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15 The development of clinical music therapy in adult mental health practice

Music, health and therapy

Case study

Helen Odell-Miller

Music therapy is interdisciplinary. It bridges art, science and many areas within the two including neurology, psychology, musicology, psychoanalysis, humanities and medicine. In this chapter I outline some current practices, research and changing trends in the professional practice of music therapy in Britain since 1945, and international influences upon these changes. I consider examples of how professional organizations, changing trends in clinical practice and research have contributed to the current position of music therapy as an important treatment in the twenty-first century. I then turn to examine clinical material, with a focus upon adult mental health populations for people without obvious organic brain damage. I write from the perspective of a clinician, researcher, trainer and developer of the profession.

The practice of music therapy

While most professional developments in music therapy have occurred after the Second World War, it is important to note the roots and early emergence of this phenomenon. Music therapists such as Helen Tyler (2000), Rachel Darnley-Smith (Darnley-Smith and Patey 2003) and Alison Barrington (2005, 2008) have comprehensively discussed aspects of the early history and development of the profession. Music was described in the thirteenth century as a central healing agent in connection to the liturgy of St Cecelia, who is now known as the patron saint of music. St Cecelia had been known for singing from the heart and for her passion about music as an access to emotions, an important concept in music therapy. Thomas Connolly (1955) describes the work of the Harford Group who, in 1891, formed the Guild of St Cecelia where musicians performed to sufferers of many types of medical and mental conditions, in order to alleviate symptoms. Darnley-Smith (2013) also draws attention to early twentieth-century publications such as the influential *Cambridgeshire Report on the Teaching of Music* (1933). Compiled by a panel of distinguished

composers, teachers, musicians and academics, its findings advocate three important ideas that can demonstrate a link with the post-war music therapy practice that was to come. It suggests that music is good for people on an everyday basis: that it brings communities together on many levels and as 'the greatest of all spiritual forces' meets many needs (CCME 1933: 11).

After the Second World War, music therapy was defined as a form of help towards lifting mood and encouraging motivation and physical activity for war veterans in the USA and in the UK (Bunt 1994). Musicians and music educationalists discovered how performance of music made connections and sometimes appeared to even have healing potential – initially with war veterans and prisoners and for children with special needs, and later for wider populations. In the UK this work developed primarily from musical roots, for example, through the work of cellist Juliette Alvin and composer Paul Nordoff, who worked in partnership with music educator Clive Robbins. Through their work and other developments, outlined below, music therapy emerged into a registered profession.

In the immediate post-war period, UK and USA definitions of music therapy focused upon the use of music as an agent of change for educational and behavioural or remedial purposes. Such behavioural approaches remained prevalent in the USA into the late-twentieth century. In 1989 Ken Bruscia, an American pioneer of music therapy, noted that '[m]usic therapy is a process. It is a sequence of events that takes place over time, for both the client and therapist, and in both musical and non-musical areas' (Bruscia 1989: 48). This definition hinted at the relationship between patient and therapist by suggesting change in both parties, but without explicitly using psychoanalytic concepts. His sequential emphasis suggested a pattern of cause and effect, which reflected the then prevalent behavioural approaches found within treatments in the USA.

Such behavioural models did not retain their dominance in late-twentieth-century Britain, where approaches to music therapy were instead increasingly drawn from psychodynamic and psychoanalytic psychotherapies, while active music making remained central. Recent UK definitions of music therapy draw upon psychoanalytic terminology in emphasizing that music therapy provides 'a safe setting where difficult or repressed feelings may be expressed and contained. By offering support and acceptance the therapist can help the client to work towards emotional release and self-acceptance' (Odell-Miller and Sandford 2009: 2). This definition of music therapy incorporates concepts from psychoanalytic tradition and shows how its practice might concentrate on internal process and mental functioning. The use of countertransference is central to this theoretical model, including musical countertransference (Odell-Miller 2001), in enabling the music therapist to understand further the inner world of the patient.

These growing links between music therapy and psychoanalysis can be related, in part, to the devolution of psychiatric services from asylums into the community in the late 1960s. A therapeutic community movement and

emphasis upon psychotherapeutic treatments for severely ill people, partly as a result of new psychotropic drug treatments and the encounter group culture from the USA, led to mainstream provision of psychotherapy within forensic and psychiatric settings, burgeoning during the 1970s and 1980s. In the UK the arts therapies developed discrete services with models such as at Fulbourn Hospital (Odell-Miller 1995; Darnley-Smith 2013). The profession became highly influenced by developments in psychotherapy, borrowing many of its concepts (Odell-Miller 2001; John 1992), while retaining music making as a central focus. Clinical supervision became central to practice, with concepts from social work (Hawkins and Sohet 1989) and general psychotherapeutic practice becoming influential. Subsequently the profession developed its own sophisticated models of supervision (Forinash 2001; Odell-Miller and Richards 2009), and in 2005 music therapy and other arts therapies were categorized in the 'major modalities' section in the *Oxford Textbook of Psychotherapy* (Schaverien and Odell-Miller 2005).

Within this psychoanalytical framework, music therapy has not only been used in an individual therapist-patient model. Music therapy in mental health services has increasingly focused upon group work, particularly through influences from the therapeutic community movement (Clark 1996; Odell-Miller 2002). 'Therapy' itself has also been broadly defined as including community change or enrichment of life (Priestley 1975; Ansdell 2002; Ansdell 1999), as helping to improve specific conditions such as communication difficulties (Alvin 1975; Nordoff and Robbins 1977) and more broadly as aiding the ability to cope with illness or stress (Wigram and De Backer 1999). Music is a social activity and when used in groups, members in music therapy can learn more about how to understand others and relate to them – both within therapy and outside in their lives (Davies and Richards 2002). Such music therapy does not resist or seek to replace medical intervention.

Although the acute medical community in the UK has not embraced music therapy in the same way as in the USA, medication works alongside music therapy and other psychological treatments in good practice. Mary Priestley (1975) advocated its use in a psychiatric in-patient setting at the outset of music therapy treatment in UK psychiatry, while more recently there has been an emphasis on Community Music Therapy approach as described by Mercédès Pavlicevic and Gary Ansdell (2004). A music therapy approach to the Tea Dance (Odell-Miller 1997) had also been established in the literature as part of music therapy tradition for some decades, which fits into the recent categorization of Community Music Therapy as described by Pavlicevic and Ansdell (2004).

Up to this point I have identified some differences between the origins and development of music therapy in the UK with that of other countries, which have also served to shape the profession and its practice in a unique way. In 2000 the Association of Professional Music Therapists (APMT)

emphasized the role of musical improvisation and a flexible approach to therapy as means to bring about change for a patient. This improvisation model can include using composed and pre-composed music, as the music is adapted to suit the people undertaking therapy in the moment. Thus the intention and process rather than the end product is emphasized within music therapy, as in many forms of arts-based intervention discussed within this volume. The APMT stated that '[m]usic therapy provides a framework in which a mutual relationship is set up between client and therapist. The growing relationship enables changes to occur, both in the condition of the patient and in the form that the therapy takes' (APMT 2000: 1).

This approach is strikingly different from the USA and Australia, where receptive techniques are prevalent. Grocke and Wigram (2007) in their book *Receptive Techniques in Music Therapy* show the efficacy of receptive approaches, but their absence in UK music therapy is probably owing to a strategy and desire by early UK pioneers to use the highly musically skilled approaches that other health professionals might not be able or trained to execute. This development suggests why there has been criticism within clinical services of territorial and exclusivity arising from the professionalizing of music therapy, details of which are discussed by Barrington (2005, 2008) and Darnley-Smith (2013). However, music therapists have often worked together with artists and arts therapists, leading national initiatives and becoming involved in debates about artists and arts therapists such as within the first Standing Committee for Artists and Arts Therapists (1990), and later The Nuffield Trust initiative clarifying the roles and boundaries of different groups involved in the arts (Coats 2004).

The profession of music therapy

Music therapy is now a legally registered profession. This would not have been possible without establishing music therapy as a formal profession, demanding documentation of competencies, curricula for basic training and continuous professional development (CPD). I argue that these structures, if applied humanely and thoughtfully, provide a safe necessary boundary that helps members of the public to access music therapy, raising its profile positively. While there could appear to be direct conflict between therapy and medicine, staying close to medicine in terms of valuing the work as 'paramedical', and later 'allied to medicine', was seen as crucial by leaders of the profession. In order to achieve the 1982 Whitley Council career structure agreement for music therapists and art therapists within the National Health Service (NHS), the then main employer of music therapists, it was necessary to gain signatures from medical practitioners and to provide an evidence base that music therapy is a profession. The professional developments outlined here were facilitated through the development of professional bodies, formalization of training and pressure on government for registration – I will consider these briefly here in turn.

In the UK, the Society for Remedial Music Therapy (later the British Society for Music Therapy) was founded in 1958 by the music therapist Juliette Alvin and the Association of Professional Music Therapists in Great Britain (APMT (Great Britain)), was formed in 1976. The latter aimed to protect and fulfil the professional needs of training and qualified music therapists in the UK. These two organizations have always worked closely together and amalgamated in 2011 to form one new organization, the British Association for Music Therapy. However, such organisations were only a first step in the process of professional recognition – which also required more formalized training and a registration process.

The first training courses in music therapy were at the Guildhall School of Music and Drama (1968) and Nordoff and Robbins established short courses at the same time. The Nordoff Robbins short courses culminated in a centre and full-time course led by Sybil Beresford-Peirce and later Pauline Etkin from 1974 onwards. Such training has developed further over the last 40 years. The first MA in music therapy was established in 1994 at Anglia Polytechnic University (now Anglia Ruskin University), Cambridge. This began the development to establishing full-time MAs (two years) as the registration point for music therapists in the UK, along with Art Therapy and Dramatherapy. Higher-level research at PhD and Professorial level has also become possible in the last two decades. As of 2013 there are seven UK training courses all approved by the Health Care Professions Council (HCPC) and a well-established reputation in universities such as City University and Roehampton University in London, University of Western England in Bristol and Anglia Ruskin University in Cambridge. The process of approval by the HCPC has served to establish some uniformity within training programmes, for example, with competencies for musical standards of proficiency and core curriculum requirements. Music therapy's professionalization in the UK thus responded to specific local requirements, although taking a similar form to professionalization elsewhere in terms of a process of formalization, centralization and increasing uniformity in training.

Music therapy was first established as a profession supplementary to medicine through the Council for Professions Supplementary to Medicine (CPSM), recorded in Hansard parliamentary debates (HL Deb. 1997). From 2000, when a strategic launch of the Allied Health Professions (AHPs) took place, examples from music therapy research, career progression and clinical work were included in major documentation (DOH 2000a and 2000b). The Health Professions Council[1] later registered music therapy (from 2003), which succeeded the CPSM. While some concerns were expressed about the possible loss of freedom within the music therapeutic relationship as a result of registration, pioneers such as Diane Waller from the British Association of Art Therapists, Tony Wigram on behalf of the Association of Music Therapists, others and myself joined forces in order to negotiate with the government. We believed that establishing arts therapies

as professions in their own right, and as legally registered, would provide a richer more stable and widely accessible service for the public. Through the Whitley Council agreement and later Agenda for Change (2003) – the pay system for ensuring a fairer, clearer system for all in the NHS — we also fought for the best appropriate pay and conditions for music therapists and other arts therapists. Music therapy was now firmly established as a mainstream therapy.

I do not wish to present an unproblematic teleological narrative of professionalization here. Indeed, early pioneers such as Juliette Alvin and Sybil Beresford-Peirce found it extremely difficult to see the need for professionalism, and much heated debate and argument was had within the then APMT in Great Britain in consequence. Some were concerned that the improved conditions would be too expensive and that arts therapists would be priced out of the market, a prophecy that to some extent has been realized during the economic downturn in recent years leading up to 2013. There are also counter-arguments to the benefits of state regulation and professionalism. Barrington (2005) writes from a sociological point of view and questions whether the patient's or client's view is lost while the professional aspects of music therapy are developed. She concludes that neither the patient's or client's view is lost through professional developments, but describes critiques of Procter (2004) and Ansdell (2002), the latter in a discussion about the emergence of Community Music Therapy.

Ansdell suggests that there is a danger of reducing the therapeutic and musical freedom of music therapists and imposing restraints upon them through professionalization, rather than the intended effect of protecting the client. Barrington, however, convincingly argues that professional organization and image can have a positive aspect and provide a framework within which music therapists can provide better access to treatments for patients. As one of the prime innovators of professionalization of the music therapy profession I hold an even firmer view, which is that without this professional status there would be fewer established posts and fewer people receiving music therapy in the UK.

Clinical considerations in recent thinking and practice

There is no longer any question about whether music therapy is a profession, as posed in the 1980s. However, there are now questions about the type of profession that music therapy has and should become. In her important research into the development of the music therapy profession, Alison Barrington (2005) discusses in detail how the profession moved from a small group of individual practitioners across the UK, to a professionally accredited cohesive group. It is striking that during the last half century music therapy has moved from being defined as 'remedial' practice, which sounds rather applied and clinical, to the current description on the British Association for Music Therapy website that UK arts therapists

are 'reflective practitioners' who are trained in psychological development and treatment delivery. Music therapy involves the therapist and patient making music, or listening together, or one listening to the other, with an emphasis upon what can be learned, changed or alleviated by the process. Sometimes known as music psychotherapy (John 1992), it draws upon behavioural, psychoanalytic, musicological–neurological, sociological and pedagogical frameworks.

The professional practice of music therapy in the UK has always demanded that music therapists were highly skilled musicians, who often worked as performers alongside their professional work as clinical music therapists. In the late-twentieth century there has been widespread tension and debate about the extent to which music is therapeutic in itself and how much the context, application, process and non-musical elements drive the therapy. A selection of published literature from the turn of the millennium typifies debates between music therapists, which included discussions about: psychotherapy and psychoanalytical concepts; the use of verbal interpretation; whether musical technique might be impaired or interrupted by too much attention to medical, psychological or clinical phenomena; and the relative value of composed music and improvisation (for example, Aigen 1999; Ansdell 2002; Barrington 2005; Brown 1999; Odell-Miller 2001, 2003; Pavlicevic 1999; Streeter 1999). The rationale and process of music therapy that I present below must be situated in the context of such debates, as an interpretation based on the available evidence and my own experience rather than a given 'truth'.

I now wish to consider the clinical rationale, process and purpose of music therapy. It is perhaps obvious to think about why musical relationship might be helpful to a child who cannot speak, when the non-verbal qualities of musical and playful dialogue found in mother–infant interaction are the basis for encouraging development and attachment. The value of music therapy for people suffering from Alzheimer's disease may also be self-evident, in terms of connecting to an innate musicality rather than depending on cognitive function. It is perhaps less clear why music therapy is a valuable treatment for those grappling with mental illness such as schizophrenia, personality disorder or depression, in which people are often highly verbally articulate and intellectually advanced in their thinking. The answer lies in the value of music therapy for emotional engagement. Therapists can play music with patients, or listen to and experience music created by patients, to better understand their emotions and how they interact with the world. These experiences and the emotions associated with them can then be made more meaningful through subsequent discussions. Such therapy does not necessarily work in a consistent way, and this chapter later demonstrates that there may be differences in the way people need to use music depending upon their diagnoses. Self-reflection may also be unsettling for some patients, but the ultimate goal of each different process remains therapeutic. Ultimately, group members engage with

music and emotions to learn how to take better care of themselves and develop concern for each other.

A case study throws up questions about the boundaries between the music for health approach and the professional practice of music therapy. In one case from my practice, a patient moved through group musical improvisation to using composed songs as a means to develop her self-confidence. The early group improvisation helped her to understand her inner world, which led to her becoming discharged from a psychatric unit, and able to live independently in the community with her three young children. She used bongo drums often to help herself think about her mood and affect, and also to connect with others in a way which, she said, relaxed her as she did not have to always talk. The patient had joined a community choir during her time as an outpatient on the unit, and sometimes she talked longingly about wanting to improve her skills as a singer. At the end of the group therapy, she asked to start singing lessons and I put her in touch with an excellent and sensitive singing teacher. In two follow-up appointments after the ending of group therapy, she brought songs to show me her progress and I accompanied her on the piano, reflecting her movement and journey into her much higher sense of worth and esteem, and towards expanding her performances to solo work within her choir. The music became what I would term an 'improvised performance', which was informed by her relationship with me as therapist and two years of individual work informed by psychoanalytical principles. The patient subsequently ceased therapy and is managing well in the community, attending the choir regularly but also drawing upon internalized processes of therapy that she developed in the group setting and through work with a music therapist.

I noted above that this case study raises some questions about the boundaries between music therapy and 'arts for health'. The approach taken with this patient could be situated within a 'music for health' framework, as the singing is a means for recovery. However, as the patient worked in collaboration with a music therapist, this case could alternatively be defined as activity-based music therapy (Odell-Miller 2007), resource-orientated music therapy (Rolvsjord 2010) or Community Music Therapy (Ansdell 2002; Pavlicevic and Ansdell 2004; Stige *et al.* 2010). This type of discourse and distinction of subtle and highly developed music therapy approaches is common in the twenty-first century, but was almost non-existent in the early post-war period in which there was virtually no clinical or theoretical research and only a few books and journal publications worldwide. While such distinctions and definitions are an important part of the professionalization process, they may also be at times restrictive and unhelpful – as indicated by the case cited above. While other contributors to this collection have noted the importance of bringing the 'arts therapies' into critical dialogue with the 'medical humanities', there is also value in acknowledging the boundaries and overlaps between different arts therapies and arts therapy frameworks.

The influence of research

At the time of writing, in relation to mental health diagnoses, there are Cochrane reviews that gather scientific evidence for the efficacy of music therapy for schizophrenia, dementia and depression. Some might be sceptical of this quantitative approach to a discipline that is related to human health and well-being, as discussed by Paul Robertson in his overview chapter for this section. However, the knowledge base provided by these reviews has also strengthened the academic and clinical profile of music therapists. Partly in response to reviews funded by the National Institute for Health Service Research (NIHR), music therapy is now included in the Clinical and Academic Careers Framework for Nurses and Midwives. In my view, such reviews do not distract or detract from the quality of the private musical and psychotherapeutic relationships with music therapists. Instead they provide a way of valuing and validating the work to the external world, while maintaining ethical discipline and protecting both patients and the public.

The process of revicwing links between mental health care and music therapy resulted in the recommendation of music therapy for people with schizophrenia and schizophrenic-type illnesses within the National Institute of Clinical Excellence (NICE) guidelines in 2009. The guideline states that:

> Arts therapies should be provided by a Health Professions Council (HPC) registered arts therapist, with previous experience of working with people with schizophrenia. The intervention should be provided in groups unless difficulties with acceptability and access and engagement indicate otherwise. Arts therapies should combine psychotherapeutic techniques with activity aimed at promoting creative expression, which is often unstructured and led by the service user.
>
> (NCCMH 2009: 257)

Within these guidelines, music therapy is described as improving symptoms of schizophrenia such as a lack of motivation, problems with socialization and difficulty making healthy relationships with others. These findings were the result of the systematic Cochrane review on schizophrenia, which included studies from Europe and China (Gold *et al.* 2005; Talwar *et al.* 2006). The nature of this review shows processes of international collaboration and transfer of knowledge between countries, which has been made much quicker and easier through new technology. The increased acceptance of music therapy within the medical profession is further indicated by the engagement of music therapists on official NICE guideline panels that determine which treatments are funded in the NHS.

Published literature on schizophrenia and music therapy is particularly prolific, but noteworthy evidence-based reviews of music therapy can also

be found in relation to other aspects of mental health. Much of this literature is published across Europe and America but reaches an international audience. For example, a study of music therapy and depression was recently undertaken in Finland and published in the *British Journal of Psychiatry* (Erkkilä *et al.* 2011). The study indicated that music therapy was effective in combination with standard care, as people with depression showed a reduction in anxiety and improved general function. Another piece of new research by Catherine Carr *et al.* (2012) concludes that group music therapy appears feasible and effective for patients suffering from post-traumatic stress disorder who have not sufficiently responded to cognitive behavioural therapy.

These developments indicate that much research has linked music therapy to improvements in mental health conditions, so that 'evidence-based healthcare' should not be viewed as a threat. They also indicate that close research has differentiated between mental health conditions and their specific links to music therapy. The following research focuses upon this latter phenomenon. The case study is used to illustrate some changing trends in music therapy practice. It highlights the importance of recognizing the heterogeneity of mental health conditions and thus the variable nature of patients' responses to, and experiences of, music therapy.

Case study: Research into diagnosis and music therapy in mental health

The following case study is drawn from a doctoral research study (Odell-Miller 2007). The study was based on a survey of 23 music therapists from five established clinical music therapy services in Europe relating to the treatment of mental health, who were surveyed using purposive sampling. Many of these music therapists were – and continue to be – leaders of the field in their own countries. They had experience spanning 30 years at the time of the survey and backgrounds in at least 12 music therapy training courses across the world, drawn from the USA, Australia, Asia and countries across Europe. Therefore, while the sample is small, the results can be considered seriously and general patterns and trends in music therapy practice can be identified. The music therapists were asked whether they used the music therapy techniques and theoretical approaches commonly described in the literature (Table 15.1) and their reasons for (not) doing so. These questions were posed in relation to the use of music therapy for five diagnostic categories: schizophrenia, bipolar disorder, depression, anxiety and personality disorder.

The first finding of the doctoral study, which was complete in 2007 but for which the research surveys began in 2004, was that music therapists did not focus upon research outcomes as a driving reason for their clinical practice. The study revealed a disparity between the level of detail that different centres provided in their responses to questions, particularly their

Table 15.1 Music-therapy techniques and theoretical approaches

Techniques	*Approaches*
Singing composed songs	Supportive psychotherapy
Free improvisation with minimal talking	Psychoanalytically informed
Free improvisation and talking/interpretation	Client centred
Free improvisation with structures such as turn taking or play rules	Behavioural
Theme-based improvisation	Developmental
Activity based	Analytical music therapy
Song writing	Creative music therapy
Musical role play	Activity based
Receptive music using live music	Guided imagery in music
Receptive music using recorded music	
Imagery in music	
Music for relaxation as part of a relaxation programme	

reasons for using certain techniques or approaches with different diagnoses. Some centres provided detailed reasoning while others gave sparse and limited reasons – for example that they had received no training in a certain technique or approach so it could not be used. However, no references were made to evidence-based healthcare or to funding concerns. This outcome suggests that the profession needs to address training in order to equip music therapists to be flexible and to provide services that are needed, but that research does not necessarily directly inform clinical practice. This finding may also be indicative of changes over time and a shift towards evidence-based practice over the last decade. As noted by many of the contributors to this volume, the rise in evidence-based healthcare has led to greater levels of concern among arts therapists about the pressure to prove their worth to the NHS, funding boards and research bodies.

The second main finding of the study was that 'supportive psychotherapy' and 'psychoanalytically informed' approaches to music therapy were the most prevalent, and ranked first or second in every diagnostic category. There was agreement between centres that behavioural approaches were not a priority for any diagnostic groups, but that an approach drawing upon psychodynamic ideas, and in some cases psychoanalytic processes, was essential. These responses correspond to and support the claims made above, about the international differences between the emphasis on behavioural and psychoanalytic models of music therapy. All respondents

perceived that being supportive of patients with schizophrenia, both musically and verbally, was a crucial aspect of the therapy. They were unanimous that being 'supportive' was not purely an analytic or interpretive exercise, but also an empathic one. This interpretation of support shaped the way that music was used. For example, one centre used sensorial play as a first stage of music therapy in which the therapist stayed with, mirrored and listened to the patient. The effect was supportive in maintaining the relationship while the patient was also allowed to find his or her own inner space. All results also showed that the building of a rapport with severely mentally ill patients was important.

The third important finding was that techniques of free improvisation, both with minimal talking and with talking/verbal interpretation, were ranked highest for all diagnoses. However, there were some additional differences demonstrated between psychotic disorders and non-psychotic disorders. Some centres explained the importance of the non-verbal qualities of musical improvisation and the potential for encouraging spontaneous interaction. Other centres did not justify their use of improvisation but rather took its value 'for granted'. The use of composed songs was ranked joint first with either form of free improvisation for music therapy with people suffering from schizophrenia and bipolar disorders. In such cases, therapists placed less emphasis upon using techniques requiring symbolic thinking for psychotic disorders.

The prevalence of the use of composed song reveals one of the main changes in the trend during the second half of the twentieth century and beginning of the twenty-first century. At this time, improvisation had become prevalent in Europe, especially in the UK, within a psychoanalytically informed approach to mental health and music therapy (Odell-Miller 2001 and 2003). However, the study revealed that music therapists prioritized the use of composed music for specific populations. The study thus emphasized the importance of examining music therapy in practice rather than only in theory, as music therapists took into account the specific requirements of patients with different mental health diagnoses. Barbara L. Wheeler (1987) supported this finding, showing the value of taking a more musically active approach with schizophrenic patients. Although Metzner (2003) discusses the limitations of using composed music if the patient is psychotic and might not be able to use the space to symbolize anything from the music, this seemingly referred to listening to music rather than interacting through composed songs.

The above finding was significant in showing that improvisation was not used as a 'one size fits all' approach to music therapy, as might have been expected from the published literature. The fifth finding was less surprising – that for patients with non-psychotic disorders, music therapists preferred to use techniques that require more symbolic thinking such as free improvisation with structures such as play rules, theme-based improvisation, musical role play and use of other media. These approaches were

also ranked as among the best approaches to music therapy with patients suffering from anxiety, depression, eating and personality disorders. This finding confirmed an agreed awareness of the characteristics and symptoms likely to be present in some of these disorders, which was also supported in the music therapy literature. Jacqueline Robarts and Ann Sloboda (1994) discuss role play and Henk Smeijsters (1996) describes a range of more symbolic possibilities for people with eating disorders.

The roots of some of these disorders arise from early trauma and difficulty, and literature in the psychological therapies has long promoted a process of working through meaning and emotions using role play, reciprocal roles (Ryle *et al.* 1997) and 'mentalization' (Bateman and Fonagy 2004). The latter refers to the capacity to think about mental states as separate from, yet potentially causing, actions. It was referred to by three centres in the survey discussed in this chapter, which is indicative of the emerging interest in this approach to music therapy. For example, Dominik Havsteen-Franklin and Anna Maratos (Central North West London NHS Trust) have recently worked with Peter Fonagy (University College London, Professor of Psychoanalysis) to develop mentalization-based training in arts therapies.

This study indicated that music therapy is difficult to define in a precise and generic way, and continues to develop a multi-theoretical basis. Within this broad church, it would be useful to try to achieve some clarity of description between some of the many approaches. The findings of this study also highlight the potential importance of population-specific training in arts therapies. This raises a debate around specialization, particularly which aspects of music therapy would fall within 'general practice' or under more specialized approaches requiring further training prior to registration. At present such specialization is being resisted, in part because music therapy is a much smaller field than medicine. There is thus potential for future development in this area, which indicates that we are not at the end of the process of 'professionalization' outlined above.

Conclusions

It is clear that every music therapist will bring his or her own style into the therapy room and that this, in addition to training and experience, will determine the essence of the therapy. It appears that enough freedom, free thinking and creative professional practice has allowed music therapy to maintain its unique musicality and techniques of live interactive connection, while benefiting from the organization that professionalism and registration have brought. In fact the profile of music therapy is higher than it has ever been, particularly when including its influence upon other disciplines such as psychotherapy, musicology, music psychology and allied health professional clinical practice. In the twentieth and twenty-first centuries, there has been a consolidation of the clinical practice of music

therapy, a rise in research and associated publications, a consolidation of training, the establishing of professional frameworks, the development of official regulation and legal registration and, finally, advances in technology in music therapy (Magee 2013).

Music therapy in adult mental health thus provides an important case study for this volume, as a form of arts and health intervention that has been clearly shaped by the context of its emergence and development. It also represents an interdisciplinary form of therapy, although this should not be unquestioningly seen as a benefit to the field. There are ongoing debates about whether music therapy has adhered too much to other disciplines and thus been in danger of diluting and detracting from the power of music as a medicine in its own right (Ansdell 2002; Barrington 2005). The debates are a sign that music therapy is established, has arrived, and is in adulthood. The profession is supported and strong enough for open debate, within and between its shifting and overlapping sub-fields relating to the adult mental health field, such as the Nordoff Robbins tradition of Creative Music Therapy (1977), Psychoanalytically Informed Music Therapy (Odell-Miller 2001), Music Psychotherapy (John 1992), and most recently, Cognitive Analytical Music Therapy (Compton-Dickinson *et al.* 2013). The influence of music therapy within the music psychology and musicology fields is demonstrated and represented within recent literature (Hallam *et al.* 2009; Malloch and Trevarthen 2009; Barnard 2012). Debates now focus on the place of music therapy in the field and the type of framework within which it should be applied, but there is little question that it can be a form of robust treatment – or, dare I say, a form of 'medicine'.

Note

1 The Health Professions Council (HPC) was set up following the under the National Health Service Reform and Health Care Professions Act 2002, to replace the Council for Professions Supplementary to Medicine, in 2003. In 2012 it became the HCPC to include Social Care.

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Appendix

A timeline of the medical humanities

Alan Bleakley and Therese Jones

1937	*USA*	At Vanderbilt University School of Medicine, E. E. Reinke calls for 'leavening technical training with a liberal education'.
1944–45	*UK*	The medical humanities 'begin' as the nascent art therapy movement. Adrian Hill publishes *Art Versus Illness* about using art to treat patients in a tuberculosis sanatorium.
1947	*USA*	George Sarton coins the term 'medical humanities' in the journal that he founded: *Isis*, the official publication of the History of Science Society.
1952–57	*USA*	Case Western Reserve medical school introduces a history of medicine innovation during an extended curriculum overhaul.
1967	*USA*	The first Department of Humanities in any medical school is established, at Pennsylvania State University's College of Medicine.
1970	*USA*	The Society for Health and Human Values (SHHV) is officially established as a membership organization.
1973	*USA*	The Institute of Medical Humanities is founded at the University of Texas, Galveston with content emphases in history, literature and religious studies.
1976	*Australia*	Anthony R. Moore, a surgeon working at the University of Melbourne, first uses the term 'medical humanities' in the medical education literature.
	Argentina	The University of La Plata medical school develops an optional medical humanities provision.
1979	*USA*	*Journal of Medical Humanities* launched.