

## **Two Kinds of Music Therapy: Exploring ‘genre’ in the context of clinical practice**

### **Abstract**

This article explores distinctions between different approaches to music therapy and how these distinctions might be relevant to clinical practice. The article adopts an exploratory subjective stance, with the author exploring the relevance of a perceived distinction between ‘music-centred’ and ‘psychodynamic’ music therapy, as described in the literature, to their own clinical practice. A series of clinical vignettes, taken from work with children and young people in an NHS context, are used to illustrate the influence of both psychodynamic and music-centred theories on clinical practice in context. An integrative client-centred approach is proposed, where psychodynamic thinking and music-centred ideas can be incorporated as needed, according to the individual needs of each client.

Key words: psychodynamic music therapy; music-centred music therapy; genre; client-centred

### *Introduction*

“There are two kinds of music: good music, and the other kind.”

(Duke Ellington)

This article develops ideas which I first presented at the IMR Research Day: "Music in the Psychoanalytic Ear: Thinking, Listening and Playing" (Institute of Musical Research, Senate House Library, London. Saturday 19th May 2018). The starting point for this presentation was the question “Can boundaries between disciplines impede creative insights and open-ended thinking?” This led to some thoughts about different schools of music therapy practice

and how these approaches relate to my work with children and young people in an NHS context. Boundaries between, for example, music therapy and psychoanalysis will not be explored here, but rather perceived or described boundaries within the field of music therapy between identified music therapy approaches.

The composer and band leader Duke Ellington has this statement attributed to him: ‘There are two kinds of music: good music, and the other kind’, made in response to attempts to categorise his music. He was not enthusiastic about the word ‘jazz’ as a label, and at times received criticism about lack of ‘jazz content’ in some of his work, presumably referring to space for improvised solos. When I presented this as a conference paper I announced it beforehand on Twitter, including the title. I received a response from a music therapist, who asked, ‘What are the “two kinds” of music therapy? I thought there were many different kinds.’ A typical response to this on Twitter would be a ‘that’s the joke’ GIF. Instead I gave the same explanation that I give here. Just as there are many different kinds, perhaps, ‘styles’, perhaps ‘genres’, of music, so there are many different approaches to music therapy. The important question is whether the therapy is ‘good’ or not, whatever that might mean. But there is another layer to the joke, because a joke is a response to something, in this case to an idea, or a perception.

### *A perceived dichotomy*

In music therapy in the UK, a perceived distinction exists between ‘psychodynamic music therapy’ and ‘music-centred music therapy’, which came to the foreground in a well-known exchange between Streeter and Ansdell in the BJMT (1999; 1999), in which Ansdell refuted Streeter’s assertions that music-centred approaches might suffer from a ‘lack of awareness of

the psychodynamic processes at play’ (p. 8). The term music-centred is particularly associated with Nordoff Robbins (NR) approaches. My training in music therapy, at the Guildhall School of Music and Drama, had a psychodynamic emphasis. In my NHS practice I work alongside therapists from other trainings, who might describe their approach differently. Aigen (1999), asserts that one can “operate from a music-centred position that is itself psychotherapeutically informed” (p. 79), and resists what he perceives to be Streeter’s dichotomy between ‘musical awareness’ and ‘psychological thinking’ (p. 79). One person who has identified a distinction more recently is Simon Procter, who, in a Q&A on the ‘Live Music Now’ website, responded to the question ‘How does the NR approach differ from other training courses?’ with the following:

“The Nordoff Robbins approach is ‘music-centred’ rather than psychoanalytic or behavioural. We take musicians and teach them to work musically with people. We emphasise musical outcomes for clients: we see music and musical experience as the stuff of life, not just as symbolic of something else. We seek to make use of all kinds of musical possibilities, including performance, as potential parts of a therapeutic process.” (Swann and Procter, 2016)

A dichotomy is clearly presented here, between ‘the stuff of life’ and ‘symbolic of something else’. I responded to this statement elsewhere, in a blog post (Annesley, 2016). This response was linked to a resistance to being pigeon-holed, both for my own sake, but also, more importantly, for the sake of the clients. Essentially, my argument was that it is perfectly possible to be psychodynamically informed, *and* music-centred, the same argument that Aigen (1999) uses in response to Streeter (1999). Sutton has more recently affirmed this perspective, stating that ‘it is possible to be “music-centred” across the

spectrum of practice' (2019 p. 5). But is the perception of a split accurate? Do music therapists make this distinction in their clinical practice? Ann Sloboda, in a podcast interview (BAMT and Annesley, 2018), suggests that an interesting experiment would be to present psychodynamic and music-centred therapists with a clinical scenario, and explore their interpretations and hypothetical responses. Perhaps this would be a useful research study. One of the challenges of designing a protocol would be to decide how these therapists were identified. Furthermore, Ellington's joke, as applied to music therapy, could assert that this dichotomy, or any other dichotomies one might apply to music therapy, is unhelpful, or irrelevant, because what matters is what works, rather than the label attached to it.

### *Music and relationship*

Aigen explores some contrasting approaches to relationship in music therapy in his later book *The Study of Music Therapy: Current Issues and Concepts* (2014). Aigen makes a clear distinction between psychodynamic and music-centred approaches to the client-therapist relationship in music therapy, and advocates for an inclusive attitude within the profession, in which there is room for practitioners with differing orientations. He draws some dividing lines, which imply that therapists in one camp do *this*, while others do *that*. In exploring different approaches to music therapy, Aigen makes the following assertions:

In the more orthodox forms of music psychotherapy influenced by traditional psychoanalytic thought, the explanation for the effectiveness of music in therapy must fit with psychoanalytic theory about the personality, human development, and the role of art in human life. In this framework, music is considered a medium for regression, a repository of unconscious emotions, a projective screen upon which unacceptable aspects of one's inner self may be placed, or a representation of objects in the world with which the individual must come to terms in order to become healthier. (p. 38)

...music therapy theories from socially-based frameworks (such as community music therapy and resource-oriented music therapy) and music-based frameworks (such as music-centered music therapy) differ from the psychodynamic approach in two important ways. First, they consider a relationship to music as an essential human need that reflects healthy tendencies within the individual. Second, as result of this belief in the positive valence of musical engagement, they seek to establish continuities between clinical and nonclinical uses of music, and they seek to establish music therapy theories based on more general theories of music drawn from ethnomusicology and the sociology of music. (p. 39)

There are some problematic statements for me here. Since I would identify my approach as 'psychodynamically informed', Aigen implies that I should disagree with the second set of assertions, but I concur with all of them. Conversely, is his characterisation of a psychoanalytic approach to music therapy too reductive to be helpful? His use of the word 'must' begs the question, 'who says so?' It suggests that the decision about what kind of therapist to be is taken a priori. While I agree with all of the statements characterised by Aigen as being typical of music-based and socially-based frameworks, I also consider that music can, at least some of the time, be 'a medium for regression' and 'a repository of unconscious emotions'. Aigen seems to be identifying different *genres* of music therapy, perhaps. This might give this article a rationale within his narrative. Perhaps I am practising a hybrid, a music therapy equivalent of jazz-rock fusion. I was particularly interested in this statement:

It may be that there are psychodynamic music therapists whose theoretical allegiance is determined by their own fears or insecurities about working primarily in the music; and it may be that there are music-based music therapists whose theoretical allegiance is determined by an inability to face their own unconscious fears and blocks. (2014, p. 117)

Another way of putting this: Music Therapists might choose their orientation because they are trying to avoid difficulty. This seems plausible, and I can identify with both scenarios. An ‘inability to face ... unconscious fears and blocks’ might be part of the human condition, and we all have our musical insecurities. Through exploring some clinical vignettes, this article will consider the relevance of these definitions to my own practice, including whether I identify as ‘psychodynamic’ or ‘music-centred’. This is done in a spirit of playfulness, to explore the intuitive ‘fit’ of one stance or the other, just as a musical ‘genre’ might be chosen with which to label recorded music prior to commercial release. The questions raised are not intended to imply assumed answers but are posed in a spirit of genuine enquiry.

*Vignette 1 – My first training client: two kinds of interpretation*

I am going to begin with a musical example from my first client, who I worked with on a training placement in 2007. This was a young man with a psychiatric diagnosis, whom I worked with in an inpatient setting for around six months. Early in our work together, which I audio recorded, there was a moment of connection in the music. We were sitting together at the keyboard and he began to play an improvised melody on the white notes in the upper register. I provided a containing accompaniment, setting the key as A minor, then affecting a modulation into D minor, using an A7b9 pivot chord. He said immediately after this, ‘You make it sound good’. I agreed, inwardly. Listening back later, before presenting it to my clinical seminar group at college I still thought it sounded nice. I thought that the harmony gave the melodic line shape and direction and brought our music together. Linked to the particulars of the client’s illness, this statement was interpreted by my supervisor as an expression of my client’s feelings of inadequacy. The idea that *I* made the music sound good, rather than *he*, was interpreted as crucial to the meaning of this musical interaction. The

music sounds good, but so what? Where is it taking the client? There might be a danger of colluding with the client's idealisation of me, expressed through his admiration of my musical skill.

An interesting question might be, would a 'music-centred' Music Therapist interpret this moment differently? Perhaps they would be more amenable to my instinctive response at the time, which was that the client and I had created a moment of shared beauty together, and that the client had noticed and asserted this. Would I still agree with my supervisor's perception today? Perhaps more importantly, but also more difficult to answer: are these questions relevant to the client themselves?

Reflecting on this now, with a few years' experience behind me, I can see at least two different possible interpretations. Firstly, I can see that my supervisor may have been turning the focus away from me, from my music 'sounding good', onto the needs of the client. This assumes an underlying meaning to the client's statement, beneath the positive-seeming surface. Secondly, one might instead take the client's statement at face value: 'I enjoyed our music, thanks for supporting me by making it sound good (one might also explore what the client meant by 'it'). Both are possible, and perhaps both can be retained. We might refer to another theory from psychoanalysis, Bion's 'negative capability' (1970), which allows us to tolerate such uncertainties. Allowing both, without dismissing one over the other, enables an openness on the part of the therapist which might be helpful for the client.

*Vignette 2 –Supervision and reframing. Re-examining my stance. Questioning my emotional responses.*

This next musical example is from my work with a client, whom I shall call Henry, who was referred to the music therapy service as part of a project where our service was working with a domestic violence charity. Henry was referred because of concerns about his behaviour and aggression towards others, including a perceived lack of empathy. From the beginning of the work he was strongly musically engaged and played with great energy and self-possession. Musically, the sessions were exciting. A memorable moment came in around session 15, when he began to scat sing in a jazz style. I responded by playing a blues with a walking bass line, which encouraged him further. He sang with a strong personality, in a genre which happened to coincide with my own musical area of expertise, and the intensity of his improvising increased from one chorus to the next. I was excited by this interaction. Our music was strongly connecting. He seemed empowered and expressive, able to be playful and creative, but also showing awareness of musical style, inventiveness, rhythmic drive, and a capacity for musical collaboration; talent, you might say.

In supervision, I was helped to reflect on the controlling aspects of this musical behaviour, to consider the possibility of my collusion with the client, and of, perhaps, a counter-transferential response where I was representing the mother, and he the perpetrator. This was helpful for the ongoing work, because it enabled me to find my therapeutic centre-of-gravity, not only to be carried along by the excitement, but to retain the capacity to reflect on the meaning of the music, and to respond reflectively, including gently challenging the client. Were my supervisor's psychodynamically informed reflections essential to this? Would a music-centred supervisor have provided a different point of view? Certainly, the process involved consideration of meaning within the musical interaction. There was something of the manic defence (Winnicott 1935) about the client's wild creativity, which it was helpful to reflect on, in order to inform my approach in further sessions. It was also important to stay



with him in the musical moment, to support his energy and validate his musical expression by creating “a musical-emotional environment with which he may feel some affinity” (Nordoff and Robbins 1977, p. 93).

*Vignette 3 – Identifying and rejecting a ‘genre’ of music therapy.*

To further explore the idea of genre in music therapy, I will provide a brief clinical vignette. I was working with a young person in a mainstream secondary school. He had been referred because of social communication difficulties and he was autistic. He was around 12 years old when we began working together. He attended sessions for around a year and a half and during this time he actually played music on just a handful of occasions. There was lots of talk, however, about *why* he wasn’t playing. He told me fairly early on that he had seen some videos of music therapy online, that he understood what I was expecting him to do, that he would ‘bang a drum or play a xylophone or something’, and I would respond on the piano, but that he wasn’t interested in doing this, that it felt ‘weird’ to him. On one occasion he did try playing a drum. He tapped a rhythm. I played a chord on the keyboard, repeating his rhythm. He sighed heavily and said ‘I was hoping you weren’t going to do that’.

We were working here with musical absence, with the client’s resistance, but also with his capacity to make decisions, to be assertive. He had seen through the genre of ‘music therapy’, and rejected it, deciding for himself how he needed to use the sessions. I wonder whether a music-centred music therapist would have seen this work as a failure, because of the absence of musical interaction, or perhaps have explored ways to push the music more, to guide the client towards musical engagement. I felt the musical absence, and experienced it as a communication from the client; ‘If I take away the possibility of music, what do you have left

to offer me?’ This both acknowledges the possibility of music implied by my role and sets both me and the client a challenge. Above all, I felt that he was seeking congruence (Rogers 1995), preventing me from ‘hiding’ behind the music, or at least hiding behind ‘genre’. He was not interested in the YouTube version of music therapy. He had developed a fantasy that this was my expectation of him, with which he was determined not to be compliant.

#### *Vignette 4 – An ecological approach?*

I worked with an adolescent client with cognitive and communication difficulties linked to a history of epilepsy, and who had recently reached adolescence. There were some significant concerns about his social isolation. Having previously been a child who had struggled with verbal expression because of his learning disability, but who was nevertheless outgoing and expressive in his relationships with family and peers, he had recently become withdrawn. He spent much of his time with headphones on, listening to music on his phone, not interacting with other people. In music therapy we began with shared improvisation using the instruments in the therapy room. After a while he expressed his wish to sing particular songs, and he began to make lists. These lists went on for many pages, growing each week. I began by bringing an mp3 player to the session, with a selection of songs from the list. After a while this became impossible to sustain, as the lists grew, and there was not time to keep up. He would sing along with the tracks and I would try to play along on piano or percussion. Then he began to bring his laptop to the sessions. This was easier, because he had now taken responsibility for the musical content, perhaps noticing my inadequacy in this regard. We followed the same procedure in sessions, where he sang along with the tracks. Sometimes, with my prompting, he would try singing without the track, with my accompaniment, with some degree of success. He felt more confident with the track, and his vocal range was very

low. He would usually be singing an octave below the singer on the recording. His musical taste was current, with an emphasis on RnB, but with some more mainstream pop elements.

Reflecting on the purpose of the session, I wondered whether we might continue forever in this vein. I wanted to encourage him to free himself from the recorded track and gain confidence in his own voice. In discussion with colleagues on the staff at school, and with him during sessions, we devised a strategy of working towards an ending in music therapy, which would overlap with strong encouragement for him to take part in the choir at school, accompanied by the SENCo, for support, who was happy to take part herself. He began attending choir and we brought music therapy to an end. Feedback from his mother was very positive. She described having the 'old' version of him back. That he had become more outgoing and communicative.

Was this a 'psychodynamic approach'? There were certainly psychodynamic elements to my reflections on our relationship, but the ultimate aim in the therapy shifted to what might be described as a more social model, an ecological approach perhaps (although I wasn't myself running the school choir). This was certainly client-centred, and it involved teamwork. I couldn't have achieved these aims on my own, without the collaboration of other staff, in particular the SENCo, who understood the project and implemented it with sensitivity. If I were to frame our therapeutic process psychodynamically, I might think about *weaning* as an aspect of therapeutic relationship, where I was facilitating, over time, the client's progress from dependence towards independence (Winnicott 1963). I also devoted substantial energy to reflecting on difficulties in the work, such as the monotony of the client's repetitive behaviour, and my internal struggle with staying with him through the process. I am not sure that, without the space for reflection about projections and unconscious communications

afforded in psychodynamically oriented supervision, I would have been able to sustain the work so effectively.

*Vignette 5 – A useful space to ‘just play’.*

I have been working with a young man who is autistic and suffers from frequent low mood. He also had a single-event trauma, which continues to disturb him and contributes to his generalised anxiety. In sessions, he plays music all the time. He arrives, there is a nod of recognition, and he sits at the keyboard and improvises continuously for the entire session. His improvisations sometimes feel a bit stuck. There can be a lot of repetition. But he can also be very creative. There’s a feeling that he is developing compositional ideas from one session to the next. He expressed the view that he finds it helpful that in music therapy he is not expected to talk about anything, that it’s ok just to play. This, perhaps, is ‘music-centred’ music therapy, in the sense that the music is at the centre of the work. Would it fit within Aigen’s (2014) definitions, within the ‘genre’ of ‘music-centred music therapy’? To revisit Aigen’s quote, I’m considering, in this instance, ‘a relationship to music as an essential human need that reflects healthy tendencies within the individual’ (p. 39). I am prepared to accept, from the client, the idea that the music might be enough, at least for now.

*A client-centred approach*

I frequently experience Aigen’s dichotomous anxieties from both sides of the fence, the worst of both worlds, perhaps. My perception is that in all these examples the client has given me direction. Sometimes I have been slow to respond, betraying my desire for music with the client who is avoiding it, or making misinterpretations in an attempt to ‘make conscious’

something that doesn't need to be, that can comfortably remain in the musical realm. I can also collude with manic music that provides excitement but avoids addressing underlying difficulties. Where one is working with a complex and varied caseload, one must be flexible enough to respond in ways that reflect this complexity and variety. It is important not to be confined to one genre, of either music, or music therapy.

Perhaps what we seek when invoking genre is clarity. But is it plausible that a music therapy client would choose a music-centred practitioner over a psychodynamic one, or vice versa, because they have done their research, and find one preferable to the other, in relation to their needs? In other words, is a distinction between 'music-centred' and 'psychodynamic' music therapy useful to the client? Or is it more important that the therapy experience is a 'good' one (rather than the 'other kind')? I would advocate the approach summarised by De Backer and Sutton (2014), which answers these questions succinctly, and with humility:

[It is] important that we understand, think about, practise and allow ourselves to be open to not-knowing the intricate, delicate and complex musical phenomena we are working with... that we remain open to learn from our patients, and to the reality that this openness will change us as well as our patients. (p. 347)

I would also add that 'not-knowing' might imply a flexible therapeutic stance, and that 'openness' might include openness to perspectives that might otherwise be confined within perceived 'genres' of music therapy. We have much to learn from our clients, and also from one other.

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