisfactory and satisfying adjustment to life processes. Growth may



mean the expansion of one's horizons, outwardly in perspective and inwardly in depth (Wilbur, 1981).

Ideally, music therapists are able to communicate in the language of the various theoretical models. Many clinicians opt for advanced training in order to practice within insight-oriented approaches. Some espouse a single theoretical model. Others, particularly private practitioners with diverse clientele, adopt an eclectic stance, using a variety of medical, environmental, and psychosocial strategies and influences to help their clients achieve optimum health.

At the heart of both unitheoretical and diverse clinical practice are carefully selected and implemented receptive and active music experiences. Ultimately, the value of music therapy ought not be assessed according to whether it reflects psychodynamic, humanistic, or scientific principles, but rather on the basis of its success in demonstrating outcome data reflecting a patient's recovery of healthy functioning.

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in order to help the client learn to control aspects of functioning and achieve optimum health.

The therapist's primary function in a behavioral approach is to design and implement a treatment protocol that enables the client to attain specific goals and objectives. The therapist assumes an active and directive role that may include setting up a contingency to help change abnormal behaviors.

The behavioral music therapist is concerned with manipulating the musical stimuli to effect a change in observable, measurable behavior. She may use Applied Behavior Analysis (ABA) techniques in order to design individual treatment programs to meet the client's needs. ABA involves observing, identifying the target behavior(s), establishing a baseline, determining strategies for change, implementing the strategies, and evaluating and documenting changes in behavior (Hanser, 1999).

Although used most frequently with children, a behavioral approach to music therapy has been applied to adults with mental disorders. In an early study, Hauck and Martin (1970) demonstrated that time-out from music experiences was effective in reducing the inappropriate mannerisms of a woman diagnosed with schizophrenia.

Overt actions and covert behaviors (e.g., cognitive, social/emotional) can be revealed, examined, and modified through music therapy treatment (Hanser, 1999). For example, the opportunity to play an instrument could be used as a reward for improved client behavior. See Taxonomy I, *Music Performing,* E. "Individual Instrumental Instruction (product oriented)," for an explanation of this technique. In addition, the client may seek to learn and develop a new musical skill or exercise and improve an existing musical skill. The therapist instructs the client in playing techniques, using materials for the appropriate learning level, and assigns practice tasks of which the client is capable. The therapist may use principles of reinforcement to increase desired behavior, both nonmusical and musical. Other techniques used in this model are relaxation training, token economies, modeling methods, systematic desensitization, assertion training, and self-management programs.

Only behaviors that can be observed and measured quantitatively are evaluated within a behavioral paradigm. One criterion for evaluating change is the extent to which learning generalizes to new situations.

Terminology utilized in this model includes *operant conditioning, conditioned response, stimulus, modeling, shaping, cause and effect,* and *positive/negative reinforcement.*

## Holistic Model

The holistic model is based on the assumption that healing comes from within. The body heals itself. The word *holistic* stems from the Greek *holos,* meaning "whole" or "entire," which relates to the words *heal* and *health.*



Unity of mind, body, and spirit is the fundamental principle of the holistic health philosophy, wherein individuals are seen as physical, emotional, mental, and spiritual beings. One major tenet is that in order to activate an individual's own healing process, the individual must take responsibility for all personal experiences including his or her own health. Another tenet is that only when an individual's incessant thinking ceases and he or she experiences stillness of mind can spirit inspire and work, opening the blockages the mind has created (Andrews, 1994).

A cornerstone of alternative medicine is the idea that the mind influences the health of the body—positively and negatively. A principle objective is to identify those currents that generate creativity, healing, and love and to challenge and release those currents that create negativity, disharmony, and violence (Zukav, 1989). Advocates of holistic models frequently advocate merging conventional and alternative medicine openly and intelligently.

According to a well-publicized survey in *The Journal of the American Medical Association,* the total number of visits to alternative-medicine practitioners has leaped by some 50% since 1990. It now exceeds visits to all primary-care physicians in the United States (Weil, 1995).

Siegel (1986) supports complementary and alternative medicine, particularly mind-body healing. His medical practice evolved after he experienced post-traumatic stress disorder, found nowhere to go, and no one to help him deal with his feelings. In overcoming illness, he professes the importance of love, family structure, and the experience of illness. The patterns associated with healing include a willingness to express feelings, change life and relationships, and deal with spiritual aspects (Siegel, 1986).

Pert (1997), a supporter of the mind-body unity school of medicine, assigns a key role to the biochemical basis of emotions. She asserts that unexpressed emotion causes illness. The "molecules of emotion" travel throughout the bloodstream, hooking onto receptors on cells in every corner of the body (Pert, 1997). Intestines are filled with neuropeptide receptors; hence the notion of "gut feelings" is not merely a metaphor, but an actual biological reality. Pert asserts that brain chemicals (neuropeptides) act as messengers between the mind and the immune system and no barriers exist between thoughts, feelings, and one's biological healing system. Furthermore, Pert has also proposed a connection between memory and emotion and that emotion creates the bridge between mind and body. This connection is demonstrated through experiments showing parts of the brain acting as the gateway into the whole emotional experience.

Perhaps the most difficult holistic principle to accommodate in clinical practice is the spiritual dimension and belief in the concept of energies. Many of the sound healing methods are based on theoretical beliefs involving energy

One could assert that Guided Imagery and Music (GIM), although associated most frequently with psychoanalytic constructs, is practiced from a humanistic/ existential stance. In GIM, receptive methods are used to assist the client in the development of self-awareness and insight, clarification of personal values, and exploration of religious and transpersonal realms, among other aims (Bonny & Savary, 1973). Furthermore, the individual "traveler" and his immediate experience of the music are of paramount importance at each stage of the therapeutic journey.

Change is evaluated by determining whether a client has achieved greater independence and personality integration. Progress toward self-actualization is evident when the client is demonstrating an ability to identify factors that block freedom and the spontaneous expression of feelings, as well as taking greater responsibility for choices and actions.

Terminology commonly used in this model includes *experiential, relationship, choice, values, personal responsibility, autonomy, here-and-now, purpose,* and *meaning.*

## Biomedical Model

The biomedical model defines mental disorder as a biologically based illness. Biomedical researchers consider three possible causes of an illness: germs, genes, and biochemistry (Rosenhan & Seligman, 1984).

Medical theories tend to place the nature and cause of mental illness in the person's biological nature. It is believed that underlying the symptoms of abnormal behavior are organic, physiological, or biochemical processes (Ruud, 1980). In determining the etiology of psychological abnormalities, those who adhere to the biomedical model search for an organic basis. They look for a germ that is causing the syndrome or study the client's family history to see if genes might be the cause. They also explore the biochemistry, specifically the brain, for any further insights that might explain the illness or abnormality.

Within the biomedical model, the therapist's role is to study the etiology, work toward understanding the diagnosis, and recommend and provide treatment based on a thorough understanding of the illness. Once the etiology is identified, a biological treatment—often a drug—will be used to mitigate the symptoms. For example, pharmacological treatment of an individual with chronic depression might include tricyclic antidepressants or monoamine oxidase inhibitors. Sometimes electroconvulsive therapy is used. A patient diagnosed with an anxiety disorder may be prescribed antianxiety drugs typically classified as benzodiazepines. Psychotropic medication is frequently prescribed to reduce the distractions, confusion, hallucinations, and delusions typical of schizophrenia.

Music therapy, as a complement to traditional medical treatment, may impact directly the biological processes related to illness or help manage the concomitant symptomatology (Taylor, 1997). Recent research indicates that music listening may be effective in altering body chemistry. For example, some studies have linked receptive methods with lowered levels of adrenal secretions present in stress reactions, such as epinephrine, norepinephrine, and cortisol (Bartlett, Kaufman, & Smeltekop, 1993; Miluk-Kolasa, 1993; Spintge & Droh, 1987). Receptive methods such as guided music listening are described in Taxonomy II, *Music Psychotherapy,* A. "Supportive Music Group and/or Individual Psychotherapy" and B. "Interactive Music Group and/or Individual Psychotherapy." Because of the close relationship between adrenal corticosteroids (stress hormones) and the immune system, data suggest a correlation between music-assisted relaxation techniques and physical health (Rider, Floyd, & Kirkpatrick, 1985). For a description of these techniques, see Taxonomy VI, *Music and Relaxation.*



Terminology used in this model includes *medical model, genetics, germs, biochemistry, psychoneuroimmunology,* and *psychopharmacology.*

## Behavioral Model

The behavioral model was first developed in the early twentieth century. Between 1920 and the middle of the century, behaviorism dominated psychology in the United States and also had wide international influence. The initial effect of behaviorism on psychology was to minimize the reflective study of mental processes, emotions, and feelings. These covert processes were abandoned in favor of the study of objective behavior of individuals by means of experimental methods. This orientation provided a way to relate human and animal research and to bring psychology into line with the natural sciences such as physics, chemistry, and biology (Bijou, 1996).

B. F. Skinner, a pioneer in the development of this model, views psychology as the study of the observable behavior of individuals interacting with their environment. Skinner's notion of controlling and modifying behavior is based on the principles of *operant conditioning,* the assumption being that changes in behavior are brought about when that behavior is followed by a consequence. Behavioral theory posits that learning or relearning occurs only when some kind of consequence is paired with the learning. *Reinforcement,* either positive or negative, serves to increase behavior, while *punishment* serves to decrease or extinguish behavior.

Today, behavioral therapists apply learning theory to a variety of practical problems. The mechanistic approach of earlier behavioral practices has largely been replaced with a more functional application of the concept of *stimuli-response* that has meaning and utility for the individual client. For example, in biofeedback, a modification technique developed in the 1940s, the client is "fed back" visual or audible signals about what is occurring in his or her body

or idealistic accounts of human experience, songwriting may be employed to dispute irrational thinking and encourage rational thinking. Learning of new responses occurs when emotional reactions are reinforced by repetition of lyrics. Ultimately lyrics become associated with actual, logical, emotional, and physical action (Maultsby, 1977).

Perilli (in Bruscia, 1991) describes the use of this creative method with a young woman diagnosed with schizophrenia. The songwriting helped the client gain insight into her irrational fears and engage in personal problem solving.

Other techniques used in cognitive approaches include homework to test new assumptions, open-ended questions, role-playing, and imagery. In this orientation, clients' imagery is considered to be representative of cognitive processes, including distortions, and is thus subject to modification (Corsini & Wedding, 1995). See Taxonomy VI, *Music and Relaxation*, C. "Music Imagery" for a description of music interventions that may be successful in eliciting imagery.

The terminology used in cognitive approaches includes *unconditional shoulds, absolutistic musts, self-defeating, self-indoctrination, judging, crooked/stinking thinking,* and *new self-statements.*

## Humanistic/Existential

The humanistic/existential view of disorder has been described as an outcome of the failure to grow, find meaning in life, and be responsible for oneself and others. Humanistic/existential theories are concerned with defining the needs that are central to human functioning. Abraham Maslow, one of the earliest and most influential humanistic thinkers, stood in opposition to Freudian and behavioral theories of human nature (Corsini & Wedding, 1995). He described human needs in terms of a pyramid, a hierarchy of basic needs ranging from biological necessities to *self-actualization,* that is, the tendency of every human being to strive toward wholeness and fulfillment. The actualized individual is a purposeful creature capable of making and acting on plans, strategies, and choices. When self-actualization is thwarted, some type of disorder may result, and the individual may be unable to successfully confront the most basic of all life questions: What is the meaning of life? How can I live up to my fullest potential? How can I face death?

This model does not offer specific technical procedures for the treatment of mental disorders; rather, it suggests a manner of being, an attitude toward change, and a way of guiding the client through the process of dealing with the fundamental issues of human existence. The existing, immediate person, rather than a prepackaged theory about that client, is the focus of all therapies claiming humanistic/existential roots, such as Gestalt therapy (Perls) and Person-Centered therapy (Rogers).



Rogers posited a number of distinctive "therapist-offered" conditions thought to be critical for client development. These include *empathy* (getting within and understanding the client's experience), *unconditional positive regard* (acting in a warm, accepting, and caring fashion), and *congruence* (a willingness to be open and honest in sharing feelings arising in the therapeutic context) (Corsini & Wedding, 1995). The therapist's role is to be immediately accessible to the client and to focus on the here-and-now experiences created in the therapeutic relationship. A respectful, attentive, caring, and understanding attitude will assist the client in breaking down barriers and achieving more satisfying levels of personal functioning.

Again, rather than prescribing specific methods or techniques for treatment, the humanistic/existential paradigm suggests a process that is grounded in genuine care and concern for the immediate human needs of the client. The humanistic/existential music therapist uses music as a tool to elicit and identify those needs as well as stimulate and support the actualization process. Various methods, both active (creative, recreative, and improvisation) and receptive (listening) (Bruscia, 1998a), are thus valid choices in the service of these aims.

Creative Music Therapy, developed by Paul Nordoff and Clive Robbins, espouses the fundamental tenets of humanism. Creative Music Therapists make extensive use of improvisation as a means of fostering the emergence of the essential core of the human being (Nordoff & Robbins, 1977). In this approach, music and musical expression is viewed not as "symbolic representations of something else but instead as direct manifestations of the self" (Aigen, 1998, p. 296). Although evolving from Nordoff and Robbins's work with children who were mentally and physically impaired, Creative Music Therapy has been used in the treatment of adults with emotional difficulties as well (Ansdell, 1995).

Van Den Hurk and Smeijsters (in Bruscia, 1991) described the use of improvisation in Person-Centered work with an adult diagnosed with a personality disorder. Some aims of therapy were to help the client abandon rigid response patterns, take responsibility, make choices freely, enjoy music making, and reduce interpersonal isolation. Techniques of empathy (e.g., imitating, synchronizing, pacing, and reflecting) (Bruscia, 1987) were used throughout treatment in order to create a safe environment and support the expression of emotions. See Taxonomy I, *Music Performing*, G. "Individual Music Improvisation/Interaction (process oriented)" for an explanation of similar improvisatory techniques.

Success and accomplishment through music instruction and performance experiences may contribute to a client's sense of mastery and power, thereby increasing confidence and self-esteem. It may benefit the individual to learn to accept the responsibility of practice as a self-imposed task and relate personal effort to an aesthetically satisfying musical result. Examples of these techniques are found in Taxonomy I, *Music Performing.*

category are designed to stimulate intrapsychic material such as thoughts and feelings related to the client's past and present life. Through catalytic music experiences, the patient is encouraged to learn and grow emotionally by tackling problems on a more realistic level (Tyson, 1981).

Bruscia (1998b) identifies improvisation as one of three types of music experience frequently employed within a psychodynamic orientation to therapy. In improvisation, the client creates music spontaneously with instruments and/or the voice as an outlet for the expression of various emotional states (e.g., frustration, elation, anxiety). Through improvisation, the client is free to express any and all aspects of himself; hence, this method may be considered a means of "free-associating with or projecting oneself onto sounds" (p. 5).

In Analytical Music Therapy, a specific approach developed by Mary Priestley and colleagues in the 1970s, improvisation is combined with movement and verbal processing. The therapist provides elementary musical structures or forms within which the client approaches and experiences difficult emotions. The improvised music "moves into the body and works on a kinesthetic level to open up blocked feelings and give access to repressed memories" (Warja, 1994, p. 79). Ego strength, that is, reality-based conscious control, may be developed through improvisatory expressive techniques such as reality rehearsal, affirmations, and programmed regression. Priestley cites freer self-expression, increased self-respect, diminution of symptomology, more satisfying relationships, and increased energy as benefits to be gained through Analytical Music Therapy processes (Priestley, 1994).

Another technique frequently used in the psychodynamic approach is music imaging, including but not restricted to the Bonny Method of Guided Imagery and Music (GIM) (see Taxonomy II. *Music Psychotherapy,* C. "Catalytic Music Group and/or Individual Therapy"). In GIM, carefully selected and ordered classical music selections are used receptively to move the client into altered states of consciousness where emotional themes may emerge through various forms of imagery. The therapist, specially trained, guides the client in a supportive fashion, reflecting, encouraging, and augmenting the imagery experience (Bonny, 1994).

Terminology used in the psychodynamic model includes *unconscious conflict, analysis, defense mechanisms, id, ego, superego, psychosexual development, oedipal stage, transference,* and *countertransference.* Terminology common to Jungian theory includes *myths, archetypes, Self, ego, shadow, persona, anima/animus,* and *individuation.*

## Cognitive Model

There are several cognitive models used in the treatment of adults with mental disorders. Each of them holds that life disturbances spring from



disordered thinking about oneself and the world. Many cognitive models are an outgrowth of and reaction to the behavioral perspective. The forerunner is Rational Emotive Behavior Therapy (REBT), developed by Albert Ellis. Maultsby's Rational Behavioral Therapy, Beck's Cognitive Therapy, Glasser's Reality Therapy, and Berne's Transactional Analysis are other specific therapeutic approaches with cognitive roots. Each of these models stresses the importance of cognitive processes as determinants of feelings and behaviors.

REBT is based on the assumption that human beings are born with a potential for both rational, self-constructive thinking and irrational, self-destructive thinking (Corsini & Wedding, 1995). Furthermore, emotions stem from beliefs in, evaluations and interpretations of, and reactions to life situations. More specifically, an *Activating Event* (A) triggers a charged emotional *Consequence* (C), mediated by the client's *Belief System* (B). For example, a client who has been diagnosed with an anxiety disorder (A) may believe that she will never be able to secure employment as a result of the disorder (B); this may lead to feelings of depression and further anxiety (C). *Debating* irrational beliefs (D) is the point of intervention, and *New Effect* (E) is a culmination of the therapeutic process (Bryant, 1987).

In REBT, clients learn skills that help them identify and dispute any acquired irrational beliefs that are prolonged by habit or self-indoctrination. Thus, an important component of the REBT conceptualization of human behavior is the detection of such irrational beliefs, often referred to as "magical," "crooked," or "stinking thinking." The "musts," "shoulds," and "oughts" in clients' thoughts and words may reveal rigid, unrealistic thinking that involves self-imposed demands. In thinking more rationally, clients are empowered to change self-damaging emotional responses into more positive reactions of their own choosing.

The REBT therapist serves as a guide yet does not believe that a warm therapeutic relationship is necessary for effective personality change to occur (Corsini & Wedding, 1995). The therapist's role is to identify and challenge self-defeating ideas that the clients have come to accept as absolute truth. The clients are then assisted in adopting and practicing new, healthier responses.

A cognitive-based music therapist might structure experiences that allow for verbal processing of individual and/or group reactions to musical material, as in guided music listening experiences, described in Taxonomy II, *Music Psychotherapy,* A. "Supportive Music Group and/or Individual Psychotherapy" and B. "Interactive Music Group and/or Individual Psychotherapy." Guided music listening often leads to a discussion of lyric content, the music's mood, and associations with past experiences of personal relevance to the individual's conscious conflicts. Maultsby (1977) maintains that the therapeutic value of music resides exclusively in lyrical forms and that such forms must be rational. As the lyrics of many precomposed songs revolve around unrealistic

(position awareness) feedback from his body when playing an instrument and singing; and *intuiting*, to get into the very essence of the composer's inspiration (Priestley, 1975).

Table 8–1 Psychotherapeutic Models

| | PSYCHODYNAMIC | COGNITIVE | HUMANISTIC/ EXISTENTIAL |
|---|---|---|---|
| Major Contributors | Sigmund Freud (1856–1939)<br>Alfred Adler (1870–1937)<br>Carl Jung (1875–1961)<br>Erik Erikson (1902–1994) | Eric Berne (1910–1970)<br>Albert Ellis (1913– )<br>Aaron T. Beck 1921– )<br>Maxie Maultsby (1932– )<br>William Glasser (1925– ) | Fritz Perls (1893–1970)<br>Carl Rogers (1902–1987)<br>Abraham Maslow (1908–1970) |
| Definition | Disorders are driven by hidden conflicts within the personality | Disorders come from irrational thinking about self and others | Disorders are the outcome of failure to grow, find meaning, and be responsible for self |
| Therapist Role | Foster transference, make interpretations | Act as guide, challenge notions that are self-defeating | Offer total and unconditional acceptance, focus on here-and-now |
| Therapist Techniques | Analysis of symbolic material (dreams, imagery), free association | Rational challenging, homework to test assumptions, change of language | Hone expression to help person move to higher level of functioning |
| Evaluate Change | Insight into and resolution of conflict leads to personality change | Problems eliminated by changing thoughts that promote them | Client identifies and addresses factors that block actualization and freedom |
| Terminology | conflict, analysis, defenses, id, ego, superego, psychosexual, transference, countertransference, myths, archetypes, shadow, persona, anima/animus, individuation | unconditional shoulds, absolutistic musts, self-defeating, self-indoctrination, judging, crooked thinking, new self-statements | experiential, relationship, choice, values, autonomy, here-and-now, purpose, meaning |



For a description of music experiences that are used to reorganize the personality structure of the client, see Taxonomy II. *Music Psychotherapy*, C. "Catalytic Music Group and/or Individual Therapy." Techniques in this

| | BIOMEDICAL | BEHAVIORAL | HOLISTIC |
|---|---|---|---|
| Major Contributors | Paul Ehrlich (1854–1915) | B. F. Skinner (1904–1990) | B. Siegel (1932– )<br>A. Weil (1942– )<br>C. Pert (1946– ) |
| Definition | Disorders are illnesses of the body due to germs, genes, or biochemistry | Learning/relearning occurs when it is paired with consequence Dis- | orders result from lack of unity of mind, body, and spirit |
| Therapist Role | Understand and recommend treatment based on diagnosis | Act in directive manner, provide treatment protocol to attain goal | Enable client to be active in the healing process |
| Therapist Techniques | Address relationship between psychosocial and neurophysiological processes | Applied Behavior Analysis, modeling, contingent reinforcement | Promote techniques to develop self-awareness, healthful nutrition, proper rest, stress management, and exercise |
| Evaluate Change | Find germ, gene, or biochemistry causing the disorder | Learning generalizes to new contexts | Client sees self as growing and changing and self-empowered, reduced level of stress and pain, increased peace of mind |
| Terminology | medical model, genetics, germs, biochemistry, psychoneuroimmunology, psychopharmacology | operant conditioning, conditioned response, stimulus, modeling, shaping, cause and effect, positive/negative reinforcement | self-care, self-empowerment, inner healing, intuitive abilities, self-responsibility, awareness training |

establishment of musical and nonmusical goals and objectives. With proper training and guided by therapeutic intent, the music therapist selects and implements various methods, procedures, and techniques (Bruscia, 1998a). Outcome evaluations will determine the effectiveness of such interventions. Clinical decisions made during each phase of the treatment process must be clearly guided by assessment, research data, the level of practice, and the psychotherapeutic model.

Current models have limitations in explaining causes and symptomatology of all mental disorders. However, no matter which model is used, the therapists working with a client who has been diagnosed with a psychiatric disorder will base their understanding of the features and etiology of the disorder on the various axes of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association *(DSM-IV-TR)*.

The six major models commonly used in the treatment of individuals with mental disorders are psychodynamic, cognitive, humanistic/existential, biomedical, behavioral, and holistic (see Table 8–1, p. 120).

The biomedical model, with its emphasis on biological processes, is not literally a psychotherapeutic approach. However, it has been included here because of its prominence in the treatment of mental disorders and the increasing interface of music therapy with medical protocols. Similarly, behaviorism in its purest form has as its focus overt and quantifiable responses rather than underlying psychological processes, yet is included here because of the widespread use of behavioral techniques within other models. The sixth paradigm, holistic, has been addressed because of the strong influence of the holistic health movement with its emphasis on consideration of all relevant information about the life of an individual as a biological, psychological, social, and spiritual organism.

Sometimes the various models are complementary, but often they are incompatible in their attempts to understand and promote optimum health. Terminology varies tremendously in descriptions of the tenets of each model as well as in language used by the therapist and/or client in clinical practice. For example, one therapist may refer to an individual as a "patient"; this same individual may be called a "client," "resident," or "consumer" within another approach (Bruscia, 1998a). Likewise, use of terms such as "abnormality," "disorder," "disease," and "maladaptation"—all designed to reflect a departure from or disruption in health—may vary according to treatment orientation. (Where appropriate and feasible, language used in this chapter is congruent with terminology in the *DSM-IV-TR*.)

This is a cursory description of the basic tenets of each of the six models. The definition of disorder, mechanisms of change, and the therapist's role within each perspective are presented, along with music therapy methods, procedures, and strategies aligned with each model.



## Psychodynamic Model

The psychodynamic treatment approach is based on theoretical constructs developed and refined by Sigmund Freud during the first quarter of the twentieth century; however, more modern views of this model exist today based on his work and that of Alfred Adler, Carl Jung, Erik Erikson, and others. The psychodynamic orientation holds that an individual's psyche functions at various levels of awareness, including *unconscious, preconscious,* and *conscious.* Jung, who constructed an analytical personality theory based on the work of Freud and Adler, posited two different kinds of unconscious. The *personal unconscious* contains an individual's repressed experiences since conception. In contrast, the *collective unconscious,* which Jung later termed the *objective psyche,* is comprised of inherited and shared human experiences and is made manifest in archetypal images, dreams, and symbols (Corsini & Wedding, 1995).

According to Freudian theory, unresolved emotional conflicts relating to an individual's instincts, early childhood experiences, and memories reside in the unconscious and are thought to be the source of personality abnormality. From this perspective, the reconstruction of personality structures is necessary for health to ensue. Thus, two fundamental goals of psychodynamic therapy are to bring repressed unconscious material into the individual's awareness and to move toward corrective emotional experiences through the processes of *transference* and *countertransference* (Bruscia, 1998b).

Simply put, transference occurs when a client transfers patterns of responding from one time period and/or context to another (i.e., the dynamics of significant relationships from the client's past are replicated in therapeutic encounters). Likewise, countertransference is said to be operating "whenever a therapist interacts with a client in ways that resemble relationship patterns in either the therapist's life or the client's life" (Bruscia, 1998c, p. 52). Analysis of transference, which occurs many times and in many ways, sheds light on how the client relates to the present in terms of the past and helps him respond in a more mature and realistic manner (Corsini & Wedding, 1995).

The therapist's role in a psychodynamic treatment approach is to demonstrate qualities such as self-confidence and controlled emotional warmth. As the therapeutic focus shifts from the identification of conflicts to the working through of those conflicts, the therapist's role may change from an analyst to that of an ally and active supporter. Techniques frequently used by the therapist include interpretation, dream analysis, free association, analysis of resistance, and analysis of transference and countertransference processes.

Music experiences may be used in addition to or in place of typical verbal methods of psychoanalysis (Bruscia, 1998b). According to Jung, performing music requires all four functions of the psyche: *thinking,* to turn the notes into music; *feeling,* to give the music expression; *sensing,* in the person's proprioceptive

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Chapter 8

# Music Therapy within the Context of Psychotherapeutic Models

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## Introduction

Music therapy clinical practice occurs at various levels. Wheeler (1983) has classified the treatment of adults with mental disorders into three types: music therapy as an activity therapy, insight music therapy with reeducative goals, and insight music therapy with reconstructive goals. Activity-based therapy is aimed at helping the client reach observable, measurable goals through various forms of music experiences. In contrast, the two remaining levels focus on facilitation of change through personal insight gained via musical experiences and verbalization about those experiences. Insight-based music therapy processes are ordinarily more intense and prolonged, in that deep emotions are evoked, and in the case of reconstructive therapy unconscious material is accessed. However, all three levels are valid treatment approaches. The type of music therapy used in any given clinical situation will depend on the individual needs of the client population, the philosophical orientation of the treatment facility, and the therapist's education and training (insight music therapy obviously requiring more advanced training than activity-based treatment).

Music therapy clinical practice also occurs within the framework of many different psychotherapeutic models. A model is a device for generating ideas, for guiding conceptualization, and therefore, generating explanation (Reed, 1984). In particular, psychotherapeutic models aid in scientific understanding of human response and guide therapeutic methods.

Diversity of practice is a strength of the music therapy discipline in that the therapist is not restricted to one philosophical orientation, but may base treatment approaches on the particular needs of the clients and the demands of the particular work setting.

No matter what level or model is espoused, the music therapy treatment process involves referral, initial assessment of client strengths and deficits, and