Thoughts on Music **Therapy**

Ruth Bright, AM, D.Mus, Registered Music Therapist,
Adjunct Lecturer, School of Health, University of New England

Introduction

Music reaches our emotions, by-passing verbal expression. Although (as I shall discuss later) there are cultural differences in the music we understand and enjoy, we find that - within any given culture - music reaches virtually every person, in one way or another.

As you may know, I composed incidental music for this conference, to be played between sessions, but - although composition of music is a music therapy skill - background music is not normally part of professional music therapy.

Background music does help to create a mood - the music in suspense movies is carefully planned to create an atmosphere of tension or foreboding.

But in therapy, background music would rarely be used. We do sometimes put on a record for a few minutes to create a particular mood, but we view with dismay the practice, found in many nursing homes, of having music played the entire time - partly because it soon becomes meaningless and (even worse) because the music is often selected by young members of staff for their own entertainment rather than because it is appropriate for the residents.

I certainly hope that the music I wrote for this conference is seen as appropriate:
☒ some items symbolise challenge and determination,

☒ others are intended to represent thoughtfulness

☒ and one is supposed to make you smile - written for the session with the person often called the Clown Doctor!

But for this paper I am focusing upon the normal tasks of professional music therapists, the skills they offer to your clients.

Many people unfortunately equate music therapy with a group sing-along, organised by someone who has limited skills in music, when everyone is supposed to be 'jolly'.

I hope to demonstrate that real music therapy is far more than that!

In Australia, music therapy is taught as a four-year Bachelor's degree course at the Universities of Melbourne and Queensland, with subsequent graduate study for Master's and PhD available. In Sydney it is available as a post-graduate qualification at UTS and UWS. All courses give eligibility to apply for accreditation, but Registration depends on additional factors, such as satisfactory clinical placements with a variety of populations.

Study includes:
✓ music skills appropriate to therapy (improvisation, song-writing, extensive repertoire, etc)
✓ knowledge of the various clinical conditions found in hospitals, rehabilitation units, nursing homes, special schools or in the community.
✓ methods of assessment and on-going evaluation.
✓ understanding the physical, mental, emotional and social challenges faced by clients, and the implications of these for music therapy.

So what does a music therapist do in support of people who are living with dementia?

Much depends on the age, culture, the extent of deterioration of the client, and the type of dementia involved. The therapist needs to know whether he or she is seeing:

- Alzheimer's disease, at an early, a moderate or an advanced level,
- Lewy Body dementia with hallucinations and delusional beliefs
- Fronto-temporal dementia - with or without personality changes
- Vascular dementia, resulting from a series of strokes
- Dementia arising from alcohol-related brain damage
- (usually in a younger person) The long-term brain impairment due to motor vehicle accident or other trauma
- The dementia of HIV-AIDS [Portegies 1994]
- Dementia resulting from anoxia,
- Dementia caused by a long period of hypoglycaemia,
- Dementia as found in some cases of Multiple Sclerosis, Parkinson's disease,
- And so on.

As you will already know, there are features that are common to all of these, of which memory loss is the most obvious, but clients are not all the same clinically - and, even more importantly - their individual personalities vary widely.

Beats [1996] has described the continuum of depression and dementia and, in some units, the music therapist will be involved in assessment, possibly also in differential diagnosis - helping to decide whether the client is depressed, dementing or faces both these simultaneously.

Whether we are working alone or with another health professional, we strive to create a therapeutic alliance [Bachelor 1991], helping both client and relative to cope with what is happening.

Although we take account of the physical effects of illness and disability, it is the personality and the culture of the individual client that form an important basis for music therapy interventions for any clinical problem.

N.B. By 'culture' I do not mean simply the language spoken and the country of origin, but also the client's educational level, social background, spiritual beliefs and practices, and - of great importance when we work with the family as well - the attitude of the culture to illness, especially attitudes towards dementia.

Is dementia - as is common in some cultures - seen as insanity? (and thus - perhaps - an indication of moral failure?) Is it seen as hereditary? Shameful? Possibly contagious, infectious? Or is it seen as brain deterioration of physical origin, for which nobody is to blame?

(Although cultural differences are important in gerontology, they also affect attitudes towards the birth of an abnormal or stillborn child, towards mental illness, and other tragic situations.)

So far I have spoken only of the background <u>knowledge</u> which Music Therapists require, and clearly we do not learn everything during a course of study - we learn the basics - and continue to learn 'on the job' - *for ever, as far as I am concerned!* (Once we stop learning, it is time we gave up!)

But what practical skills do we need for work in dementia?

We know today that there are three components of memory - declarative, procedural and familiarity [Squire 1992, Squire & McKee 1993]. In dementia, impairment of memory is on-going.

- Declarative memory gradually declines, so that few clients can ask for a specific song or give the name of a piece which is played. (But procedural memory and familiarity are initially unchanged.)
- Later, procedural memory is impaired and clients can, for example, no longer feed themselves or play musical instruments.
- Finally only familiarity is left, and - uniquely - enjoyment of music remains.

1. We need therefore a wide repertoire of music to be played from memory, from as many countries as are appropriate to the people with whom we work. (We cannot know every piece in the world, but must have many pieces 'by heart' - and know how to find others! Families sometimes tell us about the client's favourite music, but often we have to guess, from the client's age and culture.)

2. Our repertoire covers all types of music. Although there is a universal interest in music, MUSIC IS NOT A UNIVERSAL LANGUAGE! In choice of music for any individual, there are strong preferences: * some people prefer classical music,
* others prefer church music *
some people care only for the latest "hits", *
some yearn for the music of their homeland But, whatever aspect of music we consider, it is important to realise that in general, we can only understand the 'meaning' of music from the culture with which we are familiar, and my research provided clear evidence of this. [Bright 1993] Hence the therapist's need for a wide repertoire, as well as an empathic attitude towards client preference.

3. The ability to play a portable instrument (a skill required for Registration) is essential, especially for people who are in an advanced stage of dementia, who cannot participate in groupwork, and we need to sit with each one in turn, at chairside, bedside or under a tree. .

Many music therapists, especially in USA, play guitars but I, and many other Australians, use an accordion, which has a long history in Australia and arouses instant responses from many older people. It has the advantage that one is close to the clients, who can reach out to feel the vibrations if hearing is impaired, and even play a few notes if they wish.

4. But practical skills are only the beginning: we need empathic awareness of feelings of sadness or anger below the surface, in clients and their relatives. [Bright 1996, 2002]

5. We then need advanced counselling skills to help them to deal with those difficult feelings. The possibilities are endless:
* We may see an adult child who has had a difficult life-long relationship with an abusive parent, and who now has difficulty coping with the assumption by staff t hat there has always been a loving link between them.
* We may see a highly dependent adult child who is having grave difficulty in coping with the parent's deterioration, and is angry with staff for not being able to 'fix it'. * We may see the loving spouse of a client who finds visiting distressing and who needs the reassurance which music provides that there is something still remaining of the one they love.
* Alternatively, we may see the spouse clearly having difficulty in visiting because the marriage has NOT been happy!

6. Counselling in such situations will vary in depth and in the place in which we talk - sometimes a few comments at the bedside/chairside may serve to give the visitor permission to visit less often, permission to feel privately angry with the client for having been ' difficult'

or permission to express feelings of helplessness and fear at the loss of the person on whom they have depended for so long. But usually private conversation is essential for the visitor to reveal feelings that are perceived as discreditable.

7. Teamwork is important. Because music may elicit responses which are seen in no other interaction, colleagues must know what has happened, and perhaps become more hopeful about the communication that is possible with clients who are otherwise unresponsive. So face-to-face discussion is useful, informally or at case reviews, as is the ability to write notes which will give the essence of interactions and outcomes.

To sum up: Music Therapy has much to offer in all stages of dementia, those who are drawn to the profession are those who are interested in people, and the university training fits them to work effectively and co-operatively in all kinds of facilities for people of all ages - but many of us have special interests in aged care.

(The work can be distressing, and the provision of professional supervision is important.)

But our work is worthwhile!

REFERENCES

Bachelor A. (1991) Comparison and relationships to outcome of diverse dimensions of the helping alliance as seen by therapist and client. *Psychotherapy* **28(4)**, pp.534-549

Beats, B. (1996) Biological origin of depression in later life. *International Journal of Geriatric Psychiatry*, **11**, 349 = 354.

Bright, R. (1993) *Cultural influence in music therapy* (in) N. Heal & T. Wigram (editors) Music Therapy in Health and Education. London, Jessica Kingsley.

Bright R. (1996) Grief and Powerlessness. London, Jessica Kingsley. (P 6 + other references)

Bright R. (2002) *Supportive Eclectic Music Therapy for Loss and Grief.* St Louis, MMB. Chap:8+ other refs.

Portegies P (1994) AIDS Dementia Complex review. *Journal of Acquired Immune Deficiency Syndrome,* **7 (Supplement 2)** Pp 38 - 49

Squire, L.R. (1992) Memory and the Hippocampus. A synthesis from findings with rats, monkeys and humans. *Psychological Review* **99**, 195-231

Squire, L.R and McKee, R.D. (1993) On the development of declarative memory. *Journal of Experimental Psychology, Learning, Memory and Cognition* **19(2)** 397-404