Chapter 9

Music therapy: a resource for creativity, health and well-being across the lifespan

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9.1 Introduction

Music contains potential capacities to engage an individual or a group in therapeutically creative and socially communicative processes. To begin, explanation of some of the terminology in this chapter's title may be helpful. 'Resource' is used in its fullest holistic sense, demonstrating how music therapy can provide a child or adult with a full range of actions and potentialities across various domains defined thus: 'Music therapy is the use of sounds and music within an evolving relationship between client/patient and therapist to support and develop physical, mental, social, emotional and spiritual well-being' (Bunt & Hoskyns, 2002, pp. 10-11). The 'creativity' within such a resource is fundamental to engagement with processes within music therapy, contributing to a child's or adult's ongoing development of self and identity (MacDonald et al., 2002). 'Health' is construed not solely in relation to sickness but to an ongoing process and an individual's search for meaning in the world. Involvement in music, particularly improvisation, can contribute to the development of this flexible identity as well as being a resource closely linked to an individual's quality of life (Ruud, 1998). 'Well-being' is likewise construed as part of an ongoing process and balanced continuum with qualities including: 'interpersonal contact…a sense of community…fostering of a sense of self…transcendence or the loss of a sense of time…a balance of activity and relaxation' (Boyce-Tillman, 2000, p. 14). We can add pleasure, power, release, enjoyment and fun, qualities often reported regarding music therapy sessions.

While emphasizing this broad notion of creativity and ongoing balanced processes within health and well-being we must be mindful that many children and adults coming to music therapy are living with profound health problems, disabilities and difficulties, facing daily issues of struggle, loss and pain. Music therapy can contribute to how an individual adapts and copes with each unique situation.

9.2 Examples from practice and some theoretical underpinnings

In any music therapy session there will be the potential for a creative meeting to occur within the music, both client and therapist alike testing out new ways of acting and being (Bruscia, 1998). Music therapists Mércèdes Pavlicevic and Sandra Brown discovered that, in contrast to improvising together as two musicians, when exploring the roles of music therapist and client there were different ways of relating: 'it was not the music that dictated the improvisation, but how we experienced the other person, the client, in the music' (Pavlicevic, 1997, pp. 66-67). This kind of evolving relationship with a therapist contains and supports the client (or patient in some contexts) across the various domains as mentioned above.

While the relationship through the music is central to music therapy, theoretical links have also been made with other disciplines including psychology, psychotherapy, neurology and sociology. Some common theoretical concepts will be used to underpin briefly the following examples to illustrate three different social contexts for the work. These examples are illustrations of only some of the creative play and interactions that might take place in a music therapy encounter. Parallels between a child's curiosity in sounds, exploratory play and creative improvised music-making will be illustrated in the first two examples. In both of these and the following adult group example the emphasis will not be on final musical products but on socially communicative, psychological and contextually related processes. These three examples will also be referred to in later sections describing the evolution of the profession and as examples of stages in the development of music therapy research.

9.2.1 Early musical patterning

The context for the first example is hospital-based. The music therapist was part of an interdisciplinary child development team that included paediatric specialists in physiotherapy, occupational therapy, speech and language therapy and social work, working alongside a consultant paediatrician.

Baby A was referred to the team at six weeks for an assessment, given concerns that *in utero* a history of maternal alcohol abuse might have caused some brain damage (foetal alcohol abuse syndrome). Given the complexities surrounding her early history A had spent her first days in a specialist baby unit, being put up for fostering and potential adoption soon after birth. The following descriptions are drawn from video films of sessions and discussions with the staff team and A's foster mother who gave consent for the material to be presented in case studies.

A became very distressed and tense when handled by members of the team and her foster parents, and this was creating difficulties in establishing any early patterns of communication and secure attachments. She appeared to settle and become calmer when surrounded by sound, for example searching for the source when a pair of bright Indian bells was sounded. Given A's curiosity in the world of sound it was proposed that the

music therapist work with the physiotherapist for an intensive series of joint sessions (two per week) initially to provide a musical frame for encouraging a range of physical movements, for example rising and falling vocal phrases to mirror A being helped to sit up and return to lying down and the use of a sustained pulse to reflect the pace of any of her movements. As A became more relaxed, secure and trusting she began to initiate more vocal and movement gestures. By six months she would track the sounds of instruments as they moved across her line of vision; reach out to explore the instruments with both hands, for example a small drum placed in front of her; indicate with a vocal sound when she wanted a particular sound to occur; and vocalize in small bursts of sound in the gaps between short melodic phrases. Elementary turn-taking dialogues began to be established: short flute melody – A's vocal response – new melody reflecting A's sounds – further reply from A. She also began to sustain her attention in short bursts while attending to longer simple melodies played to her.

The creative process expanded when the various activities were picked up and developed regularly by members of her foster family. This use of sounds and music to support social and emotional development in a very collaborative and holistic approach contributed to a very positive outcome to this early intervention (for more details of this case example see Bunt, 1994, pp. 77-79).

The underpinning here is fundamental, rooted in our human biology and neurological processing. The sounds themselves and the inherent alternating patterns within the short pre-verbal vocal and gestural exchanges (as described above) can become the building blocks for communicative development, linking to all future physical, language, social and emotional development. Much movement and rhythmic interaction anticipates these early vocal exchanges akin to what anthropologist Mary Bateson labelled 'protoconversation' (1979, p. 65). Synchronizing movements with A helped to reduce her physical tension and motivate her in creating her own vocal sounds and communicative gestures. Much research over the last few decades has indicated that babies from their earliest days not only demonstrate inherent self-synchrony in their movements but also make instant connections with the pulse and patterned-based nature of their caregivers' movements, vocalizations and facial expressions (an early review is Schaffer, 1977). It is as if a baby arrives in the world 'hard-wired' for creative communication, with music as a source for engagement, as proposed in developmental psychologist Colwyn Trevarthen's hypothesis of a 'fundamental intrinsic motive pulse…generated in the human brain' (2002, p. 25). After extensive analysis of audio recordings of mothers interacting with their young babies, Trevarthen's research colleague, the musician Stephen Malloch, proposed a theory of 'communicative musicality' which 'consists of the elements pulse, quality and narrative – those attributes of human communication, which are particularly exploited in music, that allow co-ordinated companionship to arise' (1999-2000, p. 32). Trevarthen's and Malloch's ongoing collaboration has provided a fundamental theoretical underpinning for music therapy practice (Malloch & Trevarthen, 2009; Trevarthen & Malloch, 2000). They also built on

research that demonstrates that this interactive 'dance' between child and adult is very much two-way with both partners establishing and enjoying these closely interconnected and shared 'narratives' of emotionally expressive activity, as was demonstrated between A and the music therapist. These narrative episodes can be described using all the musical parameters of 'pulse, tempo, rhythm, accent, stress, loudness, silence, pitch and melody' (Bunt & Hoskyns, 2002, p. 71). A repertoire of shared meanings over time can thus be established.

9.2.2 Tuning in to the child

Seeing A at such an early age meant that possible difficulties in timing reactions, gross movement and potential communication problems could be addressed before any of these patterns became firmly established. The members of the team were able to work with the foster parents in creating activities to maximize A's potential across all aspects of her development.

Timing is also central to the next example. This setting is a community-based music therapy centre (see section 9.5 for more details of the registration of music therapists in the UK).

Paul (not his real name) attended with his nursery nurse for blocks of weekly half-hour music therapy sessions after referral by his paediatrician when 3 years old until he began full-time schooling just before his fifth birthday. He was diagnosed as being on the autistic spectrum, having difficulties in communication and forming relationships, speech and language delay, repetitive play and a need for keeping sameness (Wing, 1993). Short descriptions of some of his musical play are taken from sessions towards the beginning, middle and end of the music therapy process with changes in details being made to maintain anonymity.

At the start of one of the early sessions Paul explores the boundaries of the room, which contains a drum and cymbal, a large xylophone, some wind chimes on a stand, a box of smaller percussion instruments and an upright piano. He plays a few sounds by tapping the drum, makes a sweeping gesture across the wind chimes, moves past the cymbal and spins it briefly. The music therapist accompanies Paul's explorations with quiet and sustained piano chords, aiming to link together his musical fragments. The piano music is kept as unobtrusive as possible so as not to contribute to any increase in Paul's level of arousal and excitement. He is not interested in the box of smaller instruments, returns to spinning the cymbal and is joined by the therapist. Together more side-by-side interactive play on this preferred object is developed, spinning and then tapping the cymbal in turn. In this way Paul's repetitive spinning of a hard object was used as a creative kind of bridge to more shared and softer indirect communication.

Six months later Paul has become more accustomed to the setting and a repertoire of shared musical activities has been established. Early in a session from this period he vocalizes on a range of vowel sounds using his characteristic descending minor third (F-D). This is picked up on the piano and vocally by the therapist and extended into a greeting song that matches the tempo, quality and loudness of Paul's sounds. He appears to recognize that the piano sounds are connected to his sounds and responds to the singing of his name by looking more towards both the therapist and

his nursery nurse, with some smiling, especially in the gaps between the phrases. The trainee music therapist, on placement at this time, begins to play sustained D's and A's as a drone on her violin. She also matches some of Paul's vocalizations with descending glissandi. Paul appears attracted by the sounds, moves across to the violin, sitting in front of the trainee while she plays. He takes the bow and moves it across the strings in a clear focused movement. He holds the trainee's wrist as they bow together. He seems very aware of the way that the speed and weight of gestures create sounds of different qualities and energies. He spontaneously vocalizes in synchrony with the gestures. He stands up, touches and then plucks the strings. He then sits again and is very still and attentive while the trainee plays the violin to him.

A further six months have elapsed and Paul is preparing to start school when he will continue with weekly music therapy with the school's visiting music therapist. After a preliminary exploration of the room at the start of a later session Paul takes the two drum sticks offered by his nursery nurse and, responding to her encouragement, plays the large drum for a succession of his most extended episodes of engaged play to date. His whole body seems to be moving in synchrony with his drumming as he looks towards the music therapist who supports his playing with strong and rhythmic piano playing. This then moves into another favourite musical activity, taking turns to roll a rainstick across the floor from one person to the other. There is a feeling here of more confident co-created play and the beginnings of more sustained direct communication with another person.

The ongoing interactions between child and caregiver/therapist allow the child to explore an emerging sense of self. These take place within the evolving context of a relationship and, in the context of music, a shared creative encounter with another, all without emphasis on words. Daniel Stern (1985) has explored how a child develops a sense of self through these kinds of interpersonal interactions, beginning with these non-verbal levels. Some of Paul's difficulties in timing his responses, in being able to take control of his actions and in differentiating between his world and the world of the other might relate to what Stern calls the development of a 'core self'(1985, pp. 69-123; Wigram et al., 2002, p. 86). Paul also presented difficulties in recognizing which emotions were part of his own internal experience and which were part of others around him, relating to Stern's development of the 'subjective self' (1985, pp. 124-161; Wigram et al., 2002, p. 86).

In Paul's case it was clear that by tuning in to his tempo and specific way of exploring the instruments the music therapist was able to meet him at his level of play and to build the creative evolution of the interactions from this point of contact. This relates to Stern's notion of 'affect attunement' (1985, pp. 138-161), which is not simply the adult imitating the child's gesture but attempting to 'read' empathically the feelings that lie behind any gestures (in the early sessions Paul's short bursts of fragmented playing and single gestures). The therapist vocalized or played an instrument incorporating similar levels of loudness and duration to Paul's sounds yet also adding a different musical response, often including a slight extension to the length of sounds. Stern points out that these 'attunements' can take place across different modalities, for example, as in this case, a child's drum sound

matched by an adult's piano sounds. At the start of the middle session Paul appeared able to recognize his own sound world both as part of the therapist's response and also as something new. He began to incorporate some of the therapist's responses and aspects of the joint activity into his own play and interactions.

For children such as Paul, where problems in communication and some lack of both self and interactional synchrony are potentially isolating, 'the engagement of their musicality by another can be a lifeline to human sociality' (Malloch & Trevarthen, 2009, p. 6). Pavlicevic (1997) has drawn on both Trevarthen's and Stern's work in her notion of 'Dynamic Form', bringing together both the personal/emotional and musical. The fundamental nature of 'communicative musicality' and processes in synchronizing with both self and other can be observed within the musical flow of a session. When problems in communication occur music therapists can observe their musical correspondences. They not only observe and 'read' any problems in communication but, through interacting using a range of musical responses and resources, can contribute to processes of 'musical repair' (Ansdell & Pavlicevic, 2005, p. 195).

Psychoanalyst Donald Winnicott (1974) examined the way that a child begins to use toys and other objects to explore creatively the intermediate states between 'me' and 'not me', 'self' and 'other'. This transition and separation stage is a delicate one, and for children on the autistic spectrum who need to learn that what is outside of their skin boundary is not part of them it is even more fragile and difficult Tustin (1992). In Paul's case we can observe how he used the violin as a means for exploring the immediate playful environment outside of himself. The violin (and later the rainstick) was also used as a vehicle for indirect communication with another person without the overwhelming and potentially too arousing experience of direct communication. It seemed that the violin could appear both part of Paul and part of the outside world, a transitional object in a Winnicottian sense (Winnicott, 1974). As in Winnicott's explorations of a child's use of a special blanket or teddy bear, the violin existed in this transitional space between subjective and objective worlds. It also involved the subjective play of another. As observed in a child's play the transitional object is invested in all manner of feelings as in the way Paul explored a range of different creative ways of exploring the use of the bow, the strings and the violin itself.

As a means of drawing together the links being developed between creativity, development of self and attunement the psychoanalyst Kenneth Wright writes:

> Attunement is a key concept in understanding creativity for several reasons: first, it enlarges our conception of what it means to get something back in a transformed and enlivening way; second, it clearly reveals the structure of such an interaction; third, it offers a glimpse of how such an interaction might strengthen the foundations of the self and enhance the sense of personal vitality; and fourth, it offers a model for later kinds of interaction with a similar function, not least the process of artistic creation. (2009, p. 68)

9.2.3 The development of social processes and a group's sense of cohesion

The context for the final example is a centre for cancer care where people living with cancer attend a one-off music therapy group as part of a residential programme of therapies and consultations. The session occurs at the midpoint of the week's programme. To protect anonymity the following description is an amalgamation of material from different weeks.

A group of eight adults assemble for their 90-minute music therapy session. The music therapist begins by inviting each member to choose an instrument as a form of introduction. Group members play their chosen instrument and describe verbally any associations with the sounds. These might be connections with aspects of the natural world or to specific memories of people and places. Some share how they are feeling; others feel comfortable just playing; one would prefer it if the group could all play together. The therapist begins to play a gentle heartbeat pulse on a drum as a means of introducing some sense of structured support and gradually the members of the group create overlapping improvised musical patterns. One member wishes to play faster and changes the tempo and there are further variations in tempo and loudness as other members of the group initiate changes. There is a palpable increase in energy in the room and a move from individual exploration of chosen instruments to more listening and responding to each other. After this first improvisation one or two members comment that they felt their individual sounds were drowned out. The therapist invites them to play to each other and for other members to join the mood created by these interactive exchanges. A gradual sense of playing as a group emerges. More words are shared to describe the feelings evoked by this second group improvisation. Connections are made to the rapidly changing feelings of living with cancer and the metaphor of the journey of a river in all its different moods is suggested as a way of articulating and releasing some of these feelings. Each group member selects a range of instruments to represent the various stages of the river's journey. The music starts tentatively and quietly, gathers momentum, moves to a loud and chaotic climax before evening out with long flowing melodies and a resultant feeling of expansion and calm. Spontaneous verbal comments occur, making connections between the music and the diverse feelings: sadness, fear, confusion, frustration, anger and an ongoing search for acceptance and peace. The therapist suggests some listening as a way to close the session. After checking out individual musical preferences the slow movement of Bach's *Concerto for two violins* is proposed, music that has both a sense of predictability and echoes of the quiet undulations at the end of the river improvisation. The group members are invited to recline in their comfortable chairs, close their eyes, take some deep relaxing breaths, focus on the quiet and expansive feelings that accompanied the end of the previous improvisation and begin to listen to the music. After a final round of comments relating to the feelings and associations evoked by the music and whole session it is time to end.

Supporting theory now shifts from one-to-one to a group-based perspective. Irvin Yalom, a leading group psychotherapist, has identified several core 'therapeutic factors' in group work (Yalom & Leszcz, 2005). These can be viewed in microcosm

in this amalgamated example, even though it was a one-off group. The factors include:

- 'instillation of hope': demonstrated once the group members felt sufficiently comfortable to touch the instruments and confident in the knowledge that there was no right or wrong way of playing, facilitating creative and playful exploration that could be potentially beneficial to all;
- 'universality': demonstrated by the way that sharing of problems and making music together, including joint negotiation of discovery of the creative potential of the various instruments, contributed to bringing a sense of unity to the group;
- 'altruism': demonstrated by the sense of care and concern shown by the members of the group for each other, playing for each other and agreeing on a common metaphor for the final improvisation;
- 'development of socializing techniques', 'imitative behaviour', 'interpersonal learning': all demonstrated through the non-verbal nature of transaction via the musical structures through group members exploring novel ways of playing, of interacting and of learning from each other and from the very experience of creating music together;
- 'group cohesiveness': demonstrated by instantaneous music-making, by the group listening experience and the sustained silences that brought people together after both improvising and listening;
- 'catharsis': demonstrated by the venting of a wide range of feelings, both difficult and positive ones, particularly during the final theme-based improvisation, the group members feeling able to risk such explorations within the safety provided by the therapist, other members of the group and the whole setting (developed from Bunt, 1994, pp. 26-29; Yalom & Leszcz, 2005, pp. 1-2).

Bruscia's elaborations on the changes and growth from 'intrapersonal' and 'intramusical' perspectives (the individual explorations of the instruments at the start of this example) to more 'interpersonal' and 'intermusical' ones (playing to and for each other and the group improvisations) (1998, pp. 127-128) are further contributions in understanding how creative and social processes are framed in group music therapy. The responses during this example indicate the different 'connections' people make between emotions and music (Juslin & Sloboda, 2001, pp. 91-96; Juslin & Sloboda, 2010). There were the individual 'associative connections' between the sounds of particular instruments either while improvising or listening, 'iconic connections' when musical elements were linked to an external event as in the 'river' improvisation and 'intrinsic connections' when links were made (both while improvising and listening) between the group members' emotions 'and both surface and deep structural aspects of the music' (Bunt & Pavlicevic, 2001, p. 185).

Within the contained boundaries of time and space in this session the members of this group therefore created something new, ideas emerging within a socially interactive process, 'both as a means to connect with others and to share expressively significant ideas' (Young, 2005, p. 291).

The creative nature of music, in particular improvisation, is central to all three case examples. Aspects of Malloch and Trevarthen's 'communicative musicality' and emerging individual and group musical and creative identity are fundamental to all three. Each example can be underpinned by different theoretical perspectives linking with developmental, psychological, psychotherapeutic or social processes. At the heart of all three examples are emotional connections to music made by the children and adults, facilitated by the attendant yet musically active music therapist.

9.3 Socio-cultural context

These three case examples were embedded in different socio-cultural contexts. Examining the development of music therapy as a profession can be viewed as a case study in itself; the evolution of the profession has adapted to shifting social and cultural contexts. At root, music's connection to healing and medical practices has been observed since time immemorial. Historically the use of music as a healing force has been described within the magical, mythological, religious, philosophical and scientific frameworks of different periods (Bunt, 1994; Gouk, 2000; Horden, 2000; Wigram et al., 2002). But it was not until the middle of the twentieth century, while addressing the rehabilitation needs of returning US veterans from the Second World War, that the profession of music therapy began to take shape. In order to move beyond the general assumptions that listening to live music could be beneficial for patients, challenges were made to musicians to undertake further training and to justify perceived outcomes across a range of physical, emotional, cognitive and social parameters. Training and professional associations become established, firstly in the United States. In the UK the first training course was established in 1968, the professional association in 1976 and the first governmental career and grading structure in 1982 (Bunt, 1994; Darnley-Smith & Patey, 2003).

Traditionally music therapy has been practised in contexts where major disorders in communication can be found. Music therapy began to develop an early presence within large institutions for adults with learning difficulties and mental health issues and in special schools for children with wide-ranging learning difficulties and behavioural problems. In 2006 a survey of music therapists carried out by the UK-based charity MusicSpace Trust (with funding from the government's Department of Health) indicated that these were still the major areas of practice (MusicSpace Trust, 2007). The areas that ranked highest in percentage of total hours of work with adults and children per week were learning difficulties, autistic spectrum disorders, mental health issues and emotional and

behavioural difficulties. There were indications of more work developing in the areas of neurology, cancer and palliative care and preventative work in mainstream schools. Preventative and crisis intervention work in mainstream schools was also noted in another survey of therapists employed by MusicSpace, alongside work with children with attention deficit hyperactivity disorder (Bunt, 2006).

Such developments in practice have occurred alongside underpinning by theories drawn from medical, behavioural, psychotherapeutic and humanistic approaches (Ruud, 1980). Recent challenges have emerged to situate music therapy outside of the boundaried private space of hospital ward or specialist unit in more community-based social contexts (Stige & Aarø, 2011). There were aspects of this pattern observed in the three examples above.

Some of the original pioneers of music therapy were deeply committed to this more community-based aspect of music therapy, which is currently being re-assessed with the creative approaches that form Community Music Therapy, reframing music therapy within 'musical community' (Pavlicevic & Ansdell, 2004). Connections have been made with so-called 'new musicology', particularly Christopher Small's formulation of 'musicking', a creative act where all manner of relationships are set up between sounds and people (Ansdell, 2004; Small, 1998). Further links have been made with sociologist Tia de Nora's explorations of how the creative resources within music can be used by individuals in everyday life (De Nora, 2000). Her work mirrors increasing shifts within music therapy practice to explore how a whole range of music from different cultures can be used not only 'in the service of human communication' but also 'in the service of human collaboration' as a means to build communities (Pavlicevic & Ansdell, 2009, p. 362).

9.4 Some key research findings

By returning to the three case examples central to this chapter some patterns in the development of music therapy research can be highlighted, mirroring some of the shifts in the social and cultural context explored in the previous section. A strong physiological and developmental research base has already been noted in the combined music therapy and physiotherapy approach with Baby A. Exploring how listening to different kinds of stimulating and relaxing music influenced changes in such areas as respiration, heart rate, electrical resistance of the skin and muscle tone contributed greatly to the early acceptance of music therapy, particularly in the United States (Bunt, 1994; Ruud, 1980; Wigram et al., 2002). Meta-analyses and reviews of the use of music in medical and dental contexts have been carried out and the emergence of a whole body of research on the cognitive neuroscience of music has begun to inform music therapy practice (Peretz & Zatorre, 2003; Standley, 1995). For example, Michael Thaut has made major contributions in the understanding of the relationship between neural processing and the timing of a range of motor functions. His research has demonstrated how music therapy can

be used effectively not only with children but also to assist the rehabilitation of adult patients who have gait disorders resulting from Parkinson's disease, stroke, traumatic brain injury or the effects of ageing. 'Rhythmic Auditory Stimulation' has helped in the recovery of more stable walking patterns for these groups of patients (Thaut, 2005). The popular writings of the neurologist Oliver Sacks (2007) have done much to bring these positive contributions into public consciousness.

The requirement to indicate the impact of the work and for the focus to be on measurable outcomes has increasingly become a feature of music therapy research, especially so given the current external pressures of evidence-based practice (Edwards, 2002, 2005; Pavlicevic et al., 2009). Some of the author's early research began to address issues of outcome in a series of interrelated studies with young children with learning difficulties. Time-based measures and video analysis were used to compare periods of individual music therapy with no music therapy and the further control of play sessions with a well-known adult. Significant results were found in the development of vocal sounds and turn-taking. There were also positive increases in the amount of looking towards the adult, the 'child's imitative skills and ability to initiate an activity' (Bunt, 2003, p. 187).

Music therapy for children on the autistic spectrum has continued to be an important focus both in practice (as in the example of Paul) and in research. One systematic review of studies in this area has been accepted by the Cochrane Collaboration, a database established to collate evidence from randomized controlled trials (RCTs). The review is based on three studies on music therapy for autistic spectrum disorder where daily music therapy for one week indicated that music therapy might improve these children's communication skills (Gold et al., 2006). The review called for more research and recently Jinah Kim carried out a small scale RCT, finding 'significant evidence supporting the value of music therapy in promoting social, emotional and motivational development in children with autism' (Kim et al., 2009, p. 389).

Within music therapy there is also a developing tradition of qualitative research, mixed-methods and more arts-based approaches (Wheeler, 2005). In relation to our third case example a series of interrelated studies began to address the question of how engagement with the group music therapy session may be beneficial for people living with cancer. The first stage involved a counsellor who explored the constructs emerging from individual responses to the question 'Music and Us?' posed before and after the music therapy session. This was carried out across six groups, similar to the case example. A main finding was the shift from pre-session words describing the individual effects of music, for example 'relaxing', 'energising', to post-session words describing the effect of taking part in the group, for example 'group togetherness' and 'communication' (Bunt & Marston-Wyld, 1995, p. 48). There were also comments relating to temporarily transcending pain while engaged in the music.

The second stage used a mixed-methods approach to explore questions relating to experiences in both improvisation and listening sessions. Results arose from both physiological and psychological data, alongside quotes relating to the actual

experience of the participants. Physiological data from a limited sample of nine participants included increases in salivary immunoglobulin A (a possible indicator of immunity) after one listening session. Standardized psychological tests indicated a decrease in tension and energy after the listening and a corresponding increase in energy and sense of well-being after improvisation sessions for 29 participants (Burns et al., 2001).

The third stage was grounded in a qualitative approach and involved 23 lengthy telephone interviews carried out by research colleagues after the group sessions. This stage included positive results, but 'framed by personal biographies…situated within socially constructed notions of aesthetics' and cultural and musical identity (Daykin et al., 2007, p. 349). For example, a sense of creativity was found to be important but 'choice and enrichment' were contrasted with how interviewees related the 'limitation and disempowerment' connected with their cancer diagnosis (Daykin et al., 2007, p. 364). There was much discussion as to whether music was both 'good' and 'meaningful', often with comparisons being made to different styles of music. Links were made with personal biographies and the notion of 'being musical' or not. Concepts of 'talent' and personal biography came together at times with the session being a place where such notions could be explored. For example, the theme of 'latent creativity' was quite common, with some participants keen to re-introduce music into their lives. For these participants music was able to foster a sense of 'hope', transcendence and looking-forward, with effects noted after the session. However, contrastingly, for some the experience evoked feelings of 'regret and loss', particularly relating to earlier musical experiences or unhappy musical memories. Such results emphasized the sensitivity and care needed to be shown by the music therapist facilitating such a group experience (for further elaboration of the themes, see Daykin et al., 2007).

9.5 Implications for policy and practice

The profession of music therapy can be proud of its achievements in just over half a century. In the UK a major development occurred in 1997 when the profession worked with art and drama therapy to become registered as creative therapies within the Health Professions Council, moving towards further standardization and regulation of practice and protecting legally both the public and standards of proficiency and practice (Bunt & Hoskyns, 2002).

Coupled with this regulatory move have been continuing calls for justification, cost-effectiveness and demonstration of clinical impact and outcome. In spite of being a relatively small profession music therapists have embraced these challenges with quite a substantial number of published RCTs, systematic reviews and meta-analyses. A recent breakthrough for people living in England and Wales is that music therapy is now included with the other registered arts therapies in the National Institute for Health and Clinical Excellence (NICE) guidelines to be

considered for 'all people with schizophrenia, particularly for the alleviation of negative symptoms' (NICE, 2009, 1.3.4.3, p. 21).

Jane Edwards (2005) has pointed out that both music therapy trainees and professional practitioners need to have working knowledge of studies that underpin different areas of practice and to be aware of the pros and cons of different kinds of evaluation and research procedures. But there are problems if future policy decisions require dogged allegiance to the RCT and clinical trial. The nature of a small profession presents difficulties in recruiting large enough samples and adequate resources. Individual responses to music, the personal styles of different therapists, the wide-ranging variations within the populations with which music therapists work and the constraints of intervention protocols are all issues to surmount. Edwards also cautions about keeping the research 'relevant to the real-world context in which music therapy is practised' (2005, p. 296 and see also Edwards, 2002).

There are other ways of indicating evidence. This was echoed by Professor Sir Michael Rawlins (2008), the Chairman of NICE, who has argued for a wider range of approaches to analyse evidence and that alongside RCTs decisions could be made, for example, from well-run observational studies in relation to the benefits and potential risks involved with any therapeutic intervention. And music therapists may not be the most appropriately trained people to carry out this kind of research. There are other colleagues who have a whole range of appropriate research skills with whom it is both challenging and rewarding to collaborate to aid development of policy.

The case examples in this chapter have charted some of the current range of music therapy practice. Exploring the continuum of the private boundaried therapy space to more community-based and less boundaried contexts has implications for further dialogue and collaborative research with, among others, sociologists, musicologists, social psychologists and anthropologists (Pavlicevic & Ansdell, 2009). It has been argued that there is a potential danger of the profession's isolation if music therapy continues to concentrate on medical, biological and psychological models of care and practice without addressing the wider social, political, organizational, musical and cultural processes within which the work is embedded (Procter, 2004).

We need to continue to tell the creative stories of the people with whom we work and our own stories as musicians working in these different contexts, drawing from alternative notions of cultural, musical and social capital. We need to keep the stories and the vibrant relationships alive in our practices and to celebrate the synthesis of form and structure and freedom and expression in the work. We can leave the final word to one of the UK's pioneers of music therapy, Juliette Alvin, who in her last television interview (BBC, 1983) considered that the development of music therapy would very much depend on the development of music, which, after all, she noted, connects us to whom we are as human beings.

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