

Music Therapy Using an Open Group Model

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This paper is the compilation of my ideas, research, and practice regarding music and health and well being resulting in my developing model of how to create the most efficacious, ethical, and accountable community based music therapy practice.

Preparation for this presentation saw the administration of a questionnaire to staff, management, and administration at the three facilities at which I primarily work. The goal of the questions was to garner opinions from people working at the same facilities that I do regarding the approach and efficacy of the music therapy program and in particular, how it affects them directly. Participation was open to all staff, management and administration and was optional. One staff at each of two different facilities chose to share the questionnaire with their residents and their responses have been included in the count. I expect that number is less than ten. In total, I received fifty-five responses from three facilities, none of which has a large staff. Of these, fifty-three were positive including general statements such as, "I can see how this program is of benefit to the clients/residents" or more specific comments like, "I look forward every time to music day at work because it is fun". Of all the questionnaires received, two contained negative comments, both from the same community mental health group home. Conversations regarding how to rectify the concerns have already been initiated. Overall, I feel that this is a strong showing of support for the approach and the music therapy program, particularly in these times of extreme budgetary cutbacks in British Columbia, particularly in the community health sector. The aforementioned questionnaire followed up a community mental health consumer music therapy program evaluation in 2000. The results of that research can be found in the article, *A consumer-directed and partnered community mental health music therapy program: program development and evaluation*, in the Canadian Journal of Music Therapy, Vol. VIII, no. 1, Fall 2000.

The goal of this proceedings paper and presentation for the 2002 CAMT Conference is to share a synthesis of all these ideas with my colleagues and elicit their comments and opinions. I hope to follow it up with a professional journal article in the near future as well as more research.

Over my years of practice as a music therapist, even before that when I was a restaurant/pub performer and a piano teacher, a student of music, in fact, all my life, the experience of knowing holism, health, trust, love, comfort, and support for my personal experience has been the most direct, authentic and complete in the experience of music. This relationship has driven much of my personal and work experience, particularly since I began working in the field of Music Therapy.

When examining the healthcare field today, it is clear that community based efficacious fiscally accountable group models should be a significant part of healthcare structures of

the future. Although the wages are traditionally and unfortunately lower in the community healthcare sector due to on-going under-funding based on a chronic lack of funding and lobbying resources, as a music therapy practitioner, I have specifically chosen to focus my practice here. This is based on a personal belief echoed by the findings of numerous government sponsored studies, focus groups and fact finding missions that to create an efficacious and sustainable system, health and well-being need to be addressed primarily at the community level both in a preventative and restorative manner.

The goal of the presented work is to provide a model which does not rely on the current medical model of illness and treatment (a model which focuses on the negative results of poor health and is unfortunately partially governed by profit driven economics) but rather, a holistic model of health that focuses on increased personal and community experience, support, and responsibility for health and well being.

A community based approach to practice means something very specific to me. In traditional community healthcare practice, the individual client is viewed as the centre of an interrelated group of people structured by the system in which they are functioning. My community approach to music therapy practice includes the aforementioned but the focus of the work is two-fold: primarily, the good of the individual and, in addition, the good of the community as a whole. To me, this relationship is fundamental. For this work, I employ a broad based feminist critical analysis of the concepts of health, wellness, and community. In the open music therapy group, the concept of client is addressed in an inclusive manner: participants who are sitting in the music group, peripheral participants, staff, management, and administration and, the community itself. The goal of the work is to address common multi-faceted personal health needs such as isolation, motivation, and focus. Through this process, healthier identities are affirmed. Not only for individual clients but also for communities as a whole. The group affects the experience of all people in proximity to the experience of music therapy service provision in a holistic manner. In accountable and efficacious community practice, all participants of the community are affected in a positive developmental way thereby furthering the health effect on the broader public community. Two recent excellent works studying the effects of a community approach to music therapy practice in large institutions are the unpublished masters thesis of Susan Summers, *A tapestry of voices: Community building with a geriatric choir reflected in a music therapy model of practice* and that of Alpha Woodward, *The emergent voice: A systems theory perspective for environmental music therapy strategies in an extended care facility*. Although both these works specifically focus on practice with geriatrics in large long-term care facilities, the literature reviews, the philosophy contained therein, as well as the actual focus of the work is very congruent with the work being presented here. In particular, the pioneering theoretical music therapy work of both Carolyn Kenny and Even Ruud appears to have been very influential in all our work.

My particular approach to community music therapy practice is grounded in a feminist model that advocates empowerment and self-direction with a focus on building healthier identities and positive relationships and communities as the primary goals of the

therapeutic process. It is assumed that all people attending the program as well as those who place themselves in proximity to the work are interested in music and are in need education and experiences on how to be and feel well. The primary goal of the presented experience is to enhance each person's internal knowledge of the experience of health. Health and well being on physical, psychological, spiritual, and social levels as well as potentially unknown other levels are addressed utilizing the holistic experience of live therapeutically derived music.

A very important feature of this approach is that it takes place in an open space and in an open context. This idea originally came from the community mental health consumers with whom I work and is grounded in music therapy philosophy as presented in Carolyn Kenny's *Field of Play* and Even Ruud's, *Music Therapy: Improvisation, communication, and culture*.

In our open music therapy group, participants may move in and out of the space at will and participate to their own degree of motivation and comfort. All participation including being in proximity to the group is considered and supported as being successful. Participation is encouraged, both verbally and musically, and on both an individual and group level. In keeping with an empowerment approach, the format of the session is designed based on the requests of the clients, consumers, staff, management, and administration. As reported in the aforementioned article (Baines, 2000), the top four reasons community mental health consumers come to the music group is for relaxation, because they like to sing, for socializing, fun, and for leisure. Although the other client groups have not yet been surveyed for this information, it is expected that these would be some of the most common reasons for attending the music therapy group on their part as well. Active and passive participants sit in the circle and make music through singing and playing small percussion instruments, dance, request songs, and/or listen. Peripheral participants use the music group more as a back-drop to other types of social activity such as talking quietly, listening to the group from a distance while sitting in another smaller group, or simply listening individually but in proximity to other listeners, a distance from the music group.

In this approach, music is utilized both as therapy and as co-therapist. For the most part, the format by consensus consists of singing familiar songs with occasional forays into instrumental improvisation. A long-term goal of the program is to increase the use of improvisation, both instrumental and vocal, as the open music therapy group identity and context matures and become ready. Music therapy interventions take place in the context of the music of the requested familiar song material. Musical elements of song presentation such as dynamics, tempo, pulse, melody, harmony, phrasing, tone, texture, range, accents, style, and rhythmic inflection are specifically managed by the music therapist to create the most overall actively participatory and therapeutic environment for all of the people party to the process. A delightful efficacious effect of this approach is that over time, the quality and skill of the participation of the group members develops, increases, and improves. Members of the group notice and develop mutual and personal esteem through participation in this organically occurring natural skill building process. This positive experience and reflection of the self and the group then serves to strengthen

and support further personal, social, and community development. An additional benefit is that peripheral participants are similarly inspired by their more actively and intimately involved colleagues which can enhance their own motivation for health and well-being.

Based on the aforementioned information, the context for development is obvious. Of interest is that, before attending the music group, many of the participants have not attended nor participated in any way of their own volition in any other group and therefore, in their unfortunate isolation due to various health concerns, have few opportunities to address the aforementioned goal areas resulting in exacerbated health concerns. They feel isolated and overwhelmed for the most part, traumatized and held captive by their own personal circumstances. According to our research (Baines, 2000), autonomous participation in the open music therapy group often seems to begin to address some of their personal problems from very basic health concerns to more sophisticated multi-level holistic domains. This positive esteem-building experience appears to help break the ice for involvement in other health enhancing experiences and readily facilitates the development of improved relationships, another particularly difficult personal health related domain for many people.

A specific de-emphasis on verbal disclosure and process has been pursued in this approach both based on the request of many participants and the specific needs of the clinical populations with which I work. For example, in the long term care groups, many of the participants no longer function or relate particularly well in terms of verbal communication for a variety of reasons including hearing impairments, dementia, anxiety and depression, and overall loss of external focus. The majority of their waking day requires them to attempt to continue to communicate verbally with people with problems like their own and with a variety of care-giving virtual strangers. Music therapy can provide a place where health and well-being can occur personally as between group and staff members without the requirement of highly functioning verbal skills. In the community mental health groups, the reasons for a de-emphasis on the verbal process include the aforementioned reasons as well as others. For the most part, participants with a diagnosis of chronic and persistent mental illness have already experienced a great deal of psychotherapy based verbal therapy work, unfortunately without much particular success. This personal truth serves to further degrade important mental health resources such as self-esteem and motivation. In the community mental health music therapy groups that I run, there has been a very strong request for a de-emphasis on verbal process. Participants report a variety of reasons for this request including the experience of being personally re-traumatized as they retell, often yet again in the company of virtual strangers, their past hurts, the fact that many of the participants have been through a significant amount of individual and group verbal therapy utilizing a psychotherapy approach in the past (sometimes even with each other) to little or no avail, the truth that trauma can occur to sensitized people when listening to other group members tell their past hurts, the acknowledgment that verbal communication can be highly confusing due to a variety of personal, social, and cultural factors, as well as other potential reasons not named here. Once a norm of decreased verbal disclosure with holism and rehabilitation as the opportunity for developing potential is established, anxiety immediately decreases thereby enhancing authenticity and positive experiences overall. A synthesis of many

comments on the reason in the community mental health music groups for more music and less talk is that when we speak too much, we miss the opportunity to make music and what has occurred in the verbal process has not offered the participants the degree of positive impetus as what has occurred in the music. In the music, communication of holism, health, rehabilitation, esteem, support, and fun appear to occur very directly.

The open music therapy group approach offers significant safety for both the participants and the practitioner creating a potentially highly ethical and health-giving environment. Because the group takes place in a sheltered social open space within the institutional environment rather than behind a closed door like in traditional clinical music therapy work, “normal” social boundaries of decorum and behaviour for the clients, the music therapist, and the staff are often maintained for the most part. This creates decreased opportunity for dangerous, abusive, coercive or traumatic experiences to occur to clients in particular and increased opportunity for developing positive social and community relationships within a readily positive multi-faceted communicative healthy context. Participants have the opportunity to be together for a personal interest based reason to enhance their own health rather than being together because of common health problems.

An essential element of ethical and accountable practice is efficacy. Although the open community music therapy group does not subscribe to traditional tenets of clinical music therapy practice, it certainly fits the parameters of the Canadian Association for Music Therapy definition of what is music therapy and appears to efficaciously address the health concerns and goals of the various participants. In both consumer and staff evaluations of the program conducted at a community mental health agency, a long-term care facility, and a respite care facility, the group is experienced as meeting personal and group needs in a holistic and rehabilitative manner. As a group model, with no numbers restrictions, fiscal accountability is readily attained. Both clients and staff who responded to the program evaluations felt that increased numbers of participants often offered an important social context that enhanced the positive effects of the program. By focusing on the therapeutic aspects of music and de-emphasizing verbal process, participants’ initial attraction to the concept of gaining health through using the therapeutic aspects of music is supported. The participants’ ego is strengthened as this personal choice to use music for their personal development and healing actually affects their personal existence in a positive manner. Over time, a context for positive self-esteem is supported and enhanced thereby leading to holism/healing. Further research in the future will focus on gathering hard data on the process that leads to the improved health conditions.

As a music therapist, it is clear to me that the holistic manner in which I use music to promote health offers rehabilitative opportunities significantly different than any of my other healthcare colleagues: this includes other types of therapists who use music and entertainers who work in the institutional environment. Like many healthcare professionals, although the work I do usually enhances functioning in the physical domain, unlike primarily physical health based colleagues; it is not a priority any more than any other humanistic healthcare need. Similarly, although many psychological concerns are readily addressed by participation in the music therapy group in the presented approach, they are not singled out or focused on in any particular way.

Although other professionals may use music in their work, this music therapy approach uses specifically uses music and the elements of music as therapy and co-therapist creating a unique multi-level healing environment. Participants are empowered to use music in a holistic way to enhance overall awareness and development of health and well-being, both personally and in the community.

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